HOUSE BILL 1485

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By: **Chair, Health Committee**
Introduced and read first time: February 13, 2026
Assigned to: Health

A BILL ENTITLED

AN ACT concerning

Public Health – Crisis Response System – Resources for Family Members and Trauma–Informed Care Training
(Tiarra's Law)

FOR the purpose of requiring the Maryland Department of Health to develop a certain pamphlet relating to State and national crisis support resources; requiring certain health care providers and representatives of the Office of the Chief Medical Examiner to give the pamphlet to an individual under certain circumstances; requiring the Department to conduct a review of certain trauma–informed care training; and generally relating to the crisis response system.

BY repealing and reenacting, with amendments,
Article – Health – General
Section 10–1403
Annotated Code of Maryland
(2023 Replacement Volume and 2025 Supplement)

BY repealing and reenacting, without amendments,
Article – Public Safety
Section 14–3A–01(a) and (e)
Annotated Code of Maryland
(2022 Replacement Volume and 2025 Supplement)

Preamble

WHEREAS, On May 17, 2020, Tiarra Brown, a Maryland resident living with sickle cell disease, died following an overdose after developing a dependence on prescription opioids that had been prescribed to manage her chronic pain; and

EXPLANATION: **CAPITALS INDICATE MATTER ADDED TO EXISTING LAW.**
[Brackets**]** indicate matter deleted from existing law.

WHEREAS, Following Ms. Brown's death, stigma associated with substance use contributed to the mistreatment of her family and friends, exacerbating their trauma despite the medical circumstances underlying her condition; and

WHEREAS, Ms. Brown's family was not provided meaningful information, guidance, or survivor support resources by first responders or the Office of the Chief Medical Examiner, and the only documentation provided to her mother was a receipt for Ms. Brown's body; and

WHEREAS, This series of events highlights the pervasive stigma associated with drug overdose–related deaths and reveals deficiencies in first response practices, information sharing, and survivor support services; and

WHEREAS, Studies show that people of color are disproportionately affected by overdose deaths, underscoring longstanding racial inequities in public health systems and, consequently, in emergency response practices; and

WHEREAS, Families' encounters with first responders are often highly traumatic because overdose incidents are frequently framed as criminal investigations; and

WHEREAS, A structured framework is needed to train first responders, emergency medical service personnel, behavioral health providers, and core service agencies to promote consistent, compassionate, and culturally responsive practices in their engagement with family members; and

WHEREAS, In response to these circumstances, overdose and substance use disorder community partners assessed these events and developed parameters intended to prevent further systemic failures; now, therefore,

SECTION 1. BE IT ENACTED BY THE GENERAL ASSEMBLY OF MARYLAND, That the Laws of Maryland read as follows:

Article – Health – General

10–1403.

(a) The Crisis Response System shall include:

(1) A State 9–8–8 Suicide and Crisis Lifeline in each jurisdiction or region to:

(i) Provide a single point of entry to the Crisis Response System;

(ii) Coordinate with the national 9–8–8 Suicide and Crisis Lifeline to provide the full range of services provided by the national 9–8–8 Suicide and Crisis Lifeline, including:

1. Supportive counseling;

2. Suicide prevention;

3. Crisis intervention;

4. Referrals to additional resources; and

5. Direct dispatch or warm hand–offs to mobile crisis response and stabilization services and other immediate services as needed;

(iii) Coordinate with the local core service agency or local behavioral health authority, police, 3–1–1, 2–1–1, or other local mental health hotlines, emergency medical service personnel, and behavioral health providers; and

(iv) Provide other programs that may include:

1. A clinical crisis telephone line for suicide prevention and crisis intervention;

2. A hotline for behavioral health information, referral, and assistance;

3. Clinical crisis walk–in services, including:

A. Triage for initial assessment;

B. Crisis stabilization until additional services are available;

C. Linkage to treatment services and family and peer support groups; and

D. Linkage to other health and human services programs;

4. Critical incident stress management teams, providing disaster behavioral health services, critical incident stress management, and an on–call system for these services;

5. Crisis residential beds to serve as an alternative to hospitalization;

6. A community crisis bed and hospital bed registry, including a daily tally of empty beds;

7. Transportation coordination, ensuring transportation of patients to urgent appointments or to emergency psychiatric facilities;

8. Mobile crisis teams;

9. 23–hour holding beds;

10. Emergency psychiatric services;

11. Urgent care capacity;

12. Expanded capacity for assertive community treatment;

13. Crisis intervention teams with capacity to respond in each jurisdiction 24 hours a day and 7 days a week; and

14. Individualized family intervention teams;

(2) Community awareness promotion and training programs; and

(3) An evaluation of outcomes of services:

(i) In each jurisdiction or region, including an evaluation of:

1. 9–8–8 call, text, and chat volume;

2. 9–8–8 local answer rate;

3. 9–8–8 call, text, and chat resolution data, including:

A. The proportion of crises resolved by phone;

B. The proportion of crises resolved through mobile crisis team dispatch; and

C. The proportion of crises resolved by transfer to 9–1–1;

4. Mobile crisis team dispatch volume;

5. Mobile crisis team response time;

6. Mobile crisis team dispatch resolution data, including:

A. The proportion of crises resolved safely in the community; and

B. The proportion of crises resolved through transfer to a higher level of care;

7. Crisis stabilization center usage; and

8. Crisis stabilization center discharge data, including:

A. The proportion of crises resolved through a discharge to home; and

B. The proportion of crises resolved through a discharge to a higher level of care;

(ii) Through data obtained from consumers and family members who have received services from the Crisis Response System collected through ongoing data collection from 9–8–8 call, text, and chat providers and other crisis providers that is reported annually; and

(iii) Through annual crisis services data collection on the involvement of law enforcement, involuntary status of clients, and diversion from higher levels of care, including hospitals.

(b) The data derived from the evaluation of outcomes of services required under subsection (a)(3) of this section shall be:

(1) Collected, analyzed, and publicly reported on or before December 1 each year, beginning in 2026;

(2) Disaggregated by race, gender, age, and zip code; and

(3) Used to formulate policy recommendations with the goal of decreasing criminal detention and improving crisis diversion programs and linkages to effective community health services.

(c) The Crisis Response System services shall be implemented as determined by the Administration in collaboration with the core service agency or local behavioral health authority serving each jurisdiction and community members of each jurisdiction.

(D) (1) THE DEPARTMENT SHALL DEVELOP A PAMPHLET TO INFORM THE PUBLIC ABOUT THE CRISIS RESPONSE SYSTEM, THE STATE AND NATIONAL 9–8–8 SUICIDE AND CRISIS LIFELINES, AND PROGRAMS PROVIDED BY THE STATE 9–8–8 SUICIDE AND CRISIS LIFELINE.

(2) (I) IN THIS PARAGRAPH, "HEALTH CARE PROVIDER" HAS THE MEANING STATED IN § 14–3A–01 OF THE PUBLIC SAFETY ARTICLE.

(II) A HEALTH CARE PROVIDER OR REPRESENTATIVE OF THE OFFICE OF THE CHIEF MEDICAL EXAMINER SHALL PROVIDE THE PAMPHLET DESCRIBED IN PARAGRAPH (1) OF THIS SUBSECTION TO AN INDIVIDUAL:

1. ON REQUEST; OR

2. WHEN REASONABLY APPROPRIATE IN CONNECTION WITH A DEATH, AN OVERDOSE, OR A BEHAVIORAL HEALTH CRISIS RESPONSE.

[(d)**] (E)** An advance directive for mental health services under § 5–602.1 of this article shall apply to the delivery of services under this subtitle.

[(e)**] (F)** This subtitle may not be construed to affect petitions for emergency evaluations under § 10–622 of this title.

Article – Public Safety

14–3A–01.

(a) In this subtitle the following words have the meanings indicated.

(e) "Health care provider" means:

(1) a health care facility as defined in § 19–114(d)(1) of the Health – General Article;

(2) a health care practitioner as defined in § 19–114(e) of the Health – General Article; and

(3) an individual licensed or certified as an emergency medical services provider under § 13–516 of the Education Article.

SECTION 2. AND BE IT FURTHER ENACTED, That the Maryland Department of Health shall:

(1) conduct a review of any trauma–informed care training, including training regarding family engagement and post–incident support following overdose or behavioral health crises, that is provided to health care providers, as defined in § 14–3A–01 of the Public Safety Article; and

(2) on or before December 1, 2026, report to the General Assembly, in accordance with § 2–1257 of the State Government Article, on its findings and recommendations resulting from the review for changes to the trauma–informed care training required for health care providers.

SECTION 3. AND BE IT FURTHER ENACTED, That this Act shall take effect July 1, 2026.