

# Commission to Study Mental & Behavioral Health

July 13 2021

## 1. Opening Remarks

### a. Lt. Governor - Introduction

- i. This is our first in-person meeting in over 16 months. Not having in-person communication or in-person meetings adds to the challenges of isolation, mental health and substance abuse. It did, though, offer opportunities through technology for virtual meetings, allowing for more individuals to meet while at differing locations. As I mentioned, we have to balance these virtual relationships with social interactions. We are sociable beings. It is clear that the pandemic exacerbated challenges for citizens. Many are aware that a large number of people who received treatment for substance use disorder suffer from mental health issues. In 2019, we saw a decrease in overdose fatalities. However, in 2020, it increased by 18%. Between January and March of this year, it was up 5.7%. We know there has been an impact on individuals from isolation. For this reason, we launched about a month ago, the Maryland Stop Overdose Strategy, or Maryland SOS. In this fiscal year, we have put forward four million dollars in grants to support initiatives in each jurisdiction of Maryland to focus on prevention and treatment. This summer, the opioid operational command center will be holding regional town hall meetings to hear from communities. The data collected will give us a clear picture of the connection between mental health and substance use disorders. The command center and department of health are collaborating on data informed risk mitigation. Analyzing this process will examine treatment history, overdoses and types of treatment that certain individuals had. This information will help identify factors that can lead to increased risk of overdoses. Dr. Jones and Mr. James Yoe will walk us through the demographics of health outcomes for those who have died from opioid overdoses

- ii. I would like to highlight a few findings from the work. We've found that individuals who received medical services in the public behavioral health system within 30 days before their death were more likely to have also received medical services with substance use disorder services. 70% of those who died from an overdose had an interaction with a Maryland hospital in the four years before their death, and 60% of people who died from an overdose were prescribed a controlled substance at some point in a 5 year period. We hope this collaboration will lead to new insights to helping individuals.
- iii. I will move on the formal agenda.

## 2. Roll Call

- a. Commission Members Participating: Lt. Governor Rutherford, Senator Adelaide Eckardt, Delegate Lewis Young, Director Richard Abbott, Tricia Roddy, Dr. Aliya Jones, Lt. Col. Roland Butler, Dr. Tiffany Rexrode, Commissioner Kathleen Birrane, Director Robin Rickard, Mary Gable, Barbara Allen, Christian Miele, Serina Eckwood, Kimberlee Watts, Delegate Ariana Kelly and Dr. Bhaskara Tripuraneni
- b. Designees: Nithin Venkatraman, Marianne Gibson
- c. Absent: Patricia Miedusiewski, Dr. Lynda Bonieskie, Cari Cho

## 3. Minute Approval

- a. Motion to approve – Dr. Jones
- b. Second – Senator Eckardt
- c. Approved

## 4. Subcommittee Updates

- a. Crisis Services – Deputy Director Marianne Gibson
  - i. We met last Wednesday, July 7th.
  - ii. We heard 3 special presentations:
    1. First from Susan Cromwell, the senior director with the Sheppard Pratt health system.
      - a. We learned about their residential crisis model, which includes 24/7 on site staff assistance and intensive case management linkage to peer support. It was also mentioned that Sheppard Pratt's residential services are co-occurring capable and that 60% of their population had been diagnosed with a substance abuse disorder. The on-site support offers prescribing naloxone, offering on-site recovery support meetings and linkage to community providers.
    2. Next, we were joined by Frances Duru and Christine Stanley from People Encouraging People (PEP), a non-profit organization.

- a. We are mainly concerned with learning about FACT teams. PEP operates in five different jurisdictions, Each ACT or FACT team is multi-disciplinary and offers mobile evidence-based care for behavioral health conditions. Each FACT team has 10-12 people that work with a large variety of partners such as the public defender's office, law enforcement and judges. FACT teams are designed to improve behavioral health outcomes and daily functioning by addressing risks that may lead to criminal behavior and diverting individuals in need of treatment away from the criminal justice system. There is currently only one FACT team in the state, which is in Baltimore city. There is discussion about expanding more,
  3. Last, we heard from Johns Hopkins University regarding their behavioral health crisis response program. It was created as part of our recommendation by the task force on Student Health and Well-Being. The goal is to assess how the university responds to behavioral crises. This pilot will pair mental health practitioners with security officers to respond to these behavioral crises. They're hoping to launch this program this fall.
  4. Our next meeting will be September 1st at 10:00am.
- b. Youth and Families - Christian Miele
- i. We met yesterday, July 12th
  - ii. We were joined by two presenters, Senator Katie Fry Hester and Maria Rodowski Stanco.
    1. Senator Fry Hester's overview focused on the current state funding stream used to support MBH's system. The senator also gave us a summary of SB 299, SB 857, as well as an overview of other pieces that impact mental and behavioral health.
    2. Maria Rodowski Stanco from BHA discussed their child and adolescent crisis system update. That's something that our subcommittee had begun discussing at some of our recent meetings. We feel it's very timely and we're looking forward to seeing what work can be done through this stream of grant funding. Our subcommittee has spent much of the year looking at the involuntary commitment and dangerousness standard and that BHA has been leading an effort to explore this issue through the formation of a stakeholder work group to make policy recommendations. Just recently, the workgroup issued its draft report which was disseminated to stakeholders for feedback and comment and a final report will be circulated by the end of the month. There were three chief recommendations in the draft report which include clarification of dangerousness, training for better

clarity of the definition, and then data collection and monitoring. We also received an extensive breakdown of each state's dangerousness standard, as well as the emergency petition process related to that.

3. At our next meeting in September, we're going to be reviewing that, as well as discussing among some committee members whether a consensus can be reached in terms of supporting some of the findings of the stakeholder workgroup.
- iii. Our next meeting will be announced soon.

c. Finance and Funding - Patricia Roddy & Joy Hatchette

- i. Patricia Roddy - June 30th of last month we submitted our Health-Choice 11-15 waiver renewal application. The renewal application generally allows us to maintain our managed care program under Medicaid, but we added one really exciting new component to our waiver application. Specifically, it allows us to cover institutions for mental disease for adults between the ages of 21 and 65. We've talked with this group before about how the federal prohibition doesn't allow Medicaid to pay for services for adults while they're receiving services in these institutions. We've had waivers over the years; CMS's policy has changed recently, so we are asking CMS to allow us to cover adults in those institutions between 21 and 65. We originally asked to cover two non-consecutive 30-day stays. We heard from stakeholders both in this commission work group as well as other public hearings that stakeholders wanted us to ask for the flexibilities that other states received where we cover an average of 30 days for the total program, so we went ahead and made that change to the waiver application. We are looking forward to CMS's approval of the application with a January 1st start date. Secondly, around the system of care, we've been meeting internally and regrouping to make sure that we have the appropriate goals in place for the next several months.
- ii. Joy Hatchette - We're continuing our work on the mental health parity regulations and once we finish drafting those we will have an opportunity for the public to comment. The next major thing that we're working on are the network adequacy meetings. We've had two recent meetings; one really focused on basically the standards the amount of travel distance the appointment wait times and things of that nature. That meeting was held back on May the 28th. Then, we had a second meeting on June 18th that focused on telehealth utilization. Because of the pandemic, a whole lot of focus has now shifted toward telehealth and the importance of making that available. The final thing that I want to mention, on July the 18<sup>th</sup>, we're going to be holding a town hall that's going to be focused on credentialing. We have heard a lot of the providers indicate that they have issues and concerns about their ability to get into different carrier networks, so we

want to have an opportunity to listen and hear what some of those issues are and see if anything that can be done.

iii. That's going to be held on July 18th.

d. Senator Katie Fry Hester - Public Safety

- i. We've had two meetings and continue to follow on the recommendations for the state summit on mental behavioral health. Some of the leading recommendations had to do with investigating peer support specialists and also the availability of housing.
- ii. At our last meeting, we heard from three specialists in peer support services. Laurie Galloway, executive director of On Our Own in Carroll County. Richard Lewis, a peer support specialist from the eastern shore crisis response. And Katie Rouse, the executive director of On Our Own Maryland. We learned that on the individual level and how it includes advocating for people in recovery, sharing resources, building skills, building community relationships, leading recovery groups, and monitoring goals. Peer support specialists operate in three settings in the community: wellness and recovery centers, rehab programs and inpatient facilities, and in crisis settings.
- iii. We're also joined by Jim Hendrick from the Governor's Office of Children, Victim Service and Crime Prevention to give us an update on the behavioral health and public safety center of excellence. They're looking at implementing the statutory requirements according to that office and looking at how to structure the center of excellence so it meshes well with the existing CIT center of excellence.
- iv. The next step, in terms of the grant we received from SAMSA, will be to implement the Train the Trainers program on the SIM's intercept model. Looking ahead to our next meeting the next topic will be improving housing and accessibility.
- v. Our next meeting will be Tuesday, August 10th at 3 p.m.
- vi. Lt. Governor - The peer recovery specialists, are they working both with substance use disorder individuals as well as those in the mental health area?
- vii. Dr. Jones - They're predominantly found in the substance disorder phase. However, they are also utilized on the mental health side and there's more funding generally for the substance use. Its limited usage is predominantly on the mental health side. You have peer recovery specialists that work with the assertive community treatment programs, all of which have to have a peer that is on the team, which is a requirement for operation. In general, we would all like to see a greater expansion of peer review in other behavioral health treatment environments. There's a whole peer recovery infrastructure that is predominantly community based, not

necessarily attached programs. We'd like to see expansion into programs to introduce people who don't know about peer recovery supports.

**5. Special Presentation - Dr. Jones & James Yoe, Data-Informed Risk Mitigation (DORM) Report**

- a. Please see attached documents for the presentation
- b. Discussion
  - i. Lt. Governor - Students tended to use more services over time both on the mental health and on the behavioral health side before an overdose can happen. It sounds like our services aren't working.
  - ii. Dr. James Yoe - I think that's part of the discussion what can be done to engage those folks differently, particularly those with dual mental health and substance use issues. This decedent group is far less than one percent of all folks in the public behavioral health.
  - iii. Lt. Governor - We saw a presentation over a year ago about the fact that those who suffer mental health use more acute care services than others. These are individuals who have either one or co-morbidities are using one service and are still dying.
  - iv. Senator Eckardt - Is there any way to sort out what are the true suicide attempts from overdoses?
  - v. Dr. James Yoe - We don't have data that sorts that out. We have suicide data and we have the overdose intoxication data. Sometimes a portion of those deaths that get recorded as overdoses are also suicides. Something we are thinking about and trying to figure out is how we can nail that down. We are attempting to be able to get more definitive data. We are doing some work to match up the suicide data with the public data.
  - vi. Senator Eckardt - How does this data compare to other states? Because any differences might lead us back to that question of, "How does our policy positively or negatively affect outcomes?"
  - vii. Dr. James Yoe - States are collecting the data in different ways. We have some challenges to really match that up correctly, but I think that's another avenue to look.
  - viii. Dr. Jones - There's a general conception that people who have dual diagnoses have worse outcomes. This isn't established. I don't think that our outcomes are necessarily worse, but again, we don't have any point of reference other than we have a really good infrastructure for the treatment of conditions including substance use disorders.
  - ix. Dr. James Yoe - It would be interesting to engage with a few states to see if we could do a joint project around this data.
  - x. Senator Fry-Hester - Do we have any mechanisms for tracking when people stop using the services and checking in?
  - xi. Dr. Jones - That's something that's missing within our public behavior sector in general healthcare. That is an opportunity. In the last slide, we

talked about opportunities. One of those opportunities is around a system of care coordination. Tracking, monitoring and following someone as they enter and leave care is very important. Having that connection to at least to engage them to try to get them back in services is paramount. That's definitely something that's lacking in our current system. I would be happy to talk about getting a pilot program in that area.

## 6. Public Testimony

- a. *Speaker 1, Chris Compton* - I was asked to attend this meeting by my good friend Christian Mealie. For my testimony, I wanted to talk about what has helped me in order to pay it forward and help the next person. I have battled with depression, alcoholism and addiction. I am now coming up on nine years of sobriety. This would not have been possible without my wife, my family and the great people at Celebrate Recovery. Men and women of all backgrounds, professions and regions across the country gather at different times and places during the week to celebrate their steps. They come together to celebrate not only their small victories, but their common understanding that we all suffer from hurts, habits or hang-ups. The model is a shared meal for the first hour. This is followed by a live band singing and giving praise. During the time of live music, between songs there's a handout of sobriety chips along with other readings of bible verses intertwined along the way. What I found to be the most powerful part of this weekly event is the 15 minutes at the end of the music portion where someone provides their testimony before the last song. The first time I arrived, the gentleman stood up in the auditorium and mentioned about what he was addicted to. His story from beginning to end was so powerful, that the impact of it made me want to come back again and again. After that time, we would break off into small groups. At my first session, in men's addiction group, I had my head down in the back and the person leading the group said "young man in the back", and it looked exactly like my grandfather, who I hadn't seen in 27 years as he's been deceased. He said "you still have your whole life ahead of you, you still have time to get on the right track". I texted my only roommate from college and I said "this is the greatest thing that I think I've ever attended". I realized some people are not as lucky as me. I feel a responsibility now to help the next person.
- b. *Speaker 2, Lucian Parsley* - I am from Disability Rights of Maryland. We are the protection and advocacy center for persons with disabilities for the state. We're here to thank the work group and urge your continued support for people with mental illnesses and related behavioral health disabilities. We support the recommendations in the proposed report. We urge the workers to proceed carefully, as it considers how changes should be made. Specifically, we support the recommendation to promulgate regulations around the definition of the danger standard for involuntary commitment. We believe the goal for emergency and voluntary commitment should be protection of the safety of individuals in crisis,

as well as the safety of others. We support the decision to exclude psychiatric deterioration in the proposed definition. We support the increased use of community-based services including ACT team services and peer support services. In our experience, people will be more likely to engage in treatment and services if they are part of that decision to engage in services. We also support the recommendations for widespread training and also for gathering additional data. We note that the data that was presented by the office of the public defender shows that the vast majority of individuals proposed for involuntary commitment are retained at hearing, which is nearly 10,000 Marylanders per year. The OPD data also indicates that black Marylanders are more likely to be in for an emergency evaluation and more likely to be retained in hearing when compared to white individuals. This disparity mirrors the national data. Black individuals are on average up to four times more likely to receive a schizophrenia diagnosis. Any revision to Maryland's involuntary commitment process must take into consideration these disparities with an eye toward reducing inequities.

- c. *Speaker 3, Dan Martin* - I want to thank Dr. Jones and the behavior health administration for the inclusive process that was spoke on earlier. There are behavioral health providers and professionals, legal rights groups, hospitals, local system managers, and individuals with lived experience and families were all part of this inclusive process. The results and the recommendations is a good compromise. Everyone had a chance to be heard and we certainly support the calls in the report for increased training and data collection around these issues. We have doubts about the need to define danger so specifically. We do want to thank the behavioral health administration for rejecting in that report it include a psychiatric deterioration standard. We couldn't support such a standard because we think it would subject an overbroad population of Marylanders to involuntary commitment. Just because someone's symptoms may be worsening doesn't make them a danger, nor does it mean that involuntary hospitalization is the appropriate level of care. Predictions of future dangerousness are notoriously unreliable. Studies have shown that clinical assessment of future dangerousness are highly inaccurate and if mental health professionals would struggle to predict future dangerousness based on psychiatric deterioration, it seems obvious that law enforcement would certainly perform worse. I want to make it clear that there's no one organization, no one group of advocates that speaks for all family members. My sister-in-law has dealt with schizophrenia and worked and battled and lived with schizophrenia for years. It's been challenging for us how often she's involuntarily committed to the hospital because she's been determined to be a danger to herself or others. Even with medication, just by the nature of her illness, she is literally always at risk for psychiatric deterioration, again just because of the nature of her illness. She would be horrified and scared if our law allows someone at some point to petition her for involuntary hospitalization against her

will just because they feel that her symptoms are worsening and that she may become a danger to herself.

- d. Speaker 4, Katie Rouse - I'm the executive director of On Our Own Maryland and on behalf of the more than 6,000 people who find support at one of our wellness and recovery centers throughout the state, I just can't tell you how exciting it is to hear you all talk about peer support with passion and to see us as partners in making our system better. On Our Own Maryland participated in an inclusive process with the BHA and voluntary commitment stakeholders work group and we strongly support the recommendations of the report specifically to restrict involuntary treatment to recent relevant and reasonable threats to safety to implement statewide training and to begin that process of centralized collection and active analysis of the data related to emergency petitions and involuntary hospitalizations, specifically with an equity lens. Scattershot doses of emergency treatment delivered through a few days at a hospital stay can save lives, but it has little influence on the perpetuating factors that drive most crisis cycles. But, there are ways to integrate and to optimize voluntary choice even if crisis is part of your cycle, like, through a crisis plan or psychiatric advance directives. When it comes to involuntary interventions we know that our system is far too noisy and that it costs us dearly whether you measure it in the trauma and destruction experienced by peers and their loved ones in the continuing disparities for communities of color and marginalized peoples. Without a centralized way to establish expectations and measure outcomes what we're vulnerable to is biasing our system with potentially calamitous changes based on anecdotes or assumptions that confuse symptoms with safety. Our dedicated behavioral health professionals and our public servants deserve to be properly equipped with the knowledge of the basic precepts, the real harms are the high costs and the long-term consequences of involuntary practices. Maryland's behavioral health system can't truly consider itself to be trauma-informed and person-centered without us addressing these gaps in our protocol and our practices. So, as to the weight of the need to establish a baseline through training and data, the whole working group agreed that this reading was true. We urge you to adopt the report's recommendations and thank you so much for your support and you're listening.
- e. Speaker 5, Adrian Bridenstien - Like my colleagues before me, we too just want to offer our thanks to the behavioral health administration for the inclusive and collaborative process to develop the involuntary commitment report. We were one of the agencies that were also involved with helping to develop the recommendations. It is not easy to bring passionate advocates together around consensus. One of the things I do think that all of the advocates agree on is that when involuntary engagement is used, it does represent an opportunity to improve our system of care and does represent that when people have not been well served by the public behavioral health system. We offer our strong support for the

recommendations that are included in that report. One of the things that we find most valuable are the data elements that we have to look at which are looking at emergency petitions and then the end result of those emergency situations. From a systems manager perspective, that is data that we can use to show if we're being more accountable to the people that we're here to serve and we can look at it at the aggregate and the system level to assess for that. It can also provide us an opportunity to look for where there were missed opportunities to better serve those people. One of the things that I do think is important to note, until now we still don't have access to that data, so we're looking forward to working with the behavioral health administration to put the systems in place to better collect that data. As we look at policy reform, whether it's at the statutory level or regulatory level, we do think it's important to look at this data. In particular the data elements that are part of these recommendations before making any type of regulatory change

- f. Speaker 6, Stephanie Franklin - See attached Testimony
- g. Speaker 7, Anne Geddes - I'm with the Maryland Coalition of Families. I'm here to express our support for the recommendations of the involuntary commitment stakeholders work group. I'm not going to repeat all the comments that the advocates who preceded me made. We agree that psychiatric deterioration should not be included in the definition. We agree on the need for comprehensive training and the collection of data. The only thing I want to add is that we really believe that the process that informed the report was inclusive, thorough and well balanced. We especially appreciated the opportunity to present on the personal experience of one family who found that involuntary commitment did not promote the recovery of their loved one, but hindered it. We want to emphasize that many family members value self-determination and the protection of civil liberties. What they want is for their loved one to have easy access to a wide array of quality appealing and readily available mental health treatments and community supports.
- h. Speaker 8, Brian Stinton - I'd like to express my disappointment with the outcome of BHA's involuntary commitment stakeholders work group which was convened to advise BHA on the need to define danger to self or others in Maryland law. BHA will soon be presenting a report to this commission purportedly based on the deliberations of this work group, which, I was grateful to serve on you may recall at the last commission meeting you heard from me and many Maryland families who were distressed at the clear signals coming from BHA that they did not intend to include in the definition of danger to life or safety language, making clear that an individual at risk of suffering psychiatric deterioration that is permanent harm to the brain is dangerous to themselves. You will recall the

testimony of these many parents and siblings that the tragic outcome suffered by their loved ones could have been avoided had only they been able to get help on the basis of psychiatric deterioration. Since that last meeting, BHA has distributed to the work group a draft of the report they intend to send to the commission later this month, and it's not going to include psychiatric deterioration language in their proposed definition of danger. Secondly, the BHA is recommending that the definition of danger be promulgated by health regulation rather than enshrined in statute. I'd like to make clear that my sadness over this goes far beyond not getting the result that I and others had hoped for. Compounding the frustration is that the draft report leaves those of us calling for a psychiatric deterioration standard feeling unheard. The report quickly dismisses psychiatric deterioration as a proposal to authorize civil commitment of non-dangerous individuals. What we have argued is that an individual at risk of psychiatric deterioration in the absence of timely treatment represents a danger to their own life and safety. We base this argument on copious research demonstrating that extending the duration of untreated psychosis results in physical brain damage and significantly diminishes an individual's prospects for mental health recovery. Our contention all along has been that an individual who suffers such harm due to non-treatment is categorically less equipped to maintain their personal safety and avoid life-threatening hazards than someone whose brain function was preserved through timely treatment. With respect to Dan Martin's comments, the idea here is not to predict future danger based on current loss of brain function, it is to identify that loss of brain function as a danger in itself, something to rescue a person from and there's nothing speculative about it. If BHA rejects this line of argument, their report should at least engage with it and explain why it's been found unpersuasive. Instead, the draft report constructs and easily knocks down a straw man by framing the case for psychiatric deterioration as being untethered to any concern for the danger to self or others. Similarly, BHA's explanation for recommending a definition of danger by health regulation rather than statute does not engage at all with the arguments advocates have put forward as to why a statutory definition is needed. For these reasons, I sincerely hope the commission will look beyond the forthcoming BHA report and recommend that Maryland recognizes psychiatric deterioration as a form of danger to self and enshrine this standard in law not in regulation.

- i. Speaker 9, Evelyn Burton - I want to thank the Lieutenant Governor especially for his clear and strong interest in helping families overcome these barriers to care. We are extremely disheartened at the proposed danger standard language once again. The process seems interested in compromise and not solving the problem of barrier to care for families. Never once during the whole process was a proposed standard looked at in terms of the many family testimonies that I submitted to analyze if this danger standard helps these families. In many cases, it would not. Even when I pleaded with them to look at the case of the Logan

family, whose son was psychotic, turned away from the ER even though they said he needed hospitalization, he refused. They couldn't put him in because all he had was psychosis and ended up killing two sheriffs. That was greeted with silence. There was no consideration. By refusing to put in psychiatric deterioration, they're basically condemning these people to a life of psychosis. I'll just mention this one family where the individual has now had, in a course of eight months, 17 emergency department visits, two crisis evaluation center visits, 11 hospitalizations, most of them voluntary, but refusing to take medications once she's in there while still experiencing psychosis. She not only meets the current danger standard, but would not meet the proposed danger standard. This has resulted in 115 days of various hospital stays and in the past seven months at a cost of over two hundred thousand dollars. One of the arguments the department used for not putting in psychiatric deterioration was the system couldn't handle it. The system can't handle refusing to take these people to a commitment hearing get them the proper medication, and get them on the path to recovery. This individual had previously many years ago been hospitalized and voluntarily given the right medication and for 12 years was stable in the community, but that's not happening now. The process is the same as it's been. There's all these groups who aren't dealing personally with the issue. They don't see the problems, they're not willing to listen to the families and they're not willing to look at the testimonies. I agree with Mr. Stinton that especially after this experience, I would like to see it in statute. I feel very uncomfortable with just regulations after seeing this process that it could be changed every year on the whim of the administration. My families want to be able to sit down with legislators and talk to them and tell them their story and get them to understand the agony and hardships that families are going through. They can't do that with administrators who are not responsible to the families.

- j. Lt. Governor - we do have legislators on this commission and they are all free to write legislation. They would be willing to hear your thoughts.

## 7. Discussion

- a. Lt. Governor - I'll take the liberty of pointing something out that I saw in the Washington Post over the weekend. Are we seeing a lot of staff shortages as was reported in the Post? Are we approaching that in any way?
- b. Dr. Jones - They're having a lot of problems with aggressive behavior. People are feeling unsafe. 104 people resigned in four weeks. There's obviously opportunities, but that's not an issue that we're dealing with at the moment, but we are trying to make sure that people have what it is that they need to continue to provide services and care.
- c. Lt. Governor - I just wanted to bring that up. I am shocked to see the potential closings

- d. Senator Eckardt - We can put the best system in place but if we don't have the staff to stop the crisis to be able to run more intensive care that may be required. Is that going to be an issue?
- e. Dr. Jones - The behavioral health workforce is strengthening. Is there a sufficient behavioral health workforce? I don't think that any of us in the behavioral health space would say that the workforce is as robust as we likely need it to be. We certainly are doing more to provide scholarship support to help encourage interests and behavioral health fields. We are providing supports through growing our peer recovery specialist workforce and also other providers as well.
- f. Senator Eckardt - There are less services now than I've seen in many years. In my career, I've been in psychiatric work and worked in the state hospital for over 40 years and it seems to me we have less resources now than before. So, I'm just concerned that if we want to have a state-of-the-art system we really need to be focusing on workforce. We're trying to recruit people in high school and young adults into the field of health. Then, how we get folks to begin to branch out and specialize into the upper level services?
- g. Dr. Jones - Psychiatry has always been one of those fields where very few people choose.
- h. Dr. Tripuraneni - Unfortunately this has been a nationwide problem, not just the problem in the state of Maryland. Especially within psychiatry the biggest challenge is to find psychiatrists in child psychiatry because of the two years of fellowship training and hardship. We can hardly find any child psychiatry which unfortunately impacts the mental health care of the children and the adolescents who are most vulnerable to mental health issues. We find it also very difficult even within our organization to be able to recruit and retain psychiatrists.
- i. Dr. Jones - You can't just create doctors just like that. That's where it becomes important to look at the entire workforce in that collaborative care and I'm giving general practitioners the supports that they need to effectively manage treatment and that's where you look at measurement-based care. You can effectively monitor someone's progression through their course of treatment and make adjustments and or referrals so that you really are saving the psychiatrist for those who really need to see a psychiatrist. What we're seeing is that most people see the psychiatrist then they never transition back to their primary care doctors. Psychiatrists are limited to how many people they see, so having a different model of using collaborative care and really helping people in looking at creating that hub for behavioral health will increase the bandwidth of the number of people that psychiatrists can treat.
- j. Senator Eckardt - Many of our candidates are now putting together teen mental health initiatives or aid groups who are looking at the resources in the county because we've seen an increase in teen crime and then we don't have enough resources to be able to do the assessment. With the pandemic, it's aggravated. We're getting a lot of information across the board that we're having increased

anorexia in our youth population and other issues that are going to have to be addressed in the future.

- k. Senator Fry Hester - It seems this workforce issue cuts across all four of our subcommittee and all of our counties. I just wonder if given the increased need of mental health right now if there's anything going on at the state level to really take a deep dive into the workforce issue, because I recall that there were several bills looking at scholarships and nursing and therapy and different things, but I haven't seen a list of recommendations on what the state should be doing to increase providers in this area and it might be the short term, then longer-term solution. Just curious if anybody knows there's anything going on to address the workforce at this point in time?
- l. Lt. Governor - I have to go back and look and talk to on our higher education commission. Also, look into the apprenticeship programs, such as the department of labor's certification programs. But you're right, I am not sure if there are scholarships available.
- m. Senator Eckardt - We learned at our economic regional council that there's a pot of money cut out of the federal budget to workforce development. We were thinking about our community health workers as a way to get entry into a lot of the minority populations so that we can begin to grow indigenous workers and start with community health workers because of the resistance to the vaccine. So, there is money available that can be used down through the counties that would train the trainer and reimburse those folks and people can get paid while they're taking that training. I think if there's a way we can kind of pull all of that together and focus and make some recommendations, communities can bubble that up to be able to coordinate it.
- n. Delegate Lewis-Young - I think there could also potentially be some practice issues that could be looked at like any other medical profession specialty, whether it's dentists or optometry, from time to time we look to see could we be doing things more efficiently by giving a greater scope of practice, particularly for fundamental or routine issues to a psychologist versus a psychiatrist or a social worker. It's a controversial subject but it's definitely given the shortage and the crisis current worth of examination.
- o. Lt. Governor - That's a good point. The state has already done that registered nurses can do more things than some other states allow them to do. Sometimes the physicians are opposed.
- p. Senator Eckardt - As we move forward, one of the optimistic initiatives on the horizon is working in the interdisciplinary model in the community. That's the benefit of being in a facility and working, because patient psych requires a doctor, nurses and social workers and nutritionists, you get that coordinated team. We have a lot of practice initiatives around that team that I think will make a big difference moving forward and it also provides that kind of opportunity.
- q. Lt. Governor - Maybe each of our subcommittees can take a look at this issue of workforce. As Senator Hester said, it does cross over these areas. It would be

helpful to bring in members from different boards along with social workers to talk about their capabilities that may not be utilized.

- r. Senator Eckardt - Important questions to ask would be what kind of regulatory relief you need, what kind barriers do you see? All those issues may be helpful for us to hear as it impacts recruitment.
- s. Lt. Governor – Members, of course thank you for the presentation. I thank all those who testified. Thanks everyone being part of this. Our next meeting September 14<sup>th</sup>.