

# MENTAL HEALTH SYSTEM REFORM

## Mission

The mission of the Mental Health System Reform Project is to enhance the mental wellness of all Mainers. A strong and accessible mental health system is integral to this effort. There is no national benchmark for defining a “strong” or “effective” state mental health system; therefore, this project set out to define the indicators that serve as benchmarks to measure the growth and progress of Maine’s mental health system. A diverse working group sorted through over 200 individual responses from a survey to identify twelve key indicators that serve as measures of Maine’s mental health system. Identification of the indicators was a monumental task; the work that followed provides a first round of strategy suggestions for improving performance on each indicator in order to positively impact Maine’s mental health system from 2018-2020.

Our hope is that ten years from now we, the mental health community, can look back and say “Maine’s mental health system has improved its ability to support wellness as evidenced by positive changes in these twelve indicators.”

## Purpose

Historically, the indicators of a mental health agency’s success have been measured by “how much” or “how well” outputs such as: looking at the number of clients served or the number of clients who self-report “satisfaction with service.” Occasionally, we look at the outcomes of individuals within a system by assessing if people experience fewer symptoms, report more satisfaction with their daily lives, or maintain their sobriety. This type of data is frequently collected by service providers and analyzed to determine the effectiveness of a specific program or treatment approach. This data collection begins to identify the true impact made in a person’s overall wellness.

The Department of Health and Human Services (DHHS) is only a fraction of the entities and individuals that comprise Maine’s mental health system. Law enforcement,

employers, private practice clinicians, legislators, hospitals and various other state and private agencies all play a part in building a strong mental health system. Thus, the indicators outlined in this report are meant to represent success for the mental health system as a whole and the individuals that receive support and services.

The indicators in this report do not represent the full breadth and width of work being done to improve Maine’s mental health system. There are numerous committees, work groups, and other efforts currently working toward making incremental change in order to develop a more successful mental health system in Maine. Some of these efforts will be highlighted throughout this report, as they support or contribute to improvements in one or more of the indicators used in this study.

## Process

NAMI Maine first met with individuals and groups of stakeholders from across the state to hear about what is working in Maine’s mental health system and what is not. Over the course of a year, over 250 individuals representing every county in Maine were interviewed. The interviews produced a wide variety of perspectives and opinions on the current mental health system making it possible to get a full picture of where the system is succeeding and where gaps exist. It is important to note that diverse political perspectives as well as various types of lived experience were intentionally included so that this body of work would represent all perspectives in Maine.

Information from these interviews was used to develop a list of possible indicators for a successful mental health system. These indicators were sent out in a survey, from which over 700 individuals responded prioritizing the success indicators that would bring about desired change. By analyzing the survey results, NAMI Maine developed a list of twelve critical success indicators of a successfully functioning mental health system.

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# Affordable/Accessible Care

**We know that the average amount of time between when a person notices symptoms of a mental health challenge and when they seek help is ten years.** We also know it is critical to connect them with support the moment they reach out, as nearly two-thirds of people with a mental health challenge will never seek treatment.<sup>1</sup> The level of discrimination that still exists in our society quickly places blame on individuals who are struggling to manage their mental health challenges. While our culture respects physical health challenges, it so quickly demonizes those with a mental health challenge. The debilitating impact of moderate depression is comparable to severe asthma and the impact to daily living for a person living with quadriplegia is comparable to severe depression.<sup>2</sup>

Two of the most significant barriers to people receiving needed treatment are access and availability. “Accessible” is defined as being able to identify a provider that is located within a reasonable distance, has adequately trained/certified staff, and openings for appointments that an individual can afford. Insurance eligibility is a significant barrier for thousands of Mainers who need mental health care. Without access to MaineCare, paying for care is a significant hurdle for Mainers looking for mental health services. As eligibility for MaineCare has become more restrictive and trained providers grow scarcer, Maine struggles to provide high quality, evidence-based, specialized care that is accessible to its residents.

The next three indicators measure targeted efforts to increase levels of available care, reduce the barrier of cost, and promote workforce growth within the mental health field.

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<sup>1</sup> “Mental disorders affect one in four people,” in World Health Report, *World Health Organization*, (2001).

<sup>2</sup> Mental Health First Aid™ USA: First Edition (Revised) | Adult, (2015), *National Council for Behavioral Health and the Missouri Department of Mental Health*.

# Affordable/Accessible Care

## Child and adolescent psychiatrists practicing in rural areas

### MEASURE :

Number of child and adolescent psychiatric practices located in rural areas per total child and adolescent psychiatrists

### RESULTS

**7/31** ME



### NATIONAL COMPARISON

**10/20** VT



**10/27** NH



Data Source: American Academy of Child and Adolescent Psychiatry

The number of child and adolescent psychiatrists in Maine is at a crisis level. Numbers alone cannot illustrate how critical it is for a family to be able to access this level of specialized care. Child and adolescent (C/A) psychiatrists are the most skilled at providing an accurate diagnosis of children and often act as gatekeepers to various forms of treatment. Many families report having been given many inaccurate previous diagnoses because they were not able to secure access to a C/A psychiatrist. Due to the low number of C/A psychiatrists practicing in Maine, access for children and families living in rural areas can seem impossible. We must make it possible for families to access specialized psychiatric care. Transportation, high costs, and waitlists all stand in the way of accessing this level of care.

### WHAT CAN BE DONE:

- 1 Child and adolescent psychiatrists, psychiatric nurse practitioners, and physician assistants must be accessible to primary care/pediatric providers in all areas of the state.
  - 2 Provide telemedicine in rural areas with in-person support.
  - 3 Increase residency/fellowship opportunities available in rural Maine.
- Develop a curriculum for primary care physicians on mental health issues they can expect to handle and issues that require referral to Child and Adolescent Psychiatry.
  - Map the availability of each level of care being utilized (i.e. MaineCare, as well as those funded by private insurance).
  - Reimburse psychiatrists for collateral contacts in the coordination of child and adolescents care.
  - Implement a reimbursement for “hosting” telemedicine (primary care providers and pediatricians), including the cost of a support person.
  - Locate and make available telehealth equipment across the state for current practicing C/A psychiatrists.
  - Ensure high speed internet access in all parts of the state (prioritizing based on existing research that has been done on areas of need).
  - Develop surveys of potential recipients of training opportunities.
  - Develop more learning and training opportunities.

# Affordable/Accessible Care

Peer and self-help supports accessible within 30 miles of every Mainer

## MEASURE :

Number of peer and self-help groups per 100 thousand

## RESULTS

**7.7/100K** ME

## NATIONAL COMPARISON

**11.3/100K** VT

**8.0/100K** NH

Data Source: SAMHS/NAMI (significant underestimate)

Peer Support is a critical component of a high-performing mental health system. Individuals who have a diagnosis and have managed their own path to recovery are critical partners in promoting recovery and supporting wellness. The value of peer support has a long and rich history within the substance use disorder community. For the past decade, peer support has been playing an increasingly significant role in the mental health system across the nation. While professionals are critical for the insight, treatment and medication they can provide, only another person who has experienced similar struggles can provide the personal connection and support needed to move towards recovery.

The State of Maine has a certification process for intentional peer support overseen by the Department of Health and Human Services. The Department implements a model to train peers with lived experience on how to engage in a supporting relationship with other peers in their journey of recovery. Peer support often helps individuals discover the various non-medical interventions that people living with a mental health challenge and their family members can access to find community, support, and hope. While there are many issues around access to care, the challenges around accessing non-medical supports can often be greater. One can locate a mental health agency by searching online, but peer centers, Clubhouses, support groups, Inspiring Minds classes, and other non-medical supports are not as easy to locate. Finding a community and identifying effective self-help strategies is a significant challenge for individuals working to achieve recovery.

### WHAT CAN BE DONE:

**1** Develop a real-time online overview of available self-help and peer support services.

- Map current self-help resources across the state, such as: Clubhouses, drop-in centers, peer support social groups, support groups, and recovery centers.
- Contact peer resource programs to learn about their current plans for development, and identify gaps that should be filled.
- Ask peer programs: What would it take for you to expand 2-3 additional locations in your region? If you did, which locations do you believe would be most useful?
- Add those locations to Maine peer resource map with new color dots.
- 2** Develop a system of Peer Recovery Centers. These centers will have paid staff and help members with skills development. Ideally, these centers need to be available statewide, so members do not have to travel far distances for support.
- Request assistance of Consumer Council Systems of Maine to help determine useful resources, current offerings, and where we have significant gaps in self-help resources in Maine.
- Partner with DHHS to develop a coordinated system of care for Peer Recovery Centers.
- Explore Community College (CC) partnerships that would allow local CC campuses to provide the Intentional Peer Support certification course on campuses across the state.
- Explore workforce development opportunities with vocational development and rehab programs (including CCs, Work First, and career centers) and adult education programs.
- MaineCare needs to match the peer support rate with meaningful opportunities for reimbursement in Chapter 101 Sections.

# Affordable/Accessible Care

Reimbursement rates adequate to support necessary services provided by professionals

**MEASURE :** 2016 Community and Social Service Occupations' Wages

## RESULTS

**\$44,980**



## NATIONAL COMPARISON

**\$47,200**



Data Source: Bureau of Labor Statistics

Access to quality mental health care is never dependent on one factor alone. A combination of provider shortage, lack of funding, and limited workforce creates a challenging dynamic for people hoping to access services when and where they need them. Maine is at a crisis level with its lack of Master's level clinicians, psychologists, and psychiatrists. Maine must work to address its increasing workforce shortage within the mental health field; particularly specialized mental health care. Ensuring adequate reimbursement rates will attract more specially trained professionals who have the skills and training necessary to meet the needs of Mainers.

Many disciplines in the public service field offer different avenues for loan repayment and forgiveness. This is a concept Maine should adopt for a wide variety of mental health professions. In the 128th Maine State Legislature, NAMI Maine helped introduce a bill that would create the Mental Health Providers Loan Repayment Program.<sup>3</sup> This bill would allow mental health providers the opportunity to have portions of their student loans repaid if they meet certain criteria. This bill has been carried over to a Special Session of the 128th Legislature. These efforts

need to continue in order to make Maine a more attractive place to work for mental health professionals. Maine needs to ensure adequate reimbursement rates for these professionals in order to build a strong and supportive mental health system.

### WHAT CAN BE DONE:

- 1 Reimbursement rates that reflect an actual professional wage for entry level staff as reported by providers.
- Educate the Maine State Legislature about the impact of adequate workforce and reimbursement on access to care.
- Gather data on the impact of the rate-setting process on the availability of care.
- Gather data on the impact of rule changes making MaineCare more or less available.
- 2 Develop a state strategy to utilize national resources such as the National Health Service Corp. student loan repayment programs to draw specialized care providers to rural, underserved regions of the state.

<sup>3</sup> Maine State Legislature, 1879, 128th Regular Session, An Act To Enhance and Increase the Availability of Mental Health Providers in Maine.

# Coordinated Care

**Maine’s mental health system is comprised of various types of services including outpatient care, in-patient care, crisis response, community providers, peer support, and many more.**

Within the mental health system we have a tendency to operate in silos; yet the formal mental health system is just one of the many systems that interact with people living with a mental health diagnosis.

Many efforts have called for implementing cross-system or multidisciplinary approaches to serving individuals within the human services or mental health systems. Families and individuals often do not have the luxury of having only one challenge in their life; yet systems often refuse to address the underlying reason a person may need help if it is not related to the narrow mission of that system. Maine needs to work towards creating a “no wrong door” concept for its mental health system. This would mean individuals would get the mental health care and services they need no matter where they seek services.

The standard of care provided in a correctional setting is behavior management and not recovery. Jails and prison are held to a correctional standard of care, which

mandates that they provide the treatment necessary to manage behavior while The Joint Commission accreditation standards require the delivery of care to support recovery. Yet, data highlights that a significant number of adults living with untreated mental illness end up having contact with the criminal justice system. The system is backwards, as “there are three times more [individuals with mental health challenges] in prisons than in mental health hospitals, and prisoners have rates of mental illness that are two to four times greater than the rates of members of the general public.”<sup>4</sup>

It is critical to address mental health in the juvenile justice system. Research suggests 50% to 70% of youth in the juvenile justice system met the criteria for a mental health challenge and 60% met criteria for a substance use disorder.<sup>5</sup> Early intervention is crucial; therefore, we must provide the appropriate and necessary services for youth in the juvenile justice system to address the mental health challenges many of them are facing.

If we are to build a strong mental health system, the interventions implemented must reach far beyond the mental health system. We must include the justice, educational, social service and physical health care systems. Our minds and bodies are connected; therefore, mental health care cannot be fragmented and detached from the rest of the body.

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<sup>4</sup> “Ill-Equipped: U.S. Prisons and Offenders with Mental Illness,” *Human Rights Watch*, (2003).

<sup>5</sup> Criminal and Juvenile Justice, *Substance Abuse and Mental Health Services Administration*, (2017).

# Coordinated Care

## Law enforcement that have at least one full-time mental health liaison

**MEASURE :** Number of departments with mental health linkages

### RESULTS

**2/154**

**(NARROW)**

**14/154**

**(EXPANSIVE)**

### GOAL

**154/154**

*Narrow definition: employed by department; Expansive definition: connected with department*

Data Source: Hornby Zeller Associates 2016 Survey

Individuals living with mental health challenges have experienced a significant increase of encounters with law enforcement resulting in higher numbers of people with mental health challenges in jails and prisons across the country. Maine is no exception to this phenomenon. An additional lack of community supports has forced law enforcement entities to become more involved in the response to mental health challenges and crises.

Law enforcement officers cannot be trained to serve as agents of the criminal justice system and social workers. In order to build a bridge between law enforcement and the mental health system, all police and sheriff departments need to have access to a mental health liaison.

In 2009, the Portland Police Department received a grant from the Bureau of Justice to employ a mental health liaison within the department. The Portland Police Department hired a licensed clinical professional counselor and created a behavioral health imbedded unit. After the grant funds ended, the City of Portland recognized the immense value of having the unit and included the necessary funding in the Police department's budget. Other departments have formal or informal agreements with their local crisis agencies providing officers on patrol access to a clinician.

### WHAT CAN BE DONE:

**1** Ensure every police department in the state has the ability to access mental health expertise and guidance as needed.

- Create a budget item within the Department of Health and Human Services to fund a clinician to be imbedded within each Sheriff's department in the State.
  - Establish an officer mental health liaison within every department. An officer can become the mental health liaison by completing Crisis Intervention Training and ongoing professional development specific to mental health.
  - All officer liaisons, from every department within a county, should meet bi-annually with a countywide mental health liaison to review challenging mental health calls, best practices, and to collaborate on addressing the unique needs of individuals who have multiple contacts with law enforcement. The countywide mental health liaison will work with officers and consumers to identify what crucial information should be shared from the local level on a monthly basis.
- 2** Adopt a standard tracking system and unified database for mental health-related calls to law enforcement.
- The countywide mental health liaison will work with providers, officer liaisons, consumers, and advocates to define a mental health classifier to be used state-wide by departments responding to mental health calls in the community.
  - This team will work together to identify what information needs to be tracked and what the data will be used for (i.e. Identifying hotspots of mental health crisis calls to target preventative community actions).

# Coordinated Care

## Mental health receiving centers for use by law enforcement

**MEASURE :** Number of receiving centers

### RESULTS

**0** STATEWIDE

### GOAL

**5** STATEWIDE

Data Source: NAMI Maine

When faced with a mental health crisis in the community, there are limited resources available to law enforcement and family members for speedy assessment and de-escalation. According to the DHHS quarterly crisis report for quarter two of state fiscal year 2016, 60.7% of initial face-to-face crisis contacts for adults were in the emergency department.<sup>6</sup>

The majority of people who are brought to the emergency department as a result of a mental health crisis have been brought there by law enforcement. Emergency rooms are not adequately prepared with psychiatric providers who have the ability to respond to a mental health crisis. Officers are then required to wait many hours with a patient until they are either seen by crisis or admitted to the hospital. This process is extremely costly on time and resources for everyone involved.

The lack of community resources means individuals with mental health needs end up in jail instead of treatment. Nationally, jails are seeing an influx of arrests involving mental health-related issues and petty crimes, many of which could be diverted if individuals were connected to the appropriate community resources.

States across the country have found ways to reduce the amount of time spent in emergency departments for law enforcement and people in crisis. Mental health receiving centers are one approach to addressing this issue. Maine has an existing system of crisis stabilization units (CSU) that is currently inaccessible to law enforcement. Just in the past year, funding for this resource has been cut by the Department of Health and Human Services, limiting its scope of service even further.

### WHAT CAN BE DONE:

- 1 Expand existing CSUs to ensure availability for law enforcement to drop off non-violent people in crisis who are voluntarily seeking services.
  - Renegotiate state contracts to have one empty bed funded specifically for “no refusal” law enforcement drop-off.
  - Have one Certified Residential Medication Administrator on staff at all times.
  - CSUs will negotiate a memorandum of understanding (MOU) with local hospitals to provide consultation and medication as needed.
  - Peer support would be available during the day and on-call.
- 2 Within the first year of employment, every law enforcement officer will go through one shift with their local crisis agency.
  - Every department will have an MOU with their local crisis provider.
  - Develop a provisional screening list for possible dispositions such as: voluntary/involuntary or community contact (legal guardian for minors).
- 3 Create regional mental health assessment centers where families or law enforcement can bring individuals who are struggling with unmet mental health needs.
  - Assessment centers funded by DHHS and run by community-based mental health centers will employ psychiatrists and master-level clinicians in order to engage in a comprehensive assessment of individuals.
  - Assessment centers will serve voluntary and involuntary clients, as well as those being held in police custody.

### EXAMPLE: BEXAR COUNTY MODEL

Bexar County in Texas implemented a Jail Diversion Program that, in the first five years, diverted more than 4,000 individuals living with mental health challenges from incarceration to treatment. This shift saved the county at least \$5 million annually for jail costs and \$4 million annually for emergency department costs. The County Crisis Care Center is one component of this successful, coordinated delivery network.

### ABOUT THE CENTER:

“The center is unique in that it combines medical services and behavioral health care services for the consumer. . . The advantage to this style of operation is that patrol officers can return rapidly to the streets and patients are quickly cleared and can be processed by the criminal justice system. If there is a need for further psychiatric evaluation, this can also be accomplished under one roof and the officer is back on the street in approximately 20 minutes.

There are approximately ten beds, and patients can stay up to 23 hours. The same psychiatrist that handles the walk-in patients is also responsible for these beds. Professional counselors and social workers are also part of the staff, and there is a receptionist

and secretary as well as a staff member who handles financial assessment of patients. The center tries to work with medical coverage to recoup some of the costs. In the first year alone, more than 7,000 combined medical and psychiatric cases were handled.

In the “23-hour stay area,” the center averages about 14 patients daily. Approximately 600 individuals present for psychiatric services each month, with 200 of these individuals assigned to the 23-hour observation. In the 23-hour clinic, the patient is stabilized and restarted on medication. Patients who cannot be stabilized are transferred to the least restrictive setting. Depending on the benefits available to the consumer, the patient is either handed over to a private facility or to the state hospital.

The jail diversion program also runs three adult outpatient clinics, which are separate from the CCC and are operated by the [Center for Health Care Services (CHCS)]. These centers provide mental health services and intensive case management for consumers on probation and parole.”<sup>7</sup>

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<sup>6</sup> Maine Department of Health and Human Services Integrated Quarterly Crisis Report: QTR2 (October, November and December) SYF16, *Substance Abuse and Mental Health Services, Maine Department of Health and Human Services.*

<sup>7</sup> The Center for Health Care Services, “Blueprint for Success: The Bexar County Model – How to set up a jail diversion program in your community.”

# Evidence-Based Practices

**To create a more effective and supportive mental health system, Maine must invest in programs and practices that address the entire span of mental health recovery and resiliency.** Funding evidence-based practices throughout the state must become the standard and not the exception. Evidence-based practices are proven effective and have demonstrated success, which makes these practices a smart investment in Maine’s future. From prevention, early intervention, treatment, and recovery, all work funded by the state must focus on approaches that have demonstrated a tangible impact on people’s lives. It is critical to have evidence-based practices for every stage a person encounters on their path toward mental wellness.

To positively impact Maine’s mental health system, there must be mechanisms to measure how well programs are functioning and the impact they are making on the populations they serve. Evidence-based practices are developed in ways that produce measurable outcomes that can be tracked and evaluated. The ability to measure a program’s success is one of the most useful aspects of implementing evidence-based practices.

The Substance Abuse and Mental Health Services Administration (SAMHSA) has a National Registry of Evidence-based Programs and Practices (NREPP). This registry lists all mental health and substance use interventions that have met NREPP’s minimum requirements to be considered an evidence-based program or practice. It is meant to be used as a tool for the public to learn about evidence-based programs that are available to them and could be implemented in their communities. The State of Maine can evaluate programs found in the NREPP and use them to strengthen the mental health system.<sup>8</sup>

Currently, state government measures how often a service is being delivered and how many people are being served. Occasionally, services will be evaluated by how well they are being delivered. Moving toward a system that holds all entities accountable to demonstrating a true impact made in people’s lives requires the implementation of evidence-based practices across the entire mental health system.

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<sup>8</sup> Substance Abuse and Mental Health Services Administration, “National Registry of Evidence-based Programs and Practices.”

# Evidence-Based Practices

## Number of people who seek evidence-based practices and are able to access it

Maine must be strategic in its efforts to support funding for evidence-based mental health and substance use services. MaineCare is the largest insurance provider in the state and to incentivize providers to deliver evidence-based practices, MaineCare must take a leadership role in reimbursing at higher rates for programs that are registered under SAMHSA's National Registry of Evidence-Based Practices and Programs.

There are many different parties responsible for purchasing mental health services. There are state agencies such as the Department of Health and Human Services, the Department of Corrections, MaineCare, private insurance providers, and individual families. These payers play an important role in ensuring quality care is available to people who need it. The number of payers offering payment incentives for evidence-based practices will not only ensure that there is access to these services, but also that service providers are able to sustain offering the practices with fidelity.

Evidence-Based Practices are more effective than basic talk therapy; however, they come at a higher price. Without higher reimbursement rates and the legal expectation that certain services are funded, these services are simply not available to Mainers regardless of whether a person has comprehensive private insurance, MaineCare, or is able to pay for the cost out of pocket.

### WHAT CAN BE DONE:

- 1 Ensure adequate reimbursement for training, fidelity, and implementation of evidence-based practices.
- The state needs to define “evidence-based practices” using existing resources (APA language). Evidence-based practices should be defined for both adult services and child services.
- Establish a system for payer oversight of fidelity to the incentivized models.
- Pass legislation that implements evidence-based practices and requires reporting on those services. In the 128th Maine State Legislature, two bills sought to do this: LD 902, *Resolve, To Increase Access to Evidence-based Psychosocial Treatment for Children in the MaineCare Program*, which has been carried over to a Special Session of the 128th Legislature; and LD 384, *An Act to Strengthen Maine Children's Mental Health*, which is now Maine law.

# Evidence-Based Practices

## Providers and agencies utilizing trauma-informed system models

### MEASURE :

Percent of practitioners with trauma competence out of 3,300

### RESULTS

**78%** 

### GOAL

**100%** 

Data Source: Hornby Zeller Associates TIAA survey 2013

Researchers have come to the consensus that exposure to traumatic events has a significant role in the onset of a mental health diagnosis. Addressing the mental health condition that developed as a result of trauma cannot happen if the trauma is not addressed.

“Trauma can be the result of any incident experienced by a person that is perceived to be dangerous and threatens serious injury or death to themselves or others. Common examples of traumas are accidents, assault (including physical or sexual assault, mugging, or family violence), or witnessing something terrible.”<sup>9</sup> Understanding the impact that trauma can have on someone vastly changes the way mental health workers interact with people seeking support. Instead of asking “What is wrong with this person?” trauma-informed providers ask “What has happened to this person?”

In 2010, the Maine DHHS worked with non-profit entities to incorporate a trauma-informed agency assessment to help agencies working in Child Behavioral Health Services utilize a trauma-informed perspective when working with children and families. Agencies were to provide a trauma competence training of their choice to staff. Then agencies, families, and youth completed a short survey assessment. Following this survey, a contracted entity provided each participating agency with a trauma-informed report regarding trauma competency.

### WHAT CAN BE DONE:

- 1 DHHS should re-evaluate trauma-competency training being offered to ensure an evidence-based tool is being used to educate providers.
  - Solicit input from mental health agencies that participated in the first round of trauma-informed agency assessment and scored 90% or higher.
  - Offer mental health providers the choice between one of the eight trauma-specific interventions supported by SAMHSA.
  - Ensure an evidence-based assessment tool is utilized.
- 2 Implement the trauma-informed agency assessment and trauma-competency training for all Department of Health and Human Services staff who work directly with people (specifically: the Office of Child and Family Services, Substance Abuse and Mental Health Services, and MaineCare).
  - Allocate general fund dollars to support training costs.

<sup>9</sup> Maryland Department of Health and Mental Hygiene, Missouri Department of Mental Health, and National Council for Community Behavioral Healthcare, (2012), *Youth Mental Health First Aid® USA for Adults Assisting Young People*.

# Healthy Living For Communities

## Two of the most important factors that contribute to one's path towards mental wellness are stability and social connection.

Stable housing is critical for individuals to manage and improve their mental wellness. NAMI National states the “lack of safe and affordable housing is one of the most powerful barriers to recovery.”<sup>10</sup> Stable housing is a basic necessity on which all people should be able to rely. With a lack of affordable, safe, and stable housing for individuals living with mental health challenges, they often end up in jails, hospitals, shelters, or transition in and out of homelessness. This challenge is greatly increased when individuals living with mental health challenges are discharged from an inpatient care unit or jail. These individuals often have no home to return to. Due to this ongoing challenge, in the 128th Maine State Legislature, Legislative Document (LD) 1133: *An Act Regarding Access to Appropriate Residential Services for Individuals Being Discharged from Psychiatric Hospitalization* sought to require residential service providers to provide patients the reasons for why they are being denied housing.<sup>11</sup> This bill has been carried over to a Special Session of the 128th Legislature. Stability helps with recovery and self-sufficiency. Maine must work towards ensuring individuals living with mental health challenges have a place to live and thrive.

Social connection is another factor that contributes to one's mental wellness. The more opportunities a person living with a mental health challenge has to connect with others in a positive way, the better. Social connection can often come from the workplace. Unfortunately, over the last decade, employment rates for individuals living with mental health challenges has greatly decreased. NAMI National reported, in 2012, nationwide, only 1.7% of individuals served in mental health systems received supported employment services.<sup>12</sup> Helping individuals succeed in the workforce should be a priority for Maine. For individuals living with mental health challenges, maintaining employment gives them a sense of hope and the feeling of self-sufficiency.

There must be intentional focus on increasing social connection in communities. In the age of social media, social isolation is growing for those not connected through technology. It is critical that Clubhouses, Peer Centers, and Recovery Centers be a welcoming place for any person looking for assistance related to a mental health challenge or substance use disorder. These resources aimed at enhancing connection are often the first to be identified for decreases in funding. Moving forward, approaches that produce a measurable impact by enhancing social connection need to be a priority.

<sup>10</sup>National Alliance on Mental Illness, “Securing Stable Housing,” (2018).

<sup>11</sup>Maine State Legislature, 1133, 128th Regular Session, An Act Regarding Access to Appropriate Residential Services for Individuals Being Discharged from Psychiatric Hospitalization.

<sup>12</sup>National Alliance on Mental Illness, “Road to Recovery: Employment and Mental Illness,” (2014).

# Healthy Living For Communities

People who are able to access supportive housing

**MEASURE :** Percent of individuals in supported housing

## RESULTS

**7.3%** 

## NATIONAL COMPARISON

**3.1%** 

Data Source: Maine NOMS-SAMHSA 2016

Without adequate supportive housing locations in Maine, there is no provision for individuals moving toward recovery to have time necessary to learn how to manage their unique challenges. Individuals who have lost connection to family and friends due to long term struggles with substance use or psychosis often find themselves homeless. Homeless shelters are not designed or funded to provide the level of long-term support many individuals need to move toward self-sufficiency. Psychiatric hospitals are often forced to release a patient from hospitalization to a homeless shelter.

Regardless of the progress made in treatment, sending an individual who is struggling to find and maintain recovery to the uncertainty of living in a homeless shelter is not an acceptable option. This issue could be addressed by significantly increasing in the number of supportive housing units.

The lack of supportive housing also has a direct impact on the length of time that individuals are waiting in emergency rooms to be admitted into a psychiatric hospital. The more options for discharging a client to a step-down level of care, such as supportive housing, the faster beds can be made available for those with more acute needs.

### WHAT CAN BE DONE:

- 1 Establish four levels of community step-down housing options for individuals leaving hospitalization.
- State completes a comprehensive statewide assessment of housing options for individuals living with a mental illness. Assessment should examine resources provided to people transitioning out of private, non-medical institutions into the community or those who have increasing need, but not living independently, in order to identify gaps.
  - Invest state dollars to create and appropriately fund the four levels of community step-down housing options identified by completing the assessment.

# Healthy Living For Communities

Individuals with serious and persistent mental illness who are employed

**MEASURE :** Percent of individuals with mental illness who are employed

## RESULTS

**33.1%** 

## NATIONAL COMPARISON

**50.1%** 

Data Source: Maine NOMS-SAMHSA 2016

The concept of recovery is built on two basic principles: social connection and purpose. The ability to obtain employment and have the sense of satisfaction of earning a paycheck is an experience that greatly aids in one's recovery from a mental health condition. Maine's employment rate for individuals served in the public mental health system is 7.4%. This means 92.6% of individuals who have contact with Maine's mental health system are not employed. This statistic may vary by source depending on how the source defines "employment." As NAMI National states, "Employment rates are inexcusably low and getting worse for people living with mental illness."<sup>13</sup> Maine must work to change this statistic.

Maine is home to four evidence-based Clubhouses aimed at helping those living with a mental illness enter the workforce. However, the large geographic area and rural nature of Maine presents many challenges to providing employment support to all those who would benefit.

### WHAT CAN BE DONE:

- 1 Implement evidence-based practices, training, and coaching models.
  - Identify funding to have direct-practice professionals trained and models that would fit well with the rural nature of Maine.
- 2 Individuals have the ability to access a Clubhouse in each region of the state.
  - Clubhouse regions should use the Center for Disease Control and Prevention public health regions.
  - State must designate funding for the establishment and operation of additional clubhouses.
  - Explore how to incorporate clubhouse-model components into community college campuses in a way that connects the services of the community college with the mission of the clubhouse.
- 3 Promote professional training/education to ensure that a person can enter the workforce in a professional role.
  - Support the "bridge" program in high school. This program can help transition non-college bound students into vocational roles.
  - Expand the work study program within Temporary Assistance for Needy Families to encourage work requirements be met through vocational training for individuals identified as living with a mental health challenge.

<sup>13</sup> National Alliance on Mental Illness, "Road to Recovery: Employment and Mental Illness," (2014).

# Reduction In Adverse Events

**Mental well-being is an accumulation of a variety of factors that impact an individual. From pre-natal health care, to a diet rich in Omega-3 fatty acids, our brains are impacted by how we care for our bodies and the experiences we encounter.**

Mental illness is brought on by many factors, many of which are within our ability to influence. While scientists still have much to learn about the brain, it is clear that adverse childhood experiences have a profound impact on a person's future mental wellness.

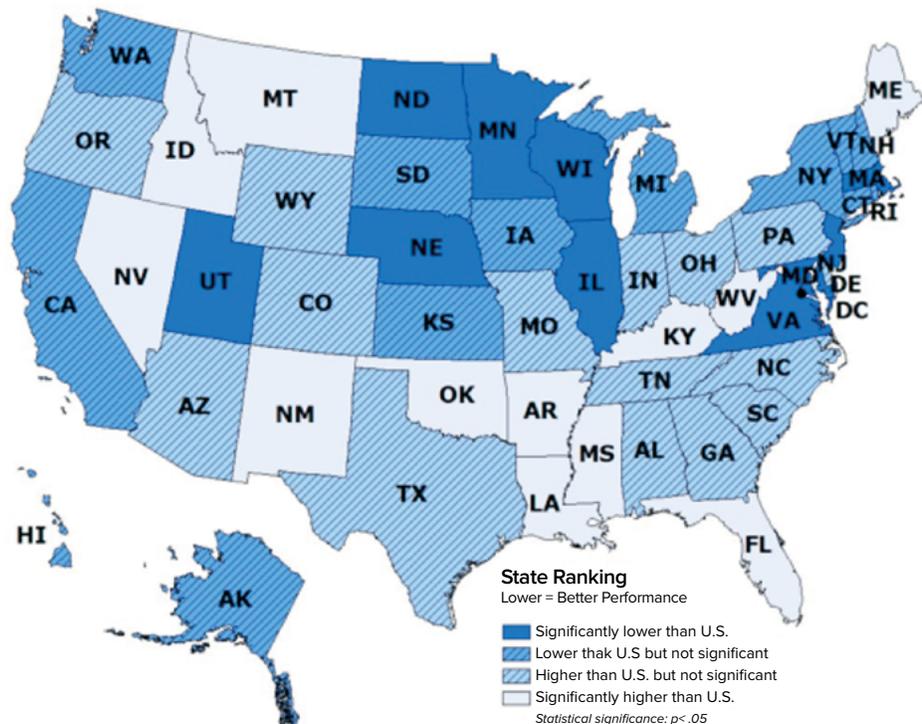
What is traumatic for a person can depend on a whole host of circumstances. What research has shown us is that dismissive or stigmatizing attitudes about the impact of a mental health challenge on an individual

has failed generation after generation. Exposure to trauma results in a chemical change in the brain that has a direct impact on the development of both physical and mental health conditions. For too long, individuals who have experienced traumatic events in childhood have been judged by their behaviors and not treated for the root cause of those actions.

The Adverse Childhood Experiences (ACE) study completed in 1997 demonstrated there was a direct link between childhood trauma and adult onset of chronic disease, as well as mental illness. Additionally, the more adverse childhood experiences one experienced, the higher the risk of medical, mental and social challenges as an adult. Treating a person for behavior or medical symptoms proved unsuccessful because the root cause of the challenge required looking back into a person's history and working to undo the damage of that trauma.<sup>14</sup>

**Percent of children age 0-17 with one or more adverse childhood experiences in the U.S.**

Nationwide: 46.3%  
State Range: 38.1% – 55.9%



**SOURCE:** Bethell, CD, Davis, MB, Gombojav, N, Stumbo, S, Powers, K. Issue Brief: A national and across state profile on adverse childhood experiences among children and possibilities to heal and thrive. Johns Hopkins Bloomberg School of Public Health, October 2017. <http://www.cahmi.org/projects/adverse-childhood-experiences-aces/>

<sup>14</sup> For more information about the study visit: <https://www.cdc.gov/violenceprevention/acestudy/about.html>

# Reduction In Adverse Events

Individuals diagnosed with a mental illness who are chronically homeless

**MEASURE :** Percent of Individuals with mental illness who are homeless

## RESULTS

**7.2%** 

## NATIONAL COMPARISON

**3.9%** 

Data Source: Maine NOMS-SAMHSA

Safe, accessible housing can provide a sense of stability that is critical for recovery and mental wellness.

Many organizations in Maine are working towards ensuring individuals have access to stable housing. Preble Street in Portland has been fostering the Housing First model with the development of Logan Place and Florence House.<sup>15</sup> The Housing First model delivers a real solution to the struggles associated with homelessness. Logan Place “provides efficiency apartments and 24 hour on-site support for 30 adults who had previously been homeless.”<sup>16</sup> This model allows individuals to succeed in their recovery by providing a safe place where they have the ability to engage in mental health care and form social connection with other individuals.

It is important for the law enforcement community to be informed about mental health challenges and homelessness in order to handle interactions in the most beneficial and effective way. Law enforcement need to be aware of community mental health supports and services so individuals can be redirected to the appropriate care they need instead of ending up in jails or emergency departments.

### WHAT CAN BE DONE:

**1** Engage mental health systems (mental health agencies, hospitals, federally qualified health centers, primary care, Statewide Homeless Council, and the State of Maine) to address housing issues for individuals with mental health challenges.

- All partners within the mental health system should have internal performance measures, standards, and outcomes for their clients related to housing.
- 2** Engage and incentivize landlords to gain skills communicating and de-escalating individuals with mental health challenges.
- 3** Educate mental health systems (mental health agencies, hospitals, federally qualified health centers, primary care, Statewide Homeless Council, and the State of Maine) with the Housing First Model.
- Implement the Housing First Model statewide with designated state funding at a level that would allow for a measurable increase in availability for housing in Portland, Augusta, Waterville, Bangor, and Houlton.
- 4** Educate mental health systems (mental health agencies, hospitals, federally qualified health centers, primary care, and the State of Maine) on Adverse Childhood Experiences (ACE) and the impact they have on readiness for services.
- 5** Work with PATH outreach services and explore “ride along” services (similar to Crisis Intervention Team Training).
- Establish a homelessness liaison through the PATH outreach services for law enforcement.
- Develop working partnerships between adult services, child and family services, behavioral health service providers, and landlords to obtain, maintain, and sustain safe, long-term housing.

<sup>15</sup> For more information about Housing First, visit: <https://www.preblestreet.org/what-we-do/advocacy-programs/home-for-good/>

<sup>16</sup> For more information about Logan Place visit: <https://www.preblestreet.org/what-we-do/housing-services/logan-place/>

# Reduction In Adverse Events

Decrease statewide number of deaths by suicide

**MEASURE :** Rate of suicide per 100 thousand in 2015

## RESULTS

**16.1/100K**

## NATIONAL COMPARISON

**13.3/100K**

Data Source: CDC/AFSP state guides 2015

The loss of a loved one to suicide results in a ripple effect across Maine's communities. This loss is felt on a profound level for generations to come. There is perhaps no better indicator as to the mental wellness of Mainers than the suicide rate. Individuals feeling lost and isolated who lose the will to live demonstrate failures across many systems in the state, but especially the mental health system. Individuals need reliable and accessible support in order to manage mental health challenges. Maine must strengthen its mental health system in order to support its people. Suicide Prevention is everyone's responsibility. The recommendations below provide a place to start developing multifaceted approaches than need to employ non-traditional partners.

### WHAT CAN BE DONE:

- 1 Implement a multifaceted statewide awareness campaign about the role Adverse Childhood Experiences (ACE) have in premature death, including deaths by suicide.
  - Promote awareness about ACE tools and the research related to the impact of trauma on individuals' life outcomes.
  - Educate providers across a wide spectrum of fields to recognizing the impact of trauma on behavior (educational institutions, criminal and juvenile justice system, judiciary, human service agencies).

- Educate mental health clinicians on the importance of addressing the underlying trauma that individuals have experienced during their lifetime.
  - The Department of Health and Human Services should fund resources and services that are trauma responsive with the purpose of assisting children with building resiliency.
- 2 Develop a Statewide Suicide Review Panel to provide accurate information and increase access to timely data.
    - Create a panel of community stakeholders to review all reports related to every suicide in the State of Maine.
    - The panel would issue an annual report with specific data markers. The results would inform providers on how to tailor responses to data about who is dying by suicide.
  - 3 Engage community partners to host and promote Mental Health First Aid training in order to develop skills and understanding around how to work with individuals experiencing suicidal thoughts.
    - Develop the expectation that employers who require First Aid certification will begin to require Mental Health First Aid certification as a condition of employment.
    - Train community partners in Mental Health First Aid to build understanding and awareness of mental illness and develop the necessary skills to respond to mental health crisis.

# Reduction In Adverse Events

Statewide number of deaths where substance use is present

**MEASURE :** Drug overdose per 100 thousand in 2014

## RESULTS

**16.8/100K**

## NATIONAL COMPARISON

**14.7/100K**

Data Source: CDC/MMWR 2014

Substance use disorder is a mental illness that has a profound impact on communities. The 2017 report funded by the Maine Office of Attorney General that provides statistics on drug fatalities in Maine stated there were 418 drug-induced deaths statewide.<sup>17</sup> The Maine Department of Transportation's Highway Safety Facts stated the average annual fatalities from car crashes where alcohol was a factor was 37.6.<sup>18</sup> Chronic heavy drinking among adult Mainers is significantly higher than the rest of the United States, as 7.2% of adults in Maine report chronic heavy drinking.<sup>19</sup>

While the current opioid crisis is resulting in a profound loss of life, we must systematically address the problem of addiction at its core. Our focus as a community should remain on the need to provide comprehensive mental health services to prevent substance use disorder. 75% of individuals who will develop a substance use disorder have done so by age 27.<sup>20</sup> If we are truly going to address substance use disorder, we must ensure early intervention services are available for our adolescents. Comprehensive treatment must be accessible across the entire state, especially in rural areas.

## WHAT CAN BE DONE:

- 1 Support a network of prevention, intervention, treatment, and recovery through a robust statewide public health infrastructure.
  - Use disaggregated data to identify trends specific to targeted needs, which would allow for the development of customized local strategies.
  - Utilize localized data around substance use to shape how public health coalitions will develop prevention and intervention strategies.
  - Support existing peer recovery centers and enhance the network of resources.
- 2 Directly address the attitudes in communities expressed toward people with a substance abuse disorder. Replace the belief that a substance use disorder is a "choice" with the understanding it is a "disorder" by raising awareness using the perspective of those with lived experience. Evidence-based awareness education and comprehensive messaging will help reduce stigma and empower recovery.

<sup>17</sup> "Expanded Maine Drug Death Report for 2017," Marcella H. Sorg, PdD, Margaret Chase Smith Policy Center, University of Maine, *funded by the Maine Office of Attorney General*.

<sup>18</sup> 2016 Maine Highway Safety Facts, *Bureau of Highway Safety and Maine Department of Transportation*.

<sup>19</sup> Maine Shared Community Health Needs Assessment State-Level Summary: 2015, *Maine Department of Health and Human Services and Maine Center for Disease Control and Prevention*.

<sup>20</sup> Mental Health First Aid™ USA: First Edition (Revised) | Adult, (2015), *National Council for Behavioral Health and the Missouri Department of Mental Health*.



# About

The System Reform Project began in 2015 due to a strong commitment from NAMI Maine’s Board President Valerie Gamache to ensure that NAMI Maine’s advocacy efforts were shaped by the larger mental health community’s perspective. Modeled after the Annie E. Casey KidsCount Report, this project required dedication and engagement from a wide array of individuals all of whom are deserving of credit for this report.

This report does not represent the views of any one individual, as it was a collaborative project that incorporated the ideas of individuals from many backgrounds.

## NAMI Maine Staff

Jenna Mehnert, *Executive Director*  
Maggie Priest, *Policy and Quality Assurance Associate*  
Aashley Malsbury, *Policy and Quality Assurance Associate*

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## Committee Members

Steve Addario  
Bill Baker  
Guy Cousins  
  
Dale Hamilton  
Stephanie LeBlanc  
Hannah Longley  
  
Richard Malaby  
Simonne Maline  
Olivia McCormack  
Troy Morton  
Joel Merry  
Trish Niedorowski  
Whitney Parrish  
Ed Pontius  
Catherine Ryder  
Patti Ross  
Dalene Sinskie  
Lindsey Tweed  
  
Shawn Yardley

## Representing

*Crisis System*  
*Law Enforcement*  
*Mental Health/Substance Abuse System*  
*Community Mental Health*  
*Community Mental Health*  
*Crisis/Law Enforcement Liaison*  
*Family Member/Legislator*  
*Peer/Consumer Council*  
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*Law Enforcement*  
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*Adult Psychiatric Services*  
*Community Mental Health*  
*Mental Health System*  
*Community Mental Health*  
*Child and Adolescent Psychiatry*  
*Family Member/Community Action Agency*



(800) 464-5767 / [info@namimaine.org](mailto:info@namimaine.org) / [namimaine.org](http://namimaine.org) / 1 Bangor Street, Augusta, ME 04330