



The 442<sup>nd</sup> legislative session of the Maryland General Assembly drew to a close on April 12. In an effort to mitigate spread of COVID-19, the 90-day session was conducted almost entirely virtually. Committee hearings and voting sessions were held remotely and public access to the process was limited.

Logistical challenges notwithstanding, MHAMD and the Maryland Behavioral Health Coalition rallied around a successful campaign to expand access to mental health and substance use services amid increasing demand. The effort secured additional investments in community services, greater accountability in the management of Maryland’s public behavioral health system, new policies to improve health equity, greater flexibility in the delivery of telehealth, enhanced school behavioral health supports, and more resources for individuals in crisis.

## **Behavioral Health Impact of COVID-19**

The mental and emotional toll of COVID-19 is profound. Isolation, loss of income and grief resulting from the loss of loved ones are all having a serious impact on our mental health.

Up to 40% of Marylanders report feeling anxious or depressed as a result of the coronavirus pandemic and state crisis hotlines are receiving a startling increase in calls from individuals at risk for suicide.<sup>1</sup> Maryland drug- and alcohol-related deaths jumped by more than 12% through the third quarter of 2020 as compared to the same period a year earlier, including a nearly 15% increase in opioid-related deaths.<sup>2</sup> A recent study of over 69 million patients in the U.S. found

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<sup>1</sup> Wegner, Y. (2020, September 29). As coronavirus rolls on in Maryland, mental health toll surges, with experts fearing spike in suicides. *Baltimore Sun*. <https://www.baltimoresun.com/features/bs-hs-mental-health-covid-20200929-yzjfdfc2ijb4vab7o3v4g7q25a-story.html>

<sup>2</sup> <https://beforeitstoolate.maryland.gov/wp-content/uploads/sites/34/2021/01/Third-Quarter-OOCC-Report-2020-FINAL.pdf>

that individuals who contracted the coronavirus had a significantly higher likelihood of developing a mental illness within three months of their COVID-19 diagnosis.<sup>3</sup>

And as with COVID-19, this behavioral health crisis is not affecting all populations equally. Black and brown individuals, older adults, lower socioeconomic groups of all races and ethnicities and health care workers are all disproportionately impacted. The CDC has reported a higher suicide risk among racial and ethnic minorities, unpaid caregivers for adults and essential workers.<sup>4</sup>

## **Keep the Door Open 2021**

Meeting this increased demand requires a comprehensive strategy, smart investment, and an efficient use of resources. Accordingly, the Maryland Behavioral Health Coalition adopted an ambitious [Keep the Door Open](#) agenda in 2021 to protect and expand services for Marylanders with mental health and substance use needs.

### *Public Behavioral Health System of Care*

Hard fought battles in prior legislative sessions secured a series of multi-year funding increases for community behavioral health services, including a 3.5% increase scheduled to take effect on July 1, 2021. Protecting this funding was high on the list of priorities this year for the Maryland Behavioral Health Coalition.

Fortunately, Governor Hogan announced in late December that, not only would this increase be fully funded, it would be accelerated to January 1, 2021. Relieved of the need to fight for these resources, MHAMD and its coalition partners turned their attention to another major systems issue threatening the stability and viability of Maryland's community provider network.

In January 2020, the Maryland Department of Health (MDH) transitioned administrative management of the public behavioral health system to a new vendor – Optum Maryland. Optum's IT system failed immediately, and over a year of chaos and uncertainty have followed.

The dysfunction led the Department to issue estimated payments to community behavioral health providers throughout much of 2020 to keep the system afloat as the parties worked to fix Optum's system. Now providers face the prospect of paying back hundreds of millions of dollars in alleged overpayments, but Optum still lacks the capacity to provide the reports and data necessary to verify the accuracy of those overpayments.

At the urging of MHAMD and the Maryland Behavioral Health Coalition, the legislature took a variety of actions to address the situation.

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<sup>3</sup> Kelland, K. (2020, November 9). One in five COVID-19 patients develop mental illness within 90 days – study. *Reuters*. <https://www.reuters.com/article/health-coronavirus-mental-illness-int/one-in-five-covid-19-patients-develop-mental-illness-within-90-days-study-idUSKBN27P35N>

<sup>4</sup> <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>

Budget committees withheld \$1 million from MDH pending a report, due August 1, detailing steps the Department has taken to assist in the reconciliation process. As part of this reporting process, MDH must:

1. Affirm that behavioral health providers have been provided with a **comprehensive claims history** in an uploadable 835 format that conforms to HIPAA standards and includes HIPAA-standardized denial codes (the claims history report must include the original submission date of each claim, as well as reprocessing and denials, and a corresponding check number and accurate check date for the full or partial amount paid on each claim);
2. Secure a **neutral, independent third-party reconciliation mediator** – selected in consultation with behavioral health providers – to provide oversight of the process and mediation in disputes of reconciliation amounts; and
3. Outline all **contract management steps** used against Optum, including fees and fines, and, if applicable, a statement indicating why MDH has not imposed the maximum allowable penalties.

Additional budget narrative requires MDH to file **ongoing status updates on Optum’s functionality**. For the initial update, MDH must consult with behavioral health providers to identify which reports and features are required for a fully functional system. Subsequent updates must then identify progress made on each of these features, identify what is not fully functional, the steps needed to reach functionality, and the estimated completion date. The initial report is due July 1. Subsequent reports must be submitted quarterly.

Lastly, the General Assembly enacted **emergency legislation** ([SB 638](#) | [HB 919](#)) authorizing the Maryland Insurance Administration to levy penalties against Optum for failing to meet minimum performance standards.

These legislative and budgetary actions are critical steps in the Coalition’s continuing efforts to address deficiencies in Optum’s management of the public behavioral health system.

### *Telehealth*

Expanded use of telehealth has been a critical component in Maryland’s effort to mitigate spread of the coronavirus. Increased flexibility in the delivery of these services has protected patients and providers from exposure to the virus, ensured continuity of care for Marylanders unable to access in-person treatment, and increased overall access to care.

The service expansion has become a vital part of Maryland’s continuum of care. Accordingly, MHAMD and its coalition partners worked this year to advance legislation designed to preserve access to telehealth beyond the immediate public health emergency.

The primary vehicle for these discussions was [SB 3](#) | [HB 123](#) (passed). Dubbed the *Preserve Telehealth Access Act of 2021*, the bill enacts a number of important policies, including:

- Retains **coverage for audio-only telehealth** in Medicaid and commercial markets through June 2023
- Requires **reimbursement for telehealth services at the same rate as in-person services** in Medicaid and commercial markets through June 2023
- **Removes all originating and distant site restrictions** so people can receive telehealth wherever they're comfortable and providers can deliver services from wherever is appropriate
- Expands the definition of telehealth to include **remote patient monitoring** services
- Allows reimbursement of behavioral health programs for **telehealth services delivered by peers and paraprofessionals**, two critical sectors of the behavioral health workforce
- Permits psychiatrists and psychiatric nurse practitioners to participate via telehealth on **assertive community treatment (ACT) teams**
- Provides that commercial insurers **may not deny coverage for an in-person behavioral health service solely because that service may also be provided via telehealth**

Additional language requires the Maryland Insurance Administration to study how telehealth can support efforts to ensure sufficient health care provider networks and to consider the bill's requirements when proposing revisions to **network adequacy regulations**.

Lastly, the bill requires a **study by the Maryland Health Care Commission (MHCC)** on the impact of telehealth. MHCC must consult with other agencies and stakeholders to analyze disparities in usage among different communities and populations, compare the effectiveness of telehealth and in-person services, assess patient awareness of and satisfaction with telehealth, and make recommendations on continued coverage. The study must be completed by December 1, 2022. It will be used to inform future delivery of telehealth, including whether to extend the time-limited reimbursement and audio-only provisions mentioned above.

MHAMD also supported [SB 646](#) | [HB 1287](#) (passed), permitting **alcohol and drug trainee (ADT) counselors** to provide counseling via telehealth while working under supervision for a licensed substance use disorder program.

### *Health Equity*

Racial and ethnic minorities are more likely to experience poor health outcomes because of their social determinants of health, including access to health care, education, employment, economic stability, housing, and environmental factors. These health disparities include, among other things, a greater risk of mental health and substance use disorders.<sup>5</sup> For these reasons,

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<sup>5</sup> [https://mgaleg.maryland.gov/2021RS/fnotes/bil\\_0002/sb0052.pdf](https://mgaleg.maryland.gov/2021RS/fnotes/bil_0002/sb0052.pdf)

MHAMD and partners supported a range of successful initiatives this session designed to improve health equity across Maryland.

[SB 52](#) | [HB 78](#) (passed) establishes the **Maryland Commission on Health Equity**. The Commission – whose membership includes leadership from over 20 state agencies – will use a health equity framework to examine the impact of various social determinants on the health of Maryland residents and provide recommendations to reduce health disparities.

Another key to eliminating health disparities is the availability of widespread, reliable, and consistent data and a diverse and appropriately trained workforce. Accordingly, the General Assembly passed legislation this year requiring the Maryland Office of Minority Health and Health Disparities to **collect and publish data** on the racial and ethnic composition of all individuals licensed or certified by a health occupation board ([SB 565](#) | [HB 309](#)) and health data generally that includes race and ethnicity information ([SB 5](#) | [HB 28](#)). The latter bill also requires **implicit bias training** for individuals seeking to renew a health occupation license or certificate.

Lastly, the legislature passed [HB 463](#) establishing a process for designation of **Health Equity Resource Communities** (HERCs) across Maryland. This emergency legislation will target state resources to specific underserved areas to reduce health disparities, improve health outcomes and access to primary care, promote prevention services, and reduce health care costs and hospital admissions and readmissions.

### *Suicide and Overdose Prevention*

Maryland has battled a persistent opioid crisis and rising suicide rates since well before COVID-19, but pandemic-related stress, grief and despair have exacerbated these concerns. According to a recent CDC survey, over 1 in 10 individuals nationally has seriously considered suicide in the previous 30 days – including over 25% of those aged 18-24 – and over 13% of respondents said they have started or increased their substance use to cope with stress from the pandemic.<sup>6</sup>

MHAMD and the Behavioral Health Coalition supported a variety of measures this year to expand overdose and suicide prevention efforts. Unfortunately, progress in this area was difficult to achieve.

In January, the U.S. Surgeon General issued a Call to Action and encouraged states to implement a series of suicide prevention strategies.<sup>7</sup> One of these strategies focuses on improving the quality, timeliness and use of suicide-related data. [SB 168](#) | [HB 209](#) (failed) would have furthered this recommendation by establishing a **Suicide Fatality Review Committee** to review and identify factors contributing to suicide deaths and develop strategies for suicide

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<sup>6</sup> <https://www.cdc.gov/mmwr/volumes/69/wr/mm6932a1.htm>

<sup>7</sup> <https://www.hhs.gov/about/news/2021/01/19/the-surgeon-general-releases-call-to-action-to-implement-the-national-strategy-for-suicide-prevention.html>

prevention. The bill received no opposition and passed unanimously in the Senate, but never received a vote in the House.

[SB 279](#) | [HB 396](#) (failed) would have allowed community-based organizations to establish **overdose and infectious disease prevention sites (OPS)** at up to six locations around the state. OPS are facilities where people can use previously purchased drugs under trained supervision. Providing sterile needles, health care services, and referrals to drug treatment, these sites aim to reduce the harms associated with drug use. Studies have demonstrated the positive impact of this particular intervention, with evidence showing that OPS facilities reduce opioid- and overdose-related deaths, reduce public drug use, serve as an access point to behavioral health care and other social services, and reduce hospital admissions and associated costs. Although opposition to the legislation was limited, this type of intervention remains somewhat controversial, and legislators were reluctant to advance the bill in a virtual session.

In another effort to stem the tide of overdose deaths, MHAMD and partners supported an effort to expand legal protections afforded under **Maryland's Good Samaritan statute**. Current law encourages people who witness an overdose to call 911 by providing immunity from arrest, charge, or prosecution for several minor drug and alcohol offenses if the related evidence was obtained solely as a result of the person's seeking medical assistance. However, callers may still be detained or prosecuted in connection with an outstanding warrant for another nonviolent crime, which discourages some bystanders from seeking medical assistance. [HB 212](#) (failed) would have extended Good Samaritan immunity to protect against such detention or prosecution, but the legislation stalled following opposition from state's attorneys.

### *Crisis Response Services*

All indicators point to an increase in the number of Marylanders experiencing behavioral health crises. According to the Behavioral Health Administration, Maryland's Helpline saw dramatic increases in calls (61% increase), texts (47%), and chats (154%) in the last quarter of 2020 as compared to the same period a year earlier. Calls to the Baltimore crisis hotline Here2Help doubled between April and July 2020, and as of September the number of callers threatening suicide was five times higher than at the beginning of the pandemic.<sup>8</sup> Fortunately, the General Assembly took several actions this year to expand access to and increase awareness of behavioral health crisis response services.

[SB 286](#) | [HB 108](#) (passed) extends funding for the **Behavioral Health Crisis Response Grant Program (BHCRGP)** and modifies the program to prioritize proposals that include mobile crisis services and those with a strong community feedback component. The bill allocates an additional \$5 million per year through FY25.

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<sup>8</sup> Wegner, Y. (2020, September 29). As coronavirus rolls on in Maryland, mental health toll surges, with experts fearing spike in suicides. *Baltimore Sun*. <https://www.baltimoresun.com/features/bs-hs-mental-health-covid-20200929-yzjfdfc2jib4vab7o3v4g7q25a-story.html>

Established in 2018 at the urging of the Maryland Behavioral Health Coalition, BHCRGP awards grants to local behavioral health authorities to develop and expand crisis response services in jurisdictions across the state. In just two years the program has expanded mobile crisis teams in Baltimore City, Caroline, Carroll, Dorchester, Harford, Somerset, Talbot, Washington, and Wicomico Counties. The program is also supporting walk-in crisis and behavioral health urgent care services in Baltimore, Carroll, Frederick, and Harford Counties.

Crisis services also received a boost this session with passage of the [RELIEF Act](#), emergency legislation introduced by Governor Hogan to provide stimulus payments, tax relief and benefit increases to Maryland families and businesses hurt by the COVID-19 pandemic. As amended by the legislature, the measure includes **\$15 million in additional funding for behavioral health crisis response services**. The Behavioral Health Administration will determine how this funding will be allocated.

Lastly, legislators took steps to increase awareness of crisis services among those enrolled at Maryland colleges and universities. In a 2019 survey of nearly 68,000 students nationwide, over 50% reported feeling overwhelming anxiety at some point during the previous year, 60% felt “very sad,” and nearly 40% felt so depressed that it was difficult to function.<sup>9</sup> [SB 405](#) | [HB 466](#) (passed) requires higher education institutions to include **crisis hotline information on student identification cards**.

## Fiscal Year 2022 Budget

The legislature gave bipartisan approval to the \$52.4 billion state budget plan in early April. The FY22 appropriation increases funding for the public behavioral health system – which is now serving nearly 300,000 Maryland children and adults with mental health and substance use disorders – to over \$2.36 billion. This is an increase of more than \$200 million (8.5%) in total dollars (state and federal), which goes primarily to the 3.5% rate increase referenced above.

The budget also includes specific language and narrative requiring a variety of agency reports and other actions of note to the behavioral health community, including:

- Interim update from Maryland Medicaid detailing initial data and findings from the ongoing **Collaborative Care Model pilot** (*due 11/1/2021*)
- Behavioral Health Administration report outlining implementation plans for the new **988 suicide hotline** (*due 10/1/2021*)
- Behavioral Health Administration report on causes for increases in **psychiatric rehabilitation program (PRP) expenditures** and steps taken to increase PRP oversight (*due 10/1/2021*)

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<sup>9</sup> American College Health Association. (2019). *National College Health Assessment Spring 2019 reference group executive summary*. Retrieved from [https://www.acha.org/documents/ncha/NCHA-II\\_SPRING\\_2019\\_US\\_REFERENCE\\_GROUP\\_EXECUTIVE\\_SUMMARY.pdf](https://www.acha.org/documents/ncha/NCHA-II_SPRING_2019_US_REFERENCE_GROUP_EXECUTIVE_SUMMARY.pdf)

- Maryland Department of Health report on factors contributing to persistently **high staff vacancy rates** across the agency (*due 12/15/2021*)
- Maryland Department of Health report on the Greater Baltimore Regional Integrated Crisis System (**GBRICS**) **Care Traffic Control System** (*due 10/1/2021*)
- Maryland Department of Health report on barriers to and options for removing the federal **Institutions for Mental Disease (IMD) designation** from certain psychiatric hospitals (*due 8/1/2021*)
- Department of Human Services report on **youth emergency room visits, hospital stays, and placements after discharge** (*due 11/30/2021*)

## Children, Youth and Families

While most young Marylanders have been spared from physical symptoms of the coronavirus, they have not been spared from the loneliness, depression and anxiety that accompanies a prolonged state of isolation from friends, teachers, and community networks. Research indicates these mental health impacts will extend far beyond the isolation, fueling an expected rise in demand for behavioral health services from younger people over the next few years.<sup>10</sup>

### *School Behavioral Health Services*

As Maryland students slowly return to the classroom following a year of school closures and remote learning, many will contend with pandemic-related trauma that could impact health and educational outcomes. Comprehensive school-based behavioral health supports will be more important than ever. Accordingly, MHAMD and the Children's Behavioral Health Coalition (CBHC) joined a successful effort this session to override Governor Hogan's veto of the [Blueprint for Maryland's Future](#) – a landmark 2020 public education reform bill that includes a range of positive school behavioral health enhancements.

The legislature also passed **companion legislation** ([HB 1372](#)) revising the *Blueprint* to account for implementation delays and revenue adjustments related to COVID-19. The revision bill includes language directing local boards of education to use state and federal relief funding to address student trauma and behavioral health needs resulting from the pandemic.

### *Access to Data*

MHAMD and CBHC spearheaded legislation this session to expand access to data that will help identify gaps in services for young Marylanders with behavioral health needs. Per legislation enacted in 2018, the state is required to publish **annual data reports** on the availability of behavioral health services for children and youth. However, these reports do not include

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<sup>10</sup> The study, "[Rapid Systematic Review: The impact of social isolation and loneliness on the mental health of children and adolescents in the context of COVID-19](#)," was published online in the *Journal of the American Academy of Child and Adolescent Psychiatry*.



important information on access to telehealth services, nor do they provide a demographic breakdown to allow for an analysis of racial and ethnic disparities in service delivery. [SB 520](#) | [HB 1243](#) (passed) amends the annual reporting requirement to include these data points.

### *Voluntary Placement Agreements*

When a child with high intensity behavioral health needs is discharged from a residential treatment center (RTC), they are usually discharged to a lower intensity setting. Unfortunately, private insurance generally does not pay for these placements, and out-of-pocket costs can be extremely prohibitive. For the past 20 years, parents and guardians in this situation have been able to enter into a voluntary placement agreement (VPA) with a local department of social services (LDSS). Under these agreements, the parent or guardian retains legal custody of their child while the LDSS is given responsibility to determine the most appropriate out-of-home placement based on treatment recommendations.

VPAs have been extremely helpful for parents that are unable to afford step-down care for their child with behavioral health needs following an RTC placement. Unfortunately, the VPA process has become overly burdensome and is beset by a series of challenges that limits its usefulness and results in significant hospital overstay and long wait times for services.

At the urging of MHAMD and CBHC, the General Assembly enacted budget language calling for a cross-agency, multi-stakeholder **review of the VPA process**. The language requires the Department of Human Services and MDH to coordinate with CBHC and others in examining best practices from other states to determine, among other things, whether the child welfare system should continue to play a role in this process. A report is due November 1.

### *ACEs and Trauma*

Adverse childhood experiences (ACEs) are potentially traumatic events that occur in a child's life such as physical or emotional abuse, neglect, extreme poverty, and experiencing or witnessing violence. These traumas impact normative development and lifelong health, and they are a significant risk factor for mental health and substance use disorders. Accordingly, MHAMD and its coalition partners supported a variety of efforts this year to prevent and address childhood trauma.

The Maryland **Youth Risk Behavior Survey/Youth Tobacco Survey (YRBS/YTS)** is an on-site survey of middle and high school students conducted biennially by MDH and the Maryland State Department of Education. It collects survey level data on suicidal ideation, depression, substance and tobacco use, bullying and violence, nutrition and physical activity. Legislation enacted this session ([SB 548](#) | [HB 771](#)) requires the YRBS/YTS to focus more specifically on ACEs and positive childhood experiences.

Additional legislation establishes the **Commission on Trauma-Informed Care**. The independent body created by [SB 299](#) | [HB 548](#) (passed) is charged with coordinating the delivery of trauma-responsive services across state agencies.

## Older Adults

In addition to the serious somatic concerns for older adults dealing with COVID-19, the disease is also having a dramatic impact on their mental health and well-being. Social isolation and loneliness resulting from pandemic-related shutdowns and distancing protocols are risk factors for increased anxiety, depression, and mortality. As chair of the Maryland Coalition on Mental Health and Aging, MHAMD worked actively this session to address these concerns, supporting legislative efforts to improve service delivery and expand access to information and resources that will support the behavioral health needs of older Marylanders.

### *Alzheimer's Disease and Dementia*

Residential service agencies (RSAs) provide supportive home health care services, such as activities with daily living and nursing services. Front line staff at these agencies are increasingly required to attend to individuals living with Alzheimer's disease, which currently impacts about 110,000 Marylanders.<sup>11</sup> [SB 275](#) | [HB 141](#) (passed) requires continuing **training for RSA staff** on Alzheimer's disease and related dementia, ensuring this workforce is prepared to deal with the unique needs of this population.

Similarly, [SB 204](#) | [HB 416](#) (passed) requires MDH to adopt regulations that establish **training and staffing requirements for assisted living programs** with Alzheimer's special care units. Additional legislation ([SB 313](#) (passed)) will require the department to include information about Alzheimer's disease and dementia in its public health **outreach and education programs**.

### *Cognitive Health Plan for Older Marylanders*

The number of Marylanders aged 60 and older is expected to reach 1.7 million by 2030 – an increase of 40% in just 15 years.<sup>12</sup> There is a need to ensure the state is prepared to meet the growing behavioral health needs of this population.

As required by federal law, the Maryland Department of Aging (MDOA) is in the process of updating its five-year **State Plan on Aging**. Given this opportunity, the General Assembly enacted budget language requiring MDOA and MDH to submit a report, in alignment with the State Plan on Aging, detailing the anticipated cognitive and behavioral health needs of Maryland's aging population and a plan for meeting those needs. The report is due October 1.

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<sup>11</sup> <https://www.alz.org/professionals/public-health/state-overview/maryland#:~:text=The%20most%20recent%20data%20show.of%20the%20disease%20in%20Maryland.>

<sup>12</sup> [https://aging.maryland.gov/Documents/MDStatePlan2017\\_2020Dated092216.pdf](https://aging.maryland.gov/Documents/MDStatePlan2017_2020Dated092216.pdf)

## Behavioral Health and Justice Systems

Black and brown individuals have less access to behavioral health services than white people, are less likely to receive needed care, and are more likely to receive poor-quality care when they are treated.<sup>13</sup> Troublingly, although this results in a disparate criminalization of Black and brown people with behavioral health disorders, incarcerated people of color are less likely to be identified as having a behavioral health disorder<sup>14</sup> and less likely to receive treatment.<sup>15</sup> As chair of the Maryland Behavioral Health and Criminal Justice Partnership (BHCJP), MHAMD worked this year to address these disparities.

### *Maryland Behavioral Health and Public Safety Center of Excellence*

[SB 857](#) | [HB 1280](#) (passed) establishes the Maryland Behavioral Health and Public Safety Center of Excellence and charges it with furthering a **sequential intercept model (SIM)** framework to divert individuals with serious mental health and substance use disorders away from the criminal justice system. The SIM is a systems-planning tool to improve outcomes for people with behavioral health needs at various ‘intercepts’ across the criminal justice system. However, the model has never been implemented with an eye toward ensuring the resulting strategies and policies are equitable across populations, particularly marginalized communities who will be most impacted.

At the request of MHAMD, this legislation was amended to include language requiring the Center to carry out its duties with an eye toward equity and a focus on reducing racial disparities in the criminalization of individuals with behavioral health disorders.

### *Juvenile Justice*

A series of statewide listening sessions hosted over the past year by the Department of Juvenile Services (DJS) identified a lack of appropriate behavioral health resources as a major factor in the overrepresentation of justice-involved Black and brown youth. This led MHAMD to support [SB 853](#) | [HB 1187](#) (passed), which would have implemented a range of reforms to divert youth – particularly those with behavioral health needs – away from the juvenile justice system. These reforms were based on recommendations from the Maryland Juvenile Justice Reform Council (JJRC). Unfortunately, although the bill passed the House, the Senate would only concur with a heavily amended version that simply **extends the work of the JJRC** for another year.

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<sup>13</sup> Office of the Surgeon General (US); Center for Mental Health Services (US); National Institute of Mental Health (US). Mental Health: Culture, Race, and Ethnicity: A Supplement to Mental Health: A Report of the Surgeon General. Rockville (MD): Substance Abuse and Mental Health Services Administration (US); 2001 Aug. PMID: 20669516.

<sup>14</sup> Bronson, J., Berzofsky, M., “Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12,” (Washington, D.C.: U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, 2017).

<sup>15</sup> Kaba, Fatos et al. “Disparities in Mental Health Referral and Diagnosis in the New York City Jail Mental Health Service.” *American journal of public health* vol. 105,9 (2015): 1911-6.

# Other Important Behavioral Health Legislation

## *Veterans*

Statistics related to the prevalence of mental health disorders among U.S. veterans are startling. According to the Substance Abuse and Mental Health Services Administration, approximately 18.5% of service members returning from Iraq or Afghanistan have post-traumatic stress disorder or depression, and 19.5% report experiencing a traumatic brain injury during deployment. Approximately 50% of returning service members who need treatment for mental health conditions seek it, but only half who receive treatment receive adequate care.

As such, MHAMD supported several bills this year to improve services for veterans with behavioral health needs. [SB 7](#) | [HB 186](#) (passed) expands Maryland's **Court Dog Program** to provide therapy dogs for individuals in Veterans Treatment Court; [SB 164](#) | [HB 605](#) (passed) requires MDH to include **Mental Health First Aid** among the behavioral health services it coordinates for veterans and their families; and [SB 550](#) | [HB 872](#) (passed) establishes a **matching grant program** to support nonprofit organizations serving the behavioral health needs of service members and veterans.

## *Medical Records Fees*

[HB 849](#) (passed) prohibits health care providers from charging a fee for copies of a medical record when that record is needed to apply for disability benefits under the Social Security Act. This includes **Supplemental Security Income and Social Security Disability Insurance (SSI/SSDI)**. Individuals applying for these benefits have little or no income and resources. Even the nominal cost of a medical record may prevent them from securing needed assistance. This bill removes that barrier.

## *Mental Health Check-ins*

*2-1-1 Maryland* is a statewide resource available 24/7 by telephone and internet to connect Marylanders to essential health and human services, including mental health and substance use services. [SB 719](#) | [HB 812](#) (passed) requires MDH to work with *2-1-1 Maryland* to establish a program whereby individuals can opt-in to receive periodic **mental health check-in calls** and be connected to a mental health provider upon request.