



**Commission to Study Mental &
Behavioral Health**

WRITTEN TESTIMONY – July 13 2021



Stephanie S. Franklin

Ashley D. Edwards
Stephanie L. Bryant
Cherie J. Jones
L. Lydia Rose

**Commission to Study Mental & Behavioral Health
Public Testimony
July 13, 2021**

Mitchell Mirviss, Esq., a partner at Venable LLP and Stephanie S. Franklin, Esq., President & CEO of the Franklin Law Group, P.C. (a child advocacy firm that has represented children in Child in Need of Assistance cases in multiple jurisdictions in the state of Maryland since 2007), are co-counsel for Plaintiffs in *L.J. v. Massinga*, the federal class action on behalf of approximately 2,300 Baltimore City foster children and youth. We submit the following written testimony for the Commission's consideration.

A. Background

As child advocates, we have serious concerns regarding the lack of systemic mental and behavioral supports for children in foster care. Three of those concerns center around insufficient placement options for foster youth in need of higher levels of care, the over-use of psychotropic medications without proper and effective oversight, and the absence of coordinated case management of the mental and behavioral health needs of foster children that addresses their acute need for appropriate and timely evaluation and treatment.

B. Insufficient Placement Options for Foster Youth with Complex Behavioral & Mental Health Needs

Placement options for foster youth with complex behavioral and mental health needs is an ongoing problem across the State. The overstays of children in emergency rooms and psychiatric wards, because of a dearth of placement resources to address their needs, and the failure of the State to provide adequate numbers of beds to meet this population's special needs, despite advocacy at the highest levels, continues to be a point of crisis and chronic failure across the State, sometimes resulting in sending children out-of-state. This places an undue hardship on families and disrupts the kids' support systems that are necessary for their mental and behavioral health stability. As of July 25, 2021, twelve foster children in Maryland custody were unnecessarily hospitalized without medical necessity. This practice is unconscionable and has been occurring for several years. More broadly, it vividly illustrates the consequences of the chronic failure to provide foster children and youth with timely and appropriate clinical and therapeutic care. Hospital overstays are merely the tip of a giant iceberg of insufficient mental health programming.

1007 Ingleside Avenue
Baltimore, Maryland USA 21228
T: 410.788.1124
F: 410.788.1176

C. Oversight, Program Planning, & Policy Initiatives for Foster Youth on Psychotropic Medications

The State has failed to comply with its duties under §8-1102(c) of the Human Services Article of the Maryland Code. Over-use of psychotropic medications on foster youth is a national and statewide issue. These concerns have been identified through federal and state laws and policies because of the significant impact it can have on children's development. To that end, Maryland addressed these concerns, in part, by passing legislation to hire a State Medical Director for oversight, program planning, and the implementation of policy initiatives to address this critical area. To date, we have information on paper, but the implementation, practice, and policy mandates appear to be lacking. This is of grave concern as the State has an important obligation and responsibility to care for children who are in their custody.

Additionally, the information that has been provided publicly and was requested a decade ago, lacks disaggregation and analysis to be able to competently identify and target vulnerable populations with specific identified needs. This continued failure places children's health at significant risk and the State must correct its failure through a serious commitment to this issue.

C. Lack of Coordinated Mental Health Planning, Management, and Services

Nationally, an estimated 80% of foster children have significant mental health issues. (Nat'l Conf. of State Legislatures, Nov. 1, 2019). Despite the critical need, Maryland does not have an organized system of providing oversight, planning, or management of their needs. Delays in providing therapy result in placement disruption. The supply of therapists varies widely statewide, and specialized care using evidence-based clinical methodologies is often unavailable. Wraparound crisis care, long promised for more than a decade, remains a distant objective in many jurisdictions. Residential providers have not been allowed to "unbundle" their services, such that children can go off-site for more appropriate care. Frequent moves of children result in frequent changes in therapists, rendering therapy ineffective. The list of needs is great; these are just some of the many shortfalls that exist.

D. Conclusion

We urge this Commission to give considerable action to the issues that have been raised as they harm one of the most vulnerable populations in need of immediate focus across the State of Maryland.

Sincerely,

/s/ and 

Mitchell Mirviss, Esq.
Stephanie S. Franklin, Esq.
Co-Counsel, *L.J. v. Massinga*



July 12, 2021

Hon. Boyd K. Rutherford
Commission to Study Mental and Behavioral Health in Maryland
100 State Circle
Annapolis, MD 21401

RE: Involuntary Commitment Stakeholders Workgroup Report - Comments

Dear Lt. Governor Rutherford:

NCADD-Maryland submitted the following comments in support of the recommendations in the June 24th report of the Involuntary Commitment Stakeholders Workgroup. We wanted to share our comments with you as well.

Proposed Revision of the Dangerousness Standard

We support the recommendation clarify through regulations, rather than statute, the definition of “danger” for purposes of detention for psychiatric evaluation and involuntary admission to a psychiatric facility. We also support the decision to exclude “psychiatric deterioration” in the proposed definition. Just because an individual’s mental health symptoms may be worsening does not necessarily make them a danger, nor does it mean involuntary hospitalization is the clinically appropriate level of care.

Research demonstrates that predictions of future dangerousness are notoriously unreliable. Those clinicians trained and experienced in mental health treatment and interventions struggle to accurately predict future dangerousness based on psychiatric deterioration. To put that judgment in the hands of law enforcement and lay persons would be wholly inappropriate. While police officers may be able to assess, based on direct observation, whether a person is currently acting in a dangerous manner, they have no expertise to form a reasonable basis that someone is experiencing “psychiatric deterioration” which will result in future dangerousness.

Training

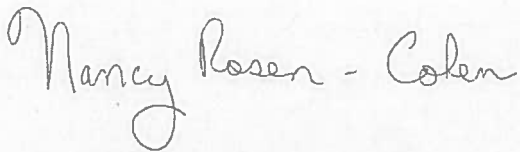
NCADD-Maryland supports the report’s recommendations for training that were made years ago in a similar workgroup’s report in 2014, but not yet implemented. The decision to use an involuntary intervention should only come after extensive consideration of all other voluntary options and the potential consequences for the person in crisis. There must be a statewide training initiative to equip the law enforcement and other relevant professionals with adequate, up-to-date knowledge of the legal, ethical, and health implications of each step of the involuntary commitment process. Maryland’s Public Behavioral Health System cannot consider itself to be “trauma-informed” without addressing this glaring deficit in protocol and practice.

Data Collection and Monitoring

NCADD-Maryland also supports the recommendation to gather additional data elements about civil commitment. We encourage the collection and analysis of this data *prior to* any substantive policy change. Given the uneven availability of crisis intervention and community-based treatment options throughout the state, and given the statistics that demonstrate a racially disparate impact of commitments, we believe data needs to be detailed, by jurisdiction, including a range of demographics, in order to inform appropriate policy changes.

Please let me know if you have any questions.

Sincerely,

A handwritten signature in cursive script that reads "Nancy Rosen - Cohen". The signature is written in dark ink and is positioned above the typed name.

Nancy Rosen-Cohen, Ph.D.
Executive Director

MARYLAND PSYCHIATRIC SOCIETY



OFFICERS 2021-2022

Virginia L. Ashley, M.D.
President

Jessica V. Merkel-Keller, M.D.
President-Elect

Carolina Vidal, M.D., M.P.H.
Secretary-Treasurer

Mark J. Ehrenreich, M.D.
Council Chair

EXECUTIVE DIRECTOR

Heidi Bunes

COUNCIL

Theodora G. Balis, M.D.
Jennifer M. Coughlin, M.D.
Catherine L. Harrison-Restelli, M.D.
Tyler C. Hightower, M.D., M.P.H.
Ronald F. Means, M.D.
Paul Nestadt, M.D.
Rachna S. Raisinghani, M.D.
Michael A. Young, M.D.

EARLY CAREER

PSYCHIATRIST COUNCILOR

Marissa A. Flaherty, M.D.

RESIDENT-FELLOW

MEMBER COUNCILOR

Karen Dionesotes, M.D., M.P.H.

PAST PRESIDENTS

Marsden H. McGuire, M.D.
Patrick T. Triplett, M.D.

APA ASSEMBLY

REPRESENTATIVES

Annette L. Hanson, M.D.
Elias K. Shaya, M.D.
Brian Zimnitzky, M.D.

MEDCHI DELEGATE

Enrique I. Oviedo, M.D.
Idris Leppla, M.D. (Alternate)

Testimony for July 13, 2021 Meeting Commission to Study Mental & Behavioral Health in Maryland

The Maryland Psychiatric Society appreciates the efforts of the Involuntary Commitment Stakeholders' Workgroup and its June 24, 2021 draft Report Refining the Definition of Dangerousness in Maryland. Our member psychiatrists are integrally involved in caring for people with severe behavioral illnesses and involuntary commitment may be the best course for some of those individuals. We agree that there are times when people are at significant risk to themselves or others, yet they are not retained. This serious problem can lead to reluctance to even begin the emergency petition process or to rely on voluntary commitment (which can result in premature discharge) when there is concern that others may interpret the statute differently. In some very heart wrenching instances, the result is tragic. The workgroup has explored what can be done to improve the outcomes for at risk patients in Maryland and drafted three recommendations.

The Maryland Psychiatric Society supports the recommendation to provide more information and training around the *current* dangerousness standard, which readily accommodates a range of gray area situations involving serious risk to the individual or others. Highly trained forensic psychiatrists generally have success with the current statute, but others with less knowledge and experience would benefit from comprehensive education in applying the law under various scenarios. This recommendation is aimed directly at the problem of understanding, which is at the root of misapplication of the statute.

We also support the recommendation to gather more data about how the current system is working. It appears that the data available are new and being revised based on current priorities. We would welcome an opportunity to partner to design a data system that can shed light on why there are a small number of cases where the system fails an individual so that effective corrective measures can be taken.

Although it is initially appealing, we disagree with the recommendation to refine the dangerousness standard in regulations. This gives the appearance of addressing the conflict between civil liberty and public safety but would not provide a comprehensive solution in our view. Even if the description of "danger to the life or safety" is more detailed and prescriptive there will still be instances when the individual is not retained but should have been.

This report does not address another serious concern, which is inadequate resources for people suffering acute mental health crises. Maryland needs more inpatient beds at both private and state hospitals. This deficiency can lead to individuals being inappropriately released from the emergency department when there is an ambiguous situation and no bed availability. We also need more specialized, high quality, community-based alternatives to hospitalization.

Thank you for this opportunity to provide input. Please contact Heidi Bunes at heidi@mdpsych.org with any questions.

Written Testimony
Erik Roskes, MD
General and Forensic Psychiatrist
Baltimore, Maryland

Note: this statement constitutes my personal opinion and should not be construed as representing the opinion of any of my employers or contractees.

I write in partial support and partial opposition to the draft of the “Involuntary Commitment Stakeholders’ Workgroup Report: Refining the Definition of Dangerousness in Maryland”. I fully support the goals of the workgroup, which is to ensure that people with serious and acute mental health problems have ready and quick access to acute care when needed. However, there is insufficient evidence that our current statute fails to fulfill this goal.

The current statute, which allows for the involuntary admission of people whose mental illness renders them dangerous to themselves or to others, is broadly worded and readily applicable to a wide variety of presentations before the police, before judges, and before clinicians. That broad wording is a strength of the statute, not a weakness. The Office of the Public Defender presented preliminary data demonstrating that almost 10,000 patients entered the involuntary admission process in 2020. Just 219 people were released at hearing. While I have deep empathy for the tragic stories presented by some of the advocates, those sad anecdotes do not indicate a systemic problem warranting a systemic response – they are outliers, not the norm.

The first recommendation should be the development and implementation of a data collection process, whereby MDH and stakeholders can learn about how this system works statewide. Only if the results of this data analysis indicate that there is a **systemic** problem resulting in an unacceptable number of false negatives (people who should have been involuntarily treated but who were not) can we know what fixes might be needed. As I noted repeatedly during the workgroup discussions, a statutory or regulatory fix may not be needed if

- there are inadequate resources for people suffering acute mental health crises (including both inpatient beds and, importantly, high quality community-based alternatives), or
- the people responsible for executing the law do not understand the law properly.

If MDH does develop a data collection process, as it should, this will need to include data regarding all of the steps in the involuntary treatment process, including data regarding

- Emergency petitions,
- The certification process, and
- The civil commitment (hearing) process.

Only by understanding how each of these steps is executed statewide can we know what intervention to implement. My hypothesis, based on over 25 years of clinical and forensic experience in Maryland, is that training and an improved spectrum of hospital and community-based resources will go a long way toward ensuring that people who need treatment get it, while also ensuring proper protection of the civil liberties of those potentially subject to involuntary treatment.

Thank you for the opportunity to comment.



mdlogix - home of bhworks software platform

Saving Young Lives Through Collaboration & Technology

Written testimony submitted July 6, 2021

by Allen Tien, MD, MHS

to the

Maryland Commission to Study Mental & Behavioral Health

I submit this written testimony to the Commission as a long-time Maryland resident, as a psychiatrist and public health scientist who previously worked at Johns Hopkins, and as a now 24-year, Baltimore-based business owner of [mdlogix](#). However, most importantly and urgently I come to you as the father of three adult sons who also reside in Maryland.

The final wave of the COVID pandemic is an unprecedented mental health crisis among youth and adults. I know it and you know it. The time to bring study and action together is now; particularly with children and teens returning to school full time in the fall. Each day we wait to take substantive action, we will lose a few more lives.

On average one person died by suicide in 2018 every 13 hours in Maryland. The total deaths to suicide reflected a total 12,229 years of potential life lost before age 65 [Source: [afsp.org](#)]. The pandemic has already increased what was already a rising rate of [youth depression](#), [[teen testimonial video link](#)] anxiety, and suicide attempts and deaths. That is unacceptable, and I have a working solution to be deployed immediately.

I propose Maryland adopt a statewide collaborative K-12 schools model layered on top of a comprehensive, validated, technology infrastructure to enable seamless communication among care providers and to provide best practices and scope of practice procedures to ensure they are followed. It is being successfully used in Pennsylvania, Michigan, Kansas, several California counties, and other locations.

Collaboration

First let me talk about collaboration. The Behavioral Health Learning Collaborative (BHLC) of Michigan, [bhcofmi.org](#), for example, is actively enabling school districts, child and adolescent health centers, state and local governments, social service agencies and healthcare organizations to seamlessly work together to identify and support students at risk for behavioral health issues. The BHLC shares best practices as well as technology, training and other resources to help lead this effort. A similar collaborative involving Pennsylvania's Student Assistance Program (SAP) has been in action since mid-2020, [bhcofpa.org](#).

Technology Infrastructure: bhworks

Second is technology. My company's software platform, [bhworks](#), can be accessed from any web-enabled device, providing organizations with the tools they need to deliver behavioral health services anywhere people live, work, study, or receive care. With easy to use features that streamline screening, care coordination, and outcomes reporting, bhworks has been leveraged to address behavioral health issues in a range of settings – from hospitals, primary care facilities, and local health departments to K-12 schools and universities, community organizations, and workplaces.

bhworks is one of the leading statewide behavioral mental health platforms. It allows providers to save time, work more effectively, collectively follow evidence-based standards, and leverage best practices.

K-12 Schools

Team mdlogix works as collaborators with school psychologists, school counselors, school social workers, school nurses, pediatricians, educators, community mental health professionals and more, to make a dramatic difference in behavioral mental health by disrupting the usual dysfunctional communications silos and using technological innovation.

Our bhworks platform enables school districts to obtain consents and screen whole populations with high accuracy, efficiency, and reliability, help with Social Emotional Learning (SEL) assessments, offer referrals, communicate via virtual visits, and securely collect data to see outcomes in real time and adjust resources and concentrate funding as needed. It can enhance Multi-Tiered System of Support (MTSS) programs. The platform software tools adhere to all required data security measures (HIPAA and FERPA compliant).

Michigan

Michigan is offering bhworks to all 56 of its Intermediate School Districts (ISDs), potentially reaching 1.5 million students.

"Our plan has been to give each student who needs help the opportunity to express their feelings with no judgment or stigma, to do so in a statewide coordinated effort, to offer the best care, and immediately monitor local and state outcomes," said Diane Golzynski, PhD, RD, Director, Office of Health and Nutrition Services, Michigan Department of Education in [an mdlogix news release](#). "By implementing this technology infrastructure, we advance the vision the department, bi-partisan state legislators, educators, and health providers made as a youth priority prior to COVID, and which is now even more critical. Michigan can help guide other states that need a defined, collaborative process with their schools as the foundation and the software management platform to carry all of it out."

Pennsylvania

With the help of Drexel University's Center for Family Intervention Science, mdlogix has been helping Pennsylvania utilize bhworks in various clinical and non-clinical settings since 2008. In 2013, the state began providing bhworks to any Student Assistance Program (SAP) team interested in using the tool. Since then, they have screened more than 110,000 students and over 4,800 students were found to have suicide ideation, 31,521 had moderate or severe signs of depression, and close to 30,000 showed signs of anxiety. They were given access to the appropriate services and monitored.

"This generation and their willingness to use technology to communicate is very different from what they would ever convey in person to an adult," said Kirsten Johnson during a June case study interview. She is with the Dover Area School District in Pennsylvania where they are employing universal screening. Her district has emphasized and repeated the message that students' mental health is as important as their academic success.

"Kudos to this system," added Kirsten, director of social work services. "It has altered how we meet the needs of students. It's providing important data, allowing us to move forward in social and emotional learning. Plus it conveys the importance of student mental health in partnership with families."

Generates Real-Time State Data for Research and Services

Of particular interest to any state government is the ability to collect and review data in real time. It's important to conduct research, to determine next steps and where resources are needed, and to show the efficacy of dollars being spent. Outcomes monitoring and progress is a critical component to the system.

I would be happy to answer any questions the commission may have. We have been tirelessly working to make Maryland government agencies aware of our solution, including the Maryland Dept. of Health and the Dept. of Education. As a Maryland-based company from our start in 1997, we don't understand why our state has not responded to us the way Michigan, Pennsylvania, Kansas, and Alabama state education and health leaders have, as well as California counties, and many others. Let's change that situation.

Allen Tien, MD, MHS

President and Chief Science Officer

Medical Decision Logics , Inc. [*known as mdlogix*]

Towson, MD

allen@mdlogix.com

443-224-8429

Note: *one attachment describing the BHLC of Michigan. Maryland could have a BHLC and use the bhworks technology to successfully manage youth mental health issues*