

INDIANA BEHAVIORAL HEALTH COMMISSION



FINAL REPORT

SEPTEMBER 2022

ARTIST STATEMENT



Throughout my life, I've struggled with my mental health, going through happy highs and hopeless lows. To me, this painting represents the duality of life with mental illness. The heavy, overwhelming struggle to keep yourself afloat amidst a seemingly endless fight, regardless of counseling, medication, and coping mechanisms— the pain always seems to trickle through. However, your eye is not drawn to the wilted flower. The resilient other half demands attention. A half that equally carries the weight. The hands reach down to the flower, symbolic of hope and the instinct to keep going in spite of everything.”

– EMILIA MINETOLA, *INDIANAPOLIS*

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LETTER FROM THE CHAIR OF THE INDIANA BEHAVIORAL HEALTH COMMISSION

The Indiana Behavioral Health Commission was created by SEA 273 and authored by Senator Mike Crider. SEA 273 was the result of several concerned state and community leaders who recognized a need to examine Indiana's behavioral health delivery system. The mandate was broad, the membership diverse, the task ambitious, and the possibilities were endless. With a clear charge and the inclusion of all necessary perspectives, it was hard to see what could get in the way. The month was March 2020.

We all know what happened next. The entire world was thrown into turmoil. The impact of the COVID-19 pandemic was felt around the world and here in Indiana. Entire paradigms shifted, sometimes seemingly overnight. We were introduced to new terms like "social distancing" and rapid acceleration of concepts like remote work and telehealth. The Indiana Behavioral Health Commission did our important work primarily through virtual meetings, which were live streamed, recorded, and shared on YouTube with links posted on the Commission page on the Division of Mental Health and Addiction (DMHA) website.

The world as we find it in 2022 is much different than the world contemplated by SEA 273. The vital task that legislation presented has only grown in importance. I am so grateful for the leaders, thinkers, and innovators that joined me as Commission members. They did their powerfully important work under impossible conditions. They have created a report that could prove transformational if we collectively come together and execute the recommendations.



Jay Chaudhary
Chair, Indiana Behavioral
Health Commission

A few principles guided the work of the Commission:

- We wanted our recommendations to be actionable, concrete, and specific. **There are many platitudes that one can spout about the changes needed to societal attitudes and structures around behavioral health (mental health and addiction).** We have done our best to avoid them.
- We wanted to be laser-focused on Indiana. Some things are missing from this report in large part because the answers to those questions are outside the scope of what the State of Indiana has any control over. Some other things are missing because no individual entity has control over them. **We did our best to answer the question, “What can the State do?”**
- Finally, although we are suggesting some bold, seismic shifts in behavioral health policy and funding, there is a sense of humility that infused the Commission’s work and is reflected in this report. We know we do not have all the answers. Real, lasting change to behavioral health requires a sustained, holistic response. **We believe that our recommendations can form a key part of that holistic response, but we know we cannot do it alone.**

I would like to thank Sen. Michael Crider, Gov. Eric Holcomb, Lt. Gov. Suzanne Crouch, and Dr. Jennifer Sullivan for entrusting me with the task of steering the Commission’s work. I would also like to thank each and every one of the Commission members, who worked tirelessly to bring these recommendations to life. Finally, a very special thanks to DMHA staff members Alexis Pless, Jocelyn Piechocki, Bethany Ecklor, Amy Brinkley, Elaine Trepanier, and Kelsi Linville, who made all the work possible by keeping us organized and on mission.

**BEHAVIORAL
HEALTH
COMMISSION
MEMBERS**





Katy Adams
President and CEO,
 Southwestern Behavioral
 Healthcare, Inc.

“The Behavioral Health Commission is an exciting opportunity for our state to engage key stakeholders with deep passion for those we serve and to develop innovative recommendations to improve the mental health system during a time of great need. The Behavioral Health Commission has allowed me to advocate for the removal of barriers for Hoosiers to access care, as well as remove the administrative burdens our workforce experiences so that we can focus our efforts on improving lives together.”



Lindsay Baywol
*Policy Manager, Coverage and
 Benefits Unit, Indiana Medicaid,
 Indiana Family and Social Services
 Administration*

“Participating in the Indiana Behavioral Health Commission allows Indiana Medicaid to better understand how our agency can assist our members and providers, such as how our agency can increase access to the behavioral health services our members need, and how we can support our behavioral health providers in rendering these services. This meeting provides our agency with the boots-on-the-ground insight needed for meaningful policy improvement, advancing improved behavioral health outcomes for our Hoosiers.”



Sharon Bowman, Ph.D.
*Professor and Chair of the Dept.
 of Counseling Psychology, Social
 Psychology and Counseling Ball
 State University*

“I am a psychologist in private practice and a professor training future practitioners. The foundation of my work rests on cultural competence and social justice. I welcomed the opportunity to identify some of the challenges facing both consumers seeking services, and those trying to offer said services. I look forward to seeing our recommendations for change implemented for the citizens of Indiana.”



Carrie Cadwell, Psy.D.
*CEO, Four County Comprehensive
 Mental Health Center, Inc.*

“To rise to the occasion of both the consumer and workforce need in behavioral treatment requires a coming together of traditional and non-traditional stakeholders to create a vision for the future that is effective, efficient, innovative, and can scale increasingly to meet need. The Behavioral Health Commission is a key group in this effort to realize Next Level Indiana behavioral health. I am humbled to be a part of this group.”



Senator Michael Crider
State Senator – District 28

“My name is Mike Crider and I am currently the Indiana State Senator representing District 28. I have routinely worked on behavioral health issues including the establishment of the Behavioral Health Commission and enjoy trying to make a difference in this area.”



Donna Culley, Ph.D.
*Licensed Clinical
 Psychologist*

“It is an honor to be selected to serve on the Indiana Behavioral Health Commission. The work of this Commission is important to me because after a 30 year career as a psychologist, I have seen the impact of mental health and addictions on the development of children, adolescents and adults. The trajectory of an individual's life can be positively impacted by a system of quality services and supports which in turn strengthens our communities. I appreciate that Indiana is focusing energy and attention to improving the mental well-being of our citizens.”



Scott Fadness
Mayor of Fishers

“The Commission's work is vital in elevating the discussion around addressing mental illness in Indiana. Just as we did in Fishers, if we marshal our collective resources, we can continue to improve the lives of all Hoosiers.”



J.D. Ford
State Senator – District 29

“I was honored to be selected to serve on this Commission. I was excited to see Indiana take this step to holistically look at our state and what we are doing well and where we may need to improve. I am excited to take this report back to my legislative colleagues and to get to work on implementing the recommendations within.”



Zoe Frantz
President and CEO, Indiana Council of Community Mental Health Centers, Inc.

“Why the work of the Behavioral Health Commission and process is important to me is that Indiana currently is just meeting an estimate of 33% of the mental health needs in our state due to the workforce shortage that is impacting our state, especially in our rural markets. I truly believe if we improve the workforce through the work the Commission has identified, we will improve access for those who need mental health and substance use services. I am proud of the work the Commission did and look forward to seeing its impact for many years to come.”



Mimi Gardner
President and CEO, Chief Behavioral Health and Addictions Officer HealthLinc

“It was truly an honor to sit on the Indiana Behavioral Health Commission. As the sole member from a federally qualified health center, it was wonderful to have a seat at the table to discuss integrated care and behavioral health in primary care. Being able to recognize the role of community health centers in the delivery of behavioral care was both important and monumental. Embedded into every conversation were opportunities to discuss health equity, identify ways our patients could receive better access to culturally relevant care, and address social determinants of health. I commend the Commission for a job well done!”



Brooke Lawson
Mental Health and School Counseling Coordinator, Hamilton Southeastern Schools

“It has been an honor to serve on the Indiana Behavioral Health Commission. Supporting the mental health needs of Hoosier children and families is not only my career but a life-long passion. I am grateful for the opportunity to assist in making recommendations that will create a better system of support for youth and their caregivers in Indiana.”



Chase Lyday
Chief of Police, Avon School Police Department

“The Indiana Behavioral Health Commission is a catalyst for meaningful progress in Indiana’s system of care. As a law enforcement officer in schools, I see daily how the intersection between policing and behavioral health are inextricably linked. It is an honor for me to serve on the Commission to be an agent for change in law enforcement, schools, and families.”



Anthony Maze
Lieutenant, City of Fort Wayne Police Department

“This Commission and being a part of it is important to me from the standpoint of being able to contribute to a cause that is long overdue. The training of law enforcement officers in dealing with the mentally ill is much needed. And, that training needs to be accessible. There also needs to be available mental health resources for those in need of those services. I am honored to have been asked to be a part of this process.”



Stephen McCaffrey
President and CEO, Mental Health America of Indiana

“I am honored to serve as a member of the Indiana Behavioral Health Commission--as I did its precursor, the Mental Health Commission in years past. The Mental Health Commission was the incubator of the mental health reform policies Hoosiers currently enjoy and I expect the Indiana Behavioral Health Commission to be the same for Indiana’s future. For far too long, Indiana has approached behavioral health policy in a piecemeal and oftentimes disjointed manner, leading to the fragmented and siloed system we have today. Through the Commission’s recommendations, we have the opportunity to create a comprehensive and integrated evidence-based system of coordinated services.”



Leah McGrath
Vice President of Public Affairs, Knowledge Services

“Whether at work or in our communities, we bring our whole selves to what we do. Without a strong foundation for mental health, we will never achieve all that we are capable of achieving as Hoosiers.”



Leslie Miller
Assistant Deputy Director, Indiana Department of Child Services

“I’m happy to be a part of supporting positive changes for kids and families. Working to ensure continuity of care and cross-collaboration can only result in better services for our communities. Improving lives for better communities is what’s it all about!”



Dr. Christine Negendank
*Chief Medical Officer,
Adult & Child Health*

"I started out my medical training volunteering in a free health care clinic in downtown Detroit. I realized from that early point in my career that our health care system was broken, especially for our most vulnerable citizens. As I have worked for the past 20 years as a forensic psychiatrist and addiction medicine specialist, I have advocated for a system of health care that was comprehensive and available to all in need. I have been honored to participate on the Behavioral Health Commission amongst so many like-minded individuals who have brought a depth of knowledge and experience to create recommendations that will be life-changing for so many Indiana citizens."



Mike Nielsen
Boone County Sheriff

"It has been an honor and a privilege to sit on the Indiana Behavioral Health Commission to discuss a broad range of mental health issues in this great state. Our county jails have become pseudo mental health centers across the state and across the country. A detailed review and overhaul of how we handle the citizens that are in a mental health crisis is long overdue. This is a great Commission and the results will change the outcome and save lives across the state of Indiana and across our country."



Katrina Norris
*Executive Director, Indiana State
Psychiatric Hospital Network*

"It has been an honor to serve on the Behavioral Health Commission because all Hoosiers deserve access to timely mental health services regardless of their income, demographics, or acuity level. The mental health system in Indiana is severely fractured, and my participation in this commission amongst the finest colleagues in the state is how I chose to contribute to sustainable solutions."



Dr. Jim Nossett
*Physician with Emergency
Medicine Specialists, PC*

"I was honored to be selected to serve on this Commission. I was excited to see Indiana take this step to holistically look at our state and what we are doing well and where we may need to improve. I am excited to take this report back to my legislative colleagues and to get to work on implementing the recommendations within."



Barbara Scott
*President and CEO, Aspire
Indiana Health, Inc.*

"I've dedicated my entire 35-year career to serving individuals with serious mental illness, serious emotional disorders and chronic addiction within the Indiana Community Mental Health system. I find the work of the Commission to be foundational to the next version of our system."



Jess Yoder
*Project AWARE Specialist, Indiana
Department of Education*

"Serving on Indiana's Behavioral Health Commission Report Subcommittee has allowed me to inform the content of the report using what I have learned over the past four years working alongside schools and school districts building comprehensive school mental health systems through the federally funded grant program, Project AWARE. The tremendous opportunity to improve education and mental health systems in Indiana and prevent some of the adverse health and achievement outcomes we are currently seeing gives me great hope."

**NOT
PICTURED**

State Representative **Cindy Ziemke**, State Representative for District 55 and Dr. **Timothy Kelly**, Medical Director of Addiction Treatment Services for Community Health Network and Physician with Clearvista Recovery Associates



FEATURED COMMISSION MEMBER MR. RAY LAY

Hello. My name is Ray Lay. I am a formerly homeless, retired, and disabled U.S. Marine living with a dual diagnosis of schizoaffective disorder and polysubstance abuse issues. By the grace of God and effort on my part, it has been over 17 years since I was last hospitalized for my mental health condition. I am over 15 years clean and sober.

My mental health and substance use journey began at the age of 5 when I was hurled through the windshield of our family car while traveling to Mississippi. I was unconscious for three weeks. When I regained consciousness, I began seeing, hearing, and interacting with what I came to know as my guardian angel. I interacted with my guardian angel off and on for about 10 years, committing an abundant amount of anti-social acts, until at the age of 15 when I was court-committed to a state-run mental institution – the Beatty Memorial Hospital for the criminally insane. I stayed there for three years and was diagnosed with paranoid schizophrenia; however, was never told of that diagnosis or what it meant. That happened in 1971. In 1974, I was called back to the court and released. I went back to Gary, Indiana with my parents and eventually joined the United States Marine Corps. I was a great Marine until I was charged with something that I did not do. I was punished, demoted, and suffered a psychotic break. It was so bad that I do not remember it, but I have read my service medical records. That helped me accept my condition and stop drinking, drugging, and smoking. Instead, I sought treatment and to help others - it is my passion.



Ray Lay
Founder and Owner,
SMI Enterprises, LLC

Today, I am the longest-serving veteran Peer Support Specialist at Roudebush VA Medical Center here in Indianapolis. I am an Indiana Community Health Worker/Certified Recovery Specialist. I am a Forensic Peer Support Specialist helping those involved with the criminal justice system, and a trainer of the same with a very good success record. I have been funded by the Division of Mental Health and Addiction to provide and promote peer support throughout Indiana for three years. I must have done well, seeing that there are many job openings today!

TODAY, I AM

- No longer homeless, but a homeowner and taxpayer
- The only person in the United States living with a severe mental illness that was asked to speak at the Stepping Up Summit in Washington, D.C., on April 19, 2016. The mission is to divert persons with mental health issues away from the criminal justice system and into treatment. Indiana has ninety-two counties yet only 3 are involved. So, there are eighty-nine counties in Indiana that have no persons with mental health issues in the county. That is not what I was told by law enforcement officers, as I am an instructor with Dr. George Parker at the Indiana law Enforcement Academy in Plainfield, Indiana and have been for over 7 years
- Helping to train correctional officers at every training facility of the Indiana Department of Correction on mental health issues (since IDOC is the biggest provider of mental health services in the state of Indiana). I have done this for almost 10 years. I spent seven years of my life in the Indiana State prison at Michigan City because the Marine Corps/Navy did not diagnose me but discharged me with an un-diagnosed psychosis
- a Crisis Intervention Training (CIT) contributor throughout the state of Indiana. I have presented with Major Sam Cochran, co-founder of CIT, and was a keynote speaker for a NAMI CIT conference in 2021. I continue to do CIT presentations
- A seven-year former member of the Indiana Balance of State Continuum Of Care (rolled off 12-31-2020)
- A six-year member of the NAMI Indiana Board of Directors
- A one-year member of the NAMI National Board of Directors
- A three-year member of the Indiana Disability Rights Commission
- A gubernatorial appointee to the Indiana Behavioral Health Commission where I serve with some very passionate persons such as Jay Chaudhary; Steve McCaffery; Katrina Norris; Dr. Christine Negendank; and Sherriff Mike Nielsen, among others

But we need the help of more than just Sen Mike Crider. We need the help of the whole legislature speaking and acting on behalf of the people of Indiana. I already live with a mental/behavioral health condition. But what about those that lack insight. I have been found incompetent to stand trial because of insufficient comprehension to understand the charges against me. People, this is real, and it happens OFTEN. I have been through the competency restoration process and look at me now. TREATMENT HELPS!!!!!!!

No one asks for a mental health condition, but it happens.

EXECUTIVE SUMMARY

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The Indiana Behavioral Health Commission was established in the 2020 legislative session, with a final report due to the General Assembly no later than October 1, 2022. As directed by the legislature, the Commission examined the functioning of Indiana's Behavioral Health System and is recommending significant changes to substantially improve the performance of that system.

The Commission acknowledges that some of the recommendations carry a significant price tag. Care has been taken to propose strategies that mitigate the long-term impact on the state budget while improving access to quality care for all Hoosiers. Furthermore, as instructed by the General Assembly, the Commission studied the cost of untreated mental illness in Indiana and estimates that cost to be a staggering \$4.2 billion annually. ⁱ

The following is a summary of the Commission's work, with the primary recommendations including, but not limited to, the following *(additional detail and recommendations are provided within this report, with specific requests for the General Assembly outlined in the Legislative Summary located in Appendix A)*:

PART I

Build a Sustainable Infrastructure

Like many other states, Indiana's Behavioral Health System infrastructure has been underfunded for years and is in need of systemic reforms to improve and enhance behavioral health care throughout the state. Now more than ever, clear pathways to those reforms exist, and that work has already begun in Indiana. These recommendations build upon that work and, if adopted, will result in a higher quality, more accessible and integrated system.

A The Commission recommends that Indiana use the nationwide push to 988 as the new three-digit number for crisis response to build a Comprehensive Crisis Response system. Thanks to the General Assembly's investment of American Rescue Plan funding, Indiana is already building the components of this system. By adopting a surcharge on phone bills, the General Assembly can provide long-term sustainability for the three-part system:

- a. [Someone to Contact: 988 Call Centers](#)
- b. [Someone to Respond: Mobile Crisis Teams](#)
- c. [A Safe Place for Help: Crisis Stabilization Units](#)

B Similar to many states, Indiana's Community Mental Health Center (CMHC) system and the underlying financial structure currently do not allow behavioral health providers to cover their costs for providing evidence-based, integrated, and whole person care. Many other states have successfully addressed these challenges by transitioning to the federally supported Certified Community Behavioral Health Clinic (CCBHC) model. CCBHCs are a proven model for increasing access, quality,

and integration of care. There are 17 CMHCs in Indiana using time-limited CCBHC expansion grants to begin the transition to the model.

The Commission recommends that Indiana take action to establish the CCBHC model as the primary mechanism for behavioral health care delivery in the state, and that the General Assembly support that transition with sufficient appropriations.

- C** Criminal Justice intersections: Both 988 and CCBHC will significantly ease the burden of mental illness on the criminal justice system by providing coordinated and effective community-based care. As a complement to those systemic changes, the Commission recommends a series of other criminal justice-focused strategies, including increasing the number of **mental health courts** and establishing a **Medicaid waiver to allow for federal reimbursement of some costs of behavioral health care for individuals while they are incarcerated.**

PART II

Overall Hoosier Mental Health/Well-Being

In order to address and improve the overall health and well-being of all Hoosiers, the Commission recommends **(1) strategies to improve Hoosiers' mental health literacy; (2) increase capacity of psychiatric consultation programs for primary care providers; and (3) increase enforcement of mental health parity requirements.**

PART III

Workforce

Access to quality behavioral health care is ultimately dependent upon having enough well-trained individuals to deliver that care. Both the CCBHC and 988 transitions will help with this issue but will not be enough. To improve the recruitment, retention, and quality of the workforce, the Commission recommends **(1) a targeted study of Medicaid reimbursement rates and corresponding increases in those rates; (2) reduce administrative barriers — such as a cumbersome professional licensing process to allow more qualified individuals to work as behavioral health professionals; and (3) fund a long-term student loan/tuition reimbursement program for behavioral health professionals, including coordination with and help navigating existing programs.**

PART IV

Additional Recommendations

The Commission produced a variety of recommendations that cross over multiple areas of focus, including **(1) use of Medicaid to pay for housing supports and other Social Determinants Of Health and (2) reduce administrative burdens and improve data-sharing capacity.** The Commission acknowledges that not all areas are covered by this report and **recommends the following three areas for follow-up examination:** (1) services to individuals with dual diagnoses of Intellectual Disabilities and Mental Illness; (2) the unique challenges and complexity of components of the mental health system serving children, including the DCS-run residential care system; and (3) addressing the increasing mental health needs of Indiana's senior citizen population.

PART V

Funding

The Commission commends the General Assembly for appropriating \$100 million of federal American Rescue Plan funds toward mental health in the 2021 legislative session. This funding has been a crucial system stabilizer and has allowed Indiana to begin much of the work detailed in this report. To provide long-term sustainability for that work and for the system as a whole, the Commission has two primary fiscal recommendations: **(1) implement a \$1 surcharge on phone bills to fund the crisis response system, and (2) provide increasing funding over a period of four state fiscal years to support the transition to the CCBHC model, with a total increase of 60% over that four-year period.**

PROCESS DESCRIPTION

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Due to the COVID-19 pandemic, the development and implementation of the Commission was delayed until October 2020. The initial meeting of the Commission was held virtually on October 9, 2020. It was used to discuss the intent and requirements of SEA 273. The focus of the Commission's responsibility was to assess and evaluate key components of Indiana's Behavioral Health System (BHS) and develop recommendations and strategies to address them. It was emphasized that the overarching expectation was for the Commission to assess the public behavioral health system, overseen by DMHA, as well as private sector behavioral health services and practices.

A total of six workgroups were formed to address the following priority areas: Overall Mental Health/Hoosier Well Being; Continuity of Care; Children and Families; Criminal Justice Interface; Behavioral Health Workforce; and Suicide Prevention and Crisis. Each workgroup developed recommendations for their targeted area which were presented to the Commission in September 2021. The Commission approved moving forward with developing actionable steps to implement those recommendations found to be the most critical and impactful.

In December 2021, per the Commission membership, a Report Subcommittee was formed to prioritize recommendations and develop actionable steps for implementation. The Report Subcommittee reviewed the initial draft report and provided feedback prior to the final review by Commission members. The final report and recommendations were presented and voted on by the Commission on August 3, 2022. The Commission-approved recommendations and strategies are incorporated into this report.



The Commission and workgroups held a total of 25 meetings to accomplish the completion of this report.



All Commission, Workgroups, and Report Subcommittee meetings' recordings, agendas, and minutes may be found at <https://www.in.gov/fssa/dmha/indiana-behavioral-health-commission/>

**BUILDING A
SUSTAINABLE
INFRASTRUCTURE**

P T 1

In the world of public policy, particularly complex problems are known as “wicked problems”. Wicked problems are multi-causal, interconnected, and often inherently irreconcilable. These problems resist easy solutions, and often require structural changes to address. The problems of the Behavioral Health System — such as chaotic funding, fragmentation, and difficulty navigating through the system, are examples of wicked problems. In recognition of that fact, the Commission’s first set of recommendations involve building new sustainable structures to form the core of the BHS that Hoosiers deserve.

The following three areas of focus with recommendations and strategies are linked together with common threads: improve access to quality care; streamline and update system designs that reflect current best practices; and build collaboration, transparency, and integration of whole-person assessment and care.

The Commission believes implementation of the following strategies and recommendations will serve as the cornerstone for building a sustainable infrastructure:

- Using 988 to build a new crisis response system through implementation of a three-part comprehensive model
- Expanding Certified Community Behavioral Health Clinics (CCBHCs) to become the primary model for behavioral health care to be delivered in Indiana and to ensure statewide coverage
- Utilizing the Sequential Intercept Model to address and redesign the interface between behavioral health and the criminal justice system



USING 988 TO BUILD A NEW CRISIS RESPONSE SYSTEM

The Commission membership and Indiana Recovery Council's (IRC) surveys (used to identify gaps and needs) recognized crisis and suicide prevention as priority areas of focus. The Commission determined a critical component of building a sustainable infrastructure must include building, implementing, and sustaining an evidence based, statewide crisis response system.

The model the Commission recommends for implementation is in three parts, based upon SAMHSA-supported best practices:



Someone to Contact



Someone to Respond



A Safe Place for Help



STATE INFRASTRUCTURE CONNECTING THE THREE

RATIONALE

Like much of the country, Indiana has struggled with inconsistent and fragmented crisis response systems. The primary entry points typically involve the police and/or hospital emergency departments. There are often delays in accessing behavioral health assessments and/or linkage to needed care, which may or may not lead to the individual getting the least restrictive, most appropriate level of care. The current system has been proven to be ineffective and inefficient, often taking a toll on the individual, their families, the police, hospitals, the community, and state resources.

Indiana has an unprecedented opportunity to use the new 988 suicide hotline number as a springboard to transform and build a new comprehensive crisis response system. The Commission believes that the voices of individuals with lived experience must be represented throughout the planning and execution of this system.

The following are responses from individuals with lived experience via a survey conducted by the Indiana Recovery Council (IRC). The answers were in response to the question:

“ If you do not feel comfortable contacting 988 for a mental health, substance use disorder, or suicide-related crisis, then what needs to happen in order for you to trust contacting 988?”

- “Anonymity option; also not having police show up at someone’s door (instead, having mental health providers show up will help increase access and decrease barriers, especially for those who are from marginalized racial/ethnic backgrounds)”
- “The feeling of not feeling like a criminal. No one wants to call because they don’t want the cops called on them or the hospital to come hog [sic] them away. You’re the last resort for some people so act as if it ends with you. People don’t trust because they don’t want a stranger to hear everything they’re feeling just to be reported. Understandably you must for dangers and life- threatening planned actions but maybe there is a way to discreetly do it?”
- “Assurance that there is support or resources available without inpatient hospitalization or criminal charges. Fear keeps people from reaching out bc they think they will simply be arrested or taken to the hospital. Need to ensure that there are COMMUNITY SUPPORTS and RESOURCES not just telling them to go to the hospital”
- “Reliability and consistency”
- “Knowing that the cops wouldn’t show up at my door.. and drag me somewhere. I just need someone to speak to. Make it through a hard day or night. Basically just a friend”

These responses from individuals with lived experience highlight and demonstrate a need for change in the current fragmented system.

The Substance Abuse and Mental Health Services Administration (SAMHSA) publication, *The National Guidelines for Behavioral Health Crisis Care Best Practice Toolkit* reports: “With non-existent or inadequate crisis care, costs escalate due to an overdependence on restrictive, longer-term hospital stays, hospital readmissions, overuse of law enforcement, and human tragedies that result from a lack of access to care. Extremely valuable psychiatric inpatient assets are over-burdened with referrals that might be best supported with less intrusive, less expensive services and supports. In too many communities, the ‘crisis system’ has been unofficially handed over to law enforcement; sometimes with devastating outcomes.”ⁱⁱ

POTENTIAL IMPACT

Comprehensive crisis response systems built on the three-part approach have been conclusively shown to save money and dramatically improve outcomes.

- A community was able to divert “37 FTE police officers engaged in public safety instead of mental health transportation/security”
- By drastically reducing/eliminating waiting in emergency departments, hospitals realized \$37 million in avoided costs/losses
- A demonstrated reduction in “Potential State Acute Care Inpatient Expenses by \$260 million....with a net savings of a \$100 million investment in a full integrated crisis continuum” ⁱⁱⁱ

THE BOTTOM LINE IS THAT

“ Good crisis care prevents suicide and provides help for those in distress. It cuts the cost of care, reduces the need for psychiatric acute care, hospital ED visits, and police overuse.” ^{iv}

Implementation of the comprehensive crisis response system will reduce cost in multiple domains (at local and state levels); improve the effectiveness and efficiency of crisis response through use of a coordinated, consistent response to behavioral health crises; and improve the individuals' experience with ultimately better outcomes for all involved.

RECOMMENDATIONS

1 Implement a comprehensive crisis system to build the sustainable infrastructure for a new statewide Crisis Response System in conjunction with implementation of Indiana's 988 system. Although the state is already working toward this goal, ongoing support from the General Assembly, along with adequate funding, is crucial to sustaining and building the system over a period of many years. This is not a short-term project. States with more mature crisis systems — such as Arizona and Tennessee — built their systems over several decades.

Indiana has the opportunity to accelerate that transition, but will need a similar multi-decade commitment to the three-part model:



Someone to Contact

Defined as the “ability to offer real-time access to a live person every moment of every day for individuals in crisis.”

RECOMMENDATION

Implementation of statewide 988 Centers that will provide call, text, chat, and follow-up services on a centralized platform (i.e., all centers will function on an Indiana-unified platform and utilize the same “care traffic control” software featured in the three-part model and SAMHSA’s National Guidelines).



Someone to Respond

Defined as *mobile crisis team services offering community-based intervention to individuals in need wherever they are — at home, work or anywhere else in the community where the person is experiencing a crisis.*

RECOMMENDATION

Implementation of a regional model of mobile crisis teams that aligns with the Indiana Department of Homeland Security’s (DHS) regional district map for Emergency Medical Services. Mandating mobile crisis teams in every county and identifying braided funding sources to ensure this mandate can be upheld, so teams will have the capacity to respond within 60 minutes when dispatched by one of Indiana’s 988 centers.



A Safe Place for Help

Defined as *24-hour, seven days a week, 365 days a year crisis receiving and stabilization facilities that accept all walk-ins, ambulance, fire, and police referrals, with the capacity to assess physical health needs and deliver care for most minor physical health challenges with an identified pathway in order to transfer the individual to more medically staffed services if needed.*

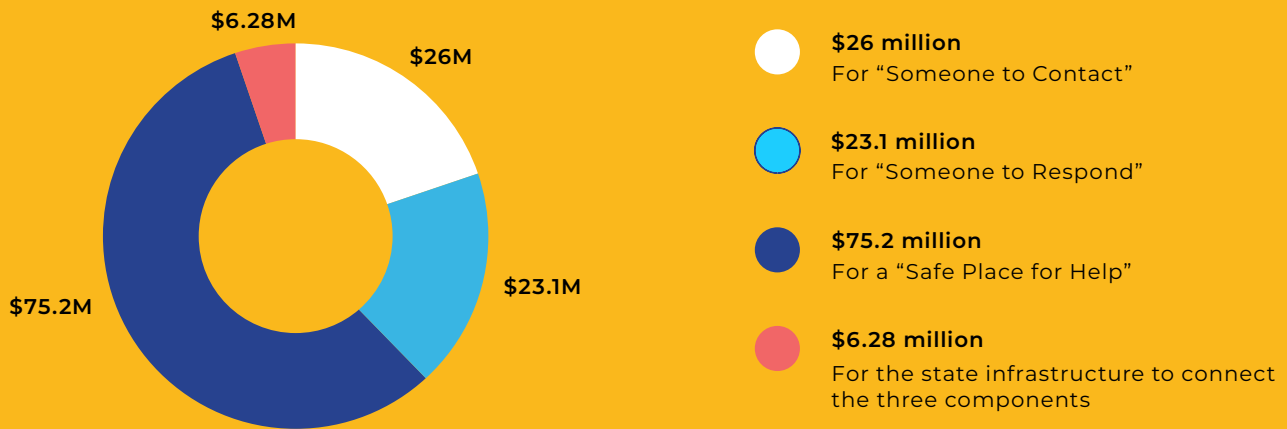
RECOMMENDATION

The state and local communities should collaborate to increase the number of **crisis stabilization units** in every DHS region/district across the state. These centers should be plugged into the statewide crisis response network.

2 The General Assembly should implement a one dollar (\$1) 988 surcharge to fund the comprehensive crisis response system.

The federal law enabling legislation allows states to impose surcharges on phone bills similar to the surcharge that funds the 911 system. Indiana is investing considerable one-time federal funding in the development of a comprehensive crisis response system, but the 988 surcharge is crucial for sustainability.

FSSA estimated the total annual cost to sustain the crisis system components at a **total of \$130.6M** as follows:



To put this annual cost in context, Arizona (also around 7 million residents) has a mature crisis system similar to the one the Commission is recommending.

Its annual crisis expenditures are approximately \$159 million. ▾

The 988 surcharge of one dollar \$1 brings in annual revenues of approximately \$90M per year. The Commission recommends this \$1 surcharge as a baseline for sustainable funding of the crisis system, to be leveraged with Medicaid and other sources to sustain the system in the long term.

3 Fully fund a CIT technical assistance program and Coordinator Position to provide CIT training for all first responders, dispatchers, and detention center staff across Indiana who provide services to both youth and adult populations.

Clarify the types of first responders who can receive funding via the 988 first responder crisis intervention account and if the CIT Technical Assistance Program should be funded from this account (IC 12-21-8-11.4). Research and consider the ability to develop and provide access to video trainings.

4 Pass legislation requiring FSSA to develop rules to authorize reimbursement of EMS for transport to behavioral health facilities.

Currently, EMS can only be reimbursed for transportation from the emergency to a hospital setting. While EMS is not the only responder to a behavioral health crisis, they are often the only option, especially in rural communities. FSSA should develop rules allowing for EMS reimbursement for transport of individuals in a behavioral health crisis to a behavioral health facility. These rules should include training and other requirements to ensure the best possible outcomes for individuals in crisis.

CERTIFIED COMMUNITY BEHAVIORAL HEALTH CLINICS

(CCBHCS)

A Certified Community Behavioral Health Clinic (CCBHC) is a specially designated clinic which must provide a comprehensive range of mental health and substance use services. The CCBHC model has shown tremendous progress toward alleviating decades-old challenges that have led to a crisis in providing access to mental health and substance use care. Three federal administrations and a bipartisan consensus in Washington, D.C., have supported expansion of the CCBHC model over the last decade.

As an integrated and sustainably financed model for care delivery, CCBHCs:

- Ensure access to integrated, evidence-based substance use disorder and mental health services, including 24/7 crisis response and medication-assisted treatment (MAT)
- Meet stringent criteria regarding timeliness of access, quality reporting, staffing and coordination with social services, primary care, criminal justice, and education systems
- Receive funding to support the real costs of expanding services to fully meet the need for care in their communities. This is accomplished through a Perspective Payment System (PPS) much like the Federally Qualified Health Center (FQHC) payment model, which covers the entirety of services that a given patient needs

HEA 1222 in the 2022 legislative session provided a mechanism to develop the roadmap for CCBHC implementation statewide. A detailed report including an action plan for expansion in Indiana will be submitted to the legislature no later than November 1, 2022.

The next phase of implementation is where the CCBHC model becomes the primary model of behavioral health care delivery in Indiana. The preferred pathway is through the Center for Medicare & Medicaid Services (CMS) “Demonstration” program. Ten states have previously received demonstration status, but the status was closed to new states until the recent passage of the Bipartisan Safer Communities Act. This will open demonstration status to an additional 10 states, and possibly more.

Other vehicles for permanent CCBHC implementation are a Medicaid State Plan Amendment or 1115 Waiver where FSSA requests that the federal government approve a permanent CCBHC model and rate within the Medicaid State Plan.

RATIONALE

The Commission identified fragmented systems, silos, lack of communication/collaboration across systems, lack of access to prevention services, and lack of consistency of care across the state. Indiana currently has 18 SAMHSA grant-funded CCBHCs. Due to the tenuous nature of a time-limited grant-funded program, the Commission recommends that Indiana take action to support the building of a sustainable infrastructure to establish and support the CCBHC model as the preferred, sustainable model for behavioral health care for Hoosiers moving forward.

Under the CMS Demonstration program, the state would be responsible for establishing and applying certification requirements (as required by CMS), certifying CCBHCs and ensuring CCBHC demonstrate ongoing compliance with standards. In addition, coordinating efforts with Indiana Medicaid to establish payment mechanisms and rate-setting for CCBHC payments will require resources and funding for the initial system build and ongoing sustenance.

POTENTIAL IMPACT

States that have expanded their use of CCBHCs have demonstrated potential impact in numerous areas.

The following are excerpts from the 2021 CCBHC Impact Report

Expanding Access to Care

CCBHCs average serving 17% more people than prior to CCBHC implementation. Missouri's CCBHC network reported a 27% increase in access to client care from their baseline to the fourth year of their program, and a growth in the number of armed forces and veterans served by almost 41% during that same period. This was primarily due to adopting same/next-day access.

Decreasing Wait Times for Care

- **50%** of responding CCBHCs provided same-day access to care
- **84%** see clients for their first appointment within one week
- **93%** see clients within 10 days

Investing in the Workforce

The CCBHC model is effectively impacting the behavioral health workforce shortage by enabling clinics to increase hiring — on average 41 new jobs per clinic.

Expanding Access to Medication Assisted Treatment (MAT)

- 89% of CCBHCs offer one or more forms of MAT (compared to 56% of substance use clinics nationwide)
- 60% of clinics added MAT services for the first time as a result of becoming a CCBHC (31% were able to offer more forms of MAT after CCBHC implementation)

Making Crisis Services and Supports Available to All

All CCBHCs deliver crisis support services in their communities, helping to divert people in crisis from hospitals, emergency departments, and jails.

- 91% of CCBHCs are engaging in one or more innovative practices in crisis response in partnerships with hospitals, first responders, and others
- 79% coordinate with hospitals and emergency departments to prevent avoidable admissions with individuals are in crisis^{vi}

Address Provider and Staffing Shortages

The Prospective Pay Structure (PPS) of the CCBHC model is a leap in progress for covering the cost of care comparatively to a Fee for Service (FFS) pay structure. The PPS rate is cost-related payment methodology that is meant to reimburse CCBHCs at a level that reflects the costs of providing comprehensive services and supports to all who seek care. The PPS rate is developed in collaboration with providers to ensure that all the direct and indirect costs of providing the level of care required are reimbursable. Part of this review involves reviewing current staffing levels and projected increases according to the community needs, to ensure the PPS rate covers the staffing costs, which in turn reduces staffing shortages. Most CCBHC demonstration states cited expansion of staff as one of the biggest system improvements resulting from the CCBHC demonstration.

Increase Financial Accountability and Transparency

The CCBHC model requires that each participating CCBHC provides an assessment of the needs of the target consumer population and a staffing plan for the prospective CCBHCs. This needs assessment is performed at least every three years. Reviewing the needs assessment and PPS rate every three years will provide greater financial accountability than our current payment methodology. Furthermore, CCBHCs are required to perform an independent financial audit annually and report these audits to the state and Federal authorities.^{vii}

RECOMMENDATIONS

The Commission strongly supports financial and administrative investment in

developing a sustainable infrastructure to support the expansion of CCBHCs in Indiana.

Hoosiers will reap many benefits from having access to this proven model of whole person care. CCBHCs provide the foundation necessary to support many of the Commission's recommendations. Similar to 988, the CCBHC transition must take place over a period of several years, and must be consistently supported throughout any transition of state administration. Therefore, the Commission's recommendations to the General Assembly are geared toward locking in funding and plans for the CCBHC transition in the 2023 session.

1 Implement the recommendations and action items provided in the CCBHC Legislative report due from FSSA to the General Assembly by November 1, 2022

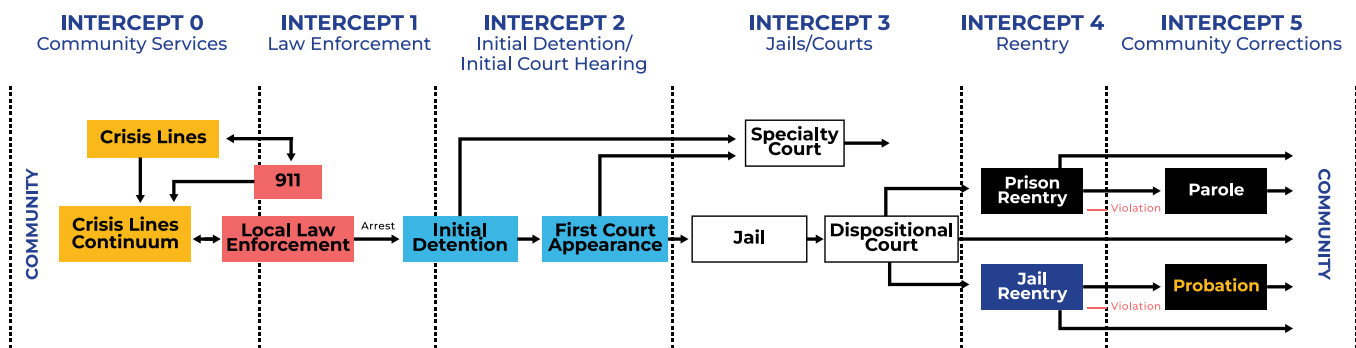
2 Pass legislation requiring FSSA to apply for CCBHC demonstration status as allowed by the Bipartisan Safer Communities Act.

The legislation should specify that if Indiana is not awarded demonstration status, FSSA must initiate another process to implement the CCBHC model, including but not limited to a State Plan Amendment (SPA) within six months of receiving notice that demonstration status was not awarded.

3 Using the Missouri experience as a model, the General Assembly should appropriate adequate, incrementally increasing funding to support permanent CCBHC expansion in Indiana. This recommendation is based on detailed financials from the Missouri Behavioral Health providers shared with the Commission.

BEHAVIORAL HEALTH & THE CRIMINAL JUSTICE SYSTEM

The Commission's Criminal Justice Workgroup utilized the Sequential Intercept Model (SIM) as the framework for assessing needs and developing recommendations. SIM is a model which "details how individuals with mental and substance use disorders come into contact with and move through the criminal justice system. The model helps communities identify resources and gaps in services at each intercept and develop local strategic action plans." ^{viii}



RATIONALE

Commission members unanimously agreed that the intersection between the criminal justice system and individuals with behavioral health issues is a priority area that needs to be addressed by the Commission.

The Commission acknowledges that the long-term goal should be to prevent as many individuals with behavioral health challenges from entering the system in the first place, and 988 and CCHBC implementation will go a long way toward that goal:

- **37%** of people in state and federal prisons and 44% of people in jail have been diagnosed with a mental illness
- **25%** of people in jails report experiencing "serious psychological distress"

- **27%** of police shootings in 2015 involved a mental health crisis
- Within the two weeks following their release, former prisoners are 129 times more likely than the general public to die of a drug overdose ^{ix}

In addition, the Healthy People 2020 Report states the impact of incarceration on families and children is staggering.

- According to data from 2011–2012, more than 5 million U.S. children (approximately 7% of all U.S. children) have experienced the incarceration of a parent they resided with at some time
- Adverse Childhood Experiences (ACES) have multiple, documented research studies indicating children of incarcerated parents are more likely to experience higher outcomes of social determinants of health as well as learning disabilities and aggression
- Additionally, children of incarcerated parents have been found to be up to five times more likely to enter the criminal justice system than children of non-incarcerated parents
- Former prisoners are also at a higher risk for committing suicide soon after their release ^x

POTENTIAL IMPACT

Implementing strategies for each Intercept will potentially:

- Facilitate the identification of and response to needs of Hoosiers with behavioral health disorders who are at risk for and/or involved in the criminal justice system
- Provide relief to over-crowding in jails and prisons by diverting individuals into treatment and out of incarceration
- Reduce cost of untreated behavioral health disorders
- Reduce the disproportionate number of individuals with behavioral health disorders incarcerated in jails and prisons
- Build partnerships between and across diverse agencies and systems in local communities and at the state level to problem solve, reduce duplication, develop, and align policy and protocols, pool resources/braid funding, etc
- Improve outcomes for individuals, their families, the collective systems, and the State of Indiana
- Facilitate adoption of payment methodologies would support coordination of care from CMHCs to individuals that flow between incarceration and treatment

RECOMMENDATIONS

Recommendations to address each Intercept were approved by the Commission. Because of the breadth and scope of recommendations, the Commission advises that the following three recommendations be given priority and are addressed first:

1 Mental Health Courts (Intercept 3)

In Indiana, mental health courts fall under the umbrella of “Problem Solving Courts” This includes drug courts, reentry courts, family courts, etc.^{xi}

THE COMMISSION RECOMMENDS

- A** Assess current functioning of active mental health courts, use to support expansion (types of referrals, availability of treatment options)
- B** Increase number of courts available, focus on local level for both adults and juvenile justice
- C** Collect recidivism data specific to mental health courts
- D** Close coordination with CMHC/CCBHCs

2 Competency Restoration (Intercept 3)

Indiana, like many other states, has been facing a substantial, ongoing backlog within the competency to stand trial process.. As more people are referred for evaluation and restoration, the wait times for these services have also increased. These wait times often take place in county jails, which are not designed to meet the significant mental health needs of these individuals.

THE COMMISSION RECOMMENDS

- A** A clear protocol and collaboration between all stakeholders to clearly address involuntary medication within court orders to support effective treatment
- B** Legislatively creating an alternate statutory path for individuals with non-violent crimes who have a mental illness and are declared incompetent to stand trial. Include judge discretion to dismiss charges when individuals cannot achieve competency
- C** Increase jail-based and community competency restoration utilizing CMHC/ CCHBCs for their expertise in treatment of individuals with SMI and in their ability to provide comprehensive community-based treatment

3

Medicaid Expansion in Settings of Incarceration (Intercept 4)

- A** HEA 1222 in the 2022 legislative session gave FSSA the option to apply for an 1115 Medicaid Waiver to cover some costs of care while incarcerated. The Commission recommends that FSSA take advantage of that option, and that any cost savings that accrue to the Department of Correction by shifting some of the costs to the federal government be reinvested to improve the quality of correction behavioral health care.
- B** FSSA, the Department of Correction, and county jails should collaborate to improve the quality of correctional behavioral health care by:
 - i. Collaborate with CMHCs/CCBHCs to ensure coordination between care on “the inside” and “the outside.” This may require reexamining the current contracts for jail mental health, which are dominated by a few providers and have resulted in a wide variance between local jails
 - ii. Access to behavioral health medications, including MAT with medication adherence planning, including improving and alignment of the formulary of psychotropic drugs within contracted health care
 - iii. Incorporate Forensic Peer Support Specialists to be used at the individual’s discretion in treatment while incarcerated and for transition planning prior to, and after release

ADDITIONAL RECOMMENDATIONS

Expand Crisis Intervention Training (Intercept 1)

CIT Programming offered for Dispatchers and Jail Staff – more widely implemented and fully funded (per SB231 from 2017 a CIT Technical Assistance Center shall be created but no funding included)

- A** Minimum standards for what mental health training officers, dispatchers, and jail staff receive (CMHC/CCBHCs should be a partner) or CIT for all counties

- B** Fund a CIT training program with a line item in the next state budget
- C** Include ongoing competency standards to assure for maintenance and growth of knowledge (comments from survey)
- D** Use in tandem with Stepping Up ^{Xii}

2

Regional Treatment Centers (Intercept 2)

- A** The Commission would like to investigate utilization in other states and possible implementation of regional treatment centers in Indiana

3

Jail Mental Health Screening (Intercept 2)

- A** Implement a screening tool; Option: <https://www.prainc.com/product/brief-jail-mental-health-screen/>

4

Conduct Recidivism Studies (Intercept 5)

- A** Limited data currently kept; establish consistent collection of recidivism data
- B** Outcomes to be used for future legislation

5

Increase Post-Incarceration Supports with a Focus on Transitional Needs (Intercept 5):

- A** Indiana's CCBHC plan should include justice system related requirements in line with national standards, including
 - i. Seven-day follow-up from release standard to be implemented by CMHCs/CCBHCs
 - ii. Outpatient forensic services focusing on re-entry supports, with liaison staff that is knowledgeable of justice and Behavioral Health Systems
- B** The legislature should explicitly provide pathways for reductions in the length of probation and parole time due to the provision of behavioral supports

**OVERALL MENTAL
HEALTH/HOOSIER
WELL-BEING**

PPT 2

Historically, the purview of the State in behavioral health has been very narrow and defined: delivering services for individuals with low income and diagnosed with severe mental illness, substance use dependence, and/or youth with a serious emotional disturbance. These are the individuals at the very top of the Mental Health Pyramid. Now, more than ever before, the State is being asked, appropriately so, “what can we do for all Hoosiers facing behavioral health challenges?”

This is an especially important question in light of the ongoing effects of the COVID-19 pandemic. The Commission considered the question and developed actionable recommendations.

Components of mental well-being include, but are not limited to, the following: assessing and addressing whole-person needs, meeting people where they are, providing education and information to reduce stigma and increasing the general public’s awareness and understanding of mental health and addiction on a continuum of need.



This section has several areas of focus, targeting key elements necessary for building a sustainable infrastructure to support the mental well-being of all Hoosiers across their lifespan.

<p>The development and implementation of Mental Health Literacy statewide</p>	<p>Harnessing and equipping primary care to better deal with mental health needs</p>	<p>Mental Health Parity</p>
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IMPROVING MENTAL HEALTH LITERACY FOR ALL HOOSIERS

A letter signed by members of the Commission and key stakeholders, provides a definition and overview of Mental Health Literacy, national and state data, potential impact of implementing Mental Health Literacy, and the rationale for recommending the state take action to support implementing in education settings across the state. Special attention is given to highlight the need for Mental Health Literacy and the potential impact on improving workforce readiness and school safety. This letter is included in the Appendix of this report.

The concepts and principles of Mental Health Literacy are important for all Hoosiers and may be applied across the lifespan.

These include

- A** Knowledge of how to prevent mental disorders
- B** Recognition of when a disorder is developing
- C** Knowledge of help-seeking options and treatments available
- D** First aid skills to support other who are developing a mental disorder or are in a mental health crisis
- E** Knowledge of effective self-help strategies for milder problems

RATIONALE

The importance of focusing on the mental health of Hoosier youth cannot be underscored. Improvements in Indiana schools have been made over the last decade and include a focus on the whole child while providing education to students, staff, and families that aim to increase and enhance knowledge, skills and attitudes related to mental health and wellness.

This education helps students to develop healthy identities, manage emotions, achieve personal and collective goals, feel, and show empathy for others, establish and maintain

supportive relationships, and make responsible decisions. Further, the focus on whole child education not only prevents Hoosier students from developing long-term mental health issues, it also assists the adults in their lives to be able to identify when a child may be struggling, and give them tools they need to cope with these issues and/or seek additional support. These preventative strategies, paired with mental health literacy, will have a lasting impact on the well-being of all Hoosiers.

POTENTIAL IMPACT

Project AWARE Indiana is federally funded through the Substance Abuse and Mental Health Services Administration (SAMHSA), providing a total of \$18 million to the Indiana Department of Education, the Division of Mental Health and Addiction, and now 14 Local Education Agencies beginning in 2018 and ending in 2026.

This funding supports mental health education and awareness in Indiana schools — helping students and the greater community develop positive habits, coping techniques, and fostering a safe and healthy learning environment for all students. Specific grant goals, data collected, and a comprehensive list of partners can be viewed at www.projectawarein.org. The work these two state agencies, schools and districts, and local mental health agencies have embarked on is an example of the infrastructure-building and prioritization of mental health supports to decrease barriers to academic success. This is a model which could be adopted by more schools if supported by state funding.

RECOMMENDATIONS

The state and other key public and private stakeholders should promote increased mental health literacy among Hoosiers by:

1 Working with various sectors including, but not limited to, child welfare, criminal justice, school systems, employer groups, and other relevant entities to adopt and implement culturally competent and responsive mental health literacy curriculums, trainings, and monitoring practices throughout multiple systems

2

Creating community-level marketing campaigns including messaging focused on those with lived experience and/or currently in recovery

3

Build policy that funds and incentivizes schools and early childcare providers to implement mental health literacy in order to increase school safety and improve the skills and mindsets needed for the next generation to be contributing members of Indiana's workforce

HARNESSING AND EQUIPPING PRIMARY CARE TO BETTER DEAL WITH MENTAL HEALTH NEEDS

One of the primary limiting factors to expanding access to behavioral health care is lack of a dedicated workforce. Addressing this issue will take years, possibly decades, so Indiana needs a solution for the increased challenges now. The Commission recommends Indiana move forward to harness and equip primary care to better deal with mental health needs which may be accomplished by supporting and expanding the Indiana Behavioral Health Access Program for Youth (Be Happy).

Be Happy is a statewide child psychiatry access program (or pediatric mental health care access program) designed to bridge the gap between primary care and behavioral health specialists. Be Happy increases Indiana's effective mental health workforce and improves Hoosier families' access to best practice behavioral health care by supporting health care providers in their communities with guidance from psychiatric specialists. Board-certified child and adolescent psychiatrists consult with community-based providers to help with assessment, diagnostic clarification, medication management, treatment planning and other pediatric mental health questions.

Be Happy services also include:

- Assistance with identifying appropriate community referrals (e.g., evidence-based treatment programs, support services)
- Free continuing education sessions on pediatric behavioral health topics (e.g., [monthly Project ECHO series; in-service workshops](#))

RATIONALE

Primary care providers play a critical role in the overall health and well-being of individuals:

- Their role as first contact providers of comprehensive and continuous care makes them well-suited to treat any mental illness
- They are well-trained to address mental health needs and currently provide the largest proportion of mental health care in the United States
- Primary care is accessible to all patients regardless of geography or ability to pay. In contrast with mental health specialists who practice mostly in urban areas, primary care physicians practice in urban and rural areas, and are more likely to take all types of insurance
- Primary care professionals are the major providers of care in safety-net settings and see patients of all ages, making them the first contact for patients in all demographics with mental illness
- Visiting a primary care physician may carry less stigma for many patients
- Many primary care physicians have a relationship with a patient before the onset of their mental illness, which allows for quicker recognition of the disease process
- Primary care providers can also identify high-risk patients and screen them for common mental health problems
- Many patients with mental health conditions seen in primary care settings have at least one concurrent medical illness ^{xiii}

Be Happy is one of over 40 similar mental health care access programs throughout the United States pursuing a sustainable funding model. An emerging best practice for sustainability is legislation requiring insurance carriers operating within the state to proportionally share in program cost based on covered lives/month. This approach involves the development of a board with representatives from relevant state entities (e.g., DMHA, IDOH), health insurance carriers, and providers to administer insurance assessments, manage funds, and ensure ongoing services. This model does not require state budgetary assistance.

The Be Happy program has been implemented since its inception with support from time-limited grant and contract funds. Current programming is primarily supported by time-limited federal grants, with additional support provided through foundation grants and philanthropic gifts.

POTENTIAL IMPACT

- **Be Happy increases Indiana’s effective mental health workforce and improves Hoosier families’ access to best practice behavioral health care** by supporting health care providers in their communities with guidance from psychiatric specialists. Board-certified child and adolescent psychiatrists consult with community-based providers to help with assessment, diagnostic clarification, medication management, treatment planning, and other pediatric mental health questions
- **Increase access to behavioral health care**
- **Reduce stigma**
- **Reduce strain on the overburdened mental health system by supporting behavioral health care** delivered in a primary care setting
- **Development of cross-system partnerships** and redesigned funding models to ensure resources are supported
- **Raise awareness and encourage primary care/ health care providers to address behavioral health** issues with support and specialty consultation which is easily accessible

The state of Washington developed the Washington Partnership Access Line (WAPAL) Fund in 2020 with minimal payor pushback and exceptional payor compliance. It has provided full program funding for pediatric, perinatal, and adult mental health access services for the cost of \$0.06/covered life/month over the past year (approximately \$3.6 million). Rhode Island is currently in the process of passing similar legislation.

RECOMMENDATIONS

Expand the scope and use of the Be Happy program model by pursuing the development of legislation including:

1

A requirement for insurance carriers operating within Indiana to proportionally share in program cost based on covered lives/month

2

Development of a board with representatives from relevant state entities (e.g., DMHA, IDOH), health insurance carriers, and providers to administer insurance assessments, manage funds, and ensure ongoing services

3

Expansion of current psychiatry access program scope to include adult and perinatal mental health consultations

MENTAL HEALTH PARITY

Access to behavioral health care has been identified as a key challenge across the Behavioral Health System in Indiana. Access is often driven by affordability and insurance coverage. Because access to care is a critical component of ensuring all Hoosiers in need of care have access to it, enforcement of federal parity legislation is important.

RATIONALE

The Mental Health Parity and Addiction Equity Act (federal parity law) was enacted in 2008 and **requires insurance coverage for mental health conditions, including substance use disorders, to be no more restrictive than insurance coverage for other medical conditions.**

Commercial insurance plans are required by federal law to have parity between behavioral health and medical/surgical care coverage, in four key areas:

- **Annual and lifetime dollar limits on benefits**
- **Quantitative treatment limitations: limits on the frequency of treatment, number of days, visits, etc.**
- **Financial requirements: deductibles, co-payments, co-insurance, and out-of-pocket expenses**
- **Non-quantitative treatment limitations including utilization review, provider network participation standards, out-of-network reimbursement amounts, and “fail first” requirements ^{xiv}**

POTENTIAL IMPACT

The enforcement of federal parity standards are largely left to the states. The Commission recommends that Indiana adopt a version of New York’s “Timothy’s Law,” which sets robust parity standards and enforcement guidelines for insurance plans in the state.

For example, under New York law health plans must cover:

- At least 30 days of inpatient care and 20 visits of outpatient care per year
- At least 60 outpatient visits per year to treat substance use disorder, up to 20 of which may be for family members
- Inpatient substance use disorder treatment, including detoxification and rehabilitation ^{xv; xvi}



The increased enforcement of parity in Indiana will improve access to behavioral health care for those Hoosiers who need it.

RECOMMENDATIONS

1

Enact legislation similar to New York's "Timothy's Law" to establish parity standards and enforcement guidelines. ^{xvii}

2

Currently, the IDOI may review insurance plans for parity compliance to the extent that they choose to include any coverage of behavioral health care, but lacks any enforcement mechanism to investigate violations that occur in practice. The Commission recommends the IDOI and/or DMHA be given such authority pursuant to enactment of a "Timothy's Law" statute.

WORKFORCE

P T 3

The lack of an adequate workforce is the single biggest obstacle to implementing many of the Commission’s recommendations. Unfortunately, the workforce issue does not lend itself to easy, short-term answers. Despite this, the Commission has delivered actionable, concrete recommendations designed to address and improve this issue — both in the short term and well into the future — by focusing on workforce recruitment, retention, and quality.

RATIONALE

In 2016 there were over 123 million Americans living in a designated Mental Health Professional Shortage Area (HPSA). Consequently, the gap between needs and access to services is stark and growing.

- It will take approximately 6,000 additional practitioners to meet the needs
- One in five adults experience a mental health condition each year and only 40% receive services
- More than 19 million Americans struggle with substance use disorders but only 11% receive treatment
- By 2025, the shortage will grow substantially worse, with a shortage of 250,510 FTEs ^{xviii}

Indiana is not immune to these challenges. The Workforce Development Workgroup identified numerous challenges for recruiting and retaining a quality workforce necessary to meet the needs of Hoosiers with behavioral health concerns: Underfunding of behavioral health safety net; low wages; high caseloads resulting in high burnout; and high turnover rates. The problems with recruiting and retaining quality staff are even greater in rural areas.

The Workforce Workgroup noted it is not uncommon for a case manager and/or peer to leave a behavioral health job to work at a fast-food restaurant. There, they can make more money per hour, have a significantly lighter workload, and have less stress.

Behavioral health provider reimbursement rates are low in Indiana, leading to low salaries. It was noted that neighboring states see Indiana as a great place from which to poach workers due to low wages in Indiana.

POTENTIAL IMPACT

Reducing the behavioral health workforce shortage will lead to improving access to care, continuity of care, and overall quality of care.

RECOMMENDATIONS

1 **Increase Medicaid rates to support competitive hiring and retention** of the necessary behavioral health workforce.

2 **Undertake Medicaid** rate study of select behavioral health and substance use specific service types to include psychotherapy CPT codes, Medicaid Rehabilitation Option rates and structure, certified peer recovery services, and residential and transitional residential per diem. Increase rates to be competitive and to support hiring and retaining the necessary workforce.

3 **The Commission identified several barriers which impede individuals from becoming licensed behavioral health clinicians in Indiana.**

In order to streamline the process for receiving an initial license or transferring a license from another state, the Commission recommends developing legislation that will:

A Expand universal licensure recognition language to behavioral health licenses issued under the State Psychology board and Behavioral Health & Human Services board

B Facilitate the implementation of physician and psychology compacts as well as other future compacts advocated for by other IPLA-recognized behavioral health professions

C Mandate the modernization and increasing digitization of the IPLA licensing process

4

Reduce barriers which prevent qualified and appropriate individuals to work in the behavioral health arena.

A Study of Criminal Record as a Barrier to Employment: Undertake study regarding criminal record barriers to employment in behavioral health including certified peer recovery positions and other behavioral health professionals. Utilize the information gained via the study to reduce barriers which prevent qualified and appropriate individuals to work in the field.

B Treatment Extenders. The Commission recognizes the reality that the majority of the behavioral health workforce are unlicensed professionals. While psychiatrists, psychologists, and licensed therapists are an irreplaceable part of the system, this group of unlicensed professionals provide critical services within the system. To that end, the Commission recommends that the state develop training and certification standards for behavioral health professionals who do not hold a clinical license and adopt sustainable reimbursement rates to ensure that there are enough of these providers to address the current and future needs.

5

Appropriate funds for a long-term student loan repayment or tuition reimbursement program for behavioral health professionals committed to working in Indiana and serving underserved communities. This program must be long-term to allow for proper monitoring and compliance, as well as a greater impact. It should also include navigation assistance for other similar programs.

**ADDITIONAL
RECOMMENDATIONS**

PPT 4

Readers of this report should not take the diverse nature of this section as any sort of reflection on the importance of the following recommendations. These are vital and were placed in this section only because they did not fit with other sections and/or components of them could be incorporated across all areas.

1 Social Determinants of Health (SDoH)

Social Determinants of Health are non-medical factors that influence health outcomes. Disparities and barriers to safe housing, nutritious food, and reliable transportation have disproportionate negative impacts on individuals with behavioral health challenges. Many Commission members identified housing instability as a priority factor to address for individuals with mental illness, through the following recommendation:

A Medicaid Housing Supports: FSSA should explore and adopt vehicles to pay for housing supports and other Social Determinants of Health through the Medicaid program. For example, California recently won approval of a Medicaid waiver that will pay for various health related social needs through a program called “CalAim”.^{xix}

2 Data Sharing and Administrative Burdens

The Commission also identified several data-sharing and administrative burden issues as a barrier to care for all Hoosiers. To address these issues, the Commission recommends:

- **Developing and funding a shared medication and data system for all levels of care (inclusive of emergency professionals, hospitals, community mental health centers, county jails, and Department of Correction)**
- **Requiring Indiana Managed Care Entities to participate in a centralized credentialing process to reduce the barriers to care and reimbursement that flow from different processes**
- **Evaluating current intake processes and develop workflow to reduce barriers to access and reduce administrative burden so that the client’s immediate needs are met in a trauma-informed manner**

3 The Commission must acknowledge that we did not cover everything that we needed or wanted to address. Three specific areas that should be examined further (either through a limited continuation of the Commission or through another mechanism) include:

- **The provision of services to individuals with a dual diagnosis of intellectual/developmental disability and mental illness. Too often, these individuals are bounced between systems and not given the care they deserve. Some of the Commission’s recommendations will be helpful, but further study and action is needed.**
- **While many of the proposed recommendations will positively impact care for Hoosier children, Indiana’s child-serving systems are complex and multi-faceted, and could benefit from further study. In particular, the children’s Residential Treatment System was identified as having limitations and being difficult to access. Other potential areas of study for youth and needed reforms include:**
 - Increasing outpatient and school-based services
 - Increasing available services between outpatient and inpatient, including intensive outpatient/IOP programs, partial hospitalization, and crisis services
 - Increasing the number of available inpatient beds for youth in the state
 - Creating access opportunities for all children regardless of insurance type, while strengthening referral pathways to reduce wait time for intake appointments
- **Finally, several Commission members identified the increasing behavioral health needs of Indiana’s growing population of older adults as an area in need of further study. The COVID-19 pandemic accelerated already alarming trends of isolation, substance use disorder, and mental health challenges among older Hoosiers. As the state moves away from a nursing facility-based model towards one where most Hoosiers can choose to age at home, behavioral health needs must be part of the conversation.**

While the Commission did not set forth any specific recommendations around the inequities and disparities which exist in the current BHS, there were robust, open discussions about social and racial equity and health disparities throughout the Commission’s work. The Commission believes that the critical steps outlined in the report will have a substantial impact on reducing disparities and inequities. However, in order to ensure that this assumption is accurate, the Commission recommends that there is intentional development of metrics to measure, track, and address disparities/inequities in the BHS system. This must be considered a crucial component of the proposed reforms.

FUNDING

PPT 5

One of the fundamental questions that the Commission was asked to address in SEA 273 was how much more money is needed, and for what, to improve and support the Indiana Behavioral Health System? The Commission determined that there are two ways to answer this question, and they ask individuals who are reviewing this report to contemplate both of them when considering their recommendations.

First, many, if not all, of the recommendations in this report will cost money to implement properly. Some key recommendations, such as appropriately implementing the CCBHC model, will require substantially more funding. If the General Assembly and Executive branch are looking to meaningfully reform the Indiana Behavioral Health System to serve all Hoosiers, the Commission recommends the Legislature be prepared to spend what it takes to implement this Commission's recommendations.

The second way to answer the question is explained in the following three-part analysis. Specifically:

1 What does untreated and undertreated mental illness cost Indiana?

2 What has Indiana's state budget historically appropriated for the care and treatment of mental illness, and what consequences has that had on the system?

3 How much more funding is needed to build a sustainable infrastructure and bridge to the future?

COST OF UNTREATED MENTAL HEALTH IN INDIANA

On December 1, 2021, FSSA and DMHA commissioned a cost-analysis of untreated mental illness, in alignment with a 2020 state statute for the Indiana Behavioral Health Commission (Indiana Code 12-21-7). The completed summary report is in the Appendices (Appendix F), with the following excerpts from the report noted below:

The burden of mental illnesses on individuals, families, and communities is substantial:

- Approximately one in five Hoosiers experience mental illness each year
- For every four Hoosiers treated for mental illness, one additional Hoosier is untreated
- Mental illness is associated with the prevalence and progression of many burdensome and costly chronic diseases, such as diabetes and cardiovascular disease
- An estimated 40% of individuals who are incarcerated have a mental illness. One in four who are incarcerated have a serious mental illness
- Nearly half (45%) of homeless individuals have a mental illness, particularly among those who are chronically homeless
- Eighty percent of Hoosiers with a serious mental illness are unemployed ^{xx}

To estimate the annual economic burden of untreated mental illnesses to the State of Indiana, previous research and evidence was reviewed to identify which societal costs are most likely affected. *Based on prior work estimating the economic burden of mental illness, a framework was developed to incorporate both **direct** and **indirect** costs:*

- Direct costs include disease-related expenditures and consist of both health care costs (i.e., inpatient expenditures, outpatient expenditures, emergency department expenditures, and pharmacy expenditures) and non-health care costs (i.e., incarceration costs and homeless shelter costs).
- Indirect costs include resources lost due to mental illness and include loss of productivity due to unemployment, workplace productivity loss (i.e., absenteeism, presenteeism), premature mortality costs, and caregiving costs. ^{xxi}

SUMMARY OF FINDINGS

The cost of untreated mental illness in Indiana is estimated to be \$4.2 billion every year. The largest cost attributable to untreated mental illness was premature mortality, which is estimated at over \$1.4 billion. Productivity losses were estimated to cost \$885 million each year, and direct health care costs \$708 million.

DIRECT HEALTH CARE COSTS	DIRECT NON-HEALTH CARE COSTS
<p>\$708 million annually</p> <p>\$142 million to Medicaid</p> <p>\$567 million to private insurers</p>	<p>\$106 million to Indiana’s criminal justice system</p> <p>\$9.9 million to Indiana through homeless supports</p>

INDIRECT COSTS

Cost of **\$1.5** billion in premature mortality

- Much of this derived from the excess risk of unintentional death attributable to mental illness in the form of annualized years of life lost
- Costs of \$431 million due to intentional death

Cost of **\$885** million due to productivity losses, **\$750** million of which was lower productivity among workers

Cost of **\$566** million for caregiving, **\$546** million of which was lower productivity among caregivers

Costs of **\$407** million in unemployment for those unable to work

Estimation of the economic burden of untreated mental illness in Indiana puts into context the nature and scope of this public health challenge. Although categories of costs represented in this report reflect those most often captured in economic analyses of mental illness, other societal costs attributable to untreated mental illness are likely to be incurred and not captured here. Despite efforts to estimate costs across the lifespan, the lack of data for direct health care costs among the Medicare-eligible population is an example of costs not included in the overall estimate. Thus, it is likely that the costs estimated in this report are an underestimate of the true economic burden.

At over \$4 billion, the economic burden of untreated mental illness in Indiana represents 1.2% of the state's gross domestic product in 2019 (\$338 billion).

For context, corn, the leading agricultural commodity for Indiana representing nearly 30% of agricultural production, had \$3.8 billion in sales in 2018.

Considering the average wage in Indiana, \$4 billion represents approximately 100,000 jobs. Spread across all Hoosiers, this is a loss of over \$600 each year for every person in the state or nearly \$1,600 for each family every year. ^{xxii}

WHAT HAVE WE SPENT, AND WHERE HAS IT GOTTEN US?

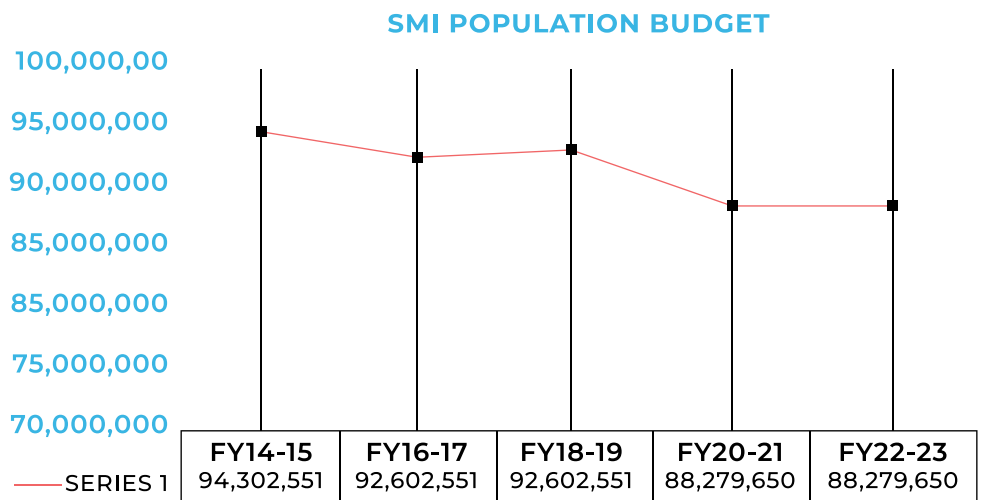
Over the past 15 years, there have been dozens of different appropriations, some temporary, some permanent, that have touched on Behavioral Health. This analysis focuses on the funds that have been consistently appropriated to support community-based care for individuals with severe mental illness and serious emotional disturbances.

The total amount spent in these funds in State Fiscal Year 2006 was slightly more than \$116M. In State Fiscal Year 2022, the appropriation from these funds was just under \$126M.

According to the Consumer Price Index inflation calculator, a dollar in SFY 2006 is worth \$1.50

at the time of completing this report. Therefore, just to keep pace with inflation, Indiana should be spending 50% more currently than we did in 2006, or \$174,000,000. Our spending has dramatically undershot the mark in the last decade and a half, and results are evident.

According to Behavioral Health Commission member Zoe Frantz, President and CEO of the Indiana Council of Community Mental Health Centers, our safety net mental health system is drastically feeling the impact. Indiana CMHCs are reporting significant staff turnover and attrition, and financial situations that range from “pretty poor” to “existential threats.” One CMHC CEO likened the task being placed upon the safety net system as being told to “fill a giant sinkhole with a single spoon.” The system needs a direct and sustained infusion of funding to correspond with the structural changes proposed by this report.



STATE OF INDIANA FISCAL YEAR COMPARISON DATA

HOW MUCH MORE FUNDING IS NEEDED?

The Commission recognizes the enormous complexity of making specific financial recommendations. However, we believe it is important to provide these recommendations for the General Assembly to take under advisement and build upon.

A good parallel can be found in Missouri's transition to the CCBHC system. Missouri is a similar state, with comparable demographics and politics to Indiana. Over a four-year period, total expenditures (including state spend and the corresponding federal matching funds) for Missouri's transition to a CCBHC based Behavioral Health System increased as follows:

\$291,027,757 → \$329,060,815 → \$362,706,886 → \$464,941,925

OR

A TOTAL INCREASED INVESTMENT OF ALMOST 60%

This information is based upon detailed financials from the Missouri Behavioral Health providers shared with the Commission.

RECOMMENDATIONS

To follow the Missouri model and give the General Assembly some fiscal parameters, the Commission recommends the General Assembly increase the appropriation for Serious Mental Illness care by no less than 60 percent over the next two biennium budgets.

As demonstrated by the local impact case studies from three CCBHC grantees detailed below, this 60% increase in mental health funding will greatly reduce the burden of undertreated mental illness on all aspects of society. Community mental health services, delivered through the CCBHC model, have consistently demonstrated the capacity to address complex mental health issues in jails, schools, and communities if provided the funding and staffing to support these efforts.

Some examples of potential impact on our local communities include, but are not limited to, the following:

- Aspire Indiana Health, Inc. is a fully integrated health system located throughout central Indiana in the counties of Marion, Boone, Hamilton, and Madison where 23.5% of the state's population reside. Aspire services include FQHC, CMHC and social determinants of health services, serving over 20,000 individuals annually. Aspire is confident that an increase of behavioral health funding through the adoption of a PPS rate for CCBHC services would impact their workforce and services at the same rate that is being demonstrated nationally.

This national trend would indicate that Aspire will be able to serve between 17% - 27% more individuals annually or 3,400-5,400 unique individuals primarily through same-day access to care and the addition of an average of 41 new staff.

- Southwestern Behavioral Healthcare, Inc. serves Gibson, Posey, Vanderburgh, and Warrick Counties, including the City of Evansville which is the 3rd largest city in Indiana. Southwestern serves approximately 8,000 people annually as the safety net community mental health center. CCBHC startup funding has allowed for expanding the crisis continuum for their community which has increased their crisis contacts by 124% in its first six months, and a 91% community placement after crisis, thus only 9% of contacts resulted in hospital or jail disposition.
- Four County is the designated CMHC for Cass, Miami, Pulaski, and Fulton counties and serves 10 other north-central, rural Indiana counties. Four County serves over 9,000 individuals annually and employs over 400 staff. Services extend beyond the CMHC continuum to include Inpatient Psychiatric Care, Crisis Stabilization Unit, and Mobile Crisis services. Four County has been a CCBHC-E SAMHSA grantee since May 2020. The CCBHC grant program, which compliments and enhances the Indiana CMHC service array, has allowed them to reach over 2,000 consumers (of which 60% are new consumers to Four County) in two years through mobile crisis deployment with law enforcement and to employ criminal justice specialists, peer recovery specialists, and emergency room navigators. CCBHC supports local emergency room and law enforcement triage that reduces time spent by these personnel on mental health and substance use crises. In rural areas of our state, it is always a challenge for all employers to find workforce, even for law enforcement and hospitals. Finally, CCBHC services have been instrumental in creating efficiencies for their under-staffed or limited staff emergency rooms and law enforcement departments.

To maximize the success of the transition to CCBHC, the Commission recommends a funding mechanism that allows for the necessary flexibility to build a bridge for existing CCBHC grantees, while providing startup funding support clinics in communities who have not yet received grants. For example, the General Assembly could create a “CCBHC fund” to allow for grants that support a clinic’s transition to the CCBHC model. If progress goes as expected, the funding could continue into the next biennium and increased to the 60% threshold to support the entire CCBHC program.

2 Passing a 988 surcharge to fund a comprehensive crisis response system

The Commission recommends this \$1 surcharge as a baseline for sustainable funding of the crisis system, to be leveraged with Medicaid and other sources to sustain the system in the long term. The appropriated \$100 million in funding for mental health from the American Rescue Plan Act has been a crucial system stabilizer and has allowed the state to lay the groundwork for this system. However, those funds will not ensure the long-term system stability and sustainability.

Both funding recommendations for the Indiana Behavioral Health System are necessary to implement the Commission’s recommendations to build a sustainable infrastructure and a bridge to the future for all Hoosiers.

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[Appendix F: The Cost of Untreated Mental Illness – State of Indiana Executive Summary Report](#)

APPENDICES

APPENDIX A

Indiana Behavioral Health Commission Report – Legislative Summary
https://www.in.gov/fssa/dmha/files/App-A-IBHC_Report_Legislative_Summary.pdf

APPENDIX B

SEA 273 – Indiana Behavioral Health Commission
<https://www.in.gov/fssa/dmha/files/App-B-SEA273-IBHC.pdf>

APPENDIX C

HEA 1468 – Various Health Matters - 988 Crisis Hotline Center and Mobile Crisis Team Requirements
<https://www.in.gov/fssa/dmha/files/App-C-HEA1468-Various-Health-Matters.pdf>

APPENDIX D

HEA 1222 – Various FSSA Matters – CCBHC Plan Requirements
<https://www.in.gov/fssa/dmha/files/App-D-HEA1222-Various-FSSA-Matters.pdf>

APPENDIX E

Mental Health Literacy Endorsement Letter
<https://www.in.gov/fssa/dmha/files/App-E-Mental-Health-Literacy-Endorsement-Letter.pdf>

APPENDIX F

The Cost of Untreated Mental Illness – State of Indiana Executive Summary Report
<https://www.in.gov/fssa/dmha/files/App-F-Cost-Untreated-Mental-Illness-Indiana-Exec-Summary.pdf>