Testimony of Kelly Barton, MaineHealth
In Strong Support of LD 1003, “An Act to Increase Access to Behavioral Health Services for Children and Individuals with Intellectual Disabilities or Autism”
Wednesday, March 29, 2023

Senator Baldacci, Representative Meyer and Members of the Joint Standing Committee on Health and Human Services, I am Kelly Barton, President of Maine Behavioral Healthcare, and I am here to testify in strong support of this legislation.

As you have heard repeatedly this Session, Maine continues to experience a crisis with people with behavioral health disabilities who are not able to access appropriate levels of care. The situation is particularly acute as it relates to children and adolescents. This Session, you have a number of bills that relate to one another on this topic, including Senator Black’s PRTF bill that you heard last week, this bill, and Rep. Stover’s bill that you will hear next.

Our intent with these bills is twofold: first and foremost, it is to ensure that individuals with behavioral health diagnoses have timely access to the levels of care necessary to best meet their needs. To accomplish that goal, organizations that provide all levels of behavioral health services need adequate resources to safely provide care for individuals whose needs can be very challenging at times. Second, we need to ensure that the Maine’s continuum of services includes all that are necessary to meet the needs of our population.

This bill is focused on two factors: providing access to crisis services, and specifically crisis beds, to support families and residential providers in meeting the needs of individuals experiencing crisis; and

Ensuring that residential providers develop a safe discharge plan that is approved by the State, in which an Emergency Department cannot be identified as a discharge option.

Among our continuum of services, Maine Behavioral Healthcare provides crisis services in seven hospital emergency departments and we operate twelve residential treatment facilities. Every day, the crisis teams see children and adults with autism and IDD who need high levels of care that would be much better served in settings designed to meet their needs. And all too often, these individuals are coming from residential treatment providers who refuse to take them back.
Let me be clear – we do not blame those providers. The crisis systems for children and adults with IDD and autism are severely broken. They lack adequate resources, and particularly crisis beds. Providers of residential services are left with no option but to bring people to the emergency department as a last resort.

Adults with mental illness who live in residential treatment housing are less likely to get stuck in hospital emergency departments. I have attached a chart that shows the average lengths of stay for children and adults with behavioral health needs, and those who have physical health needs in MaineHealth EDs in 2022. The data reflect the challenge we face. As a society, we pay for that which we value, and behavioral health services have long suffered as a result. To that end, we do appreciate the support of the Department and the Legislature in updating MaineCare rates for these services.

There is an important distinction between residential facilities for adults with mental illness and those for children and adults with IDD - mental health residential facilities are required to submit to the Department discharge plans for approval for residents of the PNMI. That policy prevents PNMIs from discharging residents to hospital emergency departments. Attached to my testimony is the MaineCare Benefits Manual section on PNMIs. I’ve highlighted on page 37 the termination requirements for adult mental health residential facilities.

As I mentioned earlier, MBH operates 12 PNMIIs for adults. So we live with this rule.

When this rule change was proposed, we joined other providers in expressing serious concerns. And we readily admit that it can be frustrating and burdensome for our care team members. Particularly when a resident actively and volitionally fails to adhere to group rules. But the policy also ensures that we do not discharge any clients without a safe, appropriate discharge plan. Which is the intent of this legislation.

Last year, we had a residential facility leave three adults with IDD at Maine Medical Center. One spent 3 months living in the ED and the other 5. Both had high levels of need, including very violent behaviors at times. Care team members were injured. Others quit. Both individuals were eventually discharged to residential facilities out of state, where they thrive today. Neither belonged in the hospital. Crisis beds would have been far more appropriate for these individuals, but were told that they were not available.

Last month, we finally discharged an adolescent who spent three months in an ED. The residential facility that left him at the ED refused to take him back because he was an elopement risk. He did not experience a single behavioral outburst during the three months he was with us.

These situations are not ok. They are detrimental for the patients’ health and well-being. They tie up needed emergency room space at a time when EDs often have to go on diversion due to capacity challenges. They take a huge emotional toll on the care team members.

This bill would take an important step in providing the resources necessary to support residential facilities when their clients experience crises. And it would further support the clients by ensuring that, when they are not a good fit for the milieu of the residence, they are discharged to an appropriate and safe option.