Hon. Cathy Breen
15 Falmouth Ridges Dr.
Falmouth, ME 04105
February 24, 2023

**TESTIMONY IN SUPPORT OF LD258, GOV. MILLS' PROPOSED BIENNIAL BUDGET**
**131st Maine Legislature**

Senator Rotundo, Representative Sachs and members of the Joint Standing Committee on Appropriations and Financial Affairs (AFA), my name is Cathy Breen and I live in Falmouth, Maine. Most of you know me as a former Senate Chair of AFA, but I'm speaking today as a volunteer Board member of Spurwink Services and as a parent of a young adult daughter who has received services in Maine's behavioral health care system, both as a child and as an adult.

My remarks today support not only the specific proposed appropriations in LD258 and the proposal to add approximately $80 million to support adult behavioral health services. In short, Spurwink supports both of those. But I also want to share some historical context as both a board member and a parent. In the interest of brevity, I'm going to summarize my testimony here in bullet points. I hope that you will read my more lengthy remarks at your convenience.

## SUMMARY

1. Maine used to be a national leader in community-based behavioral health;
2. Due to the 2008 recession and eight years of deliberate cutting of state social services from 2010-2018, Maine's network of services grew threadbare;
3. The COVID-19 pandemic required that state government - and the Department of Health & Human Services (DHHS) in particular - focus on managing that unprecedented emergency;
4. In FY21-22 and in the upcoming biennium, we've been investing in re-building community-based behavioral health services;

5. Spurwink is a leader in this arena, and has partnered with DHHS to develop a new model of crisis care known as The Living Room in Portland (please see further remarks for more information on this).
6. Pursuant to the 130th Legislature's passage of LD1262, DHHS has formulated a statewide behavioral health plan. I urge AFA to make sure that funding aligns with this plan now and going forward in future budgets.
7. One of my personal goals is to eliminate the cumbersome, arcane, and confusing silos that have developed around services that are defined by consumers' ages and diagnoses. Consumers have various diagnoses over their lifespans…Forcing consumers to navigate the separate bureaucracies of the Office of Child & Family Services (OCFS), the Office of Behavioral Health (OBH) and the Office of Aging and Disability Services (OADS) is not "person-centered." On the contrary, it often feels like a bulwark that keeps consumers in a perpetual cycle of trying to get what they need when they need it.

**MORE DETAILED REMARKS**

First, the systems that serve Maine people who live with intellectual disabilities and mental health challenges have their origins in the consent decrees that governed the closure of the Pineland Center and Augusta Mental Health Institution (AMHI) during the 1980's. These legal instruments were drafted to protect the rights of clients and to lay the groundwork for ending the isolation and warehousing of people with disabilities living in large hospitals and institutions. This was part of a national trend. What was supposed to happen next was the creation of networks of services in communities all over the country where clients and their families could access the services they needed close to home, within driving distance, in outpatient settings that would minimize the need for institutional care. During the first few decades of this transition, Maine was a national leader in building and providing community-based services.

The Great Recession of 2008 and the ensuing state revenue shortfalls took a toll on the networks that Maine had developed. Smaller agencies in less populated areas could not sustain their overhead costs. We saw a significant consolidation of services under the umbrellas of larger agencies in more densely populated areas like Portland, Lewiston, Augusta and Bangor. In addition, several large Maine hospitals expanded capacity for inpatient care.

With the election of a "smaller government is better" governor in 2010, community-based services experienced more cuts, further diminishing the availability of outpatient services. MaineCare reimbursement rates stagnated, unless particular service providers and/or lobbyists could get the ear of this committee and somehow wrangle a small increase in MaineCare Section X, Y or Z on an *ad hoc* basis. But using local emergency rooms for high acuity episodes and wait lists for outpatient services became the new normal. The passage of the federal Affordable Care Act (2010) and the eventual expansion of MaineCare (2019) made more people eligible for services, but they did not increase reimbursement rates or make community-based services suddenly more available.

With the election of the Mills administration in 2018, people like me were hopeful that we would see a renewed commitment to rebuilding the tattered fabric of our community-based systems of behavioral health care. But COVID-19 had other plans. Just as DHHS was re-building its internal capacity, building bridges with the provider and consumer communities and staffing up to begin a systemic review of MaineCare reimbursement rates, the pandemic required much of DHHS's attention in ways that no one could have anticipated. And as we know, the pandemic brought the fragility of these services - both outpatient and residential - into sharp focus. Federal pandemic relief did a lot to keep existing services afloat with several infusions of cash. But it did nothing to expand the availability of services or build long-term sustainability.

Since the ebbing of the urgent, frightening first phase of the pandemic, DHHS has turned its attention to building capacity for robust, evidence-based services. The 130th Maine Legislature passed *LD 1262: Resolve, Directing the Department of Health and Human Services*

*To Develop a Comprehensive Statewide Strategic Plan To Serve Maine People with Behavioral Health Needs throughout Their Lifespans.* I'm pleased to note that DHHS published their final version of this plan on February 17, 2023. I encourage you all to familiarize yourself with it and commit to making sure that funding aligns with the goals of the plan over time.

In addition, I'm proud to report that Spurwink worked closely with DHHS to develop and open a new model of crisis care, called The Living Room, in downtown Portland. This 24-hour program invites anyone in a mental health crisis, which clients define for themselves, and helps resolve the crisis. The program works closely with other local agencies, including the mental health liaison at the Portland Police Department, who in a recent community meeting at the site, called this program "a game changer." One of the hallmarks of this program is that 50% of the staff are peers with lived experience. Open for just over a year during the day only and having recently added overnight capacity, The Living Room has already reduced visits to local emergency rooms and jail for people in a mental health crisis.

In closing, I want to circle back to the origin story of our community-based services, that is, the consent decrees that resulted in a system of care that is organized by age and diagnosis, rather than by individuals' actual needs. In my personal opinion - I'm not speaking for Spurwink right now - the two silos of the Office of Behavioral Health and the Office of Aging and Disability should come down. We hear a lot about "person-centered care," but that's not how the funding is organized. People go through various stages and diagnoses over their lifetimes. And consumers often need very similar core supports such as transportation, medication management, help with activities of daily living (e.g. meal prep, cleaning, laundry, hygiene), support for their social life, support for education/work, and supported housing regardless of their ages and diagnoses. If AFA ever gets the chance to support this enormous systemic change, I hope you'll support it.

###