

HB0018: Medical Cannabis – Certifying Providers

For the purpose of altering the definition of “certifying provider” to include certain physical therapists, psychologists, and physician assistants.

HB0033/SB0893: Medical Cannabis – Opioid Use Disorder

For the purpose of encouraging the Natalie M. LaPrade Medical Cannabis Commission to approve provider applications for patients who have an opioid use disorder.

(Oral Testimony) While this bill is well-meaning, passage of the bill will likely result in needless, preventable deaths due to unintentional overdoses. There appears to be confusion between the use of cannabis to treat pain and the use of cannabis to treat opioid use disorder (OUD). There is mixed evidence that cannabis helps to control pain, with the best evidence suggesting that it helps with only certain types of pain (neuropathic pain). However, this is no solid evidence that cannabis is useful in treating OUD. In fact, the MMCC developed a report entitled TREATMENT OF OPIOID USE DISORDER WITH MEDICAL CANNABIS, and even this report says, "*A comprehensive review of existing medical literature shows that there is no credible scientific evidence backing up the claims that cannabis is beneficial in treating addiction, and that there is some evidence suggesting that it may exacerbate substance use and dependency issues.*" [top of page 4 of report]

If people with OUD are treated with cannabis instead of with one of the FDA-approved treatments for OUD, there is a high likelihood that some of these people will die when they relapse with an opioid containing illicit fentanyl. These approved treatments have been shown to reduce the risk of death by half. In fact, the MMCC report goes on to state that, "*In contrast, decades of high-quality clinical research conclusively demonstrates that medication assisted treatment (MAT) combined with social support is an effective treatment for OUD.*"

If you pass this bill, you risk sending the message that unproven treatment of OUD with cannabis is okay, even when proven treatment is available. This would be an unregulated experiment with the lives of vulnerable Maryland citizens who are at high risk of dying from a fentanyl-laced drug overdose. The benefits are unknown. But the risks are clear

HB0897: Psychiatric Hospitals - Units Licensed as Limited Private Inpatient Facilities

Requiring certain hospitals that provide certain care in a unit that is licensed as a limited private inpatient facility to authorize patients to seek insurance reimbursement for certain services, bill certain patients in a certain manner, and provide certain staff assistance; and requiring the Office of Health Care Quality, on or before December 31, 2019, to make a certain report to certain committees of the General Assembly.

HB0938: Behavioral Health Transformation Act of 2019

Requiring the Maryland Department of Health to establish a delivery system for certain specialty behavioral health services, rather than for only specialty mental health services, for enrollees of managed care organizations; requiring the delivery system to assume certain financial risk; requiring the delivery system to provide certain services to certain individuals; requiring the delivery system to reimburse certain providers and collect certain data.

HB1069: Child Abuse and Neglect - Required Reporting

Establishing that certain persons who are required to provide certain notice or make certain reports of suspected child abuse or neglect may not intentionally fail to provide the notice or

make the report; providing certain penalties for a violation of the Act; adding a certain minister of the gospel, clergyman, or priest to a list of individuals who are required to provide certain notice and make a certain report of suspected child abuse or neglect, subject to a certain exception. MPS opposes House Bill 1069 (HB 069) for we believe that health care practitioners who are currently required to report instances of child abuse and/or neglect as a condition of their employment do not fail to do so as a matter of malpractice, criminal intent, or depraved indifference. Rather, MPS asserts that instances of failure to report arise when a health care practitioner is not provided the requisite information necessary to determine when child abuse has occurred. Under current law, practitioners stand to lose their license to practice medicine as well as incur hefty fines if they knowingly fail to report child abuse. Thus, individuals who are now subject to mandatory reporting requirements will not fail to report in cases where they are aware that an individual has been abused or is in danger of being abused because the practitioner's livelihood, which took years of education and expense to earn, is truly at stake. Extending criminal penalties for the failure to report child abuse and/or neglect is simply unnecessary and not as meaningful as the above-referenced penalties already in place.

In addition, though the issue of mandatory reporting of child abuse and neglect seems to arise annually in the Maryland General Assembly, an important related issue is repeatedly unaddressed. MPS has repeatedly noted a 1993 Maryland Attorney General's opinion, which is still applied today, that requires reporting of child abuse and/or neglect in situations where the threat of abuse is no longer present. The Attorney General's opinion reads, "The current law does not excuse reporting even if the information available to the person who is required to report suggests that the alleged abuser is dead." The opinion goes on to state that with relation to a deceased abuser, "Of course, if it is certain that the alleged abuser died many years ago, these considerations will not apply." The Attorney General's opinion not only offers conflicting statements about situations involving deceased abuser, but it also creates a situation where patients may be unwilling to discuss former instances of abuse because it must be reported. As drafted, HB 1069 falls short of addressing this practical concern held by MPS. MPS, therefore, encourages the General Assembly to oppose legislation like HB 1069 until the definition of "abuse" has been appropriately narrowed such that abuse is limited to current or recent abuse by a living perpetrator who poses a danger to children.

HB1122: Outpatient Mental Health Centers Medical Directors

Requiring certain outpatient mental health centers to employ a medical director who is a licensed psychiatrist or psychiatric nurse practitioner, has overall responsibility for clinical services, and is on-site at least 20 hours per week.

SB0311/HB0399: End-of-Life Option Act

Authorizing an individual to request aid in dying by making specified requests; prohibiting another individual from requesting aid in dying on behalf of an individual; requiring a certain request to be made in a certain manner; requiring a written request for aid in dying to meet specified requirements; establishing specified requirements for witnesses to a written request for aid in dying; requiring a written request for aid in dying to be in a specified form; etc.

As our organization testified to last year, this bill does not require any patient who requests aid-in-dying to undergo an evaluation by a psychologist or a psychiatrist although many serious medical conditions are known to cause a variety of capacity-impairing mental disorders such as clinical depression, cognitive impairment, and delirium. Indeed, as many as 25% of patients diagnosed with terminal illnesses may suffer from clinical depression. Infection with the human

immunodeficiency virus is often associated with increased rates of treatable mood disorders and dementia. Neurodegenerative diseases like Parkinson's disease and ALS (Lou Gehrig's disease) can also cause cognitive impairment and depression. A 2012 study showed that more than half of patients in hospice care exhibit unrecognized cognitive impairment and these deficits are directly related to impaired decision-making capacity. Non-psychiatric physicians do not routinely administer bedside tests of these cognitive functions. Furthermore, a psychological screening tool that could be used by physicians is insufficient to detect all conditions that could cause impairment, nor does any existing screening tool have the ability to detect a patient who deliberately conceals his/her symptoms.

While a mental health assessment is not routinely required before most medical procedures, the provision of fatal care is unlike any existing treatment. Given the severe consequences of an erroneous outcome, decision-making capacity for fatal care should be held to a higher standard than any other medical intervention.

A full mental capacity evaluation is a complex and multifaceted process. A psychologist or psychiatrist who performs a capacity assessment must consider information from collateral sources such as family members or friends, and must also review psychiatric treatment records, if they exist. Under this law, there is no provision for an evaluator to have access to this information if the patient refuses to give consent. This is a serious shortcoming given that an evaluator would need to speak with a treating psychiatrist as part of any ordered assessment. Similarly, a treating psychiatrist could be barred from communicating potentially relevant information to the prescribing physician if the patient declines consent to that communication.

This bill also has implications for institutionalized patients in Maryland's prison and state hospital system, an issue that we believe has not been raised to date regarding this legislation. Institutionalized patients are a protected class of individuals under the federal Civil Rights of Institutionalized Persons Act (CRIPA). Failure to intervene and protect these patients from suicide is commonly accepted as a civil rights violation under CRIPA as well as by established federal case law. A patient committed to a psychiatric facility retains the legal right to make medical decisions. There are long term patients in Maryland's public institutions who have potentially terminal medical conditions. In fact, the Maryland Division of Correction maintains a hospice unit for terminally prisoners. Under the End of Life Options Act, the attending physician would be the individual who prescribes the fatal medication. For institutionalized psychiatric patients, this would require that the treating psychiatrist certify diagnosis and prognosis of a terminal medical condition. Therefore, the End of Life Options Act would mandate that an institutional psychiatrist practice beyond the scope of his or her medical training.

This bill has implications for Maryland's involuntary treatment laws. The bill is unclear regarding whether a qualified patient who possesses a lethal prescription would be required to surrender that medication if he meets civil commitment criteria because of mental illness. Maryland's civil commitment law is based upon dangerousness to self or others rather than decisional capacity. The law is unclear whether a qualified patient would be exempt, by law, from civil commitment.

A patient is not eligible for aid-in-dying if he is under guardianship or if medical decisions are being made through a health care proxy or Power of Attorney (POA). This law does not require an attending physician to notify a guardian or POA of a patient's suicidal intent when fatal care is denied. An individual who lacks capacity but expresses suicidal thoughts should be considered a psychiatric emergency and an attending physician should be required to notify a

patient's guardian to seek psychiatric care on the patient's behalf.

Finally, this past October the only existing study of the public health impact of aid-in-dying laws was published in the Southern Medical Journal. Researchers discovered that states with aid-in-dying laws have a trend toward higher suicide rates generally. Although the trend was not statistically significant, their findings indicate a need for further study and investigation of the interaction between aid-in-dying laws and suicide prevention programs generally. Public health researchers should be granted access to individual case records, with institutional review board approval, to study the effects of this law if passed.

Given the lack of adequate protections for people with mental illness and the great number of unanswered questions regarding "aid in dying" laws' impact on individuals suffering from mental illness, we urge your unfavorable report on SB 418.

HB0306/SB402: Inmate Involuntary Admission

Repealing a certain provision of law to allow an application for involuntary admission to a facility of an inmate in certain institutions to be made by any person who has a legitimate interest in the welfare of the individual; altering the circumstances under which a facility operated by the Maryland Department of Health is required to receive and evaluate an inmate in a correctional facility who has been certified for involuntary admission. MPS opposes Senate Bill 402 (SB 402) for it would allow outside mental health professionals, who are not the treating clinicians, to evaluate and certify for admission pretrial detainees and Division of Correction inmates. These not treating clinicians would have access to private medical records without patient consent and could release that information to outside agencies under the bill. Currently, local jails and state prisons employ nurse practitioners and psychiatrists who could sign certificates for admission for patients who require state hospital care, thus making SB 402 unnecessary.

SB0302: Electroconvulsive Therapy for Minors - Prohibition

Prohibiting a person from performing electroconvulsive therapy on a minor; establishing a penalty of a fine not exceeding \$100,000 or imprisonment not exceeding 2 years or both for a certain violation of the Act; authorizing an individual to recover civil damages from a certain person and a certain facility under certain circumstances; and defining the term "electroconvulsive therapy." Prohibiting a person from performing electroconvulsive therapy on a minor would be extremely detrimental to adolescents with severe psychiatric illness. Therefore, we strongly oppose Senate Bill 302.

MPS strongly opposes Senate Bill 302 (SB 302) because prohibiting a medical professional from performing electroconvulsive therapy (ECT) on a minor would be extremely detrimental to adolescents with severe psychiatric illness.

Access to ECT for adolescents is vital, particularly as epidemiological studies indicate that 8.3 percent of U.S. adolescents experience major depressive disorder (FN1) as well as a nearly 20 percent increase in suicides between ages 10 to 19 in the United States. (FN2) Untreated psychiatric illness, however, is the most remediable risk factor for pediatric suicide. (FN3) Furthermore, in some conditions, such as catatonia, which is a severe and potentially life-threatening illness, the combination of benzodiazepines and ECT is one of the only effective

treatment options that does not carry the risk for precipitating neuroleptic malignant syndrome, a life-threatening reaction to antipsychotic medication. (FN4) This Committee should note that two systematic clinician-based studies show that catatonia is found in 12 to 17 percent of adolescents and young adults with autism (FN5); hence, eliminating ECT as a treatment option could be particularly harmful to this cohort.

ECT is reserved for adolescents with "treatment-resistant" conditions. The American Academy of Child and Adolescent Psychiatry (AACAP) publishes practice parameters for the use of ECT with adolescents. (FN6) ECT is rarely considered for adolescents and, for it to be considered, the adolescent must carry a diagnosis, experience severe symptomology, and lack a treatment response to psychopharmacological agents. Psychiatric diagnoses that might prompt ECT to be considered include severe, persistent major depression or mania with or without psychotic features, schizoaffective disorder, schizophrenia, catatonia, and neuroleptic malignant syndrome. Symptoms must be considered severe, persistent, and significantly disabling and the adolescent must have failed to respond to at least two adequate trials of appropriate psychopharmacological agents accompanied by other appropriate treatment modalities to meet criteria for ECT treatment.

Prior to ECT being performed, informed consent is obtained from the adolescent's parent(s) or guardian(s) and, if possible, the adolescent. Informed consent involves the psychiatrist educating the parent(s) or guardian(s) and, whenever possible, the adolescent through discussion, written materials, and educational videotapes, when available. AACAP guidelines recommend that the initial decision to treat with ECT be followed by an opinion from a second psychiatrist, who is experienced in ECT but who is not involved in the patient's ongoing clinical care. That is, the consensus from more than one psychiatrist is recommended prior to starting ECT treatment.

Medical literature supports ECT as being an effective treatment in adolescents. A 1996 study reported a 64 percent response rate in 11 depressed adolescents, aged 13 to 18 years, who had been unresponsive to three or more antidepressants. (FN7) Other studies support the treatment is effective in adolescents with other diagnoses. For example, a 1997 study reviewed 60 studies involving 396 patients younger than 18 of age and found a 63 percent remission rate for patients with depression, 80 percent for those with mania, and 42 percent for those with schizophrenia when treated with ECT. (FN8) Hence, as already mentioned, it is a vital treatment option for adolescents with severe and treatment-resistant psychiatric illness.

In terms of adverse side effects associated with ECT in adolescents, studies provide preliminary evidence that the cognitive functioning of adolescents treated with ECT is like that of psychiatric controls and that the cognitive functioning is likely to return to its baseline three to six months after ECT. (FN9) Additionally, research suggests that adolescents who have been treated with ECT view the treatment as less aversive than the illness itself and would recommend the treatment to others. (FN10)

In closing, medical literature consistently agrees that ECT is an effective treatment for adolescents meeting certain criteria. The lack of access to ECT as a treatment option for adolescents would be harmful and potentially fatal. SB 302 would eliminate a vital treatment option for adolescents with treatment-resistant conditions and should not be passed.

[SB0568/HB0787: Child Abuse and Neglect - Failure to Report](#)

Establishing that certain persons who are required to provide certain notice or make certain reports of suspected child abuse or neglect may not knowingly fail to provide the notice or make the report; establishing the misdemeanor of the knowing failure to report child abuse or neglect under certain circumstances; providing certain penalties for a violation of the Act; and providing for the application of the Act. MPS opposes Senate Bill 568 (SB 568) for we believe that health care practitioners who are currently required to report instances of child abuse and/or neglect as a condition of their employment do not fail to do so as a matter of malpractice, criminal intent, or depraved indifference. Rather, MPS asserts that instances of failure to report arise when a health care practitioner is not provided the requisite information necessary to determine when child abuse has occurred. Under current law, practitioners stand to lose their license to practice medicine as well as incur hefty fines if they knowingly fail to report child abuse. Thus, individuals who are now subject to mandatory reporting requirements will not fail to report in cases where they are aware that an individual has been abused or is in danger of being abused because the practitioner's livelihood, which took years of education and expense to earn, is truly at stake. Extending criminal penalties for the failure to report child abuse and/or neglect is simply unnecessary and not as meaningful as the above referenced penalties already in place.

Furthermore, for psychiatrists who regularly work to help victims of child abuse and/or neglect, the knowledge standard that prompts reporting and if SB 568 is passed would trigger the possible imposition of incarceration for failing to report such abuse is simply too subjective as knowledge "may be inferred from the circumstances." SB 568 is unclear as to whom is making this inference and when this inference is being made; as we know only hindsight is 20/20. This subjective standard, therefore, provides no real assurances to mental health practitioners who in the end could be criminalized for making professional judgment calls on reporting potential, but uncorroborated, child abuse and/or neglect.

In addition, though the issue of mandatory reporting of child abuse and neglect seems to arise annually in the Maryland General Assembly, an important related issue is repeatedly unaddressed. MPS has repeatedly noted a 1993 Maryland Attorney General's opinion, which is still applied today, that requires reporting of child abuse and/or neglect in situations where the threat of abuse is no longer present. The Attorney General's opinion reads, "The current law does not excuse reporting even if the information available to the person who is required to report suggests that the alleged abuser is dead." The opinion goes on to state that with relation to a deceased abuser, "Of course, if it is certain that the alleged abuser died many years ago, these considerations will not apply." The Attorney General's opinion not only offers conflicting statements regarding situations involving deceased abuser, it also creates a situation where patients may be unwilling to discuss former instances of abuse because it must be reported. As drafted, SB 568, page 2, lines 11 – 13, falls short of addressing this practical concern held by MPS. MPS therefore encourages the General Assembly to oppose legislation like SB 568 until the definition of "abuse" has been appropriately narrowed such that abuse is limited to current or recent abuse by a living perpetrator who poses a danger to children.

[SB0746/HB0693: Correctional Facilities Mental Screening](#)

Requiring the Department of Public Safety and Correctional Services and the Maryland Department of Health jointly to establish a uniform mental disorder screening procedure for screening inmates; establishing certain requirements for a mental disorder screening test; requiring that each inmate detained or confined in a correctional facility be screened for a mental disorder at a certain time, except under certain circumstances. MPS opposes Senate Bill

746 (SB 746): Public Safety - Correctional Facilities - Mental Disorder Screening. Currently, the National Commission for Correctional Health Care (NCCHC) requires every accredited facility to perform a suicide risk assessment screening within 24 hours of arrest. In addition, NCCHC requires a licensed mental health professional to screen that same offender within seven days of arrest. This screening is also repeated when an offender moves from a pretrial facility to the Division of Corrections, because significant time may elapse between arrest and transfer to the state prison system. Presently, no standardized, accepted screening test exists for identifying mentally ill offenders at intake. Although many research tools have been developed, none have had acceptable sensitivity and specificity to replace a face-to-face clinical assessment as is being done now. Furthermore, there may be considerable variation between facilities regarding which diagnoses are considered a "serious mental illness" and which diagnoses may change over time depending upon a detainee's clinical symptoms. While standardization for the purpose of data collection is good to inform policy, a better approach would be to convene a task force to study data collection processes rather than have a statutory mandate for a tool or test.

SB0789/HB1204 - Involuntary Commitment Admission Procedures

Authorizing local correctional facilities to apply for involuntary admission to a certain facility of a certain inmate if the Behavioral Health Administration agrees to pay certain expenses; prohibiting the Administration from refusing to admit an inmate based on the source of the referral of the inmate; requiring a certain examining physician to disclose the need for a certain order to certain individuals under certain circumstances.