Testimony in Support of Senate Bill 124

Monday, February 12, 2024

My name is Dr. Shatiea Blount, DSocSci and I am a licensed certified clinical social worker practicing psychotherapy in the State of Maryland and a prevention scientist focusing on mental illness prevention. I also own and operate a 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.

Maryland Senate Bill 124 would create a healthcare infrastructure that supports mental illness and substance use prevention at all levels, strengthen health parity laws, and promote health equity. For this reason, I fully support Maryland Senate Bill 124.

Behavioral health providers can work to prevent mental illness and substance use disorders 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. At the tertiary level, we can prevent the frequency, level, and intensity of active mental illness and substance use disorder symptoms.

Maryland Senate Bill 124 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, opponents of this bill support a preventative mental health care infrastructure that emphasizes screening for anxiety and depression by primary care physicians in collaborative care models, **however, there are nearly 300 behavioral health diagnoses and many of them can only be assessed by completing a comprehensive psychological assessment as opposed to a short screening and simple questions about stress levels during a primary care visit.**

It is true that primary care physicians can conduct screenings that tally the total of scores on a Likert scale and then refer to a behavioral health provider if the scores reach a certain threshold. But, there are many behavioral health disorders that do not present as stress, anxiety, or depression. Some, somatic health practitioners may not notice signs of other behavioral health disorders and consumers of healthcare may also be unaware of symptoms. This is why

psychoeducation or client education from a behavioral health provider is important and will be a primary part of an annual behavioral health visit. I cannot emphasize enough that we need more than a two-to-three-minute screening and an assessment by a behavioral health provider includes much more. We ask questions, ask specific follow up questions to make a differential diagniosis, observe body language, notice shifts in tone, notice the way questions are answered and can carefully challenge clients as they become aware that they may have a behavioral health diagnosis. If we are not able to then treat an illness, we then can refer to a specialist within our field because we are aware of the best type of intervention for the behavioral health issue. Behavioral health providers can make more specific referrals whereas primary care physicians will make a general referral to "behavioral health" which often burdens and overwhelms the client (depending on the symptoms of the diagnosis). and so much more. Primary care providers are very useful, but they are not versed in the many mental health disorders experienced by community members. Oftentimes, the current practice results in a misdiagnosis, missed diagnosis, or prescription for medication when another intervention may be best.

In addition to Maryland Senate Bill 124 allowing for an annual behavioral health visit, it will also **remove the mandate requiring all assessments to end with a diagnosis of a mental illness/behavioral health disorder for the client so that the practitioner can be compensated.** This policy is universal and holds for any client, including children. This presents an ethical issue for practitioners and contributes to the dearth of private mental health practitioners accepting insurance.

Due to existing behavioral healthcare policy, many practitioners who focus on prevention have elected not to accept insurance 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 an adaptive and healthy response to their environment? While the previous statement speaks to a much larger issue in how we conceptualize mental health as a society, this testimony seeks to connect how diagnostic and medical necessity mandates cause some practitioners to avoid accepting insurance and impacts the number 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. But instead, we must code it as an illness to be paid. Senate Bill 124 will eliminate this issue.

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. Applying a 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 a diagnosis and forgo payment from insurance). Providing a diagnosis for a consumer, only to satisfy insurance requirements, can also negatively impact the consumer by 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.

As a system of care, we should not have to pathologize normal responses and behavioral health providers should be able to offer an annual visit. Current practices promote and uphold a culture of labeling and stigma that makes comprehensive preventative mental healthcare inaccessible for those utilizing insurance—especially for communities that are sensitive to stigma and have been historically harmed by unequal treatment by healthcare systems.

Maryland Senate Bill 124 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,

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