

Analysis of Need for Acute Psychiatric Services for Historically Underserved Populations

The estimates of need for acute psychiatric services for historically underserved populations are draft estimates that must be published for public comment. The Maryland Health Care Commission (MHCC or Commission) shall consider the comments and staff recommendations before publishing final estimates of the need for historically underserved populations. Comments, concerns, or questions regarding the estimates of need for historically underserved populations should be emailed to: mhcc_regs.comment@maryland.gov by June 24, 2025.

The Acute Psychiatric Services chapter of the State Health Plan for Facilities and Services, COMAR 10.24.21, defines historically underserved populations as the following patient populations: children; adolescents; patients with mental disorders and one or more developmental disabilities; and patients with mental disorders and a secondary diagnosis of substance use disorder.

In developing the analysis of need for historically underserved populations, MHCC staff reached out to the Maryland Hospital Association, the Behavioral Health Administration, contractors for the Maryland Department of Health, and staff at other Maryland state agencies, to seek guidance and data. MHCC staff also reviewed the needs assessments of the local behavioral health authorities for all Maryland jurisdictions to check whether a need for acute psychiatric beds or other related resources was identified. One theme across these assessments was a lack of a sufficient mental health workforce to staff needed services; six counties mention this deficit (Anne Arundel, Baltimore, Calvert, Cecil, Charles, and Harford). Three of these counties (Cecil, Charles, and Harford) report being federally designated as health professional shortage areas for mental health services. In Montgomery County, the Community Health Needs Assessment stated that the leading cause of hospitalization for youth ages five to 17 was mental health (53.9%). Six counties (Anne Arundel, Calvert, Charles, Garrett, Saint Mary's, and Baltimore City) referred to a lack of acute psychiatric beds for youth, with some adding that this creates a burden for both emergency departments (EDs) and families. Although none of the needs assessments quantified the need for acute psychiatric beds, the assessments suggest that there are some unmet needs for acute psychiatric beds for children and adolescents.

The following tables reflect MHCC staff's assessment of the psychiatric bed need for historically underserved populations, as defined in COMAR 10.24.21.05B(2)(b). Staff assumed that a patient was boarding in an ED due to insufficient inpatient psychiatric bed capacity, if a patient's ED visit spanned one or more nights before disposition to a psychiatric unit, special psychiatric hospital, or acute general hospital, or if the ED visit spanned three or more nights before a disposition to home. MHCC staff considered the trends in ED visits between CY 2017 and CY 2023, the disposition for psychiatric patients' ED visits between CY 2018 and CY 2023, the estimated total number of days boarding in an ED for children and adolescents between CY 2017 and CY 2023, and the total number of psychiatric discharges with a secondary diagnosis of a developmental disability between CY 2017 and CY 2023. For psychiatric discharges with secondary diagnoses for substance use disorder (SUD), MHCC staff considered the proportion of psychiatric discharges with a secondary diagnosis for SUD between CY 2017 and CY 2023, trends in total days and discharges between CY 2017 and CY 2023, and trends in emergency department boarding between CY 2018 and CY 2023. MHCC staff calculated

an annual estimated psychiatric bed need for CY 2023 for children and adolescents generally, and for children, adolescents, and adults with a secondary diagnosis for a developmental disability or SUD based on Health Services Cost Review Commission (HSCRC) outpatient data for ED visits with an estimated boarding time of one day or more, when the disposition of the patient was to an inpatient psychiatric unit or psychiatric hospital or an acute care general hospital, and ED visits that spanned at least three nights with the disposition to a home setting.

Children and Adolescents

Between CY 2017 and CY 2023, there generally has been a decrease in the number of ED visits for children and adolescents with a primary psychiatric diagnosis. However, the estimated number of days these children have spent boarding in EDs has generally increased, as suggested by staff's analysis of the HSCRC outpatient data for this period. There has also been an increase in the estimated number of children boarding for two or more nights. For adolescent psychiatric discharges, the number of days has decreased overall, but not as much as would be expected based on the reduced number of ED visits in CY 2023 compared to CY 2017. For children, there was fluctuation from year to year in the estimated number of days spent in EDs boarding. Due to this fluctuation, staff concluded that trending the past pattern forward may not be very reliable, and therefore estimated need based on the most recent year of data available. Between CY 2017 and CY 2023, the year with the highest number of days children spent in an ED was either CY 2022 or CY 2023 for three of the five Health Planning Regions (HPRs): Montgomery, Southern Maryland, and Western Maryland. Similarly, for adolescents, the years with the highest numbers of ED boarding days and ED visits have varied among regions, and it seems unreliable to try and project future needs based on past trends.

Tables 1 and 2 below show staff's estimated need projections for acute psychiatric adolescent and child beds. Based on CY 2023 data and assuming occupancy levels for the HPR as defined in COMAR 10.24.21.06G(3),¹ MHCC staff estimates a need for one or more psychiatric beds for adolescents in the Baltimore Upper Shore and Montgomery HPRs. In the Southern Maryland HPR, staff estimates a need for 0.9 psychiatric beds for adolescents. Based on the same assumptions for children, staff estimates a need for almost two additional psychiatric beds for children in the Baltimore Upper Shore HPR. In other HPRs, the estimated need for child psychiatric beds is well less than one bed. Supplemental tables are posted on the MHCC website at: <https://mhcc.maryland.gov/mhcc/Pages/home/news/announcements.aspx>. Stakeholders may use these tables to consider how estimates, based on length of ED visits and the inclusion or exclusion of patients with dispositions to different settings, could alter conclusions about the need for adolescent and children's psychiatric beds.

¹ Minimum occupancy standards are determined by the number of psychiatric beds at a facility: less than 20 beds (70%); between 20 and 39 beds (75%); and over 39 beds (80%).

Table 1
Estimates of ED Boarding for Historically Underserved Populations: Acute Psychiatric Adolescent Beds by HPR, CY 2023

Health Planning Region of Patient Origin	ED Visits of One Night or Greater and Disposition to Psych Unit/Hospital or General Hospital		ED Visits of Three Nights or Greater and Disposition to Home		Estimate of ED Boarding Days (A+B)	Estimated Inpatient Psychiatric Beds Needed
	Number	Total Days (A)	Number	Total Days (B)		
Baltimore Upper Shore	434	1,552	109	781	2,333	4.9
Lower Eastern Shore	49	151	6	45	196	0.4
Montgomery	143	454	26	273	727	1.5
Southern Maryland	82	288	37	182	470	0.9
Western Maryland	59	88	9	65	153	0.3
Other	32	99	5	30	129	0.2

Source: MHCC staff's analysis of HSCRC outpatient data, CY 2023.

Notes: The total ED visits are based on counts of records in the HSCRC outpatient data with an emergency charge and a primary psychiatric diagnosis. Psychiatric diagnoses are defined as the ICD-10 codes that correspond to the ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 – 319.0. The length of an ED visit is calculated based on the beginning and ending dates of service. Records for which the difference between the start and end date of service is three days or more are counted as ED visits for three or more nights. The estimated need for inpatient psychiatric beds assumes a year has 365 days. Occupancy is assumed to be 70%, except in: the Baltimore Upper Shore HPR, which is assumed to have an occupancy level of 76.4%; Montgomery HPR which is assumed to have an occupancy level of 74.4%; and Western Maryland HPR which is assumed to have an occupancy level of 75%. The assumed occupancy level for adolescent beds in each HPR is based on the weighted average of the minimum expected occupancy for existing facilities, as defined in COMAR 10.24.21.06G(3). Adolescents are defined as ages 13 through 17.

Table 2
Estimates of ED Boarding for Historically Underserved Populations: Acute Psychiatric Child Beds by HPR, CY 2023

Health Planning Region of Patient Origin	ED Visits of One Night or Greater and Disposition to Psych Unit or General Hospital		ED Visits of Three Nights or Greater and Disposition to Home		Estimate of ED Boarding Days (A+B)	Estimated Inpatient Psychiatric Beds Needed
	Number	Total Days (A)	Number	Total Days (B)		
Baltimore Upper Shore	124	576	46	358	934	1.8
Lower Eastern Shore	30	76	5	40	116	0.2
Montgomery	36	74	0	0	74	0.1
Southern Maryland	23	93	8	48	141	0.3
Western Maryland	21	33	8	42	75	0.1
Other	9	35	4	32	67	0.1

Source: MHCC staff analysis of HSCRC outpatient data, CY 2023.

Notes: The total ED visits are based on counts of records in the HSCRC outpatient data with an emergency charge and a primary psychiatric diagnosis. Psychiatric diagnoses are defined as the ICD-10 codes that correspond to the ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 – 319.0. The length of an ED visit is calculated based on the beginning and ending dates of service. Records for which the difference between the start and end date of service is three days or more are counted as ED visits for three or more nights. The estimated need for inpatient psychiatric beds assumes a year has 365 days. Occupancy is assumed to be 70% in all HPRs. The assumed occupancy level for child psychiatric beds in each HPR is based on the weighted average of the minimum expected occupancy for existing facilities, as defined in COMAR 10.24.21.06G(3). Children are defined as ages five to 12.

Secondary Substance Use Disorder (SUD) Diagnosis

Staff reviewed trends in the number of dually diagnosed SUD patients for the period from CY 2017 to CY 2023, for children, adolescents, and adults, by HPR of patient origin. A very high percentage of adult patients admitted to Maryland hospitals with a primary psychiatric diagnosis have a secondary SUD diagnosis, between 40% and 60% in CY 2023. The number of children with a primary psychiatric diagnosis and secondary SUD diagnosis is very small in all HPRs, ranging from zero to three percent. For this reason, the results are not presented here. With respect to adolescents, in three HPRs, the Lower Eastern Shore, Southern Maryland, and Western Maryland, the highest percentage of psychiatric patients with a secondary SUD diagnosis occurred in either CY 2022 or CY 2023. In the Baltimore Upper Shore and Montgomery HPRs, the highest percentage of these patients, 22.0% and 20.3% respectively, occurred in CY 2020. For adults, from CY 2017 to CY 2023, staff's analysis shows that the percentage with a primary psychiatric diagnosis and secondary SUD has been consistently high across all HPRs, ranging from approximately 40% to 65% among psychiatric patients discharged from Maryland hospitals. In two HPRs, Baltimore Upper Shore and Western Maryland, the number of adults dually diagnosed decreased by five or six percentage points in recent years, compared to the levels occurring in CY 2017, but remains over 50% in both

HPRs, as shown in the table below. Because beds are not approved through the CON process specifically for patients with a primary psychiatric diagnosis and a secondary SUD diagnosis, staff did not use trends in ED days as an indicator of need for this population.

Table 3
Adult Psychiatric Discharges with a Secondary Substance Use Disorder (SUD) Diagnosis, CY 2023

Health Planning Region of Patient Origin	Total Number of Psychiatric Discharges	Number of Psychiatric Discharges With a Secondary SUD Diagnosis	Percentage of Psychiatric Discharges with Secondary SUD Diagnosis
Baltimore Upper Shore	15,354	8,778	57.2%
Lower Eastern Shore	640	387	60.5%
Montgomery	3,812	1,603	42.1%
Southern Maryland	3,968	2,009	50.6%
Western Maryland	2,642	1,449	54.8%

Source: MHCC staff's analysis of HSCRC discharge data, CY 2023.

Notes: The total number of discharges reflect discharges, from both private psychiatric hospitals and acute general hospitals in Maryland, with a primary psychiatric diagnosis and a secondary SUD diagnosis. Psychiatric diagnoses are defined as ICD-10 codes corresponding to the ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 – 319.0. Diagnoses for SUD are defined as the ICD-10 codes corresponding to the ICD-9 codes 291.0 – 292.9, 303.0 – 305.9. Adults are defined as ages 18 and older.

Table 4
Estimate of Need for Historically Underserved Populations:
Adults with a Primary Psychiatric Diagnosis and Secondary Diagnosis for SUD by HPR, CY 2023

Health Planning Region of Patient Origin	ED Visits of One Night or Greater and Disposition to Psych Unit or General Hospital		ED Visits of Three Nights or Greater and Disposition to Home		Estimated ED Boarding Days (A+B)	Estimated Inpatient Psychiatric Beds Needed
	Number	Total Days (A)	Number	Total Days (B)		
Baltimore Upper Shore	976	1,840	189	1,152	2,992	10.6
Lower Eastern Shore	51	72	4	12	84	0.3
Montgomery	240	384	21	89	473	1.7
Southern Maryland	167	314	32	140	454	1.7
Western Maryland	30	47	9	63	110	0.4
Other	111	171	14	68	239	0.9

Source: MHCC staff's analysis of HSCRC outpatient data, CY 2023.

Notes: The total ED visits are based on counts of records with an emergency charge and a primary psychiatric diagnosis in the HSCRC outpatient data. Psychiatric diagnoses were defined as ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 - 319.0, and the corresponding ICD-10 codes. The length of an ED visit is calculated based on the beginning and ending dates of service. Records for which the difference between the start and end date of service is three days or more are counted as ED visits for three or more nights. The estimated need for inpatient psychiatric beds assumes a year has 365 days. Occupancy is assumed to be 77.4% in the Baltimore Upper Shore HPR; 70.0% in the Lower Eastern Shore HPR; 78.1% in Montgomery HPR; 72.7% in the Western Maryland HPR; and 75% for patients from “Other” HPR. The assumed occupancy level for adolescent beds in each Maryland HPR is based on the weighted average of the minimum expected occupancy for existing facilities, as defined in COMAR 10.24.21.06G(3). SUD diagnoses are defined as the ICD-10 codes corresponding to the ICD-9 codes 291.0 – 292.9, 303.0 – 305.9. Adults are defined as ages 18 and older.

Table 5
Adolescent Psychiatric Discharges with a Secondary SUD Diagnosis, CY 2023

Health Planning Region of Patient Origin	Total Number of Psychiatric Discharges	Number of Psychiatric Discharges with a Secondary SUD Diagnosis	Percentage of Psychiatric Discharges with Secondary SUD Diagnosis
Baltimore Upper Shore	2,178	467	21.4%
Lower Eastern Shore	55	12	21.8%
Montgomery	692	127	18.4%
Southern Maryland	489	114	23.3%
Western Maryland	458	42	9.2%

Source: MHCC staff's analysis of HSCRC discharge data, CY 2023.

Notes: The total number of discharges reflect discharges from both private psychiatric hospitals and acute general hospitals in Maryland, with a primary psychiatric diagnosis and a secondary SUD diagnosis. Psychiatric diagnoses are defined as ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 - 319.0, and the corresponding ICD-10 codes. Diagnoses for SUD are defined as ICD-9 codes 291.0 - 292.9, 303.0 – 305.9, and the corresponding ICD-10 codes. Adolescents are defined as ages 13 through 17.

Table 6
Estimate of Need for Historically Underserved Populations:
Adolescent Psychiatric Discharges with a Secondary SUD Diagnosis, CY 2023

Health Planning Region of Patient Origin	Total Days for Psychiatric Discharges with a Secondary SUD Diagnosis	Estimated Inpatient Psychiatric Beds Needed
Baltimore Upper Shore	5,775	12.2
Lower Eastern Shore	192	0.4
Montgomery	1,076	2.1
Southern Maryland	1,199	2.3
Western Maryland	772	1.5

Source: MHCC staff's analysis of HSCRC discharge data, CY 2023.

Notes: The total number of discharges reflect discharges from both private psychiatric hospitals and acute general hospitals in Maryland, with a primary psychiatric diagnosis and a secondary SUD diagnosis. Psychiatric diagnoses are defined as ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 - 319.0, and the corresponding ICD-10 codes. Diagnoses for SUD are defined as ICD-9 codes 291.0 - 292.9, 303.0 – 305.9, and the corresponding ICD-10 codes. Adolescents are defined as ages 13 through 17.

Secondary Diagnosis of a Developmental Disability

With respect to the psychiatric patients with a secondary diagnosis for a developmental disability, staff notes that it is primarily adults who are boarding in EDs, not adolescents or children, with this secondary diagnosis. As shown in Table 6, there is an estimated need for two beds for adults with a primary psychiatric diagnosis and a secondary diagnosis of a developmental disability in the Baltimore Upper Shore HPR, compared to a need of less than one bed for both adolescents and children in this HPR, as shown in Tables 7 and 8, respectively.

Across all age groups, the region with the greatest need was in the Baltimore Upper Shore HPR. In CY 2023, for adolescents with a primary psychiatric diagnosis and a secondary diagnosis of a developmental disability, the estimated number of ED visits that resulted in boarding was less than 50 in all HPRs, except the Baltimore Upper Shore region, which had 50 ED visits for adolescents that resulted in boarding. For children, in CY 2023, there were less than ten ED visits with boarding in all HPRs except one, the Baltimore Upper Shore HPR, for patients who had a primary psychiatric diagnosis and secondary diagnosis for a developmental disability. In the Baltimore Upper Shore HPR, there were 26 ED visits that involved boarding for children. Across all HPRs and age groups, except for adults in the Baltimore Upper Shore HPR, the estimated unmet need for acute psychiatric beds for psychiatric patients with a secondary diagnosis for a developmental disability is less than one bed.

Staff also reviewed trends in the number of discharged patients with a primary psychiatric diagnosis and secondary diagnosis for a developmental disability for the period from CY 2017 to CY 2023, for children, adolescents, and adults, by HPR. Staff noted that there is not a clear downward or upward trend for any region or age group that suggests increasing or decreasing need. Often the year with the highest number of discharges with these diagnoses was CY 2018 or CY 2019. In the Baltimore Upper Shore HPR, across all age groups the highest number of discharges with a secondary diagnosis for developmental disability was in CY 2019 or earlier (2017 for children). In the Lower Eastern Shore HPR, for both adults and adolescents, the highest number of discharges with a secondary diagnosis for developmental disability was in CY 2018. For the Montgomery HPR, for both adolescents and children, the highest number of discharges with a secondary diagnosis for developmental disability was in CY 2018. For the Southern Maryland HPR, the highest number of discharges with a secondary diagnosis for developmental disability for adolescents was in CY 2019 and for children it was in CY 2018. For the Western Maryland HPR, the highest number of discharges with a secondary diagnosis for developmental disability for children and adolescents was in CY 2021.

**Table 7
Estimate of Need for Historically Underserved Populations:
Adults with a Primary Psychiatric Diagnosis and Secondary Diagnosis for a Developmental Disability, by HPR**

Health Planning Region of Patient Origin	ED Visits of One Night or Greater and Disposition to Psych Unit or General Hospital		ED Visits of Three Nights or Greater and Disposition to Home		Estimated ED Boarding Days (A+B)	Estimated Inpatient Psychiatric Beds Needed
	Number	Total Days (A)	Number	Total Days (B)		
Baltimore Upper Shore	111	313	52	637	950	2.0
Lower Eastern Shore	1	4	2	115	119	0.2
Montgomery	26	58	6	66	124	0.3
Southern Maryland	4	4	6	29	33	0.1
Western Maryland	3	3	2	29	32	0.1
Other	4	5	1	4	9	0.0

Source: MHCC staff's analysis of HSCRC outpatient data, CY 2023.

Notes: The total ED visits are based on counts of records with an emergency charge and a primary psychiatric diagnosis in the HSCRC outpatient data. Psychiatric diagnoses are defined as ICD-10 codes corresponding to the ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 - 319.0. The length of an ED visit is calculated based on the beginning and ending dates of service. Records for which the difference between the start and end date of service is three days or more are counted as ED visits for three or more nights. The estimated need for inpatient psychiatric beds assumes a year has 365 days. Occupancy is assumed to be 77.4% for the Baltimore Upper Shore HPR, 70% for the Lower Eastern Shore HPR, 78.1% for Montgomery HPR, 72.7% for Southern Maryland HPR, and 71.5% for Western Maryland HPR, based on the weighted average of the minimum expected occupancy rate for existing facilities, as defined in COMAR 10.24.21.06G(3). Diagnoses of developmental disability are defined as ICD-9 codes 299.0 - 299.9, 317.0 - 319, and the corresponding ICD-10 codes. Adults are defined as ages 18 and older.

Table 8
Estimate of Need for Historically Underserved Populations:
Adolescents with a Primary Psychiatric Diagnosis and Secondary Diagnosis for a Developmental Disability, by HPR

Health Planning Region of Patient Origin	ED Visits of One Night or Greater and Disposition to Psych Unit or General Hospital		ED Visits of Three Nights or Greater and Disposition to Home		Estimated ED Boarding Days (A+B)	Estimated Inpatient Psychiatric Beds Needed
	Number	Total Days (A)	Number	Total Days (B)		
Baltimore Upper Shore	31	137	19	234	371	0.8
Lower Eastern Shore	3	51	1	8	59	0.1
Montgomery	12	136	1	3	139	0.3
Southern Maryland	6	29	5	41	70	0.1
Western Maryland	5	18	1	4	22	0.0
Other	0	0	2	21	21	0.0

Source: MHCC staff's analysis of HSCRC outpatient data, CY 2023.

Notes: The total ED visits are based on counts of records with an emergency charge and a primary psychiatric diagnosis in the HSCRC outpatient data. Psychiatric diagnoses were defined as ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 - 319.0, and the corresponding ICD-10 codes. The length of an ED visit is calculated based on the beginning and ending dates of service. Records for which the difference between the start and end date of service is three days or more are counted as ED visits for three or more nights. The estimated need for inpatient psychiatric beds assumes a year has 365 days. Occupancy is assumed to be 70%, except in the Baltimore Upper Shore HPR, which is assumed to have an occupancy level of 76.4%; Montgomery HPR, which is assumed to have an occupancy level of 74.4%; and Western Maryland HPR, which is assumed to have an occupancy level of 75%. The assumed occupancy level for adolescent beds in each HPR is based on the weighted average of the minimum expected occupancy for existing facilities, as defined in COMAR 10.24.21.06G(3). Diagnoses of DD are defined as ICD-9 codes 299.0 - 299.9, 317.0 - 319, and the corresponding ICD-10 codes. Adolescents are defined as ages 13 through 17.

Table 9
Estimate of Need for Historically Underserved Populations:
Children with a Primary Psychiatric Diagnosis and Secondary Diagnosis for a Developmental Disability, by HPR

Health Planning Region of Patient Origin	ED Visits of One Night or Greater and Disposition to Psych Unit or General Hospital		ED Visits of Three Nights or Greater and Disposition to Home		Estimated ED Boarding Days (A+B)	Estimated Inpatient Psychiatric Beds Needed
	Number	Total Days (A)	Number	Total Days (B)		
Baltimore Upper Shore	17	132	9	127	259	0.5
Lower Eastern Shore	4	10	1	23	33	0.1
Montgomery	5	9	0	0	9	0.0
Southern Maryland	1	0	0	0	0	0.0
Western Maryland	2	0	1	5	5	0.0
Other	3	7	0	0	7	0.0

Source: MHCC staff's analysis of HSCRC outpatient data, CY 2023.

Notes: The total ED visits are based on counts of records in the HSCRC outpatient data with an emergency charge and a primary psychiatric diagnosis. Psychiatric diagnoses are defined as ICD-9 codes 290.0 – 290.09, 293.0 – 302.09, 306.0 - 319.0, and the corresponding ICD-10 codes. The length of an ED visit is calculated based on the beginning and ending dates of service. Records for which the difference between the start and end date of service is three days or more are counted as ED visits for three or more nights. The estimated need for inpatient psychiatric beds assumes a year has 365 days. Occupancy is assumed to be 70% in all HPRs. The assumed occupancy level for child beds in each HPR is based on the weighted average of the minimum expected occupancy for existing facilities, as defined in COMAR 10.24.21.06G(3). Diagnoses of developmental disability are defined as ICD-9 codes 299.0 - 299.9, 317.0 - 319, and the corresponding ICD-10 codes. Children are defined as ages five to 12.

MHCC Staff Conclusions on Need Determinations for Historically Underserved Populations

In addition to considering trends in ED visits for historically underserved populations, MHCC staff considered trends in inpatient psychiatric discharges, as reflected in the gross and net bed need utilization projections. With respect to the assessments of need by local behavioral health authorities, MHCC staff reviewed the assessments available and noted that these documents do not have quantitative data on the need for acute psychiatric services for historically underserved populations, as defined in MHCC’s regulations. Staff’s conclusions about the need for additional acute psychiatric beds for children, adolescents, psychiatric patients dually diagnosed with a SUD, and psychiatric patients dually diagnosed with a developmental disability follow.

Children

- There may be a need for children’s psychiatric beds in the Baltimore Upper Shore HPR and the Southern Maryland HPR, but the estimate of need is below the threshold of four beds in COMAR 10.24.21B(2)(c)(i).

Adolescents

- There is a need for adolescent psychiatric beds in the Baltimore Upper Shore HPR that exceeds the COMAR threshold of four beds. An applicant seeking a Certificate of Need to add psychiatric beds in this HPR shall follow the requirements in COMAR 10.24.21.05B(2)(c).

Adults and Adolescents with a Secondary SUD Diagnosis

- There is a need for SUD treatment for adults who have been admitted for acute psychiatric inpatient treatment across all HPRs, based on the high proportion of psychiatric discharges which have a secondary SUD, over 40% in all HPRs for CY 2023. Among the five HPRs, the one with the highest proportion of psychiatric discharges with a secondary substance use diagnosis in CY 2023 was the Lower Eastern Shore with 60.5%.
- There is a need for SUD treatment for adolescents admitted for acute psychiatric inpatient treatment, for the Baltimore Upper Shore HPR, that exceeds the equivalent of the COMAR threshold of four beds.

Adults, Adolescents, and Children with a Secondary Diagnosis for Developmental Disability

- There is a need for two additional acute psychiatric beds for adults with a primary psychiatric diagnosis and a secondary diagnosis for a developmental disability in the Baltimore Upper Shore HPR. In other HPRs, the need for beds for adults with a primary psychiatric diagnosis and a secondary diagnosis for a developmental disability is well less than one bed.
- For children and adolescents with a primary psychiatric diagnosis and a secondary diagnosis for a developmental disability, the need for beds is less than one in all HPRs.