INDIANA RURAL HEALTH ASSOCIATION

15TH ANNUAL INDIANA PUBLIC POLICY FORUM

MENTAL HEALTH INFRASTRUCTURE

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MENTAL HEALTH INFRASTRUCTURE

Mental Health Infrastructure in inadequate.

Topics to consider:

- Prevalence
- Workforce
- Accessibility
- Challenges
- Legislative Initiatives

PREVALENCE IN RURAL AREAS

According to 2016 data, 18.7% of residents of nonmetropolitan counties had a mental illness

(almost 1 in 5)

3.9% of residents of nonmetropolitan counties experienced serious thoughts of suicide in 2016.

RURAL MENTAL HEALTH WORKFORCE

Over 60% of rural Americans live in mental health professional shortage areas

More than 90% of all psychologists and psychiatrists, and 80% of MSWs, work exclusively in metropolitan areas

More than 65% of rural Americans get their mental health care from their primary care provider

The mental health crisis responder for most rural Americans is a law enforcement officer

ACCESSIBILITY OF RURAL SERVICES

Providers are more isolated from each other

Services are more fragmented

Clients must often travel far distances for services

Clients receive the services available as opposed to what is required

Clients enter care later, sicker, and with a higher cost

MENTAL HEALTH INFRASTRUCTURE

Begins with:

Indiana Constitution

Article 9, Section 1:

"It shall be the duty of the General Assembly to provide, by law, for the support of institutions…for the treatment of the insane"

ASYLUMS BEGAN IN THE LATE 1800S

Indiana had 10 state psychiatric hospitals

- Housed 20,000-30,000+ persons
- Less than 1000 today

Indiana's first and largest facility, Central State Hospital, closed in 1994

The Neuro-Diagnostic Institute will be new.

INDIANA FOLLOWED NATIONAL MODEL

The Asylum/state institution based system of the 1800s was seen as inhumane

In 1963, President Kennedy called for reform

- Mental Retardation and Community Mental Center Construction Act of 1963

DMHA system of community based care was expanded significantly in Indiana via Mental Health Reform legislation in 1994.

Foundation for system today we call Community Mental Health Centers

PSYCHIATRIC HOSPITALS

Closing psychiatric hospitals without adequate funding impacted the homeless and jail population

Treatment for mental illness in the community did not include residential

Only 1/3 of community hospitals operated psychiatric units in 2014

Increased ER utilization in community hospitals

Medicaid reimbursement not permitted for Institutions for Mental Disease (IMD)

Facilities larger than 16 beds between 21-65 years old

HIP Extension would waive IMD for up to 30 days

Significant increase to short-term hospitalization

COMMUNITY MENTAL HEALTH CENTER ACT

Drastically altered the way mental health services were delivered

Moved people who had been ‘warehoused’ in state institutions into the community

Provided a community safety net for mental health services

- All counties in Indiana have coverage
  - Prioritize SMI

PSYCHOTROPIC MEDICATIONS

Community based care coincided and was made possible with the development of more effective psychotropic medications [Prozac received FDA approval in 1987]

Individuals who historically could only be served in institutions could now be served appropriately in the community

COMMUNITY HEALTH CENTERS

Funding issues resulted in insufficient behavioral health services

- Primary Care has become the de facto mental health provider

ACA funds health centers for mental health services

- 70% of all primary healthcare visits have a psychosocial basis

- Highest utilizers of healthcare have untreated/ undertreated behavioral healthcare

ADDICTIVE DISORDERS

Prior to the ACA, Addiction services were not typically reimbursed

While Addiction services are now an ACA "Essential Benefit," most students have not historically focused on addiction as a field of study due to the lack of employment positions

Created an addiction workforce shortage

BEHAVIORAL HEALTH WORKFORCE SHORTAGE

Indiana has 52 MHPSA [Mental Health Professional Shortage Areas] with another 25 counties that will qualify

Of Indiana's 92 Counties:

43 report having no practicing psychiatrist

62 report having one or fewer full-time psychiatrists

27 report no practicing psychologist

50% do not have a marriage and family therapist.

7 Indiana counties do not have one social worker

RURAL CHALLENGES

Rural Indiana:

- Indiana covers 35,867 square miles
- 1.5 Million Hoosiers
- 49 Counties

Provider reimbursement is effectively lower when costs are decentralized

Transportation barrier to in-person services

Internet barrier to telehealth.

LEGISLATIVE INITIATIVES

Mental Health Loan Repayment

HEA 1360-2014

Eligible to:

addiction psychiatrists, psychiatrists, psychologists,

psychiatric nurses,

addiction professionals, and

mental health professionals

who practice in Indiana

***Funding may not continue

RECOVERY WORKS

In Jails and Prisons

- 15-20% with a Mental Illness
- 80% with a Substance Use Disorder

HEA 1006—2015

- To provide treatment in lieu of incarceration for individuals with a felony

- $30M and $40M appropriated in the last two biennium's, respectively

- Outcome data after first year is exciting

ADDICTION TREATMENT TEAMS

HEA 1541-2017

Mobile Treatment Teams focus on rural treatment

- Masters level therapist (counseling)
- Nurse Practitioner (medication)
- Recovery Coach (Engagement)

Funding limited to Recovery Works and 21st Century Cures Act Pilots

HB 1133-2018 would expand to Medicaid/HIP

DRUG ADDICTION WORKFORCE RECOVERY PROGRAM

The loss to Indiana economy from Opioid crisis is estimated to be $1.5B per year

HB 1134-2018

Incentivizes employers to provide treatment programs for new hires that test positive for illicit drugs as a condition of employment

Retain position if complete the treatment program

Incentives for Employers to participate

CHALLENGES

Mental Health Infrastructure is inadequate for the reasons discussed

Indiana must develop both a long-term and a short-term strategy to address workforce and accessibility--as the need is too great.

THANK YOU

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