Mental Health

GOAL

Improve mental health and ensure access to appropriate, quality mental health services.

Overview

Mental disorders generate an immense public health burden that is under-recognized. For instance, in the United States, mental illness is on par with heart disease and cancer as a cause of disability.

Affecting persons of all racial and ethnic groups, both genders, and all educational and socioeconomic groups, mental disorders have been called equal opportunity disorders. Although about one in five adolescents and adults through age 64 had a diagnosable mental disorder in any given year; about one in four older adults (over age 64) experience mental disorders such as depression, anxiety, substance abuse, and dementia. Alzheimer's disease alone is one of the leading causes of nursing home placements.

IN MAINE, THERE ARE APPROXIMATELY:

160 psychiatrists – which equals 13 psychiatrists per 100,000 population (13/100,000), compared to 11/100,000 nationally;

230 psychologists – which is 18/100,000, well below the national average of 31; and

4000 social workers – which is 321/100,000, which is above the national average of 216/100,000.

Source: Maine Department of Professional and Financial Regulation.

Maine, like the rest of the nation, is undergoing an evolution in the way mental illnesses are recognized and treated. With the development of numerous medications and other therapies over the past four decades that successfully treat a number of mental illnesses, the locus of intervention for significant mental illness has changed from centralized institutions such as the Augusta Mental Health Institute (AMHI) or the Bangor Mental Health Institute (BMHI) to communities, with only occasional assistance from centralized institutions. We continue to face major challenges in de-stigmatizing mental illness and assuring access to appropriate services at the community level.

PRIMARY
SECONDARY
TERTIARY

Strategies

- **Community-Based and Statewide Initiatives:** Creating supportive environments in which people live, work, play, and attend school. These initiatives assure people live in communities in which mental illness is de-stigmatized and there is availability of meaningful work with a living wage, transportation, good education and job training, and infrastructure such as telephones and internet. In addition, the community of people with mental illness is empowered to advocate for issues that affect them.

- **Screening:** Identifying, and linking to appropriate next steps those who may be at risk for mental illness such as people with histories of trauma (such as physical or sexual abuse), stressful life changes (such as loss of a loved one, divorce, or job loss), and family history of mental illness.

- **Assuring Access to Appropriate Treatment and Recovery Services for Mental Illness:** Assuring availability of appropriate physicians and therapists, community support services, recovery services, services during transition to adulthood, access to health insurance, and parity of mental health insurance coverage and treatment. Critical aspects of these services are those that assure a supportive environment for those with mental illness, including housing, food, meaningful employment, and healthy social contacts.

Mental Health: a state of successful performance of mental function, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and to cope with adversity.

Mental Disorders: health conditions that are characterized by alterations in thinking, mood, or behavior that are associated with distress and/or impaired functioning and spawn a host of human problems that may include disability, pain, or death.

Mental Illness: all diagnosable mental disorders.

Health Disparities

(Populations at risk for mental disorders, based on national data in *Healthy People 2010*)

- **Adolescents and Young Adults** (higher rates of onset of schizophrenia)
- **Elderly** (Those in nursing homes or with concurrent heart disease or hip fractures have higher rates of depression and higher rates of Alzheimer's disease.)
- **People with Disabilities** (higher rates of depression)
- **Women** (higher rates of depression; higher rates of eating disorders in young women)
- **Men** (Elderly white men have a suicide rate six times the national average.)
- **History of physical or sexual abuse** (higher risk for suicide attempts)
- **Sexual orientation minorities** (higher rates of suicide among sexual orientation minority youth and young adults)

Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability of and access to its services. These disparities are viewed readily through the lenses of racial and cultural diversity, age, and gender. (DHHS, Mental Health: A Report of the Surgeon General, 1999, p. vi.)

THREE COMMON CATEGORIES OF MENTAL DISORDERS:

Schizophrenia: A mental disorder lasting for at least six months, including at least one month with two or more active-phase symptoms. Active phase symptoms include delusions, hallucinations, disorganized speech, grossly disorganized or catatonic behavior, and other symptoms. Schizophrenia is accompanied by marked impairment in social or occupational functioning, but symptoms tend to wax and wane. Increasing numbers of people with schizophrenia are doing well with modern treatments, and recovery is increasingly an achievable goal.

Affective Disorders: Include major depression and manic depressive illness. Major depression is the leading cause of disability among adults in developed nations such as the United States. It is not simply a "blue" mood, but rather a variety of feelings such as despair and loss of interest or pleasure in nearly all things that interfere with one's daily living.

Anxiety Disorders: Include panic disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and phobia. These are the most common mental disorders, affecting as many as 1 in 13 Americans annually.

Objectives

Objective numbers are *Healthy People 2010* objective numbers.

- **18–3 (Developmental) Reduce the proportion of homeless adults who have serious mental illness (SMI).**

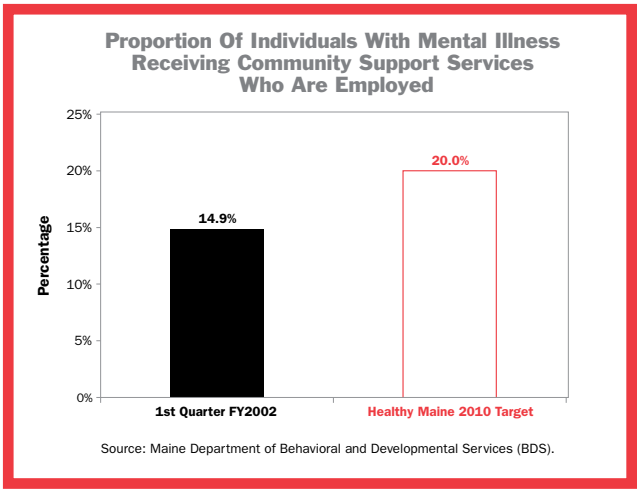
This objective is also a Maine Department of Behavioral and Developmental Services (BDS) major indicator. No data is currently available. BDS will develop a methodology to collect homeless status information for individuals served by the Department as a requirement of the newly received Federal Infrastructure Development Grant. Measuring this objective should be achievable over the next few months.

Approximately one-quarter of homeless persons in the US have a serious mental illness. Effective strategies to reduce homelessness among those with SMI include connecting them to mainstream treatment systems as well as case management that helps assure housing, skill-building, and employment.

- **18–4 Increase the proportion of persons with serious mental illness who are employed.**

Healthy Maine 2010 Baseline: 14.9%
Healthy Maine 2010 Target: 20%

BDS currently collects employment data as a performance indicator within community support services (CSS) delivered to Maine people with mental illness. For the first quarter of FY02, an average of 14.9% of individuals receiving CSS were employed. The Department's target is 20%. Also, employment data is part of the above-referenced Federal Infrastructure Grant and indicators will be developed or revised, allowing BDS to capture information on a larger sample of adult mental health consumers. This may allow BDS to revise the 20% target.



Source: Maine Department of Behavioral and Developmental Services (BDS).

Creating a stable and supportive environment for people with a serious mental illness is an important goal to improve outcomes. Assuring a consistent home and meaningful employment are two specific strategies to achieve this goal. Studies consistently show that most people with mental illness want to work and that meaningful employment improves their overall life satisfaction. Employment provides some independence that the paycheck gives, as well as workplace companionship and improved self-esteem.

Nationally, an estimated 43% of adults with a serious mental illness were employed in 1994. In Maine, data is currently collected on employment status of those who receive community support services. Therefore, the *Healthy Maine 2010* objective is measured using this data source.

- **18–5 (Developmental) Reduce the relapse rates of persons with eating disorders, including anorexia nervosa and bulimia nervosa.**

Anorexia nervosa is the most severe eating disorder, characterized by extreme, and often life-threatening, weight loss associated with a distorted body image and a pathological fear of gaining weight.

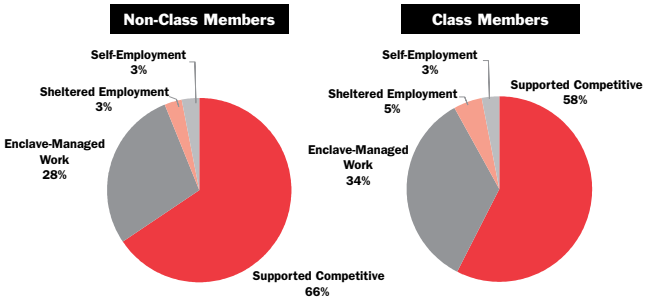
Bulimia nervosa is an eating disorder that involves eating a lot of food (binge eating) and then eliminating it (purging), whether through self-induced vomiting or through the use of diuretics or other medications.

Although relatively effective short-term treatments for both of these serious mental illnesses exist, relapse is very common. For anorexia nervosa, 30–50% of those treated successfully in the hospital relapse within one year. For bulimia nervosa, about half relapse within nine months after initially successful treatment.

Employment and Access to Crisis Services Characteristics of Class Members in Maine

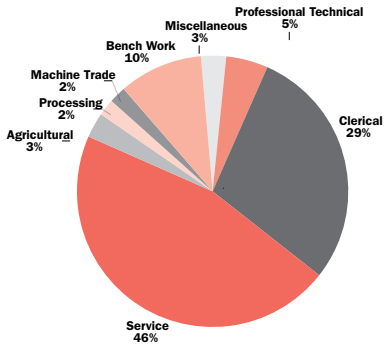
Class members are all persons who, on or after January 1, 1988, were admitted to the Augusta Mental Health Institute (AMHI) and all persons who will be admitted to AMHI in the future until the Maine Department of Behavioral and Developmental Services is found in compliance with a Maine Superior Court Consent Decree. Non-class members are those individuals who may have received inpatient/hospital level of care, but not at AMHI during the time frames noted.

Proportion Of Employed Class And Non-Class Members By Types Of Employment Fiscal Year 2000



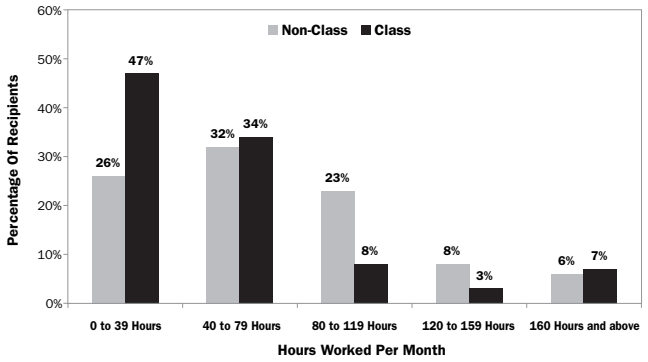
Source: Maine Department of Behavioral and Developmental Services, Regional Vocational Services Data.

Occupational Categories Of Employed Class Members Proportion Employed Per Category Fiscal Year 2000



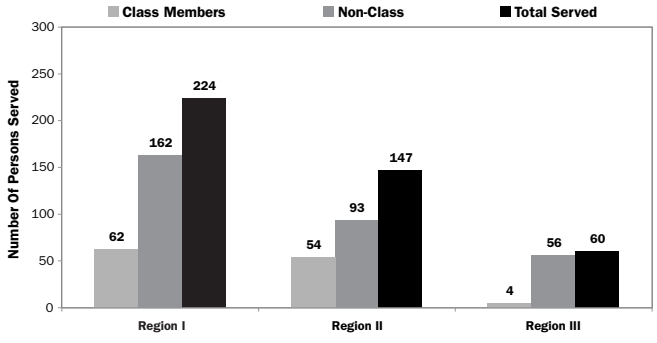
Source: Maine Department of Behavioral and Developmental Services. BDS Regional Vocational Database, FY 2000.

Number Of Hours Worked Per Month By Class And Non-Class Members Fiscal Year 2000



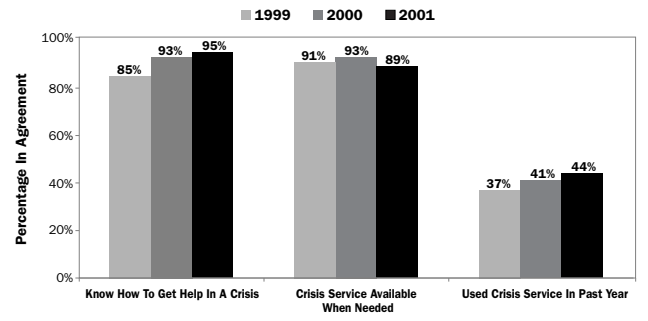
Source: Maine Department of Behavioral and Developmental Services (BDS), Regional Vocational Services Data.

Utilization Of Regional Vocational Services Provided By Maine Department Of Behavioral And Developmental Services Fiscal Year 2000



Source: Maine Department of Behavioral and Developmental Services (BDS), Regional Vocational Services Data.

Mental Health Crisis Services Annual Class Member Survey 1999–2001



Source: Maine Department of Behavioral and Developmental Services (BDS), Annual Class Member Survey: 1999, 2000, and 2001.
Note: Sample sizes for the 1999, 2000, and 2001 Community Class Member Surveys are N = 59, N = 98, and N = 82, respectively.

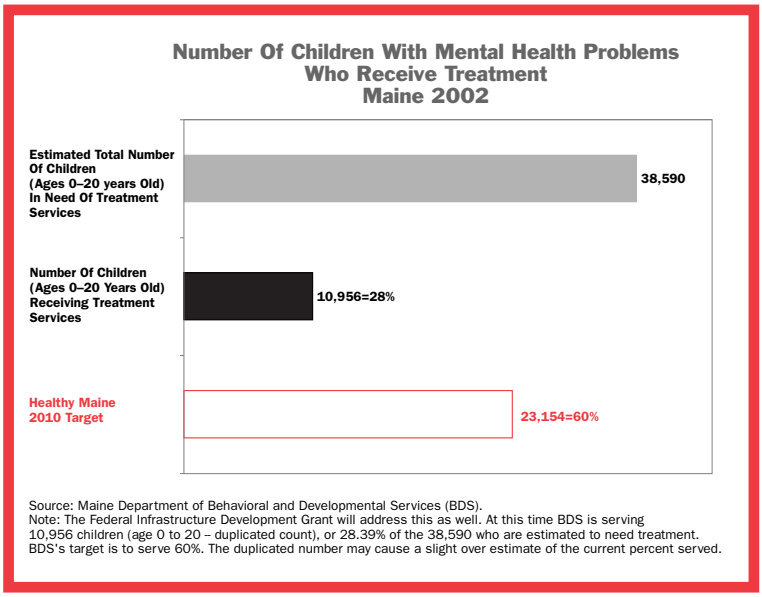
- **18–6 (Developmental) Increase the proportion of persons seen in primary health care settings who receive mental health screening and assessment.**

  The general medical sector is often the initial point of contact for many adults with mental disorders and, for some, these providers may be their only source of mental heath services. Close to 6% of the adult US population use the general medical sector for mental health care, with an average of about four mental health visits per year – far lower than the average of 14 visits per year found in the specialty medical sector. Therefore, attention to mental state in primary care settings can promote early detection and intervention for mental health problems.

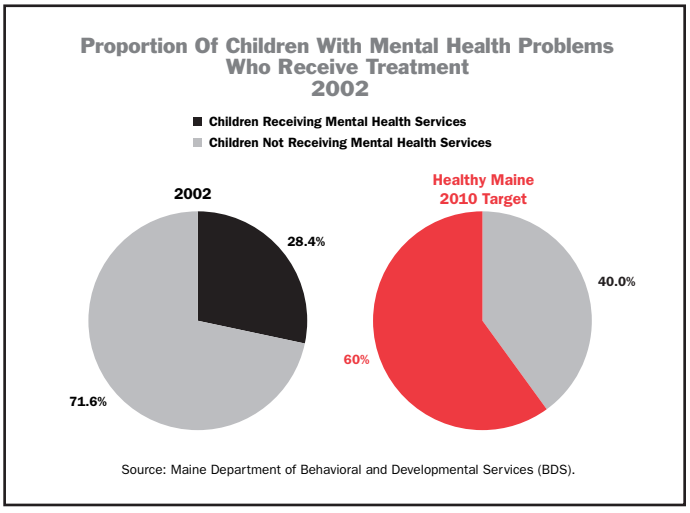
- **18–7 Increase the proportion of children with mental health problems who receive treatment.**

  Healthy Maine 2010 Baseline: 28%
  Healthy Maine 2010 Target: 60%

  For many adults with lifelong mental disorders, these disorders started in childhood. For many of these children, normal development is disrupted by environmental and psychosocial factors which impair their mental health and prevent them from realizing their full potential as adults. Early detection and intervention during childhood of mental disorders or factors leading to mental disorders can result in greater school retention, decreased contact with the juvenile system, improved stability of home life, and improved development.



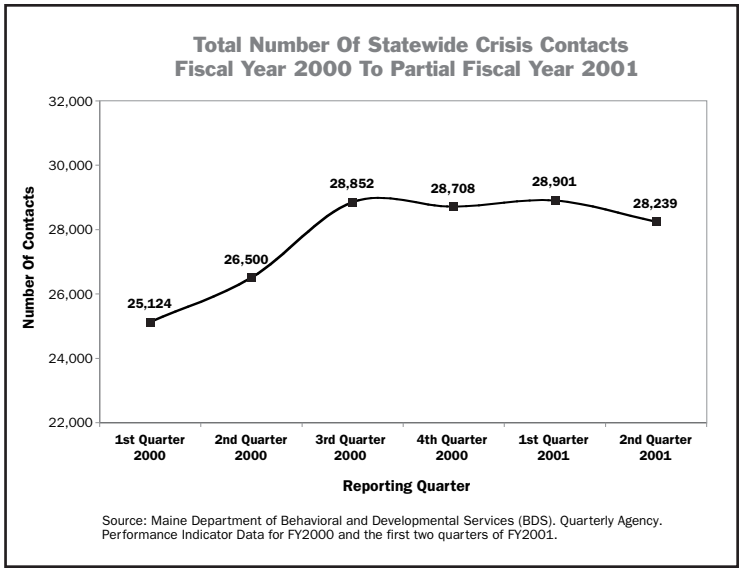
Source: Maine Department of Behavioral and Developmental Services (BDS).
Note: The Federal Infrastructure Development Grant will address this as well. At this time BDS is serving 10,956 children (age 0 to 20 – duplicated count), or 28.39% of the 38,590 who are estimated to need treatment. BDS's target is to serve 60%. The duplicated number may cause a slight over estimate of the current percent served.



Source: Maine Department of Behavioral and Developmental Services (BDS).

- **18–8 (Developmental) Increase the proportion of juvenile justice facilities that screen new admissions for mental health problems.**

  Although the exact numbers of youth entering the juvenile justice system with mental disorders is unknown nationally as well as in Maine, the proportion is considerably higher than the general population. Not surprisingly, disorders of conduct are common in these facilities. Therefore, identifying those with a treatable mental health problem is critical to assuring that these youth experience improved outcomes.



Source: Maine Department of Behavioral and Developmental Services (BDS). Quarterly Agency. Performance Indicator Data for FY2000 and the first two quarters of FY2001.

- **18–9 (Developmental) Increase the proportion of adults with mental disorders who receive treatment.**

  Untreated mental illnesses incur vast human and economic costs that can be prevented by treatment. For instance, available medications and psychological treatments can help 80% of those with depression, one of the most commonly diagnosed mental illnesses in the United States. Effective treatments for schizophrenia and anxiety disorders also assist people in returning to normal daily functions such as work and home life.

  National data show an estimated 47% of adults ages 18–55 with a serious mental illness received treatment in 1991; only 23% of adults with depression in 1997; 60% of adults with schizophrenia in 1984; and 38% of adults with anxiety disorders in 1997.

- **18–10 (Developmental) Increase the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.**

  Development of measuring this objective will occur through the Federal Infrastructure Grant. When that is in place, the Department, through the use of Medicaid data, will be able to ascertain who is receiving mental health and substance abuse treatment.

  About one in five Americans experience a mental disorder in the course of a year, and nearly one in three adults who have a mental disorder in their lifetime also experiences a co-occurring substance abuse (alcohol or illicit drug) disorder. This co-occurrence not only complicates treatment but also changes prognosis, since individuals with co-occurring disorders are more likely to experience a chronic course.

The history of how society is evolving in its ability and willingness to deal with mental health issues is apparent from the evolution of how Federal and State government mental health departments have been formed and named. One example is Maine's own history of its Department:

1939 Maine Department of Institutional Services is created, consisting of the State's institutions for prisoners and the mentally ill.

1981 Department of Corrections is formed as a new department, separating the prisons from the Department.

Maine Department of Mental Health and Mental Retardation is established.

1996 Office of Substance Abuse Services is added to the Department, forming the Maine Department of Mental Health, Mental Retardation, and Substance Abuse Services.

2001 Maine Department of Behavioral and Developmental Services is established as the new name for the Department.

- **18–11 (Developmental) Increase the proportion of local governments with community-based jail diversion programs for adults with serious mental illness.**

  An estimated 7% of the US jail population are individuals with severe mental illness, a higher proportion than the general population. Many of these inmates could be more effectively served by interventions that treat their underlying mental illness. Therefore, if we are to improve our overall mental health, an important and vulnerable population to reach out to with effective strategies to treat mental illness is our inmates.

- **18–12 (Developmental) Increase the number of states that track consumers' satisfaction with the mental health services they receive.**

  Increasingly, the American health care industry is relying on consumer satisfaction to adjust its services. Because mental health services are particularly spread between our market-driven health care industry and government-sponsored services, a coordinated approach to measuring consumer satisfaction with access, appropriateness, quality, and outcome of care is important.

- **18–13 (Developmental) Increase the number of states with an operational mental health plan that addresses cultural competence.**

  The Maine Department of Behavioral and Developmental Services Diversity Team is developing a plan that includes an annual Diversity Conference as well as other activities aimed at promoting awareness of diverse cultures in Maine. The recently completed Multicultural Resource Guide can be accessed via the Department's web site (www.state.me.us/bds/).

  The way people perceive mental health, mental illness, and treatment services affects whether people seek mental health services, how they describe their symptoms, and the outcome of their care. Our cultural background is a major factor that determines our perceptions and, therefore, the way we interact with the mental health care system. Consequently, mental health systems need to be culturally competent.

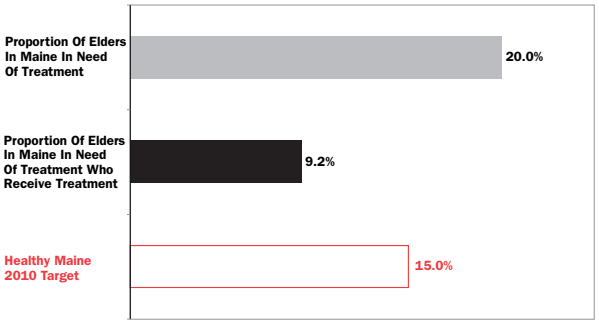
  With this principle in mind, the Maine Department of Behavioral and Developmental Services has made improving cultural competency of the services it provides a high priority and has implemented a number of initiatives to accomplish this.

- **18–14 Increase the number of states with an operational mental health plan that addresses mental health crisis interventions, ongoing screening, and treatment services for elderly persons.**

  Healthy Maine 2010 Baseline: 9.2%
  Healthy Maine 2010 Target: 15%

  With the population of the US aging rapidly, the mental health needs of those over age 65 is growing. Certain mental disorders are particularly prevalent in this population. For instance, mood disorders affect 2–4% of community-living elderly, and older Americans with clinically significant depression symptoms are estimated to be 10–15% of the population. Therefore, our mental health systems must become increasingly engaged in meeting the mental health needs of elders.

Proportion Of Elders (60+ Years) In Need Of Mental Health Treatment And Those Who Receive BDS Services 2001



Source: Maine Department of Behavioral and Developmental Services (BDS). The Maine Department of Behavioral and Developmental Services is currently piloting an assessment protocol for use with elder populations and is awaiting results from the pilot sites prior to implementation of the protocol in late 2002. BDS Indicator: Percent of elders (60 years and older) in need of mental health treatment and who receive BDS Services. Numerator: Number of individuals 60 years and older who received BDS services (Outpatient, Community Support, Residential Treatment, In-home Supports, and Crisis Services) in 2001 = 4,398 individuals. Denominator: Population estimate of number of individuals 60 and over who are in need of mental health treatment in Maine. 2000 Census persons 60 years and over in Maine = 238,099. National estimate of elderly in need of mental health treatment = 20% of individuals 60 years and over (National Health Report of the Surgeon General – Chapter 5: Older Adults and Mental Health) Number in Maine in need of mental health treatment = 47,620. Percent of total in need who receive treatment = 9.2% for FY2001. Goal for 2010 is to increase service rate to 15%.

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