Testimony of Jason Goodrich

Regarding LD 1799: "Resolve, Directing the Department of Health and Human Services to Review the Progressive Treatment Program and Processes by Which a Person May Be Involuntarily Admitted to a Psychiatric Hospital or Receive Court-Ordered Community Treatment"

Senator Ingwersen, Representative Meyer, and members of the Health and Human Services Committee:

My name is Jason Goodrich. I've served Mainers as a case manager, crisis response worker, and forensic intensive case manager. I now direct outreach at a warming center and grassroots ministry in Bangor. I'm here today neither for nor against LD 1799, but to raise a cautionary voice.

Forced treatment is already permitted by law in Maine. Before we move to expand or further entrench these powers, we must first examine whether the Progressive Treatment Program (PTP) and civil commitment processes are functioning as intended—and whether they are serving the people they are meant to help.

In my work with unsheltered folks, across every level of Private Non-Medical Institutions (PNMIs), at Dorothea Dix, with the Office of Behavioral Health, in warming centers, and in emergency rooms across this state, I have seen the real outcomes of coercive care. I've watched people comply with treatment orders out of fear—fear of being locked up, of losing their housing, or of being cut off from the very system that failed them to begin with. That is not recovery. That is survival.

The CCSM is right to say it plainly: coercion breed mistrust. It damages not just the person subjected to it, but every person watching. It undermines future engagement, and it turns treatment into punishment. We must not confuse forced medication and court orders with healing. They are not the same.

It's also important to point out the cost—both human and financial. Court-ordered treatment drains judicial and clinical resources, creates adversarial relationships between providers and clients, and leads to poor long-term outcomes. These cases often bounce between hospitals, jails, and shelters in a loop we all know too well. That loop is expensive. And it doesn't work.

If a workgroup is to be convened, it must reflect the full spectrum of voices—not just institutions. That means:

- Reducing the number of hospital-based representatives,
- Including more people with lived experience,
- Ensuring a disability rights advocate or attorney is at the table.
- Too often, those most impacted are least heard. That must change.

We need to ask hard questions about the efficacy of PTP. Are people getting better? Are they staying better? Are we building trust, safety, and community, or are we enforcing compliance at any cost?

I've seen what works: voluntary engagement, persistent outreach, harm reduction, and peer support. It's slower. It's harder. But it lasts.

Please do not rush to expand a system of forced care without first reckoning with the one we already have. Thank you for your time, your thoughtfulness, and your willingness to hear these truths.

Respectfully,

Jason Goodrich

Brewer, Maine