Indiana Behavioral Health Commission

Commission Member Survey Results

Beginning October 29, 2020, DMHA's Indiana Behavioral Health Commission (IBHC) began collecting responses from commission members to identify major barriers related to access, funding, and general administration of Indiana Mental Health Systems (IMHS) and to establish priorities in addressing these barriers. A total of 16 responses were collected from Commissioners.

During the month of September 2020, the Indiana Recovery Council (IRC) opened a survey to those in recovery and with experience interacting with Indiana's Mental Health Systems to collect insight into the consumer perspective regarding Mental Health treatment barriers. During its four-week run, 199 individuals responded to the survey. Of these, 43 open-ended responses were collected related to barriers to treatment.

This document presents what commission members identified as being the most common and impactful barriers in Indiana Mental Health Systems. Alongside the barriers identified by commission members, the collected community responses from the IRC survey are presented numerically. These paired responses were then grouped by their relevance to priorities identified during the first IBHC meeting and sorted accordingly. This document is meant to support the integration of the priorities of the IBHC, IMHS challenges and barriers, and consumer experiences navigating IMHS to ensure the focus and forward momentum of the Commission.

Bolded responses appear more than once on the table. A response followed by an italicized number (i.e. "*(n)*") indicates that the response was mentioned "n" number of times by IRC Survey respondents.

Identified Priorities	Mental Health Systems	Access to Mental Health Systems	Mental Health Systems Providers	Mental Health Systems Funding
Increased county council involvement in Stepping Up Initiative	• History with carceral system barriers *(2)*			• Lack of funding for jail/prison-based services
Workforce shortage of mental health professionals	• **Generally inadequate number of providers** *(2)* ◊ **Inadequate number of psychiatric providers** *(2)* ◊ Mental health demands outpacing supply of mental health practitioners ◊ Difficulties in recruitment of qualified practitioners • **Lack of persons with lived experiences engaging clients and part of clinical team**	• **Generally inadequate number of providers** ◊ Impedance to provider availability to attend to clients reaching out in need of services ◊ **Inadequate number of psychiatric providers** *(2)*	• **Generally inadequate number of providers** ◊ Mental health demands outpacing supply of mental health practitioners ◊ **Inadequate number of psychiatrics and psychologists** *(2)* • Burdensome and lengthy certification, regulation, credentialing, and accreditation requirements ◊ **Lack of centralization** ◊ Large overhead/administrative burden to get staff paneled and time it takes to accomplish this ◊ Inability to diagnose at LCSW, LMHC, and LFMT levels • Administrative burden burns out new hires and contributes to high turnover • Education does not reflect job duties/experience requiring lengthy and difficult training and onboarding processes • **Noncompetitive pay** • Vicarious trauma • Lack of diversity of providers ◊ Lack of appropriate language services	• **Noncompetitive pay** ◊ Due to substandard reimbursement rates means recruiting cannot compete with hospitals, FQHCs, or private practice • **Lack of persons with lived experiences engaging clients and part of clinical team**

Identified Priorities	Mental Health Systems	Access to Mental Health Systems	Mental Health Systems Providers	Mental Health Systems Funding
Lack of psychiatric services	• Lack of outpatient psychiatry follow-up for new patients • **Lack of consistent access across the state** *(5)* • Lack of mental health supports in schools • **Lack of focus on preventative and early intervention services**	• **Lack of consistent access across state** *(5)* ◊ Rural areas lack workforce to support programming • **Lack of preventative and early intervention services** ◊ Point of entry too far from initial mental health challenges ◊ Demanding access to "highest level of care"	• Lack of consistent access across the state, especially in rural communities • Rural communities lack workforce to support programming • **Lack of programming focused on addressing SDoH** ◊ Causes oversaturation of "special populations" better served in other ways	• **Lack of funding into early intervention and preventative services**
Ease in treatment access at all levels	• Intake assessment disparities across providers – with same practitioner, similar intakes range anywhere from 20-90mins depending on private practice vs. CMHC practice • **Complicated insurance regulations/ restrictions** *(11)* ◊ Disparity in how insurances define medical necessities ◊ **Administrative burden in claims, PA processing, and successful reimbursement—system needs to be streamlined** • **General lack of insurance coverage** *(6)* ◊ Poor insurance coverage forces people into understaffed community health system	• **General lack of insurance coverage** *(6)* ◊ Poor insurance coverage prevents access to some providers and forces people into understaffed community health system • Pinholing effect by requiring access to services through licensed provider • System difficult to navigate on part of the client *(4)* ◊ **Complicated, bureaucratic admission criteria and commitment procedures** • Lack of transportation *(5)* • Stigma/discrimination from providers *(2)*	• CMHCs are overburdened with need to serve growing special populations with growing demand for access • **Lack of consistency in integration sites vs. private practice vs. CMHCs** • Results in those with mild to low moderate MH/SA needs having the easiest time accessing services • Finding inpatient beds nearly impossible in some areas of state	• **Lack of programming focused on addressing SDoH** • **Insurance issues** ◊ Not all CMHCs provide services to people without insurance ◊ Not all hospitals provide services to clients with certain insurance ◊ Service coverage differences private vs Medicaid • Concerns about clients staying with "county assigned" CMHC
Expansion of services to those experiencing a mental health crisis	• Limited emergency inpatient availability/psychiatry for mental health crises • Current lack of crisis response/ mobile crisis teams and associated reimbursement models	• Limited emergency inpatient availability/psychiatry for mental health crises ◊ Frequent diversions to psychiatric facilities		

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Financial sustainability	• **Lack of and/or inadequate funding for services** • Need for strategic alignment of resources and need • **Reimbursement rates** • Medicaid barriers	• **Lack of and/or inadequate funding for services** • No "capacity building," prevention, or promotion funding available to CMHCs • **Lack of awareness of available resources and programs** *(2)* ◊ No reimbursement to CMHCs for engagement services – contributes to lack of awareness of available resources • **General issues obtaining reimbursement** ◊ **Discrimination in reimbursement**	• **Lack of and/or inadequate funding for services** • **Lack of awareness of available resources and programs** • **General issues obtaining reimbursement** ◊ **Discrimination in reimbursement** • **Low Medicaid reimbursement rates** ◊ **Impedes competitiveness of wages for CMHC vs. private practice employment** • Uncertainty regarding funding sources and plans makes it difficult to ensure investment, plans, and decisions are sustainable and relevant • MCE credentialling process for providers too long and pushes reimbursement far downstream	• Inadequate state budget, federal support, and local/corporate matching • **General issues obtaining reimbursement** ◊ **Discrimination in reimbursement** ◊ Late/untimely payments • **Low, stagnant Medicaid reimbursement rates** ◊ **Don't keep pace with market salary rates—noncompetitive wages** • Medicaid is basically the sole funder of public mental health ◊ Overreliance on MRO in attempt to be competitive and fiscally sound in absence of alternatives • Value based funding has yet to materialize • Funding system convoluted ◊ Different claims processes for each part of MCE Medicaid regulations difficult to adhere to • **Inconsistent and burdensome PA process** • Inadequate consideration to roles of providers, employers, state, and insurance companies in funding • Community health systems underfunded • Fragmented funding • SOFs appropriations not sustainable in current economy

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Services across the full spectrum of needs	• Full array of services across crisis continuum not available and forces compartmentalizing of services – crisis continuum needs to be built out *(1)* • Single-site integration ultimately hits a ceiling in capacity – focus should be on integrated system delivery • **Siloing and lack of integration between ID/DD, mental health, SUD, and chronic health conditions – need to be treating whole person** ◊ No common language between systems ◊ Lack of collaboration of care • Insufficient amount of inpatient/ step-down beds	• **Siloing and lack of integration between ID/DD, mental health, SUD causes "wrong door" entrance into system**		• Lack of funding for innovative treatments
Increase in leveraging of technology		• **Lack of technology/internet connectivity in rural areas** ◊ Limits access to telemedicine services	• **Lack of technology/internet connectivity in rural areas**	• Consistently changing telemedicine requirements • Different telemedicine requirements for billing code, facility, and documentation between insurers
Expansion of supportive housing		• Housing first *(4)*		
Outcome and treatment collections equity and standardization			• **Lack of centralized credentialing** • **Lack of consistency in integration sites vs. private practice vs. CMHCs** • Lack of access to/use of evidence-based practices	• Catchment areas is an outdated model needing replacement
Misuse of emergency departments for mental health and addiction related crises				