

# Commission to Study Mental & Behavioral Health

November 5, 2020

4:00-6:00PM

## Meeting Minutes

### I. Call to order

Lieutenant Governor Rutherford called to order a virtual meeting for the Commission to Study Mental and Behavioral Health on November 5 at 4:00PM.

### II. Roll Call/Attendees

Commission Members Participating: Lt. Governor Rutherford, Senator Adelaide Eckardt, Senator Katie Fry Hester, Delegate Lewis Young, Dr. Aliya Jones, Christian Miele, Dr. Lynda Bonieskie, Tiffany Rexrode, Commissioner Kathleen Birrane, Richard Abbott, Director Steve Schuh, Mary Gable, Barbara Allen, Patricia Miedusiewski, Dr. Bhaskara Tripuraneni, Cari Cho, & Kimberlee Watts

Designees: Tricia Roddy, MDH

Absent: Delegate Ariana Kelly, Roland Butler, Serina Eckwood

### III. Sub-Committee Update:

#### a) Crisis Services - *Director Steve Schuh, Chair:*

- Last year, we had two recommendations in the 2019 Annual Report
  - (1) Develop a comprehensive crisis response system
    - Our colleagues at the Behavioral Health Administration, (BHA) are taking lead on developing a comprehensive crisis system.
    - They have determined there is value in having an external group guiding the project.
    - This group will include external and internal stakeholders.
    - During their first meeting, BHA will present for review & comment a foundational document based on Substance Abuse and Mental Health Services Administration's (SAMSHA) national guidelines for behavioral health crisis care.

- The OCCC has provided over a quarter of a million to fund the Maryland Medicaid Administrations implementation of a pilot project that will expand comprehensive crisis response centers using the state's existing Outpatient Mental Health Clinic, (OMHC).
  - The MD Health Services Cost Review Commission's Regional Catalyst Grants Program, the Health Department State Opioid Response II (SORII) funding and the Behavioral Health Crisis Fund (HB1092) will each be sources of monies to enhance our comprehensive system's capabilities.
- (2) Improve our crisis hotlines
- A portion of the State's SORII funding has been allocated to enhance our 211 press 1 system.
  - 211 press 1 will offer 24/7 support anywhere in the state for people experiencing a substance use or mental health crisis.
  - The hotline staff will be able to offer Marylanders a screening assessment, intervention and referral services over the phone.
  - Additionally, BHA is working on infrastructure enhancements that will allow local 211 press 1 calls to be routed to local crisis hotlines instead of to the 5 regional hubs.
- We continue our work to promote standardized training in the behavioral health field. Our office facilitated an agreement among BHA, the MD Institute for Emergency Medical Service Systems (MIEMSS) and the Mental Health Association of MD.
- (1) Agreement provides mental health first aid training to health care professionals and first responders.
- b) Youth & Families - *Co-Chairs Deputy Secretary Christian Miele & Asst. Deputy Secretary Tiffany Rexrode:*
- Formed 3 workgroups:
    - (1) Licensure and reciprocity
      - Created to explore areas related to licensure out of state related to telehealth services.
        - (i) Focusing on how providers and licensing could move more fluidly between states
        - (ii) Common denominators across all the health professionals that have a licensure component
        - (iii) Reciprocity laws checks and balances and enforcement
        - (iv) Working document that outlines all the licensure boards that offer information on licensure statues and whether or not they have interstate compacts.

- (2) Maryland's Behavioral Health rating
    - Looking at language and policies surrounding involuntary commitment
    - Looking at the definition of anosognosia and its relation to involuntary commitment
  - (3) Youth and adolescence substance use and treatment
    - Discussing whether or not the absence residential treatment of adolescence with a serious substance use disorder in the state is a violation of parity laws for youth on Medicaid or of the early screening diagnosis and treatment Medicaid regulation.
- c) Financing & Funding - *Co-Chairs Tricia Roddy & Commissioner Birrane:*
- As Steve Schuh mentioned the grant we received from the Opioid Command Center, it is about \$270k.
    - (1) We had our kickoff meeting this past week with a group of stakeholders.
    - (2) Using the money to look at OMHCs as Steve mentioned and to see how we can leverage the existing provider network that they already offer in the state of MD.
    - (3) Looking at new services we could potentially add to that network.
  - System of Care update – started to get our workgroups back together with a focus on the main workgroup. Had presentations from the MCOs to learn from them of how they develop their networks and different tools that we can leverage. Working on provider manuals.
    - (1) Continuing work on requirements under The Hope Act, developing cost base rates with providers.
  - Focused on 2 things:
    - (1) Parity in terms of insurers coverage and access
      - MD General Assembly did pass legislation this past Session which is now caught by the 15144 that has MIA developing regulations to assess parity between medical surgical services and mental health services.
      - MIA's first task will be to promulgate regulations that identify metrics and measurements.
      - First public stakeholder meeting on November 23.
    - (2) Network adequacy – update from David Cooney, MIA
      - Update on MIA's network adequacy regulations and access plans.
        - (i) MIA convened a stakeholder workgroup last fall to analyze our existing adequacy regulations and identify areas for improvement.

- (ii) Based on feedback we received from stakeholders, we have had several meetings with our internal workgroup and began drafting revisions to the regulations.
- (iii) On November 4, we posted a draft prepublication version of those revised regulations on our website. We will be accepting public comments on that draft for the next 30 days.
- (iv) After public comments, we will hold another public meeting, likely to be in mid-December.
- (v) The draft does reflect a greater emphasis on measuring network adequacy for mental health substance use specifically. Also how telehealth fits in with network adequacy.
- (vi) Reviews of network adequacy plans themselves, we have obtained and analyzed the necessary information and the orders are being finalized. We expect to start issuing them very soon. In the meantime, we have received the 2020 network access plans on July 1 and those reviews are ongoing. Information we received included revised executive summaries and that is public information so that is posted to the website. Overall improvement of compliance. All the plans failed to meet the standards for at least one of the mental health substance use disorder metrics.

d) Public Safety & Justice System - *Co-Chairs Senator Katie Fry Hester & Dr. Lynda Bonieskie:*

- Discussed Assisted Outpatient Treatment (AOT) at our last subcommittee meeting. We had presentations from Brian Stettin, the Policy Director of the Treatment Advocacy Center. He presented on the experiences of other states with the AOT model. Also a presentations from Debbie Plotnick, the public Policy Director of Mental Health America on their inset program in New York. This was followed by a deeper dive on a local case study, Adrienne Bernstein, President of Policy and Communications at Behavioral Health Systems of Baltimore. She presented on Baltimore City Outpatient Civil Commitment Pilot Program. Finally, Dan Martin presented on the perspective of the Outpatient Civil Commitment stakeholder panel.
- We are hosting the Sequential Intercept Model Summit on November 17.
  - (1) The first day of the summit is open for everyone to register. Speakers and presenters will be sharing their work at the nexus of mental and behavioral health services across the intercepts.
  - (2) Day 2 – participants will split into 3 different groups of 25 people. The first part of the morning will be spent in these breakout groups trying to identify best practices as well as gaps in services. Then the groups will

report back their findings. Consultants at Policy Research Associates, (PRA) will put together a report that we can read once we return for our next meeting.

**IV. Update on 2019 Recommendations, Mark Newgent, Deputy Chief of Staff to Lt. Governor Rutherford:**

- a) Recommendation One: Design a comprehensive Crisis System
  - Dr. Jones – We have begun internal conversations and looking at the standard for involuntary commitment and trying to expand them so that they are clear and lend to more consistent outcomes for when someone is emergency petitioned to an emergency department and then evaluated to be held. Our state is lacking when we compare ourselves to states that have more clear criteria for involuntary hospitalization.
- b) Recommendation Two: Continue coordination with the Behavioral Health System of Care Workgroup
  - Tricia Roddy – we are beginning to meet again and talking through the issues.
- c) Recommendation Three: Increase funding for the Second Chance Act Grant
- d) Recommendation Four: Improve the Crisis Hotline
- e) Recommendation Five: Promote standardized training in behavioral health
- f) Recommendation Six: Ensure proper warnings regarding cannabis use
- g) Recommendation Seven: Standardize mental and behavioral health programming in schools
  - Senator Hester – I talked to Christian Miele last Session to see what we could be doing. There are several states that have done something. I would like to compare with MSDE what other states are doing. There is the training requirement for teachers, mental health aid and there is the training of students themselves so they can recognize suicide tendencies in their peers. There are also states that have consolidated resources like a one stop shop of resources for children. Utah has an app that can connect you to providers. MSDE has definitely been dealing with COVID19 like the rest of us so we probably are not as far along as we might think. I would like to work with somebody on comparisons.
  - Mary Gable – We have done training of teachers, administrators, bus drivers, anyone that can be trained and many of those are trained as a trainer to identify those behaviors that indicate a mental health issue. Also training what can be done and what are the resources to refer the students to. We have a requirement to teach health education K-8 annually and once in high school. In health, there are standards and curriculum that teaches students to

help them understand such behaviors and what help is available. For the K-2 level, we also work to identify any help that we can provide students.

- h) Recommendation Eight: Improve access to information and services
- Christian Miele – MDOD just hired an IT accessibility coordinator who is a whiz at making sure that the web-based applications that are posted online are fully accessible to those with a disabilities. I can connect you with him, his name is Andrew Drumin.

**\*See additional materials for detailed updates**

#### V. Public Testimony:

- a) Austin Torsch, *Family Peer Support Specialist, MD Coalition of Families (MCF)*  
– A good portion of my job is to support parents of those with children experiencing substance use disorder. In almost 2 years with MCF, I have witnessed an alarming rate of parents seeking substance use treatment for their child with little to no avail. Unless you have been referred to a DJS program, a residential treatment does not exist for adolescents in MD. While outpatient programs exists sparingly, they are not available in every county making it unrealistic for parents who would have to transport their children to a program on a consistent basis. These have forced parents to put their children in programs that focus more on mental health over substance use. In some cases, it forces parents to send their children out of state and that's if you are fortunate enough to have insurance coverage on any of these alternatives. Residential facilities are a necessity for families that have an adolescent struggling with substance use. Thank you for your time and consideration.
- Commission: I know there is a challenge associated with children and adolescents. We had discussions with the new hospital going into Prince George's County and how many psychiatric beds they had and if any were designated for children and adolescents. In addition, the adolescents and children need to be separated. Montgomery County recently started a program for substance use disorder, we are not sure how that is going at this point. Frederick County has something similar for the high school aged children.
- b) Dan Martin – Administrative Service Organization, (ASO) Transition issue. For those that are unaware, the state transitioned the administrative management of the public behavioral health system to a new vendor in January and to say that it has been challenging would be an understatement. We really want to thank the Maryland Department of Health, Behavioral Health Administration, and Medicaid for all the work that has gone into this. We do have concerns about continuing deficiencies in Optim's claims processing system and the resulting chaos for the

community providers. It is having a destabilizing effect on those community providers. We are concerned about the viability of the system and the impact on the public. Those concerns are so great that the Behavioral Health Coalition sent a letter to Governor Hogan a few weeks ago cosigned by over 80 organizations in the state calling for drastic actions to rectify this issue. I know everyone is working really hard on this and we appreciate the effort, we just felt it necessary to impress upon this Commission the level of continuing concern from the community on that issue.

The second issue – I do want to push back and challenge the narrative regarding Maryland’s ranking in the eyes of one particular group with one particular agenda. The Youth and Families Subcommittee even has a workgroup for it. There has been a lot of talk about this “F” grade from the Treatment Advocacy Center but that report did not look at Maryland’s whole Behavioral Health System of Care, it didn’t evaluate the array of services that our outpatient mental health centers are delivering. It didn’t look at the growth in our school behavioral health program or our early intervention efforts or our network of peer run recovery centers. Instead it looked at 2 metrics, how easy it is to commit someone to treatment involuntarily, inpatient or outpatient. We have problems in our state of course, our public behavioral health is underfunded. We have challenges with our commercial networks. We need more harm reduction, suicide prevention efforts and our system of care for children needs work but that’s not to say that we have nothing. We actually have a lot to be proud of here in Maryland and we are actually doing a lot better than other states. Another national report that was released from Mental Health America, which gives a more holistic look at state behavioral health care systems overall and access to care, Maryland was ranked 4<sup>th</sup> in the nation. So, we have of course have a lot of work to do and we can always make improvements and the behavioral health fallout from this Pandemic is going to test us and require us to double down on our commitments and our efforts but to say that we are failing or have a failing grade is disingenuous and dismissive of all the great work that is going on in the state.

- c) Evelyn Burton, *Advocacy Chair for the MD Chapter of Schizophrenia and Related Disorders of America (SARDA)* – I am excited to share with the Commission the recently released outcome measures of the first 18 locations that received a four year federal grant from SAMHSA to establish evidence based AOT programs. The locations for these grants range from small rural communities to large cities across 12 states. The results compared pre-enrollment data to data at least 6 weeks after enrollment. They found that psychiatric visits to emergency departments declined 25.9%. The percent of participants with hospitalizations for mental health care dropped 85%. The percentage that spend

time in jail decreased by more than 44% and the percentage that spent 1 or more nights homeless fell by 48.5%. 91.8% of participants agreed or strongly agreed with the statement “I liked the services I received here”. There was significant savings reported, both Reno, NV and Baldwin, AL saw \$1million of savings beyond the funding of the program. In contrast, according to last year’s report of the Baltimore’s Pilot OCC Program, it did not serve any new court ordered patients, there has never been reported any hard data on outcome measures for ER visits, hospitalization, homelessness, jail times or cost savings. The recent regulation changes only affected voluntary participants and will not do anything to help individuals who need a court order. In my view, the Baltimore Pilot has tried unsuccessfully to reinvent the wheel in dealing with court ordered patients. It is time for MD to plan and act according to the data and evidence and move on from the failed Baltimore OCC Pilot to evidence based AOT for those who need court ordered treatment. We urge the Commission to recommend that an AOT statute be passed in MD as the first step. Thank you for all your work.

- d) Jim Perrone – I have been both a clinician and a director of a substance use program and youth service bureau for over 38 years. Sadly, the outpatient program that I ran that served Baltimore County for more than 40 years is now closed due to the way programs are funded. When grants went away, it became very difficult and as the state and insurance companies started requiring qualified staff, licensed at the highest possible level, there were no significant changes made to the reimbursement rate leaving many providers inadequately paid for their services. At least for Baltimore County, all 8 publically funded substance use programs and 2 of the 3 services bureaus have now shuttered their doors. While I am aware that the focus today was about the need for inpatient programs and I wholeheartedly agree that sending our children out of state is not conducive to the best possible treatment, there are other concerns I just want to keep in mind. Over my 38 years in the field, I have found that outpatient treatment is not only a good option to have, it is often a lifesaver. We do need to address a more comprehensive system of care based on for example what I just told you has happened in Baltimore County. Outpatient treatment resources are critical in meeting the needs of adolescent and their families. The first place that people ought to be able to turn for help, should be right in their own communities. I cannot stress enough the benefits of a good comprehensive assessment. My experience has been that even though we have tried to talk about behavioral health as one grouping – behavioral health professionals see mostly behavioral health issues and mental health professionals see mostly mental health issues. We need to make sure clinicians are trained about co-occurring disorders. After an inpatient stay, certainly outpatient treatment serves a valuable role in reinforcing new behaviors and new coping mechanisms all while providing ongoing support



- which is critical to continued recovery. I 100% support the need for more inpatient treatment but we need to advocate for a robust continuum of care and a workforce that is appropriately trained.
- e) Christine Lewis – I am the parent of a 16 year old that suffers not only from mental health issues but substance use issues as well. I wanted to share with you all our struggle in finding a treatment center that can address our daughter's dual diagnosis. Due to the lack of substance use treatment available to adolescents, we were left only seeking help from our primary care physician (PCP). The PCP admitted that she did not have the proper knowledge to treat our daughter and was unsure on how to direct us to the treatment our daughter needed. I spent hours online and on the phone trying to seek help. We found a psychiatrist who would see our daughter, however instead of getting treatment for her dual diagnosis, she is seeing a psychiatrist for mostly her mental health while they will monitor her substance use issues instead of receiving a complete treatment. Adolescents need these treatment centers now, more than ever. They need the proper help before they spiral, advancing use, end up with a criminal record or become adults with full blown addictions. Our daughter is on board with the treatment that she needs and she wants us to seek the help and get better. It is heartbreaking and frustrating that we continue to try to explain to her that we cannot get the proper help that she needs that it isn't offered here in our state. We need that treatment, not just for our daughter but for the other daughters and sons who need equal treatment. I hope that there is continued conversation on this and I thank you for your time and attention on this matter.

**VI. Closing Remarks:**

Next Meeting December 8 at 4:00-6:00pm

Please visit our webpage: [Ltgovernor.maryland.gov/mbhcommission](http://Ltgovernor.maryland.gov/mbhcommission)