EYE IN ME

Senate Finance Committee
Testimony in Support of Senate Bill 108

Wednesday, February 1, 2023

Mental illness and substance use disorders can be prevented at all three levels of prevention. At the primary level, we can prevent mental illness and substance use from ever happening. At the secondary level, we can assess risk factors leading to mental illness and substance use disorders and create prevention plans to mitigate risk, and at the tertiary level, we can prevent the frequency, level, and intensity of active mental illness and substance use disorder symptoms.

My name is Shatiea Blount and I am a licensed certified clinical social worker, mental illness prevention professional, and a practicing psychotherapist in Maryland. I also own and operate a group psychotherapy practice, Eye In Me, LLC, located in Prince George's County. Within my various roles, I have been committed to providing culturally relevant and social justice informed psychotherapy and coaching services to Black people across the Diaspora while also advocating for the use of psychotherapy for mental illness prevention. Because Maryland Senate Bill 0108 would create a healthcare infrastructure that supports mental illness and substance use prevention at all levels, strengthen health parity laws, and promote health equity, Eye In Me, LLC is happy to support Senate Bill 108 with any amendments made by the sponsor..

This policy would allow mental and behavioral healthcare practitioners to realize a major part of our career that drove us to do this work– to **prevent** psychological and emotional suffering associated with psychological distress, mental illness, and substance use disorders. Currently our mental health infrastructure emphasizes screening for common mental health disorders in collaborative care models, treatment of an established diagnosis through behavioral and mental health care, and acute crisis intervention for new and established diagnosis in emergency situations. But, did you know that there are nearly 300 behavioral health diagnoses and many of them can only be assessed by completing a comprehensive psychological assessment as opposed

5557 Baltimore Avenue
Suite 500-118
Hyattsville, Maryland 20781
www.eyeinme.com
833-393-5669

to a short screening during a primary care visit? Also, did you know that in order for a practitioner to provide a comprehensive mental health assessment and be paid by insurance companies, the provider must diagnose the client (this includes children) with a mental or behavioral health disorder?

Due to existing behavioral healthcare policy, many practitioners who focus on prevention and work from a health equity and parity lens have elected not to accept insurance in order to maintain their integrity and avoid ethical (and possibly legal) conflicts inherent in insurance diagnostic mandates. Can you imagine how a practitioner may feel when diagnosing a child with a disorder when the practitioner knows the child's behavior is actually an adaptive and healthy response to their environment? While the previous statement, speaks to a much larger issue in how we conceptualize mental health, this testimony seeks to connect how diagnostic mandates cause some practitioners to make a value-based decision that contributes to the dearth of available and affordable practitioners paneled to accept public and private insurance. For practitioners who choose to work within the established infrastructure, they may elect to apply the least stigmatizing diagnosis (i.e., F43.20 Adjustment Disorder, unspecified), when the person may be having a very normal psychological response to a real stressor and could benefit from some behavior recommendations to prevent their psychological response from advancing to a mental illness.

Similar to the healthcare infrastructure offered to somatic health practitioners who are able establish trust and familiarity with their patients by offering annual wellness visits without the requirement to find and treat an illness, mental and behavioral healthcare practitioners need the same healthcare system to allow us to offer an annual comprehensive assessment and suggest prevention interventions that do not force us to make a diagnosis even when issues may be subclinical so we may be paid. Applying less stigmatizing and less severe diagnosis in cases where there may not be a diagnosis is a work-around that can place practitioners in an ethical dilemma (i.e., offer a diagnosis and get paid for the work completed or forgo the diagnosis and forgo payment) while also establishing a history of mental illness for the consumer that can impact their ability to secure a security clearance for a job or impact access to affordable life insurance policies.

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We should not have to pathologize normal responses because it promotes and upholds a culture of labeling and stigma that makes preventative mental healthcare inaccessible especially for communities that are sensitive to stigma and have been historically harmed by unequal treatment by healthcare systems.

Maryland Bill 108 is a promising policy that strongly pushes the healthcare parity and equity agenda while simultaneously creating a supportive infrastructure toward true mental illness prevention in Maryland. I am a strong proponent of this legislation and hope to see Maryland make this important shift toward mental illness and substance use prevention.

Respectfully,

Shatiea Blount
CEO
Eye In Me, LLC
5557 Baltimore Avenue
Suite 500-118
Hyattsville, Maryland 20781
shatiea@eyeinme.com