NAMI Maryland
National Alliance on Mental Illness

# 2015 General Assembly Legislative Wrap-up

The last, or 90th day of the 2015 Legislative Session, also known as Sine Die was on April 13, 2015. NAMI Maryland's **2015 Policy and Advocacy Agenda** outlined key objectives that support our goal of ensuring that individuals with mental illness receive timely and effective treatment and that they and their families have the supports they need to lead full and productive lives. This legislative session began on January 14, 2015 and 188 Maryland General Assembly members, almost 70 of which were new, were sworn in to represent their legislative districts for the next four years. Maryland also welcomed its 62nd Governor, Larry Hogan, to Annapolis and he was officially sworn in on January 21, 2015. In the General Assembly, over 2000 bills were introduced and legislators worked diligently to ensure that all had a fair hearing and vote.

**We know that treatment works and recovery is possible.** Sharing our stories is the perfect way to deliver this concept to elected officials when asking for support for policies that will increase the availability, accessibility and quality of comprehensive mental health treatment, prevention and recovery services throughout the state of Maryland. NAMI Maryland kicked off the legislative session with our annual Advocacy Day event. On January 29, 2015 over 80 NAMI Maryland members and supporters traveled to Annapolis and met with elected officials to discuss **NAMI Maryland's top three legislative priorities:**

- **Appropriate funding for timely and effective services and supports is provided in the FY2016 Behavioral Health Budget.**
- **Effective implementation of health care reform in Maryland in order to expand access to behavioral health services.**
- **Implement strategies and programs for appropriate intervention by law enforcement, corrections, and parole and probation, as well as discharge planning for successful reentry to the community.**

**NAMI Metropolitan Baltimore Advocacy Day**
From Left to Right: Caitlin Mulrine, Communications Director, Sherry Welch, Executive Director, and Buddy Dyer, Member of Board of Directors

In addition to NAMI Maryland's legislative priorities, legislators considered a variety of other behavioral health bills aimed at reducing barriers to accessing behavioral health services. We were deeply involved in critical conversations about these bills and provided testimony during committee hearings. A few highlights:

- **SB321 (Nathan-Pulliam)/HB926 (Sydnor)** requires the Baltimore City Police Department and the Baltimore County Police Department to establish, to the extent practicable, a behavioral health unit by October 1, 2016. This bill passed the House and the Senate and the Governor signed the bill into law on May 12, 2015.
- **SB526 (Raskin)/HB244 (Anderson)** passed both the House and the Senate and the Governor signed the bill into law on May 12, 2015. Eligible individuals will now be able to petition a court to shield their court records and police records relating to one or more "shieldable convictions".
- **SB90 (Kelley)/HB293 (Morhaim)**: as originally introduced would authorize a court to appoint a guardian for a disabled person for a limited period of time. The bill further required a 72-hour waiting period after a declarant revokes an advance directive for mental health services before the revocation would become effective, when the declarant has been certified incapable of making an

informed decision. Lastly, the legislation would repeal a prohibition against surrogates authorizing treatments for mental health disorders. The bill was heavily amended and the final language that passed permits a declarant, in an advance directive, to waive the right to revoke any part of or the entire advance directive during a period when the declarant has been certified as being incapable of making an informed decision by the declarant's attending physician and a second physician.

- **SB469 (Madaleno)/HB367 (Rosenberg):** This legislation would have authorized expanded and fully operational crisis services throughout Maryland. However, to establish a comprehensive crisis response system, a large fiscal investment is also necessary. In such a stretched fiscal environment, the bill was amended to make it budget neutral. The most notable provision that remained from the original bill was the removal of language that prohibited the state from expending more than $250,000 in state general funds, in each fiscal year, to implement the Maryland Mental Health Crisis Response System.
- **SB157 (Nathan-Pulliam)/HB662 (Cullison):** The legislation, which passed the General Assembly and has been signed by the Governor, allows a minor who is 16 years or older and the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a health care provider.

Meaningful steps were definitely made during the 2015 General Assembly session to develop a comprehensive system of behavioral health care. Yet, there remains more to be done in areas such as, early identification and intervention, expanded crisis and community services, and the development of collaborative crisis intervention team (CIT) programs in every jurisdiction across Maryland.

NAMI Maryland also remains committed to our efforts to establish a state managed Outpatient Civil Commitment (OCC) program in Maryland. We spent a considerable amount of time leading up to the 2015 General Assembly session providing input to the Behavioral Health Administration and elected officials regarding the importance of OCC as a treatment option for a small and clearly defined population when it is the least restrictive alternative to maintain an individual's health and safety. We had hoped that the Administration would introduce legislation creating a state managed OCC program to allow for court ordered treatment in the community.

Unfortunately, we learned early in the session an OCC bill would not be introduced. The legislation had a projected fiscal impact of $3 million. In light of the structural deficit, the state was not in a position to pass legislation that could not be funded. NAMI Maryland will continue conversations with the Behavioral Health Administration, members of the General Assembly and the Governor to establish a state-managed OCC program. Individuals with mental illnesses and their families deserve to receive effective services in their communities and break the seemingly endless cycle of crisis, expensive inpatient services, discharge, and cycling down into the "freedom" of yet another crisis.

## FY16 Behavioral Health Budget

Maryland faced a challenging fiscal environment when legislators began their work in Annapolis. Not only had significant behavioral health cuts been made prior to the start of the 2015 General Assembly session by Governor O'Malley and the Maryland Board of Public Works, Governor Hogan included further reductions in the 2016 Behavioral Health budget he presented to members of the General Assembly.

The statewide community provider organizations, mainly nonprofits, serve most of the 175,000 children and adults who use the public mental health system. Even in prosperous years, the Behavioral Health Administration has been underfunded. The additional cuts to reimbursement and provider rates, in the Governor's budget, significantly **affect the ability of community mental health providers to treat individuals with mental illnesses and their families.** If enacted, there is no doubt the cuts will increase patient wait times and reduce effective services and programs that help people live well in the community. Individuals living with mental illness do not have the luxury of waiting 4 to 6 months to receive treatment!! Further, the high cost of *not* treating serious mental illnesses vastly exceeds the cost of treatment. The cumulative effect of cutting the behavioral health budget will just increase the substantial cost and growing burden that is imposed on the "default" systems that are too often responsible for serving children and adults with mental illness who lack access to treatment. These costs fall most heavily on the criminal justice and corrections systems, emergency rooms, schools, families and homeless shelters.

NAMI Maryland spent a significant amount of time this session urging the House Appropriations Committee and the Senate Budget and Taxation Committee to restore the community mental health reimbursement and provider rates that were cut from the Governor's FY16 Budget. NAMI Maryland also participated in an extensive and well-coordinated advocacy campaign, "Keep the Door Open," by the Maryland Behavioral Health Coalition. Over the course of the 90-day session, members of the General Assembly and Coalition members urged leaders to "Keep the Door Open" and restore and expand behavioral health funding by submitting op-eds and letters to the editor, by organizing a rally, creating a petition and gathering signatures, and by driving our message on social media. Hundreds of advocates joined the "Keep the Door Open" rally on February 5th and thousands of Marylanders have signed the petition asking Governor Hogan not to shut the door on Marylanders who use mental health and substance use disorder services.

With the end of session looming, the House Appropriations Committee and the Senate Budget and Taxation Committee set-aside (fenced off) $6.5 million to restore community mental health provider rates to FY15 levels, over $1 million to restore psychiatrist evaluation and management rate cuts and $2 million to expand substance use disorder treatment targeted at individuals with heroin addiction. The budget passed both the House of Delegates and the Senate with a substantial amount of bi-partisan support.

NAMI Maryland was hoping the Governor would appropriate the money fenced off by the General Assembly in a separate supplemental budget, but he only included the $2 million to expand substance use disorder treatment. In the end, the supplemental budget was not passed by the legislature. While this was disappointing, there was still one more opportunity to allocate the money fenced off by the legislators. While the Governor, cannot veto the final budget passed by the General Assembly, he has the choice to appropriate the fenced off money. If he does not appropriate the funding, he may not make use of it for other purposes and it will revert back to the General Fund.

Since the legislature adjourned, we are thankful that Governor Hogan committed to releasing the $2 million set-aside for the treatment of heroin addiction. We also learned, just last week, he will release the funds set-aside by the legislature to restore the FY16 community mental health provider rates and

partially restore psychiatrist evaluation and management rate cuts. This was a huge win for NAMI Maryland and the Behavioral Health Coalition! Without the voice of the thousands of advocates that lent their voice to the "Keep the Door Open" campaign, this win would not have been possible!

**Take Away**: As stated above, even in prosperous years, the Behavioral Health Administration has been underfunded. The mental health workforce has had a history of low payments, with no real investment in the sustainability of the programs and services they provide to some of Maryland's most vulnerable citizens. The stigma associated with mental illness continues to be a barrier to equal funding and treatment among other important sectors of health care. **A genuine investment must be realized to ensure funding and sustainability for the behavioral health workforce and in the programs in which they provide.** This can be accomplished by passing legislation in 2016 requiring the budget to reflect a 3% provider rate increase for the next five years.

## Effective Implementation of Health Care Reform

Access to timely and effective treatment and support for individuals with a mental illness is a crucial element in leading a full and productive life, paying taxes and contributing to society. Yet, individuals with mental illness have historically found private health insurance to be costly, hard to get, hard to keep and limited in its mental health benefits. With the passage of the Affordable Care Act (ACA) and the establishment of the Maryland Health Benefit Exchange, Maryland Health Connection, 460,000 Marylanders have acquired insurance since 2013, without limitations such as excluding coverage for previously existing conditions. [1]

Maryland has the potential, more than ever before, to deliver better, comprehensive mental health care to Marylanders who have previously been unable to access or afford private insurance. We know that the availability and coverage of services and supports, integrated with psychiatric medications, can help people with even the most serious mental health conditions recover and lead fulfilling lives. We know that individuals with mental illness need in-person treatment and that treatment must be readily accessible to the individual in his or her community. Long waits for treatment tend to increase the severity of a mental illness and consequently the intensity and cost of the services being provided. Lastly, we know that behavioral health treatment reduces the need for costly hospitalization and emergency room services.

In order to prevent barriers to treatment and care we must ensure that the anti-discrimination provisions of the Affordable Care Act, Mental Health Parity and Addiction Equity Act and Maryland's state mental health and addiction parity laws are upheld, both in the private marketplace and the Maryland Health Benefit Exchange. Undue restrictions on access to treatment, such as high out-of-pocket costs and inadequate networks of specialty care providers, penalize people with chronic conditions and violate the anti-discrimination provisions of the Affordable Care Act. Two notable reports were released during the General Assembly session revealing alarming evidence that the country, including Maryland, still has a long way to go to ensure individuals with mental illnesses are able to afford and access timely and effective treatment.

[1] Maryland Health Connection. Retrieved January 28, 2015, from http://marylandhbe.com/wp-content/uploads/2014/03/March21Report.pdf.

NAMI, our national organization, released a report, *A Long Road Ahead: Achieving True Parity in Mental Health and Substance Use*, based on a survey of 2,720 individuals and an analysis of 85 insurance plans in 15 states examining the accessibility of mental health care through health insurance plans in this country. The report spotlighted the difficulty many consumers still have accessing needed mental health care through their health insurance provider. For example, the report found that: 1) individuals and families had difficulty finding mental health providers in their plan network; 2) mental health claims are denied at a much higher rate than medical-surgical claims; 3) there appear to be significant barriers to accessing psychiatric medications; 4) even when covered, high out-of-pocket costs create a roadblock to participating in care; 5) high out-of-pocket costs create barriers to individuals accessing both inpatient and outpatient care and 6) consumers and family members often lack access to information necessary to make informed decisions. NAMI Maryland used this report to call on decision makers, such as the Maryland Insurance Commissioner, to make the goal of insurance parity a reality and improve access to mental health and substance use disorder care.

The second report was released by the Mental Health Association of Maryland, *Access to Psychiatrists in 2014 Qualified Health Plans A Study of Network Accuracy and Adequacy Performed from June 2014-November 2014*, early during the General Assembly session. The report examined Maryland's psychiatric provider network. The report found a glaring deficiency in the psychiatric provider network among Maryland's commercial providers; only 14% of the 1,154 psychiatrists listed on the Qualified Health Plan networks sold through the Maryland Health Benefit Exchange were accepting new patients and were available for an appointment within 45 days.

Several bills were introduced during the 2015 General Assembly session that would require insurance carriers to be transparent and provide adequate information for consumers, to prevent discriminatory practices and allow for sufficient reporting and review, in the following areas:

- Medication formulary decisions are based on medical evidence and allow for timely review of new medicines.
- Treatment for mental health and substance use conditions are equal to coverage for other types of health care.
- Provider and hospital networks, including the number of specialty providers and geographic service areas, are adequate.
- Providers are able to deliver care in a timely fashion.

**SB586 (Middleton)/HB1010 (Kelly)**: This bill would have required insurance carriers, subject to the federal Mental Health Parity and Addiction Equity Act (MHPAEA), to submit a report to the Maryland Insurance Administration's Commissioner certifying and outlining how insurance plans offered for the next plan year comply with MHPAEA and applicable State mental health and addiction parity laws. Unfortunately, these bills met with fierce opposition from the insurance carriers and the Maryland Insurance Administration (MIA) and the bills did not pass. Chairman Middleton of the Senate Finance committee wrote a letter to the insurance commissioner requesting the MIA perform a market conduct survey over the next three years to confirm compliance with the MHPAEA, as well as provide a summary of the survey done each year. The letter also requested the MIA to investigate the feasibility of a

prospective review, which provides the consumer an opportunity to make an informed decision about his/her health care coverage.

**SB834 (Pugh)/HB990 (Kelly)**: This bill was similar to SB586/HB1010, in its effort to ensure consumer protections and transparency. However, the bill only applied to carriers participating in the Maryland Health Benefit Exchange. In an attempt to prevent discrimination in available coverage and benefits, health plans would have been required to submit clear and thorough data to the Maryland Health Benefit Exchange, showing compliance with the ACA's non-discrimination principles. Consumer protections in these bills included safeguards to access benefits without discrimination, protection against mid-year prescription drug formulary changes, adequate provider networks, and reasonable cost-sharing for medications and out-of-network care. These bills were met with the same opposition from insurance carriers and the MIA and ultimately did not pass.

Health care reform is a complex issue that is constantly evolving. NAMI Maryland is committed to working with decision makers, coalition partners and our membership to ensure an on-going dialogue about the importance of making comprehensive mental health services available to individuals who need them.

## Criminal Justice Reform

NAMI Maryland's members include countless families and friends of persons living with serious mental illness that have been incarcerated or otherwise involved with the criminal justice system. NAMI Maryland and local affiliates have worked for years to improve mental health services in the community, to increase diversion from the criminal justice system to the mental health system, where appropriate, and to improve the criminal justice system's response to mental illness. We work regularly with many agencies at a local, state and national level to improve training and procedures for criminal justice staff.

NAMI Maryland would like a Crisis Intervention Team (CIT) program in every jurisdiction across Maryland. CIT programs are local programs designed to improve the way law enforcement and the community responds to people experiencing behavioral health crises. CIT programs reduce arrests of individuals with mental illness in crisis, and improve the chances that an individual needing mental health care will get care rather than go to jail. CIT also has an impact on the day-to-day work of officers. CIT officers, i.e. CIT officers use less force, but are better at ensuring a safe outcome.

The strength of CIT is in the local and state partnerships between the criminal justice systems, mental health system and advocates representing individuals and families affected by mental illness. NAMI Maryland supported **SB321 (Nathan-Pulliam)/HB926 (Sydnor**), which has been approved by the Governor, and requires the Baltimore City Police Department and the Baltimore County Police Department to establish, to the extent practicable, a behavioral health unit by October 1, 2016. It also requires training to be developed in consultation with the Behavioral Health Administration (BHA). Lastly, the Baltimore City Police Department must complete a study and make recommendations regarding implementation of the unit by December 1, 2015. NAMI Maryland will monitor the implementation of the bill.

NAMI Maryland is concerned about the extensive use of segregated confinement and other forms of administrative segregation in both adult and juvenile correctional facilities. A significant percentage of individuals incarcerated in correctional facilities suffer from pre-existing serious mental illnesses. Segregated confinement has been shown to cause and worsen psychiatric symptoms.

**SB414 (Gladden)/HB301 (Carter)** would have required the Department of Public Safety and Correctional Services (DPSCS) to make an annual report on segregated confinement to the Governor. Information collected in the report would include information about the mental health status of an inmate assigned to segregated confinement. The report also required reporting of certain information about the inmate's individual treatment plan, as well as information about mental health staff training.

The reasons for the excessive placement of persons with mental illness in segregated confinement are multiple, including for purposes of discipline, protection from other inmates, or because their psychiatric symptoms are so severe that they are unable to function in the general prison setting. These placements are highly inappropriate and cause extreme suffering and often long term damage. Yet, the **Department of Legislative Services analysis for SB414/HB301**, found that DPSCS's Mental Health Division only maintains monthly records of the number of inmates in segregation who are designated as having a serious mental illness. They do not keep specific demographic data on each individual, including age, race, sexual identification, sexual orientation, releases from segregation, reasons for segregation, lengths of stay, or the amount of out-of-cell time for exercise.

Without this type of information, it is difficult to determine whether the inmates' symptoms are the result of placement in segregated settings or of the mental illness. Further, without information about what services and supports are available to inmates, including adequately trained staff, there is no way to know to know if the facility is effectively helping inmates with a mental illness reach and maintain recovery for successful community reentry.

Unfortunately, these bills did not pass out of their respective committees. Without the collection of certain data, meaningful reforms aimed at reducing the use of segregated confinement cannot be realized. NAMI Maryland will continue to work with other partner organizations to take steps at the state level to address the need to reduce or eliminate the use of segregated confinement in state correctional facilities.

Unfortunately, diversion from the criminal justice system is not always possible. Upon release, an individual with a mental illness is often unable to obtain employment because of their criminal record. For people living with a mental illness, employment can be a critical factor that helps promote health, recovery and social inclusion. These bills, known as the "Second Chance Act", have been introduced for several years but did not become law. However, this year, **SB526 (Raskin)/HB244 (Anderson)** passed both the House and the Senate and the Governor signed the bill into law on May 12, 2015.

Eligible individuals will now be able to petition a court to shield their court records and police records relating to one or more "shieldable convictions". This law only applies to non-violent, misdemeanor convictions. An individual is not eligible to petition the court until three years after the individual has satisfied their sentence requirements, including parole, probation, or mandatory supervision. Work provides an individual a reason to take care of themselves and they are more likely to be engaged with

their mental health treatment. Employment can provide an individual with meaning and a purpose in life, knowing they are contributing to society. The state should be applauded for allowing individuals to have a "second chance" and increase their likelihood of finding stable employment.

## Advance Directives

NAMI Maryland believes that with adequate professional consultation, every person with a serious mental illness who has the capacity and competence to do so should be entitled to manage his or her own treatment. However, when an individual lacks capacity and competence because of his or her serious mental illness the substitute judgment of others -subject to sufficient safeguards with frequent review - may be justified in determining treatment and possible hospitalization. Advance Directives are an important tool to ensure an individual's plans for their treatment, services, and supports are followed, if they are unable to make an informed decision about their need for treatment.

**SB90** (Kelley)/**HB293** (Morhaim) as originally introduced would authorize a court to appoint a guardian for a disabled person for a limited period of time. The bill further required a 72-hour waiting period after a declarant revokes an advance directive for mental health services before the revocation would become effective, when the declarant has been certified incapable of making an informed decision. Lastly, the legislation would repeal a prohibition against surrogates authorizing treatments for mental health disorders.

NAMI Maryland supported these bills, but with amendments. While we were pleased that this legislation was introduced addressing situations in which an individual can revoke their advance directive for mental health services, we felt the 72 hour time limit outlined in the bill was arbitrary and did nothing to ensure that the individual's ability to make an informed decision had returned. The ability to revoke an Advance Directive should be based solely on the physician's determination that the individual's ability to make an informed decision has been restored. NAMI Maryland recommended that the bill be amended to reflect that the revocation of an advance directive not define a timeframe, but rather be based on whether or not the individual has the capacity and competence to make informed decisions about their need for treatment.

There was opposition to the legislation by stakeholders that felt advance directives should always be revocable, regardless of capacity. Fortunately, NAMI Maryland was able to work with BHA, the sponsors of the bills and opponents to work out a compromise. The final bill, that passed the Senate and the House of Delegates, and was signed by the Governor on May 12, 2015, permits a declarant, in an advance directive, to waive the right to revoke any part or all of the advance directive during a period when the declarant has been certified as being incapable of making an informed decision by the declarant's attending physician and a second physician. Unfortunately, the provisions in the bill that would have allowed the individual's surrogate, to consent to mental health treatment, were struck from the bill.

## Increased Access to Behavioral Health Services

In Maryland 300,000 individuals suffer from illnesses such as schizophrenia, major depression or bipolar disorder. It is essential that people with mental illness have access to the necessary services to keep them stable and living well in the community. An important part of the behavioral health service array is a fully operational Crisis Response System (CRS). Many areas of Maryland do not have access to this vital

service which can help provide immediate access to life-saving crisis stabilization/response, and can prevent unnecessary hospitalizations for some people. For several years, expanding crisis services was a component of the Mental Health and Substance Use Disorder Safety Net Act that was championed by the Behavioral Health Coalition. Unfortunately, attempts to pass a comprehensive bill were unsuccessful.

This year the Coalition parsed the crisis services section out and introduced a standalone crisis services bill; **SB469 (Madaleno)/HB367 (Rosenberg)**. This legislation would have authorized expanded and fully operational crisis services, such as:

- mobile crisis teams operating 24 hours a day and 7 days a week to provide assessments
- clinical crisis walk-in services
- expanded capacity for assertive community treatment
- individualized family intervention teams
- crisis residential beds to serve as an alternative to hospitalization
- a community crisis bed and hospital bed registry, including a daily tally of empty beds

However, to establish a comprehensive system a large fiscal investment is also necessary and in such a stretched budget environment, the bill was amended to make it budget neutral. The bill passed and has been signed by the Governor; however, many amendments were made. The most notable provision that remained from the original bill was the removal of language that prohibited the state from expending more than $250,000 in state general funds, in each fiscal year, to implement the Maryland Mental Health Crisis Response System. NAMI Maryland will continue with our coalition partners, state agencies and members of the General Assembly throughout the year to strategize on how to fulfill the other elements of the bill.

NAMI Maryland does not typically take positions on legislation related to professional scope of practice, however, this year an exception was made for **SB157 (Nathan-Pulliam)/HB662 (Cullison)**. The legislation, which passed the General Assembly and has been signed by the Governor, allows a minor who is 16 years or older has the same capacity as an adult to consent to consultation, diagnosis, and treatment of a mental or emotional disorder by a health care provider. The bill defines "health care provider" as an individual licensed under the Health Occupations Article and acting within the scope of the individual's license to diagnose and treat mental and emotional disorders. The bill does not allow the minor the ability to refuse the consultation, diagnosis, or treatment for a mental or emotional disorder for which a parent, guardian, or custodian of the minor has given consent.

We know that 50% of lifetime cases of mental illness begin by age 14 and 75% by age 24. Yet, only about 20% are identified and receive services, leaving an alarming 80% behind. Worse, suicide is the third leading cause of death in youth ages 10-24.[2] If a minor, who is 16 years old or older, is able to recognize that their feelings of sadness are more than just going through a rough patch and wants to seek help from a mental health professional, parental consent should not be a barrier for that individual to seek help from a licensed professional. NAMI Maryland felt that this bill is an appropriate step to address access to effective and appropriate care and treatment for adolescents who experience mental and emotional disorders.

[2] This document cites statistics provided by the National Institute of Mental Health. www.nimh.nih.gov

Perinatal depression and postpartum depression are a common problem during and after pregnancy because of the extreme hormonal changes and the natural and physiological and psychological stress of pregnancy. They are serious disorders that require serious attention. About 10-15 percent of women experience clinically significant depressive symptoms during pregnancy, but the majority do not receive adequate treatment.[3] It is estimated that 10 to 15 percent of women experience postpartum depression after giving birth[4]. Symptoms may include extreme difficulty in day-to-day functioning due to cognitive impairment and feelings of guilt, anxiety and fear. Women with post-partum depression may experience a loss of pleasure in life, insomnia, bouts of crying and thoughts of hurting themselves or the child.

NAMI Maryland wants mothers and their families to know that maternal mental health disorders exist, that it is important to intervene early and that it is treatable. Therefore, NAMI Maryland supported, **SB74 (Feldman)/HB739 (Kelly)** which creates a Task Force to Study Maternal Mental Health. NAMI Maryland was named as a member of the task force. The task force is responsible for exploring and making recommendations regarding maternal mental health disorders that occur during pregnancy and the first postpartum year. The task force will work to identify areas such as, vulnerable populations and risk factors for maternal mental health disorders prevention, treatment strategies and successful postpartum mental health initiatives in other states, and recommend programs, tools, strategies, and funding sources needed to implement similar initiatives in Maryland. Finally, the taskforce will make recommendations on legislative or policy initiatives, funding requirements, and budgetary priorities to address maternal mental health needs in Maryland. **SB74/HB 739** is an important step to ensure that Maryland provides appropriate resources and evidence-based care to the countless women and families that may face maternal mental health issues.

## Behavioral Health Integration

Since 2011, NAMI Maryland has supported the decision and advocated for the integration of the Mental Hygiene Administration (MHA) with the Alcohol and Drug Abuse Administration (ADAA) into one Behavioral Health Administration (BHA). In 2014, the culmination of the integration process was addressed in HB 1510, which among other things officially merged ADAA and MHA. Now that the merger is official we must ensure that the rest of the Health-General Article of the Code of Maryland reflects the creation of an integrated behavioral health system.

Several bills were submitted during the 2015 General Assembly session that ensure the Behavioral Health Administration is able to move forward with the next phase of integration and implementation. The first bill that NAMI Maryland supported was **SB 174 (Eckardt)/HB1262 (Sample-Hughes)**, which repealed and replaced the Maryland Advisory Council on Mental Hygiene and the State Drug and Alcohol Abuse Council with one Behavioral Health Advisory Council in the Office of the Governor. The bill also outlines the Council's responsibilities. NAMI Maryland is named a member of the Advisory Council. NAMI Maryland takes seriously its role as a member and will work with the other representatives to ensure the responsibilities of the Council are met.

[3] http://womenshealth.gov/publications/our-publications/fact-sheet/depression-pregnancy.pdf
[4] [4] http://www.nimh.nih.gov/health/topics/depression/index.shtml

NAMI Maryland also supported the passage of **HB1109 (Chairman Hammen)**. This bill made a series of technical, clarifying, and important updates related to the powers, duties, and responsibilities of the Department of Health and Mental Hygiene's (DHMH) Behavioral Health Administration (BHA). With the passage of this bill, BHA will now begin the regulatory process needed for implementation of a system of care that ensures individuals with mental illnesses have access to all levels of services necessary to keep them stable and living well in the community.

NAMI Maryland is dedicated to improving the lives of all those affected by mental illness, including ensuring that individuals simultaneously combatting mental health and substance use disorders receive effective and efficient treatment. NAMI Maryland advocates and policy makers must be vigilant that the behavioral health system is offering an array of proven, cost-effective services that identify and provide children, youth and adults with the mental health care they need to recover and live healthy lives. **SB607 (Klausmeier)/HB896 (Bromwell),** which NAMI Maryland supported, created an oversight committee, the Joint Committee on Behavioral Health and Opioid Use Disorders, to accomplish this goal.

The Joint Committee is a 10-member committee consisting of 5 members of the Senate and 5 members of the House of Delegates. The committee has been charged with several purposes, such as evaluating the state's behavioral health system and the state's Overdose Prevention Plan, reviewing the extent to which the state's health insurance carriers are complying with federal and state mental health and addiction parity laws, and identifying areas of concern and recommend corrective measures to the Governor and the General Assembly.