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Mental Health and Substance Abuse in Maine: Building a community-based system

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Issue Brief

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Overview

One in five persons experiences a diagnosable mental illness in a given year.[1] Half of all persons will experience a diagnosable mental illness during their lifetime.[2] Mental illness strikes people of all ages, gender, race, and income affecting their well-being, health, and productivity. The World Health Organization has found that mental illness imposes the second highest burden (including direct care, family impact, and lost productivity) of any disease – behind only cardiovascular disease and ahead of cancer.[3]

Policy makers are confronted with a variety of issues as to how to help persons with mental illness. This may come before you in several very demanding ways, including:

- The state's responsibility to provide care for persons with severe mental illness who may be a danger to themselves or to others. This requires deciding how to deliver and how to fund appropriate services to these persons. Historically, treatment had been primarily provided in state psychiatric institutions, such as the Riverview Psychiatric Center. Thanks to improved treatment and knowledge, these persons can now be treated, and fare much better, in the community.

- The increasing share of Maine's MaineCare Program expenditures spent on mental health care. From 1996 through 2004, mental health expenditures increased more sharply than other health care areas within MaineCare. Many states have experienced similar dramatic increases in Medicaid mental health expenditures. How does Maine meet its commitment to provide mental health services, while at the same time providing other health care services, under MaineCare and also meet other non-health care obligations with state revenues?

- The demand that persons with mental health problems and illness place on non-specialty mental health systems, services, and venues. Persons with emerging, undiagnosed, or untreated mental illness are found needing or seeking care in many diverse settings including schools, emergency rooms, prisons and jails, and child welfare and social services. The gap between needed and available mental health resources and services results in on-going pressure on these non-specialty mental health systems. It is estimated that half the prisoners in county jails have a mental illness.[4]

- Requests from constituents about where to turn to, or what to do, when they, or a family member, need help for a mental health problem. Mental health systems in all states are fragmented and incomplete especially for children's mental health.[5] In Maine, as in the rest of the country, there is usually not an obvious place to go for parents concerned about their child's behavior and mental health.

The medical and scientific understanding of mental illness is steadily increasing, as are effective ways to address and treat it. Yet, there still remains much misunderstanding, fear, and stigma about mental illness. This issue brief tries to provide a way to understand the scope of the problem, Maine's responsibilities in addressing it, and to suggest ways to think about mental health and resources you may use in working to meet these responsibilities.

Fast Facts

- One in five persons experiences a diagnosable mental illness in a given year. Half of all persons will experience a diagnosable mental illness during their lifetime.
- The World Health Organization has found that mental illness imposes the second highest burden of any disease – behind only cardiovascular disease and ahead of cancer.
- By their senior year in high school, 20% of Maine students will have misused prescription drugs, 9% within the previous 30 days. Nearly three quarters of students will have tried alcohol, half within the past 30 days.
- In Maine, and nationally, there are not enough mental health specialists to provide the care that is needed. The Maine Health Access Foundation is sponsoring long-term initiative to promote integration of physical and behavioral health in Maine.

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Prevalence of Mental Illness

The overall prevalence of mental illness is generally consistent across states and over time.

Children

One in five children (20%) experiences a diagnosable mental illness in a given year. A smaller group of children, 4-7%, have conditions severe enough to qualify for public funded services through state block grants, family income supplements from the Social Security Administration, or other public support funds.[6] These children meet the Federal definition for having a serious emotional disturbance. Estimates of this group are important because they suggest the relative magnitude of responsibility that a state has to provide access to treatment to children.

Adults

One in five adults experiences a diagnosable mental illness in a given year. It is estimated that 3% of adults have psychiatric conditions severe enough to be classified as a disability that qualifies a person for publicly funded mental health services. Such conditions include schizophrenia, bipolar disorder dementia, or a mood disorder so severe that it requires hospitalization or major psychotropic medications. These adults meet the Federal definition of having a serious and persistent mental illness and are entitled to access to treatment, usually covered by a state's Medicaid program.[7] This group roughly corresponds to those persons a state is responsible for protecting from themselves or others. Another 18% of the adult population, age 18-54, experiences mental illness in a year. Adult Medicaid beneficiaries tend to have higher rates of mental illness than non-Medicaid adults. (Research suggests that these higher rates are associated with poverty, low-income and low or unemployment.) This explains, in part, why growth in adult enrollment in MaineCare has been accompanied by increased spending on mental health.

Older Adults

Mental illness is slightly less prevalent for older adults than it is for children and adults. Mental illness among older adults, however, is more likely to be undiagnosed and go untreated, even when diagnosed, than among younger persons. This is unfortunate in that mental health treatment, particularly for depression, is often more effective in older adults than in younger persons. It can also improve the effectiveness of treatment for chronic physical health conditions, such as cardiovascular disease and diabetes that are often co-morbid with depression and anxiety disorders among older persons. Cognitive disorders are relatively common among older persons and can mask, or complicate treatment of, other mental health and physical health problems. In Maine, as in other states, it is often difficult to access treatment for geriatric mental health problems either in community-based or long-term care settings.

Co-Morbidity

Mental illness often co-occurs with other health problems and illnesses. Mental illness and substance abuse often co-occur (and are commonly referred to as "dual diagnosis" or "co-occurring disorders"). Half of all persons with a severe and persistent mental illness abuse substances.[8] Substance abuse is also relatively common among persons with less severe forms of mental illness, including adolescents and young adults. Among all types of mental illness and age groups, the presence of substance abuse compounds the problem and makes effective treatment more difficult. Over the past ten years, Maine has been among the leaders nationally in attempting to address the problem of co-occurring disorders. Depression and anxiety disorders are relatively more common among persons with chronic health problems, including cardiovascular disease, diabetes, and cancer. This is significant in that these chronic health problems increase with age and Maine has an aging population.

Substance Abuse

Substance abuse is an addictive disorder involving chemical dependency that may either be independent of, or co-occur with, mental health disorders. Drug deaths in Maine have continued to rise over the decade, increasing over 400% from 34 in 1997 to 176 in 2005.[9] Most of this increase is related to misuse and diversion of pharmaceuticals, particularly narcotics and tranquilizers. Abuse of heroin, cocaine and methamphetamine have all risen during the same time period resulting in substantial use of public dollars to protect the safety and health of Maine citizens. Alcohol abuse, however, continues to claim the lion share of public dollars, accounting for about 75% of the direct and indirect costs of substance abuse in Maine.

By their senior year in high school, 20% of students will have misused prescription drugs, 9% within the previous 30 days. Nearly three quarters of students (74%) will have tried alcohol, 49% within the past 30 days. It is important to note that the use of prescription drugs and alcohol among youth has declined since 2000.[10]

Maine's Mental Health System

Although the term "mental health system" is commonly used, it is a bit misleading. Mental health systems in all states are generally under-resourced and provide fragmented services.[11] It is useful to distinguish the different sectors in which persons may receive mental health care: Specialty Mental Health, General Medical Primary Care, Human Services, and Voluntary Support Networks.

Anchoring Maine's specialty mental health system is made up of six community mental health centers; two state psychiatric institutions, the Riverview Psychiatric Center in Augusta and the Dorothea Dix Psychiatric Center in Bangor; two non-profit psychiatric hospitals, Spring Harbor Hospital in South Portland) and Acadia Hospital in Bangor; eight inpatient units in community based hospitals, and a number of smaller community based specialty agencies and practitioners. Over the last forty years, there has been a major move away from caring for persons with severe and persistent mental illness in inpatient psychiatric facilities and caring for them in the community. This is consistent with what we know allows people to live fulfilling, healthier lives and the availability of treatments, medications, and peer-supports to make this a reality. However, coordinating and funding these services is an ongoing-challenge which Maine has wrestled with under the AMHI Consent Decree.[12]

In Maine, and nationally, there are not enough mental health specialists to provide all the care that is needed. As a consequence, more people receive mental health care from providers who are not mental health practioners than those who are. In 1978, a NIMH psychiatrist dubbed the general health care sector, the "De Facto Mental Health System". In the 30 years since, the role of the general health care system in providing mental health care has continued to grow. How to best "integrate" primary care and mental health has emerged as a very important policy and clinical consideration nationally and in Maine.

The Maine Health Access Foundation (MeHAF) is currently sponsoring a major, long-term initiative to promote the integration of physical and behavioral health services in Maine. MeHAF's Integration Initiative will fund 40 grantee programs over the next five years. The Muskie School has recently completed a study – *Barriers to Integration in Maine*, funded by MeHAF.[13] This study identified and discussed a number of barriers to integration prominent in the national literature, including:

- National and system-level barriers (limited supply of mental health specialists, misdistribution of specialists relative to need, separate funding streams);
- Regulatory barriers (licensure laws, scope of practice);
- Reimbursement barriers,
- Practice and culture barriers (different practice styles, culture, language and administration) and
- Patient-level barriers (poor access; limited insurance coverage and reimbursement; stigma).

The study found that within Maine, facility licensure issues are complex and impact the ability to integrate across settings. The study also found that reimbursement barriers were a much more significant problem to integration than scope of practice issues and that potential changes in reimbursement and facility licensing have political and budgetary implications that must be taken into account.

Substantial mental health and substance care is provided in child welfare and social service agencies, as well as the criminal justice system. In a perfect world, this care would be better coordinated with mental health and substance abuse systems, Maine has been among the leaders nationally in examining how to better assess and address substance abuse within child protective cases. Consumer-run and self-help groups (sector) have been very effective in Maine helping persons with severe mental illness remain and do well in the community.

How is Maine's mental health system doing?

State public mental health systems are usually in the news when there is a problem and things are not going well. The National Alliance for the Mentally Ill (NAMI)'s 2006 Report, Grading the States": A Report on America's Health Care System for Serious Mental Illness" provides an outside perspective on how Maine is doing.[14] The NAMI study gave Maine an overall grade of B-. While this may not seem like a positive assessment, Maine was one of only five states to receive a B: all other states received a grade of C or lower (19 states received a D and eight states received an F). Maine received an A for its recovery supports; a B for its services; a C- for its information access. The Report praised Maine for its mental health parity law and its progress in improving conditions in county jails. The Report urged Maine to (1) reduce its long waitlists for community services; (2) relieve crowding in emergency rooms; and (3) improve access to crisis and inpatient beds. NAMI is in the process of updating its Report Card Study and "new grades" and analysis are due out shortly and can be reviewed by visiting: http://www.nami.org/.

Managed care initiative.

In December 2007, Maine implemented an Administrative Service Organization (APS Maine) to better manage the state's mental health care and resources. Maine is one of over twenty states that have turned to such an arrangement to help improve the efficiency and effectiveness of the behavioral health services provided to persons enrolled in the state's Medicaid program. APS Maine manages services on a fixed fee basis, including prior authorization, utilization management, quality management, and provider and member services. APS Maine does not assume medical or financial risk for the members it manages, which distinguishes it from other forms of managed care such as managed behavioral health organizations (MBHOs). An MBHO includes administrative functions similar to an ASO, but also manages services on a capitated fee basis and assumes medical and financial risk. The literature has shown that capitation may lead to more efficient (less costly) use of services, but also may adversely affect access to and quality of services. Since ASOs offer states a less costly, easier to administer form of managed care, it appears to have been a reasonable approach for Maine to have adopted. Key issues for policymakers include whether there are sufficient standards and oversight to monitor the program, whether the program is sufficiently transparent, what the service use and cost are under the ASO compared to historical trends. Because other programs, initiatives, and events (such as significant changes and reductions in mental health reimbursement under the Medicaid Modernization Act) affect service use and cost, it is difficult to evaluate precisely what the impacts of APS Maine are.

Stigma

Despite the substantial strides that have been made in the diagnosis and treatment of mental illness, the myths and stigma associated with mental illness persist and prevent many persons from getting the care and help they need. The stigma associated with mental illness is often reinforced by outdated or misinformed public policies at the state and community levels. Over half of the states restrict voting rights based on a variety of definitions of mental capacity. These types of policies make it more difficult for persons with mental illness to be equal participants in their communities. A very encouraging event is the passage in October of the Paul Wellstone-Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 as part of the Emergency Economic Stabilization Act (HR 1424). This

Act culminates a 20 year effort to require group health plans to cover treatment for mental illness on the same terms and conditions as all other illnesses. The law becomes effective in 2009.

Things To Keep In Mind

During the next two years, the Legislature will face a number of issues related to mental health and substance abuse. Some of the more pressing issues may include:

- Implementation of a plan to address the AMHI Consent Decree.
- Determining how to respond to federal cuts to the Medicaid program in the area of behavioral mental health.
- Monitoring and deciding whether to revise the statewide administrative service organization (APS Maine) currently responsible for helping to manage mental health resources more effectively.
- Continued restructuring of the Department of Health and Human Services that supports a community based delivery system.
- Focusing more attention on services for children and adolescents.
- Improving crisis intervention programs and creating more beds in community based hospitals.
- Addressing fatalities due to drug overdoses.
- Reducing underage drinking and drug use.
- Supporting the effort to integrate behavioral health and primary care throughout the state.

When examining these issues, it might be useful to consider that:

- A good way to continue to invest in a community based service delivery system is by building upon successful programs.
- Treatment does work. Prevention and early intervention, particularly with children and adolescents, leads to better treatment outcomes.
- Integrated services can be more effective when addressing both substance abuse and mental health issues.
- The availability of affordable housing and employment opportunities are critical to assisting persons with persistent mental health problems.
- Individuals live in systems (family, community) and, consequently, systemic interventions are most effective.
- Behavioral health initiatives may be strengthened when coordinated or integrated with other initiatives, such as developing and implementing patient-centered medical homes.

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