SUPPORT:

HB 262: Criminal Procedure - Examination of Defendant by Maryland Department of Health - Access to Judicial Records: Requiring that the Maryland Department of Health have access to certain information maintained by the Judiciary about a criminal defendant who is subject to a certain examination, committed to the Health Department, or on conditional release under certain circumstances; and requiring the Department and the Judiciary to enter into an agreement regarding certain matters before exchanging any information. MPS supports House Bill 262 (HB 262) for it will assist the Maryland Department of Health (MDH) with supervising and monitoring those found Not Criminally Responsible or Incompetent to Stand Trial (collectively referred to herein as insanity acquittees) in the community. HB 262 would give MDH access to vital information, namely arrest and court supervision information, of insanity acquittees in the community that will provide the necessary insight to MDH as to whether these acquittees are following the conditions of their hospital release. Furthermore, information from the Maryland Judiciary is essential for it will ensure that court-ordered evaluations contain accurate information and that mandated forensic reports are submitted to the court in time to prepare for hearings.

HB 277/SB 367: State Department of Education - Guidelines on Trauma-Informed Approach: Establishing the Trauma-Informed Schools Initiative in the State Department of Education to expand the use of the trauma-informed approach used in schools and to intensively train schools on becoming trauma-informed schools; requiring the Department, to develop and distribute certain guidelines and to develop a website on the trauma informed approach; requiring, on or before July 1, 2020, the Department to select one school each from certain areas to receive intensive training on the trauma-informed approach; etc. MPS supports House Bill 277 (HB 277) as many Maryland children are all too often the victims of trauma, which may impact both their mental health as well as their functioning in school as well. Unfortunately, these children also do not receive the mental health treatment that they need. Trauma-Informed Schools Initiative established under HB 277 is a positive step for the state to take as it would aid Maryland schools in identifying children who are the victims of trauma as well as help these children and their families access meaningful mental health treatment.

HB 332/SB 441: Mental Health - Emergency Facilities List - Comprehensive Crisis Response Centers, Crisis Stabilization Centers, and Crisis Treatment Centers: Providing that the list of emergency facilities the Maryland Department of Health is required to publish may include comprehensive crisis response centers, crisis stabilization centers, and crisis treatment centers. MPS supports House Bill 332 (HB 332), which allows the Maryland Department of Health to expand the information given to police, sheriffs, judges, and the secret service by providing a list of crisis services that would hopefully divert individuals from preventable emergency room and inpatient admissions. Crisis services can also provide an alternative to incarceration while creating the opportunity to link individuals with needed community services. Crisis stabilization centers, for example, offer a safe place for individuals who are under the influence of drugs and/or alcohol to sober and receive short-term interventions, such as buprenorphine induction and medical screening and monitoring. More importantly, these individuals are also offered the opportunity to connect with ongoing behavioral health treatment, peer and recovery support services, and case management assistance." Similarly, comprehensive crisis response centers (CCRC) noted as a resource in the bill provide 24/7, 365 days/year care for individuals who have behavioral health needs, whether mental health, substance use, or comorbid substance use disorder and mental illnesses. CCRC services also include: assessments, on-site crisis stabilization in a nonemergency department setting, linkages to services, outreach, and peer recovery support services. Services can be walk-in voluntary or emergency petition.

HB 374/SB 453: Behavioral Health Administration - Children With Mental Disorders - List of Available Services: Requiring the Behavioral Health Administration to maintain an updated list of the specific service categories in psychiatric rehabilitation, therapeutic, care coordination, and home health aide services available to a child in the State who has a mental disorder; requiring that the list include services available to any child in the State who has a mental disorder and who is enrolled in the Maryland Medical Assistance Program or has health insurance coverage; etc. MPS supports House Bill 374 (HB 374) as many children throughout Maryland suffer from mental illness and yet do not have knowledge of the resources that provide meaningful mental health services. As a result, Maryland children are all too often not receiving the mental health treatment they so desperately need and would benefit. The list of services created under HB 274 would provide information about integrated mental health services, including necessary home medical support. Today, no resource exists that provides this degree of detailed information.

HB 447/SB 475: Health Insurance - Pediatric Autoimmune Neuropsychiatric Disorders - Coverage: Requiring the Maryland Medical Assistance Program, beginning January 1, 2021, to provide services for pediatric autoimmune neuropsychiatric disorders associated with streptococcal infections and pediatric acute onset neuropsychiatric syndrome under certain circumstances; requiring carriers to provide coverage for certain diagnosis, evaluation, and treatment of pediatric autoimmune neuropsychiatric disorders; applying the Act to all policies, contracts and health benefit plans is-

sued, delivered, or renewed in the State on or after January 1, 2021; etc. MPS supports House Bill 447 (HB 447). Extensive research exists that documents the emergence of tics and obsessive-compulsive symptoms in some children who have been exposed to streptococcal infections. Referred to as PANDAS, Pediatric Autoimmune Neuropsychiatric Disorders Associated with Streptococcal infection, the first-line treatment is with antibiotics. However, for subset of children who develop severe symptoms from the infection, intravenous immunoglobulin (IVIG) has shown to be an effective treatment. MPS therefore supports insurance coverage of pediatric autoimmune neuropsychiatric disorders in order to ensure that children in need will have access to this treatment.

HB 455/SB 334: Health Insurance - Coverage for Mental Health Benefits and Substance Use Disorder Benefits - Treatment Criteria: Requiring certain carriers, on or before March 1 each year, to submit a report to the Maryland Insurance Commissioner to demonstrate the carrier's compliance with the federal Mental Health Parity and Addiction Equity Act; requiring a carrier, on or before March 1 each year, to submit a report to the Commissioner on certain data for certain benefits by certain classification; establishing the Parity Enforcement and Education Fund to provide funds to support and conduct outreach to inform certain consumers of certain rights; etc. MPS supports Senate Bill 334 (SB 334), which would require the Maryland Insurance Commissioner to ensure that carriers in the state demonstrate compliance with the federal Mental Health Parity and Addiction Equity Act (MHPAEA). Patients with mental illness, substance use disorders, or the comorbidity of both mental illness and substance use disorder often face additional barriers to receiving adequate care than patients who seek treatment for somatic illnesses. SB 334 would address a part of that inequity by requiring carriers to submit a report on how they design and apply non-quantitative treatment limitations for mental health and/or substance use disorders treatment. Additionally, SB 334 authorizes the Insurance Commissioner to levy fines for MHPAEA non-compliance. Ensuring access to quality evidence-based services to treat mental health and/or substance use disorders should be a priority for legislators, particularly at a time when our state is experiencing an ongoing suicide epidemic and opioid crisis. Even a small delay in coverage for these services can pose irreversible harm to individual patients and produce higher downstream costs to the health care and social service systems, such as inpatient hospitalizations, patient death or disability, and avoidable emergency room utilization and boarding.

HB 607/SB 305: Public Safety - Crisis Intervention Team Center of Excellence: Establishing the Crisis Intervention Team Center of Excellence in the Governor's Office of Crime Control and Prevention to provide technical support to local governments, law enforcement, public safety agencies, behavioral health agencies, and crisis service providers and to develop and implement a crisis intervention model program; requiring the Office to appoint certain coordinators to the Center; requiring the Center to take certain actions; requiring a certain annual report; etc.. Many consider crisis intervention services as a critical service in the provision of comprehensive mental health care. Such services not only provide an immediate need for crisis intervention, but they often help to prevent the use of higher levels of care such as inpatient hospitalization and emergency room visits. Collaboration between police and crisis mental health care providers is also a well-studied and effective collaboration. This bill wisely promotes the education of police officers by mental health providers, which will ultimately result in more measured police interactions with citizens who are experiencing mental health care crises. In addition, coupling crisis providers with police who are responding to calls for mental health-related matters will results in better outcomes, including the use of less violent interventions by officers.

HB 611: Baltimore County - Behavioral Health - Hub and Spoke Pilot Program: Establishing the Baltimore County Hub and Spoke Pilot Program to offer and provide addiction treatment on demand through a model that offers ongoing opioid use disorder treatment integrated with general health and wellness services; requiring the Baltimore County Department of Health, in consultation with the Behavioral Health Administration in the Maryland Department of Health and certain stakeholders, to develop and implement the Program in a certain manner; requiring a report on the pilot program's results by October 1, 2023: etc. The Hub and Spoke model is an evidence-based model that has proven to increase access to MAT by expanding support and training to providers who may not feel equipped to manage OUD patients with complicated needs. The model has been shown to reduce overdose deaths and presents an opportunity to reach patients where they are. As Maryland continues to grapple with the opioid crisis, this pilot will ensure that more patients get the specialized care they need and provide valuable lessons for the entire state.

HB 656/SB 545: Pharmacists - Administration of Self-Administered Medications and Maintenance Injectable Medications: Authorizing a pharmacist who meets the requirements of certain regulations to administer a maintenance injectable medication to a patient under certain circumstances; requiring the State Board of Pharmacy, on or before September 1, 2021, and in consultation with the State Board of Physicians and the State Board of Nursing, to adopt certain regulations requiring pharmacists to complete a certain training program in order to administer a maintenance injectable medication; etc. MPS supports Senate Bill 545: Pharmacists - Administration of Self-Administered Medications and Maintenance Injectable Medications (SB 545) as many of our patients would benefit from better access to long-acting maintenance medications that treat conditions such as schizophrenia, bipolar disorder, or substance use disorder. Currently, a pharmacist can administer flu shots and other vaccines. SB 545 seeks to expand a pharmacist's ability to administer injections of prescriptions that MPS's members prescribe, such as haloperidol, risperidone, and naltrexone (Vivitrol).

Access to maintenance injectables would hopefully avoid patient relapse due to nonadherence to their medications. While this expansion may be good for patient care to have the flexibility and convenience of getting a monthly shot at the local pharmacy, MPS believes that the effectiveness is contingent on communication between the prescriber and the pharmacist. We thank the sponsor of the bill along with the proponents for accepting an amendment last session, and keeping it in the bill this session, that requires such communication. If passed, MPS acknowledges that the Maryland Department of Health with have to develop robust regulations around pharmacist training to include screening for Neuroleptic malignant syndrome (NMS), Tardive dyskinesia (TD), and dystonia before the shot. In addition, MPS believes that for some drugs, there should be a time window between the physician's last clinical assessment and the shot administration by the pharmacist. For example, clozapine has clinical checkpoints when attempting to mitigate the effects of schizophrenia over time. MPS looks forward to being a part of that regulatory discussion.

HB 736/SB 565: Police Officers – Mental Health – Employee Assistance Programs: Requiring each law enforcement agency to develop and implement an employee assistance program to protect the mental health of police officers and provide police officers access to confidential low- or no-cost mental health services; establishing certain requirements for a certain program; requiring each law enforcement agency to develop standards for annual assessments of the employee assistance program to identify deficiencies and areas for improvement; etc. MPS supports Senate Bill 565 (SB 565), because law enforcement professionals are under increased stress, have a higher risk of suicide, and patrol our streets in the most stressful situations while armed. When police officers are willing to seek help when struggling, the State must ensure that they are able to reach that help. In 2014, President Obama ordered the creation of the President's Task Force on 21st Century Policing to identify best practices and provide recommendations on effectively reducing crime and increasing public trust in police. One of the task force's six identified pillars was officer safety and wellness, which emphasized that "the wellness and safety of law enforcement is critical not only to themselves, their colleagues, and their agencies, but also to public safety." The taskforce defined wellness as including not only physical health but also mental health and resilience and noted that the "culture" of law enforcement can be prohibitive in officers seeking mental health treatment that they need. Similarly, in his August 2015 address, the then president of the International Association of Chiefs of Police emphasized, "We cannot forget about ourselves and our colleagues . . . if we don't make it a priority to keep ourselves healthy . . . we won't be able to protect our communities or our fellow officers"

HB 1121: Maryland Mental Health and Substance Use Disorder Registry and Referral System: Establishing the Maryland Mental Health and Substance Use Disorder Registry and Referral System in the Maryland Department of Health to provide a statewide system through which health care providers can identify and access available inpatient and outpatient mental health and substance use services for patients in a certain manner; requiring the Department to develop and implement the Registry and Referral System in collaboration with the State-designated Health Information Exchange; etc.

HB 1140/SB 624: Health - Mobile Response and Stabilization System for Children and Families in Maryland - Study: Requiring the Maryland Department of Health and the Governor's Commission to Study Mental and Behavioral Health in Maryland jointly to take certain actions in order to develop and implement a comprehensive mobile response and stabilization system for children and families in the State; and requiring the Department and the Commission jointly to submit their findings and recommendations to certain committees in the General Assembly on or before December 1, 2020.

HB 1461: Behavioral Health Programs – Outpatient Mental Health Centers – Medical and Clinical Directors: Requiring that regulations adopted under certain provisions of law regulating behavioral health programs include a provision requiring that the medical director of a behavioral health program licensed as an outpatient mental health center be a licensed and appropriately trained physician; and altering the requirement that certain regulations include a provision authorizing a psychiatric nurse practitioner to serve as clinical director, rather than a medical director, of a certain outpatient mental health center. HB1461 does not rescind HB1122, which passed in 2019. It merely clarifies that a nurse practitioner may not hold the title of "medical director" if he or she is not a licensed physician. Clinics may hire whomever they wish and current COMAR does not mandate one specialty over another, nor do the current regulations ensure that administrators have the requisite psychiatric training and experience. This bill serves to ensure that clinics have access to, and hire, individuals best qualified to serve seriously mentally ill people with complex medical conditions.

HB 1470/SB 454: Public Safety – Mandatory Mental Health Training – First Responders and Law Enforcement Officers: Requiring each first responder and law enforcement officer in the State to complete certain mental health awareness training approved by the Maryland Police Training and Standards Commission. MPS supports Senate Bill 454: Public Safety – Mandatory Mental Health Training – First Responders and Law Enforcement Officers (SB 454). First responders and law enforcement officers routinely encounter individuals with mental illness in many different types of situations and in roles that include criminal offenders, disorderly persons, missing persons, complainants, victims, and persons in need of care. Because the individual's mental illness is not always self-evident to a first responder or law enforcement officer,

he may try to handle the situation as usual by giving directions, issuing commands, or making an arrest. For an individual experiencing a mental health crisis, such routine encounters for first responders and law enforcement officers can be upsetting and potentially exacerbate the anxiety or paranoia that the individual is experiencing. The approaches taught in a mandatory mental health training course, as established under SB 454, should help defuse the uncertainty of a situation, both for first responders and the individual experiencing the crisis. Mental health training will provide crucial and potentially life-saving skills to ensure the safety of law enforcement professionals, first responders, and those they encounter in the course of their work. De-escalation techniques can defuse tense situations involving people with serious mental illness, but also involving people in the midst of severe life stress or who are acutely intoxicated. Furthermore, information about crisis intervention services and mental health supports may ensure that individuals get appropriately diverted to treatment rather than jail. Finally, sensitivity to the early signs of depression or post-traumatic stress disorder may be life-saving for the first responders and law enforcement officers themselves, given that as many as 12% of police officers have considered suicidal thoughts

HB1486:/SB0752: Public Health - Non-Controlled Dangerous Substance Prescription Record System Program: Establishing the NCDS Prescription Record System Program under the Maryland Health Care Commission; providing the purpose of the Program is to improve patient safety and reduce health care costs by allowing a prescriber and prescriber delegate to access NCDS prescription drug history of patients; requiring the Commission to establish standards for selecting a certain prescription information system and any other means for the transmission of certain information within the Program; requiring that certain standards include certain requirements; etc.

HB1504/SB1015: Task Force to Study Access to Mental Health Care in Higher Education: Establishing the Task Force to Study Access to Mental Health Care in Higher Education; providing the purpose of the Task Force is to study policies and procedures related to the treatment of mental illness in students, and review certain best practices and models for accessing certain mental health services; requiring the Task Force to make certain recommendations on certain matters; requiring the Task Force to submit an interim report by December 1, 2020, and a final report by December 1, 2021, to certain committees of the General Assembly; etc.

HB 1515/ SB 904: Sheila E. Hixson Behavioral Health Services Matching Grant Program for Service Members and Veterans - Establishment: Establishing the Sheila E. Hixson Behavioral Health Services Matching Grant Program for Service Members and Veterans; providing for the purpose of the Program; requiring the Maryland Department of Health to administer the Program; requiring the Program to award certain grants to nonprofit organizations to establish and expand certain community behavioral health programs; establishing a certain eligibility requirement; requiring an eligible nonprofit organization to secure certain contributions for the proposal; etc. MPS supports Senate Bill 904 (SB 904). The United States has been actively involved in military conflicts for almost two decades with many United States military personnel serving multiple deployments to places such as Afghanistan, Iraq, Syria, and Africa. Deployments of this nature are extremely stressful situations as modern-day combat has become much more non-conventional. Rates of post-traumatic stress disorder (PTSD), depression, and other psychiatric illnesses are extremely high with our military veterans. Unfortunately, suicide amongst active-duty soldiers and veterans has become all too commonplace. The United States Department of Veterans Affairs and the individual branches of the United State military are struggling to provide mental health care to both veterans and soldiers alike. Maryland, through bills such as SB 904, is taking thoughtful steps in assisting veterans and their families to heal. SB 904 if codified through will expand community behavioral health programs for veterans by awarding competitive matching grants to local nonprofit organizations that provide such services. MPS believes that connecting more military personnel and veterans to meaningful mental health services as well as potentially reducing fatalities due to overdose and suicide in the military community are sound public policies and so MPS asks the committee for a favorable report **.**

SB 324: Veterans - Behavioral Health Services - Mental Health First Aid: Requiring that the behavioral health services for which the Maryland Department of Health provides service coordination for veterans under certain provisions of law include mental health first aid; requiring that mental health first aid consist of training for veterans and the immediate family members of veterans on how to identify and respond to signs of mental illness and substance use disorders; requiring entities teaching a mental health first aid course to report certain information to the Department; etc. MPS supports Senate Bill 324 (SB 324). The United States has been actively involved in military conflicts for almost two decades with many United States military personnel serving multiple deployments to places such as Afghanistan, Iraq, Syria, and Africa. Deployments of this nature are extremely stressful situations as modern-day combat has become much more non-conventional. Rates of post-traumatic stress disorder (PTSD), depression, and other psychiatric illnesses are extremely high with our military veterans. Unfortunately, suicide amongst active-duty soldiers and veterans has become all too commonplace. The United States Department of Veterans Affairs and the individual branches of the United State military are struggling to provide mental health care to both veterans and soldiers alike. Maryland, through bills such as SB 324,

is taking thoughtful steps in assisting veterans and their families to heal.

SB 637: Children - Therapeutic Nursery Program - Funding: Establishing the Therapeutic Nursery Program to provide specialized child care and early childhood education by educators, early intervention providers, mental health providers, and health-care providers to children under the age of 6 years who have delays in development, social or emotional functioning or physical disabilities; requiring, beginning in fiscal year 2022, the Governor to include in the annual budget bill a certain appropriation to the Program; and authorizing the Program to be funded from the General Fund; etc. MPS supports Senate Bill 637 (SB 637). The goal of therapeutic nursery programs is to provide early interventions for youth with developmental delays. Intensive early interventions are critical, especially for the developmentally delayed population. These programs seek to address common problems in these children including attention, socialization, and language deficits in a structured school setting. Studies have shown that the earlier these interventions can begin, the greater their effect. Currently, services for many of these toddlers are offered via programs such as Infants and Toddlers or Child Find if the family is knowledgeable of and capable enough to identify and participate in such services. These children might continue to receive services to some extent while in pre-school programs such as Head Start, but there are limitations to the services offered. The benefit of Therapeutic Nursery Program envisioned under SB 637 is that services can be integrated in the school setting thus providing optimal access to early intervention services that allow for the best treatment outcome."

OPPOSE:

HB 26: Attendance of Students - Lawful Absences - Mental Illness: Specifying that a student's absence from school due to the student's mental illness is a lawful absence; requiring each county board of education to develop a certain attendance policy for students with mental illness that may identify a certain number of absences allowed within a marking period, semester, or school year; and requiring each county board to publish its attendance policy for students with mental illness on the county board's website. Though MPS recognizes that House Bill 26 (HB 26) is very well-intentioned, the Society must oppose it as child and adolescent psychiatrists share concerns about the unintended consequences of this legislation. MPS fears that HB 26 may actually worsen already-existing stigmas associated with mental health by conflating self-care with mental health. Currently, school systems do not typically inquire about a student's physical illness when parent or guardian requests a school absence for their child; yet, HB 26 takes the exact opposite approach when it comes to mental health and thus distinguishing it and the children and adolescents dealing with mental health disruptions as different. In addition, HB 26 if enacted may be problematic and potentially counterproductive to appropriate mental health treatment in children and adolescents. Rarely, should children and adolescents be excused from school for mental health purposes unless they require a higher level of care such as day hospitalization or inpatient care for which they would already receive an authorized absence. Attending school is usually part of the necessary treatment for children and adolescents being treated for depressive and anxiety disorders.

HB 317 /SB 541: Mental Health - Involuntary Admissions - Procedures: Authorizing a facility or Veterans' Administration hospital to take an individual who is involuntarily admitted under certain circumstances into confinement on observation status; requiring an individual confined on observation status to be examined within 24 hours by a physician, psychologist, or psychiatric nurse practitioner; requiring that certain regulations require that an impartial hearing officer receive testimony from the physician, psychologist, or psychiatric nurse practitioner; etc. MPS opposes House Bill 317 (HB 317), which would authorize a sole physician, psychologist, or nurse practitioner to involuntarily commit a patient. This is in direct contradiction to Maryland statutes that preceed the section in question today. MD Code, Health - General, § 10-615 states that:
Each application for involuntary admission to a facility or Veterans' Administration hospital under this part shall:
(1) Be in writing;
(2) Be dated;
(3) Be on the form required by:
(i) The Administration, in the case of a facility; or
(ii) The Veterans' Administration hospital, in the case of a Veterans' Administration hospital;
(4) State the relationship of the applicant to the individual for whom admission is sought;
(5) Be signed by the applicant;
(6) Be accompanied by the certificates of:
(i) 1 physician and 1 psychologist;
(ii) 2 physicians; or
(iii) 1 physician and 1 psychiatric nurse practitioner; and
(7) Contain any other information that the Administration requires.

Of the two certificates required, at least one must always be a physician. Maryland legislators were very wise to make this a requirement: only a physician has the education and training to properly evaluate a patient for involuntary commitment, and a physician should be involved at all times during the evaluation process. Involuntary admission to treatment is extraordinary authority that should not be taken lightly; Maryland justifiably restricts the situations under which it permits this practice. In fact, a key component of medical school training is understanding the ethical implications of physicians involved in involuntary admissions. Procedures for involuntary admissions should always be designed to minimize adverse impacts on patients and expanding this authority would expose patients to safety risks. HB 317 would also allow testimony from only one physician, psychologist, or psychiatric nurse practitioner in an involuntary admission hearing. MPS opposes this expansion as neither psychologists nor psychiatric nurse practitioners have the education or training to individually evaluate patients for involuntary admission, and as previously stated, Maryland law already requires more than one physician to certify this process. Psychiatric nurses and psychologists are both vital components of the care team. However, expanding their scope to evaluate patients without physician involvement for involuntary admission and testifying in hearings would be dangerous to patient safety. Nurse practitioners are not trained to practice independently; they are trained to practice in a care team. Even physicians do not work independently before the end of their residency, although at that point they have much more education and training than nurse practitioners. Nurse practitioners are only required to have 500 – 700 hours of nursing training, compared to a physician's 12,000 – 16,000 hours of medical education and training. It is simply not possible for nurse practitioners to receive the same depth and breadth of knowledge in this much shorter period of time. Nurse practitioner training is highly variable, and programs do not have equivalent, consistent requirements like MD or DO degrees. While psychologists are experts in important behavioral interventions, they have no medical training. Psychologists do not go through the rigorous medical training that gives physicians the ability to perform differential diagnoses, which is the process of differentiating between two or more conditions which share similar signs or symptoms. Since physical illnesses can sometimes present as mental illness, training in differential diagnoses is crucial. Physicians spend years learning differential diagnoses, pharmacology, and honing their medical skills. This is a critical component of expertise for psychiatrists and other physicians, who under current Maryland law must be at least one part of the health care team credentialing an involuntary commitment. Patient safety must be paramount when considering the change of any law, and HB 317 would allow medically untrained individuals to involuntarily commit patients.

HB 639: Public Health - Health Care Professionals - Cultural Competency Coursework or Training: Prohibiting a hospital or related institution, on or after January 1, 2022, from employing or granting privileges to a certain health care professional unless the health care professional provides certain documentation; requiring each health care professional to complete coursework on cultural awareness and competence in the provision of medical services and provide documentation that the coursework has been completed by January 1, 2022, and with a certain frequency thereafter except under certain circumstances; etc.

HB 643/SB 701: End-of-Life Option Act (Richard E. Israel and Roger "Pip" Moyer Act): Authorizing an individual to request aid in dying by making certain 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 certain requirements; establishing certain requirements for witnesses to a written request for aid in dying; requiring a written request for aid in dying to be in a certain form; etc. *Extensive testimony available upon request.*

HB 782 /SB 611: Health – Mental and Emotional Disorders – Consent (Mental Health Access Initiative): Providing that all minors, rather than only minors who are 16 years old or older, have the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a health care provider or clinic; and providing that a health care provider may decide to provide certain information to a certain parent, guardian, or custodian under certain provisions of law unless the health care provider believes that the disclosure will lead to harm to the minor or deter the minor from seeking care. MPS opposes Senate Bill 611 (SB 611) over concerns about minor children not being able to consent to medication. Psychiatrists have increasingly come to rely on psychoactive medications in the treatment of both adults and children. Drug therapy is now regarded as one of the most useful and important forms of treatment available for mental illness. The medical standard of care in child psychiatry, however, is to obtain parental or guardian consent prior to treatment with psychotropic medication. MPS believes that SB 611 unintentionally lowers the standard of care for children since these medications can have long term physical consequences that children are not capable of understanding.

HB 1516: Washington County - Opioid-Associated Disease Prevention and Outreach Program - Prohibition on Establishment: Prohibiting the establishment of an Opioid-Associated Disease Prevention and Outreach Program in Washington County.

SB 296: Family Law – Preventing or Interfering With Report of Suspected Child Abuse or Neglect – Statute of

Limitations: Altering the statute of limitations for a violation of the prohibition on preventing or interfering with the making of a certain report of suspected child abuse or neglect; providing that a person who violates the prohibition on preventing or interfering with the making of a certain report of suspected child abuse or neglect may reserve a point or question for in banc review; etc. This bill creates an unlimited period of risk during which a physician could be criminally prosecuted for failure to report child abuse. The intent of a mandatory report is to open an investigation. The investigation may or may not eventually substantiate a report of abuse. Thus, in theory, a physician could be indefinitely at risk of prosecution when in fact no abuse took place. MPS has consistently opposed the criminalization of a mandatory reporter's failure to report instances of child abuse and/or neglect because a patient's disclosure of child abuse and/or neglect does not always provide a health care practitioner with the requisite information necessary to determine if and when such abuse and/or neglect has occurred. A physician, who is subject to mandatory reporting requirements, does not fail to report in cases where she is aware that her patient 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. The extension of criminal penalties for the failure to report child abuse and/or neglect that occurred last session was, therefore, unnecessary.SB 296 builds on an already flawed public policy by creating an unlimited period of risk during which a physician could be criminally prosecuted for her failure to report child abuse. The intent of a mandatory report is to open an investigation on the abuser. The investigation may or may not eventually substantiate a report of abuse. Thus, in theory, a physician could be indefinitely at risk of prosecution when in fact no abuse ever took place. Furthermore, MD. Code Ann., Health–Gen. §§ 4-403(a)–(c) outlines the minimum medical record retention periods for records held by medical doctors. Physicians of adult patients maintain records for 5 years after the record or report was made. For minor patients, physicians maintain records for 5 years after the report or record was made or until the patient reaches the age of majority plus 3 years (i.e., until the patient turns 21), whichever date is later. A physician safeguarding herself from the infinite reach of SB 296 would presumably maintain her client's medical records indefinitely to defend herself in potential criminal prosecution 10, 15, 25 years down the road. This becomes problematic as a person's medical records most likely contain an array of information about his health and personal information, including medical histories, diagnoses, immunization dates, allergies, and notes his progress. Medical records may also include test results, medications that he has been prescribed and billing information. In an August 2019 online article, AARP reported that "[e]verything a crook needs to commit financial identity theft — personal data such as your SSN and bank account numbers — sells for about $25 on the black market. But stolen health insurance and medical records can fetch about $1,000 per person. The greater potential yield of medical identity theft justifies the higher price. Older Americans are particularly vulnerable; Medicare billing scams cost taxpayers over $60 billion a year." As the Maryland General Assembly works to protect personal information on many fronts, whether digital or in paper form, SB 296 will create a sizeable gap in those protections because of the necessity to maintain records into perpetuity.

SB 502: Health Insurance - Telehealth - Delivery of Mental Health Services - Coverage for Home Settings: Requiring the Maryland Medical Assistance Program to provide, subject to a certain limitation, mental health services appropriately delivered through telehealth to a patient in the patient's home setting; altering the definition of telehealth as it applies to certain provisions of law governing coverage of telehealth by certain insurers, nonprofit health service plans, and health maintenance organizations to include the delivery of mental health care services to a patient in a certain setting; etc. MPS opposes Senate Bill 502 (SB 502). Unlike the provision of somatic telehealth care to the patient's home, providing telemental health care to the patient's home is potentially counterproductive. Many interventions of psychiatrists involve behavioral activation for depression or graduated exposure for anxiety. Using home-based telemental health likely impedes such interventions. In addition, the difficulty of managing acute mental illness, such as acute psychosis, suicidality, or homicidality, in a telemental health care setting when a patient is in their home is also tremendously more complicated. From a child psychiatrist's perspective, MPS contends that the use of home-based telemental health is particularly problematic. For the same reason that Home and Hospital schooling is contraindicated for the school avoidant population, home-based telemental health results in the same problems, namely, reinforcement of the avoidance. Thus, providing telemental health care may unintentionally result in more children with mental health issues staying in their homes, which from a psychiatric perspective would otherwise indicates the need for a higher level of care.

SB 519: Public Health - Behavioral Health Programs and Health Care Facilities - Safety Plan: Requiring that the regulations adopted by the Behavioral Health Administration under certain provisions of law governing requirements for the licensure of behavioral health programs include a requirement that a behavioral health program establish and implement a safety plan for the safety of the individuals served by and the community surrounding the behavioral health program before being issued a license; etc. MPS opposes Senate Bill 519 (SB 519) as this bill reinforces stigma and unwarranted fear of individuals presenting with mental or other forms of illness by suggesting that every facility which treats these individuals must protect the community from them. In actuality, people with mental illness are at increased risk of violence and victimization from the community. Therefore, portraying a behavioral health treatment program as a source of danger will deter people from seeking treatment at that program. In addition, SB 519 may inadvertently create liability issues for the clinic for circumstances that are beyond their control and thus drive up the cost of mental health and sub-

stance use disorder treatment.

SB 520: Behavioral Health Programs - Opioid Treatment Services - Limitation on Licenses: Prohibiting the Behavioral Health Administration from approving more than five licenses in each county for behavioral health programs that provide opioid treatment services; and authorizing the Administration to approve licenses for certain behavioral health programs in a county above a certain amount if the Administration is authorized by legislation passed by the General Assembly. MPS opposes Senate Bill 520 (SB 520). Individuals suffering from opioid use disorder exist in all regions of Maryland. Thus, the location of opioid treatment services should be based solely upon need and not upon misconceptions of those in need. A 2013 National Institute on Drug Abuse-supported study suggested that citizens' concerns about opioid treatment services fostering serious crime are unwarranted. Dr. Susan Boyd and her colleagues at the University of Maryland School of Medicine in Baltimore found that crime rates in the immediate vicinities of the City's methadone treatment centers were level with the rates in the surrounding neighborhoods. Dr. Boyd believes that such empirical evidence demonstrating that opioid treatment services are not hot spots for crime will reduce public resistance to the building of new centers, and thus remove an impediment to making opioid treatment services more widely available. Unfortunately, SB 520 moves the Baltimore City and the rest of the state in the opposite direction.

SB 521: Behavioral Health - Opioid Treatment Services Programs - Medical Director: Requiring each opioid treatment services program to be under the direction of at least one on-site medical director; requiring the medical director to be on-site at the opioid treatment services program at least 20 hours per week; and prohibiting opioid treatment services programs from satisfying certain requirements through telehealth. MPS opposes Senate Bill 521 (SB 521). Maryland continues to struggles with an opioid epidemic. Substance use disorders are conditions which commonly co-occur with serious mental illness. A bill such as SB 521, which has the potential to limit or close certain treatment facilities, would also have a negative impact on psychiatric patients. Integrated care, in other words care that is coordinated with medical and substance use treatment, is most effect for reducing morbidity and mortality, including suicide as some deaths from opioid use disorders are, in fact, suicide deaths.

SUPPORT WITH AMENDMENTS:

HB 512 /SB 166: Drugs and Devices - Electronic Prescriptions - Controlled Dangerous Substances: Authorizing certain controlled dangerous substance prescriptions to be dispensed on an electronic prescription; requiring, except under certain circumstances, a certain health practitioner to issue a prescription for a controlled dangerous substance electronically; authorizing an authorized prescriber to issue a written or oral prescription for a controlled dangerous substance only under certain circumstances; authorizing the Secretary of Health to issue certain waivers; etc. MPS supports Senate Bill 166: Drugs and Devices - Electronic Prescriptions - Controlled Dangerous Substances (SB 166), but asks the committee to consider the following two exemptions. 1. MPS asks the committee to exempt low-volume practices that write fewer than ten controlled dangerous substances (CDS) prescriptions per month. This would help older practitioners, typically psychotherapists, who maintain smaller, part-time practices, but yet still provide meaningful mental health services to Maryland residents. 2. MPS also asks the committee to exempt practitioners who consult with the United States Department of Defense facilities. Currently, military pharmacies do not accept electronic CDS prescriptions, this includes CDS prescriptions sent via fax. Thus, paper prescriptions are still needed for those patients.

HB 666: Workgroup on Screening Related to Adverse Childhood Experiences: Establishing the Workgroup on Screening Related to Adverse Childhood Experiences; providing for the composition, chair, and staffing of the Workgroup; requiring the Workgroup to update, improve, and develop certain screening tools, submit certain screening tools to the Maryland Department of Health, and study and make recommendations on the actions a primary care provider should take after screening a minor for a mental health disorder that may be caused by or related to an adverse childhood experience; etc.

HB 1443/ SB 896: Commission on Student Behavioral Health and Mental Health Treatment - Establishing the Commission on Student Behavioral Health and Mental Health Treatment; requiring the Commission to study, evaluate, update, and revise guidelines for student behavioral health treatment and practices in general, including school-based health centers; requiring the Commission to make recommendations to improve current practices and revise guidelines for student behavioral health treatment and to report to the Governor and the General Assembly on or before December 1, 2020, and December 1, 2021; etc.

HB 1476: Independent Oversight and Review Board for Health Care of Inmates in State Correctional Facilities - Establishment: Establishing the Independent Oversight and Review Board for Health Care of Inmates in State Correctional Facilities; providing for the composition, chair, and staffing of the Board; requiring that the Board be granted ac-

cess to copies of certain policies, procedures, and data; requiring the Board to review certain policies, procedures, practices, and data, make a certain assessment, develop certain processes and procedures, determine certain expenditures, and make recommendations regarding certain matters; etc.

SB 106: Health Care Facilities - Certificate of Need - Exception for State-Owned Facilities: Altering the definition of "health care facility" to exempt State-owned facilities from the requirement that a health care facility have a certificate of need issued by the Maryland Health Care Commission.

SB 789: Public Health - Maryland Suicide Fatality Review Committee (Suicide Mortality Review and Prevention Act of 2020): Establishing the Maryland Suicide Fatality Review Committee to identify and address the factors contributing to suicide deaths and facilitate system changes in the State to prevent suicide deaths; requiring the Committee to meet at least quarterly each year, report at least annually to the Governor and the General Assembly on certain matters, perform certain annual studies, and disseminate certain findings and recommendations to policymakers, health care providers, health care facilities, and the public; etc.