Commission to Study Mental & Behavioral Health

March 9, 2021
4:00-6:00PM

Meeting Minutes

1. **Call to order**
   Lieutenant Governor Rutherford called to order a virtual meeting for the Commission to Study Mental and Behavioral Health on March 9, 2021 at 4:00PM.

2. **Roll Call/Attendees**
   - **a.** Commission Members Participating: Lt. Governor Rutherford, Senator Adelaide Eckardt, Director Richard Abbott, Dr. Aliya Jones, Lt. Col. Roland Butler, Dr. Lynda Bonieskie, Dr. Tiffany Rexrode, Commissioner Kathleen Birrane, Director Steve Schuh, Mary Gable, Christian Miele, Barbara Allen, Patricia Miedusiewski, Dr. Bhaskara Tripuraneni, Cari Cho, Serina Eckwood & Kimberlee Watts
   - **b.** Designees: Nithin Venkatraman, Senate Designee and Tricia Roddy, MDH
   - **c.** Absent: Delegate Ariana Kelly, and Delegate Lewis Young

3. **Minute Approval**
   a. Motion to approve – Steve Schuh
   b. Second – Cari Cho
   c. Approved

4. **Subcommittee Updates**
   a. Crisis Services – *Director Steve Schuh, Chair:*
      i. We met last week, March 3.
      ii. We discussed an action plan to identify specific steps to improving the crisis services delivery system.
      iii. We heard 3 special presentations:
         1. Update on crisis related bills being considered during this year's Session.
         2. Behavioral Health Administration (BHA) and Every Mind Montgomery County on the State's plan to migrate to the national suicide hotline – 988.

a. BHA is convening a statewide coalition to assist with the implementation of 988 as the state's new suicide hotline which will become effective in 2022. This coalition will begin meeting in April.

3. Dr. Maria Rodowski from BHA on the Administration's plans to expand crisis services for youth and adolescence. We were pleased to hear about the additional resources that have been dedicated to expanding the youth and crisis services system as we often hear about the needs of this population.

iv. BHA has convened the Crisis Services Advisory Workgroup to identify ways to expand Maryland's Crisis Services delivery system utilizing best practices outlined in the crisis now model and Substance Abuse and Mental Health Services Administration (SAMHSA) best practices guide. We will continue to participate in BHA's meetings on a regular basis.

v. Next Meeting is Wednesday, May 5 at 10:00am.

b. Youth and Families – *Co-Chairs Deputy Secretary Christian Miele & Asst. Deputy Secretary Tiffany Rexrode:*

i. We met yesterday, March 8.

ii. National Alliance on Mental Illness (NAMI) MD presented on Assisted Outpatient Treatment (AOT). Their presentation included considerations of appropriate uses, successful components and challenges. With the respect to the ongoing evaluation of the danger standard, NAMI MD agrees that it is worthy to continue with discussions. These discussions have continued among the workgroup and BHA. They are considering language proposals related to the danger standard and plan to issue a questionnaire.

iii. The Youth and Families Subcommittee also received an update that the school psychology association met with Maryland Medicaid to discuss a path forward for reimbursement for school psychologist.

c. Finance and Funding – *Co-Chairs Tricia Roddy & Commissioner Brianne:*

MD Insurance Administration Update, Commissioner Birrane:

i. We have been very busy since session started. We reconvened the internal workgroups for the MHPAEA reporting bill and the network adequacy regulations.

1. We will be holding the next public meeting for each group shortly after session concludes.

ii. Our next Sub Committee Meeting will be 3/22/2021 from 3 PM to 4 PM

1. During our Sub Committee Meeting, we will have a presentation by Path Forward. Their discussion will be regarding Commercial

Insurance Purchasers and how they are currently dealing with Mental Health.

2. This presentation will be done by John Miller of the Mid Atlantic Business Group on Health and/or Linda Raines of the Mental Health Association of Maryland

Medicaid Update, Tricia Roddy:

iii. The Finance Subcommittee last met on January 11, we did not meet in February. The next meeting is March 22 at 3 PM.

iv. The full Behavioral Health System of Care Workgroup met on February 16. During this meeting, ideas were presented for potential projects the Workgroup could undertake in the next four to six months while the transition to the new ASO continues. The Workgroup discussed these ideas and some members presented additional topics of interest.

1. One potential project is a data sharing initiative between Chesapeake Regional Information System for our Patients, (CRISP) and the Managed Care Organizations, (MCO)s.
2. Workgroup members were encouraged to consider the topics discussed during the meeting and were sent a survey for submitting their project choices in writing would be provided before the next System of Care meeting.
3. The next System of Care meeting will be April 28 at 12:30.

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

i. Report from the SIM Summit has been sent back and is available on our website. SHAMSA has developed 13 recommendations to strengthen services, close gaps and continue services of care within the state.

1. We did decide to act on a couple of those recommendations during session with SB 857 and HB 280 cross filed by Delegate Pena-Melnyk. In that legislation, we would be creating a Maryland behavioral and public health Center of Excellence. This will serve as a central repository of information related to behavioral health, criminal justice and public safety. They will work to provide technical assistance to localities, foster collaboration between jurisdiction as well as the state behavioral health and justice systems and help statewide models for programs that will increase treatment and decrease incarceration for justice involved individuals.

ii. Next meeting is March 24 at 1:00pm.

5. Special Presentation

a. Policy Director of the Treatment Advocacy Center, Brian Stettin
   i. *The Need to Define "Danger" in Maryland Civil Commitment Law*
   ii. Please see additional materials for presentation

b. Commission Discussion:
   i. Pat Miedusiewski – I know this focus is on those with mental illness, what about those with co-occurring issues or substance use disorder?
      1. Brian Stettin – there are states that have a separate process for civil commitment for someone with substance abuse, but I think the data is a lot less compelling and effective in terms of making a significant intervention in someone's life in a way that civil commitment for mental illness is. In Maryland, civil commitment is only allowed when diagnosed with a mental illness.
      2. Pat Miedusiewski – Do we have any prevalence? Do we see a lot of co-occurring existence?
      3. Dr. Bonieskie – We see about 70% in the prison system.
      4. Lt. Governor – We heard testimony last week about an individual whose child was diagnosed with Bipolar Disorder and they subsequently started using illicit drugs. It is either a person trying to self-medicate or they may have started with the drugs and it induced psychosis.
      5. Pat Miedusiewski – There does not seem to be an integration here. We have a mental health court and a drug court and even the treatment we give now, we know that the providers are seeing some of these people and we are not looking at what the prevalence of that is. What do we need to do to change the system to be more welcoming to people with both? Even from a financial reimbursement standpoint that the way we reimburse also fragments how we treat and so it's not just the clinical, but we have to work together with the financial piece.
      6. Lt. Governor – We have spoken to the breakdown of what is considered physical health versus behavioral health. When you have drug court or mental health court – it's trying to bring all these factors together because that person may have an underlying mental health or substance use issue and you need break down the barriers. We're asking primary care doctors to ask about substance use and mental health. Then the question is where do we send them? To someone who specializes in mental health or substance use – I think there are going to be some new specialties.
      7. Cari Cho – There are models for both. Cornerstone Montgomery has been following the Integrated Treatment for Co-Occurring Disorders (ITCOD) model for 15 years. We have done so under

our mental health umbrella. We are not certified as substance use providers. All the research shows that people do better when you treat both disorders at the same time with the same team and you don't make one diagnosis primary. That causes an issue with insurance. But all of our staff is trained to treat both at the same time. Both courts have to treat both, there is no way around it but it is a challenge.

8. Pat Miedusiewski – We don't require that all of our providers be co-occurring capable so then we have that gap.
9. Richard Abbot – Treatment courts do deal with co-occurring in most cases.

ii. Kimberlee Watts – To Brain, where does the information about narrow interpretation come from? My office represents people in involuntary commitment hearings, and I know that last year we probably had more than 6,000 of them but only 230 of our clients were released. My second question was how does the proposed bills distinguish someone with anosognosia and someone who is in denial?

1. Brian Stettin – The point of which your office of public defenders having a case is pretty far down the chain of having someone civilly committed. So when you have that narrow interpretation that is happening at earlier points in the process, when police officers are making decisions about what they're observing in the community about the danger standard or when 911 operators are taking calls from family members describing situations and trying to assess if this constitutes or represents danger to self or others or when clinicians are evaluating those being brought into ERs and making determinations if they should go forward and seek civil commitment. At all those points in the process, a narrow interpretation is preventing those cases to getting to the point where your office is involved. We are hearing challenges of how they can't get the care they need because they were told they are not dangerous to their selves or others and to follow up when they are. That waiting around led them to be involved with your office. I have reason to believe that is happening often.
   As for your second question, how the law incorporates the presence of anosognosia or not. I didn't mean to suggest that anosognosia is in any way part of the legal determination that's made here. I brought it up only as a explanation as to why I think we are never going to get to a point where our system of voluntary care is so good that everybody is going to come flocking into it. There is nothing in the law that would distinguish whether someone has anosognosia or not.

iii. Senator Eckhardt – Thank you Mr. Stettin. We have been dealing with this since 1970. On all of the other states where they have that standard of dangerousness, what is their success rate? What is the outcome? How has it changed their system in getting people care and is it effective?
   1. Brian Stettin – Having a civil commitment standard that allows action at a sooner point in a person decompensation doesn't lead to more people winding up at the hospital. These horror stories that we hear and the folks that testified about this bill, all of them will tell you that their loved one eventually did windup on the hospital. So, what we are trying to facilitate here is earlier intervention. So having a civil commitment law is not that more people come into the system but that the same people come in sooner.

iv. Dr. Tripuraneni - The changes in the civil commitment law in the state of Maryland was long overdue and I am glad you are introducing these amendments which will go a long way in helping members who are not acknowledging the deceased process that they have and are going through this vicious cycle and revolving door and eventually they could be either homeless or going through the criminal justice system rather than getting the help at the right time.

v. Lt. Governor – I have also mentioned to legislators that the negative interactions of individuals with law enforcement in many cases is when a person is in a mental health crisis. Training the law enforcement will help but that is not their main job. So, if we can get to the person before they are in that crisis stage then we could avoid these interactions.

6. Public Testimony

a. Katie Rouse, On My Own:

Please see additional materials for written testimony

Barbara Allen: We have On Our Own wellness discovery center, (WRCs). There was an evolution of mental health centers for those that were in recovery and there was a substance use program. For me, I find that whether it's the mental health or the substance or those that are integrated, like Howard County, I think they're such critical sources for the continuum of care. If you are a loved one that has a family member and you are trying to find a connection for them, where do they go? That's a big challenge. How does the family with problems find the source of solutions? It's important to consider that wellness centers or on your own, that families can find them. Of the programs that are offered, how many of them do the co-occurring care or don't?

Katie Rouse: All of the centers in our network are independent non-profits. If they are associated with us, one of our standards are that you have a board that's at least 51% of people with lived experience. Every center is different and some of them are able to use funding sources from various places and enhance their services. All of our centers have the ability to support people who are in a

recovery journey, whatever that looks like, I think over time each center has molded it's particular menu of services and supports to the group of people that are coming in asking for help. That's the point of peer support services, it's not a treatment of goals or something I am telling you to do, it's what do you want to do? How can I help you get there? We do a lot of work helping file for unemployment and applying for benefits or looking for jobs. Whatever you need help with, we will find a pathway there.
Barbara Allen: I am not convinced that the peers always know where to send people for the appropriate care. We need these people to know that there is a peer available and how can they contact them.
Katie Rouse: There is a training program for our peer community, and it does involve resource awareness. I want to share our link onourownmd.org
Dr. Jones: I hope 211 press 1 is a resource that people know they can use as well. They can also reach out to their local behavioral health resource authority and they would know the resources available.

b. Scott Davis, Police Officer:

I am heavily involved in our crisis intervention team and I have been doing it for 18 years and 27 years total law enforcement experience. From being in ERs on a everyday basis, dangerousness is subjective in nature. It could vary to position of clinician to social worker to police officer. It is difficult to see family members bringing someone to the ER for services and the person refuses to sign the paperwork to get the treatment that they need. It's difficult to compare that with parity, I like to use the work disparity in a hospital that because I don't think people with mental illness are treated as well as someone with a heart condition or asthma. It's important for legislation to define what the dangerousness would be. If it is incorporated in law, we would be able to teach that to the recruits on an entry level as well as ongoing service training.

c. Evelyn Burton on behalf of Mary Ellen Moran:

I have bipolar disorder and have never met the danger standard for involuntary commitment. When I become hyper manic and then psychotic, my behavior is not threatening, it is weird. I slip in and out of reality. I can't safely drive a car, prepare meals or take proper care of myself and my son of 58 years old who lives with me as a result of his serious mental illness. I am not able to make a rational decision on any matter including rather to seek treatment. The danger standard in Maryland needs to be changed. I had an episode when I was visiting my sister in Virginia. She called 911 and a crisis team was sent. I do not remember most of the event, but I do remember a police officer talking me into going to the hospital. According to my sister, it took hours. I was in the hospital for 5 days, medicated until I was stable and discharged. It is concerning that some people think it violated my civil rights to have had received involuntary treatment in the

circumstances mentioned previously. I disagree. The danger standard needs to be changed so that I have the right to treatment when I need it. Thank you.

7. **Closing Remarks**

Email: mbh.commission@maryland.gov
Next meeting is May 11 at 4:00pm