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Testimony Submitted by:
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Testimony in support of; LD 328 **"An Act to Improve Mental Health in Maine"**

SUMMARY: 328: This bill brings MaineCare regulations into alignment with Dartmouth Assertive Community Treatment Scale fidelity items, ensuring high-quality, evidence based Assertive Community Treatment (ACT) services for Maine residents with psychotic disorders and high needs.

Senator Baldacci, Representative Meyer and esteemed members of the committee,

Good morning,

My name is Catherine Ryder and I serve as the chief executive officer for Tri-County Mental Health Services (TCMHS) which serves Western Maine and Northern Cumberland County. I submit this testimony in support of LD 328, An Act to Improve Mental Health in Maine.

TCMHS has provided Assertive Community Treatment (ACT) for over 30 years and was an early innovator in the state of Maine, deeply dedicated to those living with serious and persistent mental illness, who without such supportive services in the community might have lived their lives in locked institutions. We are committed to providing the highest quality of care in a manner which best meets the needs of those we serve.

The current MaineCare standards for ACT have resulted in a program that is faltering financially, is clinically challenging, and which threatens program collapse. It is antithetical to what we know works, and so we ask you to carefully consider the language in LD 328 as a viable alternative to being fiscally and clinically accountable for the work we do.

To aid your understanding, I am offering de-identified examples of services we have provided that do not meet the current MaineCare service definition, in spite of significant amounts of *assertive outreach*.

Person 1: Currently off medication and decompensating. This person is refusing to allow staff in his apartment "without a warrant" and keeps the door closed at all times.
18 attempted contacts, including weekends, with only 7 face-to-face contacts resulting in only 1 billable week for the month.

Person 2: Experiencing audio-visual hallucinations, delusions and disorganized thinking at baseline. Fears staff may be unsafe at his home due to his roommate and "ghosts", so he has reduced the frequency he allows staff to visit. Does well processing his fears and worries on the phone, but is unable to follow through on appointments to meet someplace other than his home.
20 attempted contacts and only 4 face to face contacts resulting in only1 billable week for the month.

Person 3: Engagement is impacted by substance misuse. We expected to meet on the final day of the month for the 12th required face to face contact, but were unable to locate him in spite of *assertive outreach*.
Lost 2 weeks of billing for the month due to the loss of the 12th face to face contact.

Person 4: Experiences baseline paranoia, delusions and auditory hallucinations; when unmedicated often loses housing and engages in threatening behavior. Struggles with disorganization including taking medication consistently, and although team delivers 5-6 times a week, is often difficult to locate.
In April, of 23 attempts to deliver medication, this individual only received 10 doses and we were only able to bill for 2 of 4weeks.

I share these examples so you can see the thoughtful actions and responses of our staff who provide compassionate care metered out with a "client first" approach. I hope you also see that for some we serve, imposing face to face contact is clinically contraindicated. We currently have over (80) individuals enrolled in our ACT team services, and would be most grateful for your support of this bill so that we may remain a viable program which is in question at this time.

Thank you for hearing my testimony, and I'd be happy to answer any questions you may have.

Catherine

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