Testimony of Doug Dunbar from Hermon, Maine

In Support of LD 445

"Resolve, Directing the Department of Health and Human Services to Apply for a Waiver from the Federal Government for the Medicaid Limitation on Payment to a Facility with More Than 16 Inpatient Beds for Psychiatric Treatment"

Public Hearing: March 17, 2023

Senator Baldacci, Representative Meyer and Members of the Committee, my name is Doug Dunbar. I am a resident of Hermon in Joe Baldacci's district and appreciate the opportunity to testify in support of LD 445. I have friends who support this legislation and others who oppose it. I appreciate everyone's interest in this very important issue.

Since my earliest recollections as a child, I suffered from two mental illnesses—obsessive compulsive disorder (OCD) and anxiety. They made life a daily struggle. These illnesses were debilitating and often tormenting. Because of fear and stigma, I kept them concealed from everyone, even family members and closest friends.

Among other aspects of daily life, reading was terribly problematic, as I might read the same sentence, paragraph or page over and over and over again. Despite this, I somehow graduated from high school, college and even earned a master's degree. My professors would be unhappy to know how little I read, but I managed to get by. That was life for me, managing in silence day-by-day.

As a young person, I also had a strong desire to help people and was interested in politics. In high school and college, I got involved in campaigns. It led to a 30-year career in government. Again, I simply found ways to manage through my career…until 9/11.

When the terrorist attacks occurred that horrible day, I was working on Capitol Hill in Washington as then-Congressman John Baldacci's communications director. As the events unfolded, my OCD and anxiety spiraled out of control. The very next day, I began self-medicating with alcohol.

As the years went by, I moved back to Maine and worked as John's press secretary in the Governor's office and then served as Maine's Chief Deputy Secretary of State. I went on to work in other capacities, all the while drinking myself to death in order to deal with mental illness.

About ten years ago, I began to have legal problems. Very poor decision-making caused by my alcohol use disorder led to six arrests, several months in three Maine jails and over a year in the Penobscot County Adult Treatment and Recovery Court.

Although I had served in the Secretary of State's office and understood the consequences well, I couldn't stop drinking and driving. I kept drinking because I was an alcoholic. I kept driving, because I didn't want anyone in my world to know problems were developing. Fortunately, I never harmed anyone.

Going to jail was the most fascinating and eye-opening experience of my life. I recommend it for my friends who are judges, attorneys, prosecutors, legislators and anyone who touches any aspect of the criminal legal system. I no longer call it the justice system, because there's far too little justice for many parties, including the victims of crime.

These days, more than 5 years in recovery and working to assist others who have struggled with substance use disorder, mental illness or been incarcerated, I tell people of my two great regrets. First, putting the public at risk by regularly operating under the influence of alcohol.

Second, paying little attention to the pervasive injustices and inequities within the criminal legal system. As a society, we've created and perpetuate a system that does tremendous harm. We've done so many things wrong as a state and nation, it's breathtaking.

One of the most troubling, and what brings me here today, is the criminalization of mental illness.

Due to our failure to create an appropriate community-based mental health care system after asylums were rightly closed, and because of lawmakers' insatiable and misguided appetite to criminalize so many things, a staggering number of individuals suffering from mental health challenges and brain disorders are jailed and imprisoned.

According to research conducted by the Prison Policy Institute and many other organizations, an alarming percentage of people in our places of incarceration suffer from a mental health disorder (www.prisonpolicy.org/research/mental_health). Percentages vary, but whether it is 30, 40 or 50 percent, the figures should shock and disturb us all.

In a report last month, the Pew Charitable Trusts indicated over 1 in 9 individuals with co-occurring substance use and mental health disorders are arrested each year (www.pewtrusts.org/en/research-and-analysis/issue-briefs/2023/02/over-1-in-9-people-with-co-occurring-mental-illness-and-substance-use-disorders-arrested-annually).

It was astonishing, at times horrifying, to watch the way many of these individuals were treated in Maine jails. I was released from incarceration determined to find ways to make sure far fewer people experiencing mental illness would be institutionalized in our jails and prisons.

That brings me to LD 445. I understand some opponents worry about returning to a time of large institutional settings for people suffering from mental illness. Like those opponents, I am working hard to ensure more community-based services are available We should all endeavor to make sure support and treatment are accessible across Maine.

However, I believe there's a need for more resources and a way for people to get needed care in a variety of settings. Some individuals require treatment that may only be available in larger health care facilities. I don't want them denied services because they're poor and the federal government won't cover the cost. Included below this testimony is a page from the National Alliance on Mental Illness (NAMI) website. I hope you'll have time to read it below or here: www.nami.org/Advocacy/Policy-Priorities/Improving-Health/Medicaid-IMD-Exclusion.

No, I don't want people institutionalized and harmed as in the past, but that is essentially what's happening today in our jails and prisons. We need more choices and funding. LD 445 will help in this regard. Thanks for your time and consideration of this testimony. If there are questions or additional information is desired, please contact me by e-mail (dougdunbar@yahoo.com) or call (207) 299-5626.

Medicaid IMD Exclusion

Where We Stand

NAMI believes that health insurance should provide comprehensive mental health and substance use disorder coverage without arbitrary limits on treatment. NAMI opposes Medicaid's discriminatory prohibition on paying for mental health treatment delivered in certain inpatient settings, known as "institutions for mental disease" (IMDs).

Why We Care

Currently, the law prohibits states from using Medicaid to pay for care provided in "institutions for mental disease" (IMDs), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds. This is the only part of federal Medicaid law that prohibits payment for the cost of providing medically necessary care because of the type of illness being treated. This discriminatory exclusion has been in place since Medicaid's enactment in 1965, and it has resulted in unequal coverage of mental health care.

Recently, states were given the option to cover short-term stays in psychiatric hospitals by applying for a waiver from the federal government. While this option shows progress, we need to permanently remove the IMD exclusion. People with mental health conditions — just like people with any medical condition — need a range of care options from outpatient services to hospital care. Updating the IMD exclusion to allow for short-term stays in psychiatric hospitals helps strengthen the mental health system and provides those who rely on Medicaid with more treatment options.

How We Talk About It

- About one in eight visits to hospital emergency rooms involves a mental health or substance use condition. However, emergency departments are often not equipped to help people experiencing a mental health crisis.
- Unfortunately, emergency department staff often have nowhere to send a person in crisis because of the limited number of inpatient psychiatric beds in the U.S., which have decreased significantly since the 1950s.
- When there are not enough inpatient beds available, emergency departments often release people in crisis — leaving them to deal with their illness on their own.
- We know what happens when people don't get the treatment they need when they need it — they can end up in jail or on the streets — leading to worse outcomes for the person, greater pain for their families and a higher cost to the state and the federal government.

- Federal Medicaid policy has contributed to the mental health system's lack of a full range of treatment options, including inpatient care, for people with mental illness.
- Medicaid doesn't pay for care provided in "institutions for mental disease" (IMDs), which are psychiatric hospitals or other residential treatment facilities that have more than 16 beds. This is discriminatory.
- This policy, known as the "IMD exclusion," is the only part of the Medicaid program that doesn't pay for medically necessary care simply because of the type of illness.
- The IMD exclusion is discriminatory and has a real-life impact on people's ability to access needed treatment.
- Recently, states were given the option to cover short-term stays in psychiatric hospitals under Medicaid by applying for a waiver from the federal government. While this option shows progress, we need to permanently remove the IMD exclusion.
- Every person who relies on Medicaid should have access to the full range of treatment options they need — bringing us one step closer towards full and equal treatment under the law.

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Hermon
LD 445

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