
Mental Health Working Group

20 SEPTEMBER 2019 / 9:00 am – 12:00 pm
Department of Health and Human Services
109 Capitol Street, Room “Maine A”

AGENDA

Introductions
- Participants
  - Sen. Cathy Breen, Chair
  - Rep. Charlotte Warren, Chair
  - Commissioner Randall Liberty from the Department of Corrections
  - Ali Lovejoy, Supervisor, Clinical Intervention Program at Preble Street
  - Chief Leonard MacDaid, Newport Police
  - Tom McAdam - Kennebec Behavioral Health
  - Dr. Jessica Pollard, Dir., Substance Abuse and Mental Health Services (DHHS)
  - Darcy Shargo, Maine Primary Care Association
  - Kevin Voyvodich, Disability Rights Maine
- Staff
  - Kathryn Temple, Mental Health Program Manager, DHHS
  - Molly Bogart, Government Relations, DHHS
  - Craig Nale, Sen. Pres. Office
  - Patrick Rankin, Sen. Pres. Office
  - Reggie Parsons, Speaker’s Office
  - Denise Gilbert, Legislative Coordinator DHHS
- Also present
  - Julie Finn, Judicial Branch
  - Patty Wight, Maine Public
  - Joe Lawlor, Press Herald
  - WABI TV station
- Note: several appointees including Simonne Maline, Karen Evans, Eric Meyer, and others sent regrets due to other obligations and will attend future meetings. The meeting was recorded by Disability Rights Maine for review by Simonne and Karen.

Objectives
- Reading of the statute
- Determining the scope of our work
  - Capacity but no staff – common and persistent problem
  - No reserve staff
  - This bill lives in DHHS but we will report back to four committees
  - DHHS is already doing good work as part of the Mills Administration
  - Important to take snapshot of what is happening right now – what we do right and where we can improve
  - The group will determine what is working well in the mental health system and what is not working well. How do we measure this? A key concern driving the implementation of this bill is that too many people with mental health and substance abuse treatment needs are being housed for long periods of time in hospital emergency departments, prisons and jails. Some issues to be considered are costs, lack of staff, medication management, effect of MaineCare Expansion.
Discussion

- Evaluation of the current state of mental health care and management
- How are we succeeding?
  - NAMI has done a good job with Crisis Intervention Training (CIT)/Diversion
    - Divert individuals to appropriate resources instead of jail
  - Criminal Justice Academy requires officers to have mental health first aid as part of mandatory curriculum. Corrections officers receive 20 hours of mental health training
  - Maine is a leader in early detection, which reduces incarceration and hospitalization and improves long-term outcomes
    - Sen. Breen has sponsored a bill, LD 1461, to expand Maine Med program; the bill is carried over to the Second Regular Session
  - Reduced number of children held at Long Creek; receiving treatment but some may be sent out of state
    - Many needed treatment, not incarceration
    - Services not available in Maine
  - Increased focus on identifying social determinants of health
  - Expansion of Medicaid
  - Bridging Rental Assistance Program (BRAP)
    - State-funded housing voucher with hopes that client gets Section 8
    - Useful for individuals leaving Riverview, Dorothea Dix
    - Uses Section 17 eligibility to confer eligibility for BRAP - may create gap for those with substance use disorder but not a co-occurring mental health challenge.
    - No wait list for vouchers, but a delay with administration and finding placement
    - BRAP less affordable than Sec. 8 (51% of income (BRAP) vs. 30% (Sec. 8)) - can we see what it looks like at different percentages? If these are equal, there’s no push to get off of BRAP, which is supposed to be temporary
  - Supervised Community Confinement: What do we do when folks are ready to get back into community but can’t find a home? 80% of clients fit this description.
  - More autonomy, individual rights for people to deny services - may have positive and negative implications
    - Many providers use Critical Case Unit to strategize on ways to support people
  - Maine has high answer rate for crisis hotline - we actually answer the phone and can direct people to the appropriate resources
    - Opportunity Alliance in Portland is hub - 24/7
    - OA has updated text line as well - for teenagers, mainly
  - Behavioral Health Home program - coordination of services. Comprehensive way to do case management
    - Can we measure success? Kathryn (DHHS) will follow up

Where are our opportunities for improvement?

- See previous section for potential improvement within BRAP (available housing, eligibility, and income requirements)
- Rep. Warren: We need to know when clients are incarcerated or hospitalized - need improved flow of information between those systems
  - Comm. Liberty: we are working on enhancing communication so we do not place them back in jail to wait for a bed at Riverview - quicker we can get individuals from ER or jails to resources, the better
  - IMHU - can next meeting be at prison/IMHU?
- Reimbursement rates and reimbursement structure/care coordination
  - Providers need to be able to submit bills for various services (care coordination)
  - Minimum wage is having an effect
- Matching supply and demand more effectively. Fewer resources, but also being more systematic. Better matching of services to clients.
- Knowledge about resources among providers - centralized source of information should be a priority
Overcoming stigma/discrimination – many people believe that SUD and mental illness can be cured by a job or just dealing with it
  - Some legislators propose increasing penalties/punishment for people with persistent mental illness who need treatment. Society seems OK with this.
Continuity of care. Lack of follow up from PNMI to shelter, for example; clients keep starting over
Support for individuals with co-occurring disorders.
Med Mgmt.: waitlist of 400-600 for psychiatry services.
  - Difficult to recruit psychiatrists and Maine doesn’t produce many
  - Not everyone wants to work in a rural state, we don’t have incentive programs
Rep. Warren: We have to figure out how we feel about incarcerating people with SUD
  - Should be treated with medical model – it’s a public health issue
  - Our laws have not caught up to this way of thinking
  - Comm. Liberty Police are not always given the tools to respond in a medical/mental health way. They use tactics they know, which may unintentionally escalate a situation.
Increased access to peer services

Which metrics should we use to determine success or failure?
  - Data needs:
    - Inventory of waiting lists (DHHS and Providers)
      - SUD
      - Med Mgmt.
      - DHHS can provide waitlists for funding for services, providers will have to provide waitlists due to staffing.
    - Number of homeless with severe and persistent mental illness (HMIS)
      - Problematic because of self-reporting
    - Number of open staff positions on provider side (Providers)
    - Jail diversion programs data (DHHS)
      - DHHS is just beginning to collect this in EIS system
    - Number of arrests/jail days for population DHHS is serving
      - Both categories of behavioral health: mental health and SUD
      - Need integration of software, data by county
      - Rep. Warren will ask Sheriff Joyce for existing data on arrest, matching up to services
      - Every jail has different formulary for medication
      - Define limitations. How many times does someone come to jail and medication is switched
    - Status of consent decree? Useful to get update from Judge Wathen? We will invite him to meeting on 10/4 (Senator Breen)
    - Emergency department/diversion data. Reach out to hospitals/DHHS for data on length of stays, arrests, etc. (DHHS, Hospitals, Providers)
    - Interaction on emergency department/blue paper/crisis situation
    - Adult Protective Services: tools to help are limited if the person is determined to have “capacity”
    - Housing Data – list of fair market values to get at assets for housing resources – cost of living in certain communities
      - Possibility of inviting a representative from Maine Housing (MSHA)? Shalom House?
    - On-the-ground, anecdotal stories will be helpful – people with knowledge of what’s happening
    - Other states’ approaches – Craig Nale is pursuing this
      - Connecticut
      - PEW report on Vermont
    - Data on impacts of not treating individuals. If we make investments, what do we save in the long run?
      - When we incarcerate, who relies on the incarcerated individual that is left behind? What does it cost the state?
什么比例的人口是我们正在服务的？（DHHS将找出）
数据在俱乐部中——Tom将提供（MEJ可能有这个）
服务目录，每个服务的花费是什么，每个服务的花费。地理覆盖将是有帮助的
危机呼叫数据
额外有多少天会阻止个体在医院等待位置？
治疗后等待MaineCare扩展的人数？我们还在要求人们在五周内回来吗？（提供商）
处方数量？
有多少是实际使用的？（Gordon Smith可能有这个）（DHHS可能也能找到）
从转介到首诊之间的时间？（Julie Finn可以帮忙提供共病，退伍军人的法院）
自杀率


数据基于种族/性别的服务公平性

当前实践由部门
- DHHS当前实践相关的减少住院和入狱率
  - 有待改进
    - 希望通过一个交互式、实时工具来改进等待名单和转介，连接客户到合适的服务
    - 进展：与PEW合作，将数据与资源匹配，需要将它们与社区需求匹配，以确定我们的差距在哪里
    - 旨在改进危机时的暖手交接。一个有前景的模式是危机介入中心——一个物理位置，可以在其中完成暖手交接，大约需要10分钟，客户可以连接到服务。其他州已经这样做了，并且它是成本效益的。Dr. Pollard将提供信息
    - 引入新员工，他们致力于正向改变
    - 承诺于司法介入项目
    - 强制性精神健康单位（IMHU）
      - 约7百万州资金用于心理健康服务
    - DOC已启动一个MAT项目，为入狱的个人
      - 治疗/处方/骑回家。85%的成功率
      - 困难：有些监狱不参与；不确定要多久继续MAT；药物非常昂贵
      - 需要10百万来继续该计划
      - 与Gordon Smith合作，研究最佳实践，开发州的SOP

十分钟休息

展望
- 我们的目标是什么？
- 我们可以合理地在给定的时间内达成什么？
Further discussion
  • What information do we need to achieve our goals?
  • Whom do we need to invite to inform our work?
    o Maine State Housing Authority?
    o Shalom House?
    o Prosecutor to report on diversion programs
    o Defense attorneys
    o District Attorneys
    o NAMI (Jenna Mehnert will be at the next meeting)
    o Private provider
    o Judge Wathen
    o Elizabeth Simoni (pretrial services)?
    o Someone in system to give suggestions (have consumers appointed to the group, they can hopefully attend future meetings)
  • Establishment of norms for communicating and working together
  • List of participants and alternatives from each participant

Next meeting
  • Friday, October 4, 1pm - 4pm