**Mental Health Working Group**

**November 1, 2019**

**9:00 am – 12:00 pm**

**Department of Health & Human Services**

**109 Capitol St.**

**Room “Maine A”**

**Minutes**

**Introductions**

**Update from Jessica Pollard, Director of DHHS Office of Substance Abuse and Mental Health Services (SAMHS):**

Current top priority: rebuilding SAMHS, which has seen its staffing level decreased

Notes specific to slide presentation:

* Maine has a higher level of demand related to schizophrenia, bipolar disorder than the national average
* While opioid addiction is a critical issue, 91% of those who need treatment for alcohol abuse don’t receive it
* 211 is small snapshot of how people access care
* Suicide and self-harm is on the rise – clearly there is a demand for services
* SAMHS will travel to Kentucky to observe its state-developed system that makes information public and available to all - FindHelpNowKY
* Next steps:
  + SAMHS needs stakeholder engagement
  + Act quickly but thoughtfully
  + Preliminary DHHS plan contains not just an array of services but the appropriate level of care and ability to connect clients to them. Ultimate goal: least restrictive settings

Comments:

* Eric Meyer: Our biggest crisis is the shortage in behavioral care workforce. It’s noted as a “long-term goal” but it needs attention in the short term
  + Dr. Pollard response: yes, it is noted as long term because that’s when we’ll be able to achieve the goal. We’re working now to make that a reality.

**Updates from Subgroups:**

Mapping

* Eric Meyer presented a table containing stages where a mental health consumer moves through the system
  + Ensuring least restrictive services
  + Warm handoffs
  + Continuity
  + 24/7 options
  + Non-jail
  + Non-ER
* Craig Nale: Table format should underscore that there is no linear way through the system for anyone
* Categorization of intensity levels of treatment, recognizing that any of the services might be the right one at any point in time
* Lack of continuity is a large issue

Comments:

* Rep. Warren: What are the significant gaps?
  + Eric Meyer: Issues involving transition: the lack of handoffs, the disconnect between need and the ability to access a higher level of service.
* Sen. Breen: Are there waitlists for medical management?
  + Eric Meyer: It did not come up.
* Simonne Maline: One barrier that is not represented: misinformation from service providers and the lack of clarity about what/how/when you can get help. For example: Who is eligible for Section 17? How does one become eligible? This administration should engage the community on what is available and educate the providers. This is actionable and doable.
* Ed Pontius: The process is more difficult than it needs to be. Sec. 17 is very complex—it’s not clear what purpose it serves. There is no program for new arrivals or case management.
* Malory Shaugnessy: People must know how to gain access to case management. Information is a huge piece. Law enforcement doesn’t have enough information.
* Donna Yellen: There is not enough accessible case management for the homeless population. There used to be a resource guide by county, generated by DHHS. This was helpful.

Workforce:

* Subgroup will meet on Monday; there is nothing to report

Resource allocation:

* Subgroup has gathered information and will share in another section of agenda

Housing:

* Six highlights:

1. We need some type of resolve or agreement that there will be information on what’s available for housing upon discharge from a hospital or jail
2. PNMIs – we need more beds, quick access, a flow-though system, and supportive apartments—not just congregate living
3. There should be no transfers from hospitals to homelessness
4. Adopt DHHS recommendations on housing from innovation accelerator program
5. Creation of low barrier housing – legislation to expand Housing First services
6. There should be a waiver to increase the value of BRAP vouchers so people can live in Portland. Clients could apply to Shalom House for waiver.

Crisis services:

* Overview: There are not enough resources, not enough information about accessing services
* Malory Shaughnessy: There was a redo of the system 6 years ago when a RFP was reissued; it moved away from therapeutic intervention toward assessments and referrals, and the funding structure was changed to fee for service
* Kevin Voyvodich: in some areas of the state crisis services are subcontracted out, so there may be multiple assessments and people just end up at the ER because the crisis process can be so convoluted
* Jenna Mehnert: crisis has shifted from providing actual help to finding a way to move people into a different service; need for multidisciplinary team at the local level
* Needed: more peer support, telehealth, warm handoff via phone during crisis moment
* What are the Crisis Stabilization Unit standards? How does Maine measure up?
* One way to improve crisis services may be to employ medical alert wrist bracelets that don’t give too much information but simply state who to call in a crisis
* Recovery Centers:
  + Should be separated by youth/adult
  + Should be separated by SUD/mental health
    - Karen Evans: When SUD/mental health is combined, mental health patients don’t feel welcome
* Karen: When one calls, they do an assessment, then say they will meet you at hospital, where they will be assessed again. Why call crisis if you are only going to go to the hospital anyway?
* Has shift been philosophical or financial? A little philosophical but the main change is the system converted to a “fee for service” model. With fewer calls, there is less money and staff has to be cut.
* Eric Meyer: This boils down to determining what the vision is for crisis services: first responder system with resources, or a risk assessment for other services?
* What we did for Child Protective Services, we need to do for crisis services: More funding, more positions
  + Money was cut from crisis services because we spend too much in criminal justice system
  + 86% of inmates are on psychotropic medications – $95m/year in county jails alone
  + We need a crisis system for kids. It costs $300k/yr. per child for kids in Long Creek

Bureaucracy:

* Legislation could be necessary to reduce administrative burden and combat redundancy
  1. New legisation could say we will investigate/eliminate some steps
  2. Quarterly meetings with stakeholders on how to reduce barriers to care

Communications and collaboration:

* Main issue: Serious lack of communication and lack of access to reliable information
* Recommendations:
  1. Ask DHHS to develop a comprehensive plan for ongoing multi-stakeholder communication as has previously occurred
     + Not just comprehensive plan for how to communicate, but also create flow chart indicating a simple series of clear messages to increase access to the appropriate service and care
  2. Bring back navigators and liaisons, maybe case mgrs.—these roles have gone away, precipitating a lack of communication
     + Jenna Mehnert: keep 211 service, but it needs to be more user-friendly on web site and may need specific mental health training and increased staff to connect people to services they may not know exist
  3. Gaps in service and lack of warm handoff need to be owned within DHHS. They are the central hub of being the payer, providing the contract, etc.

Overview of current funding/spending levels for mental health-related programs:

* Funding information distributed by the Office of Fiscal and Program Review and the Office of MaineCare Services. Funding information from SAMHS is forthcoming. All are posted online.

Comments:

* These are the best numbers we have today from the Legislature’s Office of Program and Fiscal Review
* $1.5m spent on MH services by jails, according to OFPR
* Sen. Breen: Legislators point to the amount we spend and ask why isn’t it enough? Advocates have best expertise to lay out how we can use current funding for better outcomes
* Cullen Ryan: case management funding being cut is concerning because it’s such an effective way to connect people to the appropriate service; continuity will allow people to not ricochet between poor outcomes. Case management spending dropped by more than 100%. Maybe spend more on case management to save money downstream?
* Simonne Maline: Look at reduced funds in transportation. If people can’t get to services, it doesn’t matter how good services are.
  + DHHS noted that funding changes may be attributable to how the services are delivered and may not be comparable to more/fewer services, but funding coming from other categories or programs.

Identify preliminary recommendations: areas of agreement:

* Donna Yellen: Housing First is a good solution for those who go untreated. It allows people to live with dignity
  + Some landlords won’t rent to people who aren’t on a treatment plan
* Jenna Mehnert: We need to build a therapeutic crisis response system, crisis “first responders”
* Cullen Ryan: We can’t discharge into homelessness or force people to go to PMNIs. We must provide options and be sure that the appropriate service is actually available upon discharge
* Cullen Ryan: We must have case managers to create continuity. If there are intensive case managers upon release, there are likely different outcomes
  + We can recommend that everyone released has an intensive case manager, but the role and scope of service provided by a case manager should be well defined – Simonne pointed out that there are many times that case managers continue after they’re needed.
* Ensure that there are multiple touch points for eligible people to get signed up for Maine Care
* Need more first episode programs to help when challenge is developing

Formation of subgroup to form recommendations

* Each subgroup will designate one person for the new subgroup on recommendation consolidation. Subgroups will provide prioritized recommendations.
* Representatives:
  + Cullen Ryan — housing
  + Eric Myer – consolidation of maps
  + Malory Shaughnessy – crisis services; bureaucracy
  + Jenna Mehnert – workforce
  + Simonne Maline – communications and collaboration; resource allocation

Next Meeting: Monday, December 2, 9-12

Following meeting: Monday, December 16, 9-12

* To review recommendations as a group and make sure they are unanimous