State of Indiana

Family and Social Services Administration

Division of Mental Health and Addiction

Psychiatric Crisis Intervention Services Review Report

Senate Enrolled Act No. 248 of 2014

September 2015

Table of Contents

SENATE ENROLLED ACT No. 248

AN ACT concerning human services.

Be it enacted by the General Assembly of the State of Indiana:

SECTION 1. [EFFECTIVE UPON PASSAGE] (a) As used in this SECTION, "psychiatric crisis intervention" means services to identify and treat symptoms and conditions of psychiatric emergencies, including attempted suicide, substance dependence, alcohol intoxication, acute depression, presence of delusions, violence, panic attacks, and significant, rapid changes in behavior. The services may include diagnostic assessment, short term treatment, mobilization teams to carry out interventions at patients' residences and other locations, emergency management services to prevent further crisis, inpatient and outpatient psychiatric services, telephone counseling that is provided on a twenty-four (24) hours a day, seven (7) days a week basis, and other related services.

(b) Before September 1, 2015, the office of the secretary of family and social services shall provide to the legislative council a report setting forth the following concerning comprehensive psychiatric crisis intervention services:

(1) The services that are available in Indiana for psychiatric crisis intervention in urban and rural areas of Indiana.

(2) To what extent the psychiatric crisis intervention services are coordinated and integrated across health care delivery systems.

SEA 248

(3) New services that are needed in Indiana for psychiatric crisis intervention.

(4) The cost of the needed new services identified under subdivision (3), including any cost offset for current expenditures that would no longer be needed.

(5) The roles of private sector providers and the public sector, including local and state government, for services identified under subdivisions (1) through (4).

A report to the legislative council under this subsection must be submitted in an electronic format under IC 5-14-6.

(c) The report required in subsection (b) must include recommendations to coordinate and integrate the state's response to psychiatric crisis, including an evaluation of the need for or better use of the following:

(1) Prevention services.

(2) Assertive community treatment.

(3) Telephone crisis and triage intervention.

(4) Crisis intervention teams.

(5) Mobile crisis outreach teams.

(6) Urgent care centers.

(7) Crisis residential services.

(8) Transportation services.

(9) Medically monitored detoxification.

(10) Hospitalization.

(11) Linkage to community based services.

(d) This SECTION expires December 31, 2015.

SECTION 2. An emergency is declared for this act.

Introduction

In 2014, the Indiana Division of Mental Health and Addiction (DMHA) partnered with the National Alliance on Mental Illness of Indiana (NAMI Indiana), Mental Health America of Indiana (MHAI), the Indiana Hospital Association (IHA), Key Consumer, and the Indiana Council on Community Mental Health Centers (ICCMHC) to conduct a review of Indiana's mental health and substance use crisis services. The review was in response to Indiana Senate Enrolled Act No. 248 of 2014, which mandated DMHA to conduct a psychiatric crisis intervention study ("crisis study") and report the results to the legislative council by September 2015.

The crisis study included a review of psychiatric and addiction crisis services available in Indiana, a survey of professionals and individuals in Indiana who have experience with the current state of Indiana's crisis response, and a review of crisis services and models implemented by other states that could improve outcomes for individuals who experience psychiatric or addiction crises.

According to the National Survey of Drug Use and Health from 2009 to 2013 in Indiana about 207,000 adults (4.3%) had serious thoughts of suicide within the year prior to being surveyed. The average nationally during this same time was 3.8%. In addition, in Indiana, about 150,000 individuals aged 12 or older (2.8%) per year were dependent on or abused illicit drugs within the year prior to being surveyed. The national average was during the same time was 2.7%.[1]

In Indiana, there is a need for increased options for individuals in psychiatric and/or addictions crises. Indiana citizens rely heavily on general hospital emergency rooms to handle individuals in acute crisis. Crisis lines often instruct individuals in need of immediate assistance to emergency rooms and police officers trained in crisis intervention are instructed to take individuals with signs of mental illness to the emergency room for assessment. According to a 2007 analysis by Agency for Healthcare Research and Quality (AHRQ), one in eight emergency room visits are due to mental health or substance use disorders.[2] Unfortunately, the majority of emergency department physicians are often without the professional education, training, and/or the resources necessary to successfully assist these individuals to stabilize and attain long-term recovery. As a result, emergency departments often become an expensive revolving door for individuals with mental illness and addictions disorders, many of whom never connect with community-based treatment and supports after being discharged.

---

[1] http://www.samhsa.gov/data/sites/default/files/State_BHBarometers_2014_1/BHBarometer-IN.pdf
[2] http://archive.ahrq.gov/news/newsroom/news-and-numbers/070810.html

Coverage Expansion under HIP 2.0

NAMI National's *State Mental Health Legislation 2014: Trends, Themes & Effective Practices* referred to a state's decision to reform the Medicaid program as "an opportunity to strengthen state mental health systems and provide life-changing care for people affected by mental illness, paving the way to recovery and independence." Coverage expansion in Indiana opened the door for approximately 350,000 Hoosiers previously ineligible for Medicaid to access Healthy Indiana Plan (HIP 2.0) coverage. The Healthy Indiana Plan also pays providers at a higher reimbursement rate than traditional Medicaid, which is intended to attract more providers to participate in the program and improve access to care for members.

Coverage expansion has already inspired several new initiatives to enroll low-income Hoosiers in HIP, particularly those with serious mental illness or addictive disorders. Specifically, House Enrolled Act No. 1269 of 2015 will assist inmates of a prison or jail facility to enroll in the Healthy Indiana Plan prior to release, which is intended to reduce recidivism particularly among those with substance use and mental disorders. In addition, Community Mental Health Centers are now eligible to enroll as a presumptive eligibility (PE) qualified provider. PE will allow CMHCs to be reimbursed for services provided to individuals before they have completed the full enrollment process – critical when addressing a mental health or addiction crisis.

Indiana Mental Health and Addiction Service System Overview

DMHA certifies addiction treatment providers, opioid treatment providers, private inpatient facilities and community mental health centers (CMHC). As of August 24, 2015, there were 187 addiction treatment providers, 13 opioid treatment providers, 26 private inpatient mental health facilities and 25 CMHCs.

Community mental health centers provide both mental health and addiction services. They can serve individuals that have no insurance or are low income. In 90 counties, there is at least one CMHC satellite office and outreach and transportation is provided for individuals who live in counties without a satellite office. In addition, there is at least one additional addiction treatment provider in 57 counties.

Indiana Administrative Code and DMHA contracts require CMHCs to provide a defined continuum of care directly or through subcontract, which includes the following:

Map 1: Locations of CMHC satellite offices in Indiana
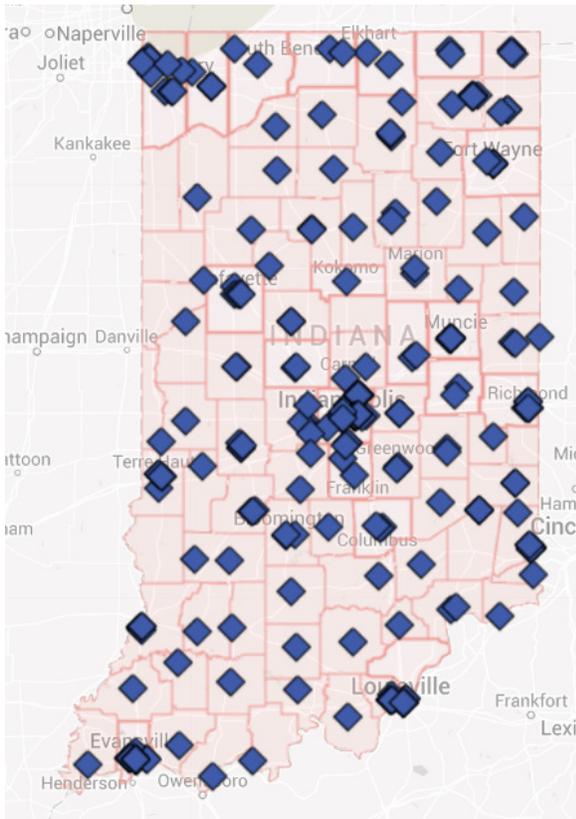
- Individualized treatment planning to increase patient coping skills and symptom management, which may include any combination of the services listed under this section
- Twenty-four (24) hour a day crisis intervention
- Case management to fulfill individual patient needs, including assertive case management when indicated
- Outpatient services, including intensive outpatient services, substance abuse services, counseling and treatment
- Acute stabilization services, including detoxification services
- Residential services
- Day treatment
- Family support services
- Medication evaluation and monitoring
- Services to prevent unnecessary and inappropriate treatment and hospitalization and the deprivation of a person's liberty

24-Hour Crisis Intervention Services and Acute Stabilization Services

All CMHCs are required to provide a 24-hour access number that is available for those in crisis. However, they differ in their response. Some refer to the nearest emergency room while others make a prompt appointment for a face-to-face assessment with the caller.

However, if the individuals are in need of medical attention, they are instructed to either call 911 or transport themselves to the nearest emergency room where an in-person assessment can be conducted. If 911 is called for a psychiatric emergency, law enforcement officers are most commonly dispatched to assess the situation. If a law enforcement officer believes that an individual is mentally ill, a danger to themselves or others, or gravely disabled and is in need of immediate hospitalization or treatment, he/she is permitted to transport the individual to the nearest appropriate facility for an emergency psychiatric evaluation (IC 12-26-4).

Emergency psychiatric assessments are most frequently made in general hospital emergency rooms, not psychiatric hospitals, because it must be confirmed that there is not an underlying medical cause, including substance use, for the psychiatric crisis and/or there is not a medical situation that needs more immediate attention. This is a process called "medical clearance."
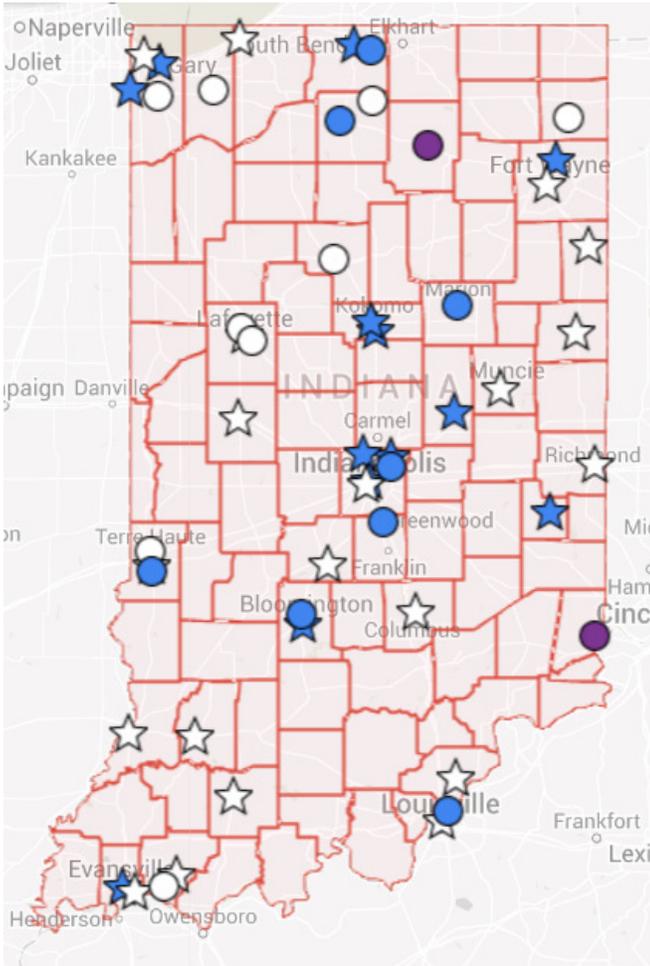
All CMHCs are also required to provide or subcontract for acute psychiatric stabilization services, including detoxification services. In June 2014 NAMI Indiana completed a bed count of these services and found there were approximately 1674 acute inpatient beds for psychiatric care (337 youth, 907 adult, and 430 geriatric) available through community-based hospitals (some of which are affiliated with a CMHC). These beds are only utilized after an individual in psychiatric crisis is evaluated to be in need of acute inpatient care. Map 2 illustrates the location of these beds and the type of care provided at each location.

Note on State Psychiatric Hospitals (State Operated Facilities)

While Indiana does operate six hospitals for individuals with serious mental illness, these facilities do not play a role in Indiana's acute psychiatric crisis response system. Beds at state hospitals are accessed only through a gatekeeper model whereby a CMHC must facilitate the placement of an individual in a state operated facility only after community-based treatment has failed. State hospitals do not provide services for individuals living in the community who experience an acute psychiatric or addiction crisis.

However, this may change in the future as DMHA has instituted a System Integration Council to standardize the way state hospitals operate, identify best practices, and address gaps in care. As a result, state hospitals in Indiana are looking at ways to partner with community providers to utilize excess facility capacity to provide crisis stabilization and potentially acute care services in communities. In addition, plans are being developed for a new institute that would provide neuro-diagnostic assessments and rapid throughput of patients allowing for refinement of diagnosis and, in conjunction with the current network of state hospitals, movement of patients into the most appropriate treatment setting.

Psychiatric and Addiction Crisis Survey

Survey Design and Distribution

Following a review of crisis system studies and best practices, the Crisis Study Workgroup drafted a survey to measure the perception of the availability, quality, and coordination of crisis services in Indiana.

DMHA distributed the Psychiatric and Addiction Crisis Survey in December 2014 and January 2015. Tailored surveys went out to respondent groups including mental health and addiction treatment providers, hospital emergency department staff, first responders, consumer and family advocates, and probation and parole officers. Respondents were asked to provide their zip code, which was used to determine their rural/urban status. Rural/urban status was calculated using the USDA's 2013 Rural Urban Continuum Code.

Response rate was highest among mental health and substance abuse providers, consumers and family advocates, and probation and parole officers. 78% of respondents lived/worked in a metropolitan area and only 22% of respondents did not. Fewer responses were received by first responders and hospital emergency departments, although a higher percentage of those responses were from individuals outside of urban areas.

Survey Respondents by Group and Setting Type

Respondent Group	Metropolitan (#/%)	Nonmetropolitan (#/%)	Total #
Mental Health and Substance Abuse Providers	182/ 85%	31/ 15%	**213**
Consumers and Family Members	119/ 76%	38/ 24%	**157**
Probation/Parole	94/ 76%	30/ 24%	**124**
First Responders	15/ 58%	11/ 42%	**26**
Hospital Emergency Department	11/ 48%	12/ 52%	**23**
Total #	**421/78%**	**122/22%**	**543**

Note: Responses were received by only 26 first responders, over half of whom identified as Crisis Intervention Team (CIT) officers. CIT officers are specially trained in their local psychiatric crisis response system and generally have good working relationships with both mental health providers and consumers alike. Their input was helpful, but their responses may not be reflective of the law enforcement community as a whole.

Availability of Psychiatric and Addiction Crisis Services

Respondents were asked to rate their level of agreement or disagreement to the statement "*There is adequate availability of psychiatric/addiction crisis services in my community*." A summary of responses can be found in the table below.

There is adequate availability of psychiatric/addiction crisis services in my community.					
Answers were coded between 1 and 5; 1 for "strongly disagree" and 5 for "strongly agree"					
	Mental Health and Substance Abuse Providers	Consumer & Family Advocates	Emergency Depts.	First Responders	Probation	**Average**
Psychiatric Crisis Services	3.01	2.01	1.87	2.89	2.94	**2.7**
Addiction Crisis Services	2.66	1.94	1.83	2.7	2.96	**2.5**

Respondents had a neutral to negative perception of the availability of psychiatric and addiction crisis services, and reported that psychiatric crisis services were slightly more available than addiction crisis services in their community. Respondents reported that underfunding for crisis services, lack of appropriate options for crisis situations, and transportation to such services were the most problematic barriers when trying to access appropriate crisis services.

At the time the survey was conducted, Indiana had not yet expanded the Healthy Indiana Plan (HIP 2.0), which left many childless adults with incomes below 138% federal poverty level uninsured. It is therefore not surprising that many respondents cited individual funding barriers as a primary obstacle to accessing appropriate addiction and psychiatric services during and after a crisis. One provider pointed out that, "Clients in crisis situations become defeated easily, yet are often turned away due to lack of insurance." Similarly, a parole officer suggested, "If no fees were charged for accessing services, the most problematic/needy subjects desperately desiring services or change in their life may be able to participate, as most often times they have used their last dollar on their habit and are precluded from participation due to financial ability to pay for services."

Funding was also tied to a lack of appropriate options for individuals experiencing psychiatric and addiction crises. While emergency rooms continue to serve as de facto psychiatric and addiction crisis receiving centers, respondents suggested that appropriate options and interventions were not available. One provider wrote, "Underfunding prevents the development of a continuum of care, (resulting in) many holes at every level."

Substance use disorder providers commonly highlighted the lack of availability of appropriate addiction crisis services, specifically, a significant gap between medical detoxification and outpatient detoxification. Providers' answers suggested that while outpatient detoxification options are not sufficient for many in addiction crisis, it is far too difficult for the majority of those individuals to qualify for inpatient detoxification. One provider wrote, "Insurance companies will not pay for inpatient opioid detoxification, arguing that it is not a 'life threatening condition,' when in fact heroin addicts die of accidental or intentional overdoses all the time." Similarly, another provider wrote, "There are no addiction crisis services in our community. If it is not life threatening, then you have to detox on your own." Another provider wrote, "We need to actually require insurance providers and Medicaid to fully cover care for clients that have addictive disorders and support community inpatient detoxification programs with enough funding. Half measures will not get the job done."

> *"We send families to the ER as this is the only way to be assessed in the middle of the night."*
> *-Provider on need for 24/7 mobile crisis teams*

An inpatient care provider suggested that while inpatient units are often too restrictive for psychiatric and addiction crises, emergency rooms are inefficient in dealing with a crisis situation: "Many patients are sent to us who would have been better served by 6-24 hours of observation / crisis stabilization with medication and crisis intervention counseling. Many of these patients end up being discharged within 24 hours, which is a huge waste of time and money. Many of these patients have also had multiple ER visits where they were patched up and released without much in the way of treatment because of the pressure in the ERs to move patients through and not tie up an ER bed."

Consumer and family advocate respondents also called for better options for dealing with psychiatric and addiction crisis situations. One consumer advocate said, "Those who just need support… need crisis walk-ins to calm down but not the threat of being put inpatient." These responses highlight that emergency room (and subsequent inpatient) levels of care are far more intensive than many in or approaching crisis need or desire. However, alternative/"step down" options such as crisis respite are unavailable to the majority of Hoosiers.

The lack of crisis options beyond emergency room care was also reflected in respondent commentary about wait times for care during and immediately following a crisis. A law

enforcement officer wrote, "The wait times for an emergency detention order to be processed and taken care of is sometimes in excess of 7-8 hours and is fraught with hesitations and poor communication…This creates a hostile environment between our law enforcement and emergency room staffing." A provider, citing the long wait times for outpatient care even after a crisis wrote, "We need a person who is able to bridge the gap between the hospital and their follow up with a mental health provider. Oftentimes patients have to wait too long and become hopeless about the process."

Transportation was another common theme mentioned by respondents, especially those who live and/or work in more rural parts of the state. Respondents observed that services seem to be more centered in urban areas. Several providers called for improving options for individuals living outside of urban areas. "Transportation can be an issue for clients needing to access crisis services. Incorporating a way (other than ambulance) for clients to get these services would improve the system."

Quality of Psychiatric and Addiction Crisis Services

Respondents were asked to rate their level of agreement or disagreement to the statement "*Psychiatric/Addiction crisis services in my community are of adequate quality.*" A summary of responses can be found in the table below.

Psychiatric/Addiction crisis services in my community are of adequate quality.						
Answers were coded between 1 and 5; 1 for "strongly disagree" and 5 for "strongly agree"						
	Mental Health and Substance Abuse Providers	Consumer & Family Advocates	Emergency Depts.	First Responders	Probation	**Average**
Psychiatric Crisis Services	3.37	2.2	2.43	2.93	3.02	**2.9**
Addiction Crisis Services	2.95	2.14	2.13	2.81	2.98	**2.7**

Respondents had a neutral to negative perception of the quality of psychiatric and addiction crisis services, and reported that psychiatric crisis services were slightly better quality than addiction crisis services in their community. Poor reimbursement for crisis services, short

length of stay/intervention, gaps in the availability of appropriate interventions, and an overwhelmed workforce were the most common themes that respondents identified as reasons for shortcomings in the quality of crisis response services.

Poor Medicaid reimbursement and lack of payment for uninsured individuals were primary concerns for respondents when discussing the quality of crisis services. Consumer and family advocates in particular, felt that services were of poorer quality for individuals with Medicaid or without any insurance at all. One advocate wrote, "If you are receiving Medicaid, you are limited with the type of care and help you may receive. You can only go to certain facilities/providers." Another advocate, pointing out that the few providers that accept Medicaid patients are overwhelmed, wrote, "Patients want to feel listened to and not shrugged off because of a busy census." Similarly, a probation officer observed, "The most significant barrier to services is money. There are free services available for addictions therapy in my area, but their quality and end results are not as impressive as the therapy that costs money."

Another common theme was that individuals in crisis did not receive appropriate care for their specific needs because of short lengths of stays, a shortage of beds, and a lack of alternatives to the emergency room to address the crisis. Respondents were clear that while the emergency room is the de facto crisis center, the quality of care received in these settings is far from perfect. For example, a provider observed, "The normal noise, chaos, and limited interventions available in an emergency room can exacerbate some clinical presentations."

Short lengths of stays were frequently referred to as problematic by respondents from all respondent groups. "(Patients need) longer periods of time in treatment at these facilities instead of getting them in and out at a rapid pace to ensure payment," said a provider, citing an often difficult to meet "medical necessity" standard that must be met for providers to receive payment for continued care. Likewise, a family advocate wrote, "Individuals must have a safe environment in which to reach stabilization. Hospital stays are very brief and the aftercare is often not intensive enough."

Visits to the emergency department that do not result in any sort of inpatient care were another commonly cited quality concern, particularly among law enforcement and family advocates. In these situations, the emergent crisis considered stabilized in the emergency department and the individual is released after only a couple of hours, sometimes with no discharge planning whatsoever. Some respondents considered a lack of beds to be the cause of this problem, while others cited a lack of step-down options (discussed above in *Availability*), or insufficient follow-up to ensure individuals connected with outpatient care.

Lack of appropriate follow-up care and an overwhelmed workforce were closely related. The need for follow-up was frequently cited as a barrier to quality crisis care, but it was clear that there are generally neither enough personnel in the emergency room to coordinate this care (i.e. follow-up with the patient to ensure they connect with care in the outpatient setting), nor are there enough providers in the community to provide post-crisis care in a timely fashion. Still, respondents (particularly consumer and family advocates) insisted this service is desperately needed.

"There has to be some kind of follow-up… The feeling of depression is the absolute worst feeling! …If no one follows up, you feel like no one cares… a (repeat) visit to the ER could be avoided if a meaningful follow-up would have been made to ensure that the person was getting the services needed."
--Consumer Advocate

Finally, an overwhelmed workforce, especially those willing to accept those individuals on Medicaid or without insurance, was a clear barrier to quality. A provider observed, "Many staff work very long hours which decreases their functioning and efficiency and limit (their) ability to form healthy professional relationships with clients." A consumer advocate wrote, "Often there is a great amount of turn-over at CMHCs for therapists, and just when you get comfortable with someone, they disappear."

Coordination and Integration of Psychiatric and Addiction Crisis Services

Respondents were asked to rate their level of agreement or disagreement to the statement *"Psychiatric and addiction crisis intervention services are well coordinated and integrated across health care delivery systems."* A summary of responses can be found in the table below.

Psychiatric and addiction crisis intervention services are well coordinated and integrated across health care delivery systems.					
Answers were coded between 1 and 5; 1 for "strongly disagree" and 5 for "strongly agree"					
Mental Health and Substance Abuse Providers	Consumer & Family Advocates	Emergency Depts.	First Responders	Probation	**Average**
2.63	1.77	1.74	2.44	2.69	**2.3**

Respondents, particularly consumer and family advocates and emergency room staff, had a negative perception of the coordination and integration of psychiatric and addiction crisis

services across health care delivery systems. Respondents commented on a disconnect between community-based services (typically provided by a CMHC) and crisis services (typically provided by a hospital).

Respondents overwhelmingly called for improving communication between emergency room staff, outpatient staff, and the clients themselves in order to better integrate and coordinate care across healthcare delivery systems. One provider wrote, "Enlisting outpatient care coordinators directly in the care the patient is receiving while hospitalized (would help) to reduce barriers to wellness and strengthen outcomes/reduce (readmissions)." Another provider suggested, "If staff from outpatient teams would meet with patients prior to discharge…information (would) be provided directly to the patient in addition to (allowing them) to ask questions and possibly reduce some anxiety about following up."

Other commonly identified barriers to coordination and integration across healthcare delivery systems were frustrations with a lack of interoperability between the electronic health records (EHRs) of different provider networks, communication between providers in different systems, and provider and consumer knowledge of services available within a community (asset awareness).

Recommendations

Improve Resource Coordination and Awareness

One main theme seen in the survey was, even if a crisis response resource existed, the majority of the respondents were not aware of it. To help improve resource coordination and awareness, we recommend the creation of an online list of crisis resources, including a description of what the resource does. This list should be jointly maintained by the state health department and the division of mental health and addiction.

In addition to a resource list, the Committee explored the idea of an electronic bed board (EBB) which tracks the availability of sub-acute, acute, and residential psychiatric crisis beds. This resource would assist small hospitals without psychiatric services locate available resources for individuals in crisis who are taken to the emergency room. Costs for EBB systems are relatively small. In Vermont, the original contract for the bed board (contract was with the Minnesota Hospital Association for base system software, customization, and training) was $138,000. In addition to staff time to ensure the system is up-to-date (an estimated 10 hours per week by a state employee), Vermont pays the $10,800 per year to maintain the online database. EBBs requires voluntary participation from community based hospitals in order to be successful, so the committee referred this idea to the Indiana Hospital Association's Council on Behavioral Health for further review.

The Committee saw opportunities for intervention and linkage to addiction treatment services and resources when individuals were given naloxone in response to overdose and at needle exchange programs. Services must include access to medical services, detoxification, Medication Assisted Treatment, therapy and counseling.

Ensure Safety Net Providers Are Meeting Local Crisis Needs

The committee recommends implementing an online survey semi-annually so that local professionals, family members, consumers, and advocacy organizations can report real or perceived system gaps. The committee will review the data, track "gap areas," and discuss potential solutions.

In addition, the DMHA Quality Improvement (QI) Team will include the issues of accessibility, availability and care coordination as they perform QI reviews of providers. DMHA will be addressing the inconsistent responses to crisis found amongst the CMHCs.

Increase Addiction Treatment Options

The Committee recommends increasing addiction treatment options, especially detoxification services and medication assisted treatment. Services must be accessible, coordinated and integrated and include the type of therapy, medication, and method of detoxification that best meets the needs of the patient with a goal toward abstinence when possible. A continuum of detoxification services must include inpatient, outpatient and residential services. In addition, the Committee believes that determination of eligibility for inpatient detoxification should be based on the treatment plan and the needs of the consumer, and not on whether it is determined to be medically necessary as defined by risk of life.   Medication assisted treatment needs to be more accessible for consumers, including access to FDA approved long- acting, non-addictive medications for the treatment of opioid or alcohol dependence.

Create Alternatives to Emergency Room and Inpatient for Psychiatric and Addiction Crisis

The Committee's review showed a need for alternatives to emergency rooms and inpatient for consumers experiencing crisis. The Committee explored several models used in other states. One idea was the Alameda Model, which serves as a Regional Dedicated Psychiatric Emergency Service (PES) in California.

Both the Alameda Model and the electronic bed board (EBB) ideas were presented at the Indiana Hospital Association's (IHA) Council on Behavioral Health, which is comprised of both private and non-profit free-standing psychiatric hospitals and hospital-based psychiatric departments, and community mental health centers, both free-standing and hospital-based. Even with the diversity in membership, there was a singularity in consensus that alternatives to

crisis stabilization, utilization of emergency services, and access to inpatient care need improvement. The Council expressed its interest in being a resource to be used in working towards further development of both concepts on a state-wide and regional basis.

Workforce Development

Not only is access and availability of care limited, a growing problem is a lack of providers. Although the Affordable Care Act and the Healthy Indiana Plan (HIP 2.0) have given more individuals a means to pay for mental health and addiction services, they also increase the demand for providers. In addition, thanks to HEA 1006, eligible individuals involved with the criminal justice system who need addiction and mental health services will now be able to receive them, even if they do not have insurance.

According to a study of the Indiana Mental Health Workforce by the Department of Family Medicine, Indiana University School of Medicine (2014), even though there has been an increase of active licenses in clinical social work, social work, family therapy and mental health counseling from 2004 to 2012[3], the total number of professionals practicing has remained relatively constant. The issue is that individuals in the growing workforce are not providing clinical care as a part of their service. Also, Indiana has had a declining number of practicing psychiatrists since 2009. Of the 92 counties in Indiana, 43 reported no practicing psychiatrists, 62 counties report one or fewer full-time psychiatrists, and 27 counties reported no practicing psychologists[4].

To meet this need, DMHA is partnering with the Substance Abuse and Mental Health Services Administration in order to gain ideas to use in Indiana and learn best practices from other jurisdictions.   DMHA has implemented a student loan assistance program to provide loan assistance to persons working in Indiana in the mental health and/or addiction field.

Crisis Study Recommendation Implementation Committee

The Committee recommends that it meets during the next year it oversee the implementation of these recommendations and progress/gaps seen in the semi-annual survey. At a minimum, the committee will meet once every six months following the semi-annual survey data on system gaps.

Service Coordination and Integration with Health Care

One of the main themes from survey respondents commenting on barriers to adequate quality and coordination of care was inability to bill for follow-up and care coordination between the hospital and CMHC after a hospitalization for psychiatric or addictions crisis.   DMHA and other stakeholder partners are working to develop integrated care models that will provide for care

---

[3] http://www.in.gov/children/files/cisc-2014-1119-2012-Indiana-Mental-Health-Workforce-Report.pdf
[4] http://www.in.gov/children/files/cisc-2014-1119-2012-Indiana-Mental-Health-Workforce-Report.pdf

coordination among providers. This coordination will enhance service delivery and allow for better healthcare outcomes.

Better Utilization of the State Operated Facilities

The five adult state hospitals are tremendous resources that can be used for a variety of purposes to meet local mental health and addiction needs. Partnerships with local hospitals and community mental health centers can be leveraged to increase access to acute crisis beds and services. DMHA has reviewed such a model in operation in Louisville, KY, and believes there is an opportunity to replicate such services. A number of statutory and operational modifications may be needed to expand these services at the state hospitals. FSSA staff are currently undertaking a review of current laws, rules, and procedures that will allow for this flexibility to meet local crisis response needs.

Crisis Services – Evaluation of Need

Crisis Services	Evaluation of Need
Prevention service	There is a need for crisis escalation prevention services. While appointment-based services at CMHCs play an important role in prevention, more must be done to assist individuals with mental illness and substance use disorders who may be headed toward crisis. Crisis residential services (or crisis respite), peer-support through warm lines, and crisis walk-in centers would all help to prevent the escalation of psychiatric and addictions crisis. Providing education/training to individuals, families and support members that begins with what can be done at home, intervention approaches, resource availability and creation of a safety plan for those times of crisis. The State should continue to work with stakeholders to ensure accurate information is available and shared.
Assertive Community Treatment (ACT)	Both providers and consumer and family advocates called for increased funding for ACT teams, are be very effective in deterring hospitalizations. Although Indiana has several ACT-like teams, only three ACT teams are currently certified by DMHA.
Telephone crisis and triage intervention	All Indiana CMHCs have 24 hour crisis lines; however, survey responses highlighted a lack of consistency in the way crisis calls are handled. DMHA will provide CMHCs with guidance on operating crisis lines, and conduct random test calls to ensure the hotline is referring callers in an appropriate manner.
Crisis Intervention Teams (CIT)	CIT is effective in diverting individuals with mental illness away from the criminal justice system and toward treatment. However, in order to be effective, crisis intervention teams must be supported by a mental health system that supports individuals after crisis de-escalation. Senate Enrolled Act No. 380 of 2015 established a technical assistance center to support the development and sustainability of local crisis intervention teams. The CIT Advisory Committee established under this Act will be able to provide DMHA with examples of where the system is working and where there are still gaps.
Mobile crisis outreach teams	Lack of transportation was frequently cited by survey respondents as a barrier to both routine mental health and crisis care. While mobile crisis teams are not widely available in Indiana due to high costs and large rural areas, DMHA found that Wisconsin has successfully implemented mobile crisis teams despite similar barriers. In addition, the committee plans to explore how Medicaid Cabs can and cannot be utilized to connect assist individuals in rural areas access prevention and crisis care.
Urgent care centers	Many respondents highlighted a need for walk-in services that could serve an individual before the need for hospitalization. Similar to how urgent care centers provide a pre-emergency room alternative for physical health needs, crisis respite and sub-acute care centers can serve this purpose for mental health and addiction disorder crises. This service is not widely available in Indiana, although several urban areas

	offer this service on a small scale. There is a need to expand this service and incorporate it into every CMHC's continuum of care.
Crisis residential services	Indiana needs alternatives to inpatient for consumers that need short-term treatment. Park Center's "Transitional Care Services" in Fort Wayne is an example of this service.
Transportation services	Unsurprisingly, transportation was a commonly identified barrier for individuals in need of both preventative and crisis care. Medicaid Cab is a potentially untapped resource for many that the committee will explore. In addition, the new corrections program related to HEA 1006 will offer transportation assistance as one of its services, but the service will be limited to those involved in the criminal justice system.
Medically monitored detoxification	Not only are there few resources for this service, but also it is also hard to get the service approved as the consumer needs to prove medical necessity based on a risk of life standard. Detoxification must be made available as determined by the treatment plan and must include inpatient, outpatient, and residential medically monitored detoxification as required to meet the needs of the patient.
Hospitalization	The committee recommends developing alternatives to acute hospitalization to ensure that hospital beds are available to those in need of that level of care. Survey responses indicated a desire for interventions that were longer term but less clinical, such as crisis residential services. (Park Center's Transitional Care Services is an example.)
Linkage to community resources	Survey responses indicated that providers, consumers, and families were often unaware of the availability of crisis resources in their community. Confusion was also expressed about when certain resources should be used. The recommended development of a publicly-accessible, online crisis resource list will help communities know what is available.