

Commission to Study Mental & Behavioral Health

January 19, 2021

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 January 19, 2021 at 4:00PM.

II. Roll Call/Attendees

Commission Members Participating: Lt. Governor Rutherford, Senator Adelaide Eckardt, Delegate Ariana Kelly, Delegate Lewis Young, Dr. Aliya Jones, Lt. Col. Roland Butler, Christian Miele, Tiffany Rexrode, Commissioner Kathleen Birrane, Director Steve Schuh, Mary Gable, Barbara Allen, Patricia Miedusiewski, Dr. Bhaskara Tripuraneni, Cari Cho, Serina Eckwood & Kimberlee Watts

Designees: Nithin Venkatraman, Senate Designee and Tricia Roddy, MDH

Absent: Director Richard Abbott and Dr. Lynda Bonieskie

III. Minute Approval

- a) December 18, 2020 meeting minute approval
- Motion to approve - Senator Eckhardt & Second - Director Schuh

IV. Sub-Committee Update:

- a) Youth & Families - *Co-Chairs Deputy Secretary Christian Miele & Asst. Deputy Secretary Tiffany Rexrode:*
- Last met on January 11, 2021
 - (1) Two items of business:
 - The MD Medicaid program amended regulations of COMAR to allow for reimbursement of school psychologists who are certified by MSDE when they are providing services under an IEP or an ISFP. We are going to take a vote to see if we want to bring this to the full Commission as an addendum of our recommendation or a future recommendation.
 - (i) Tricia Roddy – This is a federal audit issue. You can't have two different licensing standards for psychologists. School

psychologists do not follow the same standard as a community psychologist.

- Involuntary Commitment Standard - we have a workgroup that is going to come up with some language for us to consider during our next meeting.

b) Financing & Funding - *Co-Chairs Tricia Roddy & Commissioner Birrane:*

- Tricia Roddy - Medicaid update – Met on Jan 11. Medicaid portion was a quick update on two issues:
 - (1) System of Care update - reviewing comments and ideas from subcommittee members. Meeting again on Feb 16.
 - (2) Update on the Opioid Operational Command Center Grant that we received and is looking at expanding OMHC's Crisis Stabilization Network
- Commissioner Birrane-
 - (1) Mental health parity - our public meeting was held on Nov 23 and we received a large amount of comments that we are reviewing. We will likely reconvene after session for another public meeting.
 - (2) Network adequacy - First public meeting in December with our proposed regulations. Reviewing those public comments within our internal working group as well. Will meet after the session.
 - (1) We did have a successful webinar to help understand how to access insurance coverage for mental health and substance disorder treatment. We approached it with a set of scenarios and examples that people can relate to. Will be doing more outreach like that moving forward.

c) Crisis Services - *Director Steve Schuh, Chair:*

- Released our quarterly report last week. Preliminary data shows that all drug and alcohol related fatalities were up 12% compared to the same time last year. This data highlights an increase in suffering among some of Maryland's most vulnerable people. For this, we must remain committed that all Marylanders are able to access behavioral health services.
- Our Subcommittee last met on January 6. During this meeting, we received updates from all 3 health services cost review commission regional catalyst grant program recipients. The 3 regional partnerships will work to expand services in central Maryland, Prince George's County and the lower eastern shore.
- Two recommendations from our subcommittee was included in the Annual Report both related to Assertive Community Treatment Teams (ACT Teams):

- (1) Continue to identify ways to expand ACT Teams to defined areas of geographical areas of the state. Our subcommittee will continue to study Forensic Assertive Community Treatment Teams (FACT Teams)
 - (2) Our subcommittee will continue to track progress related to the developments of a comprehensive crisis response system as well as improvements made to Maryland's crisis help line, 211 Press 1.
 - (3) Our next meeting is March 3 at 10:00am.
- d) Public Safety & Justice System - *Co-Chairs Senator Katie Fry Hester & Dr. Lynda Bonieskie:*
- (1) Nithin Venkatraman (designee) - Met on January 11 to review the draft of the SIM Summit report and discuss potential legislative initiatives. We are currently reviewing the input we received from the report and compiling in a format that is useful. A recommendation we received from the report is to establish an academic center of excellence. This would be run by consultants, university and state partnership and would provide technical assistance to counties in regards to structuring and implementing systematic approaches of handling the intersection of mental health and the criminal justice system.
 - Discussed Assisted Outpatient Treatment (AOT) expansion beyond the pilot.

V. Special Presentation:

- a) Judy Harris & Norm Ornstein - Please see additional materials for written testimony, documentary and presentation.
- b) Follow Up Comments -
 - Lt. Governor - We know that in Maryland, our biggest mental health facilities are our state prisons. Something has to be done and that is why I have been pushing for Assisted Outpatient Treatment and looking at what we can do in our criminal justice system. We want to be able to intercept that person before it gets to that and Senator Hester's group is working on that but we also need laws that make it clear to intercept this before it reaches that point.
 - Norm Ornstein - A core part of what Judge Leifman has done in Miami-Dade County was the implementation of crisis intervention training to 7,600 police officers. This is a 40 hour program that originated in Tennessee and this cut the arrest in half, cut the number of shootings dramatically - from 2 per month to 1 in the last 5-6 years. They have been able to close a jail and save 84 million dollars over 12 years because of those changes. Because of the decline in wrongful death suits, they were able to improve the bond rating in the city of Miami. So we need extensive training combined with

the folks that are responding to the 911 calls and mental health professionals.

- Judy Harris - If I can add about clarifying the standard. Everything we read is about the importance of early intervention and getting to someone at first episode psychosis, but the way the standard has been interpreted now, the person has to be so far along in their illness that it's too late to do anything. So I urge you while you're trying to clarify that standard to take into consideration the tension between how sick you want someone to be to get help versus how much more likely the help is to be viable if you get to that person early.
- Barbara Allen - I would like to thank them for the work that they have done. As a parent who has experienced similar, I hear you. I want to thank you for the presentation material as well.
- Judy Harris - The notion of asking for someone to designate a power of attorney when you get a driver's license. It would be great if Maryland would be the leader in this.
- Dr. Aliya Jones - I do want to say thank you for sharing your story so transparently with us what your loss has been like. I do want to tell you about some resources in MD that we do have. One of the things you mentioned is CIT Training - I do hope that you know that CIT training is widely available in Maryland. One of the departments that does the best CIT training in the nation is in Anne Arundel County according to the National Accrediting Organization. In regards to early intervention, through MD Psychiatric Research Institute, they have an early intervention program that has been active for many years. Recently, this program has been expanding to have wider catchment of younger individuals throughout the state to get referred for treatment so they don't have to have the same experiences that your son experienced. I wanted to let you know about that as well.
- Judy Harris - I am familiar with that but my understanding is you're not able to access that same care if you're 25 years old. So my ask would be for the laws to include that later care to be available.
- Dr. Aliya Jones - The last thing in regards to people identifying who it is that someone can reach out to for help if someone does become ill - one of the things we have been pushing around the state is psychiatric directives because that can serve that purpose. They are not as widely used as many of us would like them to be used and a lot of that is about community education but we are doing what we can to make sure that patients/people are able to communicate when they are not well.

VI. Public Testimony:

- a) Ashia Mann, *Help of the Home*
 - Please see additional materials for written testimony

- b) Luciene Parsley, *Disability Rights Maryland*
 - Please see additional materials for written testimony

- c) Elvira Arnal
 - Please see additional materials for written testimony

- d) Nicole Briscoe, *Choice Clinical Services & Maryland Public Health Association*
 - Please see additional materials for written testimony

- e) Christina Billingmeier, *On Our Own Maryland*
 - I would like to share my experience with forced treatment and this approach in psychiatric settings. I have been receiving psychiatric care since I was 17 and I'll be 37 next month. It has often felt like something that I have not had a choice with. Even in the moments when I knew I needed help and a higher level of care, there were always times when my ability to make decisions were disregarded. Of the 8 times I have been hospitalized in the last 20 years, only 4 of those times did I feel that it was my decision. I felt for a very long time that I didn't have a choice in the type of care I received. I have never wanted to be on psychiatric medication but it has always been forced on me. My story is a prime example of the harm and trauma that can be caused when patients are stripped of their choice. It also shows how people with mental health issues are discredited and often not believed. In 2007, while on a trip out of state, I discovered that I had been blacking out. I had recently learned that seizure disorders can frequently exist alongside psychotic disorders. I was concerned and when I returned home to Maryland, I was admitted to an outpatient program. I expressed my concerns to the intake staff that I hoped they would do diagnostic work to figure out what was wrong and what was possibly going on. The staff asked me to sign myself into the hospital as an inpatient. They didn't tell me what I was signing myself in for. I assumed it was going to be for diagnostic work, some scans and a doctor looking at my issues to rule out a seizure-type thing. 10 minutes later, I found myself on the psych ward that ended up being a 2 week stay. Not once were my concerns addressed by a doctor about having seizures. My stay at the hospital was traumatic. There were several occasions where I was forced to remove my clothing in front of male guards and I was forcibly medicated without my consent or

knowledge of the medication. I know this is often seen as standard protocol but it is incredibly humiliating and hurtful. Being forced into the hospital and frequently told that I am getting the help I need when really I am being traumatized. In 2015, I voluntarily admitted myself to Sheppard Pratt. While there, they informed me that they wanted to put me on Lithium. I have a pre-existing thyroid condition and my psychiatrist had never prescribed it to me because of this. I declined and reminded them I was not supposed to take Lithium. Sheppard Pratt gave me an ultimatum; they said take the lithium or I would be subjected to electric shock treatment (EST). As I had no idea what the long term effects of EST were, I gave in and agreed to take the lithium. Immediately after I was released, my psychiatric took me off the Lithium because she confirmed it would have affected my thyroid. I am happy to say that I haven't been hospitalized in a few years and I contribute that to the community peers that I have found at On Our Own, Frederick County. They have been incredibly supportive to me. They supported me in my goal to come off psychiatric medicines and every aspect of my recovery. I urge you to listen to my story and the stories of others like me and understand the harm that forced medication and treatment can do to someone. It is often dehumanizing and often traumatizing. It instills the belief that individuals with serious mental health issues are unable to make treatment decisions on their own. Very important information like physical health conditions can be ignored. If we are to cultivate a more recovery focused behavioral health system, we really need to listen to the voices of people like me that receive these services. Thank you for your time.

- (1) Lt. Governor - Thank you, this was extremely informative. I had no idea they were still performing EST. I thought that was a bygone era.
- (2) Christina Billingmeier- Some people actually do choose this form of treatment, voluntarily. I knew a fellow patient who made that choice. It's not that this treatment doesn't work for people, it just wasn't something that I wanted.
- (3) Dr. Tripuraneni - EST is actually a very effective treatment as long as it is used for a specific condition. I guess we have this negative notion of EST because of history and the use of this in movies. Unfortunately, this causes a negative perception but EST is used for patients who are catatonic with severe depression and severe suicidal idealization and are not responsive to medication. The current EST that is administered now is very sophisticated. The patient is anesthetized and they are given intravenously, a muscle relaxer that completely paralyzes all the muscles. Then a controlled electrical stimulus is given to the brain through a special

machine. Where you are creating an electrical seizure of the brain. It is supposed to create a flood of hormones into the brain like dopamine and what it does is the huge boost of hormones helps the patient to recover much faster. It has to be used only in certain patients and it does help in patients that are totally catatonic and on the verge of decompensating to the point that they could die. It can also help with postpartum psychosis. In the 40's, 50's and 60's, EST was used for everyone. EST should not be used for everyone. It can only be given with informed consent by the patient. It can never be administered involuntarily. It is called ECT, Electroconvulsive Convulsing Therapy. The patient recovers in about 10-15 minutes.

f) Ann Geddes, Maryland Coalition of Families (MCF)

- MCF helps families care for someone with behavioral health needs. Using our personal experiences as parents, caregivers of other loved ones through support and navigation services. We have a family peer support staff of about 50 employees with lived experience. We also have administrative staff with lived experience. We have found that there is not universal agreement among our staff or the families that we support regarding involuntary commitment. I want to make that point that not all families are in agreement that this is the way we should be moving forward. Personally, I am the parent of a child who is now 32 and was diagnosed with bipolar personality disorder as a teen. When he was under 18, we did have the power to have him committed to inpatient treatment and we did this multiple times. He still talks about how traumatic the experience was especially since he was subject to the use of constraints and seclusions during his hospitalizations. He says that it has forever turned him off to getting health treatment. Indeed since he turned 18, he has refused any kind of psychological treatment and medication. We must be aware that this aversion to receiving psychological services can frequently be the consequence of involuntary treatment. After our son turned 18, we have had sporadic contact with him. We subsequently learned that over the next few years, he had multiple emergency department visits with inpatient stays. He began using illegal drugs and ultimately developed an alcohol use disorder. Despite all of this, I am concerned about the expansion of involuntary commitment. I believe that we need to focus on the provision of evidence based culturally competent informed care that is appealing to individuals and meets a person where they are at. This will take a tremendous investment and I think we need to be prepared as we look at AOT, we need to be prepared to make an investment in this kind of services. This is the

right thing to do and will both help those who are suffering from severe mental illness and their families, thank you.

- Lt. Governor - Can AOT be formulated for voluntary commitment. In a way that addresses those issues so that it doesn't force you to do what you don't want to do but it requires you to have some type of outpatient counseling.
- Ann Geddes - I just think it needs to be carefully looked at and studied. I am not an expert, I am a family member but I have heard in states where they did invest in community based services, it has been successful.
- Dr. Jones - To add, with AOT, you are talking about a person who traditionally does not want to agree to services. When someone is willing to agree to care, then there are a whole host of different types of services that are available. There are no programs that force people to do anything. You cannot force people to take medications or force them to come to appointments. If someone is willing to get care, you wouldn't need AOT ACT teams because you could get them outpatient care.
- Senator Eckhardt - the other alternative I was thinking about is the psychiatrist advance directive. I had a client one time that had been hospitalized. He had struggled with schizophrenia and his dad had been in the legislature and one of the things he requested was that he would outline what he did when he was out of control, could he get one of his therapists that worked with him back under the advance directive. In the past, to leave the hospital, you had to be signed up for that type of care.
- Lt. Governor - Maybe the term could be changed to "Advance Health Care" instead of psychiatric.
- Cari Cho - I am working with a group that is trying to make advance directives more accessible to people with mental illness and right now, one of the frustrations is - in Maryland, you have to complete two forms, one for medical issues and one for psychiatric issues. That is obviously a lot of extra work and also adds to the stigma when really, it's health. It should be one form.
- Commissioner Birrane - The forms come together, there are two signature spaces. One element only deals with physical health and the other deals with mental health. So you could have somebody who only wants to articulate advanced directives with respect to that reason alone and doesn't want to address the mental health component of it. That may be one of the reasons why but that doesn't mean you couldn't have a consolidated form.

VII. Closing Remarks:

For those who didn't get a chance to testify, please send your testimony to our email. Thank you to those who were able to testify. Thank you Mr. Ornstein and Mrs. Harris for your presentation. Thank you to the Commission.

Please visit our webpage: Ltgovernor.maryland.gov/mbhcommission