Report of

The Commission on the Future of State Psychiatric Hospitals

To

Governor William Donald Schaefer

President of The Senate - Thomas V. Mike Miller, Jr.

and

Speaker of the House of Delegates - R. Clayton Mitchell, Jr.

October, 1987

James W. Howe, Chairman

2-3-10-49

881875

Report of

The Commission on the Future of State Psychiatric Hospitals

To

Governor William Donald Schaefer

President of The Senate - Thomas V. Mike Miller, Jr.

and

Speaker of the House of Delegates - R. Clayton Mitchell, Jr.

October, 1987

James W. Howe, Chairman

Foreward and Acknowledgements

The 1986 Session of the Maryland General Assembly by resolution called upon the Governor to establish a special commission to study and make recommendations on the future of State psychiatric hospitals in Maryland. These facilities were to be looked at in the context of a community-based system of care for Maryland's citizens who are mentally ill. Mental illness is far more widespread than is generally perceived. National data suggest that about 1% of the population will be striken by schizophrenia, and about 1% by manic-depression, the two common forms of mental illness that can be most disabling for long periods. Applied to Maryland this would mean that about 80,000 citizens are afflicted or nearly as many as the combined populations of Queen Anne's, Caroline, Somerset, and Kent Counties! Clearly, mental illness is a major health problem, one deserving a major focus by the Government of Maryland.

This Commission was established in November, 1986, and began work in early December. This report is the product of much hard work by the Commission members (see Appendix III), each of whom cheerfully performed extensive research and writing tasks, as well as by those who served at the request of the Chairman as informal members. In addition, the Commission is grateful to the scores of witnesses who gave invaluable advice and testimony to the Mental Hygiene Administration, the source of much data, and to those who prepared the Goldman Report and the Abt staffing study. Finally, the Commission acknowledges the competent services given the Commission by Kathy Gioffre, Charles Stevenson, and Mary Naramore of DBFP and Linda Stahr of the Department of Fiscal Services.

James W. Howe, Chairman
September, 1987

Table of Contents

Table of Contents
(cont'd)

Appendices

Chapter One

The Problems and Recommended Solutions

I. The Present State-Operated Hospital System is Plagued With Problems

After meeting 19 times including meetings with the management of four hospitals, and hearing 75 hours of testimony from professionals, patients, families, employees, representatives of the private care-giving sector, scholars, government officials and out-of-state experts, numbering in total more than 100 witnesses, it became apparent to the Commission that Maryland's present system for the care of its citizens with mental illness is beset with problems. Chief among these problems are the following:

1. During FY 1988, the Mental Hygiene Administration (MHA) will spend $255 million on its citizens with mental illness who use publicly funded mental health services. Of this amount, $157 million or 62% is spent on care in the State hospitals for only about 25% of those with mental illness, leaving only 38% available for care in the community of the remaining 75% of mentally ill people. One serious consequence is that thousands of mentally ill citizens survive in jails, prisons, streets, in inadequate or inappropriate housing, or with aging parents without the services that could help them achieve their potential and prevent them from rotating in and out of hospitals. This imbalance needs to be corrected.

2. Yet, even in the hospitals there are not enough resources. Nurses and psychiatrists are in short supply. Maryland is no longer competitive in recruiting psychiatrists because of salaries that are low in relation to salaries paid in other jurisdictions. Two facilities (Springfield and Spring Grove) do not have accreditation by the Joint Commission on the Accreditation of Hospitals (JCAH) and one has lost and one is in danger of losing Health Care Finance Administration (HCFA) certification. These deficiencies will cause Maryland to lose Federal revenues. To bring staff levels up to where they should be would cost at least $35 million each year more than the present budget, unless, of course, we can reduce the number of patients in State hospitals.

3. Giant capital outlays will be needed. Buildings are old and need to be replaced. Asbestos contamination presents a major health hazard in some. The total (one-time) capital bill facing Maryland amounts to between $35.6 and $52.2 million.

4. Governmental red tape is a major burden to good management of State hospitals and other State facilities such as the Regional Institutes for Children and Adolescents (RICA) and government operated Community Mental Health Centers (CMHCs). Managers of these facilities must spend much of their time justifying and getting prior approval for even the most routine decisions such as what to purchase, small shifts of money between budget items, whom to hire, what to pay, and firing or reassigning people. Many of these decisions may take days, weeks or months before action can be taken. There is little possibility and not much incentive for good management. Requirements by governmental authorities for written reports are so burdensome that, when combined with staff shortages, they leave little time for staff to spend with patients.

5. Turf battles are constant. Every night across the State, acutely ill persons wait for hours in the emergency rooms of public and private hospitals while staff sort out whether the patient belongs in a State or private facility. If the patient is awaiting admission in a State hospital but it is learned that he/she has insurance or other means of covering costs, the patient is referred to a private hospital. If the nearest one is full, the State staff must make the patient wait until they find a private hospital with an empty bed. Then, sometime later, just as the patient is getting accustomed to the tensions of a new place, his/her insurance may expire and, after hours of negotiation among staffs, back she/he goes to the State hospital. This is not a therapeutic procedure. It is also true that a patient waiting in the emergency room of a private hospital, but without a means of paying for care, will be referred to a State facility. If that facility has no beds, it must improvise. These jurisdictional problems add immeasurably to the pain of the patient and family and are a major consumer of staff time.

6. Liaison between the State hospital and the community facility to which he/she will be discharged is fragile because of the physical and bureaucratic distance between the two. Staff from the receiving community facility may find it hard to visit the patient who is to be discharged, and hospital staff may find it difficult to make arrangements for the patient to visit his/her future home. Even more of a problem, one hears of miscommunications where hospital authorities say the bottleneck to discharging a patient is lack of a space in the community, and community rehabilitation staff claim that the problem is that the patient is not yet clinically ready for discharge. The result is to add stress to that already inherent in a change of homes.

7. Because of Federal rules, Federal support to which a mentally ill person is entitled (i.e., SSI, SSDI and Medicaid) is lost whenever a person who is over 22 and under 65 enters a State hospital. This threatens the client's home because there is no means to pay for his/her rent. These entitlements would not be lost if that person were admitted to the psychiatric ward of a general hospital.

8. Maryland has not yet developed a comprehensive, coordinated system of services for children and adolescents with mental illnesses and emotional handicaps. State hospital child and adolescent units are seriously overcrowded, yet there is a shortage of community-based inpatient, outpatient and residential services that could relieve the pressure on State facilities and provide more appropriate service to children who are currently sent out of state or to juvenile service facilities in-state. Finding acute care beds is a continuing problem, particularly for children aged 12 and under. There are no residential treatment beds for adolescents on the Eastern Shore. Simply put, we are not meeting the mental health service needs of our children.

One way to resolve these problems would be to examine the detailed reasons for each problem and to undertake to unravel the complexities of changing laws or rules, of battling for resources, of refining procedures, of assaulting entrenched bureaucracies and - perhaps quixotically - of attempting to change Federal entitlement procedures. These are undertakings that would daunt the most hardy souls. The prospects for achieving our goals through this method are not bright. A more promising approach is discussed in the next section.

II. Moving Toward More Reliance on the Private Sector May Resolve Many Problems

Another approach would be to move toward having care provided by the private sector. This could circumvent many of the problems discussed above:

1. Moving elderly and chronic patients from State hospitals to community facilities would do much to correct the present imbalance where so much of Maryland's budget is spent giving inpatient care to such a small fraction of those needing care.

2. Reducing the number of patients in State facilities would permit staff levels to be brought up to Federal standards without adding $35 million to the State hospital budget. Private general hospitals are already accredited and certified. Private hospitals generally have more flexibility in recruiting and retaining staff with specialty skills than public hospitals.

3. Reducing State hospital census could reduce the need for capital outlays for State buildings. Because of the relatively small impact on any one facility in the private sector, it is unlikely that much additional construction would be needed for that sector or, if it is, that much public money would be required.

4. The oppressive weight of governmental rules and procedures would be minimized. Better management should be possible.

5. If all or most acute care were provided by private hospitals there would be little or no need to spend time sorting out which patients are eligible for public and which for private care. There would still be delays when a receiving hospital lacked bed capacity and had to call around to find space in another. However, patients would not be shifted from private to public or vice versa because of changes in their eligibility status.

6. The distance between hospital and community-based care and rehabilitation facilities would be shortened. In some cases the distance would be short, indeed, because the community-based facilities are linked to the community hospital.

7. Federal entitlement benefits (SSI and Medicaid) would continue for persons placed in the psychiatric wards of general hospitals. It is estimated that these benefits would amount to about $30 million per year if all acute care were provided in such facilities. Because SSI/SSDI would continue, and because of the closer link between hospital and community care, the patient's home would not be threatened when he/she enters the hospital.

8. Greater use of private accredited hospital and community facilities for children and adolescents could reduce Maryland's neglect of this underserved population by funding expanded services with increased Federal Medicaid revenues.

III. But We Should Not Burn Our Bridges Behind Us

The Commission believes that Maryland should move toward far greater reliance on the private sector to care for its mentally ill citizens. Perhaps one day virtually all care can be privatized. In that case, Maryland's state hospital system could be radically reduced. As of this moment, we cannot be sure how far the private sector can or will be able to go toward providing such care; nor do we know yet what it will cost and how good the quality of care will be. And the experience in other states with privatizing care, although encouraging, is far too limited to serve as a guide.

Given these facts, the overwhelming weight of testimony given to the Commission was to make sure we know whether the proposed new system will work before we close down the present one. Foremost in everybody's mind was the colossal error America made in pushing mentally ill people out of State hospitals in the past two decades into the "loving arms of the community" (to quote the more lyrical partisans of deinstitutionalization) before making sure that there was a place in the community to care for those people. The result was an increase in the number of mentally ill people in the streets, jails and prisons, and in inadequate or inappopriate housing, about as large as the reduction in the number of patients in State hospitals. That is not a mistake anybody wants to see repeated.

Thus, the Commission's recommendations that follow would press ahead with a pilot effort of privatizing care for the next four years and then would review the results of that pilot effort before deciding whether to close or further reduce public facilities. Meanwhile, certain limited facilities could be turned over to the private sector to operate.

Is this approach too timid? We do not believe so because our recommended pace of privatization would be as brisk as an orderly process would permit, even if Maryland were to irrevocably commit itself at this time to full privatization.

Would this cautious approach cost more because of the need to maintain the present hospitals while developing the private, more community-based system? The costs should not be greater than those of the present system

because, just to keep from going downhill, the present system will require an additional $35 million a year in staff costs and that much or more in one-time capital costs. While moving toward privatization will not permit an early reduction in staff costs, it will avoid these large cost increases because the expected reductions in hospital patient census over the next four years will permit the ratio of staff to patients to move toward the needed level without increasing staff. Similarly, that decline in patient census will permit the closing of the most marginal buildings, thus avoiding large capital outlays for construction or renovation. Thus, our recommendations should only cost marginally more, and might cost less, than continuing the present system over the next four years. In subsequent years cost trends should be even more favorable.

IV. Specific Recommendations

The recommendations below deal separately with four populations of mentally ill persons:

- Children and Adolescents.
- Elderly Psychiatric Persons.
- Adults with Chronic Mental Illness.
- Adults with Acute Mental Illness.

A. Children and Adolescents

1. There is a grave shortage of care facilities of all kinds, such as hospital beds (especially for children under 12), residential treatment beds - especially on the Eastern Shore - specialized foster care, clinical outpatient services including staff to provide treatment for young people where they live and go to school, therapeutic group homes, educational services, and support for families.

Evidence of this serious shortage includes the following:

a. Approximately 450 handicapped children, many of whom are emotionally disturbed or mentally ill, are now placed in other states at Maryland's expense.

b. There are waiting lists at many community mental health centers and private providers.

c. There is a scarcity of day-treatment programs of any kind and a complete absence of such programs on the Eastern Shore.

d. The MHA estimates that at least 50 foster care spaces are needed.

e. MHA identified 209 children and adolescents who needed placement in therapeutic group homes.

f. There are no residential treatment beds on the Eastern Shore.

g. Demand for space at the Regional Institutes for Children and Adolescents (RICAs) far exceeds supply.

h. There are virtually no inpatient or outpatient residential facilities for children under 12. Yet, it is clear that there are many children in this age group who are seriously emotionally disturbed and need such facilities.

i. A recent study on youth committed to Montrose and Hickey Schools found that at least 50 percent do not require incarceration in a juvenile services facility, but do need mental health services which are not adequately available.

j. In a suit filed against Maryland earlier this year in behalf of mentally ill children in institutions it was alleged that (among other things) "Maryland's inpatient facilities for children are in a state of crisis."

Unfortunately, such has been the neglect of this population that Maryland does not yet even have solid data on the numbers needing the several kinds of service. Maryland has in draft a Five-Year Plan for this group. That plan needs to be completed so that we can know with confidence what are the needs for service for this vulnerable group. Meanwhile, it is clear that much more needs to be done.

The Commission recommends that Maryland finalize the preparation of its plan for children and adolescents who are seriously emotionally disturbed or mentally ill and that, pending the completion of the plan, Maryland substantially increase the amount of money now being spent on this group.

In preparing its Plan, Maryland should take account of the work done at the community level through local child and adolescent task forces and should consult with these local leaders.

2. Maryland now pays for the care of approximately 450 handicapped children and adolescents in some 11 other states. Many of these children are emotionally disturbed or mentally ill. Costs are high and it is generally considered anti-therapeutic and painful for these patients to be so far from their parents.

We recommend that the public and private sectors collaborate in developing or expanding specialized private residential treatment and educational services in Maryland as well as other community-based alternatives, so that handicapped children and adolescents now served out-of-state can come home as soon as possible.

3. **The Commission recommends that as soon as alternative facilities are available, all children and adolescents now in hospitals be re-evaluated and those who do not require hospital care be moved to such alternative places.**

4. There are no State run hospital beds or residential facilities for mentally ill children under 12 and few in the private sector. **The Commission recommends that Maryland develop a full range of care and educational facilities for such children.**

5. Private hospitals now report only a 40% occupancy rate in their pediatric beds. The current State Health Resources Planning Commission (HRPC) acute psychiatric plan allows beds for this population, but not all of these beds have been applied for by private hospitals.

The Commission recommends that DHMH, HRPC and the private hospitals in Maryland explore converting some vacant general hospital pediatric beds to acute care beds to serve children under 12 who are mentally ill.

6. Currently families who cannot afford to pay for services for their children must surrender custody of those children to the State to get services.

The Commission recommends that Maryland revise its legislation, rules and procedures so that caring and competent parents can get services for their children without surrendering custody.

7. Adolescents who graduate from high school are no longer eligible for Federal assistance under PL 94-142. Hence, those who have been lucky enough to be in treatment are prematurely discharged. Many are still in their teens and are not yet ready for placement in adult facilities (assuming such are available). This leaves them and their parents in limbo without an alternative for care during that period.

The Commission recommends that Maryland's Five-Year Plan for Children and Adolescents include proposals for handling this transitional period between graduation and adulthood.

8. **The Commission recommends that Maryland's Five-Year Plan for children and adolescents include day-treatment of a variety of types, as well as after-school and summer programs for severely emotionally disturbed or mentally ill children from nursery school ages through late adolescence.**

9. **The Commission recommends that the Five-Year Plan include creation of a MAPS-like, non-profit network to offer community housing and rehabilitation for children and adolescents under contract with Mental Hygiene, as well as contracts with providers of outpatient treatment, crisis, and emergency services - be they community mental health centers or otherwise - to ensure availability of 24-hour evaluation and treatment services for children and adolescents.**

10. There are currently no State acute care beds or residential treatment beds for minors on the Eastern Shore.

The Commission recommends that as soon as possible Maryland establish a private residential treatment center for minors on the Eastern Shore.

11. **For the near future, the Mental Hygiene Administration should give priority to those children and adolescents with serious psychiatric disorders, or who are at risk of such disorders.**

B. Elderly Psychiatric Patients

Maryland is already in the process of moving mentally ill patients over 65 years old to private nursing homes. The average direct costs of care in a State hospital are $95 a day, whereas nursing home costs average about $60 per day. Most studies indicate that most geriatric patients do not need hospitalization.

Nursing home industry representatives have indicated their willingness to see privatization of this population proceed, but have expressed their desire that training be given the nursing home staff in dealing with psychiatric problems, that financial inducements be continued, and that there be easy access through the emergency rooms of general hospitals to their psychiatric wards. Chief among the concerns expressed by nursing homes is the difficulty of recruiting trained mental health professionals.

The Commission recommends:

1. **That Maryland continue moving from state hospitals to nursing homes or supportive residential alternatives all psychogeriatric patients eligible for such facilities.**

2. **That Maryland continue the process of transferring to private nursing homes about 200 patients from its nursing facility located on the hospital grounds of Spring Grove.**

3. **That Maryland include in its Five-Year Deinstitutionalization Plan (for chronic adults) a full range of supportive residential alternatives to nursing homes including Level V (intensive care) homes for the elderly.**

4. **That Maryland continue to give training to private nursing home staff in dealing with psychiatric problems. The Medicaid Administration should increase the rates currently paid for such training.**

5. That Maryland continue to give special time limited financial inducements to cooperating nursing homes. In particular, Maryland should adopt a reimbursement mechanism that provides adequate compensation for direct services by mental health professionals to persons with psychiatric illnesses in nursing homes.

6. That Maryland explore and develop models to access more Federal money for this population.

7. In many instances, behavior and emotional problems of the elderly are a reflection of an underlying physical problem. Unfortunately, because the elderly have been stereotyped as normally having such emotional behavior problems, they are often misdiagnosed and referred inappropriately by their nursing home to State psychiatric facilities. Instead, these patients should be admitted into acute general hospitals for evaluation and treatment. In addition, the acute general hospitals are frequently reluctant to admit such patients because if they come from nursing homes the nursing home will not keep the bed available for the patient upon discharge. Therefore, the hospital must seek out a new placement which is very time-consuming, expensive and extremely difficult.

The Commission recommends that the State should amend its laws to require that nursing homes maintain an open bed for any patient who is referred for acute psychiatric or physical treatment, so that the patient may return to the same nursing home. The Medicaid Administration should simultaneously develop a financing process so that the nursing homes are not penalized for keeping such a bed open.

8. That the Maryland Health Resources Planning Commission ensure that an adequate number of Certificates of Need for nursing home beds be made available to ensure that psychogeriatric patients and deinstitutionalized patients not be placed in competition with existing community patients presently on waiting lists.

C. Citizens with Chronic Mental Illness

1. In 1985 Maryland developed a Five-Year Plan which would make a place for nearly half of the backlog of chronic mentally ill persons, either in the community or in state hospitals, who needed supportive housing in the community, but for whom no such place existed. About 2,000 spaces were planned, or about 400 each year. In the first two years of the plan, only about 400 spaces have been budgeted and developed, a pace only half that called for in The Plan. Currently, there continue to be some 1,025 such persons in the hospital, and a larger number in the community, including homeless persons who need supervised housing and other supportive services in the community. The cost of care in the hospital for this kind of patient is about $112 per day compared with about $95 per day in the community for the more intensive care (Level V). Many patients could manage with lower levels of care in the community, which are less expensive.

Although the Five-Year Plan was intended to provide community placements for chronically ill persons not only in hospitals but also for those living without adequate support in the community, in fact, the pressures on the Mental Hygiene Administration to reduce hospital censuses have been such that in actual implementation of the Plan, the needs of those in the community have been neglected in favor of those in hospitals.

The Commission recommends that Maryland provide an additional 2,000 beds with associated supportive community services in the community in the next three years. This should include a number of intensive care (Level V) spaces and include adequate funds for vocational employment services. Associated supportive community services should include, among other things, case management, job training, low stress jobs or other constructive daily activities, clinical treatment, food and clothing, crisis care and recreation. Up to 1,000 of these spaces would be available to reduce the number of chronic patients in the State hospital. Theoretically this could remove essentially all of the 1,025 chronic patients now in hospitals. In practice, however, it is possible that there will remain in State hospitals perhaps 200 to 300 individuals who are too disabled to be cared for in the community. However, the goal should be to move all chronic patients to the community who can do well with an optimum community support system.

The remainder of the 2,000 community spaces would be assigned to persons now living outside hospitals (e.g., in jails or prisons, in streets and shelters or in the care of aging parents).

It is recommended that Maryland should accelerate the expansion of the case management system for chronically mentally ill citizens not currently in State or private hospitals in order to prevent hospitalization. Further, DHMH should move to access Medicaid payments for case management services for mentally ill citizens as is currently being done in several states.

Included in the 2,000 would be temporary spaces developed by contracting with private providers to give care and rehabilitation using existing or renovated buildings on hospital grounds.

2. Currently an increasing number of young adult chronic patients suffer from substance abuse as well as mental illness. Many facilities - both in hospitals and communities - refuse to accept such persons. Facilities designed for the substance abuser often refuse to accept anybody with a history of mental illness and vice versa. Similar problems exist for mentally ill persons who are retarded.

In either case, once their mental illness is treated, the remaining problem complicates the care for the patient. Addictions and mental retardation professionals have expressed the same type of stigmatic attitudes as the lay population. Thus, they resist treating the retarded or addicted individual because of a past history of mental illness.

The Commission recommends that inpatient psychiatric hospital beds not be inappropriately used by patients whose primary diagnosis is addiction or mental retardation. The Developmental Disabilities Administration should take the lead in planning community and facility placements for mentally retarded people who have secondary mental health problems. Similarly, the Commission recommends that the Addictions Administration take the lead in planning community and residential placements for patients in any of the State mental hospitals with a primary diagnosis of addiction.

Both DDA and AA should involve the Mental Hygiene Administration in the planning and delivery of services to their patients (both inpatients and outpatients) with mental health problems. All three Administrations (MHA, DDA and AA) should require training of their respective professionals so that they are capable of recognizing patients with dual diagnoses and feel comfortable in dealing with them.

D. Adults with Acute Mental Illness

1. There are now 565 acutely ill citizens in state hospitals not including 65 forensic patients. It costs about $180 per day to care for these patients in state hospitals compared with a cost of about $360 per day in private hospitals. However, this difference is offset in part by the facts that (1) the length of stay in private hospitals tends to be shorter and (2) there is a Federal payment (medicaid) for about 38% of the costs of patients in the psychiatric wards of general hospitals. Moreover there is much agreement that quality of care in private hospitals is often superior.

Currently MHA has authority to write an agreement with private hospitals to create up to 76 partially state-subsidized acute beds designed to permit the state to eliminate a like number of beds in state hospitals. There appears to be interest on the part of the private sector in participating. These beds are called "proxy beds" because they substitute for state beds.

The Commission recommends that Maryland transfer sufficient beds to private hospitals as soon as possible via the existing proxy bed mechanism in order to phase out the admission of short-stay acute patients to state hospitals. The State should treat this proxy bed approach as a pilot program through which it can learn more about the following issues:

a. Whether it is possible, and if so how, to ensure access to private hospitals for all who need it.

b. How to prevent private hospitals from deflecting hard to treat patients to a state hospital or, having admitted such patients, from discharging them prematurely or transferring them to a state hospital.

c. How to assure patients whose illness is complicated the latest and best diagnostic and treatment techniques which might be beyond the capabilities of small psychiatric units.

d. Whether the Medicare waiver is adversely affected.

e. Whether state hospital beds are reduced.

f. Whether unforeseen problems can be satisfactorily resolved.

Note that it should not be considered a failure of this pilot program if a minor fraction of the acute patients came to the end of their "short stay" without becoming clinically ready for discharge. Until recommendation 3 below is implemented, it would be expected that such patients would be transferred to State hospitals.

2. **The Commission recommends that Medicaid make the following changes to encourage and support good care of patients in the private sector.**

a. **Phase out the Medicaid limits on mental disorders.**

b. **Make substantial increases in Medicaid reimbursement for services provided by psychiatrists and other mental health professionals via the psychiatric CPT* codes. Further expansion of proxy beds should be accompanied by substantial increase of professional fees.**

3. **The Commission recommends that Maryland should explore a pilot program to shift sub-acute or "extended" acute beds (30 - 90 day length of stays) to the private hospitals. This will require new licensing, financing and regulatory incentives.**

4. **The Commission recommends that Maryland develop alternatives to acute and sub-acute hospital care, private or public, by creating crisis and respite beds in the community which may prevent many hospitalizations.**

*CPT - Current Procedure Treatment

5. **The Commission recommends that the Governor and Legislature pursue both State and Federal legislation that enables citizens who are enrolled in HMOs and self-insured health plans to be assured coverage for mental health services which equal the level of coverage provided for physical conditions.**

6. **Maryland should continually review the experience with privatization of acute care with particular attention to quality of care, access and costs. As the privatization of acute care proceeds, the State should (1) ensure that the private sector beds are in place before State beds are eliminated, and (2) be prepared to maintain or reopen State beds for acute and sub-acute care if the experiment with privatization is not successful.**

E. What Would Become of State Psychiatric Hospitals and Their Staffs?

1. **No recommendation is made for closing state hospitals at this time.** After a reasonable period of experimentation (three or four years from now) it will become much clearer what state hospital services will be needed as we learn how well the private sector has been able to serve the four key populations: children and adolescents, elderly psychiatric patients, chronically ill adults, and acutely ill adults, and as we learn more about the needs of those who continue to be served by the state hospitals. The most consistent advice this Commission has received from virtually all witnesses has been to postpone closing hospitals until we see how well private alternatives serve.

2. Nonetheless, if privatization works we do expect a radical reduction in the need for state hospital facilities.

3. In some cases (including Crownsville, Spring Grove and Springfield) the existing hospital campuses no longer need to be as large as now. Some of the land should be sold or leased and the proceeds set aside either to meet costs involved in privatizing care or in re-configuring the remaining state facilities.

4. With respect to state hospital staff:

   a. For years, experts across America have decried the lack of objective standards for determining the proper ratio of staff to patients in psychiatric hospitals. Within the past year, Maryland has taken two important steps toward filling this void. In December the Mental Hygiene Administration completed its own study of such standards, and in April a study of staffing standards was completed by an outside consulting firm. These two studies represent the most serious effort to date of which we are aware to develop objective standards for staffing. Maryland may well lead the way in guiding hospital authorities throughout America.

The Commission recommends that Maryland set as a goal to adhere to the standards in the MHA staffing study which are slightly more economical than the consultant's version.

   b. **No early cuts are recommended in hospital jobs because hospitals are now understaffed.**

   c. However, the process of privatization will let us avoid adding to the numbers of state hospital personnel.

   d. Even in the long term, the cumulative number of jobs in all jurisdictions (State, County, City and private) will not be reduced.

   e. In any event, a guiding principle must be to protect the rights of present state employees.

   f. Ultimately there will be savings which should be devoted to implementing the recommendations in this report.

4. The Role of State Hospitals in the Long Term

If experience over the next few years tells us that most children, elderly, chronic and acute patients can be cared for by the private sector, what role remains for state hospitals to perform?

a. Responsible for chronic patients who are hard to serve, multiply handicapped patients (including deaf persons) and brain trauma patients whose primary problem is psychiatric or behavioral. There is a need for better diagnostic and treatment techniques for head injuries.

b. Responsible for intermediate and long-term in-patient care for children and adolescents for whom no appropriate private hospital facilties exist. This would include very difficult children and adolescents.

c. Responsible for forensic patients.

d. Responsible for working with the private sector to provide sophisticated, high-technology diagnosis and experimental treatment to a limited number of acute and sub-acute patients who do not respond adequately to the more routine treatment available in most private hospitals with small psychiatric wards. This function would include cooperating with the University systems to perform research on diagnosis and treatment.

F. Quality Assurance

The Commission recommends the following:

1. **Provide some choice for consumers with respect to their assignment (e.g. to hospital, community facility or therapist). Let them turn down an offer of housing or other service without losing their place on the waiting list. Let them ask for a change in the staff assigned to them. Do not limit**

a consumer's choice to just one facility because of the geographic area he/she falls into. This not only would give the consumer more choice but might also create some competition among providers to make their services attractive to consumers. Design county or city "single-point-of-entry" systems so they do not prevent a consumer from shopping around.

2. Provide a State-mandated procedure through which patients or their representatives may appeal decisions by service providers (e.g. decisions on being ejected from a facility).

3. As the focal point of service shifts from hospital to community, protection and advocacy groups (e.g. civil rights lawyers, On Our Own, Alliance for the Mentally Ill and the Mental Health Association) should re-direct some of their monitoring efforts which have heretofore focused largely on state hospitals -in order to give more attention to monitoring private hospitals and providers of community-based services.

4. The State's own system for monitoring quality should not rely on burdensome written reports and should not prescribe procedures in such detail as to limit the flexibility of the provider to be a good manager. The State's system should instead rely on volunteer groups and professional regulators to monitor and report flaws to the state. The state should concentrate its staff resources on providing quick response to the reported problems. In addition, the State, itself, should make some surprise inspection visits as often as staff resources permit. Patients and families should be interviewed as part of the State's quality assurance efforts.

5. As Maryland moves responsibility for implementation to the private sector, there will be a strong temptation for government employees to cling to control over operational details, such as what to purchase and where and what to pay, whom to hire and at what salaries, and there will be a temptation to issue detailed procedures for operating housing projects and the like. We understand that the drive to cling to controls is due in part to a commendable concern that quality of care be kept high and costs kept low. But detailed governmental control will not achieve these commendable goals. Indeed, by diverting the energies of the private

provider into ensuring that the "jot and tittle" of the regulations are adhered to, they divert energies from good care and from efficient management and, in the process, they drive overhead costs up. A better approach for MHA is to develop common sense performance criteria and to judge private providers' performance against such criteria in determining contract or grant renewals. MHA staff should be expanded if needed to accomplish the above.

The Commission recommends that the Government of Maryland make every effort to avoid enmeshing the private sector in red tape.

In sum, to ensure quality of care, the Commission would rely on three factors: (1) a State-ordered procedure for appeals with State-enforced sanctions, (2) consumer choice and the ensuing competition among providers and (3) vigilant volunteer monitoring systems along with the state's own professional regulators.

G. The Community Mental Health Centers

In expanding the role of the private sector and the community in the provision of mental health services, it is important that management at the community level be enhanced as well. If it is the responsibility of local government to manage and monitor community mental health center services, the Commission questions whether local government should be in the business of delivering these same services. At this time, 80% of state-funded community mental health centers and clinics in Maryland are operated by local health departments, while nationally 80% are under private auspices. The Commission recognizes that in some jurisdictions, local governments must necessarily both provide and monitor services because private providers and practitioners are not available.

The Commission, therefore, recommends that Maryland encourage county governments to consider privatizing community mental health centers and clinics.

H. The Need for Ongoing High Level Attention

During the past few months the Office of the Governor, as well as the Governor personally, have devoted a great deal of attention to Maryland's future system for the care of its mentally ill citizens. That attention has made it possible for busy bureaucrats, providers, and advocates to lay aside other demands and to think intensively and creatively about this important topic. A lot of work has been achieved in a short time. But, if the recommendations herein are accepted, a far greater amount of work lies immediately ahead in implementing them. This will call for many rapid, crisp decisions, for innovativeness far above the norm, for risk-taking and creativity uncommon in the workaday world, and for freedom from business as usual attitudes and from the normal fetters imposed by those whose task it is to ensure that the system abides by the rules. To infuse the governmental system with such a spirit will require continued attention by the Office of the Governor.

The Commission recommends that both the Executive and Legislative branches continue to devote enough attention to this subject to ensure that the necessary sense of urgency is communicated to the relevant parts of the Government so that approved recommendations will be implemented quickly.

The Commission further recommends that the State of Maryland quickly develop an operational plan which will begin to implement these recommendations in FY 1989.

Chapter Two

Discussion of the Issues

A. Children and Adolescents

In January, 1987, the Maryland Disability Law Center filed a civil suit in Federal court against the State of Maryland on behalf of seven named children age 18 and under and on behalf of "all other children who are now or in the future may be unnecessarily confined in Maryland's state mental hospitals or who within the last six months have been or in the future may be discharged from the hospitals into clinically inappropriate placements."

In the opening statement of that suit, MDLC alleges that: "Maryland's in-patient psychiatric facilities for children are in a state of crisis. An increase in admissions combined with a lack of community services for children who are ready for discharge has produced serious overcrowding. The stress of overcrowding has led to increased assaults and suicide attempts. Because of the overcrowding, children are being warehoused on adult units, or forced to sleep in seclusion rooms, quiet rooms, and hallways. They are being physically restrained and secluded, and deprived of adequate treatment. While they are awaiting discharge, they are being subjected to harmful and threatening conditions."

"In the opinion of the professionals who treat them, many of these children should not be in a hospital. These professionals have classified approximately one-half of the children now housed in Maryland's mental hospitals as clinically ready for discharge. These children could be transferred immediately into more appropriate, less restrictive settings if the (State) would establish the necessary residential treatment programs, group homes, therapeutic alternative living units, and therapeutic foster homes recommended by the professionals who have been treating the children. Instead, the children are being arbitrarily and unnecessarily institutionalized. The wait for an appropriate community placement is often months and even years."

While allegations made in a law suit are not to be construed as facts until so determined by the courts, the issues of inappropriate hospital confinement and inadequate availability of community alternatives have been raised by many other sources, including:

* The State Mental Hygiene Administration in its draft "Children and Adolescents Five Year Plan" (January 7, 1987).

* The Interagency Committee for Children in its "Interagency Plan for Children with Special Needs" (July, 1986) and again in its March, 1987, "Progress Report." The ICC includes DHR, DHMH, MSDE, the Office for Children and Youth, the State Coordinating Council for Residential Placement of Handicapped Children, and representatives of several advocacy organizations.

* Local child and Adolescent Mental Health Task Forces See, for example, "Better Mental Health for Our Children and Adolescents: A Prince George's Strategy," prepared by the Child and Adolescent Mental Health Interagency Task Force, March 1987.

It should be pointed out that the problem of inadequate or inappropriate services for children and adolescents with mental illnesses or emotional handicaps confronts not only the Mental Hygiene Administration but other public agencies as well:

* state and local departments of education which often remove emotionally disturbed children from the home and sometimes place them out-of-state in order to provide services called for by federal PL94-142.

* local departments of social services who often find abused or neglected children to be in desperate need of mental health services.

* the Juvenile Services Agency whose institutional programs have been found to contain vast numbers of children not so much "delinquent" as in need of intensive mental health treatment.

The "Progress Report" of the Interagency Plan for Children with Special Needs contains an introductory paragraph to its "Substitute Care Services" section (p. 28) that should serve as a guide to the Government of Maryland:

"When it is not in the best interest of the child to remain at home, an appropriate form of substitute care must be available. These services include emergency and shelter care, foster family care, alternative living units, group homes, semi-independent living arrangements, residential treatment facilities, and psychiatric hospitals. The child who requires out-of-home care may need it for only a short period of time or may require specialized substitute care services to treat severe mental, social, or emotional disorders. The finding of the recent study of youth committed to the Montrose and Hickey schools that 50 percent did not require institutionalization underlines the need to expand the continuum of available community-based residential placements and other support services."

If there was one point of strong agreement among the many and diverse individuals who appeared before the Commission to discuss children and adolescents, it was this: Maryland is not meeting the mental health service needs of its children. Although the Commission's mandate is to report on State psychiatric hospitals, hospital services cannot be examined in a vacuum, particularly in the case of mentally ill and emotionally handicapped children and youth for whom so few alternatives to hospital care are available and for whom so many public agencies share service responsibility.

In Unclaimed Children, her 1982 report for the Children's Defense Fund, Jane Knitzer concluded that two million of the estimated three million young people in the U.S. with serious emotional handicaps were not receiving needed treatment services. She also concluded that the most restrictive and costly level of care - inpatient hospital treatment - was also the most accessible. The Office of Technology Assessment, an analytical arm of the U.S. Congress, reported last year that 70 to 80 percent of children in need may not be getting appropriate mental health services.

While the Commission did not obtain comparable data for Maryland, it did receive information clearly indicating that the demand for appropriate and accessible child and adolescent mental health services of all types, from inpatient treatment to home-based intervention, far outstrips the supply. The Maryland Health Resources Planning Commission estimated that 11.8% of children under 18 (130,000) are in need of mental health services; 5% (55,000) have serious emotional handicaps and .53% (5,800) are considered chronically mentally ill. A partial listing of problem areas brought to the Commission's attention may illustrate the point:

* State hospital child and adolescent units are severely overcrowded, children have been reported to be sleeping in hallways and residing on adult wards.

* Maryland has been very slow to develop community-based residential services, such as specialized foster care and group homes, even though many of the young people residing in State hospitals - more than half by some estimates - could be served more appropriately in such settings. There are only two Mental Hygiene-funded group homes for children now operating in the entire State. Community opposition at several proposed sites has been one obstacle.

* There are no residential treatment beds on the Eastern Shore. Children from the Shore who require that level of care must travel to the Regional Institute for Children and Adolescents (RICA) in Baltimore, leave the State or go without services.

* There is a critical shortage of outpatient treatment services available through community mental health centers and clinics, both for on-site counseling and outreach to schools and other child-care agencies. At the Wicomico Health Department clinic, for example, only one psychiatrist is available only one day a week to serve 200 children.

* Difficulty in recruiting child mental health professionals is an ongoing concern.

* Case management services for children with mental illnesses and emotionally handicaps are virtually non-existent.

* There are too few services available for children age 12 and under. For example, there are no acute beds in the State hospital system for this group. General hospitals report that finding beds for young children in need of acute care is a continuing problem.

* Spaces at the three RICAs are always full.

* Transition services for emotionally handicapped adolescents who "age-out" of the special education system are not being provided in a coordinated fashion, particularly for those coming back to Maryland from out-of-State placements.

* The majority of handicapped children who are sent out of State for residential and educational services are emotionally handicapped/mentally ill. It was reported that the average cost for each such placement is $38,000 per year with an average stay of 2-1/2 years. Appropriate services for these "invisible children" are not being developed closer to home.

* The Departments of Education, Health and Mental Hygiene, Human Resources and the Juvenile Services Agency are striving to improve coordination of children's services, through both the State Coordinating Council for Residential Placement of Handicapped Children and the Interagency Planning Committee for Children at the State level, and Local Coordinating Councils at the local level. While these are innovative and encouraging developments, families and other advocates report that the overall system or non-system for young people in need of mental health services remains "user unfriendly." Examples are: the education system's admission, review and dismissal special education placement process that can take up to 180 days by law for final decisions except in emergency cases - too long for children with emotional handicaps; the social service system's requirement that "children in need of assistance" must be removed from parental custody to be eligible for certain services; the lack of basic information to help families obtain appropriate resources and services.

The Commission's recommendations in Chapter 1 attempt to address as many of these problems as it can given its mandate, though its proposals are by no means comprehensive. It is hoped that implementation of Commission recommendations, coupled with a Statewide commitment to support efforts already underway within the Executive and Legislative branches to improve services for all children with special needs, will produce the kind of child-centered, community-based system of mental health treatment and support services our children and their families have a right to expect.

B. Psychogeriatric Citizens

Many patients over 65 years of age in Mental Hygiene Administration facilities have been identified by their treating clinicians as appropriate for placement in nursing homes. A 1981 Peer Service Review Organization (PSRO) study of patients over age 65 in MHA facilities identified nursing homes as the optimal setting for approximately 300 patients. MHA data indicate that there has been little change in that number over time.

To alleviate facility overcrowding and still recognize the needs of the patient, MHA should transfer all appropriate patients to private nursing homes. Maryland has 24,245 licensed nursing home beds (with 21,000-22,000 currently operating). Currently there are 428 patients in state hospitals and 228 in a nursing home on the grounds of Spring Grove Hospital.

A Department of Health and Mental Hygiene advisory group, in consultation with representatives of the nursing home industry, has explored several mechanisms to encourage nursing homes to more readily accept patients from State facilities. A decision was reached to begin in July, 1987 to offer nursing homes an increased level of reimbursement, through the Medical Assistance Program, for patients transferred from special hospitals, which includes State psychiatric facilities. This financial incentive is conceived of as a "patient management transition fee." Nursing homes will be paid a fee equal to thirty percent of the facility's heavy-care nursing service cost center rate (approximately $8/day) for 6 months for each patient admitted. While no requirements have been set on how the additional monies should be used, one can anticipate that additional hours of care and additional training for staff may be purchased with these funds.

Concerns have been expressed by nursing home administrators that some patients may have extreme difficulty in adjusting to the nursing home and may need to return to the hospital to address this problem. Patients will initially be placed on 28-day visit status so that if the need arises the return to the hospital will be easy. Another concern frequently expressed by nursing home administrators is that they may be unable to handle the psychiatric treatment and behavioral interventions that may be needed by patients transferred from State hospitals. In 1986 the Medical Assistance Administration developed a cost center for funding mental health consultation and related staff training in nursing homes. The MHA has been encouraging nursing homes and local community

mental health centers to work cooperatively on developing programs to be billed under that cost center. In the past year a specially trained quality assurance monitoring team was initiated by the Division of Licensing and Certification to review care provided to the psycho-geriatric patient in nursing homes. In addition, the MHA has devised a detailed mechanism for follow-up of the patients placed in the nursing homes in each region which will allow the Administration to measure how well private nursing homes are able to serve this population.

The MHA is in the process of identifying appropriate patients for referral to nursing home care, completing all necessary paperwork to allow for transfer of patients, and has even placed approximately ten patients under this initiative. A master list of potential referrals includes 50 patients from Crownsville, 125 patients from Springfield, 27 patients from Spring Grove, and 17 patients from the Walter P. Carter Center. Although this master list includes 194 potential referrals, a certain percentage of these patients continue to exhibit extremes in symptomatology or behavior which may make nursing homes unwilling to accept them.

Prior to the development of this financial incentive program, the Maryland Health Resources Planning Commission, in collaboration with the Mental Hygiene Administration, had developed a clause in the State Health Plan, Institutional Long-Term Care Services section, which states that nursing homes which designate beds specifically for direct transfers from State psychiatric facilities would be given preference in the Certificate of Need (CON) review process for new nursing home beds. As a result of this, in the FY 1986 CON review, 124 new nursing home beds were committed for State hospital transfers. Construction of these beds is expected to be completed in FY 1988 and FY 1989. Additional beds are being allocated for Mental Hygiene Administration patients in the 1987 Nursing Home CON review which is presently in process. This will also contribute to the State's ability to reduce the census and number of beds in its own facilities.

Potential benefits of implementation of these plans include:

1. Patients would be placed in the most appropriate, least restrictive settings.

2. Many patients would be placed closer to their homes/families, allowing increased contact, communication, and involvement.

3. With no individual nursing home facility burdened with more than a few transfers, patients can be more easily absorbed into this more normalizing milieu.

4. The potential exists for the elimination of 200-300 State hospital beds over the next few years.

5. There would be a net savings to the health care industry since nursing home care is less expensive (and more appropriate clinically) than hospital care for those clients deemed appropriate for nursing home placement.

6. The present overcrowding in MHA facilities would be reduced.

7. Some construction and renovation in State facilities could be avoided, resulting in significant savings in the Capital Budget in future fiscal years.

8. Reduced censuses in State facilities would enable hospital staff to provide active, appropriate care to patients requiring hospital care and would help to minimize the need for increased funding for staffing.

9. Implementation of initiatives to place appropriate patients in nursing homes has already begun.

Potential drawbacks and sensitive implementation issues include:

1. Transfers may be disruptive to individual patients and their families and will need to be handled with great care.

2. Some nursing homes may need to modify their programs to adapt to this new patient population.

3. The waiting time for a nursing home bed for a patient already in the community (e.g., at a general hospital or at home) may be increased slightly.

4. There may be a slight financial impact for some nursing homes which would need to be remedied by state action.

5. Significant MHA staff time will be required to prepare patients for the transition and to appropriately match patients with nursing homes.

6. The successful implementation of plans to place appropriate patients in nursing homes could generate the need for some staff layoffs, unless this is avoided through reallocation and normal attrition.

7. The MHA will need to work with the community mental health centers to encourage them to utilize their resources to provide services for this population.

C. Citizens with Chronic Mental Illness

For decades, the State Hospital served as the primary care provider for individuals with long-term mental illness. Ten years ago, except for very few programs in Montgomery, Baltimore and Carroll Counties, there were no professionally run residential facilities. Therefore, families and foster care placements served as the primary methods for care of chronic patients outside hospitals. Many such citizens have had to enter the hospital due to the lack of day programming designed to assist them to integrate in the community. Even the creative efforts of several hospitals (e.g., the Day Treatment Programs of Crownsville and the Community Clinic Programs of the Eastern Shore Hospital) were not enough to maintain some of these individuals in a community environment. Consequently, the hospital remained the primary mode of treatment and rehabilitation for this population.

The emergence of psychosocial rehabilitation programs in the late seventies created an opportunity for deinstitutionalizing chronically mental ill patients from hospitals to appropriate community settings. Since 1978, chronically mentally ill persons have been served by Community Rehabilitation and Residential Programs (CRP) now numbering 51, which provide a cadre of community-based services which include but are not limited to:

Rehabilitation Assessment
Social Skills Training
Recreational/Leisure Services
Independent Living Skills Training
Work Adjustment Training
Vocational Evaluation
Vocational Skills Training
Supportive Job Placement
Residential Rehabilitation Services
Case Management
Respite Care Services
Crises Housing
Family Support and Education
Educational Skill Development

In addition, the CHMHs offer important services to citizens with chronically mental illness. The services provided by the CMHC include but are not limited to:

Psychiatric Evaluation
Treatment Planning
Diagnosis and Assessment
Psycho-therapy
Medication Therapy
Crises Intervention
Family Therapy
Day Treatment
Case Management
Consultation and Education

In 1985, the General Assembly passed a resolution calling upon the Executive Branch to develop and keep up to date a five-year plan to provide supportive community-based living arrangements for those persons in psychiatric hospitals who could be moved to such supportive places. The Government responded with the "Five-Year Plan for the Deinstitutionalization of Chronically Mentally Ill Persons in Maryland." That Plan called for about 2,000 new spaces in the community which, when added to the 1,100 spaces existing at the end of FY 1985, would total a little under half of the 6,500 spaces needed. Measured against the need, it was a conservative goal that would ask some of the backlog of ill people awaiting service to wait for ten years. Nonetheless, it represented a dramatic speed-up over the lethargic pace up to that time - a pace that would not have taken care of the last person in the backlog until the year 2020 if that person were still living.

The Government's Plan called for an average of about 400 spaces each year. In fact, the budget requests have only provided for about half that number during the first two years of the Plan. Patients, families, professionals and concerned citizens have called upon the Government to keep up with the pace of the Plan and to make up for the shortages in the first two years of the Plan. They have argued that care in the community will be better for the health of the patient, for his/her rehabilitation, and it will also conform to Maryland's law calling for care in the least restrictive setting. With respect to costs, the Goldman report (Study of Statewide Inpatient Mental Health Services, by Howard H. Goldman, MD Ph.D, Kevin Marvelle, M. Susan Ridgely and

Mary Gabay, June, 1987) indicates that direct costs in the state hospitals for chronic adult care is about $45,000 per year (pp. 4-22) whereas the cost of the most intensive level of community care is about $35,000 per year (pp. 4-30).

Implementation of the Five-Year Plan since 1984 has clearly demonstrated that a community-based mental health system can be very effective for adults with long-term mental illness. Residential services have been an essential part of a community-based mental health delivery system. Currently there are about 1,500 adults with long-term mental illness in publically financed residential spaces throughout the State including foster care. These services include a variety of apartment settings, foster care, group homes and boarding homes. However, many individuals with long-term mental illness continue to live with families or in inappropriately supervised housing environments due to a lack of adequate available community resources. Often the lack of these services contributes to unnecessary hospitalization. It is essential that a continuum of residential services be developed throughout the State including apartments,small group homes of 4 to 12, larger domiciliary type facilities in the community, and respite care.

Another essential factor to a community-based delivery system is a range of psychiatric/mental health services. These services must include adequate outpatient therapy, crises intervention, flexible clinic hours to provide services to employed clients and mobile treatment. In addition to the 46 mental health centers in Maryland, there is also a need for day treatment services for this population. Currently there are only 9 day treatment programs in Maryland serving adults with long-term mental illnesses. Day treatment provides intense psychiatric services for individuals whose symptomology prevents them from functioning appropriately in a rehabilitative setting, but who do not require hospitalization. They also serve as a transition from a hospital setting to the community or as a means of preventing hospitalization.

Any discussion of care for those with chronic mental illness must take account of the fact that the majority of such citizens live in the community and only occasionally have to use hospitals. There is ample evidence that the need for hospitalization can be markedly reduced by high quality care systems in the community. Thus, to minimize the need for hospital care calls for good community care not only for those ready for discharge from the hospital, but also for those living in the community who are subject to hospitalization in times of acute episodes of illness.

Thus far, the progress of the Five-Year Deinstitutionalization Plan together with joint efforts of the CRPs and CMCHs has contributed to a decrease in the hospital census from 4,153 in 1975 to 1,858 in 1985, or more than 50%. On the other hand, the number of consumers being maintained in organized community support programs has increased from 80 in 1979 to 2,695 in 1987.

Vocational/employment services are also needed to assist consumers to integrate into the community. During the past two years, none of the funds for vocational/employment services requested in the Five-Year Plan have been approved or allocated. Despite this, in FY 1987 community rehabilitation programs have assisted approximately 368 consumers to gain employment generating approximately $16,000 in wages monthly (MAPS Vocational Survey). In addition, the relationships developed between the CRPs, employers and private business people have reduced stigma and dispelled myths about individuals with mental illness. Vocational services should include a variety of sheltered employment opportunities, competitive employment, and opportunities for career development beyond entry level competitive jobs.

Despite the shortfalls in funding for the Five-Year Plan, it is becoming clear that care of persons with chronic mental illness in the community is an attractive alternative to care in the hospital.

D. Citizens who are Acutely Mentally Ill

The proposal to privatize acute care has raised a number of concerns and issues in the case of acute care. A number of important concerns were expressed by those who met with the Commission.

Perhaps the fear mentioned most frequently is that private hospitals will not be willing to accept difficult patients. A related fear is that they might discharge prematurely any patient who becomes difficult. Will they be conscientious in working with the providers of after-care in the community or will they be loathe to concern themselves with matters that are not strictly medical? Who will be responsible for the patient who does not respond to medications and remains too ill for community-based systems? Who will take responsibility for patients who are mentally ill and substance abusers or mentally ill and retarded? What is to keep a private hospital from requiring a parent or spouse of a person in crisis to sign forms accepting financial responsibility as a part of the process of admission? In times of acute illness, families will sign anything to get help, even though it may be financially disastrous to them. What about those patients whose illness requires sophisticated equipment and rare skills to diagnose and treat - resources beyond those found in small psychiatric wards of general hospitals? How can we ensure that private hospitals can care for patients who have no insurance or private resources without the hospitals being financially damaged? Might the Maryland Medicare waiver be endangered?

The recommendations in Chapter One undertake to deal with each of these fears and the Commission believes that the feared results can be avoided entirely or substantially minimized. However, we cannot be sure that this is true. For that reason, we propose a three or four year trial period to test privatization before we dismantle the ability of the state hospitals to provide acute and sub-acute care.

E. Citizens in Need of Specialized Care

Chapter One has recommended moving toward a system of private care for four groups of mentally ill citizens: children and adolescents, psychogeriatric, acutely ill adults, and adults who are chronically ill. This leaves a group of persons who are in need of specialized hospital care including (1) those committed to psychiatric care for criminal offenses, (2) those patients of all ages who require intermediate or long-term care in hospitals because they are not clinically ready for placement in even the most intensive community-based outpatient care system, (3) multiply-handicapped patients including dually diagnosed persons whose primary diagnosis is psychiatric (e.g., substance abusers, retarded and hearing impaired) and patients who present severe behavior management and treatment problems and (4) patients whose psychiatric history suggests the need for sophisticated diagnosis and treatment beyond the capacity of the psychiatric ward of the general hospital where they may have been admitted.

For these groups of persons, care in State psychiatric hospitals should continue to be available. Chapter Four discusses the role of the State hospitals in serving these citizens in need of specialized care.

Chapter Three

Costs

This chapter will discuss the costs associated with the various recommendations in this document. Many of these proposals have not quantified the exact number of beds or patients to be shifted out of State hospitals; therefore, the cost description will need to be somewhat general. In general, these recommendations are based on the financial assumptions of the Goldman Study since it was reasonably comprehensive and clarifies the costs of most options.

A. Cost of Current State Hospital System

The FY 1987 budget for the four regional State hospitals, i.e., Springfield Hospital Center, Spring Grove Hospital Center, Crownsville, and the Eastern Shore Hospital Center is $109.5 million while the budget of the four community-based State hospitals (i.e., Carter, Highland, Finan and Upper Shore) is $27.8 million. The budgeted funds for Perkins, Tawes-Bland Bryant, and the three RICAs are not included in the above.

In order to compare costs across State facilities for different ward types, the MHA, as represented in the Goldman Study, estimated averages for three different types of wards: acute, geriatric, and adult chronic. It is estimated that in FY 1987 the MHA costs for acute patients were approximately $180 per day, for chronic adults $112 per day, and for geriatric patients $95 per day. This analysis makes it possible to further compare costs for different types of patients to be shifted under these proposed alternatives.

The study titled, "Study of Casemix, Facilities and Staffing at the Regional Psychiatric Hospitals," done by Abt Associates in April, 1987, provided an in-depth analysis of the four regional State hospitals and documented the costs of providing quality staffing and building standards. In summary, Abt Associates recommended that an additional $30 million of staff and $32 to $50 million of additional capital resources would need to be added to the existing budget of the four regional

hospitals.* These costs would be necessary if the census remains the same and if the State is going to deliver quality care in modern facilities and give mentally ill patients a one-class system of inpatient care whether in private or public hospitals. Therefore, it is important to note that if the State does nothing to shift patients to alternative settings, it will have to add between $60 and $80 million State dollars to the existing four regional State hospitals in the first year and $30 million a year thereafter, just to bring the system up to acceptable standards.

B. Care of the Elderly Patients

In Chapter One, this Commission recommended shifting all nursing home appropriate patients from State facilities to private nursing homes, as well as shifting some elderly patients into community-based settings. The costs for the community programs will be outlined in that section while the costs for the nursing home shifts will be summarized here. Currently, there are varying estimates of the exact number of geriatric patients in State facilities who are appropriate for transfer. The range is between 500 to 600 with about 200 of these patients currently in a State-operated nursing home, i.e., Tawes-Bland Bryant which is located on the grounds of Spring Grove Hospital Center. The estimated costs of maintaining an elderly patient in a State hospital geriatric unit is $95 per day.

This can be compared to an average cost for a patient in the community (rated as "heavy" in the Medicaid payment system) of approximately $60 per day. Virtually all of these patients would be Medicaid eligible; therefore, the Federal Government would pay part of the care in private nursing homes as it does in State facilities. As can be seen, the State will save a considerable amount of money by shifting these patients into more appropriate private settings. The total amount of savings would depend on the total number of patients shifted. With a savings per patient day of $35, and, at one extreme, assuming all 600 patients were shifted, the savings would be $7,665,000 per year.

* For all eight hospitals the figures are $40 million for staff and $35 million to $50 million for capital expenses.

C. Care in the Community for Adults with Long-term Illness

Currently, the State of Maryland is in the process of partially implementing the MHA's Five-Year Deinstitutionalization Plan (DI Plan). The total five-year cost of the original plan, before supplements were added last year, was approximately $45 million in new State general funds, approximately $9 million to be added each year. In Chapter One, the Commission recommended that this plan be fully implemented including a range of such services for chronic mentally ill (CMI) adults who are already in the community. Chapter One of this report recommended that in addition to the community support services identified in the Five-Year Plan, certain additional specific community services be developed for the long-term CMI adults remaining in State hospitals. The original Five-Year Plan identified only approximately 300 patients in State hospitals (at that time in 1985) who could be moved into community spaces as the Five-Year Plan was implemented. The Commission believes that it is important for this Plan to be fully implemented so that (1) the thousands of CMI adults released from State mental hospitals over the past three decades receive treatment, and (2) that a complete support system in each community be developed to give care in those communities to more difficult chronic patients.

The approximate cost of implementing the remaining portion of the Five-Year Plan for FY 1989-1991 would be $48 million. The Goldman Study projected that full implementation of the remaining Five-Year Plan services would only reduce the census of State hospitals by 250 unless the design of the residential services were modified to include some facilities with 24-hour supervision. By contrast, Goldman estimated that 1,025 patients in the eight State hospitals, excluding Perkins, could potentially be moved to community settings, but only if those settings were intensively supervised and had complete support services, e.g., case management, Community Mental Health Centers (CMHC), and day rehabilitation programs. The FY 1987 costs of maintaining a chronic adult in a State hospital is $112, while the cost in the community for more intensively supervised settings would be approximately $95 per day, depending upon the level of care needed by the patient to be transferred. Not only would this $17 difference represent a savings to the State, but that savings would increase since once patients are in the community, part of their care will be financed by the Federal Government via SSI, SSDI, and Medicaid, which is not available to the State hospitals. The exact costs and savings

to the State will depend on the number of patients to be shifted. The Commission wants to point out, however, that while it will be cheaper to maintain a patient in the community, there will need to be new State funds allocated in the budget to develop the community services prior to shifting patients. Moreover, as noted above, additional costs will be incurred as chronically ill citizens now living in the streets, or with aging parents, or in inadequate quarters begin to access the newly available community services.

D. Care for Acute Patients

1. The Commission recommended that the short stay acute patients be shifted from State hospitals to private hospitals and that the State develop mechanisms to shift sub-acute patients, i.e., those who stay 30 to 90 days. This is the only action recommended by the Commission in which the alternative to a State hospital is more expensive per patient day.

The State Health Services Cost Review Commission (HSCRC) has estimated the average cost per day in a private psychiatric unit is $360, while a day in a State hospital acute unit is $180. As explained below, these increased total costs will be partially offset by several factors.

Currently, the MHA estimates that approximately 10% of its admissions have an active Medicaid card and another 10% have other third party coverage. It is further estimated by the HSCRC, the MHA, and Goldman that of the other 80% of the acute patients going into State hospitals without identifiable insurance, approximately 50% will be Medicaid eligible if this entitlement is actively pursued. A pilot program at Liberty Hospital has provided some confirmation of this estimate. This would mean that approximately 40% of the total short stay acute patients to be shifted to the private sector would be uninsured. Several members of the Commission have expressed concern that any additional shifts of acute State patients should not increase the bad debt percentage already incurred by private hospitals due to the potential threat to the Medicare waiver. Therefore, the Commission is recommending that at this time State General Funds be put or retained in the MHA budget sufficient to cover the additional bad debt costs for uninsured patients. The MHA and Goldman have estimated that approximately 200 to 250

new beds would need to be created in the private hospitals in order to shift the short stay acute patients. The total cost of this initiative cannot be determined until the exact number of beds is identified. However, an example of the cost for a 20-bed unit based on the variables above is provided as follows:

Total Cost in Private General Hospitals (20 Bed x 85% Occupancy x $360/day x 365 = $2,233,800)

Payment Service	
60% Medical Asst.	$1,340,280
10% Other	223,380
30% Bad Debt	670,140
Total Costs	$2,233,800

Total State Costs of a 20-Bed Unit in a General Hospital (including State match for Medicaid)

$1,554,725

Total Costs for a 20-Bed Unit in State Hospitals at $180 per day

$1,116,900

It is not possible to calculate the costs of shifting sub-acute care as the HSCRC would need to set different rates for such units. The Commission has also recommended removing the Medicaid DRG limits on psychiatric patients in general hospitals in order to enhance the private sector's capacity to handle all psychiatric patients. It is not possible at this time to calculate the costs of this.

2. Increased current procedure treatment Code Payments -

The Commission has recommended that the Medicaid CPT Code rates for psychiatric services be significantly increased. The MHA has estimated that the cost to the State General Fund of a 100% increase for these rates would be $2.5 million.

E. Care for Children and Adolescents

The Goldman Study estimates that there are 93 children and adolescents in the State hospitals who could be transferred to acute general hospitals or some other private facility. The financing mechanism for transferring children and adolescents would be the same as that discussed in Section D above. The amount of dollars involved will depend on the number of children to be transferred. However, the Commission has recommended that the State finalize its plan and then fund a complete array of community services for children and adolescents that would provide less expensive settings for some hospitalized children. The draft MHA Five-Year Plan for Children and Adolescents is approximately $40 million, but these costs may increase when the plan is finalized.

F. Cost Impact on Remaining State Hospitals

If all of these recommendations are adopted and implemented, then there will be a significant reduction in the census of the State hospitals. This will clearly generate savings in later years which should be used to finance these alternative mental health services. The Commission has also recommended that the MHA Staffing Standards be adopted for remaining State hospitals, which will mean that no State hospital funds or staff can be reallocated until these standards are met. This will allow the State to (1) fully implement the recommendation of the first Cost Containment Study without new State funds, and (2) achieve a one-class system of inpatient care for mentally ill citizens.

G. Sale or Lease of State Hospital Property

If the State facilities were sold there would be some savings from selling the land once the facilities were closed. The State should consider selling or leasing the excess land at some State facilities and devoting the proceeds to services for mentally ill citizens. The amount of money realized will depend on the price per acre that the State can obtain. The Goldman Study estimated that between $68,000,000 and $208,000,000 can be obtained from selling this land. It should be pointed out that the Goldman Study does not reflect the cost of removing asbestos from the buildings. The Commission heard from a number of witnesses and the Department of General Services that this was a significant problem which would

decrease the savings realized from selling the land. General Services gave an estimate to the Commission that if land at the four regional hospitals now considered by those hospitals to be underutilized were sold, the proceeds would be $4,234,000. The Commission believes that private developers should be invited to make proposals to develop the excess land at the State facilities and that these revenues be retained for mental health services.

H. Summary of Costs

The Goldman study projected a cost savings to the State if most patients were shifted out of State facilities. However, Goldman did not develop an operational plan, and when this is done the State will incur additional costs during the early years of the plan in order that the alternative private and community services may be created before patients are shifted. Further, this Commission has recommended funding the MHA Child Plan and the complete Five-Year Adult Deinstitutionalization Plan, which will provide services for thousands of patients not currently utilizing the State hospitals. The rationale was the tremendous unmet need for children and also adults discharged from State hospitals over the past three decades, when sufficient community services were not available. It is likely that if the State invests in the development of a complete array of community services for children and adults, it will reduce future utilization of both State and private hospitals so that cost increases in the early years should be offset by lower costs later on.

This Commission has not developed an operational plan, but recommends that the Governor and Legislature direct the DHMH to do so quickly and that this plan be used in the development of the FY 1989 Budget. Summarized below is the Commission's estimate of the cost impact of all of the recommendations. These cost figures are approximate and many variables may be changed that will influence their accuracy. First, the total costs could vary depending on how many alternative private beds and community spaces are developed and how they are phased in.

Second, if the State only developed alternate State hospital services and did not fund the Child Plan and the complete Five-Year D.I. Plan, then the costs will be about 50% less. This would produce a short-term savings, but in the long run may increase hospital costs and therefore the fiscal burden on the State.

Third, the MHA could only give rough estimates as to the amount of savings produced in the State hospitals and the revenues lost to the State. When a specific operational plan is developed, then these estimates can be verified.

Table 1 depicts the summary of operating costs to implement the major proposals of the Commission. There are a few recommendations, such as the need for increased quality assurance staff for which the (probably minor) fiscal impact is not shown.

1. The Commission has recommended a range of acute beds to be opened in the private sector, but the figure of 200 is used here for the cost projections. The fiscal assumptions are those shown in this chapter, Section D. It is assumed that one State hospital bed will be reduced for each private bed that is developed.

2. For this summary projection, the number of elderly patients to be shifted into private nursing homes is 500. This includes patients to be shifted from Tawes-Bland Bryant. It is possible that the number of patients shifted will be higher or lower. The cost assumptions are those used in Section B of this chapter. It is assumed that one State bed will be reduced for each nursing home bed that is developed.

3. The Commission has recommended the creation of approximately 2,000 additional community beds, up to 1,025 for the State hospital patients and the rest for long-term mentally ill adults already in the community.

The Goldman Study estimated that 1,025 long-term adults in State hospitals could be shifted into intensively supervised community spaces. This projection shows the cost of creating 1,025 supervised housing slots with associated case management, clinic, and day rehabilitation costs, based on current MHA funding levels. It is assumed that 500 will be current

Level IV spaces and 525 a new Level V at a cost of $2,900/month per person for supervised housing spaces as well. It is assumed that one State hospital bed will be reduced for each community bed that is created. The other community costs are shown in the projection for completing the Five-Year D.I. Plan.

4. The cost of implementing the rest of the MHA Five-Year D.I. Plan is $48.3 million and this would achieve the following:

a. 1,202 housing spaces in the community (a mixture of Level II, III, and IV) for adults who are chronically ill

b. 4,921 case management spaces

c. 1,615 community mental health center spaces

d. 1,987 vocational rehabilitation spaces

e. 2,382 community rehabilitation (CRP) spaces

This also includes complete implementation of the Emergency Services and Case Management Addendums to the Five-Year Plan. The cost for each space is based on current MHA payments. It is not assumed that any current State hospital beds will be reduced as a result of these services. It is known that future acute admissions will decline as a result, but we have not been able to make a reliable estimate of the savings that would ensue.

5. The cost for children and adolescents is based on the numbers and types of services and rates of payment identified in the draft MHA Child and Adolescent Plan published in FY 1987. We have made no estimate of how many current State hospital beds will be reduced due to these services.

6. At the request of the Commission, the MHA has estimated the State hospital savings based on a projected census reduction of 1,725 (200 acute, 500 geriatric, and 1,025 long-term adults) and retaining enough MHA employees to fully implement the MHA staffing standards. In FY 1988, the MHA has 2,722 budgeted beds and a 1,725 reduction would bring them to a census of 997. It is assumed that Perkins and the RICAs would not be affected by these reductions.

As can be seen from Table 1, if Maryland fully implemented the recommendations of the Commission, there would be increased out-of-pocket State costs of $87.4 million. But, over 50% of these increased costs are due to funding supportive places in the community for children, adolescents and adults not currently utilizing State facilities.

While $87 million in additional State funds over four years needed to implement this Commission's recommendations may seem like a great deal of money, it does not take into account how much money this will save the State in cost avoidance. The Cost Containment Studies and the MHA have determined that the State will have to spend approximately $40 million for staff (each year) and $50 million (one time only) for necessary capital improvements (for all eight hospitals) based on the assumption that the census in the State hospitals remains the same and that the State wants to achieve a quality, one-class system of care for the hospitalized mentally ill. This has been the State's policy for every other citizen needing hospital care. This does not take into account the fact that the State will be able to achieve some savings by the sale of excess State hospital land, which will further reduce the costs of this initiative. When the staff and capital cost avoidance factors are taken into account, the actual cost of this initiative in new State funds is significally reduced. In our illustrative example (in Table 1), the $87 million total operating costs is reduced to $17 million by subtracting the $90 million needed for State hospital staff and buildings. When the new State funding requirements of $17 million is spread over four years, then the actual increase in new State funds per year is only $4 million. This amount is substantially less than the MHA was awarded in new State funds for the community in FY 1988. (See Table 2 for a hypothetical four-year phase-in.

Table 1

Four-Year Summary of Estimated Costs

Recommendation	Cost (in Millions of $)	
1. Develop 200 Acute Care Beds	20.1	
2. Develop 500 Nursing Home Beds	12.5	
3. Develop 1,025 Long-Term Community Beds	33.6	
4. Fully Implement MHA Five-Year D.I. Plan	48.3	
5. Fully Implement MHA Child and Adolescent Plan[2]	37.7	
6. Gross Costs (including Federal Funds)	152.2	
7. Less Federal Fund Participation	-14.8	(1)
8. Gross State Costs	137.4	
9. Less Savings through State Staff Reductions	50.0	(3)
10. Net State Out-of-Pocket Costs (Cost Avoidance not assumed)	87.4	
11. Cost Avoidance[4]		
Buildings	7.5	Per Year
Staff	10.0	Per Year
Total Annual Cost Avoidance	17.5	Per Year
12. Total Four-Year Cost Avoidance	70.0	
13. Net Cost to State over Four Years	17.4	
14. Annual Average Cost to State	4.35	

(1)$14.8 million of the $152 million cost of implementing the recommendations of the Commission would be covered through Federal Fund participation. Some additional collections such as SSI are still shown as State costs.

(2)The costs indicated would be those incurred by the Department of Health and Mental Hygiene (Mental Hygiene Administration, Medical Assistance), Department of Human Resources, and the Department of Education.

(3)State savings indicated are those direct care and support services savings which could be anticipated after implementation of MHA staffing standards. These savings could be realized without closing one of the regional State hospitals. The first 500 reduction in State hospital census would not yield savings. Rather, it would permit the staff to patient ratio to come up to quality standards. However, any subsequent reduction in the number of patients would yield significant savings.

(4) In addition to the savings in the operating budget indicated in Item 9 of the table, it is estimated that about $50 million in capital cost avoidance could be realized based on the first Cost Containment Study. This would be reduced to $30 million because an estimated $20 million of capital costs would be needed to acquire facilities in the community. Capital cost avoidance would amount to $7.5 million annually over the next four years. In addition, our recommendations would permit cost avoidance for staff increases of $40 million, or $10 million per year.

The gain/loss of revenues collected by State facilities is not shown due to the difficulties in making an accurate projection without a specific operational plan. However, it is assumed that there will be some increase in revenues initially as the MHA staffing standards are implemented and Springfield and Spring Grove gain JCAH and HCFA certification. Eventually revenues will decrease somewhat.

Table 2

Four-Year Hypothetical Phase-In of State Costs

(in Millions of $)

Year	(1) New Net State Costs	(2) Staff Reduction	(3) Staff Cost Avoidance	(4)c Net Capital Cost Avoidance	(5) Sum of Columns 2, 3 and 4	(6) Costs (+) or Savings (-) to State
1	34.35	0	10	7.5	17.5	(+) 16.85
2	34.35	0	10	7.5	17.5	(=) 16.85
3	34.35	25	10	7.5	42.5	(-) 8.15
4	34.35	25	10	7.5	42.5	(-) 8.15
Total	137.4	50	40	30.0	120.0	+ 17.4
Average Annual State Costs over Four Years						4.35

7. State Out-of-Pocket Costs

The following discussion takes into account out-of-pocket costs to the State. It does not consider State cost avoidance which, if included, would yield savings to the State of $8.15 million in each of the last two years in our four-year projection.

While the above figures must necessarily be imprecise until an implementation plan is completed, the following is clear:

(1) The recommendations on children and adolescents will cost more than Maryland has been devoting to this most neglected population.

(2) The recommendations on elderly will cost less and we believe the service will be more appropriate for their needs.

(3) The recommendations on long-term mentally ill adults will cost less for those who are now in hospitals (except that in the short-run, because community places must be built before the patient leaves the hospital, it may cost more).

However, the recommendations go beyond those who are now in hospitals to make a place for those who are in streets, shelters, slums or (as needed) with aging parents. This will cost more because we are making up for the mistakes of the past in dumping people out of hospitals with no supportive place.

(4) The recommendations on care for acutely ill citizens will cost more per bed than at present, at least in the short-run. However, these cost increases may be offset in the long-run depending on how the following factors play out:

a. increased Federal reimbursements.

b. decreased length of stay per hospitalization.

c. decreased admissions as better community care of those who are chronically ill reduces the number who revolve in and out of acute hospital wards.

d. the major savings that will ultimately accrue if and as it becomes possible to close whole State hospital campuses.

(5) In short, on a per-patient-day basis our recommendations will cost less except for acutely ill citizens (in the short-run), but because more citizens will receive services, State out-of-pocket costs will go up for a time. However, for each of the categories of patients except children, savings should approach or even equal cost increases within a few years. For children, if early services prevent later heavy expenses, the balancing out of costs will take longer. This should be true even if cost avoidance is not taken into account.

(6) Like so much of America, Maryland must make up for decades of neglect of these four very vulnerable populations. Viewed in a time frame of a decade or more, the increased out-of-pocket expenditures recommended in this report will prove to be wise indeed, for they will be able to turn people from lives of misery into active and fulfilling lives. And that, in itself, can save money. In the words of one consumer, "two years ago I was a tax consumer, a burden on the State's budget; today I'm so happy to be a taxpayer." The fulfillment of these individual dreams of becoming less dependent will make the recommendations in this report a sound investment in the future of Maryland, an investment that will repay itself over and over in the years ahead.

Chapter Four

The Future Role for State Psychiatric Hospitals

Presently State psychiatric facilities perform a wide variety of functions including, but not limited to, acute inpatient care and crisis stabilization, intermediate and long-term hospitalization for adults, residential treatment for adolescents and nursing care for psychogeriatric patients whose psychiatric symptomatology has subsided, due in part to the aging process. For many of these functions, there is considerable overlap and duplication between the public and private sectors. In areas where such duplication exists, particularly nursing home care and acute inpatient hospitalization, the major share of care is provided by the private sector, with State facilities serving those patients who cannot access care in other settings. Frequently, the reason for the patient's inability to access a private nursing home or general hospital bed is simply an inadequate supply of beds to meet the demands of individuals needing admission. Less often, ability to pay, behavioral problems, and/or perceived chronicity account for an individual's referral to a State facility for admission. The ultimate result is that the mission of Maryland's publicly supported psychiatric facilities has become confused.

The Commission's recommendations in Chapter One would, in effect, redefine the role and mission of State psychiatric facilities as a provider of quality care for those individuals requiring intermediate, long-term, or highly specialized care which is unavailable in the private sector. Those recommendations would result in State hospitals continuing to provide care to the following major groups of patients:

1. forensic patients requiring evaluation and/or treatment;

2. adult patients requiring intermediate and/or long-term hospital level care for their psychiatric disorder. This group would be comprised of patients transferred from general hospital psychiatric units who still require inpatient treatment after the first 30 days of care.

3. some adolescents who require intermediate and long-term hospital care may also be included in this category; and

4. multiply-handicapped patients of all ages whose combined disorders present major treatment challenges.

As the population served in State facilities narrows down to these four groups, greater specialization in the development of treatment modalities and programs for specific sub-groups of patients sharing similar behavioral characteristics, psychiatric symptomatology, and treatment needs will evolve. Presently, there is little specialization for the intermediate/long-term care hospital population which comprises the major group for whom no other alternatives for care exist now or will be developed in the near future.

At a minimum, specialized treatment programs and/or units should be developed for treatment of:

1. dually diagnosed patients whose primary disorder is psychiatric. Specialized programs should be developed for, but not limited to, the following: mentally ill substance abusers, mentally ill retarded, developmentally disabled, and hearing impaired mentally ill patients (one unit for the latter group already exists).

2. patients who present severe behavior management and treatment problems. This would include individuals whose psychiatric disorder is attributable to brain trauma sequelae or degenerative brain disorders;

3. forensic patients. This already exists but further consolidation of patients and resources on to a single campus would be beneficial.

The State should also encourage the development of research on the diagnosis and treatment of mental disorders. Sophisticated diagnosis and experimental treatment, utilizing the latest technologies available should be provided for a limited number of acute and sub-acute patients who do not respond adequately to the more routine treatment now available in most private hospitals with small psychiatric wards.

The Commission has recommended that, as State facilities are down-sized and consolidated, the remaining facilities be provided with adequate resources, both operating and capital, to provide quality treatment to all who rely on State hospitals. This includes, in particular, enough direct care staff to meet the MHA staffing standards.

Privatization initiatives and continued expansion of community support programs present Maryland with opportunity to meet these standards without increasing the budgets of State facilities if staff are retained as the inpatient population shrinks. Sufficient numbers of support staff should also be retained at each facility to ensure sufficient management and support services capability.

The physical plant and campus of each facility should be well maintained and include all modern conveniences which society has come to expect as basic necessities for adequate care. Presently, many patient care areas in State facilities are not equipped with central air-conditioning and the window units and fans are frequently out of commission. The need to address such basic requirements further diverts already limited staff time from care and treatment of the patients' psychiatric disorders. Similarly, several of the older, larger physical plants contain many buildings which are no longer used by the hospitals but which, nonetheless, need to be maintained to some degree to prevent total deterioration. Thus, limited resources are again drained for non-essential purposes. Physical plants should be consolidated to include only those buildings used and needed by each facility for its operation; campuses should be attractively landscaped to permit and encourage active use by patients and staff.

The Commission believes that, as Maryland's public psychiatric hospitals are reorganized and reconfigured, care and attention should be paid to access and availability issues. With the majority of intermediate and long-term hospital care still being provided by State facilities in the future, facilities should be located as close as possible to the patient's home community to encourage and permit continued involvement of families and friends and to facilitate linkages with support services and community agencies, and to facilitate the transfer of patients to community facilities as soon as clinically feasible.

State facilities should be an integral part of the communities they serve to the greatest extent possible. The location and size of remaining facilities should be determined taking into account access and availability issues and ideal facility size from both clinical and administrative perspectives as well as cost efficiency. The possibility of local governments ensuring control and/or becoming involved in the operation of publicly funded inpatient mental health services would be enhanced by locating State facilities near the jurisdictions they serve.

Chapter Five

Views of Concerned Groups

A. Views of Present and Former Patients

The ex-patient advocacy movement is relatively new in Maryland dating back to 1982. With any group of people one is likely to get many different viewpoints on a given topic. Such is the case with the question, "What is the future of state psychiatric hospitals?" There are those who believe that state psychiatric hospitals should be abolished completely, including the private hospitals; some feel state hospitals are better places of care than private hospitals like Sheppard-Pratt or Taylor Manor. Ex-patients are concerned about their legal rights and have found a better monitoring mechanism in the state facilities than in the private ones; some feel that the four large regional hospitals should be closed and smaller community-based hospitals established. In other words, there are a variety of views on this question and consensus can often be difficult to reach. For the most part, the ex-patient/consumer perspective is that an "alternative" system needs to be established and the large state hospitals gradually closed.

We are united in the belief that one of the most important initiatives that must take place before hospitals are phased out is the development of a comprehensive community-based system of care for the consumers of mental health services. This includes a wide range of services, from consumer operated drop-in centers and housing programs, to respite care homes and crisis residential services. Also needed are mobile crisis/treatment teams, along with more supervised housing programs, low income housing for those consumers that do not need supervision, more community rehabilitation programs, enhanced community mental health centers, case-management services, and special programs to deal with those with dual diagnoses from alcohol/substance abuse problems, those who are hearing impaired and programs designed to help those caught up in the criminal justice system. Many services are needed in the community and these should be funded at a level to provide quality care for people who have traditionally been left behind by society over the years, both from a philosophical and literal perspective.

Spring Grove Hospital was founded in 1797, Springfield Hospital Center in 1896 and Crownsville was opened as the Hosital for the Negro Insane of Maryland in 1911. Today, with the advent of modern technologies and treatment modalities the state is still treating its mentally ill citizens in a system of care over 100 years old - out in the country far away, for the most part, from their families and friends and the community that they are familiar with. It seems more humane to us, to establish a system of care that is community-based, close to home, close to families and friends - a natural support system. This would be less stigmatizing for the client, easier to access and in the long run less costly for the state.

Many mental health professionals agree that psychiatric hospitalization, as known in the past, should be changed:

> Lamb (1979a) has stated that, with the many effective alternatives to hospitalization, "for a large portion of acutely ill psychiatric hospitalization as we have known it in the past is not necessary." Lamb notes that there are numerous examples of alternatives to hospitalization where persons who would otherwise be hospitalized are treated as effectively or more so than they would have been in conventional hospitals. In the alternative service settings, they are less likely to be labeled and stigmatized and are less separated from the community. Lamb and Lamb (1984) also emphasized that, as costs for acute inpatient care rise, hospitals command a larger and larger share of the mental health budget, leaving less and less money for other community-based mental health sevices. This underscores the need to develop lower cost alternatives to inpatient care.[1]

For the most part, the ex-patient/consumer viewpoint is unified in the belief that the large state hospitals should be scaled down and gradually phased out of existence - some could remain as "specialty" hospitals, designed to serve very difficult populations. We are firm in our belief that creative "alternative" programs to psychiatric hospitalization are necessary in a comprehensive community-based system; certainly more humane, less stigmatizing and offer a better quality of care. This has been proven in states like Rhode Island and Colorado. These alternative programs include, but are not

[1]Stroul, B.A. (1986) Crisis Residential Services: Review of Information. 15-16. National Institute of Mental Health

Lamb, H.R. (1979a). Changing concepts in acute twenty-four hour care. In Lamb, H.R. (Ed.), New directions for mental health services - Alternatives to acute hospitalization, 1. San Francisco, CA: Jossey-Bass

Lamb, H.R. and Lamb, D. (1984). A nonhospital alternative to acute hospitalization. Hospital & Community Psychiatry, 35, (7), 728-730.

limited to, crisis residential services, respite care services, 24 hour crisis telephone services, walk-in crisis intervention services and mobile crisis outreach services. Consumer operated drop-in centers should be established in all counties in the same proportion as community mental health centers.

It must be stated that the role of the consumer is critical. Programs should be designed to fit the needs of the individual rather than the consumer having to adapt to what is available in the community. It is critical that programs remain flexible so they can address the varying needs of different people. It should be emphasized that the role of the consumer should not just be as a recipient of services but also as a provider of services. Community programs should be encouraged to hire qualified ex-patients as members of their staff.

Now is the time to make substantive changes in the way the state of Maryland provides psychiatric services to its citizens. The state hospital system is archaic and changes are urgently needed.

B. Views of the Mental Health Assoc. of Prince George's County, Inc.

The Mental Health Association of Prince George's County welcomes this opportunity to present our views on the future of Maryland's system for providing care and rehabilitation to its citizens with major mental illnesses. A copy of the questions the Commission is interested in was distributed to our Board of Directors, our Professional Advisory Council, and to community leaders in political, business and health related areas.

Input was received from a significant number of persons from diverse backgrounds including Prince George's County Councilman Richard Castaldi, Betty Humphrey, R.N., D.P.A., a member of our PAC and on the staff of St. Elizabeth's Hospital, staff from our County Health Department, and from our own members. A meeting was held on July 28th where this input was compiled and an Association position was developed. That position as it relates to each of the questions is presented below.

Question #1. The answer to this question is yes but we would restrict it to general hospitals. The positive aspects are that: Medicaid reimbursement is more likely in the psychiatric unit of a general hospital; patients would be closer to their natural support system; it will be easier to develop linkages to other parts of the service delivery system and, it would create jobs in the local area.

We do have some concerns, the primary one being indigent care. The State will have to take up the slack when actual costs exceed Medicaid reimbursement for both public and private hospitals. There is presently a system where DHMH can contract with a general hospital to open or add to the number of psychiatric beds. The hospital is responsible to help the patient qualify for Medicaid. If patient is not eligible and has no insurance, DHMH will pay the hospital the same as Medicaid with the same length of stay limitations. We know that costs almost always exceed Medicaid reimbursement. Hospitals would lose money. There is no incentive to contract with DHMH. The Mental Hygiene Administration needs to develop realistic and attractive incentives. We recommend that MHA work with the Maryland Hospital Association on this.

Question #2. Many psychogeriatric patients could be cared for in a properly equipped nursing home with adequate and properly trained staff capable of providing quality psychiatric nursing care. The staff would need regular consultation with mental health professionals and there must be a working system for frequent medication reviews. Financial accessibility is also a problem that needs to be addressed. We need to look at changes in the reimbursement patterns by non-profit and commercial carriers, medical assistance that does not require the complete divestiture of the patient's assets, and purchase-of-care contracts with state and/or local governments.

Question #3. Before answering yes, we need to carefully define what is meant when a facility is considered "developed." Chronically ill adults who are appropriate for community-based care need sufficient income to live in the community and they need decent, comfortable housing. There needs to be in place an adequate community support system including but not limited to access to medical, dental and psychiatric care. It is essential that a case manager be assigned to each patient released into the community. There has to be a modicum of community acceptance so that the environment in which they live is not so hostile as to impede their recovery. In this regard, it might be well to coordinate with the state committee that is currently looking into saturation in some communities.

There are many persons, particularly young adults, whose chronic mental illness is complicated with substance abuse and who have not been hospitalized for a long enough time to qualify for community-based care. These persons need the same continuum of community care services described in the paragraph above. Treatment and rehabilitation programs for this population can be provided in creative and innovative ways such as the mobile care teams of Dane County, Wisconsin.

It is also vital to remember that persons with chronic mental illnesses are a heterogeneous group of individuals. They require a variety of services offered in intensities that respond to their special needs.

Question #4. This solution would be acceptable with many qualifiers. There has to be a marked distinction for the patient between life in the hospital and life in this temporary situation. First of all, it has to be "temporary" with an established time limit for the patient to reside there. The facility itself must not resemble the ward the patient just left but should be rehabbed into apartments, or something similar. We must insure that the patient not lose the motivation to take the next step into the community. The patient should experience some of the same opportunity, freedoms and care they would experience in a community-based program: employment, schooling, suitable recreational activities, and not be treated as a patient. There should be easy access to community programs. And most important, from the day the person moves into this temporary arrangement, someone (i.e., case manager) needs to begin working toward moving the client into the community.

Question #5. An Interagency Task Force funded by a grant from the Maryland Department of Health and Mental Hygiene's Mental Hygiene Administration's Southern Regional Office to the Prince George's County Health Department's Directorate of Mental Health conducted an exhaustive study of the mental health needs of children and adolescents in our county. A Recommendations Committee of the task force developed from the study, "Better Mental Health For Our Children and Adolescents: A Prince George's County Strategy," fourteen priority recommendations. The group developing the Association's position felt strongly that these recommendations form the core of our answer to this question.

These recommendations are listed by sections of the Continuum, not by priority order:

SYSTEMS ISSUES

Local Coordinating Council—Agencies within the Local Coordinating Council seek resources for a coordinator and other necessary staff to assist in processing cases referred to them.

Case Management—The Health Department create a distinct and accountable mental health case management system to serve children and adolescents. Once created, this case management unit would participate in the development of a

county-wide interagency case management system. This system would be developed by an ad hoc committee composed of the major County agencies serving children and adolescents.

Personnel—The Health Department's Directorate of Mental Health obtain funding from the Mental Hygiene Administration and the County to hire additional trained child and adolescent mental health staff. These staff need to be assigned to each Community Mental Health Center. In addition to outpatient therapy, a certain percentage of their time needs to be designated for providing outreach to schools, consultation, education, training, planning and home visitation services.

PRIMARY PREVENTION ACTIVITIES:

Mental Health Education—The Prince George's County Public Schools require a semester of health education for all high school students prior to graduation. This course would include information, concepts, and decision-making skills relative to optimal physical, mental, social and emotional health.

EARLY INTERVENTION SERVICES:

Parent Education and Support—An agency such as the Directorate of Mental Health's Consultation and Education Unit, Prince George's County Public Schools, Mental Health Association, or Family Service Foundation to: locate funding, stimulate the development of, provide and coordinate community parent education and support programs throughout the County.

EVALUATION, ASSESSMENT, AND DIAGNOSIS SERVICES

Evaluation—The Directorate of Mental Health seek Mental Hygiene Administration funds to create multidisciplinary evaluation teams which would be a single point of entry to the public mental health system in the County.

IN-HOME AND COMMUNITY SERVICES

Youth Service Bureaus—The Juvenile Services Administration using State, County, and/or local funds, seeks to establish and expand Youth Service Bureaus or Multi-Service Centers, particularly in Southern Prince George's County.

Walk-In Counseling Centers in Schools—The Prince George's County Public Schools and the Directorate of Mental Health utilizing interagency funds, develop a pilot project to establish walk-in counseling centers in a variety of schools.

Suicide Prevention—The Mental Hygiene Administration and the County allocate funding to the Mental Health Association's Suicide Prevention Center to expand hotline, information and referral, and crisis outreach services in accordance with the Community-Wide Task Force on Suicide Prevention's 1987 Report.

Intensive Family Services—The Mental Hygiene Administration, Juvenile Services Administration and other agencies utilize the Department of Social Services' Intensive Family Services program as a model for developing similar flexible short-term intensive services, and that the Department of Social Services expand upon this model.

Respite Care—The Mental Hygiene Administration fund the County Department of Social Service's Respite Care program to provide services for families with severely emotionally disturbed children and adolescents.

SUBSTITUTE CARE SERVICES:

Community Residential Care—The Mental Hygiene Administration continue to provide funding for the development and expansion of community-based residences for emotionally disabled children and adolescents to supplement residential services provided by the Juvenile Services Administration and the Department of Social Services.

Residential Care—The Mental Hygiene Administration insure that the quality of life is enhanced for RICA-Cheltenham students by improving personnel practices through training programs and by improving staffing ratios, the physical plant, furniture, decorations, and recreation programs.

Inpatient Substance Abuse Unit—The Directorate of Addictions facilitate the development and implementation of an inpatient substance abuse program targeted for PCP victims and adolescents who are emotionally ill substance abusers.

The Association has additional concerns on this subject. Acute inpatient psychiatric care and residential or long-term care should be available within 45 minutes travel time of 95% of the population and meet 100% of the need. These units must admit involuntary patients and our universal concern for financial accessibility applies to this also. Appropriate grade level education must be provided to children and adolescents while in residential care.

While speaking of residential care, it is widely believed that children under the age of 12 should never be institutionalized. Adequate and aggressive early intervention, assessment and diagnostic programs as recommended above may be the best way to avoid institutional care.

Day treatment for up to three times the residential capacity needs to be provided for children and adolescents who are recovering. Education requirements need to be considered in a day treatment program as well as alternative community living arrangements for those for whom home placement is not recommended. Family members or guardians must be included in all therapeutic treatment.

A most important part of any service delivery system is transportation. Children and adolescents as well as family members or guardians need transportation to acute and long-term residential facilities and to day treatment programs. This need is especially critical in large parts of our county.

Question #6. The Association agrees that there will always fall to the State the responsibility for care for persons with certain needs. The present State psychiatric hospital system is not the way to meet this responsibility. State psychiatric hospitals for the care of those persons whose needs are delineated in this question should be geographically located within 60 to 90 minutes of 95% of the population. The hospitals should be as small as is economically and programmatically feasible. They should be located in the proximity of a general hospital with a contract with that hospital to provide medical-surgical inpatient care and outpatient general health services as needed.

The programs in these hospitals should include meaningful activities including employment, in order to promote healthy, satisfying use of time and talents for those patients who can benefit. To the extent that statutes permit, some patients

could be employed for fair compensation, then pay for their room, board and treatment. Programs should be designed to impose as few restrictions as the patients' behavior permits, consistent with their safety and the safety of the community.

The Association believes that the Clifton T. Perkins forensic psychiatry facility will serve a continuing need for the foreseeable future.

The travel time figures used in answers to Questions 5 and 6 are taken from recommendations made by the Southern Maryland Health Systems Agency.

C. Views of Employee Representatives

Views of MCEA

Historically, the treating of mentally ill individuals has been a function of the states. This is particularly true for those persons who have no insurance and no other means to pay for private sector hospital treatment. Therefore, the Maryland Classified Employees Association believes the State should be extremely cautious about moving patients from State psychiatric hospitals to private sector hospitals, nursing homes and other community placements. Contracting out the provision of these services would create a situation where profit, and not quality of care, becomes the bottom line.

MCEA is concerned that private sector hospitals may resist taking large numbers of mentally ill patients from state hospitals for three reasons:

1. Lack of proper space.

2. Lack of adequate treatment programs.

3. Many would be non-paying patients.

At the July 30, 1987 public hearing held by the Commission, a representative of the Maryland Hospital Association said, "The private psychiatric hospitals and the psychiatric units in acute hospitals do not have the capability of caring for all acute psychiatric disorders. There are a significant number of acute cases that the private sector does not have the clinical or programmatic ability to care for simply by expanding the number of acute psychiatric beds. New clinical modalities of care and facilities would have to be developed." The speaker went on to say that treating these additional patients in the private sector would generate approximately $21,759,840 of additional bad debt for the acute general hospitals.

Two recent studies of local nursing homes found that nursing home contracts were found to be vague, contradictory and asking clients to sign over their legal rights. The studies also found that contracts had clauses allowing the nursing homes "...to evict elderly residents for vague offenses defined as being immoral,

intemperate or negligent..." The Maryland Bar Association study found that "nursing homes take advantage of the anxiety of their customers to get them to sign contradictory contracts with provisions that are often illegal or questionnable."

Placing patients in community housing is not new. There are limits on funding to support these programs as well as limits as to which communities will be supportive of chronic patients residing in their neighborhoods. Through past deinstitutionalization efforts, the "better" patients have been moved to the community, leaving patients with behavioral patterns that are unacceptable to the community and patients which require close supervision and special treatment provided at the State hospital. One need only to look at the sorry experience of other states which rushed to empty mental hospitals. The patients became part of the new homeless and street people as the community-based facilities simply could not handle them. Do we want Maryland to repeat this experience?

For some time, the state psychiatric hospitals have been underbudgeted and understaffed. In spite of this dilemma, the State employees have been providing quality care to the patients they serve. Therefore, MCEA is taking the position that the budgets and staff of the state psychiatric hospitals should be increased. This would bring up the level of care, which would result in decreased length of stay and decreased census. We also believe this would be less costly to the taxpayers than contracting with private, for-profit hospitals and nursing homes.

C. Views of Employee Representatives

Views of AFSCME

I. Children and Adolescents

The consensus of the committee emphasizes privatization. Children would be moved from hospital care to community care as soon as possible. This assertion clearly sidesteps the questions regarding care of the most severely impaired and behavior problems. Secondly, the committee suggests contacting private hospitals to detemine whether some pediatric beds could be converted for SED children, including those under 12. Such privatization benefits no one but the private hospitals. The SED children may receive less care due to staff inexperience and turnover in a private hospital. Also, the committee emphasizes the privatization of the Regional Institutes for Children and Adolescents (RICA). If I am not mistaken, at least one of these facilities is relatively new. There should be additional information as to why the operation of RICAs should no longer be functional.

There is a nationwide trend of states trying to rid themselves of child and adolescent mental health care. Part of the reasoning suggests that if all the children and adolescents are being treated in the community, some day there will be no need for State mental helath institutions. We believe this reasoning is flawed, because some SED children may be untreatable in community settings.

II. Elderly Psychiatric

Moving psychiatric patients to homes is a questionable practice. Most often elderly psychiatric patients are moved to nursing homes to capture Medicaid funds for the home depopulation. The psychiatric elderly, at a rate of 100 per year, may or may not jeopardize the status of nursing homes but it nevertheless constitutes a form of patient dumping. The disability characteristics of the psychiatric elderly should be assessed and individuals should then be placed in appropriate operational facilities.

III. Chronically Ill Adults

In concept some aspects of this deinstitutionalization might be feasible. In reality, Maryland communities do not currently have the capacity or expertise to support chronically ill individuals. It is not clear how soon or whether Maryland will develop that capacity.

The recommendation to permit residential spaces temporarily developed under contract to private providers in existing or renovated spaces on hospital grounds are not unacceptable to AFSCME Council 92. Such a plan only substitutes lower paid worker and lower quality assurance standards for what currently exists.

IV. Acute Adults

The recommendation of the commission is that 200 acute care patients would be moved to private hospitals during the next three years. In essence, the commission is recommending treating the proxy bed approach as an expanded pilot project designed to determine whether the private sector can treat acutely disabled individuals. The evidence from other states indicates both an unwillingness and an inability on the part of private sector providers to provide care for the most disabled individuals.

Moreover, if the state wishes to obtain answers for the four stated pilot project objectives surely a pilot project of less than 200 of 550 total individuals could be developed. After the three-year examination period, what would the State do if 200 individuals had been placed in private hospitals and the programs had failed miserably?

V. The Role of State Hospitals in the Long Term

All of the groups cited should be cared for in public sector facilities. State hospitals, according to the commission, should work with the private sector to provide sophisticated high technology and sub-acute patients who do not respond adequately to the more routine treatment available in most private hospitals with small psychiatric wards. From the findings contained in the "Study of Statewide Inpatient Mental Health Services," it appears that the future state hospital role in this area may not be limited, moreover, to the psychiatric public sector individual.

VI. The Number and Configuration of State Psychiatric Hospitals

AFSCME Council 92 wholeheartedly supports the commission's recommendation that no State hospitals will be closed in the near future. Indeed, the value of Maryland's State Mental Hospitals is contained within the Commissioner's own statement:

> "the most consistent advice this commission has received from virtually all witnesses has been to postpone closing hospitals until we see how well private alternatives serve."

If the State's privatization plans are not realized, State hospital populations will remain relatively stable or perhaps would grow. No state land should be sold within the next three years to insure maximization of the States and commission's ultimate goals.

VII. State Hospital Staff

There would be no job loss in Maryland due to deinstitutionalization. It appears, from all available evidence that Maryland's State hospitals are continuing to play an important role in the State's continuum of mental health care. If facilities ultimately phase down or close, the existing skilled and experienced work force should be used to provide care in State-operated facilities or othe appropriate community services.

VIII. Quality Assurance

Efforts must be undertaken to insure that enough case managers are employed to oversee the State's current community mental health population. In addition, efforts must be made to guarantee that both public and private sector facilities are fulfilling their quality care obligation to their clients.

It is obvious that a quality community care system does not now exist in Maryland. Whether a quality private sector community system will exist in the future remains an open question.

The number of disabled individuals living in Maryland will grow over time. The demand for services for treating the young chronic schiophrenias and similarly disabled individuals will also increase.

In conclusion, AFSCME Council 92 supports a continuum of public sector delivered services ranging from State hospitals to State-operated community facilities where absolutely needed.

D. Views of Families of Adults. (Alliance for the Mentally Ill of Maryland)

We are happy to a be able to report to you on the questions you have raised. We note that some of these questions concerning acute care, long term care and nursing home care were addressed by the Goldman report to the Department of Health and Mental Hygiene and our response to your questions also addresses the recommendation of the Goldman Report.

Our response is "go slow" - increase community services and measure the impact on needed hospital care before moving quickly. We generally say "no, not until" or "yes, to a point, if"

We well understand the problems with the present hospitals, the present cost and the proposed cost of increased staff and renovations. We understand that continued funding at the present level, while simultaneously creating alternatives in the community, will require greatly increased expenditures for a period of time. We see no alternative. We believe that a phased reduction in hospitals and the increased provisions of services in the community is sound and sensible.

We do believe that Maryland stands at the crossroads and can, in the foreseeable future look to a reduced need for hospital care, including acute care, if there is available in the community a spectrum of services "the continuum of care" for the involuntary patient, and a changed commitment standard so that patients will not deteriorate until they present a clear and imminent danger (existing law), followed by long hospital stays, but can receive therapeutic intervention before the condition becomes acute.

We subscribe to the present effort to provide care for the mentally ill in the community whenever possible and hope that experience will prove this to be effective in reducing the need for hospitals.

As to the future of state hospitals for the mentally ill, we urge that the full cost of providing adequate care for all mentally ill persons in this state be planned for and be made available before any changes are made in the hospitals.

We urge that no hospital be closed until a fully developed support system, adequate for all, is created.

We urge that the proceeds of any sale of existing facilities, after the implementaion of an adequate community support system, be placed in a trust fund dedicated to the care of the mentally ill.

We urge that a plan be developed which will permit the ultimate phasing out of some hospitals and the replacement of others.

We agree with the expressed goal of the Goldman Report looking toward a one class system and wonder if this will also apply to the community mental health centers, with privatization of those centers.

We support a commitment to the development of level V Housing for the chronic mentally ill, and we support the utilization of existing facilities for domicillary care, under the auspices of local government.

We do not believe that a cost saving is possible by changes in the utilization of the hospitals, but we believe that quality of care should be the highest concern.

We agree with the concept of small regional hospitals.

We are uncertain that small general hospitals have the ability to provide acute care since they lack security and the needed specialized staff.

We believe that it is possible, after an adequate system of care exists, to move to nursing homes some of the geriatric mental patients.

We urge that the children, now placed out of state for necessary services, be returned to the State when services become available and that the long waiting lists for services be addressed, and that parents not be forced to relinquish custody because of lack of ability to pay for services, and that hospital care be available for the one to twelve year old and for adolescents.

E. Views of Families of Children and Adolescents

CONCERNS ABOUT RESOURCES FOR SERIOUSLY EMOTIONALLY DISTURBED CHILDREN

A Summary of Testimony for the Commission
On the Future of State Psychiatric Hospitals

Presented by Nancy S. Chisholm
For the Alliance for Mentally Ill Children and Adolescents

The Alliance for Mentally Ill Children and Adolescents is extremely concerned about the inadequacy of available resources to serve seriously emotionally disturbed children and their families. Our members experience crises created both by poor delivery of available resources and by the simple lack of sufficient resources to meet their needs.

Sometimes we are injured by the way our children are handled by the several systems that attempt to serve them — the school system, the courts, the mental health service system and social services. Examples of such poor delivery of services are:

1. School officials and teachers are not well informed about the availability of resources to serve seriously ill children. One of our members sent her child to California and with her husband worked a total of four jobs in order to pay for private residential care. School officials told her the school system had no responsibility in the matter. We believe that all classroom teachers should know about the responsibility of the school system to educate mentally ill children and should be able to provide at least the basic information needed to start the parents moving in the reight direction to obtain appropriate resources.

2. The time required to process children through the school placement office is too long. One of our members stayed at home with a child who had attempted suicide, waiting for placement through the school system. The child made a serious attempt at suicide and was hospitalized before any placement was offered. Another member spent $25,000 from her son's college fund to keep

him in a private hospital while they awaited placement through the school system. We believe that seriously emotionally disturbed children should be given priority by the placement office and moved quickly to adequate care.

3. The school placement office is extremely reluctant to make a finding that a child needs residential care (Level VI care.)

4. The judicial system all too frequently retains children in detention centers, without benefit of schooling, when the children would be far better served in a residential program for seriously emotionally disturbed children. The Montrose Center is frequently named as one such center.

5. The CINA Program (Children in Need of Assistance) is used to provide financial resources to children in residential placements. Under the program, parents have to relinquish custody of their own children to the State so that the State will pay for their care. This is a brutal act toward parents already suffering intense anxiety and stress. It should not be necessary for a parent to give up custody so that the child can be placed.

Many times our families discover that the kind of service they need is simply not available. Examples of lack of resources are:

1. The state mental hospitals are severely overcrowded, with children sleeping in the hallways, awakened by every event during the night. Supplies are woefully inadequate. There are frequent staff shortages and turnover. The Muncie Center was without a director for an extremely long period. Nevertheless, we hve experienced staff as helpful, caring, thoughtful people, trying to provide good service in an extraordinarily inadequate environment. It seems to us highly likely that the state hospital will be a very important resource to our members for a long time to come, despite the emphasis on the possibility of developing alternative residential care. We strongly urge that the present state hospital centers be adequately funded and fully staffed to provide appropriate services to our children. We cannot accept the shrinkage of hospital services until it is clear that new facilities have been developed so that there are sufficient beds for all those who must be in residential care.

2. Alternative residential services are needed so that children can be helped in the manner that is least restrictive. In many cases this cannot be the child's home, but hospitalization with the attendant locked doors and extremely careful monitoring is not needed. Therapeutic foster care, therapeutic group homes, and other forms of residential treatment should be developed to meet this need.

3. There needs to be a case management system for the seriously ill children who are being served by any of the four systems. In some cases, the parent is the case manager in effect and is able to handle the responsibility. However, it is sometimes the case that the family is under serious stress and is not at all able to determine what services are available, which may be appropriate for the child, and how to access the systems.

4. There is far too little assistance available for seriously ill children twelve years of age and younger. Crisis beds are extremely few in number throughout the state, and residential care is almost totally absent. Nevertheless, there are children who need such services, and such services should be developed.

5. For the many situations where the children remain at home, but require a highly structured setting and almost full time supervision, there needs to be summer programs, after-school programs, special transportation, and respite care for the families. For older children, there should be supervised summer employment opportunities.

6. Many of our children have been sent out of state into residential facilities. This creates a terrible hardship for the family, which tries to provide love and support for the child despite the time and money demands of long distance visits. it is also extremely difficult for the child to be readied for re-entry into the family, school, and community when the child is so far away. For example, weekend passes are relatively meaningless if most of the weekend would have to be consumed in travel. The pain of parenting a seriously ill child is intensified a thousand times over when the child is sent away from the community.

7. Finally, far greater assistance is needed for the children as they leave the school system and move into adulthood. They need housing, training,

employment, and supportive care. A case management system for these young adults is critical, because they need to learn to function independent of their families to the extent possible.

In times of severe budget austerity, it is very difficult to face up to the needs of the seriously emotionally disturbed because the costs per person are so high. It is surely easier to spread available funds to serve many less needy children. But private insurance and personal finances are almost always totally inadequate to address the needs of a seriously ill child. Government — local, state, and Federal — must bear the burden.

F. Views of private Hospitals

Introduction

"Private Hospitals" in Maryland refer to general hospitals with psychiatric units, which are in the majority, and free-standing private psychiatric hospitals. In February 1987, 55 general acute and psychiatric hospitals were sent a letter asking: "If it was determined that additional acute general psychiatric beds were available, would your facility be interested in adding additional psychiatric beds to your present complement of licensed beds?" Forty-three of the 55 hospitals responded with the following results:

TABLE I

Hospital	Definitely Interested	Possibly Interested	Not Interested
Total	26	5	12
%	60	12	28

That 60% of the hospitals reponding indicated "definitely interested" is important. This takes on added significance in that nine of those 26 "definitely interested" hospital have already applied for or recently received CON approval for acute psychiatric beds. Given the Goldman Report in which one or more scenarios recommend transfer of the adult needing acute psychiatric care to the private sector, the private hospitals seem open to finding means to accommodate such patients - though not without serious concern. That there is a commitment to the care of such patients is definite, given adequate planning, funding, staffing and facilities.

Concerns and Recommendations

Based on interviews with representatives of hospitals and practicing psychiatrists and public testimony, a number of common concerns from the private sector emerged as the impact on private hospital systems was weighed given the shift of acute psychiatric care from the state to the private sector. The most frequently mentioned problems and related recommendations were as follows:

I. Medicaid Imposed DRG's On Psychiatric Care of Inpatients

The DRG's established by MA for care of psychiatric patients is seen as unrealistic and unreasonable by the hospital community. This imposes a serious problem, since a main assumption for shifting acute care to the private sector, is to make a larger number of patients eligible for Medicaid insurance (Medicaid will not reimburse State hospitals for care of patients ages 21 to 64). The question is asked, "If the acute care in State hosptals averages 30 days LOS, what will happen to patients under MA in the private sector where stays are now limited to 9-16 days?". Other related DRG issues are:

a. Involuntary patients have longer stays than voluntary. More such patients under the proposed system will enter private hospitals. Current DRG system fails to recognize this factor.

b. The DRG's for psychiatry were put into place on a temporary basis by Medicaid to meet an emergent situation. MA resists attempts to have this policy reversed.

c. Maryland has a waiver that exempts it from DRG's. In addition, under federal regulations psychiatry services are an exempt specialty at the present time. Paradoxically, psychiatry in Maryland is not exempt from DRG.

Recommendation

1. Medicaid must phase out the Medicaid DRG's limits which are totally unacceptable to the hospital community.

II. Funding For Services.

Sufficient financial, clinical, programmatic and facility resources must be allocated to the private sector for care of these patients. The State's response, so far, seems to be equivocal and uncommitted. The hospital community perceives that the State expects the private sector to raise its bad debt level, which will occur from the shifting of costs of care for such patients, so that this cost will be past on in terms of higher rates in an all payor system. However, this poses a threat to the waiver for the State of Maryland (discussed elsewhere in this report), and therefore, is opposed by the hospital community.

Recommendations

1. Mental Hygiene Administration must submit a definitive and detailed plan on how to transfer the care of hundreds of psychiatric patients to the private sector. A definite commitment must be made for directing resources saved to the funding of non-insured and under-insured patients, which would improve MHA's credibility with the private sector.

2. HMO's and self-insured plans, which are free of state and federal regulations, frequently deprive plan members of mental health benefits, thus forcing their care onto the State system. A concerted effort through the legislature should be carried out in order to provide a mandated level of mental health benefits for these groups as provided by insurance plans under state and federal regulations.

III. Care of the Extremely Behaviorally Disordered (violent) Patient

The Goldman Report in all of its scenarios addresses the need for the State to maintain a separate forensic unit. However the private sector feels there is a need for designated units to treat violent patients and treatment resistant patients who have in the past been cared for in State operated facilities. Both groups require special facilities and staffing patterns not currently available in the private sector. If this issue is not addressed, it will become a major source of resistance in the private sector to accepting the care of this patient group.

Recommendation

1. There should be available at least one State operated facility for more difficult, severely violent, and other long-termed patients who may require less active treatment but do not qualify for nursing homes. An alternative would be to have the private sector bid on the operation of such specialized units.

IV. Reimbursement for professional services

Lack of discussion of reimbursement for professional services in the Goldman Report is striking by its omission. The same failure to address reimbursement for professional services in the private sector is evident in all reports submitted by

DHMH Health Services Cost Review Commission (HSCRC), State Health Resources Planning Commission (SHRPC) and Medicaid. The focus of the above groups has been solely on reimbursement for hospital costs under MA. No methodology was developed for estimating the cost to the health care system for services of psychiatrists, psychologists, social workers and other mental health professionals. The neglect of this issue leaves the private sector concerned as to the intent of the State planners. It also detracts from the validity of projected costs for the various scenarios developed in Goldman Report.

On the other hand, certain private sector hospitals have been and are continuing to treat MA insured patients on acute care psychiatric units. Models exist which provide for professional reimbursement in different ways. For example, one model is that psychiatrists are fully salaried on Psychiatric unit and the hospital bears responsibility for the professional costs. The second model is that a hospital guarantees private practicing psychiatrists an agreed upon fee for service to MA patients.

Recommendations

1. The HSCRC, SHRPC, and MA need to determine costs for professional service as part of their overall plan if competent and dedicated professionals are to be involved in the providing of such care.

2. MA must move in the direction of making more substantial professional reimbursement for mental health services, given the time and intensity of service required by this population.

3. The private sector needs to develop models of care, uniquely suited to each institution, which will optimize on available reimbursement for professional services.

4. The community of private practicing mental health professionals must be more willing to accept the challenge of caring for MA patients, at probably lesser rates than private patients, in efforts to make the system work for those who have limited financial resources.

Summary

The private sector sees an opportunity for collaboration and communication between the public and private sector for the optimal delivery of psychiatric care. The above problems, and recommendations for their solution, must be addressed in order to bring this about.

G. Views of Private Community-Based Rehabilitation Providers

MAPS Reaction to Hospital Based Transitional Rehabilitation Program

MAPS, The Maryland Association for Psychosocial Services represents 45 Community Rehabilitation Programs in the state of Maryland. Since its inceptions, MAPS has endorsed strongly the concept of services being rendered to consumers in the least restrictive environment. In addition we have advocated a philosophy of consumer empowerment which allows for those receiving services to have meaningful input into the decision making process affecting their lives. Our experience has shown that the traditional state hospital environment has not consistently afforded this consumer empowerment process. Therefore, we naturally have some concerns about a hospital based program environment.

On the one hand we are also keenly aware of the following:

1. That there are individuals in state hospitals who are not ready for the community but did not require the traditional-medical model services provided in that facility and a quality based rehabilitation program developed and run by a non profit CRP could well serve the needs of those who still require a structured supervised environment.

2. That currently there are not enough adequately staffed programs in all the communities to provide services to this particular group of individuals.

3. That the possibility of community backlash is greater should these individuals be discharged into the community without appropriate preparation and supervision.

Therefore, MAPS is open to the exploration of these propose Transitional Rehabilitation Programs with the following concerns in mind.

1. That these TRPS be a temporary and not permanent mechanism for addressing the problems of overcrowding and/or providing services to this population in a community-based environment. We are concerned that the

intense struggle to develop a community based delivery system not be abandoned for band aid measures.

2. That adequate resources be allocated to ensure that quality rehabilitation services are provided with adequate and professionally trained staff. It is our opinion that such projects must have every opportunity to be successful and adequate resources are essential.

3. That once initiated, a commitment to complete the project must be ensured. Maps is concerned that other demands on the hospital (i.e., personnel freezes, short-staff units, etc.) may interfere with negotiated staff sharing arrangements.

4. That non profit organizations be allowed to maintain the ability to be flexible, creative and spontaneous and not be forced to adhere to the rigid systems which have prevented the current state hospitals from being successful in providing services to this population.

With these concerns in mind, MAPS supports any initiative designed to provide a better sevice to the consumers we all share in the mental health delivery system.

H. Views of Community Mental Health Centers

The Maryland Council of Community Mental Health Centers enthusiastically supports the work of the Governor's Commission on the Future of State Psychiatric Hospitals. The Commission will be making its recommendations in the near future and the Maryland Council wishes to be on record both in support of the Commission's work and to provide recommendations of its own which may be complimentary to the final report of the Commission.

First, the Maryland Council strongly recommends the further development of a comprehensive community based system of care before the closure of any state hospital facility. Such development must increase the treatment capability of the community mental health centers as well as expanding rehabilitation and residential services. A comprehensive system must also include mental health emergency services and mobile treatment services.

Second, we recommend consolidation of the four regional state psychiatric hospitals into three such facilities with the closure of one regional hospital center. The consolidation of the state hospital system should result in the saving of state funds which must be reallocated to community programs.

Third, the State should plan to shift all acute psychiatric admissions from state psychiatric facilities to private community hospitals. The Maryland Council recognizes that the state Mental Hygiene Administration is already moving in this direction and we support and encourage the transfer of acute care to community hospitals. In a similar way, the State should continue its efforts to transfer geriatric mental health patients from state facilities to private nursing homes and we encourage our member centers throughout the state to cooperate with this effort.

Fourth, treatment services at the community level for the care of children and adolescents must be enhanced. The Mental Hygiene Administration has already begun such enhancement, and the Maryland Council supports these efforts. However, the needs of children and adolescent care surpass the present level of enhancement now being provided for community based treatment services. In addition, the need for inpatient facilities for the younger child should be carefully assessed and appropriate plans formulated.

Fourth, treatment services at the community level for the care of children and adolescents must be enhanced. The Mental Hygiene Administration has already begun such enhancement, and the Maryland Council supports these efforts. However, the needs of children and adolescent care surpass the present level of enhancement now being provided for community based treatment services. In addition, the need for inpatient facilities for the younger child should be carefully assessed and appropriate plans formulated.

Fifth, the role of the state psychiatric hospital of the future should be in the areas of intermediate and long term care with specialty services provided via special units. The dually diagnosed patient, the treatment resistant patient and other specialty groups will provide appropriate populations for psychiatric research and intensive patient care. The Maryland Council believes that the State's inpatient role in serving special populations needs to have further planning and development.

The Maryland Council is fully appreciative of the opportunity to make comments to the Commission and we support the goal of making Maryland a model state for the treatment of persons with a mental illness.

I. Views of Psychiatrists

William H. Arnold

My name is William Arnold and I have been practicing psychiatry in Maryland for the past 26 years. I am a past President of the Maryland Psychiatric Society and a Clinical Assistant Professor of Psychiatry at the University of Maryland. Recently I have spent three years working on the clinical staff of the Springfield Hospital Center. Currently I am a staff psychiatrist at the Frederick County Mental Health Clinic and a psychiatric consultant to Way Station, a rehabilitation, residential and mobile services program in Frederick.

Questions 1, 2, 3: Yes, as rapidly as the resources can be made available we should shift acute psychiatric care to community facilities, geriatric psychiatric care to nursing homes with mental health services, and chronic adult open ward patients to community-based rehabilitative facilities.

Questions 4: No! This is "warehousing," not rehabilitation. Such a facility on the grounds of a State hospital would be a shelter or domiciliary but not a therapeutic setting nor one favoring rehabilitative care. The advantage is that hospital costs would be reduced. If this is necessary it would be better that such shelters and domiciles be in the community and accessible to community resources rather than hidden in remote hospital locations. But please don't confuse this kind of shelter with rehabilitation!

Question 5: I am only familiar with the Adolescent Unit at Springfield. Because of chronic inadquate resources I believe that this unit should be closed and the services contracted privately in the community.

Question 6: Much smaller but not necessarily fewer hospitals. It depends on the success in developing community programs and inpatient units. They should be more closely integrated with the counties they serve (clinically, administratively and fiscally).

I have reviewed the Executive Summary dated June 22, 1987. There are many unpredictable factors that affect the need for beds and the available resources. For example, the State of the economy affects the incidence of mental ilness and the available financial support. The savings and loan crisis seriously affected the State budget. And judicial decisions and settlements can alter projected plans as in the formation of the Deaf Unit. I have not seen any inclusion in this study of the projected needs for AIDS patients, although dementia is their most typical disabling symptom. Finally, I have personally observed at Springfield the destructive consequences to some fine clinical programs, the deterioration, and the loss of competent staff because of overly ambitious expectations and the inaccuracies of planning for needed beds.

There is some good news about our potentialities. The vast majority of our family members, friends, neighbors, and fellow citizens who suffer from severe chronic mental disabilities and reside in our State hospitals can, with the development of appropriate resources, receive better care, and function with a better quality of life at much less cost in the community. This is true for all except the very dangerous.

This is true with the present state-of-the-art capabilities, but not with the present level of our resources. We need well staffed mental health clinics with a commitment to the chronic patient, working together with quality residential and rehabilitaton programs and able to provide 24-hour mobile services, crisis intervention and aggressive case management. With that in place most hospitalizations can be averted.

1. Views of Psychiatrists

William R. Breakey, M.D.
Associate Professor
Director of Community Psychiatry Program

I was unable to be present at the public hearing on July 30, 1987, but I would like to make some comments on the future of Maryland's system for providing care and rehabilitation for the mentally ill. I hope that these comments may be of some interest to the Commission. I am the Director of the Johns Hopkins Community Psychiatry Program and for a number of years we in East Baltimore have had very restricted access to long-term hospitalization for persons with chronic mental illnesses. We have, nevertheless, endeavored to provide a comprehensive system of services for such persons in our catchment area in Baltimore's inner-city. My program is wholly funded by State dollars, though operates within the "private" context of Johns Hopkins Hospital. Because of our contract with the Mental Hygiene Administration and the Baltimore City Health Department, we are closely regulated by these agencies, so that the distinction between "public" and "private" becomes less clear.

My opinion, based on a decade of experience in Baltimore, is that in general the highest quality of care can be obtained by "private" organizations providing services under contract with State agencies. In general (though there are notable exceptions) the standards of care are less adequate in health care facilities that are managed and staffed by public entities, such as the Mental Hygiene Administration. The best outpatient, partial hospitalization, and rehabilitation services are also those that are provided by private non-profit organizations.

Hitherto this model has not been employed for long-term inpatient care in Maryland. I would suggest that this should be explored and strongly encourage the development of a pilot project in the immediate future.

The care of geriatric patients with psychiatric problems is more complex than your question might suggest: "Should geriatric patients with psychiatric problems now cared for in State hospitals be shifted to nursing homes with access to mental health staff?" The answer to this question clearly depends upon the

nature of the nursing home and the clinical needs of the patient. Many nursing homes provide barely adequate custodial care which is no better than what is provided in the State hospital and may indeed be worse. If a new category of nursing home can be developed, which will provide comprehensive psychiatric evaluation, treatment and rehabilitation on a long-term basis for the elderly disabled, that would be an ideal situation. Under current funding mechanisms, this is a dream that is unlikely to be realized. Nursing homes are not motivated to develop active rehabilitation programs, nor is there funding support for expert psychogeriatric evaluation and treatment.

As has been the policy for a number of years, I support the movement of chronic adult psychiatric patients to community-based care and rehabilitation facilities as rapidly as possible. For the majority of psychiatric patients this is the best setting in which they can receive care. There will remain a small residual group of patients who are, for example, severely handicapped or violent, who require long-term institutional care. I would advocate that this care be provided in facilities that are considerably smaller than the existing State hospitals and are under private management, as outlined above. I would be apprehensive that if existing housing on hospital grounds were made available for the care of long-term patients that the "mental hospitals" would be replaced by "mental colonies," which would retain the stigma and institutionalizing potential of the former institutions. I would therefore urge that housing for long-term patients be provided away from the hospital context, as much in the heart of the community as possible.

There has been general agreement that the deinstitutionalization movement has been hampered by the paucity of resources in the community and rehabilitation of the severely mentally ill. It should be underlined also that there are considerable knowledge gaps; our technologies are limited. There are categories of patients with whom we are quite unsuccessful. There still is a need for strong efforts for research and development in relation to community treatment and rehabilitation. This involves both innovative funding mechanisms and organizational approaches, as well as clinical and service provision methods.

I. Views of Psychiatrists

Lawrence Y. Kline, M.D.

My name is Lawrence Y. Kline, M.D. I am a past president of both the Suburban Maryland and Washington Psychiatric Societies. Time did not permit review and approval by these organizations of this testimony. They will be advancing formal positions on the issues you raised at a later date. I hope that what I have to say will reflect the practical realities which could interfere with the realization of goals we all share.

I am going to limit my comments to the first question posed by the Chair: Should acute psychiatric care be shifted from State to private hospitals? In their report, Goldman et.al. focused primarily on the population eligible for medical assistance. In fact, public hospitalization is a safety net enjoyed by many middle class and "working poor" persons not ordinarily seen as candidates for medical assistance. I will discuss problems in implementing a shift in acute care insofar as both populations are concerned.

Modern psychiatric care is provided, most successfully, when families are involved in the provision of that care and when there is a continuity in the providers of that care from one setting in which it is delivered to another. Families can best be involved and providers can only continue with a patient if care is provided as close to a patient's home as possible. Hence, most psychiatrists fully support efforts to shift acute care from State Hospitals to local general hospitals, psychiatric specialty hospitals, and day hospital facilities.

Nevertheless, there are four very serious impediments to this shift.

(1) The Maryland "All Payors" hospital cost control system which relies on DRGs,

(2) Arbitrary and discriminatory limitations in HMO and "self-insured" plan services,

(3) Unjustified limitation in mandated inpatient psychiatric hospital insurance coverage, and

(4) Inadequate Medical Assistance payment.

I will describe each.

Hospital cost control systems such as Maryland's rely on a methodology whereby reimbursement is set prospectively based on diagnosis. Since there are so many diagnoses, to simplify this approach, the Federal Government grouped the diagnoses and called each group, DRGs. Recognizing that psychiatric diagnoses ill fit this methodology, Congress exempted organized general hospital psychiatric units from compliance with prepayment rules. However, Congress also exempted two jurisdictions, Maryland and New Jersey, from the federal program, altogether, because these states had already placed in operation "all payors" systems. In these systems, rates are set for all hospital admissions, not just Medicare ones.

Maryland elected to base its rates on the federal DRGs, but it did not exempt psychiatry. Hence, in setting its allowed daily hospital room rates for general hospitals, the state does not permit Maryland hospitals to allow for costs for psychiatric lengths of stay greater than what they would incur were the average length of stay that which would result from DRGs. Put it simply, in Maryland, psychiatry is <u>not</u> exempt from DRGs.

One way hospitals have avoided huge losses has been to limit psychiatric lengths of stay by transferring psychiatric patients to State hospitals, and this is true for all patients, whether medical assistance or privately paid.

I recently contacted the Springfield State Hospital to determine if one could relate general hospital ALOS to the number of state hospital transfers. Indeed, a hospital which maintains a relatively lengthy ALOS (though no longer than the national average), Suburban Hospital, transferred only two patients to Springfield during a six month period. On the other hand, a hospital which met the DRG predicted norm by having an average length of stay five days shorter than Suburban, Montgomery General, transferred 18 during that same period!

Another local general hospital was foolish enough, or public spirited enough, to agree to accept involuntary admissions. The availability of facilities for involuntary hospitalization within a local catchment area is a cornerstone of any effort to shift acute psychiatric care to the private sector. It is well known that lengths of stay for involuntary patients are longer than those for voluntary ones. However, the DRG system fails to recognize this factor. The consequence to the hospital has been staggering. This hospital's psychiatric service is a fraction of its internal medicine service, in terms of numbers of admissions and number of beds. Yet, the psychiatric service produced more "days beyond the DRG" than did the entire internal medicine service, 459 as compared to 444, for the entire year of 1986. Needless to say, that hospital, Washington Adventist, is seriously considering closing its involuntary unit! Hospital administrators share information amongst themselves and, as the Washington Adventist Hospital experience becomes more widely know, the possibility of gaining support from the Maryland Hospital Association for the shifting of acute care psychiatric patients will become quite unlikely.

Why can't psychiatric patients be treated within the prescribed DRG-LOS? Is it simply a question of greed or incompetence?

DRGs are extremely accurate in predicting the length of stay for patients receiving surgical procedures who are otherwise healthy. This is not surprising. Only one factor is involved in determining the length of stay — the surgical procedures, itself. This is not true for many medical illnesses in which a number of factors effect lengths of stay. How long will a diabetic need to stay in a hospital? Obviously, this would be expected to vary tremendously depending on the patient's age, intelligence, emotional status, income, availability and willingness of the family or of community resources to provide support, severity as reflected in blood sugar and electrolyte levels, treatment philosophy and training of caregivers, etc. For psychiatric patients, there are the same factors plus additional factors, and diagnosis, in and of itself, is even less powerful in determining the length of stay. Indeed, the American Psychiatric Association, National Association of Private Psychiatric Hospitals, Veterans Administration, and NIMH have, independently, confirmed that the diagnosis predicts no more than 12% of the variance in length of stay for psychiatric patients and often less. Indeed, the actual ALOS for psychiatric patients would be expected to vary

not merely from state to state, but from rural to suburban to inner city, even within the city itself, according to income levels, ethnicities, even medical school affiliations of the caregivers. These regional variations really demolish the predictive value of any national norm.

Indeed, people think they have 30 days of inpatient psychiatric care covered in their insurance. Those with Medical Assistance may think that they have at least 15 days in which their hospital will be paid. In fact, the state is only allowing the hospital to have rates based on 9.5! That is the theoretical average length of stay under DRGs.

There may well come a day when all of the factors determining length of stay for psychiatric patients will be known, quantified, and readily measured. At that point, it might be possible to establish five hundred new DRGs strictly for psychiatric and other complex disorders. This time has not yet come. Yet, the State of Maryland tells us, in effect, forget all you learned about individual treatment planning: consider only cost, and send the "complex" cases to the public sector!

What will happen if there is no public sector facility providing acute care? Hospitals will have no choice but to close down acute care psychiatric units.

In short, acute care cannot be shifted from State hospitals to private ones unless and until psychiatric units in the State of Maryland are exempted from DRGs as has been done in almost every other state in the Union. I hope this will be the Commission's number one recommendation.

Middle class and "working poor" patients rely on private insurance programs and HMO services. HMOs also base their expenditures on prepayment based on anticipated utilization. In the case of all other diagnosis, if the HMO guesses wrong, it is the plan which suffers, financially. It is this incentive which encourages HMOs to put in place programs for prevention and to encourage office based treatment. This is not the case insofar as psychiatric treatment is concerned. The Congress permitted federally qualified HMOs to limit psychiatric care to those conditions which, in the HMOs opinion, would respond to crisis intervention or for which short-term evaluation, alone, was required.

Likewise, the Department of Health and Human Services chose to interpret the law as not requiring that HMOs provide any inpatient psychiatric care. And, in a competitive market place, non-federally qualified HMOs will not be likely to provide as much as a qualified one. Indeed, the largest HMO in Baltimore did not, until recently, provide any inpatient psychiatric care, transferring all patients needing it to state facilities. In fairness, most HMOs do provide some inpatient treatment, However, unlike the case in all other diagnoses, they always restrict the lifetime number of hospitalizations covered to one to three per lifetime, even if the remainder are acute, and they limit the length of stay to 10, 20 or 30 days per stay regardless of medical necessity.

Bear in mind, mandated benefit laws will not keep patients in the private sector if HMOs are exempted from them, as they are in Maryland, or if so called "self-insuring" companies are permitted to be exempt from them, as is also the case in the state.

Competent legal counsel has advised us that states may require a higher standard for HMOs than the Federal Government does. Also competent counsel has advised us that the notion that Federal law requires that self-insuring plans be exempt from insurance laws has never been tested in the courts and could be untrue.

Therefore, the second recommendation of this Commission ought to be that HMOs and self-insuring plans be required to offer those benefits otherwise required by Maryland law.

Yet, even this will not be enough. Unfortunately, the most seriously, acutely ill patient can need more than 30 days of hospitalization in a year. Thirty percent of manic depressive patients have acute episodes despite modern medication. They may well require a three to four week hospitalization in the Spring for their mania and another, of equal length, in the Winter for their depression. That adds up to more than 30 days, and, if there is no state hospital for acute patients, where will they go? Likewise, persons suffering from schizophrenia or from Borderline Personality Disorder may have years in which the total length of all their medically necessary hospitalizations equal 45 or 60 days, not 30. Still another group are those who suffer "atypical" and "treatment

resistance" depressions. These persons require time-consuming trials of several different drugs and ultimately may require electroconvulsive treatments, all the while, being seriously suicidal and not dischargeable, regardless of some arbitrary insurance limit.

Fortunately, we are speaking of a minority of patients. We are not speaking of enormous cost. We are speaking of a need for a human attitude that recognizes the patients real needs even if this adds up to a few more than an arbitrary number of days.

Out of a consideration for situations such as those I have described, the states of Massachusetts and Connecticut require a benefits level of 60 days. The SMPS and the WPS support nondiscriminatory insurance coverage. We believe that there is no fiscal or clinical justification for any discriminatory limitation on benefits. Indeed, the states of West Virginia, New Hampshire, and Louisiana have enacted legislation requiring that inpatient psychiatric insurance benefits be no less than those provided for any other diagnosis.

The 60 day requirement has not noticeably interfered with the economic growth of Massachusetts or Connecticut, which have some of the highest economic growth in the country. The states of West Virginia, New Hampshire, and Louisiana, on the other hand, are noted for low state revenues, whether because of the absence of a state income tax, as in the state of New Hampshire, or because of economic recesssion, as in the other two states. In those states, the nondiscriminatory coverage requirement should be seen as a method by which the state has reduced its financial responsibilitry for the care of the mentally ill by shifting it to the private sector exactly as Goldberg et.al. recommended in "scenario 1."

As a minimal first step, Maryland should follow the example of Connecticut and Massachusetts. But, if Maryland is sincerely interested in shifting care, it should follow the examples of New Hampshire, West Virginia, and Louisiana. The third recommendation of this Commission should be that mandated benefits for psychiatric hospital care be increased to at least 60 days per year or simply required to be nondiscriminatory subject to utilization review.

Finally, in their report, Goldman et.al. anticipated that much of the additional cost of shifting acute care patients would be borne by the Maryland Medical Assistance Program. Since this program is half federally funded, the State would realize an immediate savings, one noted in the report. Unfortunately, Goldman et.al. failed to note the inadequate physicians' and hospital payment in the program which have strongly discouraged physicians and institutions from opening wide their arms to this group. Due entirely to federal insistence, Maryland no longer discriminates against the mentally ill by paying less for mental treatment than it does for all other treatments. However, all that has been done is to raise payment levels for psychiatrists from 16% of the prevailing fee to 40%, as was and continues to be true with other physicians. In short, a psychiatrist will earn more than twice as much for seeing a privately paying patient as by seeing a Medical Assistance one. Hospitals, of course, receive no payment at all from the DRG day limit until the so called "outlyer" provision comes into effect. Though these restrictions do not differ from those imposed for the treatment of any other diagnosis, they are more onerous for psychiatry because of the time intensive nature of our treatments. The state of Virginia pays its doctors their usual and customary fees for seeing Medicaid patients. It does not promote a two tier system in which indigent people are treated as if they were only worth 40% of other people.

Physicians and hospitals are not going to invest the sort of effort needed to treat Medical Assistance patients needing acute psychiatric care until the State pays a fair fee. The Commission should strongly recommend that psychiatrists be paid their usual and customary charge for Medical Assistance payments (subject to peer review) and that hospitals be paid for all medically necessary care.

Despite the major successes Maryland has made in "deinstitutionalizing" patients, establishing and subsidizing community treatment including psychosocial centers, recruiting the most qualified psychiatrists of any state for its public system, Maryland now has almost 300 patients beyond capacity in a state hospital system. This, I assert, is a direct consequence of unwise state policies which, as I have noted, direct patients to state hospitals at the very time the State Legislature is trying to get them out of them!

J. Views of Child Psychiatrists

James C. Harris, M.D.

STATEMENT BY THE MARYLAND REGIONAL COUNCIL OF CHILD AND ADOLESCENT PSYCHIATRY

The Maryland Regional Council for Child and Adolescent psychiatry is the representative body for child psychiatrists in the State of Maryland and the local chapter of the national organization, the American Academy of Child and Adolescent Psychiatry. Our members include over 70 child psychiatrists in the State of Maryland. Members include child and adolescent psychiatrists in all sectors, public, private and academic. Among them are the Directors of the 3 university based or affiliated training programs at Johns Hopkins University, the University of Maryland, and the Sheppard and Enoch Pratt Hospitals, the child psychiatry program directors at public and private hospitals, and those in private practice.

We are particularly concerned about gaps in service delivery for psychiatric disorders in children and adolescents in the State of Maryland, particularly for younger children, children with dual diagnoses (psychiatric problems in mentally retarded, learning disabled, autistic and other developmentally disabled children and adolescents), and the growing population of adolescents in need of mental health services. Recent developments in diagnoses and treatment for young people and new research in the neurosciences have made it possible to treat severe emotional disorders more promptly and effectively. These developments emphasize the need for modern hospital facilities to carry out treatment. Methods are available for comprehensive assessment and the monitoring of therapeutic interventions.

We would call the attention of the committee to the following:

1. There are gaps in the provision of service at all levels, outpatient, day treatment, and inpatient services. Of particular concern is (a.) the rapid rise of admissions for severe emotionally disturbed adolescents and (b.) that there are no state facilities for acute psychiatric care of preadolescents. A hospital based facility is urgently needed for preadolescent children who require acute admission and who do not have access to private facilities. Programs for adolescents require expansion.

2. Major mental disorders do begin in childhood or adolescence and require long term treatment and management. The chronicity of these conditions often is not appreciated and the service focus frequently is primarily on the more immediate management issues rather than long term care.

3. Services for the developmentally disabled population, particularly the mentally retarded, suffer from their being in separate state administrations, one the mental retardation administration and the other the mental hygiene administration. Consequently those most vulnerable to psychiatric disorders are often not serviced and state facilities are not specifically supported or designated for the dually diagnosed. A considerable expense to the state is the practice of sending children to programs out of state at costs up to 60,000 dollars per year.

4. The recent discussions about drastically reducing beds in state training schools raise unresolved questions about where the many mentally ill juvenile offenders can be treated. A study which one of our members participated in last year revealed that 60% of those studied have serious psychiatric disorders.

5. There is no agency in the state that has both authority and responsibility for child and adolescent psychiatric services and a designated and defined budget. The philosophy seems to be that children and adolescents are entitled to what is left over after adult programs are funded.

6. Finding hospital beds for children and adolescents who need an acute disposition is a continuing problem. A central coordinating and monitoring agency would help facilitate such placements.

7. There is a need to develop good program evaluation procedures so we can continue to determine the most effective interventions.

8. Clearly more attention needs to be directed to planning which involves key individuals from all sectors, public, private, and academic. A commitment to programs for children and adolescents separate from the focus on adult programs is of utmost importance.

The regional council has offered to work with the mental hygiene administration in the past. This offer still stands. We appreciate the establishment of this commission and are available to assist in any way that we can be of help.

Appendix I

The Commission on the Future of State Psychiatric Hospitals

The Commission on the Future of State Psychiatric Hospitals was established by the Governor of Maryland in accordance with House Joint Resolution No. 60 of the 1986 Session of the Maryland General Assembly. The Commission's purpose was to study and make recommendations concerning the role and utilization of State psychiatric facilities in a community-based mental health care delivery system. In addition, the Commission was to make recommendations concerning budgets, service standards, scope of patient care and appropriate number of State psychiatric facilities.

The Commission consisted of 15 representatives as follows:

(1) 1 member of the Senate of Maryland, appointed by the President of the Senate;

(2) 1 member of the House of Delegates, appointed by the Speaker of the House;

(3) The Director of Mental Hygiene Administration;

(4) 1 representative of the State Health Resources Planning Commission, appointed by the Governor;

(5) 1 representative of the State Health Services Cost Review Commission, appointed by the Governor;

(6) 1 representative of the Department of State Planning, appointed by the Governor;

(7) 1 representative from the Maryland Council of Community Mental Health Centers, appointed by the Governor;

(8) 3 representatives from the Coalition for Citizens with Long Term Mental Illnesses;

(9) 1 representative of the Governor's Advisory Council on Mental Hygiene;

(10) 1 representative of the Maryland Association of Counties;

(11) 1 representative of State employees;

(12) 1 representative of the Maryland Hospital Association; and

(13) 1 superintendent of a State psychiatric facility, or the superintendent's designee;

In addition, representatives of On Our Own, American Federation of State, County, and Municipal Employees (AFSCME) and Maryland Classified Employees Association, Inc., (MCEA) were invited by the chairman to particpate.

The Commission held its first meeting on December 16, 1986 and continued to meet on a regular basis through August 1987. During that time the Commission visited two State psychiatric hospitals and one private medical facility; contacted several states concerning their laws and regulations governing mental health services; received periodic briefings on the cost containment studies; invited testimony from various interested parties and held two public hearings.

The concerns and contributions of numerous organizations and interested parties were considered by the Commission, including:

State and County government agencies
State and private hospitals
Community care providers
Unions
University of Maryland School of Law
Maryland Disability Law Center
Maryland Psychiatric Research Center
ABT Associates, Inc., & Dept. of Psychiatry, School of Medicine, University of Maryland
Alliances, Associations & Affiliates
Citizens

Additionally, the following materials were reviewed:

- Mental Hygiene Administration's Annual Report 1986
- Mental Hygiene Administration's Master Facilities Plan
- Statistics on Admissions, Discharges, Average Daily Populations and Selected Ratios for Fiscal Years 1984, 1985 & 1986
- Excerpts from various articles and periodicals
- Mental Hygiene Administration Inventory of Facilities and a Weekly Report of Wednesday Night Census
- Study of Statewide Inpatient Mental Health Services, Maryland Mental Health Administration
- Study of Casemix Facilities and Staffing at Regional Psychiatric Hospitals

- Portions of Mental Hygiene Administration's operating and capital budget for the four regional hospitals

- Written views and opinions from interested parties

Appendix II

HOUSE JOINT RESOLUTION NO. 60

A House Joint Resolution concerning

State Psychiatric Hospitals - Study of Future Utilization

FOR the purpose of requesting the Governor and the General Assembly to establish a Commission on the Future of State Psychiatric Hospitals to study and make recommendations concerning the role and utilization of State psychiatric facilities.

WHEREAS, The Mental Hygiene Administration in its Master Facilities Plan states a goal of providing treatment and rehabilitative services to persons with mental disorders in the least restrictive environment; and

WHEREAS, the Mental Hygiene Administration has prepared a 5-year deinstitutionalization plan, as ordered by the General Assembly, with the goal of providing community-based residential and support services for individuals who have a mental disorder; and

WHEREAS, the average daily populations at the Mental Hygiene Administration regional psychiatric hospital centers - Springfield, Spring Grove, Crownsville, and Eastern Shore - have declined 37% since Fiscal Year 1980, but the cost to the State of maintaining these facilities continues to increase; and

WHEREAS, the Joint Chairman's Report of the 1985 Session of the Maryland General Assembly included a request that the Department of Health and Mental Hygiene conduct a study of the Mental Hygiene Administration regional psychiatric hospital centers to provide information for determining the most cost-efficient and effective use of space throughout the system; and

WHEREAS, The regional psychiatric hospital centers are the largest and oldest of Mental Hygiene facilities and contain many acres of unused land and buildings that are empty or in need of extensive repair; and

WHEREAS, Asbestos has been discovered in many State psychiatric hospital buildings and abatement of this problem may be extremely costly; and

WHEREAS, The 5-year deinstitutionalization plan of the Mental Hygiene Administration calls for development of additional community housing, therapeutic, rehabilitation, case management, and other community support services for persons with mental disorders, some of whom now reside in State psychiatric facilities; and

WHEREAS, State expenditures for State psychiatric hospitals continue to represent at least 80% of all funds expended by the State for mental health services; and

WHEREAS, There exists no clear policy as to how State psychiatric hospitals are to be integrated into a community-based mental health care delivery system; now, therefore, be it

RESOLVED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Legislative Policy Committee and the Governor are requested to establish by June 1, 1986, a ~~13~~ 15 member commission, called the Commission on the Future of State Psychiatric Hospitals, to study the most appropriate utilization and role of State psychiatric hospital centers in a community-based mental health care delivery system and make recommendations concerning the budgets, service standards, scope of patient care and number of these facilities; and be it further

RESOLVED, That the Commission consist of ~~13~~ 15 members including:

(1) 1 member of the Senate of Maryland, appointed by the President of the Senate;

(2) 1 member of the House of Delegates, appointed by the Speaker of the House;

(3) The Director of Mental Hygiene Administration;

(4) 1 representative of the State Health Resources Planning Commission, appointed by the Governor;

(5) 1 representative of the State Health Services Cost Review Commission, appointed by the Governor;

(6) 1 representative of the Department of State Planning, appointed by the Governor;

(7) 1 representative from the Maryland Council of Community Mental Health Centers, appointed by the Governor;

(8) 3 representatives from the Coalition for Citizens with Long Term Mental Illnesses;

(9) 1 representative of the Governor's Advisory Council on Mental Hygiene;

(10) 1 representative of the Maryland Association of Counties; and

(11) 1 representative of State employees; ~~and be it further~~

(12) 1 representative of the Maryland Hospital Association; and

(13 1 superintendent of a State psychiatric facility, or the superintendent's designee; and be it further

RESOLVED, That the Governor designate the Chairman of the Commission; and be it further

RESOLVED, That the Commission report its findings and conclusions, including specific recommendations regarding the role and utilization of existing facilities, to the General Assembly and the Governor by ~~December~~ June 1, 1987; and be it further

RESOLVED, That the staff for the Commission be provided by the Department of Fiscal Services and the Department of Budget and Fiscal Planning; and be it further

RESOLVED, That copies of this Resolution be forwarded by the Department of Legislative Reference to the Honorable Harry Hughes, Governor of Maryland; the Honorable Melvin A. Steinberg, President of the Senate of Maryland; the Honorable Benjamin L. Cardin, Speaker of the House of Delegates; the Honorable Adele Wilzack, R.N., M.S., Secretary of Health and Mental Hygiene, 5th Floor, 201 W. Preston Street, Baltimore, MD 21201; the Honorable H. Louis Stettler, III, Secretary of Budget and Fiscal Planning, Goldstein Treasury Building, Annapolis, MD 21404; ~~Alp—Karahasan, M.D., Ph.D.~~ Henry Harbin, M.D., Director, Mental Hygiene Administration, 201 W. Preston Street, Baltimore, MD 21201; Carville M. Akehurst, Chairperson, State Health Resources Planning Commission, 201 W. Preston Street, Baltimore, MD 21201; David P. Scheffenacker, Chairperson, State Health Services Cost Review Commission, 201 W. Preston Street, Baltimore, MD 21201; Edward Matricardi, President, Maryland Council of Community Mental Health Centers, 522 Sussex Road, Baltimore, MD 21204; The Honorable Constance Lieder, Secretary, Department of State Planning, 301 W. Preston Street, Baltimore, MD 21201; Marjorie Sue Diehl, Chairperson, Governor's Advisory Council on Mental Hygiene, 201 W. Preston Street, Baltimore, MD 21201; Raquel Sanudo, Executive Director, Maryland Association of Counties, 169 Conduit Street, Annapolis, MD 21401; and Richard J. Davidson, President, Maryland Hospital Association, 1301 York Road, Lutherville, MD 21093.

Appendix III

MEMBERS OF THE COMMISSION ON THE FUTURE OF STATE PSYCHIATRIC HOSPITALS

Mr. James W. Howe - Chairman	Representative, Coalition for Citizens with long-term mental illnesses
Mr. Thomas E. Arthur	Representative, Coalition for Citizens with long-term mental illnesses
Mr. Herbert S. Cromwell	Representative, Coalition for Citizens with long-term mental illnesses
Ms. Jacqueline D. Hilson, D.S.W.	Representative of MACO
Mr. Edward Matricardi	Representative, Maryland Council of Community Mental Health Centers
Dr. M. Lawrence Spoont	Representative, Maryland Hospital Assoc.
The Honorable Catherine I. Riley	Maryland Senator
The Honorable Samuel I. Rosenberg	Maryland Delegate
Mr. Lynn Garrison	Representative, State Health Services Cost Review Commission
Mr. Otis Warren	Representative, State Health Resources Planning Commission
Mr. Harvey Bloom	Representative, Dept. of State Planning
Dr. Henry T. Harbin	Director, Mental Hygiene Administration
Ms. M. Sue Diehl	Representative, Maryland Advisory Council on Mental Hygiene
Dr. Thomas Krajewski	Superintendent of a State psychiatric facility or designee

In addition, we would like to acknowledge the following people served as members at the request of the Chairman:

Mr. Bill Bolander	American Federation of State, County and Municipal Employees (AFSCME)
Mr. Mike Finkel	On Our Own
Mr. Allen Gaddis	Maryland Classified Employees Assn. (MCEA)

We would like to acknowledge the invaluable contributions of Ms. Ellen Anderson, Mental Hygiene Administration and Mr. Edward Pigo, State Services Planning Commission.

Appendix IV

COMMISSION MEETINGS

1.	December 16, 1986	Dept. of Health & Mental Hygiene, Baltimore
2.	January 5, 1987	Dept. of Health & Mental Hygiene, Baltimore
3.	January 19, 1987	Spring Grove Hospital Center, Baltimore
4.	February 25, 1987	Francis Scott Key Medical Center, Baltimore
5.	March 9, 1987	Louis L. Goldstein Treasury Bldg., Annapolis
6.	March 30, 1987	Spring Grove Hospital Center, Baltimore
7.	May 1, 1987	Springfield Hospital Center, Sykesville
8.	May 14, 1987	Spring Grove Hospital Center, Baltimore
9.	June 1, 1987	Crownsville State Hospital, Crownsville
10.	June 16, 1987	Louis L. Goldstein Treasury Bldg., Annapolis
11.	July 1, 1987	Louis L. Goldstein Treasury Bldg., Annapolis
12.	July 16, 1987	Spring Grove Hospital Center, Baltimore
13.	July 30, 1987	Louis L. Goldstein Treasury Bldg., Annapolis
14.	July 30, 1987	Public Hearing, State House, Annapolis
15.	August 6, 1987	Old Hall of Records Building, Annapolis
16.	August 12, 1987	Spring Grove Hospital Center, Baltimore
17.	August 26, 1987	Louis L. Goldstein Treasury Bldg., Annapolis
18.	September 9, 1987	Spring Grove Hospital Center, Baltimore
19.	September 23, 1987	Spring Grove Hospital Center, Baltimore

Appendix V

Private Sector Hospital Mental Health Services

	Emergency Services	Inpatient Services	Outpatient Services	Other Services
Allegany County				
Sacred Heart	x	x		
Anne Arundel County				
Anne Arundel General	x			
North Arundel	x			
Baltimore City				
Francis Scott Key	x	x		
Johns Hopkins	x	x	x	
Liberty	x	x	x	
Sinai	x	x	x	x a/b
Maryland General		x		
North Charles General		x		
University of Maryland		x	x	x b
Wyman Park		x		
Bon Secours			x	
Mercy			x	
Gundry (Women Only)		x		
Baltimore County				
Baltimore County General		x		
Franklin Square		x		
Greater Baltimore Medical Center			x	
St. Joseph		x		
Sheppard & Enoch Pratt		x	x	
Calvert County				
Calvert Memorial	x	x		
Carroll County				
Carroll County General	x			
Cecil County				
Union Hospital	x			
Charles County				
Physician's Memorial	x			
Dorchester County				
Dorchester General	x			
Eastern Shore Hospital Center		x		
Frederick County				
Frederick Memorial	x			

Private Sector Hospital Mental Health Services

	Emergency Services	Inpatient Services	Outpatient Services	Other Services
Harford County				
Fallston General	x			
Howard County				
Howard County General	x	x		
Taylor Manor		x		
Kent County				
Kent & Queen Anne's General	x			
Montgomery Conunty				
Holy Cross	x	x		
Montgomery General	x			
Shady Grove Adventist	x			
Suburban	x	x		
Washington Adventist	x	x		
Psychiatric Institute		x		x c
Chestnut Lodge		x		
Prince George's County				
Greater Laurel Beltstille	x	x		
Eugene Leland Memorial	x	x		
Prince George's General	x	x		
Southern Maryland	x	x		
St. Mary's County				
St. Mary's	x			
Talbot County				
Memorial Hospital at Easton		x		
Washington County				
Washington County Hospital Assoc.		x	x	
Brooklane		x		
Wicomico				
Peninsula General	x			

Notes: a) Children's Services
b) Community Rehabilitation Services
c) Day Treatment

Source: Directory of Mental Health in Maryland; May 1986

Appendix VI

Maryland Council of Community Mental Health Directors

Eligible Membership

Central Maryland Region

Richard K. Greenback, M.D., Dir.
Annapolis Mental Health Center
3 Truman Parkway
Annapolis, MD 21401 841-6750

Diep Le, M.D., Director
Glen Burnie Mental Health Center
101 Crain Hwy., Suite 305
Glen Burnie, MD 21061 787-0010

Maxie T. Collier, M.D., Acting Commissioner of Health
Balto. City Health Dept.
111 N. Calvert St.
Baltimore, MD 21201 396-1438

Wayne Swartz, LCSW, Admin.
Dept. of Comm. Psychiatry
Francis Scott Key Med. Center
4940 Eastern Avenue
Baltimore, MD 21224 955-0070

Leon Levin, M.D., Dir. Outpatient Services
Walter P. Carter Center
630 West Fayette Street
Baltimore, MD 21202 528-2139

Larry E. Alessi, M.D., Dir.
HARBEL Comm. Men. Health Ctr.
5807 Harford Rd.
Baltimore, MD 21214 426-5650

William R. Breakey, M.D., Dir.
Comm. Psychiatry Program
Johns Hopkins Hospital
600 N. Wolfe Street
Baltimore, MD 21205 955-2236

James P. Connaughton, M.D., Dir.
Children's Men. Health Ctr.
Johns Hopkins Hospital
600 N. Wolfe Street
Baltimore, MD 21205 955-3598

S.B. Katta, Program Dir.
Liberty Community Mental Health Ctr.
3101 Towanda Ave.
Baltimore, MD 21215 578-3500

John Urbaitis, M.D., Asst. Dir. of Psychiatry
Community Psychiatry Program
Sinai Hospital
Belvedere & Greenspring Aves.
Baltimore, MD 21215 578-5457

Peter Coleman, M.D., Medical Dir.
North Baltimore Center, Inc.
2519 N. Charles St.
Baltimore, MD 21218 366-4360

Stanley Mopsik, Director
The Children's Guild, Inc.
5921 Smith Avenue
Baltimore, MD 21209 542-3355

Ed Matricardi, Asst. Director
Bureau of Mental Health
Balto. Co. Health Dept.
401 Jefferson Bldg.
105 W. Chesapeake Ave.
Towson, MD 21204 494-2731

Gene Ostrom, Ph.D., Director
Eastern Comm. Mental Health Ctr.
9100 Franklin Square Dr.
Rosedale, MD 21237 687-6500

Arlene Leis, LCSW, Director
Northwestern Comm. Mental Health Ctr.
3517-A Langrehr Road
Baltimore, MD 21207 922-0105

Ed Bills, Ph.D., Director
Southeastern Comm. Mental Health Ctr.
7702 Dunmanway
Dundalk, MD 21222 282-1383

Paul D. Imre, M.P.H., Director
Southwestern Comm. Mental Health Ctr.
10 Winters Lane
Catonsville, MD 21228 366-4360

Phyllis Diggs, M.A., M.P.H.
Director of Community Programs
Northern Balto. Co. Comm. Mental Health Ctr.
1840 York Road
Timonium, MD 21093 252-8010

Howard M. Held, LCSW, Director
Bureau ofMental Health
Carroll Co. Health Dept.
P.O. Box 845
Westminster, MD 21157 876-2156

Stan Kotula, Director
Mental Health & Addictions
Harford Co. Health Dept.
P.O. Box 191
Bel Air, MD 21014 838-3373

Richard Bacharach, M.D., Director
Bureau of Mental Health & Addictions
Howard Co. Health Dept.
Suite 203, Trellis Center
10760 Hickory Ridge Rd.
Columbia, MD 21044 997-5880

Ted Pope, Acting Director
Howard Co. Mental Health Ctr.
Suite 203, Trellis Center
10760 Hickory Ridge Rd.
Columbia, MD 21044 997-5880

Southern Maryland Region

Richard Sampson, M.S., Executive Dir.
Community Psychiatric Clinic
8311 Wisconsin Avenue
Bethesda, MD 20814 656-5220

Douglas Weems, Director
Mental Health Programs
Calvert Co. Health Dept.
Prince Frederick, MD 21678 532-2151

Peter Pociluyko, Director
Mental Health & Addictions
Charles Co. Health Dept.
P.O. Box 1037
La Plata, MD 20646 934-7092

Frank Sullivan, Director
Div. of Mental Health & Alcoholism
St. Mary's Co. Health Dept.
6 Lincoln Avenue
Lexington Park, MD 20653 863-7092

Heidi Hsia, Ph.D., Director
Gaithersburg Health Ctr.
542 N. Frederick Avenue
Gaithersburg, MD 20877 840-2660

Peter Holt, Director
Div. of Mental Health Services
Montgomery Co. Health Dept.
100 Marhland Ave., Suite 240
Rockville, MD 20850 251-7420

Abe Goldstein, M.D., Director
Rockville Health Center
50 Monroe Street
Rockville, MD 20850 279-1623

Paul Glass, Director
Child Mental Health Services
2000 Dennis Avenue
Silver Spring, MD 20902 681-7376

Jay Miller, M.D., Director
Silver Spring Health Center
8641 Colesville Road
Silver Spring, MD 20910 565-7567

Mary Murphy, R.N., Director
Northeast Health Center
14015 New Hampshire Avenue
Silver Spring, MD 20902 384-0503

Hugh Sickel, M.D., Director
Weaton Health Center
2424 Reedie Drive
Wheaton, MD 20910 565-5716

Morton Albert, M.D.,Executive Dir.
Upper Montgomery Mental Health Center
Montgomery General Hospital, Inc.
18101 Prince Philip Drive
Olney, MD 20832 774-7800

Fran Nadash, Director
Directorate of Mental Health
Prince George's Co. Health Dept.
Hospital Road
Cheverly, MD 20785 386-0166

Marie Rawlings, Director
Central Mental Health Center
6100 Jost Street
Fairmount Hgts., MD 20743 925-9650

Susan Strober, Acting Dir.
Laurel Mental Health Center
217 Main Street
Laurel, MD 20006 498-7500

Paula Howland, Ph.D., Director
Northern Community Mental Health Ctr.
Prince George's Co. Health Dept.
Hospital Road
Cheverly, MD 20785 386-0202

Mickie Crimone, Director
Southern Community Mental Health Ctr.
Suitland Outpatient Clinic
5408 Silver Hill Rd., Suite 310
Suitland, MD 20748 568-0440

Carolyn Francis, R.N.
Community Health Nurse
Clinton Outpatient Clinic
Clinton, MD 20735 868-8000

Theodore Schwartz, Director
Mental Hlth. Ctr. for the
Deaf & Hearing Impaired
7580 Annapolis Road
Lanham, MD 20706 459-2121

Soo K. Chai, Ph.D., Coordinator
Fairmount Hgts. Adult Treatment Ctr.
6100 Jost Street
Fairmount Hgts., MD 20743 925-9511

Eastern Maryland Region

Gloria Dill, R.N., Coordinator
Mental Health & Addictions Programs
Caroline County Health Dept.
411 Franklin Street
Denton, MD 21629 479-3800

Richard Bayer, Ph.D., Clinic Dir.
Cecil Co. Mental Health Ctr.
126 E. High St., #6
Elkton, MD 21921 398-5104

Deborah Gootee
Mental Health Services
Dorchester Co. Health Dept.
P.O. Box 319
Cambridge, MD 21613 228-6800

Robert Dennison, LCSW, Clinic Dir.
Mental Health Services
Queen Anne's Co. Health Dept.
206 Commerce St.
Centreville, MD 21617 758-0720

Gordon Jennings, Adm. Dir.
Mental Health Services
Talbot Co. Health Dept.
P.O. Box 480
Easton, MD 21601 822-5580

Deborah Jones, R.N., M.A., Dir.
Mental Health & Addictions Svcs.
Kent County Health Dept.
P.O. Box 229
Chestertown, MD 21620 778-6800

Judy Gray, R.N., M.S. Clinic Dir.
Mental Health Services
Somerset Co. Health Dept.
P.O. Box 129
Westover, MD 21871 651-0822

Martin Kubi, Director
Mental Health Clinic
Wicomico Co. Health Dept.
300 West Carroll St.
Salisbury, MD 21801

Bruce Broman, Mental Hlth. Coord.
Worcester Co. Health Dept.
P.O. Box 249
Snow Hill, MD 21863 632-1100

Western Maryland Region

Dolores A. Gingerich, LCSW, Admin.
Mental Health Center
Allegheny Co. Health Dept.
P.O. Box 1745
Cumberland, MD 21502 777-5621

Dan Roff, Director
Mental Health Services
Frederick Co. Health Dept.
500 W. Patrick St.
Frederick, MD 21701 694-1757

Scott Ward,Director
Mental Health & Addictions Svcs.
Garrett Co. Health Dept.
253 N. Fourth St.
Oakland, MD 21550 334-8111

Bob Brandt, Dir. of Mental Health
Washington Co. Health Dept.
1302 Pennsylvania Ave.
Hagerstown, MD 21740 791-3223

Appendix VII

MARYLAND'S COMMUNITY REHABILITATION AND HOUSING PROGRAMS

The following is a list of all community rehabiitation and housing programs which are subsidized by the Department of Health and Mental Hygiene (DHMH). Also included are those private providers known to DHMH.

KEY:

1 = Subsized by the Maryland Department of Health and Mental Hygiene, Mental Hygiene Administration.

2 = Offers apartment living situations.

3 = Offers group home living situations.

COMMUNITY REHABILITATION PROGRAM

HOUSING PROGRM

BALTIMORE CITY

PEP,Inc. (1)
Northwest Shopping Plaza
5730 Wabash Avenue
Baltimore, MD. 21215
Exec.Dir.Steve Baron
Prog.Dir. Angelina Anthony
Phone: 764-8560

Ascension Homes (1,3)
Lutheran Church of Holy Comforter
5513 York Road
Baltimore, MD. 21212
Dir: Rev. Carol Youse
Rev. Joan Sharp
Phone: 435-9188

Associated Catholic Charities (2)
320 Cathedral Street
Baltimore, MD. 21201
Dir. Ellen Rocks
Sister Patricia McLaughlin
Nancy Clark
Phone: 547-5544

Sinai Hospital Apt Prg.(1,2)
Dept. of Psychiatry/Sinai
2401 W. Belvdere & Grnsprng Ave
Baltimore, MD. 21215
Exec.Dir. Steve Baron
Res.Coord. Kathryn Martis
Phone: 578-5457
764-8560

COMMUNITY REHABILITATION PROGRAM

Harbor City Unlimited
W.P. Carter Center - 5 West
630 W. Fayette Street
Baltimore, MD. 21201
Dir. John Heron
Res.Coord. Sandra Williams
Phone: 328-2177

Changing Directions
1400 East Federal Street
Baltimore, MD. 21213
Exec.Dir. Thomas E. Arhtur
Asst. Dir. Pat Johnson
Phone: 727-2611

C.O.R.P. (1)
Suite 304, Metro Plaza
Baltimore, MD. 21215
Clin.Dir.
Phone: 523-4400

Crossroads (1)
6500 Eastern Avenue
Baltimore, MD. 21224
Dir: Tom Marshall
Coord: Cathy Cavell
Phone: 955-0972

Harbel Haven
% Harbel CMHC
4708 Harford Road
Baltimore, Maryland 21214
Coord: Elaine Snyder
Phone: 426-1525

North Baltimore Center
2117 Maryland Avenue
Baltimore, Maryland 21228
Dir: Jim McClafferty

Phone: 625-5788

HOUSING PROGRM

Harbor City Unlimited (1,2)
W. P. Carter Center - 5 West
630 W. Fayette Street
Baltimore, MD. 21201
Dir. John Heron
Res.Coord. Sandra Williams
Phone: 328-2177

Changing Directions (1,2)
1400 East Federal Street
Baltimore, MD. 21213
Exec.Dir. Thomas E. Arthur
Res.Coord. Marie Nickens
Phone: 727-2611

C.O.R.P. (1,2)
Suite 304, Metro Plaza
Baltimore, MD. 21215
Prog. Adm. Rosa Neal
Housing Spec. W. P. Avery
Phone: 523-4400

Keypoint, Inc. (1,2)
7444 Holabird Avenue
Dundalk, MD. 21222
Exec.Dir. Karl Weber
Phone: 282-3831
Res.Coord. Ken Iman
Phone: 282-6830

North Baltimore Center (1,2)
2117 Maryland Avenue
Baltimore, Maryland 21228
Dir: Jim McClafferty
Res. Coord. Terry Langdon
Phone: 625-5788

COMMUNITY REHABILITATION PROGRAM

HOUSING PROGRM

Project PLASE, Inc. (2)
2029 St. Paul Street
Baltimore, MD. 21218
Exec. Dir: Gregory Hunter
Phone: 837-1400

Transitions, Inc.
335 W. 27TH St.
Baltimore, MD. 21218
Dir: Roberta Rubinstein
Phone: 366-0408
Phone: 366-0399

Charles Village House (1,3)
2636 North Charles Street
Baltimore, Md. 21218
Exec.Dir.
Asst.Dir. Constance Blakey
Phone: 243-0717

Fellowship House, Inc. (3)
707 St. Paul Street
Baltimore, MD. 21228
Exec. Dir: Sandra Philip
Asst. Dir: Charles Hammond
Phone: 752-6448

Glen Manor (3)
% Jewish Family & Children's
Services
5750 Park Heights Avenue
Baltimore, MD. 21215
Exec.Dir. Vacant
Phone: 466-9200

Hamilton House (1,2,3)
509 Cathedral Street
Baltimore, MD 21201
Exec.Dir. David Freelander
Phone: 539-7775

Mar-Lyn, Inc. (2)
6616 Vincent Lane
Apt. 204
Baltimore, MD. 21215
Dir. Marilyn Azwalansky
Phone 486-8074

COMMUNITY REHABILITATION PROGRAM

Vocational Program
STEP, Inc.
701 St. Paul St. Suite 402
Baltimore, MD. 21202
Exec.Dir. Fred Isbister
Phone: 625-1877

HOUSING PROGRM

St. Paul House, Inc. (1,3)
1921 St. Paul Street
Baltimore, MD. 21218
Exec.Dir. Cathy Horton
Phone: 385 -3023

ALLEGANY COUNTY

Archway Station, Inc. (1)
121 Memorial Avenue
Cumberland, MD. 21502
Exec.Dir. Louis Van Hollen
Prog.Dir. Lamar Gunter
Phone: 777-1700

Archway Residential Servs.(1,2)
121 Memorial Avenue
Cumberland, MD. 21502
Exec.Dir. Louis VanHollen
Res.Dir. Jackie Morrissey
Phone: 777-1700

ANNE ARUNDEL COUNTY

Arundel Lodge, Inc. (1)
1623 Forest Drive
Annapolis, MD. 21403
Exec.Dir. Rhonda Mewshaw
Prog.Coord. Cathy Howard
Phone: 269-5414

Arundel Lodge, Apts. (1,2)
1623 Forest Drive
Annapolis, MD. 21403
Exec.Dir. Rhonda Mewshaw
Res.Coord: Nancy Bass
Phone: 269-5414

OMNI House, Inc. (1)
P.O. Box 1270
Glen Burnie, MD. 21061
Exec.Dir. Lois Miller
Asst.Dir. Diane Rich
Phone: 768-6777
768-6778

OMNI House, Inc. (1,2)
P.O. Box 1270
Glen Burnie, MD. 21061
Exec.Dir: Lois Miller
Res.Coord. David Herring
Phone: 768-6777
768-6778
Casemanager: Linda Guy
Phone: 760-9349

BALTIMORE COUNTY

Alliance, Inc. (1)
% Eastern CMHC
9100 Franklin Square Drive
Suite 322
Baltimore, MD. 21237
Exec.Dir. Kali Mallik

Prog.Dir. Beroz Farrel
Phone: 687-6500

Future Horizons, Inc. (1,2)
% Eastern CMHC
9100 Franklin Square Dr.
Suite 322
Baltimore, MD. 21237
Res.Dir. Barbara Crum

Phone: 391-2204

COMMUNITY REHABILITATION PROGRAM

Prologue: Club Liberty (1)
50 Painters Mill Road Suite K&L
Owings Mills, MD 21117
xec.Dir. Howard Eisenberg
Prog.Coor.Sendy Rommell
Phone: 363-8884

Revisions, Inc. (1)
P.O. Box 21059
Catonsville, MD. 21228
Exec.Dir. Scott Graham
Prog.Dir. Lee Deckelnick
Phone: 747-4492 Office
747-4231 Program

New Ventures, Inc. (1)
10540 York Road-Suite M
Cockeysville, MD. 21030
Com.Prog.Dir. Edith Hanson
Prog.Dir. Gay Williams
Phone: 666-8300

Key Point Foundations, Inc. (1)
7702 Dunmanway
Dundalk, MD. 21222
Phone: 282-3831 Office
282-6860 Program
Prog.Dir. Bill Kordonski

HOUSING PROGRM

Prologue, Inc. (1,2)
12035 Reisterstown Road
Hannah More Center
Reisterstown, MD. 21136
Exec.Dir. Howard Eisenberg
Res.Coord. Marsha Young
Phone: 833-5073
363-8884

Revisions, Inc. (1,2,3)
P.O. Box 21059
Catonsville, MD. 21228
Exec.Dir. Scott Graham
Res.Prog.Mgr. Patricia Robinson
Phone: 747-4492
298-0310

Dulaney Station, Inc. (1,2)
10540 York Road-Suite M
Cockeysville, MD. 21030
Com.Prog.Dir. Edith Hanson
Res.Dir. Joe Sellmayer
Phone: 666-8300

Keypoint, Inc. (1,2)
7445 Holabird Avenue
Dundalk, MD. 21222
Exec.Dir. Karl Weber
Phone: 282-3831
Res.Dir. Ken Iman

CALVERT COUNTY

BLESS, Inc. (1)
P.O. Box 998
Prince Frederick, MD. 20678
Exec.Dir. Jack Hillyard
Prog.Coord.
Phone: 535-4787

BLESS, Inc. (1,2,3)
P.O. Box 998
Prince Frederick, MD.20678
Exec.Dir. Jack Hillyard
Res.Coord. Alice Austin
Adm. Asst. Lori Denton
Kathy Smallwood
Phone: 535-4787

COMMUNITY REHABILITATION PROGRAM

HOUSING PROGRM

CARROLL COUNTY

Carroll Hall (1)
181 E. Main Street
Westminster, MD. 21157
Dir: Carol Mathis
Phone: 857-0010
876-8595

Granite House, Inc. (1,2)
P.O. Box 2072
98 N. Court Street
Westminster, MD. 21157
Exec.Dir. Tanya Shewell
Phone: 857-0299
Casemanager: Vonnie Fiore
Phone: 876-3007

CECIL COUNTY

Cecil County (1)
SHARE
% Cecil County
Mental Health Clinic
206B South Street
Elkton, MD. 21921
Exec.Dir. Richard Bayer, Ph.D.
Prog. Dir. Jeanette Ayars
Phone: 398-4950

CHARLES COUNTY

Charles County
Freedom Landing, Inc.
P.O. Box 1728
LaPlata,MD. 20646
Exec.Dir. Joyce Abramson
Prog.Dir. Theresa Potts
Phone: 753-9101

Charles County
Freedom Landing, Inc. (1,2)
P.O. Box 1728
LaPlata, MD. 20646
Exec.Dir. Joyce Abramson
Hous.Dir. Lisa Brazil
Phone: 753-9101

FREDERICK COUNTY

Way Station, Inc. (1)
P.O. Box 3826
Frederick, MD. 21701
Exec.Dir. Grady O'Rear
Assoc.Dir. Tena Meadows O'Rear
Phone: 694-0070

Way Station, Inc. (1,2)
P.O. Box 3826
Frederick, MD. 21701
Exec.Dir. Grady O'Rear
Dir.Res.Serv. Linda Sowbel
Phone: 694-0070

COMMUNITY REHABILITATION PROGRAM

HOUSING PROGRM

GARRETT COUNTY

Lighthouse (1)
306 East Alder Street
Oakland, MD. 21550
Prog.Coor. Bill Kimball
Phone: 334-9126

Lighthouse
306 East Adler Street
Oakland, MD 21550
Prog. Coor.
Phone: 334-9126

HARFORD COUNTY

The Marigolds (1)
112 A Hays Street
Bel Air, MD. 21014
Psych.Coor. Lealia Story
Aftercare Coor. Bob Pinkus
Phone: 836-0070

Homecoming, Inc. (1,2)
112 A Hays Street
Bel Air, MD. 21014
Exec.Dir. Mutee Mulazim
Phone: 879-1270
836-0070

HOWARD COUNTY

The Growth Center (1)
Trellis Center
10760 Hickory Ridge Road
Columbia, MD. 21044
Dir. Jean Wagner Orton
Asst. Dir. Alice Mark
Asst.Bur.Dir. Rita Puleo
Phone: 997-0646

Vantage Place, Inc. (1,2)
8045 Guilford Road
Columbia, MD. 21044
Exec.Dir. Sam Bauman
Asst.Dir. Laurel Gardner
Phone: 531-5551
Casemanager. Sandy Corbin

MONTGOMERY COUNTY

Montgomery House (1)
615 S. Frederick Ave.
Gaithersburg, MD. 20877
Exec.Dir. Barbara Bryant
Prog.Coord. Steve Beech
Phone: 963-1700

Montgomery House (1,2)
615 S. Frederick Ave.
Gaithersburg, MD. 20877
Exec.Dir. Barbara Bryant
Res.Coord. Bill Ingram
Phone: 963-1700

Montgomery House (1)
10335 Kensington Parkway
Kensington, MD. 20815
Exec.Dir. Barbara Bryant
Prog.Coor. Eileen Weiss
Lylia Weber
Phone: 949-1000

Montgomery House (1)
615 South Frederick Avenue
Gaithersburg, MD. 20877
Exec.Dir. Barbara Bryant
Res.Coor. Bill Ingram
Phone: 963-1700

COMMUNITY REHABILITATION PROGRAM

Montgomery House
Administrative Office
Family Service of Montgomery Co.
1 West Deer Park Road, Suite 201
Gaithersbury, MD. 20877
Exec.Dir: Charles Brambrilla
Phone:

Rock Creek Foundation, Inc. (1)
Cornerstone (For dual diagnosed
8435 Georgia Avenue
Exec.Dir. Fred Chanteau
Prog. Dir. Judy Itkin
Prog.Dir. Mindy Kurtz
Phone: 589-8303

Rock Creek Foundation, Inc. (1)
Milestone
1107 Spring Street, Suite 2C & D
Silver Spring, MD. 20910
Dir.Prog.Serv. Judy Itkin
Prog.Dir. Bob Kern
Phone: 589-6675

HOUSING PROGRM

Rock Creek Foundation, Inc. (1,2)
8435 Georgia Avenue
Silver Spring, MD 20910
Exec.Dir. Fred Chanteau
Res.Dir: Pamela Kivistik
Sam Hampton
Phone: 589-8303

Rock Creek Foundation, Inc. (1,2)
8435 Georgia Avenue
Silver Spring, MD. 20910
Exec.Dir. Fred Chanteau
Res.Dir.
Phone: 589-8303

St. Luke's House, Inc. (1,2,3)
6030 Grosvenor Lane
Bethesda, MD. 20814
Exec.Dir. Joan Petersen
Assc.Dir. Pam Cudahy
Fac.Planner: Georgia Weiss
Res.Coord: Chris Tetrault
Phone: 493-4200

Threshold Service,Inc. (1,2,3,)
912 Thayer Avenue
Suite 210
Silver Spring, MD. 20910
Exec.Dir. Lynne List
Assoc. Dir. Martha Bramhall
Phone: 495-9356

Independent Living Serv. (2)
410 Wheaton Plaza North
Wheaton, MD. 20902
Dir. Jim Keethers
Phone: 933-1712

COMMUNITY REHABILITATION PROGRAM

HOUSING PROGRM

Mar-Lyn, Inc. (2)
6630 Eberle Drive, Apt. 102
Baltimore, MD. 21215
Dir. Marilyn Azwalinsky
Phone: 486-8074 (Balto)

PRINCE GEORGE'S COUNTY

C.C.D., Inc. (1,2)
5120 Frolich Lane
Cheverly, MD. 20781
Exec.Dir. Charlene Brisco
Prog.Man. Bert Maddox
Casemanager: Doreen Branch
Patricia Lourey
Phone: 341-4640

Family Serv. Found.,Inc.
Mental Health Serv. for Deaf
7580 Annapolis Road
Lanham, MD. 20706
Prog.Dir. Theodore Schwartz
Phone: 459-2121

Family Serv. Found., Inc. (1,2)
Mental Health Serv. for Deaf
7580 Annapolis Road
Lanham, MD. 20706
Prog.Dir. Theodore Schwartz
Phone 459-2121

Vesta Foundation, Inc. (N) (1)
4321 Hartwick Road - Suite 416
College Park, MD. 20740
Exec.Dir. Aash Vyas
Prog.Coor. Donna Coe
Phone: 927-9111

Vesta Foundation, Inc. (1,2)
4321 Hartwick Road
College Park, Md. 20740
Exec.Dir. Aash vyas
Housing Dir. Orita Carr
Phone: 927-9111

Vesta Foundation, Inc. (S) (1)
5408 Silver Hill Road
Room 507
Forestville, MD. 20747
Exec.Dir. Aash Vyas
Prog.Coor. Harry Schwartz
Phone: 736-2636

Vesta Foundation, Inc. (1,2)
5408 Silver Hill Road
Room 507
Forestville, MD. 20747
Exec.Dir. Aash Vyas
Housing Dir. Orita Carr
Phone: 736-2636

COMMUNITY REHABILITATION PROGRAM

HOUSING PROGRM

QUEEN ANNE COUNTY

Crossroads Community, Inc. (1)
205 North Liberty Street
Centreville, MD 21617
Exec.Dir. Wendy Margolis
Prog.Dir. Helen Lampman
Phone: 758-1787

ST. MARY'S COUNTY

St. Mary's Freedom Ladning (1)
P.O. Box 217
Loveville, MD. 20656
Exec.Dir. Gerard McGloin
Prog.Dir. Kitty Norton
Phone: 475-8061

St. Mary's Freedom Landing (1,2)
P.O. Box 217
Loveville, MD. 20656
Housing Dir. Mary Lynn Logsdon
Phone: 475-8061
475-8062

TALBOT COUNTY

Channel Marker, Inc. (1)
114 N. Washington Street
Easton, MD. 21601
Exec.Dir. Nancy Clem
Prog.Dir. Karen Craig
Phone: 822-4611

Channel Marker, Inc. (1,2)
114 N. Washington Street
Easton, MD. 21601
Exec.Dir. Nancy Clem
Res.Coor. Helen Smith
Phone: 822-4611

WASHINGTON COUNTY

Turning Point, Inc. (1)
25 North Avenue
Hagerstown, MD. 21740
Exec.Dir. Donna Chrisman
Prog.Coor. Mary Luby Howser
Phone: 733-6063

Turning Point, Inc. (1)
25 North Avenue
Hagerstown, MD. 21740
Exec.Dir. Donna Chrisman
Res.Coord. Jack Stringfellow
Phone 733-6063

COMMUNITY REHABILITATION PROGRAM

HOUSING PROGRAM

WICOMICO COUNTY

Go Getters, Inc. (1)
P.O. Box 2581
108 W. Lehigh Avenue
Salisbury, MD. 21801
Exec.Dir. Pat Strott
Prog.Coor. Vacant
Phone: 546-0381

Go Getters, Inc. (1,2)
P.O. Box 2581
108 W. Lehigh Avenue
Sailsbury, MD. 21801
Exec.Dir. Pat Strott
Hous.Coor. Mary Ann Tyler
Phone: 546-0381