

**Continuing Care Legal Workgroup
Meeting Minutes
Spring Grove Hospital Center
Room 129
September 27, 2013**

Attendees:

Dan Martin
Laura Cain
Kait Roe
Sarah Rhine
Nevett Steele, Jr.
Brian Hall
Megan Ix
Denise Sulzbach
Randy Nero
Stacy Reid Swain
Evelyn Burton
Janet Edelman
Mike Finkle
Ed Kelley
Lois Fisher
Crista Taylor

Conference Call:

Lyn Albizo
Dan Malone
Scott Rose

Issued to be discussed – have positions be heard if there is no consensus
Outpatient civil commitment is out ; no consensus on recommendations

Housing- Presentation

Sarah Rhine (MDLC)

Overall recommendation: (see slides) opening statement – all individuals have right to housing
What is charge? Those in public mental health system or otherwise (everybody for this)
Are shelters a component of housing? Short term gap & not solution
Housing First – vulnerability index for how close someone is to death – physical, mental health, addictions & complex factors – the sicker you are the more likely you are to get in
Different housing first might have different levels of services and spending, sometimes requirements attached to other programs (ie section 8) which is a barrier – this shouldn't be part of recommendations
– funding for Housing First would be a good recommendation

Public housing versus section 8

Public housing; project based; subsidy attaches to unit and not person; deep subsidy public housing – tenant rent is 30% of income; to evict have to have good cause to evict or to not renew their lease
Section 8 – can be evicted and terminated at end of lease – project based 30%; this is a problem bc person cant leave that unit, money doesn't follow person, section 8 has to find rental like any other person, but there is a coupon for rent

Provider supported housing – directly controlled and monitored by DHMH, funded by ASO – individual provider making individual decisions – programs designed to be part of treatment system not

independent housing (RRP) DHMH doesn't consider this to be housing, things they are part of service package – strange that this is considered treatment or housing – this can be taken away quickly if your clinical needs cannot be met – often results in homelessness

HUD housing - federal money – select # of unit in larger complex

Private rental – problems with wage and costs

Low income tax housing

Nicer new buildings may have higher rent that allows them to be choosy – can double up on subsidy though

Homeless shelters

Code blue

Year round

Private

Many different rules for each type of shelter

Admission procedures

Recommendation: What kind of vulnerability index do we want housing first program to focus on?

Recommendation: Should they be tied to other subsidies?

Public housing wait 6 years

Section 8, as long, longer or closed in those jurisdictions

Both are very unlikely options – also application must be submitted and updated every year – this is a problem for transient people even if they get to top of list (if can't reach emergency contact)

Sometimes applicants don't give opportunity to indicate need – so may realize after waiting they can't be accommodated

Criminal background or previous eviction issues –

Recommendation: housing has ability to make choices about screening they do and who they admit.

Federal government provides outlining guidelines of who absolutely cannot come in (small group) so lots of things a housing authority can deny someone but they don't have to – MD big issue b/c some jurisdictions are liberal, some are not (i.e. even arrest not conviction denied) – can make reasonable accommodation request for this but not easy to overcome

Housing authorities don't have to give search assistance

HUD can ask for rental history – which would require homeless shelter, treatment, can't be discriminated but must be disclosed b/c time spent in facility counts as rental history

Can ask HUD for denial in writing – HUD needs reason

Many barriers to private rental housing

Shelters –

- Many restrict due to age (ie over age of 12 can't enter family shelter with parent) over 18 has to go into adult, gender, singles, family composition is an issue
- Homeless services placement system – encourage families to split up
- Not sure increasing funding for shelter system is a good recommendation because want permanent housing
- Many have requirements regarding medications and activities, but some lack capacity to store medication, aren't safe to have in shelters

Challenging denials of eligibility – there is a formal process for sec 8, public, HUD

Other ones have informal processes

Recommendation:

Consensus – everyone should have housing

1. **Expand housing first statewide with unrestricted access (consensus – qualification to make clear that it is without reduction of funding for any other option) (is this legal)**
2. **Standardize admission and termination procedures statewide for public housing and sec 8 (consensus)**
3. **Standardize & mandate process RRP termination/admission – some providers have a process, some don't – need procedure**
4. **Standardize admission and termination for emergency shelters & establish wet shelters, provide education to shelter directors on mental illness (concerned about private rent shelters)**

Question:

(Martin) Are we going to specify the standards we want?

- What about criminal conviction lookbacks – caught in it from time of application vs time at top of list
- Really big difference across counties
- Can recommend subcommittee
- Recommendation: Annapolis legislation so landlords can't discriminate based on source of income (section 8 or SSI) – 5. **support source of income legislation (consensus)**

Recommendation: Smaller group that just looks at housing (not a consensus)

Scott Rose – serious opposition to #3 – have to balance needs and safety of consumers against each other – have been working on this and right now is the best balance that can get to. There is a need in the way regulations and stakeholders have worked through is best balance – adding more restrictions will lead to chilling effect on people they think they can handle. Regulations are good now.

NAMI – complicated issue – if there are issues where provider/someone is at risk is there a way to ensure there is an alternative so that this person isn't homeless

#3 – communal housing;

- Problem is level of care is tied to the housing
- **Recommendation: form workgroup to figure out how MHA can support housing where level of care is not tied to housing – how can they not lose housing but have levels**
- RRP serves a role, but if MHA is valuing housing, how do they further support that

#4 - concerns with regulations and making places take people they can't handle

Lois

- Assisted living – may fall under private housing – there are extensive regulations – may be unnecessary for people just need housing because of mental illness, makes it prohibitive
- Recommendation: Subcategory or separate category of licensing of housing for mental illness, not just elderly
- Recommendation: Private RRP's have trouble getting authorization but its not costing state anything – law or regulation that state cannot limit # of authorizations for private RRP beds if they meet standard

Issue of leases not being renewed for police coming to unit –

Standardize law around reasons for termination about housing for any subsidized housing

Slide changes:

Forced Medication:

No consensus – call everything issue to address/"ISSUES RAISED"

- Send response
- Eliminate pro and con – **issues raised**
- Guardianship

- List as an issue – need to address that make it an issue that needs clarity

Confidentiality (Kait)

- Difficulty of information sharing with jails, considering those mental health providers (see notes from two weeks ago) (Expanding crisp to jails, juvenile facilities)
- HIPAA issues
- **Put together document as to what confidentiality is in MD and what the federal rules are (this will be distributed) ,AGs office clarify that providers can communicate directly with each other**
- How can providers of care have requisite insight – current privacy laws doesn't provide access to mental health records if people go from hospital to hospital (lack of insight)
- Barrier: limitations – law allows for patient to release information – law allows for nuances but computer systems are all or nothing – **technology update so systems can pull data separately**
- Ability to share partial information via computer systems – communication concerns about mental health records from hospital to hospital
- How do you establish what minimum necessary is? When disclosing information against wishes of person

Insurance coverage for involuntary – don't have to pay for it and go by medical necessity – legislation that insurance must authorize payment if someone is involuntarily commitment

Concerns – should we use the words barriers? Is it misunderstood or misinterpreted and works against continuity of care?

Guardianship:

Move advance directives out of guardianship and change to psychiatric advance directives?

- Waive the fee (**consensus**)
- **Provide education (consensus)**
- **Ulysses – when have capacity and making advance directive you can if you want - recommendation could be person while competent can make it non-revokable and that becomes legally binding? (no consensus – someone could be coerced into including that)**
- **Competent to make medical decisions vs. competent to stand trial**
- **Define competency – use competent to stand trial – vs capacity to make decisions**
- **New issue: delay in terms of revoking an advance directive to not take effect until 72 hour delay**
- **Discrepancy b/w two sections of guardianship – only way to admit to psychiatric under civil commitment – but others say don't lost**
- **Propose: Amend Health general 632 to allow determination by ALJ as to whether or not someone has capacity to sign voluntary so people under guardianship but are competent to not lose civil 0 make informed decision as to confinement – but shouldn't ALJ ask guardian?**

Does this apply to people perceived to have psychiatric symptoms

First bullet unclear – guardianship statute – amend so that if a person has a guardian for any reason – mental forcibly keep them if – who is it targeted at – if diagnosis is just SMI – add concern: issue – is that discriminating on basis of disability

(issues raised; issued to be discussed)

People don't know what high bar to competency means
Number the slides

Accountability -

**Issue raised: If there is history of violence against a family than family should be notified
In public mental health system patients may have history of being abused too...that could be a
concern how do you protect individual - there is another side, any changes that give
information still need to protect the patient due to reversed history**

**Housing - shouldn't discharge to homelessness - but many concerns about that - need more
case management - care coordination - hospital should connect to care coordination - should
be included in pre-discharge - get them in pre-discharge - probably not legal recommendation
but include**

**Issue to be raised: If you have housing and you have to be hospitalized, shouldn't there be a
bed-hold or guarantee you will still have housing? Revolving door problem - NO CONSENSUS
(problem with fee for service environment and private pay etc).**

**Issues raised: Confusion between how long charges are active and how long they can be remain
hospitalized**

No consensus

(include apple report)