# Treatment Not Trauma

Urgent Action Required
to Protect Patients at the
Clifton T. Perkins Hospital Center

Issued May 2026

A Report for the Maryland Department of Health
by **Disability Rights Maryland**

The Protection and Advocacy System for the State of Maryland

DRM Disability Rights Maryland

Empowering People to Lead Systemic Change

# Executive Summary

Disability Rights Maryland (DRM) conducted a two-year investigation into one of Maryland's forensic psychiatric hospitals, the Clifton T. Perkins Hospital Center (CTPHC). DRM launched the investigation as a result of the receipt of numerous complaints of abuse and neglect, including alleged violations of the following basic rights:

- The right to be free from sexual assault and sexual harassment;[1]
- The right to be free from restraint and seclusion, unless used in an emergency when one's behavior poses a serious threat of violence or injury to self or others;[2]
- The right to individualized treatment;[3] and
- The right to receive care that restricts one's liberty and freedom only "…to the extent necessary and consistent with the individual's treatment needs…"[4]

DRM's investigation into these concerns included patient surveys, interviews with staff members at all levels of hospital operation, and an analysis of relevant records.

Overall, DRM finds a need for the State to increase transparency and strengthen accountability by improving oversight systems. In light of Governor Moore's mission to ensure that "No One is Left Behind," DRM urges immediate action to protect the hundreds of people currently left behind at CTPHC. [5]

Key findings and recommendations are summarized here.

[1] Md. Code Ann., Health-General §10-705; 42 C.F.R. §482.13
[2] Md. Code Ann., Health-General §10-701; 42 C.F.R. §482.13.
[3] Md. Code Ann., Health-General §10-701.
[4] Id.
[5] https://dbm.maryland.gov/Documents/MFR_documents/2026-MFR-Annual-Performance-Report.pdf, pg.2

# Key Findings of DRM's CTPHC Investigation

1. **Lack of Appropriate Medical Care**
    a. CTPHC does not always address emergencies promptly or adequately.
    b. The hospital does not always provide consistent follow-up care and specialist care.
    c. When problems occur, hospital staff are not consistently held accountable.
    d. The quality of the medical care provided by CTPHC physicians is uneven.
    e. Ineffective oversight by the State leaves patients vulnerable.

2. **Lack of Appropriate Behavioral Health Care at CTPHC**
    a. Many CTPHC patients do not receive individual mental health or substance abuse therapy because of waiting lists and other barriers.
    b. The Individual Therapy policy at CTPHC prioritizes care based on criminal charges and anticipated discharge date, leaving others who could benefit from individual therapy unable to receive it.

3. **Unlawful Use of Seclusion and Restraint at CTPHC**
    a. Patients are restrained and secluded in the absence of behavior that poses a serious and imminent danger to physical safety.
    b. Staff do not always properly document restraint and seclusion, resulting in collection of incomplete and unreliable data by the hospital.

4. **Safety Concerns at CTPHC**
    a. Patients frequently assault other patients.
    b. Special observation status does not always ensure safety.
    c. Patient care does not consistently align with the principles of trauma-informed care.
    d. CTPHC does not provide sufficient patient programming, resulting in too much unstructured time.
    e. CTPHC's significant infrastructure deficiencies frequently cause unsafe environmental conditions.

5. **Lack of Transparency, Accountability, and Oversight**
    a. CTPHC administration and the State often fail to hold hospital staff accountable.
    b. Existing oversight systems do not always ensure that patients at CTPHC receive appropriate medical care.

# Key Recommendations of the CTPHC Investigation

## Recommendations for CTPHC

1. **Provide Appropriate Medical Care to Patients at CTPHC**
   a. Improve patient care tracking and monitoring, including for patients who require specialty care.
   b. Ensure that all patients receive a nutritional assessment and the provision of a specialized diet if needed to address a medical condition such as diabetes.
   c. Ensure that policies and procedures clearly outline how and when to seek emergency care for patients.
   d. Continue the work already underway to provide trauma-informed care.

2. **Provide Appropriate Behavioral Health Care to Patients at CTPHC**
   a. Ensure that patients have prompt access to substance abuse treatment.
   b. Remove barriers that prevent or impede patients from receiving individual mental health therapy and ensure that patients for whom individual mental health therapy is medically recommended have prompt access to such therapy.
   c. Eliminate the prioritization process outlined in the current Individual Therapy policy.

3. **Reduce and, to the Greatest Extent Possible, Eliminate the Use of Restraint and Seclusion**
   a. Recognize that restraint and seclusion represent treatment failure, not treatment, and provide more robust training to staff to de-escalate crises without the use of these interventions.
   b. Prohibit all forms of prolonged seclusion.
   c. Assess and provide individualized treatment to patients who were subjected to prolonged seclusion at CTPHC.
   d. Create and implement a plan to reduce the use of seclusion and restraint, with the goal of eliminating these interventions to the greatest extent possible.
   e. Identify and advocate for the resources needed to reduce the use of restraint and seclusion.

4. **Ensure Safety at CTPHC**
   a. Clarify the role and responsibilities of 1:1 support staff.
   b. Reduce factors known to cause aggression.
   c. Increase patient programming.
   d. Improve security staff training.
   e. Ensure safe and healthy environmental conditions within the facility by addressing structural problems including mold and clean water access.

5. **Improve Transparency and Accountability**
   a. Increase public visitation hours and eliminate scheduling requirements that pose a barrier for families and friends to visit their loved ones.

b. Unless patients disagree, provide advance notice to family members, advocates, and the patient of treatment team meetings, and permit family members and advocates to attend these meetings with the patient.
c. Participate in national data reporting platforms to improve quality of care.

## Recommendations for the Maryland Department of Health

6. **Improve Oversight Systems**
   a. Reform the Resident Grievance System (RGS).
   b. Reform the Office of Health Care Quality (OHCQ).

7. **Improve Transparency and Accountability**
   a. Prioritize the implementation of an Electronic Medical Records (EMR) system at CTPHC.
   b. Analyze and make publicly available the data on restraint and seclusion.
   c. Produce public reports to the MD General Assembly semi-annually for two years.

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# Introduction

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## About Disability Rights Maryland (DRM)

Disability Rights Maryland (DRM) is a private, nonprofit organization and Maryland's designated Protection and Advocacy agency (P&A). DRM's federally funded Protection & Advocacy for Individuals with Mental Illness (PAIMI)[6] program provides services to Marylanders with significant mental illness. DRM investigates allegations of abuse and neglect, including deaths, and protects the rights of psychiatrically hospitalized individuals with mental illness and those who are at risk of psychiatric hospitalization to appropriate treatment, freedom from harm, and services that will enable them to live in a less restrictive setting with needed supportive services.

DRM investigated conditions at the Clifton T. Perkins Hospital Center (CTPHC) using its P&A access authority,[7] following receipt of complaints about abuse and neglect at CTPHC. The investigation included surveys, interviews, and an analysis of relevant records over the course of more than two years. (See a list of investigation elements on the next page.)

### What is ABUSE?

An "…act or failure to act . . . which was performed, or which was failed to be performed, knowingly, recklessly, or intentionally, and which caused, or may have caused, injury or death to an individual with" a disability.[8]

### What is NEGLECT?

An "…act or omission by an individual responsible for providing services… which caused or may have caused injury or death to an individual… or which placed an individual… at risk of injury or death, and includes an act or omission such as the failure to:

- establish or carry out an appropriate individual program or treatment plan;
- provide adequate nutrition, clothing, or health care; or
- provide a safe environment, including failure to maintain adequate numbers of appropriately trained staff."[9]

[6] 42 U.S.C. §10802(2).
[7] 42 U.S.C. §10805(a)(1)(A).
[8] 42 U.S.C. §10802(1); 45 C.F.R. §1326.19.
[9] 42 U.S.C. §10802(5); 45 C.F.R. §1326.19.

## Elements of DRM's Investigation

- Review of CTPHC policies and procedures
- Data collection and analysis
- Review of patient medical records
- Interviews and surveys of patients and family regarding:
    - Communication with friends and family (visitation, phone, mail, email)
    - Staffing (vacancies, treatment by staff, training, professionalism)
    - Treatment groups and activities (substance use, mental health, gym)
    - Somatic medical care (access to clinic, dental care, sanitary practices)
    - Safety (contraband, restraints, seclusion, quiet room, violence)
    - Rights protection and experience with the Resident Grievance System
- Analysis of internal and public reports and other available documents
- Interviews and informal conversations with staff members, including psychologists, social workers, physicians, security staff, nurses, and administrators regarding:
    - Roles, responsibilities, work history, and training received
    - Challenges of the job
    - Patient care
    - Hospital infrastructure
    - Hospital response to the presence of contraband
    - Staffing and staff vacancies
    - Climate and safety
    - Restraint, seclusion, and "Voluntary Safe Space Monitoring" (VSSM)
    - Somatic medical care for patients
    - Patient rights and fresh air breaks
- Regular on-site monitoring visits with a focus on:
    - Interactions between patients and staff
    - Unit cleanliness and maintenance
    - Access to personal belongings
    - Programming available and engagement in activities
    - Accessibility equipment and assistive/medical devices
    - Restraint, seclusion, VSSM, and quiet rooms
    - Security measures and surveillance cameras
    - Condition of bedrooms and bathrooms

## About the Clifton T. Perkins Hospital Center (CTPHC)

- Founded in 1959, CTPHC is one of Maryland's state-operated psychiatric hospitals.[10]
- The hospital currently has 650 staff positions and an annual budget of $97 million.[11]
- In February 2025, Aliya Jones, M.D. was appointed Chief Executive Officer (CEO) after the Secretary of the Maryland Department of Health removed the two previous CEOs.
- From April - July 2025, the Joint Commission downgraded the hospital's status to preliminary denial of accreditation status due to serious safety violations.
- CTPHC is the only state psychiatric hospital for which the Maryland Department of Health has chosen not to seek accreditation by the Centers for Medicare & Medicaid Services (CMS); as a result, CTPHC does not receive federal funding.
- CTPHC has a total of 289 patient beds on twelve units, including:
    - Three maximum-security admissions units: one for female patients and two for male patients.
    - Three maximum security units and two combined maximum and medium security units that each have a capacity for 29 male patients.
    - Four minimum-security units including three co-ed units and one unit for male patients.
- More than 85% of the hospital residents are male.
- Most patients at CTPHC have been court-committed to the hospital involuntarily as either:
    - Incompetent to Stand Trial (IST), meaning they were charged with a crime but cannot understand the nature or object of the proceeding or to assist in their defense. If the court finds they are also dangerous, they are committed to a state hospital to be restored to competency, or
    - Not Criminally Responsible (NCR), meaning at the time they engaged in the criminal conduct that resulted in their charges, the person, because of a mental disorder or an intellectual disability, lacked substantial capacity to appreciate the criminality of that conduct or conform that conduct to the requirements of law.

*Figure 1. CTPHC exterior, June 2025.*

[10] https://health.maryland.gov/perkins/Pages/History.aspx
[11] https://msa.maryland.gov/msa/mdmanual/16dhmh/html/dhmh.html

## Summary of Recent Events at CTPHC

**2023**

- A 40-year-old African American female patient ("Marissa"[12]) died in November; according to the autopsy report, the psychotropic drugs prescribed by CTPHC physicians caused her death. During DRM's investigation into "Marissa's" death, DRM found that another patient, "Latasha," died in November 2020 and CTPHC had failed to appropriately report the death.
- In December, CTPHC staff sent an anonymous letter to the Secretary and Governor outlining their serious concerns about human resources, security, and contraband.

**2024**

- The Washington Post reported problems within CTPHC in several articles.[13]
- Then-CEO Dr. Scott Moran was terminated in May, and his medical license was suspended.[14] Dwain Shaw was installed as Interim CEO.
- Following a patient death ("Marissa"), the Office of Health Care Quality (OHCQ) issued a Plan of Corrections in June to address several deficiencies.
- In September, MDH contracted with National Association of State Mental Health Program Directors (NASMHPD) to "review operations… and provide recommendations for improvements regarding quality of care and safety."
- DRM raised significant concerns to the Secretary of MDH about the then-CEO's mishandling of a serious sexual assault case involving a staff member and a patient.
- During a December hearing of the Joint Committee on Fair Practices and State Personnel Oversight, the Secretary of the MDH was questioned regarding the "on-going drumbeat" of concerns at CTPHC.[15]

**2025**

- NASMHPD issued a report on conditions within CTPHC in January with twenty-five recommendations. MDH has not chosen to release this report publicly.
- Then-CEO Dwain Shaw left suddenly in January, and the State put an Acting CEO in place.
- In February, Dr. Aliya Jones took over leadership of CTPHC from an Acting CEO.
- The Joint Commission issued a preliminary accreditation denial in April after finding six immediate threats to health and safety and 29 additional safety violations. The Joint Commission restored accreditation in August.
- In September, a 45-year-old African American man, "Charlie", died suddenly at CTPHC.

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[12] All patient names used in this report are pseudonyms.

[13] https://wapo.st/4eZb5es

[14] https://www.baltimoresun.com/2025/01/15/clifton-t-perkins-hospital-center-acting-head-resigns/

[15] https://mgaleg.maryland.gov/mgawebsite/Committees/Media/false?cmte=fps&clip=FPS_12_11_2024_meeting_1&ys=2024rs, at 1:12min

# Maryland Department of Health Accountability Structures

## Resident Grievance System (RGS)

Individuals in Maryland's state-operated psychiatric hospitals, including CTPHC, can report abuse, neglect, and rights violations to the Resident Grievance System (RGS) for assistance.[16] Regulations require the RGS to investigate when:

- "Resident's rights have been unfairly limited or violated or are likely to be violated in the immediate future."
- "Resident has been abused, neglected, or mistreated."
- "Facility has acted in an illegal or improper manner with respect to a resident or a group of residents."[17]

The RGS was established in 1985 pursuant to a consent decree that resolved a class-action lawsuit, *Coe v. Hughes, et al*.[18] Complaints can be made by calling 1-800-RGS-7454 and by speaking with a Rights Advisor.

In 2023, the RGS at CTPHC received a total of 65 grievances[19] including:

- 22 civil rights complaints;
- 17 complaints of alleged abuse, defined as "cruel or inhumane treatment or an intentional act that causes injury or trauma to another person;"[20]
- 11 complaints alleging violations of treatment rights; and
- 7 complaints regarding environmental conditions.

In the following year, 2024, complaints to the RGS at CTPHC significantly increased to a total of 112 grievances.[21] (See Figure 3.) As compared to 2023, RGS received more complaints in 2024 in several categories of violations, including:

- 42 complaints regarding treatment rights,
- 13 complaints about environmental conditions,
- 11 complaints regarding property rights or money, and
- 4 "freedom of movement" complaints, which include restraint and seclusion.

In addition to the 112 grievances received in 2024, there were 148 additional cases classified as needing only "information or brief assistance" that were primarily concerns about environmental conditions, patient-on-patient assaults, and treatment rights.

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[16] COMAR 10.21.14.
[17] COMAR 10.21.14.03.
[18] Civil Action No. K-83-4248 (1985).
[19] https://health.maryland.gov/yourrights/SiteAssets/Pages/reports/RGS%20PSYCHIATRIC%20INPATIENT%20FACILITIES%20ANNUAL%20REPORT%20FY23.pdf, 11.
[20] Id., p.8.
[21] The RGS Director provided DRM with the 2024 RGS report.

DRM found that reforms are needed to improve the effectiveness of the RGS in achieving its mission "…to protect the rights of patients" and "…to provide a timely, fair, efficient, and complete mechanism for receiving, investigating, and resolving residents' complaints."[22] During DRM's investigation, patients reported that the RGS is not effective at resolving their concerns. Although regulations require that RGS "…render a decision on a grievance within 10 working days of receipt of the grievance," patients report that they often receive no response.[23]

DRM found a lack of independence throughout the four stage RGS process due to existing statutes and regulations. The Rights Advisor makes stage 1 decisions, a CTPHC hospital administrator is responsible for rendering stage 2 decisions, and the hospital CEO determines the validity of grievances at stage 3. The committee that reviews stage 4 grievances is the most independent of the hospital as it is comprised of the Director of the RGS and the Director and Clinical Director of the Behavioral Health Administration. CTPHC has too great a role in policing itself at the levels below stage 4; it is unreasonable to expect the hospital to provide effective oversight of itself. Without a more effective grievance system, patient rights at CTPHC remain at risk.

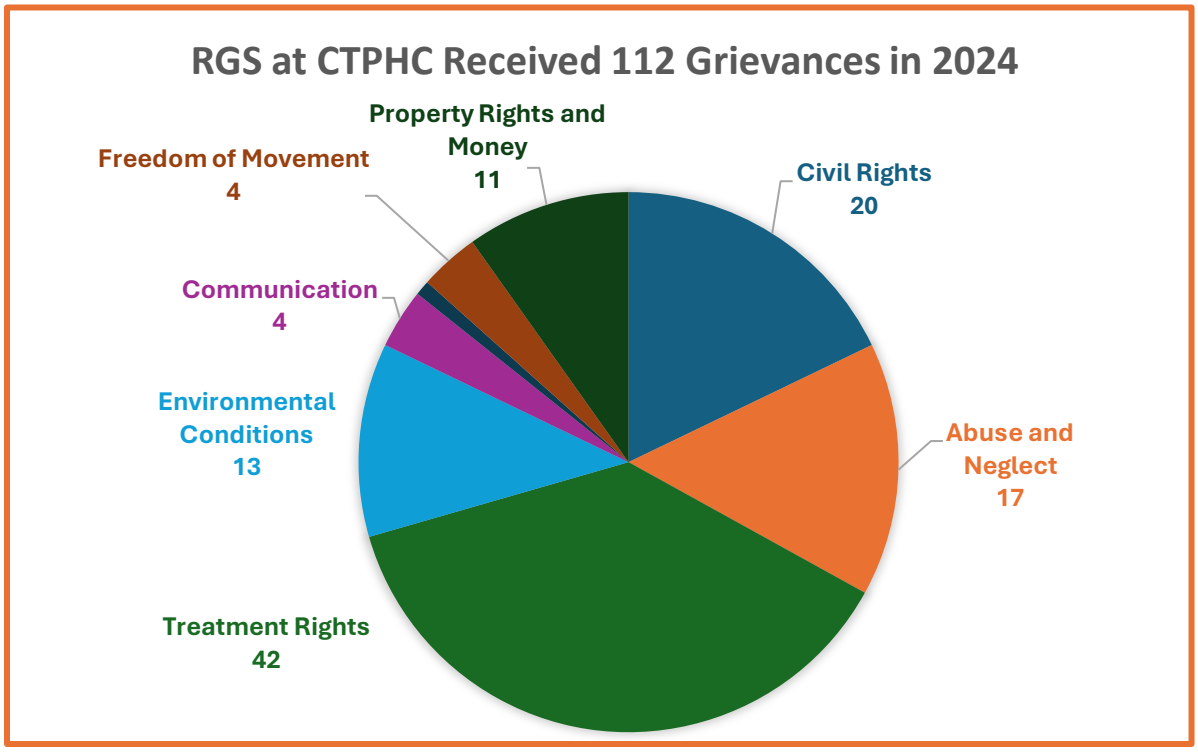



*Figure 2. Summary of grievances received by RGS at CTPHC in 2024.*

[22] RGS annual report, Fiscal Year 2023, pg.3. https://health.maryland.gov/yourrights/SiteAssets/Pages/reports/RGS%20PSYCHIATRIC%20INPATIENT%20FACILITIES%20ANNUAL%20REPORT%20FY23.pdf

[23] COMAR 10.21.14.06.

## Office of Health Care Quality (OHCQ)

The Maryland Office of Health Care Quality (OHCQ) is the state survey agency within the Maryland Department of Health; OHCQ is responsible for monitoring the quality of care provided in health care facilities, including CTPHC. OHCQ licenses facilities and programs, certifies facilities on behalf of the Center for Medicare and Medicaid Services (CMS), and conducts surveys to determine compliance with regulations.

The following chart illustrates the complaints received by OHCQ related to CTPHC in a five-and-one-half-year period. Despite troubling conditions within the facility, including patient deaths, between 2020 and 2023, only one complaint resulted in a finding with deficiencies. Four complaints submitted by DRM in 2021 remain in 'pending' status.

DRM concluded that reforms are necessary to improve OHCQ's effectiveness with respect to both the comprehensiveness of its investigations and the management of corrective action plans in those situations in which OHCQ does find violations.

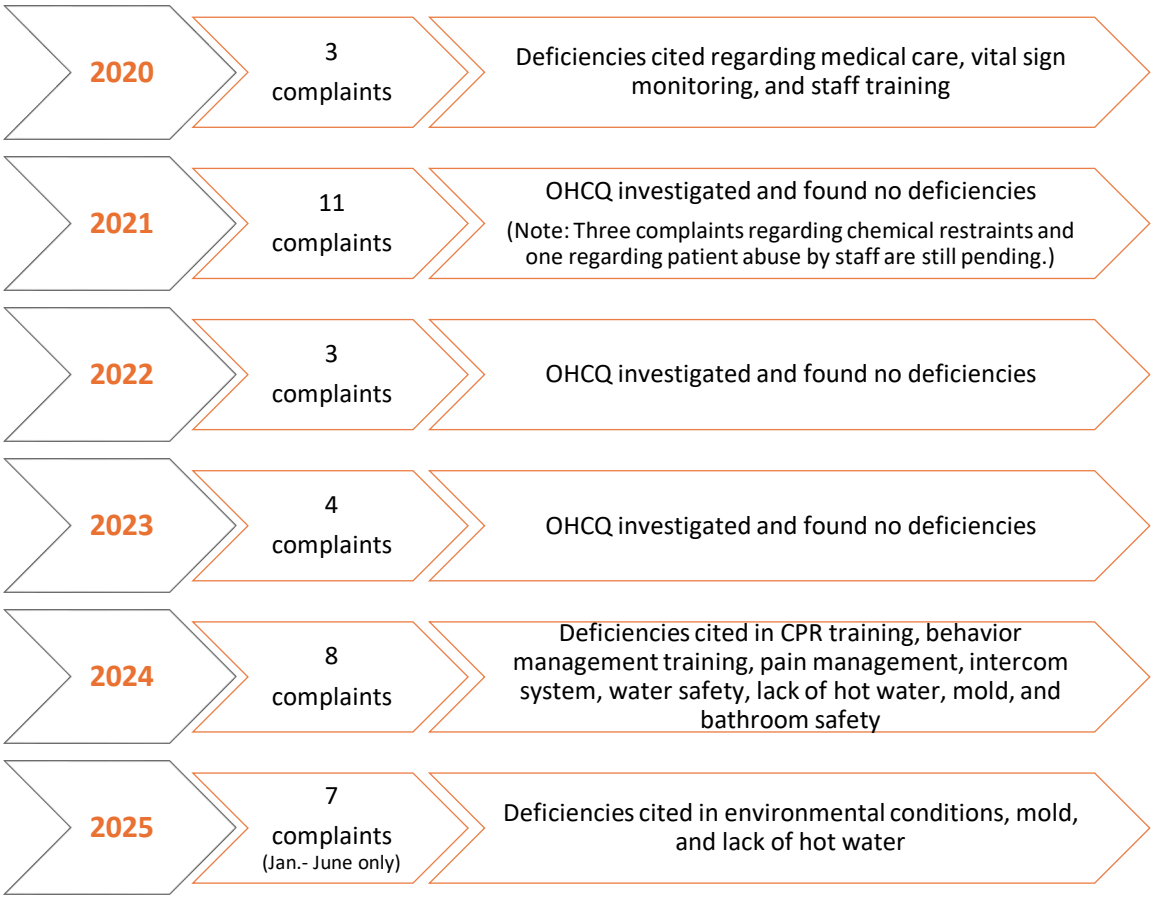



*Figure 3. OHCQ Complaints Received for CTPHC, 2020-2025. (Sources include: OHCQ, The Washington Post: https://wapo.st/4eZb5es, and the Joint Committee on Fair Practices and State Personnel Oversight hearing in Dec. 2024.)*

# Key Investigation Findings

# Key Investigation Findings

The Maryland Department of Health's goals for CTPHC are:

- To provide treatment and care in the least restrictive and least intensive setting, as measured by the use of seclusion and restraint.
- To provide a safe and therapeutic environment for patients and staff, as measured by assaults and injuries.
- To provide excellent care and to improve psychiatric outcomes for all patients, as measured by a patient satisfaction survey. [24]

Unfortunately, DRM's investigation concluded that CTPHC is not meeting these goals. People held at CTPHC are denied basic rights, including their right to receive adequate health care, to be free from seclusion/restraint, and to live in a safe environment.[25] CTPHC has failed to provide basic medical care, specialty care services, and emergency medical care to patients. Some patients do not receive adequate access to therapy, substance use treatment, or trauma-informed care, despite clinical recommendations for these services. In addition, patients are exposed to harm and traumatic experiences while hospitalized at CTPHC, including physical assaults and over-use of restraint and seclusion.

This report distills DRM's most significant concerns into five key findings with examples to support the findings. However, it does not address every concern or every violation of policy or law identified by DRM during its monitoring/investigation process.

Finally, DRM acknowledges recent positive developments under the leadership of the new CEO, Dr. Jones. This gives cause for cautious optimism that CTPHC will become a safer, more therapeutic setting for its patients.

[24] Goals are listed on the MDH - Maryland Hospital System's "Key Goals, Objectives, and Performance Measures," M00A. https://dbm.maryland.gov/Documents/MFR_documents/2025/MDH-Maryland-Hospital-System-MFR.pdf

[25] See Wyatt v Stickney, 325 F. Supp. 781 (M.D. Ala 1971).

## Finding #1: Lack of Appropriate Medical Care

The most critical finding from DRM's investigation is the inadequate access to medical care at CTPHC, which has resulted in adverse health outcomes and possibly contributed to patient deaths. To illustrate this finding, this report includes the detailed investigation findings of two women and one man who died ("Marissa", "Latasha", and "Charlie") and one man ("James") who suffered serious medical complications following delayed medical care. See the appendices to this report for detailed investigation findings for each case.

The poor medical care these patients received is not isolated or unique; these cases are representative of a systemic failure to provide essential medical care to patients. The four highlighted examples illustrate delays and denials in basic medical care, specialist care, mental health care, and emergency medical care that meet the protection and advocacy statutory criteria for "neglect."

Neglect in mental health facilities is defined as "…a negligent act or omission by an individual responsible for providing services… which caused or may have caused injury or death to a[n] individual… or which placed a[n] individual… at risk of injury or death, and includes an act or omission such as the failure to establish or carry out an appropriate individual program plan or treatment plan…, the failure to provide adequate nutrition, clothing, or health care…, or the failure to provide a safe environment.., including the failure to maintain adequate numbers of appropriately trained staff."[26]

### Key Investigation Findings Related to Medical Care

- CTPHC does not always address emergencies promptly or adequately.
- The hospital does not always provide consistent follow-up care and specialist care.
- When problems occur, hospital staff are not consistently held accountable.
- The quality of the medical care provided by CTPHC physicians is uneven.
- Ineffective oversight by the State leaves patients vulnerable.

[26] 42 U.S.C. §10802(5); see 45 C.F.R. §1326.19

## *"Marissa"*

"Marissa" was a 40-year-old African American woman who died in November 2023, just three months after her admission to CTPHC. Just days before she died, her social worker noted in her medical record that she was "stable" and "preparing for discharge."[27] Unfortunately, she never had the opportunity to return to the community.

DRM's investigation found multiple concerns with the medical care Marissa received:

- CTPHC failed to provide care for Marissa's chronic health conditions, and she was not seen by relevant specialists.
- CTPHC failed to provide adequate staffing to ensure patient safety.
- CTPHC failed to respond appropriately to her emergent medical needs during the days preceding her untimely death. Over the four days preceding her death her health continuously deteriorated, yet she was not taken to an emergency department for assessment and treatment. The day before she died staff called 911 but then cancelled the ambulance and Marissa remained at CTPHC.
- On the day she died, CTPHC medical staff failed to provide even basic life support, including CPR.
- CTPHC did not report Marissa's death to DRM or OHCQ as required by statute.
- Marissa's autopsy report states that she died due to "acute intoxication" of chlorpromazine, diphenhydramine, and sertraline. Each of these medications had been prescribed by CTPHC physicians.

The death investigation completed by OHCQ found that many CTPHC staff did not have current CPR certifications, and that the overhead emergency paging system was not operational. OHCQ's report did not cite many additional problems identified by DRM with respect to the medical care provided to Marissa by CTPHC.

CTPHC's failure to provide adequate medical care for Marissa constituted neglect as defined by 42 U.S.C. §10802(5) and 45 C.F.R. §1326.19.

[27] Social work monthly note for October 2023 in Marissa's medical record.

## *"Latasha"*

"Latasha" was a 55-year-old African American woman who died in November 2020, just five months after her admission to CTPHC. She was a widow with six children and three grandchildren. Although it has been more than five years since she died, CTPHC staff have never reported Latasha's death to DRM or the State Police, as required by law.[28] DRM only learned of her death four years after it occurred, while investigating the death of another woman, Marissa, who resided on the same unit at CTPHC.

About three months after Latasha was admitted to CTPHC she had abdominal pain, vomiting, and difficulty breathing and was sent to Johns Hopkins Howard County General Hospital (JHHCGH) Emergency Department (ED). She was diagnosed with three "ventral abdominal wall hernias" and a "severe mitral regurgitation" and was admitted as an inpatient for several days. When she returned to CTPHC, the discharge instructions directed her to follow up with both a cardiologist and a surgeon to repair the hernias.

CTPHC did not provide access to either a cardiologist or a surgeon for the critical follow-up care ordered by JHHCGH. Additionally, although the JHHCGH discharge instructions prescribed a low-sodium diet to protect her heart, CTPHC did not provide the recommended diet to Latasha. Reducing sodium intake can significantly lower one's risk of developing Atherosclerotic Cardiovascular Disease (ASCVD), later determined to be one of the causes of Latasha's death.[29] There is also no record of CTPHC obtaining blood work, despite her abnormal laboratory values while she was at JHHCGH, including a high white blood cell count, indicative of infection and possible bleeding in her gastrointestinal tract,[30] and the presence of nucleated red blood cells, indicative of a possible life-threatening condition.[31]

CTPHC also failed to provide Latasha with appropriate emergency medical care in the days before she died. On at least three occasions preceding her death, the CTPHC nursing staff consulted the CTPHC physician because of her symptoms, including abdominal pain and vomiting. Given that Latasha had recently been diagnosed with a heart condition and several

[28] Md. Code Ann., Health-General § 10-713.
[29] Hanna M. Knauss et al., Dietary sodium reduction lowers 10-year atherosclerotic cardiovascular disease risk score: Results from the DASH-sodium trial, 22 Am. J. Preventative Cardiology, June 2025 at 100980, https://doi.org/10.1016/j.ajpc.2025.100980.
[30] Mank, V., Azhar, W., Brown, K. (2024, April 21) Leukocytosis. StatPearls. https://www.ncbi.nlm.nih.gov/books/NBK560882/
[31] Hüseyin, N., Mehmet. M.O., Cüneyt. A., and Mehmet, B.Y.Ç. (2021). Nucleated red blood cells as predictor of all-cause mortality in emergency department. The American Journal of Emergency Medicine. https://doi.org/10.1016/j.ajem.2020.10.002.

hernias (at least one of which was suspected of being incarcerated), her symptoms should have been carefully evaluated, but she was not sent to the ED in any of these three instances. After the nursing staff were unable to detect Latasha's blood pressure, they made a fourth call to the CTPHC physician. This fourth call resulted in a second transport to the ED. Latasha died soon after arriving in the ED.

According to the autopsy report, Latasha died from Atherosclerotic Cardiovascular Disease (ASCVD) complicated by Ischemic Bowel. Both hernias[32] and atherosclerosis[33] (when plaque builds up inside blood vessels causing them to narrow), are known causes of ischemic bowel. It is also important to note that both hernias[34] and atherosclerosis[35] are treatable conditions.

Accountability measures in place did not work as intended because CTPHC did not provide required notice of Latasha's death. The Maryland State Police did not investigate Latasha's death because CTPHC administrators never provided the death notification required by law. Neither did CTPHC notify DRM of the death; had they done so, DRM could have initiated a timely investigation, rather than one that occurred four years later.

Despite the facts stated above, OHCQ's investigation of the death did not find any deficiencies with Latasha's care.

CTPHC's failure to provide adequate medical care for Latasha constituted neglect as defined by 42 U.S.C. §10802(5) and 45 C.F.R. §1326.19.

[32] Pastorino A, Alshuqayfi AA. Strangulated Hernia(Archived) [Updated 2022 Dec 19]. https://www.ncbi.nlm.nih.gov/books/NBK555972 and see https://my.clevelandclinic.org/health/diseases/incarcerated-hernia

[33] Atherosclerosis: What Is Atherosclerosis?, National Heart, Lung, and Blood Institute, https://www.nhlbi.nih.gov/health/atherosclerosis

[34] Pastorino A, Alshuqayfi AA. Strangulated Hernia(Archived) [Updated 2022 Dec 19]. https://www.ncbi.nlm.nih.gov/books/NBK555972/

[35] Atherosclerosis: Treatment, National Heart, Lung, and Blood Institute, https://www.nhlbi.nih.gov/health/atherosclerosis/treatment

## "James"

"James," the father of two young boys and a teenage daughter, contacted DRM for assistance after CTPHC denied him the medical care he needed to treat his type one diabetes. Hospital staff did not provide James with a diabetic diet, access to testing supplies for the presence of ketone bodies, or an insulin pump – even though his endocrinologist had prescribed these items. As a result, for the two years he was at CTPHC his blood glucose levels were uncontrolled, with dangerously low and high levels. Uncontrolled blood glucose levels increase risk for complications such as cardiovascular disease, retinopathy, neuropathy, and diabetic kidney disease.[36] In fact, James experienced two life-threatening medical emergencies and suffered from several serious and preventable complications while a patient at CTPHC, including rhabdomyolysis, severe diabetic retinopathy, and hepatic encephalopathy.

DRM met with CTPHC on many occasions and filed two OHCQ complaints about James' health care. James also filed several RGS grievances regarding his care, including complaints regarding the denial of an insulin pump and the failure of CTPHC to provide him with a diabetic diet.[37] Unfortunately, despite prevailing in the RGS process, James did not receive appropriate diabetes care.

James was transferred to another Maryland state hospital in May 2025 and has since received all needed medical care, including an insulin pump, continuous glucose monitor, diabetic diet, and regular appointments with specialists. The provision of these services led to an immediate and positive impact on his health and well-being.

CTPHC's failure to provide appropriate diabetes care to James constituted neglect as defined by 42 U.S.C. §10802(5) and 45 C.F.R. §1326.19.

[36] ElSayed NA, Aleppo G, Aroda VR, Bannuru RR, Brown FM, Bruemmer D, Collins BS, Hilliard ME, Isaacs D, Johnson EL, Kahan S, Khunti K, Leon J, Lyons SK, Perry ML, Prahalad P, Pratley RE, Seley JJ, Stanton RC, Gabbay RA, on behalf of the American Diabetes Association. 6. Glycemic Targets: Standards of Care in Diabetes-2023. Diabetes Care. 2023 Jan 1;46(Suppl 1): S97-S110. doi: 10.2337/dc23-S006. PMID: 36507646; PMCID: PMC9810469

[37] RGS #044615CP2025.

## "Charlie"

"Charlie" was born and raised in Washington, D.C. and had a large extended family. He was admitted to CTPHC in December 2020 and died unexpectedly at the hospital in September 2025. He was 45 years old and did not have any known medical conditions, other than the mental health condition that led to admission to CTPHC for treatment. During his time at CTPHC, Charlie gained 74 pounds. He weighed 256 pounds when he died; his autopsy determined his cause of death to be cardiovascular disease and obesity.

DRM's investigation found that Charlie's CTPHC doctors prescribed antipsychotic medications, including olanzapine. Although the clinical guidelines[38] are clear that a patient on olanzapine should be closely monitored for possible adverse side effects, DRM's investigation found that this monitoring did not occur. In fact, Charlie's doctors continued to order olanzapine, despite his weight gain, and even requested an exception to be able to prescribe more than the maximum allowed dose.

CTPHC also failed to provide appropriate care for Charlie on the day of his death. Another patient found him unresponsive on the bathroom floor after he had been alone in the bathroom for about an hour. The time that had passed since his medical emergency is unknown despite a policy that requires staff to check every patient at least every 15 minutes. DRM's investigation found that staff did not observe or check on him as required. Additionally, there was a seven-minute delay in calling 911 and a four-minute delay in getting the emergency supplies to him. DRM concluded that CTPHC staff neglected Charlie, as defined by Federal regulations at 42 C.F.R. Part 51, in that they "…caused or may have caused injury or death to an individual with mental illness or which placed an individual with mental illness at risk of injury or death...[.]"[39]

OHCQ's investigation into Charlie's death found several deficiencies, including repeat findings from their investigation of Marissa's death. As reported in a previous section of this report, Marissa died in November 2023, nearly two years earlier. In both death investigations, OHCQ found that some staff did not have current CPR certification and that the overhead emergency paging system was not operational. Even though these two deficiencies were cited as possible contributing factors in both death investigations, as of April 2026, CTPHC still does not have a functioning emergency paging system, putting all patients and staff at continued risk.

[38] NICE Guidelines 1.1.2. https://www.nice.org.uk/guidance/cg178/chapter/Recommendations#care-across-all-phases
[39] 42 C.F.R. Part 51.

## Finding #2: Lack of Appropriate Behavioral Health Care at CTPHC

In addition to deficits in the provision of somatic medical care (Finding #1), DRM found that CTPHC patients do not consistently receive needed behavioral health treatment. CTPHC should provide patients with mental health treatment that provides "a realistic opportunity to be cured or improve the mental condition for which they were confined."[40]

The psychiatric hospitalization of an individual does not in and of itself constitute treatment for their behavioral health needs. As the authors of "Inpatient Psychiatric Care in the 21st Century: The Need for Reform" explain, a "focus on ensuring only safety leads to an overemphasis on the biological aspects of care (generally psychopharmacologic) to reduce aggressive behavior and leaves far too little time to address the psychosocial aspects critical to understanding and intervening in the larger context and changing the course of illness."[41]

Patients at CTPHC deserve access to a full array of treatment options, not just medication. Without meaningful therapies, activities, and personal engagement, CTPHC risks becoming no more than a holding area, or worse – a prison for people who have not been sentenced. **The hospital's mission and vision include providing "recovery-based, trauma-informed care...within a … therapeutic environment"[42].** That mission and vision necessitate looking at the patient as a whole person and offering treatment to meet their medical and psychiatric needs.

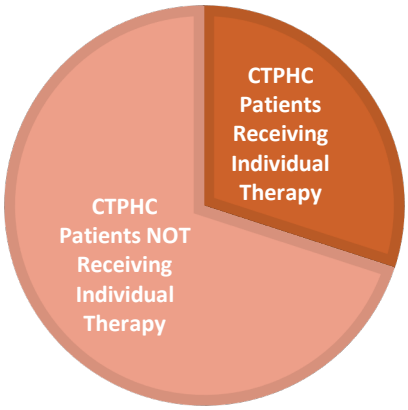
### Key Investigation Findings Related to Behavioral Health Care

- Many CTPHC patients do not receive individual mental health or substance abuse therapy because of waiting lists and other barriers.
- The Individual Therapy policy at CTPHC prioritizes care based on criminal charges and anticipated discharge date, leaving others who could benefit from individual therapy unable to receive it.

[40] *Sharp v. Weston*, 233 F.3d 1166, 1172 (9th Cir. 2000) (citing *Ohlinger v. Watson*, 652 F.2d 775, 779 (9th Cir. 1980)).
[41] Ira D. Glick, Steven S. Sharfstein & Harold I. Schwartz, Inpatient Psychiatric Care in the 21st Century: The Need for Reform, 62 Psychiatric Services, 206-09 (2011), p. 207. https://psychiatryonline.org/doi/abs/10.1176/ps.62.2.pss6202_0206.
[42] https://health.maryland.gov/perkins/Pages/hOME.aspx *(emphasis added)*

## Individual Mental Health Therapy

Federal regulations require that CTPHC "must provide or have available psychological services to meet the needs of patients"; regulatory guidance makes clear that these services include the provision of individual therapies.[43] Mental health therapy is a psychological service that "…is cost-effective, reduces disability, morbidity and mortality, improves work functioning, [and] decreases use of psychiatric hospitalization..."[44] Yet, DRM found that many patients do not have access to individual therapies; CTPHC reports that only about 30% of patients receive individual mental health therapy.[45]




CTPHC denies access to individual mental health therapy for some, while placing others on waiting lists, resulting in significant delays in care that can extend for months at a time. According to the principles of patient-centered care, patient participation and choice in treatment decisions is critical. Yet, CTPHC patients report that they often feel unheard in the treatment planning process, particularly in terms of access to mental health therapy.

Common types of individual mental health therapy include Cognitive Behavioral Therapy (CBT), Dialectical Behavioral Therapy (DBT), and psychodynamic therapy. CBT is "…is aimed at identifying and modifying the client's maladaptive thought processes and problematic behaviors through cognitive restructuring and behavioral techniques to achieve change."[46]

- CBT for psychosis: SAMHSA's guidelines state that providers should offer people experiencing psychosis both medication and Cognitive Behavioral Therapy for psychosis (CBTp) as it is "recommended as standard of care in U.S. psychosis practice guidelines."[47]
- CBT for schizophrenia: CBT is also the standard of care for people with schizophrenia, with results including improved insight, a reduction in negative symptoms, and

[43] 42 C.F.R. §482.62(e).
[44] https://www.apa.org/about/policy/resolution-psychotherapy
[45] Data provided by CTPHC administration on 8/8/2025.
[46] https://dictionary.apa.org/cognitive-behavior-therapy
[47] SAMHSA: Routine Administration of Cognitive Behavioral Therapy for Psychosis as the Standard of Care for Individuals Seeking Treatment for Psychosis: State of the Science and Implementation Considerations for Key Stakeholders. Center for Mental Health Services, SAMHSA Health Services Administration, 2021, p. 7.

protection against depression.[48,49] The American Psychological Association (APA) and the National Institute for Clinical Excellence (NICE) both recommend CBT for people with schizophrenia, with NICE advising a minimum of 6 months of CBT treatment.[50]

- CBT for PTSD: The American Psychological Association Clinical Practice Guidelines for the treatment of PTSD "strongly recommends" CBT. [51]

Despite these standards and clinical guidelines, DRM found that CTPHC does not always provide patients with psychosis, schizophrenia, or PTSD access to CBT and other forms of individual mental health therapy.

## Waiting Lists

Even when patients receive a referral for individual therapy from their treatment team, they are still subject to long waiting lists. Twenty-three patients are currently on a waiting list to receive individual mental health therapy;[52] according to the CTPHC administration, the waiting period is typically five or six months.[53] Such waits can delay the patient's recovery, extend their time in the hospital, and result in delays for others who are waiting to be transferred to CTPHC. It also results in significant additional costs to the State and Maryland taxpayers, as inpatient care at CTPHC is more costly than the community-based mental health supports typically provided to individuals once they have been discharged. CTPHC administrators maintain that waiting lists are necessary because of insufficient staffing; however, courts have held that "lack of funds, staff, or facilities cannot justify the State's failure to provide [the] treatment necessary for rehabilitation."[54] Research in a prison context shows that when treatment options are limited, disciplinary problems, physical assaults, and the use of restraint/seclusion increases.[55]

## CTPHC's Individual Therapy Policy

DRM found that CTPHC's Individual Therapy policy causes unnecessary barriers to obtaining this care. In 2022, for example, the policy did not allow people with pending criminal charges to access any form of individual mental health therapy, even when requested by the individual

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[48] Kreyenbuhl, J., Buchanan, R. W., Dickerson, F. B., Dixon, L. B., & Schizophrenia Patient Outcomes Research Team (PORT) (2010). The Schizophrenia Patient Outcomes Research Team (PORT): updated treatment recommendations 2009. Schizophrenia bulletin, 36(1), 94–103. https://doi.org/10.1093/schbul/sbp130

[49] Taylor, T.L., Killaspy, H., Wright, C. et al. A systematic review of the international published literature relating to quality of institutional care for people with longer term mental health problems. BMC Psychiatry 9, 55 (2009). https://doi.org/10.1186/1471-244X-9-55, p.8.

[50] NICE Quality Statement 2: https://www.nice.org.uk/guidance/qs80/chapter/quality-statement-2-cognitive-behavioural-therapy#quality-statement-2-cognitive-behavioural-therapy

[51] Summary of the clinical practice guideline for the treatment of posttraumatic stress disorder (PTSD) in adults. American Psychologist, 74(5), 596–607. https://doi.org/10.1037/amp0000473

[52] Data provided by CTPHC administration on 8/8/2025. Note that all people on the waiting list are NCR.

[53] Per meeting with CTPHC administration on 9/11/2025.

[54] *Or. Advocacy Ctr. v. Mink*, 322 F.3d 1101, 1121 (9th Cir. 2003)

[55] Gonzalez, J.M.R. and Connell, N.M. Mental Health of Prisoners: Identifying Barriers to Mental Health Treatment and Medication Continuity. American Journal of Public Health. https://doi.org/10.2105/AJPH.2014.302043

and/or recommended by their treatment team. Following advocacy by DRM, CTPHC revised the policy in 2023 to allow all patients, regardless of legal status, to have access to individual therapy. However, CTPHC staff have not consistently implemented the new policy. In fact, based on data provided to DRM nearly two years after the policy was revised to expand access, CTPHC reported that nobody who is pretrial or who has pending charges is receiving individual mental health therapy.[56] For those being held at CTPHC for competency restoration, a delay in obtaining appropriate, medically-recommended mental health treatment may contribute to their spending longer periods in the hospital and may violate their substantive due process rights.

DRM also found that the current Individual Therapy policy has a problematic rationing and gatekeeping process. Those referred for therapy are assigned a priority level for care, not based on medical necessity, but rather on legal status and anticipated release date. Further, those referred for therapy but without an expected release date are not assigned a therapist until all referred patients with discharge dates are assigned first, resulting in a never-ending waiting list.

## Behavioral Health Care for Sexual Abuse Survivors

State law requires the hospital to provide additional protection and services when a patient has a history of sexual abuse and/or is subject to sexual abuse while in the hospital. The individualized treatment plan for patients with a history of sexual trauma must include "…treatment and education that is evidence-based or reflective of best practices to reduce the likelihood of the patient being the victim of repeated sexual abuse."[57] Clinical staff must be "…trained in at least one trauma recovery modality that is considered to be a best practice."[58]

Current clinical practice guidelines for the treatment of trauma[59], including trauma resulting from sexual abuse, focus on the provision of "psychotherapy over pharmacology" and further specify as best practice the following three types of therapy:

> "Adults with PTSD can be treated with cognitive processing therapy (a cognitive behavioral therapy-based program that walks patients through processing trauma by examining trauma-related beliefs), prolonged exposure therapy (an approach that guides patients through facing trauma-related reminders and memories), and trauma-focused

[56] CTPHC reports that 82 patients are receiving 1:1 mental health therapy in August 2025: 74 patients are NCR, 8 are voluntary patients, and no patients have pending charges, per email to DRM dated August 8, 2025.
[57] MD Code Ann., Health - General, §10-705.
[58] Id.
[59] American Psychological Association (2025). APA Clinical Practice Guideline for the Treatment of Posttraumatic Stress Disorder (PTSD) in Adults. https://www.apa.org/about/policy/guideline-ptsd-in-adults.pdf

> cognitive behavioral therapy (a combination that often includes psychoeducation, relaxation, cognitive restructuring, and exposure therapy components)."[60]

Despite these requirements, patients with a history of sexual abuse prior to or at CTPHC have reported to DRM that they have had difficulty obtaining individual trauma therapy.

## Substance Use Disorder Treatment

During its investigation, DRM found that patients do not have sufficient access to substance use disorder treatment. In fact, during DRM's two-year investigation and monitoring of CTPHC the hospital did not have any substance use counselors on staff. CTPHC now has a full-time substance use counselor-- a welcome development. However, while this position was unfilled, critical substance use treatment was not available for patients.

The American Psychiatric Association's (APA) practice guidelines for substance use disorders state that evidence-based psychosocial treatments, including CBT, behavioral therapy, psychodynamic therapy, and interpersonal therapy "…are essential components of a comprehensive treatment program."[61] According to the National Institute of Health (NIH) National Institute on Drug Abuse, treatment for people with both substance use disorder and a mental health diagnosis should include the following three elements:

1. Behavioral therapy/psychotherapy,
2. Medication for opioid, alcohol, and nicotine addiction, and
3. Referral to self-help support groups.[62]

Although self-help support groups, especially those that are peer-led, are important supports, they do not provide treatment or therapy. CTPHC maintains only one Narcotics Anonymous (NA) and one Alcoholic Anonymous (AA) group; both groups have waiting lists to join. As of August 2025, 49 patients were participating in AA, 20 patients were participating in NA, and 20 patients were on the waiting list to join these support groups.

CTPHC must provide access to evidence-based psychological treatment, therapy, and medication for patients with a substance use disorder in addition to their mental illness. SAMHSA advises that providing integrated substance use and mental health treatment improves "…psychiatric symptoms and functioning" and increases the likelihood of "…successful

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[60] Pappas, S. (2025, July 1). CE Corner: PTSD and trauma: New APA guidelines highlight evidence-based treatments. Monitor on Psychology, 56(5). https://www.apa.org/monitor/2025/07-08/guidelines-treating-ptsd-trauma

[61] Practice guideline for the treatment of patients with substance use disorders: Second edition. American Psychiatric Association. (2006), p. 10.

[62] Center for Substance Abuse Treatment. A Guide to Substance Abuse Services for Primary Care Clinicians. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1997. (Treatment Improvement Protocol (TIP) Series, No. 24.) Chapter 5—Specialized Substance Abuse Treatment Programs. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64815/

treatment and recovery for both disorders."[63] Access to substance use treatment should be a core service, as it promotes recovery and successful discharge.

[63] https://www.samhsa.gov/co-occurring-disorders

## Finding #3: Unlawful Use of Seclusion and Restraint at CTPHC

Among the more serious complaints raised by patients at CTPHC is the violation of one's right to be free from restraint and seclusion of any form when used as a means of coercion, discipline, convenience, or retaliation.[64] Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.[65] A physician's order for restraint or seclusion of an adult may not exceed four hours. In addition, before using restraint or seclusion, staff must first consider other less restrictive strategies.[66]

### Key Investigation Findings Related to Restraint and Seclusion

- Patients are restrained and secluded in the absence of behavior that poses a serious and imminent danger to physical safety.
- CTPHC maintains incomplete and unreliable data on restraint and seclusion because staff do not always properly document the use of restraint and seclusion.

Restraint is "any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely." Restraint is also a "…drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition."

Seclusion "…is the involuntary confinement of a patient alone in a room or area from which the patient is physically prevented from leaving."

*42 USC § 482.13*

[64] COMAR 10.21.12.03; COMAR 10.21.13.03; 42 C.F.R. §482.13.
[65] COMAR 10.21.12.03; COMAR 10.21.13.03; Md. Code Ann., Health-General §10-701.
[66] Joint Commission Standards PC.03.05.01 and RI 01.06.01
https://publicstandards.tools.jointcommission.org/2.DOMESTIC , and see
https://digitalassets.jointcommission.org/api/public/content/1976b0291a284a8fa7a7b47d26808b5a?v=73722715

## Restraint

DRM is concerned that CTPHC restrains patients for lengthy time periods and that the rate is increasing. Publicly reported restraint rates for CTPHC show 0.56 hours in restraints for every 1,000 patient hours.[67] When a physician orders restraint, CTPHC staff typically use either a restraint chair (Figure 4) or a restraint bed to immobilize the patient for up to four hours at a time.

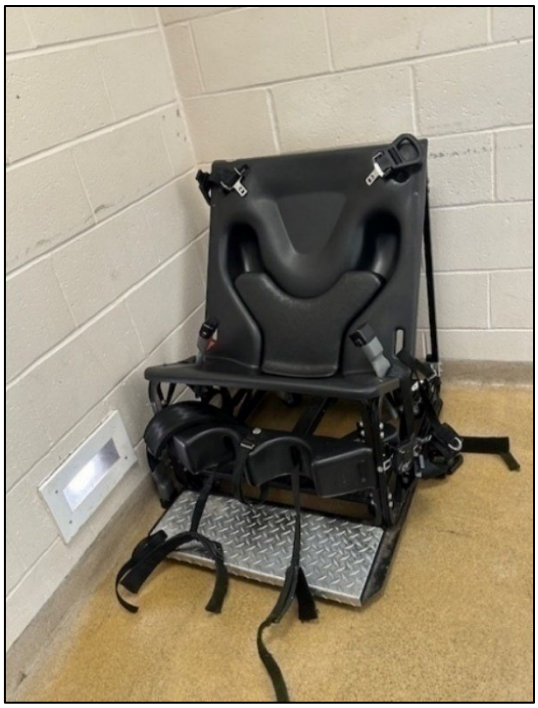

*Figure 4. Restraint chair at CTPHC, March 2025*

In 2022 and 2023, the restraint rate was 0.47 hours and 0.42 hours, respectively. Based on data provided by CTPHC to DRM, there were 347 episodes totaling 1,256 hours in 2022 and 412 episodes totaling 1,417 hours in 2023.

In 2024, the upward trend continued with 434 total episodes and 1,813 total hours in restraint.[68] A total of 106 patients spent more than 1,813 hours in restraint – in other words, a third of all patients in the hospital were restrained at some point that year.

CTPHC subjects some patients to restraint with disturbing frequency. For example, one patient was restrained 82 times in 2024. Three other patients were restrained 20 or more times that year.

Although most episodes of restraint lasted for fewer than four hours, 22 of the 434 incidents exceeded eight hours in duration.[69] Eleven episodes exceeded 12 hours in duration and six restraint episodes lasted for more than 24 consecutive hours. The Centers for Medicare and Medicaid Services (CMS) guidelines advise that "when restraint or seclusion techniques are used, patients are placed at a higher risk for injuries or even death" and further cautions that "**twenty-four hours of restraint or seclusion for the management of violent or self-destructive**

[67] MD Dept. of Budget and Management. https://dbm.maryland.gov/Documents/MFR_documents/2026/MDH-Maryland-Hospital-System-MFR.pdf, p.6.

[68] Restraint data provided to DRM by CTPHC. Data for January to August 2025 indicate similar trends with 263 total restraint episodes totaling 898 hours in restraints.

[69] While each physician's order for restraint of an adult may not exceed four hours maximum, restraints can continue to be used beyond four hours under certain circumstances and if the patient's behavior continues to pose a risk of serious, imminent danger to someone's physical safety.

**behavior is an extreme measure with the potential for serious harm to the patient**."[70] (Emphasis added.)

Additional data analysis found that restraint was more likely to be used on certain units. While it is unsurprising that most instances occur on CTPHC's maximum-security units, documentation reveals markedly different numbers of incidents on the two maximum security admissions units for men; patients housed on 1 West were restrained 173 times in 2024, while patients on 1 East were restrained 17 times in the same time period. In fact, one third of all incidents within CTPHC occur on 1 West. Additionally, patients housed on 1 West are restrained for longer periods--an average of nearly eight hours-- as compared to averages on other units, which range from one to five hours. Given the similar patient populations and unit size, an additional examination of the staffing differences between these two units would be useful.

Additional information is necessary to explain why the CTPHC restraint rate is significantly higher than the rate in most of the other psychiatric hospitals in the state. Further examination is warranted to determine if CTPHC's use of restraint and seclusion is related in any way to the waiting lists for therapy, staffing levels, inadequate training of staff, the lack of sufficient meaningful programming for patients, or a combination of factors.

Finally, DRM found that CTPHC staff often use restraint as a response to physical assaults between patients. For example, during the first three months of 2024, about half of all patient fights resulted in the use of restraint. A total of 59 incidents of patient-on-patient physical assaults were recorded during these three months and staff responded by restraining one or more of the patients involved in 31 of these incidents. (See Figure 6). While these episodes may have been legally justified (i.e. restraint was appropriately used during an emergency in which the patient's behavior posed a serious threat of violence or injury), this data indicates the need to prioritize interventions that will reduce the likelihood of patient assaults as part of the strategy to reduce the use of restraint and increase safety overall. CTPHC administrators report that they are implementing plans to increase recreational options and to foster an environment in which staff and patients can interact in more social ways. DRM applauds these initiatives and encourages CTPHC to consider additional evidence-based strategies for reducing aggressive behavior, including increasing patient privacy, encouraging teamwork among staff members, and improving staff training in de-escalation techniques.[71]

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[70] Center for Medicare and Medicaid Services Memo. (2008). Hospitals - Restraint/Seclusion Interpretive Guidelines & Updated State Operations Manual (SOM) Appendix A. https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/scletter08-18.pdf , p. 108.

[71] Weltens, I., Bak, M., Verhagen, S., Vandenberk, E., Domen, P., van Amelsvoort, T., et al. (2021) Aggression on the psychiatric ward: Prevalence and risk factors. A systematic review of the literature. PLoS ONE 16(10): e0258346. https://doi.org/10.1371/journal.pone.0258346

## Seclusion

CTPHC has reported very low seclusion rates in recent years, as illustrated in Figure 6. In fact, this publicly available data indicates zero seclusion hours per 1,000 patient hours for both 2022 and 2023. However, DRM's investigation found that these data are not accurate. As a result of its April 2025 survey, The Joint Commission also found widespread issues with CTPHC's restraint and seclusion data and cited the hospital for violating the standards that require the collection of restraint and seclusion data and the monitoring of trends.[72]

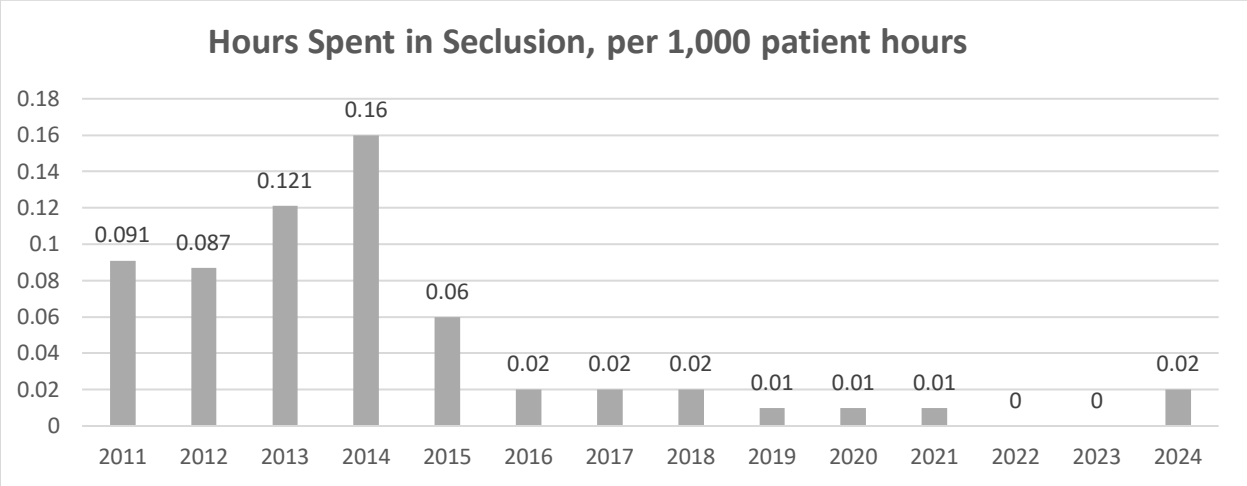


*Figure 5. Data provided by Maryland Department of Budget and Management.*

DRM found that CTPHC had been using seclusion by other euphemistic names, including "Voluntary Safe Space Monitoring" (VSSM) and "zones." CTPHC's Special Observation policy described VSSM as an intervention that "…is utilized when the patient is deemed unsafe for unmonitored movement on the ward for the other patients and staff in the milieu or the milieu is too dangerous or stimulating for the patient." Although CTPHC distinguished VSSM from seclusion, OHCQ found in 2019 that VSSM constitutes seclusion.[73] Despite this finding, CTPHC continued to illegally subject people to prolonged seclusion by continuing to utilize VSSM for years after OHCQ's finding. CTPHC administrators did not revoke the VSSM policy until August 2025.[74]

[72] Joint Commission Standard PC.13.02.15 and PI.13.01.01 https://publicstandards.tools.jointcommission.org/2.DOMESTIC and see https://digitalassets.jointcommission.org/api/public/content/1976b0291a284a8fa7a7b47d26808b5a?v=73722715

[73] October 2019 Statement of Deficiencies for OHCQ #MD00146487.

[74] DRM's findings about VSSM are included in this report because of CTPHC's history of reverting to the use of VSSM but naming it something different.

In fact, for a two-year period (March 2022 to March 2024), CTPHC reported that 29 patients were held in VSSM for an average of 55 days. In total, these 29 patients spent 1,730 days (about 41,520 hours) in VSSM.[75]

While some of these 29 people were confined alone for a few days, others spent months in prolonged seclusion. According to CTPHC's own records, one individual spent a total of 654 days in seclusion, nearly the entire two-year reporting period.

## The Impact of Seclusion

Voluntary Safe Space Monitoring (VSSM) and other forms of seclusion have no therapeutic value[76] and can be physically and psychologically damaging. In fact, the "…use of seclusion and restraint can have substantial deleterious physical and more often psychological effects on both the patient and the staff."[77] The impact of prolonged seclusion can also include a multitude of negative effects including intense agitation; random and impulsive violence; anxiety; sleep disturbances; paranoia; and hypersensitivity to stimuli.[78]

Patients on VSSM also had limited social interaction with other patients and staff. Through conversations with patients, family members, and CTPHC staff, DRM learned that patients on VSSM were often confined alone to their room all day except for access to the shower, and were not usually allowed access to computers, television, radio, books, magazines, or newspapers. They may also have had restricted access to visitors, phone calls, and other social activities.

As OHCQ concluded, DRM also found that VSSM meets the legal definition of seclusion: "the involuntary confinement of a patient under the direction of a physician or registered nurse alone in a room which a patient is physically prevented from leaving," as delineated below.[79]

- **"Involuntary confinement."** DRM staff saw patients being kept behind locked doors while in their "safe space" and patients report that when they want to leave, they must first request and obtain permission from a nurse. This procedure was outlined in the CTPHC Special Observation policy before it was revised in August 2025: "Patient's request to move from one space to another will trigger an assessment by an RN or MD to ascertain whether the patient's request could be accommodated based on the patient's clinical status and availability of alternative space on the ward. If no alternative safe space is available at the

[75] CTPHC provided DRM with this data on prolonged seclusion/VSSM.
[76] Sailas, E. & Fenton, M. (2000). Seclusion and restraint for people with serious mental illnesses. The Cochrane database of systematic reviews, 2000(2), CD001163. https://doi.org/10.1002/14651858.CD001163
[77] Id.
[78] Grassian, S. (2006) Psychiatric Effects of Solitary Confinement, https://openscholarship.wustl.edu/law_journal_law_policy/vol22/iss1/24 , p. 328.
[79] COMAR 10.21.13.02.

time of the request, the patient will be advised to remain in the current location until the RN or MD can identify an alternative safe space on the ward."

- **"Under the direction of a physician."** The need for a physician's order for VSSM was also outlined in the CTPHC policy, as follows: "This level of observation [VSSM] requires a physician order and physician documentation to justify use and is to provide nursing with specific direction as to how to monitor the patient."
- **"Alone in a room."** DRM's monitoring visits and record reviews noted that VSSM orders were almost always for the patient's bedroom, devoid of other people and objects, except for a mattress.
- **"Physically prevented from leaving."** Although CTPHC policy stated that a patient would "…be reminded that they may leave their room at any time," DRM found that patients were physically prevented from leaving their room. DRM staff observed locked doors with staff members posted outside the room, and patients reported that CTPHC staff told them if they try to leave the room, they would be restrained.

In August 2025, CTPHC administrators revised the hospital's Special Observation policy to remove VSSM as a permitted intervention.[80] DRM hopes that under the current leadership, CTPHC has permanently laid to rest the harmful practice of prolonged seclusion.

## CTPHC's Failure to Properly Document the Use of Restraint and Seclusion

Federal law requires that a patient be evaluated in person, face-to-face, by a medical provider "within 1 hour after the initiation of the [restraint or seclusion] intervention;" this evaluation must assess the "patient's immediate situation" including their "medical and behavioral condition," and must include a determination to either end or continue the intervention.[81] Federal law also requires documentation in the patient's medical record of evaluations, the patient's behavior, and the patient's condition.[82] Further, the Joint Commission standards require restraint or seclusion to be used "in accordance with a written modification to the patient's plan of care."[83] However, DRM found that many required documents, including physician's orders for restraint and seclusion, were missing from patient medical records. These orders are important to ensure that the patient is protected and that the physician's orders are properly followed. For example, in medical records reviewed by DRM as part of this investigation, there was often no indication in the patient's medical record that CTPHC staff:

- wrote the necessary orders to justify restraint, seclusion, or VSSM;
- conducted proper assessments or monitoring; or

[80] The CTPHC Special Observation policy was updated most recently in August 2025.
[81] 42 C.F.R. §482.13(e)(12).
[82] 42 C.F.R. §482.13(e)(16).
[83] Joint Commission Standard PC.03.05.03.

- attempted redirection or de-escalation techniques first, as required by COMAR 10.21.12 and 10.21.13.

## OHCQ's Lack of Effective Oversight for Seclusion Issues

DRM found that CTPHC has a history of circumventing seclusion regulations, resulting in excessive and prolonged seclusion without oversight or patient protections. Nearly **ten years ago**, DRM raised concerns about the illegal use of seclusion at CTPHC, which at the time was occurring under a practice known as "zoning," in which patients were required to stay in their bedroom for extended periods. In fact, DRM sent a complaint to OHCQ in October 2016 about the use of zoning and seclusion at CTPHC. Subsequently, CTPHC changed its policy to eliminate the practice of "zoning" patients. Although the updated policy no longer authorized the practice of "zoning," CTPHC replaced it with the similar practice of VSSM — unlawful prolonged seclusion by another name.

In an October 2019 investigation OHCQ focused on the use of VSSM at CTPHC. OHCQ found that VSSM was initiated in response to a mandate from a physician and was not voluntary in practice.[84] OHCQ cited several deficiencies and noted that the term VSSM is a "misnomer" and "was tantamount of [sic] an administratively sanctioned seclusion process applied in the absence of imminently dangerous behaviors." Unfortunately, although OHCQ's Plan of Corrections to address the problems included additional training and oversight by administrators as well as an emphasis on advising patients subjected to VSSM orders that they have access to a second "safe space" to move to whenever they want, illegal seclusion under the guise of VSSM persisted.

Given the ongoing problems with prolonged seclusion, DRM sent a complaint to OHCQ about the use of VSSM in October 2022 but received no response. In May 2025, two and a half years later, DRM sent an updated complaint about the use of VSSM with the same client. In the 2025 complaint DRM pointed out the discrepancy between DRM's direct observations and statements made by CTPHC administrators. For example, during a DRM on-site visit in March 2025 CTPHC administrators told DRM staff that they no longer use VSSM. However, during that same visit DRM staff personally witnessed the client in VSSM and were denied access to meet with him, in violation not only of seclusion regulations but also of Maryland law permitting patients to meet privately with an attorney at any reasonable time.[85] Unfortunately, the OHCQ investigation report for DRM's 2025[86] and 2022[87] complaints do not cite any deficiencies related to seclusion. DRM is pursuing inconsistencies with the OHCQ report.

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[84] OHCQ #MD00146487.
[85] COMAR 10.21.09.03.
[86] OHCQ #MD00218268.
[87] OHCQ #MD00184318.

## Finding #4: Safety Concerns at CTPHC

During interviews with DRM staff, CTPHC patients and staff raised concerns about physical and psychological safety in the hospital. For example, some interviewees expressed concern about assaults by other patients or that they might face retaliation or intimidation for speaking up or raising concerns. In fact, concerns about safety at CTPHC stretch back decades. In 2012, after three patients were killed in the facility, the State responded by commissioning an independent evaluation and report by Drs. Appelbaum and Dvoskin.[88] Unfortunately, many of the recommendations in their report have still not been implemented[89] and significant safety concerns persist.

### Key Investigation Findings Related to Safety

- Patients frequently assault other patients.
- Special observation status does not always ensure safety.
- Patient care does not align with the principles of trauma-informed care.
- CTPHC does not provide sufficient patient programming, resulting in too much unstructured time.
- CTPHC's significant infrastructure deficiencies frequently cause unsafe environmental conditions.

### Physical Assaults

From 2011-2015, following the three patient deaths, CTPHC saw an average of 140 patient-on-patient physical attacks each year, or an average of about 12 attacks per month.[90] More recent data reveals that during the first three months of 2024, there were 59 incidents of patient-on-patient physical assaults, an average of about 20 attacks per month (Figure 6). Patients sustained injuries in about a third of these incidents and in four cases, the injuries were significant and required transport to an emergency department for treatment.

[88] Appelbaum, K.L. and Dvoskin, J.A. (2012, January 10). Consultation report on the Clifton T. Perkins Hospital Center.
[89] https://www.baltimoresun.com/2012/01/12/experts-offer-safety-measures-at-perkins-hospital-2/
[90] https://dbm.maryland.gov/Pages/ManagingResultsMaryland.aspx

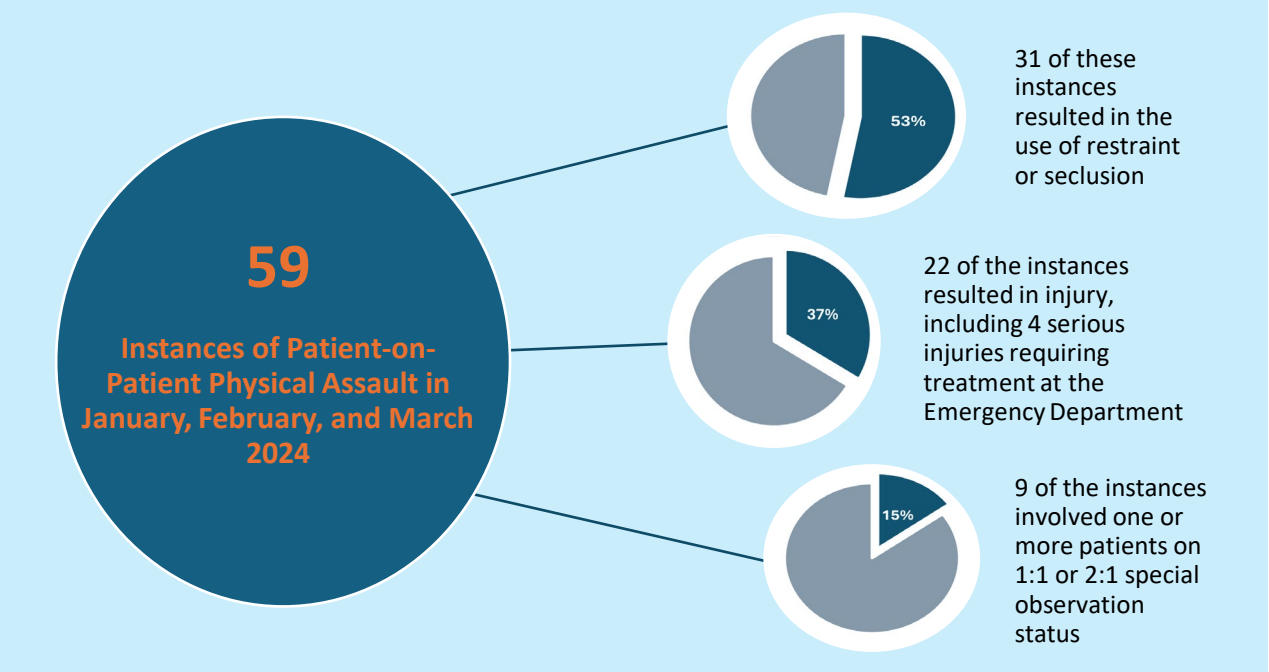



*Figure 6. Physical assaults (patient-on-patient) January-March 2024.*

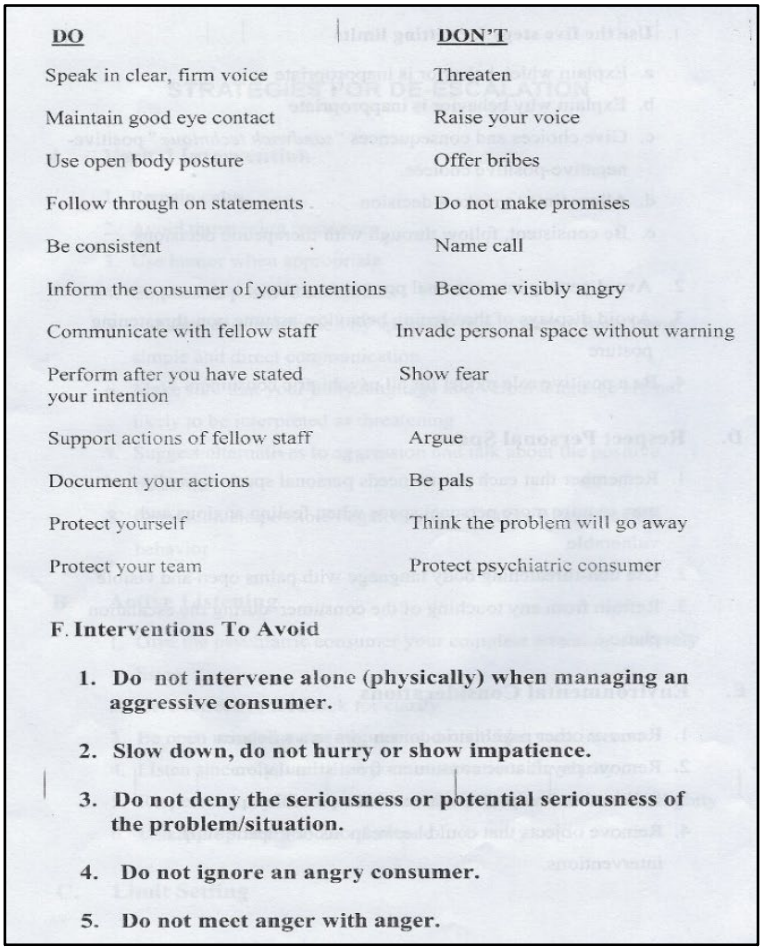
When a patient may be dangerous to themselves or others, a physician can order that the patient be placed on "special observation status" with a dedicated staff observer(s) assigned to watch the patient continuously to ensure safety. However, DRM found that "special observation status" is often ineffective in achieving this goal. Nine incidents of patient-on-patient physical assaults during the first three months of 2024 involved patients on special observation status. This raises concerns about the effectiveness of this intervention; it is not clear if the staff who provide special observation are qualified or trained to fulfill this role.[91]

## Staff Training

Highly trained and experienced staff are key to ensure that patients and staff are safe. DRM identified two issues with training: (1) not all CTPHC staff are trained, and (2) the training is rudimentary and inadequate to train staff for their roles. CTPHC currently uses the Prevention and Management of Aggressive Behavior (PMAB) training program for staff. However, as of October 2024, 43 security staff, 40 nursing staff, and 28 other employees lacked current PMAB certification.[92] Without adequate training, CTPHC staff cannot de-escalate behavior or keep patients safe; without other strategies to employ, staff too often rely on the use of restraint.

[91] While the data presented here are for January-March 2024, DRM analyzed assault data provided by CTPHC for a two-year period (March 2022-March 2024) and found that about 14% of the nearly 500 assaults that occurred during that time involved a patient on special observation status.
[92] Data from the October 3, 2024 "Training Report" highlighted in the January 2025 NASMHPD consultants' report.

Additionally, it is not clear that the PMAB behavior intervention program itself is robust enough to provide an effective behavior intervention tool for CTPHC staff. Multiple staff members expressed the need for improved training in how to prevent aggression and violence. As Figure 7, a screenshot of a PMAB training handout provided to CTPHC staff, illustrates, the training is simplistic and, likely, inadequate to enable CTPHC staff to reduce violence at the hospital. CTPHC has recently invested in staff receiving "train-the-trainer" PMAB certification.[93] However, without further information about how this training differs from the standard PMAB training, DRM cannot determine if this will meet staff needs effectively.



| DO | DON'T |
|---|---|
| Speak in clear, firm voice | Threaten |
| Maintain good eye contact | Raise your voice |
| Use open body posture | Offer bribes |
| Follow through on statements | Do not make promises |
| Be consistent | Name call |
| Inform the consumer of your intentions | Become visibly angry |
| Communicate with fellow staff | Invade personal space without warning |
| Perform after you have stated your intention | Show fear |
| Support actions of fellow staff | Argue |
| Document your actions | Be pals |
| Protect yourself | Think the problem will go away |
| Protect your team | Protect psychiatric consumer |

**F. Interventions To Avoid**

1. **Do not intervene alone (physically) when managing an aggressive consumer.**
2. **Slow down, do not hurry or show impatience.**
3. **Do not deny the seriousness or potential seriousness of the problem/situation.**
4. **Do not ignore an angry consumer.**
5. **Do not meet anger with anger.**

*Figure7. PMAB training handout, page 8, provided during CTPHC training for new staff.*

## Patient Programming

Through monitoring visits, interviews with staff and patients, and record reviews, DRM gained a deeper understanding of daily life for patients at CTPHC. For example, the hospital restricts many people to their individual unit for most of the day and CTPHC staff bring meals and activities to them. This is especially the case on the maximum-security units, where most physical assaults occur.

The layout of most of the hospital units includes two hallways lined with bathrooms and bedrooms. In between the two hallways is a common area, which usually consists of three "day rooms" in front of the nursing station. Patients spend much of their time in this common area either watching television or sleeping. It is also common to see patients pacing the hallways.

[93] Per meeting with DRM and CTPHC administration in July 2025.

Activities that occur off the unit include exercising in the gym and shopping at the hospital store, Clifton's Corner.

DRM found that insufficient programming for patients is a root cause of physical assaults and that patients need more programming options, both for treatment and so they will have less down time in which to become bored. Staff interviews conducted as part of the investigation, particularly with security staff, emphasized the need for more activities to reduce the number of assaults and other security incidents. The Maryland General Assembly's December 2024 Joint Committee on Fair Practices and State Personnel Oversight hearing also addressed the issue of inadequate patient programming as a cause of patient assaults. As noted during the hearing, patient assaults continue to be a serious concern and CTPHC needs more programming to engage patients in recovery, treatment, and purposeful activities to reduce assaults.[94] Twelve years earlier, the Applebaum report addressed these same concerns.

The Applebaum report also found the frequent use of double shifts and other practices that left, and continue to leave, staff unsupported and stretched too thin. Tired staff working double shifts is not conducive to the provision of creative and engaging patient programming.

## Unsafe Environmental Conditions

Poor environmental conditions at CTPHC have been a persistent and well-known source of concern and complaints. DRM has received reports of a lack of clean drinking water, mold (Figure 8), significantly high/low temperatures within the facility, a lack of hot water available for showers, and rust (Figure 9). The Resident Grievance System (RGS) received seven grievances about environmental conditions in 2023[95] and thirteen grievances in 2024. The Joint Commission cited CTPHC for several serious environmental issues in its April 2025 report.

*Figure 8. Mold on shower ceiling, March 2025.*

94 https://mgaleg.maryland.gov/mgawebsite/Committees/Media/false?cmte=fps&clip=FPS_12_11_2024_meeting_1&ys=2024rs

95 PSYCHIATRIC INPATIENT FACILITIES ANNUAL RGS REPORT FY23- Draft. AL approved 11.29.docx

OHCQ has also received multiple complaints about environmental conditions. OHCQ investigated these issues in March and April 2024. Among the deficiencies cited were a lack of hot water in the showers, loose bathroom tiles, mold, and failure to properly monitor/remediate drinking water for the presence of Legionnaire's bacteria.[96] CTPHC responded, in part, with a plan to have a mold remediation vendor in place by September 2024. OHCQ conducted a second investigation into environmental conditions about a year later, and as a result, issued another statement of deficiencies in April 2025 that included several unresolved **"repeat findings:"**

*Figure 9. Rust on shower room door, March 2025.*

- Inadequate hot water temperatures,
- Mold growth in the bathrooms, and
- Loose flooring tiles.[97]

CTPHC has recently made significant progress in addressing these environmental concerns. However, the hospital will need to perform regular repairs to maintain the progress. A commitment from the Maryland Department of Health is also necessary to fund necessary ongoing maintenance.

[96] OHCQ #MD00201791; OHCQ #MD00201838; OHCQ #MD00205443.
[97] OHCQ #MD00216474.

## Finding #5: Lack of Transparency, Accountability, and Oversight

Many of the problems identified in this report have persisted, at least in part, because of the lack of meaningful oversight and accountability on the part of CTPHC leadership, OHCQ and MDH.

### Key Investigation Findings Related to Oversight

- CTPHC administration and the State often fail to hold hospital staff accountable.
- Existing oversight systems do not always ensure that patients at CTPHC receive appropriate medical care.

OHCQ has made repeated noncompliance findings but has been unwilling or unable to ensure that the violations are remediated. It appears that MDH has only stepped in to make leadership changes and provide additional resources when called to task by the Maryland General Assembly or by news articles over the years that focused attention on violence and dire conditions in the hospital. Of concern is that MDH has not made the NASMHPD report public. Particularly after the recent Washington Post articles about conditions at the hospital, release of the report along with the steps MDH is taking to implement the report's recommendations would be a welcome step towards rebuilding public trust in the Department's ability to meet the needs of patients at CTPHC.

Additionally, CTPHC leadership itself has not held staff accountable for their actions or failures to act when patient health and safety have been endangered, as DRM found in its investigation of the deaths of Marissa, Latasha and Charlie, and the lack of appropriate medical care for James. Further, CTPHC's lack of transparency in reporting resulted in DRM learning of Latasha's death from another patient, rather than through hospital leadership.

# Recommendations

# Recommendations

In this section DRM makes five recommendations to CTPHC and two recommendations to MDH. DRM requests that MDH submit semi-annual reports to DRM for a period of two years to document progress toward implementation of the recommendations made throughout this report.

## Recommendations for CTPHC

People confined to forensic psychiatric hospitals, including CTPHC, have the right to be safe, receive treatment, and be free from abuse and neglect. DRM is hopeful that the findings and recommendations in this report will help propel efforts already underway to improve conditions for patients and staff at CTPHC and make the hospital a model for the treatment of forensic patients with mental illness.

DRM appreciates the efforts of new CTPHC leadership to address many of the issues identified in this report. These recommendations are offered knowing that efforts are underway. DRM looks forward to seeing continued progress and improvements for patients at CTPHC. At the same time, DRM will continue to fulfill its role to monitor the hospital and investigate concerns.

## Recommendation #1: Provide Appropriate Medical Care to Patients at CTPHC

- **IMPROVE PATIENT CARE TRACKING AND MONITORING, INCLUDING IDENTIFICATION OF PATIENTS WHO REQUIRE SPECIALTY CARE.**

  DRM recommends that CTPHC administrators take immediate action to improve the quality of medical care provided at CTPHC. Patients need improved monitoring and management of their somatic care, including arranging for specialty care when needed. Experts advise that "…screening and treatment for physical health problems is an important aspect of care for individuals with severe mental health problems receiving longer term care" especially for conditions with increased risk for mortality, such as "respiratory disease, cardiovascular disease, and cancer."[98] CTPHC should develop and implement policies that clearly set out the responsibilities of staff for the provision of health and psychiatric care, with provisions that address the accountability measures hospital administrators will take if the policies are not implemented.

  DRM recommends that medical clinic staff attend patient treatment team meetings to improve patient care through coordination between service providers.

  Finally, DRM recommends that, to the extent not already done, CTPHC promote preventative health strategies such as regular physical and dental exams, monitoring of weight, blood pressure, and potential side effects from psychotropic medications, and wellness programs.

  DRM is encouraged that CTPHC recently hired a full-time somatic medical director; this should help to address the problems identified in this report.

- **ENSURE THAT ALL PATIENTS RECEIVE A NUTRITIONAL ASSESSMENT AND THE PROVISION OF A SPECIALIZED DIET IF NEEDED TO ADDRESS A MEDICAL CONDITION SUCH AS DIABETES.**

  When a physician writes an order for a special medical diet for a patient, CTPHC must provide these meals. As the cases of James and Latasha detail, the consequences of an inappropriate diet can be significant for patients with medical diagnoses in addition to their mental illness. DRM is encouraged that CTPHC recently hired a registered dietician to fill a long-vacant position; DRM understands that she has undertaken a nutritional assessment of each patient at CTPHC. This is a welcome step forward, and DRM looks forward to learning the results of this effort during future monitoring visits and meetings with patients.

[98] http://www.biomedcentral.com/1471-244X/9/55

- **ENSURE THAT POLICIES AND PROCEDURES CLEARLY OUTLINE HOW AND WHEN TO SEEK EMERGENCY CARE FOR PATIENTS.**
  Through its review and analysis of patient deaths and interviews with current patients, DRM learned that staff do not consistently ensure emergency transport or care when patients experience a medical crisis. DRM recommends that CTPHC administrators review policies and procedures to clearly outline what constitutes a crisis, how to obtain emergency care and, if 911 is contacted, what steps staff should take while waiting for the arrival of emergency medical technicians or paramedics. DRM further recommends that the policies include requirements about documentation of the event, including notice to relatives or guardians.

- **CONTINUE THE WORK ALREADY UNDERWAY TO PROVIDE TRAUMA-INFORMED PATIENT CARE**
  Individual studies estimate that most individuals with severe mental illness experience PTSD;[99] the stress from traumatic experiences may increase symptom severity.[100] DRM recommends that CTPHC screen patients for a history of trauma and then make specialized treatment available for patients who need such services as part of their overall treatment plan. DRM also recommends that hospital administrators take steps to minimize the chances that patients will experience traumatic experiences within the facility.

  DRM recommends that CTPHC continue its efforts to provide trauma-informed care, as required by statute.[101] DRM commends CTPHC for recent efforts to create peer support programs for patients. SAMHSA recognizes that "peer support and mutual self-help are key as vehicles for establishing safety and hope, building trust, enhancing collaboration, and utilizing their lived experience to promote recovery and healing."[102] DRM supports these efforts and several new trauma-informed initiatives at CTPHC. DRM also encourages CTPHC to engage in a thorough review of all CTPHC policies and practices and revise them to align with the principles of trauma informed care, as required by statute.[103]

[99] Frueh, et al. (2020). "Trauma within the Psychiatric Setting." Administration and Policy in Mental Health, 147.
[100] Treatment Improvement Protocol (TIP) Series, No. 57. Center for Substance Abuse Treatment (US). Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2014. https://library.samhsa.gov/sites/default/files/sma14-4816.pdf , 10.
[101] Md. Code Ann., Health-General §10-701.
[102] https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs

[103] Md. Code Ann., Health-General §10-701.

## Recommendation #2: Provide Appropriate Behavioral Health Care to Patients at CTPHC

- **Ensure that patients have prompt access to substance use treatment.**
  Medically assisted treatment and self-help support groups can be important components of substance abuse treatment for patients. DRM recommends that all patients be screened for substance use disorder; an individualized assessment should be used to guide treatment plan decisions.[104] "The American Society of Addiction Medicine (ASAM) levels of care continuum offers a way to determine which treatment options are appropriate based on individual risks and needs as well as strengths, skills, and resources."[105] DRM further recommends that CTPHC leaders take steps to ensure that patients seeking treatment obtain prompt access in order to maximize their chances of success and to facilitate their eventual return to the community.

  The American Psychiatric Association's (APA) practice guidelines for substance use disorders assert that evidence-based psychosocial treatments, including CBT, behavioral therapy, psychodynamic therapy, and interpersonal therapy "…are essential components of a comprehensive treatment program."[106] According to the National Institute of Health (NIH) National Institute on Drug Abuse, treatment for people with both substance use disorder and a mental health diagnosis should include the following three elements: behavioral therapy/psychotherapy; medication for opioid, alcohol, and nicotine addiction; and referral to self-help support groups.[107] Additionally, SAMHSA advises that providing integrated substance use and mental health treatment "is a best practice" because it results in "improved psychiatric symptoms, reduced substance use, and decreased rates of reoffending and recidivism."[108]

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[104] Addiction Medicine Primer: An Overview of Treatment of Substance Use Disorders. CDC. https://www.cdc.gov/overdose-prevention/media/pdfs/2024/07/Addiction-Medicine-Primer.pdf
[105] Id, p. 5.
[106] American Psychiatric Assn. Practice Guideline for the Treatment of Patients with Substance Use Disorders. https://psychiatryonline.org/pb/assets/raw/sitewide/practice_guidelines/guidelines/substanceuse-1410197810077.pdf ,10.
[107] Center for Substance Abuse Treatment. A Guide to Substance Abuse Services for Primary Care Clinicians. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 1997. (Treatment Improvement Protocol (TIP) Series, No. 24. Chapter 5—Specialized Substance Abuse Treatment Programs. Available from: https://www.ncbi.nlm.nih.gov/books/NBK64815/
[108] SAMHSA. Substance Use Disorder Treatment for People with Co-Occurring Disorders. Treatment Improvement Protocol (TIP) Series, No. 42. SAMHSA Publication No. PEP20-02-01-004. Rockville, MD: Substance Abuse and Mental Health Services Administration, 2020, p. 189. https://www.ncbi.nlm.nih.gov/books/NBK571020/pdf/Bookshelf_NBK571020.pdf

- **REMOVE BARRIERS THAT PREVENT OR IMPEDE PATIENTS FROM RECEIVING INDIVIDUAL MENTAL HEALTH THERAPY AND ENSURE THAT PATIENTS FOR WHOM INDIVIDUAL MENTAL HEALTH THERAPY IS MEDICALLY RECOMMENDED HAVE PROMPT ACCESS TO SUCH THERAPY.**

  Patients at CTPHC have the right to medical care, and for people with mental illness, individual therapy can be a critical part of their basic health care. DRM recommends that CTPHC clearly explain how staff determine if a patient can benefit from individual therapy, and clearly explain how patients who want individual therapy can obtain it. DRM also recommends that CTPHC leadership examine the barriers that prevent patients from obtaining medically recommended individual therapy, including waiting lists. Lack of sufficient staff is not an acceptable reason for failing to provide medically recommended services.

  All patients at CTPHC should be able to obtain individual therapy; the policy should be revised to reflect access to this essential care.

- **REMOVE THE PRIORIZATION SCHEME IN THE CURRENT POLICY.**

  The CTPHC Individual Therapy policy assigns priority levels based on a person's expected discharge date, not clinical factors, to determine who will receive treatment and how quickly that care will be delivered. The policy gives priority status to patients who are preparing for imminent discharge. Patients who are preparing for a discharge that is more than eighteen weeks away are assigned to the second tier in the prioritization scheme. The lowest priority is assigned to those patients with an acceptable referral for therapy from the treatment team, but without a projected discharge date. Level three patients are only assigned a provider after all level one and two patients have been assigned first. This ranking of patients, all of whom need essential treatment means that most patients will not receive individual therapy, even when clinically recommended.

  In 2022, prior to the current leadership at CTPHC, DRM worked with administrators to revise an earlier version of the Individual Therapy policy to address the denial of treatment for patients with pending legal charges. While the policy was revised in 2023 to allow these patients to access therapy, it does not appear that the practices have changed as a nominal number of patients with pending charges have actually accessed therapy in the past two years. Additionally, the current version of the policy retains language discouraging care for this group of patients. DRM is further concerned that the policy requires pretrial patients to sign a consent form and may constitute the provision of legal advice.

  DRM suggests that CTPHC work with MDH to ensure sufficient availability of staff to provide individual therapy and that decisions about eligibility for individual therapy be made in accord with a rebuttable assumption that such therapy will be provided.

## Recommendation #3: Reduce and, to the Greatest Extent Possible, Eliminate the Use of Restraint and Seclusion

- **RECOGNIZE THAT RESTRAINT AND SECLUSION REPRESENT TREATMENT FAILURE, NOT TREATMENT, AND PROVIDE MORE ROBUST TRAINING TO STAFF TO DE-ESCALATE CRISES WITHOUT THE USE OF THESE INTERVENTIONS.**

  Although the culture at CTPHC has begun to shift under the hospital's new leadership, additional efforts are necessary to transform the facility into a hospital that focuses more on patient-centered treatment than a prison-like environment focused on control over patients. Currently, hospital staff seem to consider restraint and seclusion to be standard interventions necessary to control behavior deemed dangerous. Some of DRM's other recommendations, such as thoughtful room assignments and more opportunities for patients to engage in structured activities should help patients and staff avoid situations that lead to conflicts that escalate to the point at which restraint or seclusion is needed. DRM applauds efforts underway to shift practice to be more patient-oriented. Using a trauma-informed approach should result in less reliance on restraint and seclusion.

- **PROHIBIT ALL FORMS OF PROLONGED SECLUSION.**

  CTPHC must prohibit all forms of solitary confinement and prolonged seclusion whether called Voluntary Safe Space Monitoring (VSSM), zoning, or something else. DRM appreciates that CTPHC recently revised its policy to eliminate VSSM but will continue to monitor CTPHC to ensure that staff do not return to the practice of restricting patients to their rooms or another space for extended periods of time by calling the practice something different, as has happened in the past.

- **ASSESS AND PROVIDE INDIVIDUALIZED TREATMENT TO PATIENTS WHO WERE SUBJECTED TO PROLONGED SECLUSION AT CTPHC.**

  DRM recommends that CTPHC administrators identify the patients who were subjected to prolonged seclusion, assess them, and develop a plan of remedial services if they have been harmed by their time in seclusion. DRM recommends that the assessments be conducted by an independent mental health provider, with neurological and other examinations if indicated, as required under 24 C.F.R. § 482.61(a)(5).[109] If CTPHC staff are unable to identify effective treatment options, DRM recommends that they consult with outside experts to make treatment recommendations; Maryland law requires that if CTPHC "…is unable to provide the treatment necessary to address the rehabilitation needs of an individual under a plan of treatment for the individual, the State facility shall: (1) Make arrangements for the

[109] https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/som107ap_aa_psyc_hospitals.pdf

individual to receive necessary treatment from another facility or other health care provider outside the State facility."[110]

- **CREATE AND IMPLEMENT A PLAN TO REDUCE THE USE OF SECLUSION AND RESTRAINT, WITH THE GOAL OF ELIMINATING THESE INTERVENTIONS TO THE GREATEST EXTENT POSSIBLE.**

  SAMHSA encourages programs to create "coercion and violence-free treatment environments" through a commitment "to reducing and ultimately eliminating the use of seclusion and restraint." While SAMHSA notes that restraint and seclusion were once viewed as "therapeutic practices," they are known to be "traumatizing" and should only be used as a "last resort."[111] Likewise, the World Health Organization (WHO) has found that a key to improving patient care and implementing trauma-informed care is to eliminate the use of coercive and potentially re-traumatizing interventions such as restraint and seclusion.[112]

  DRM recommends that CTPHC administrators lead a cultural shift to redefine the use of restraint and seclusion as a sign of treatment failure[113] and closely examine the use of restraint and seclusion to better align with trauma-informed care principles. Other forensic hospitals have been able to achieve the goal of ending restraint and seclusion, including Ann Klein Forensic Center in New Jersey and the Virginia Center for Behavioral Rehabilitation, which is the secure state sex offender facility.[114] DRM recommends that CTPHC leadership

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*"Ending coercive practices in mental health – such as involuntary commitment, forced treatment, seclusion and restraints – is essential in order to respect the rights of people using mental health services. Coercion is harmful in terms of both physical and mental health, alienating people from mental health and support systems. Moreover, many persons with mental health conditions and psychosocial disabilities have experienced trauma in their lives. When violence, coercion and abuses occur in mental health services, not only are people failed by the service, but they may also be retraumatized and their original difficulties compounded."*

*Mental health, human rights and legislation: guidance and practice.*
*Geneva: World Health Organization and the United Nations. 2023. License: CC BY-NC-SA 3.0 IGO.*

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[110] Md. Code Ann., Health-General §10-706.
[111] https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs
[112] Strategies to end seclusion and restraint. WHO Quality Rights Specialized training. Course guide. Geneva: World Health Organization; 2019. License: CC BY-NC-SA 3.0 IGO.
[113] Smith, G. M., Davis, R. H., Bixler, E. O., Lin, H.-M., Altenor, A., Altenor, R. J., Kopchick, G. A. (2005). Special Section on Seclusion and Restraint: Pennsylvania State Hospital System's Seclusion and Restraint Reduction Program. Psychiatric Services, 56(9), 1115–1122. https://doi.org/10.1176/appi.ps.56.9.1115
[114] Per email on 11/5/2024 from Michael Partie, Therapeutic Options.

consult with these facilities and with other experts to assist in crafting a plan to reduce and, to the extent possible, eliminate the use of restraint and seclusion at CTPHC.

- **IDENTIFY AND ADVOCATE FOR THE RESOURCES NEEDED TO REDUCE THE USE OF RESTRAINT AND SECLUSION.**

  CTPHC staff need adequate training and resources to maintain a safe environment without over-relying on the use of restraint and seclusion, which can only be legally used when these three criteria are met:

  1. when a physician has ordered it in writing,
  2. after "less restrictive or alternative approaches have been determined to be ineffective to ensure the safety of the patient, staff, or others," and
  3. "only during an emergency in which the behavior of the patient places the patient or others in serious [and imminent][115] threat of violence or injury."[116]

  In August 2025, CTPHC initiated new staff training on communication skills and cultural diversity. These types of staff trainings are important to ensure that staff have the skills to de-escalate situations before patients behave violently. DRM commends these efforts and encourages additional commitment on the part of hospital leadership to enhance staff training.

  DRM recommends that CTPHC explore environmental changes that could reduce the need for restraint. For example, Philadelphia's Belmont Hospital was able to eliminate the use of restraint, in part by providing access to sensory rooms.[117]

[115] While the Maryland regulations do not specify that the patient's behavior must present an imminent risk, this criterion is in both Federal regulations (42 CFR § 482.13) and the Joint Commission definitions (PC.03.05.01 and RI 01.06.01).

[116] COMAR 10.21.12; COMAR 10.21.13.

[117] Bausman D, Gigliotti S, Meshok M. Transition to a Restraint-Free Inpatient Behavioral Health Setting. Patient Safety. 2024;6(1):115424. doi:10.33940/001c.115424

## Recommendation #4: Ensure Safety at CTPHC

A key component of trauma-informed care is that patients and staff feel physically and psychologically safe.[118] During an October 2025 briefing for the state legislature, Dr. Jones presented patient assault data that indicates a recent downward trend in assaults from 2024 to 2025.[119] CTPHC has also recently announced the adoption of a "Just and Learning Culture" aimed at improving patient safety. Also launched in November 2025, CTPHC's new "Unified Strategic Direction" emphasizes safety. These are welcome updates, and DRM supports efforts underway at CTPHC to continue to improve safety. DRM presents several additional recommendations for consideration by CTPHC leadership.

- **Clarify the role and responsibilities of 1:1 support staff.**
  As noted previously, a physician may order a dedicated staff observer ("1:1") to continuously watch a person who may be dangerous to themselves or others. These staff are asked to stay within a certain distance of the patient and document the patient's behavior while under observation. In reality, this intervention is of limited utility as a strategy for keeping patients and staff safe. Patients assigned a 1:1 observer are frequently involved in physical assaults. The current scope of responsibilities for the 1:1 staff is passive, with the focus on physical proximity and record keeping. DRM recommends that CTPHC leadership consider a more active role for 1:1 staff in order to allow for better patient care and improved safety. Staff assigned a 1:1 role could, for example, actively engage with their assigned patient and provide care aligned with the patient's individualized treatment goals. This change would require the hospital to provide the staff in a 1:1 role with documentation of the individualized activities beneficial to the assigned patient and provide 1:1 staff with additional training.

- **Reduce factors known to cause aggression.**
  DRM recommends that CTPHC examine how hospital units that are known to increase the risk for aggressive behavior could be modified to make them safer. For example, CTPHC could look for ways to increase choice and freedom within the confines of the hospital without compromising safety. Other interventions that could potentially reduce aggression include increased structure in daily activities and providing more privacy to patients. Interventions related to staffing include improving teamwork amongst the staff; involving

[118] https://www.samhsa.gov/mental-health/trauma-violence/trauma-informed-approaches-programs
[119] https://mgaleg.maryland.gov/meeting_material/2025/fps%20-%20134061478837778215%20-%20Meeting%20Materials%2010-29-25.pdf, p.35-36

both staff and patients in treatment decisions; and hiring qualified staff into permanent positions.[120]

- **Increase patient programming.**
  A structured daily schedule is known to reduce aggression.[121] DRM recommends that CTPHC provide patients with daily access to fresh air and exercise. DRM applauds recent efforts to increase patient programming, such as ordering more recreation supplies in July 2025. CTPHC may want to consider partnerships with area graduate schools to increase staffing capacity by using students and/or volunteers to facilitate activities and recreation for patients.
- **Improve security staff training.**
  DRM supports increased training and requirements for security staff. Currently, security staff must be over the age of 21, possess a high school diploma or GED, and take CPR and PMAB training; security staff do not need a license. Until a few years ago, CTPHC required correctional academy training for security staff but then replaced this training with a significantly shorter, less robust hospital-administered training program. At a recent legislative hearing, legislators asked the CTPHC chief executive officer about training for security staff. Dr. Jones testified that she and MDH administrators all support the longer training requirements. DRM recommends that CTPHC ensure appropriate initial training and "refresher" trainings on an ongoing basis. CTPHC may also want to consider replacing or supplementing the current PMAB training with more robust training.
- **Ensure safe and healthy environmental conditions within the facility by addressing structural problems including mold and clean water access.**
  The poor environmental conditions within the facility are well-documented. Following the Joint Commission accreditation review in 2025, the administration and staff made substantial progress towards improving environmental conditions. CTPHC reports that the roof was repaired in early July and that cleaning services to prevent mold growth have been enhanced. Among the outstanding issues that must still be addressed are the inoperable drinking water fountains and replacement of the HVAC system, which is underway but is a multi-year process. DRM also cautions that the emergency overhead paging system requires immediate attention to ensure safety for patients and staff.

[120] Weltens, I., Bak, M., Verhagen, S., Vandenberk, E., Domen, P., van Amelsvoort, T., et al. (2021) Aggression on the psychiatric ward: Prevalence and risk factors. A systematic review of the literature. PLoS ONE 16(10): e0258346. https://doi.org/10.1371/journal.pone.0258346
[121] Id.

## Recommendation #5: Improve Transparency and Accountability

- **Increase public visitation hours and eliminate scheduling requirements.**
  DRM recommends that CTPHC increase public visitation hours to improve patient care and increase transparency within the hospital. Studies have shown psychological benefits of visits, including decreased anxiety and depression.[122] Additionally, patients have a right to receive visitors and communicate with friends and family.[123] Several years ago, visitors were not required to schedule an appointment in advance. DRM recommends a return to this policy. These strategies will improve the relationship between family, friends and hospital staff and will facilitate family and friend involvement in patient care.[124] Maintaining social supports will also allow individuals to be more successful after discharge from CTPHC.

- **Unless patients disagree, provide advance notice to family members, advocates and the patient of treatment team meetings, and permit family members and advocates to attend these meetings with the patient.**
  Patients' famiy members and advocates need better access to treatment team meetings, the regular meetings held to review treatment plans and progress towards treatment goals. Hospital staff should, but do not always, provide sufficient advance notice of meeting dates and times. This in turn will allow for attendance by family members and advocates, and preparation by the patient for their meeting. CTPHC should provide in-person access to treatment team meetings.

- **Participate in national data reporting platforms to improve quality of care.**
  DRM recommends that CTPHC participate in quality measurement programs to improve the quality of patient care. These include CMS Inpatient Psychiatric Facility Quality Reporting Program, National Association of State Mental Health Program Directors (NASMHPD) Hospital-Based Inpatient Psychiatric Services (HBIPS), and NRI's Behavioral Healthcare Performance Measurement System (BHPMS). The Inpatient Psychiatric Facility Quality Reporting (IPFQR) Program provides data on substance use treatment, the use of physical restraints, time spent in seclusion, preventive care, and follow-up care.[125] For example, the data set includes information about the quality of somatic medical care, including the percentage of patients that are screened annually for metabolic syndrome by monitoring body mass index, blood pressure, blood sugar, and cholesterol levels. Although this data is available for the other four state psychiatric hospitals, data for CTPHC is not available.

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[122] Engström, Å. and Söderberg, S. (2007), Receiving power through confirmation: the meaning of close relatives for people who have been critically ill. Journal of Advanced Nursing, 59: 569-576. https://doi.org/10.1111/j.1365-2648.2007.04336.x
[123] 42 C.F.R. §482.13(h)
[124] Berwick, D.M., and Kotagal, M. (2004). "Restricted visiting hours in ICUs: time to change." JAMA.
[125] https://data.cms.gov/provider-data/topics/hospitals/psychiatric-unit-services

## Recommendations for the Maryland Department of Health

DRM found a need for improved oversight by Maryland Department of Health (MDH). Without MDH resources and support, it is unlikely that any set of recommendations can be fully implemented. DRM's finding that CTPHC patients have been harmed by inadequate or ineffective care implicates both OHCQ and MDH. MDH should strengthen the Resident Grievance System and the Office of Health Care Quality, the two primary oversight agencies for CTPHC. Additionally, CTPHC is currently the only state psychiatric hospital without certification by the Center for Medicaid and Medicare Services (CMS). DRM recommends that MDH and CTPHC consider CMS certification.

DRM's status as Maryland's protection and advocacy agency afforded access to many documents that are not publicly available. However, patients, families, staff, and taxpayers have a right to know what is happening in state facilities that care for people with disabilities. For example, as discussed in this report, in 2024, MDH commissioned NASMHPD to provide recommendations for CTPHC. The content of this report is vitally important and therefore the report, or a redacted summary, should be made public.

Similarly, the public cannot currently view the Joint Commission's April 2025 report that resulted in CTPHC's "preliminary denial of accreditation status." The Joint Commission's policy statement asserts that "in order to maintain the trust necessary to conduct our work with healthcare organizations and maintain patient confidentiality, The Joint Commission does not release reports or findings about any specific healthcare organization or complaint investigation to the public or media."[126] However, Maryland's citizens have a right to know what the Joint Commission found at CTPHC and DRM encourages MDH to provide transparent information about the report.

[126] https://www.jointcommission.org/en-us/policies/media-information-policy

## Recommendation #6: (MDH) Improve Oversight Systems

- **Reform the Resident Grievance System (RGS).**
  DRM found that reforms are needed to improve the effectiveness of the RGS in achieving its mission: "…to protect the rights of patients in MDH-HCS [Maryland Department of Health – Health Care System] facilities and to provide a timely, fair, efficient, and complete mechanism for receiving, investigating, and resolving residents' complaints."[127] DRM recommends that MDH strengthen the RGS by making it independent of the hospitals in which the system operates. Currently, the second and third stages of the four-stage grievance process are managed by the hospital administration; this undercuts the independence of the RGS staff, who should be impartial and have unfettered independence throughout the grievance investigation process.

  In addition, DRM found a need for better enforcement of RGS decisions. RGS decisions, including those of the final stage four Central Review Committee, are not consistently implemented by CTPHC. As a result, patient rights and patient confidence in the RGS suffer. DRM urges MDH to review all stage four decisions and ensure that the hospital implements the decisions promptly.

  Patients are supposed to receive written notice of the status of their grievance; however, patients report that this critical and required element of the process often does not occur. Therefore, DRM recommends that MDH take any needed steps to ensure that this information is provided to patients in a timely manner. DRM also recommends that the annual RGS public reports include, without divulging any confidential information, more detail on the grievances filed, including the date filed, date resolved, stage at which the grievance was resolved, a summary of the specific grievance, and the RGS finding with any recommendations. Public access to this information would, if the system is working well, enable patients to understand the value of the RGS system to resolve complaints or, if the system is not working well, spur additional needed changes. The RGS system was intended, and ought to be able, to resolve many of the complaints raised by patients.

  Finally, the RGS "Managing for Results" goals and objectives can be improved to better measure the degree to which RGS is achieving its mission of protecting patient rights.

[127] Resident Grievance System, Annual Report for FY2023, p. 3. https://health.maryland.gov/yourrights/SiteAssets/Pages/reports/RGS%20PSYCHIATRIC%20INPATIENT%20FACILITIES%20ANNUAL%20REPORT%20FY23.pdf

Current objectives do not align with the mission and include, for example, reducing the number of grievances filed and closing cases before stage four.[128]

Although complaints should be resolved at the lowest level, these are the wrong measures by which to judge the efficacy of the RGS system since the number of complaints is directly tied to hospital conditions and whether patients' rights are violated. A reduction in grievances without a concomitant improvement in hospital conditions could indicate that patients are discouraged from filing grievances or choose not to file grievances because the process is empty and does not result in positive change for them. DRM encourages MDH to reconsider the goals and objectives that would indicate that the RGS system is both efficient and effective.

- **Reform the Office of Health Care Quality (OHCQ).**
  OHCQ is responsible for monitoring and addressing complaints for an enormous number of facilities and programs. The breadth and scope of OHCQ's duties results in some complaints made by or on behalf of patients pending for years, making the process ineffective for patients raising serious concerns. The problem is exacerbated when OHCQ does make findings but they are not corrected, resulting in repeated findings, as has occurred with the inoperative overhead paging system at CTPHC.

  Although OHCQ has an expedited investigation process for issues jeopardizing the health and life of patients, this is not well-known by patients or even advocates and is not evident from OHCQ's website or complaint form. OHCQ should ensure that its policies and procedures are transparent, and MDH should ensure that OHCQ has sufficient resources and staff to comply with its statutory obligations to ensure patient safety.

  When OHCQ repeatedly finds violations and its corrective actions are not implemented, MDH must step in to ensure enforcement and accountability. Patient health and safety require nothing less.

[128] 2026 Managing for Results Annual Performance Report, page 306.
https://dbm.maryland.gov/Documents/MFR_documents/2026-MFR-Annual-Performance-Report.pdf

## Recommendation #7: (MDH) Improve Transparency and Accountability

- **Prioritize implementation of an Electronic Medical Record (EMR) system at CTPHC.** More than a decade ago, Drs. Appelbaum and Dvoskin recommended that an Electronic Medical Records (EMR) system be immediately implemented at CTPHC, yet the hospital continues to use paper medical charts. Although DRM expected the hospital to implement EMR in the fall of 2025, CTPHC's CEO recently explained that the timeline has been pushed back yet again and the current expected date for CTPHC to receive an EMR system is "late 2026-2027." Implementation of an EMR system is an example of a concrete step to improve care and to increase both transparency and accountability within CTPHC. DRM recommends that MDH work with CTPHC leadership to prioritize implementation of an EMR system at CTPHC.

- **Analyze and make publicly available the data on restraint and seclusion.** DRM calls for close monitoring of restraint and seclusion data, including publicly reporting data and data trends. State hospitals should report data annually, including the number of restraint or seclusion incidents and the date and time of the incident. The data should be disaggregated for each person who had at least one incident of seclusion or restraint, by disability, race, ethnicity, gender, age, number of incidents and type of each incident. Data should also be reported in a manner to track unduplicated counts of individuals secluded or restrained, to track trends in incidents, and with detailed description of steps considered and taken to reduce use of restraints and seclusion.

- **Produce public reports to the Maryland General Assembly semi-annually for two years.** DRM recommends that for a period of two years, MDH file public semi-annual reports about CTPHC with the Maryland General Assembly. DRM recommends that these reports include:
    - All incident reports and sentinel event reports, including death reports;
    - Any patient complaints;
    - Quality assurance reviews;
    - Documentation for each use of restraint or seclusion;
    - Logs and minutes from committee meetings;
    - A complete list of staff members that includes the status of trainings and certifications, such as CPR and PMAB; and
    - Demographic data for current patients, including sex, race, ethnicity, age, disability, and court status.

Additionally, DRM requests that MDH submit semi-annual reports to DRM for a period of two years to document progress toward implementation of the recommendations made throughout this report.

# Conclusion

# Conclusion

DRM initiated comprehensive monitoring and investigation culminating with this report because of the volume of patients reporting concerns about inadequate conditions, the care they were receiving, and other violations of their rights. The project spanned three hospital CEOs, and DRM is pleased to have established a respectful and professional relationship with the current CEO. DRM also appreciates that Dr. Jones has made robust efforts in a short period of time to address a number of the issues identified in this report. Much work remains to be done, but DRM is hopeful that CTPHC administrators will view the recommendations in this report with an eye toward continuing to move CTPHC forward "to re-establish Clifton T. Perkins as a nationally premier institution, renowned for safety, excellence in patient care, clinical training, and research for Maryland's forensic psychiatric patients."[129] DRM looks forward to continuing to support CTPHC in its efforts to make the hospital the therapeutic environment it is intended to be.

DRM recognizes that some of the issues faced by CTPHC cannot be solved by CTPHC alone. Our recommendations to MDH are aimed at strengthening accountability and oversight and ensuring that the needs of patients and staff are not overlooked as budget and administrative decisions are made.

## Acknowledgements

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[129] https://mgaleg.maryland.gov/meeting_material/2025/fps%20-%20134061478837778215%20-%20Meeting%20Materials%2010-29-25.pdf