Community Mental Health Needs Assessment Report for Marion County

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Foreword

As leaders of the four community mental health centers in Marion County, we are grateful to be participating in some of the most significant changes to mental health care delivery that our state and country have seen in decades. We are all familiar with the urgent challenges posed to mental health by the opioid epidemic, COVID, rising youth suicide rates, and critical workforce shortages, to name just a few of the most pressing crises. With these dilemmas in the forefront, the implementation of Certified Community Behavioral Health Clinics (CCBHC) and the 988 Suicide & Crisis Lifeline could not come at a better time. These initiatives present meaningful opportunities to improve access to mental health services and create needed mental health support across a wide spectrum of needs.

We commissioned this Marion County Community Mental Health Needs Assessment first and foremost with the goal of promoting the health and well-being of our county with a clear understanding that there is no health without mental health. This report is the first of its kind for Marion County and can be credited in part to our collective adoption of the CCBHC model, which requires a mental health needs assessment to inform and influence services. It was important to us that, more than just meeting a requirement, this study provide a robust and rigorous review of mental health needs and available resources to help identify and prioritize gaps that would drive collaboration across the community. Indeed, the creation of the report itself has been an exercise in collaboration that has helped solidify a shared understanding of our local context and setting collective goals for our community mental health centers to work together to improve mental health.

While many exciting changes are occurring at state and federal levels, we also recognize that, in an important way, all health care is local. While national- and state- level challenges and resources may influence our care delivery system, there is no state or national solution that does not ultimately rely upon the availability of trusted support at a local level. No strategy transcends the importance of collaboration among local partners working together to address the concerns we share as citizens in the community we are proud to call home. Every sector of our community has a role to play in promoting mental wellbeing and in supporting those with mental illness and addiction.

We are indebted to many people for their tireless mental health advocacy and support throughout this project and so many other initiatives that benefit our community. We are grateful to Dr. Marion Greene and her team from the Indiana University Richard M. Fairbanks School of Public Health at Indianapolis for their expertise and guidance in creating this report. We appreciate the dozens of consumers, family members, and other stakeholders who generously shared their time to participate in interviews that provided important perspectives and input. It is the ongoing efforts of these and other advocates that have led to the exciting momentum that resulted in Governor Holcomb's first Behavioral Health Commission, chaired by Jay Chaudhary, Director of Division of Mental Health and Addiction within FSSA,

resulting in mental health being a priority in this year's state legislative agenda as part of Senate Bill 1. This is the first time in our state's history that mental health has held such a prominent legislative position, and we hope it will not be the last!

We look forward to sharing the results of this report and engaging our community in the ongoing work needed to realize the significant improvements that we hope to see in mental health and wellbeing for Indianapolis.

Executive Summary

This report assesses the mental health needs and service gaps in Marion County, Indiana. It was developed in collaboration with the four Division of Mental Health and Addiction (DMHA) designated Community Mental Health Centers (CMHCs): Sandra Eskenazi Mental Health Center, Community Fairbanks Behavioral Health, Aspire Indiana Health, and Adult and Child Health.

Data were collected through focus groups and in-depth interviews with CMHC clients and family members of clients, clinical and administrative CMHC professionals, community stakeholders, and representatives from statewide agencies or organizations. Additionally, community data were analyzed to estimate the prevalence of mental health disorders and provide a socio-economic context of the residents in Marion County.

Based on prevalence rates from the National Survey on Drug Use and Health (NSDUH, 2018-2019), we estimate that in the past year in Marion County:

- Over 58,000 adults had an alcohol and/or illicit drug use disorder
- 163,000 adults had some type of mental illness
- Over 39,000 adults had a serious mental illness
- Nearly 41,000 adults had serious thoughts of suicide
- Nearly 14,000 adults made a suicide plan
- Over 5,000 adults attempted suicide

Comparing these estimates to data provided by the four CMHCs indicates that almost 26,000 adults needed but did not receive treatment for their serious mental illness, and close to 55,000 needed but did not receive treatment for their substance use disorder in Marion County.

In 2022, the four CMHCs served almost 57,000 persons in Marion County. The most common diagnoses among the adult population were depressive (30%), substance use (23%), and anxiety (19%) disorders. Among the youth population, disruptive, impulse-control, or conduct disorders were most common (27%), followed by depressive (24%) and anxiety (20%) disorders. Clients receiving services for their substance use disorder (SUD), predominantly reported using alcohol (24%), cannabis (24%), stimulants (18%), or opioids (16%). Nearly one-third of the persons served experienced housing instability.

The CMHCs identified the most needed evidence-based services that should be offered to clients but are currently missing or are provided only at limited capacity, due to resource constraints. These services fall within the categories of: Levels of care, evidence-based treatments, and services for special populations.

- Services covering all levels of care, including prevention and education, sub-acute levels of care, partial hospitalization, and residential programs.
- Evidence-based treatments, including assertive community treatment (ACT), electroconvulsive therapy (ECT), supportive employment, and family therapies.
- Services that address the needs of special populations, including re-entry services for justice-involved individuals, services for individuals with comorbidities or dual diagnosis, and services for individuals with developmental disorders.

We summarized the key issues that were consistently identified by participants in the interviews and focus groups, and aggregated the resulting recommendations into five categories. It is important to note that these recommendations are not meant as the sole responsibility of the CMHCs but should be viewed in the larger context of the community and the mental health system.

Sustainable funding for CMHCs
CMHCs are over-burdened and under-resourced. Although costs have increased over the years, reimbursement rates have not been updated in decades.

It is recommended to: Increase the state budget and raise Medicaid/Medicare reimbursement rates to adequately fund CMHCs. Change the current reimbursement model from fee-for-service to whole-person care, and for commercial insurance to reimburse case management. Adopt the federal Certified Community Behavioral Health Center (CCBHC) Model.

Workforce development (recruitment and retention)
We have a workforce shortage and there are not enough CMHC staff to address the community's mental health needs. Working long hours and dealing with substantial administrative requirements and restrictions, many staff members are overwhelmed and experience burnout. With sustainable funding, CMHCs will be better able to provide a competitive salary to recruit and retain the workforce.

It is recommended to: Hire more staff, update licensure requirements, and reduce the administrative burden to help reduce staff burnout. Create a career pipeline, starting in college or even high school, to prepare future mental health providers. Aim to increase diversity, equity, and inclusion (DEI) within the workforce, especially in higher-level and leadership roles.

Treatment access and services
Access to treatment is often dependent on a person's insurance (public or commercial) and the severity of their mental health condition. Individuals with commercial insurance, who are not able to pay for non-reimbursable services out-of-pocket often "fall through the cracks." Also, people

who need mental health services may not know how to navigate the complex system. Furthermore, social determinants of health also play a significant role; they may increase a person's risk of developing a mental health or substance use disorder and can make it more difficult to obtain services and remain in treatment.

It is recommended to: Expand access to mental health services and help clients (or potential clients) to navigate the system. This can be accomplished by hiring more staff, increasing the peer workforce, and providing more community navigators. Furthermore, expand wrap-around youth services and improve transitional services and care for those coming out of incarceration. Also, provide support services to address the social determinants of health and help individuals meet their basic needs (e.g., food and affordable housing) and offer transportation to and from their place of treatment.

System coordination
The mental health system is complex and fragmented, with multiple, interacting systems and different gatekeepers.

It is recommended to: Provide opportunities for stakeholders of the mental health system and the adjoining agencies, such as the Department of Child Services, Criminal Justice and the Courts, and the school system, to come together and increase coordination. Promote policy changes to improve the upstream conditions (e.g., risk factors and social determinants of health) and address the drivers of substance use and mental illness early on with effective prevention and outreach.

Stigma reduction
Stigma is still a considerable barrier to accessing mental health services, especially in communities of color.

It is recommended to: Increase awareness and reduce stigma in the community. Promote use of non-stigmatizing language. Educate communities in culturally appropriate ways to normalize mental health and substance use disorder treatment.

Introduction

The purpose of this project was to conduct a community mental health needs assessment (CMHNA) specific to the services available for serious mental illness and substance use disorders across the lifespan in Marion County, Indiana.

The CMHNA was developed in collaboration with Sandra Eskenazi Mental Health Center, Community Fairbanks Behavioral Health, Aspire Indiana Health, and Adult and Child Health. These four organizations are Division of Mental Health and Addiction (DMHA) designated Community Mental Health Centers (CMHCs) as well as grantees of the Substance Abuse and Mental Health Services Administration's Certified Community Behavioral Health Center (CCBHC) award.

This report contains all findings from the assessment, including:
  a. Identification of the level of need, including cultural, linguistic, treatment and staffing needs
  b. Identification of the level of services available, including resources to address transportation, income, culture, and other barriers
  c. Identification of the gaps between needs and services
  d. Recommendations derived from the interviews and other data.

Methodology

This study was conducted between August 1, 2022, and April 30, 2023. For the CMHNA, we gathered information from several primary and secondary sources. Secondary (already existing) data were obtained as follows:

  • Population-level data, including social determinants of health indicators, from the U.S. Census Bureau and the University of Wisconsin, Population Health Institute
  • Prevalence estimates of mental health disorders from the federal Substance Abuse and Mental Health Services Administration (SAMHSA)
  • Treatment and organizational information were provided by the four CMHCs, Sandra Eskenazi Mental Health Center, Community Fairbanks Behavioral Health, Aspire Indiana Health, and Adult and Child Health.

Primary (new) data were collected by the research team through focus groups and in-depth interviews with key informants. Key informants included CMHC clients and family members of clients, clinical and administrative CMHC professionals, community stakeholders, and representatives from statewide agencies or organizations. We conducted 7 focus groups and 19 interviews, speaking with a total of 52 individuals.

Terminology used: In the realm of community mental health, there are various terms that are often used interchangeably. Here in this report, we used "mental health" instead of "behavioral health" to describe services related to both mental health and substance use disorders. We also chose the terms "person served" or "client" instead of "patient" when discussing individuals who are receiving mental health services. We made exceptions to these rules when a different term was used by a key informant, and we included a direct quote.

The study protocol was submitted to the Indiana University Institutional Review Board (IRB) and deemed exempt (Protocol # 16238).

Marion County Population Profile

Marion County is located centrally in Indiana. It is the most populous county in the state with 971,102 residents. Nearly two-third of residents are white, and African Americans represent over one-fourth of the county's population. In terms of ethnicity, 11% are Hispanic or Latino (U.S. Census Bureau, 2021).

Social determinants of health

Social determinants of health (SDOH) have a major impact on people's health, well-being, and quality of life. They also contribute to health disparities and inequities. These SDOH can be grouped into five domains including:

1. Economic stability
2. Education access and quality
3. Healthcare access and quality
4. Neighborhood and built environment
5. Social and community context (U.S. Department of Health and Human Services, n.d.).

The following statistics are key SDOH indicators in Marion County (U.S. Census Bureau, 2021a):

Economic status: 67% of residents aged 16 and older were in the civilian labor force; the median household income was $54,601; and 15% of residents lived in poverty.

Education: 87% of residents aged 25 and older had a high school degree or higher, and 33% had a bachelor's degree or higher.

Healthcare: 9% of residents under the age of 65 were without health insurance.

Housing: 55% lived in a house they owned.

According to the *County Health Rankings*, Marion County ranked 86 out of 92 Indiana counties on health outcomes. This means that the county is among the bottom 25% in the state, making it one of the least healthy communities. An estimated 18% of residents considered themselves to be in poor or fair health (Indiana: 15%). On average, Marion County residents experienced 3.7 days of poor physical health and 5.3 days of poor mental health in the past month (Indiana: 3.3 days and 4.9 days respectively). The ratio of population to mental health providers was 290:1, meaning there was one mental health provider per 290 people registered in Marion County. On this statistic, Marion County fared better than the state overall, which had one mental health provider per 530 Indiana residents (University of Wisconsin, Population Health Institute, 2023).

Furthermore, 4.4% of people aged 16 and older were unemployed but seeking work, and 21% of children lived in poverty in Marion County (Indiana: 3.6% and 16% respectively). Furthermore, 13% of Marion County residents experienced food insecurity (Indiana: 11%). Violent crime is another major concern in the community. There were 1,251 violent crimes such as rape, homicide, robbery, and aggravated assault, reported per 100,000 people. This is more than three times higher than the rate for all of Indiana (385 per 100,000) (University of Wisconsin, Population Health Institute, 2023).

Of all the households in Marion County (n=394,717), 8.1% are Spanish-speaking, 3.1% speak other Indo-European languages, 2.0% speak Asian and Pacific Island languages, and 2.4% speak other languages. Also, 3.6% of households in Marion County have limited English proficiency (LEP), meaning that English is not their primary language, and they have difficulty communicating effectively in English (U.S. Census Bureau, 2021b)

Of the households with LEP (n=14,325), 22.3% speak Spanish, 24.9% speak other Indo-European languages, 29.4% speak Asian and Pacific Island languages, and 18.8% speak other languages. The percentage of LEP households in Marion County (3.6%) is more than twice as high as the state's percentage (1.5%) (U.S. Census Bureau, 2021b).

Indiana 211
Indiana 211 is a free service that connects Hoosiers with health and human service agencies and resources in their local communities. It is a division of the State of Indiana Family and Social Services Administration (FSSA, n.d.).

During calendar year 2022, over 57,000 calls were made to Indiana 211 by Marion County residents, representing nearly 39,000 distinct callers. The top five needs categories reflected in these calls were:

1. Housing (19,051 calls)
2. Utility assistance (10,975 calls)
3. Food/meals (9,275 calls)
4. Individual/family/community support (8,275 calls)
5. Legal/consumer/public safety services (8,257 calls)

Out of all the distinct callers, 94% spoke English and 4% spoke Spanish. Demographic data such as race, age, gender, and education level were asked of the callers, but the majority declined to answer (FSSA, n.d.).

Health Professional Shortage Areas (HPSAs)
There are 9 mental health HPSAs in Marion County, one low-income population designation and eight facility designations. A population HPSA refers to a defined geographic area with a shortage of providers for a certain population group, e.g., low-income, or homeless populations. Facility HPSAs refer to public or non-profit private medical facilities that serve a population or geographic area with a shortage of providers. Some of these facility HPSAs are automatically designated, based on statue or through regulation, such as Federally Qualified Health Centers (FQHCs) or FQHC Look-A-Likes (Health Resources & Services Administration, HRSA, n.d.).

Each mental health HPSA is assigned a score from 0 to 25, with higher scores indicating greater need. The score is based on seven criteria that are summed up: population-to-provider ratio (up to 7 point), percent of population below 100% of the Federal Poverty Level (up to 5 points), percent of people over age 65 (up to 3 points), percent of people under age 18 (up to 3 points), alcohol abuse prevalence (up to 1 point), substance abuse prevalence (up to 1 point) and travel time to the nearest source of care outside the HPSA designation area (up to 5 points) (HRSA, n.d.).

The mental health HPSAs in Marion County are:

| Name	HPSA Designation	Score
Low-income - Central Indiana MHCAs	Population	13
Indiana Health Centers Incorporated	Facility	22
Raphael Health Center, Inc.	Facility	22
The Health & Hospital Corp of Marion County	Facility	21
Shalom Health Care Center, Inc.	Facility	20
HealthNet, Inc.	Facility	20
Jane Pauley Community Health Center, Inc.	Facility	18
Adult And Child Mental Health Center Inc	Facility	14
Indiana Women's Prison	Facility	12

Mental health disorders

Population-level estimates on mental health disorders are not available at the county level. To provide some background on the prevalence of these conditions, we included key statistics for the state of Indiana. This information was obtained through SAMHSA's National Survey on Drug Use and Health (NSDUH), the nation's annual survey on substance use and mental health conditions and treatment needs. The following information is based on pooled 2018-2019 NSDUH data, which are currently the most recent estimates.[1]

An estimated 3.5% of Hoosiers aged 12 and older experienced an illicit drug use disorder in the past year; the age group most affected were young adults between 18 and 25 years (8.1%). Furthermore, 5.6% of Indiana residents had an alcohol use disorder; again, 18- to 25-year-olds were the most affected (10.3%). The prevalence for any type of substance use disorder (SUD) was at 8.0% among those aged 12 and older; SUD prevalence in young adults aged 18 to 25 was at 14.8% (SAMHSA, 2018-2019). **See Figure 1**.

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[1]For a short period of time, SAMHSA provided state estimates for 2019-2020; however, these are no longer available due to methodological concerns with combining 2019 (pre-pandemic) and 2020 (during pandemic) data. It was determined that averages across the two years may be misleading. Therefore, the state estimates for 2019-2020 are no longer available. For more detail, see State Data Tables and Reports From the 2019-2020 NSDUH (samhsa.gov).

Figure 1. Prevalence of experiencing some type of substance use disorder in the past year among Indiana residents aged 12 and older (NSDUH, 2018-2019)
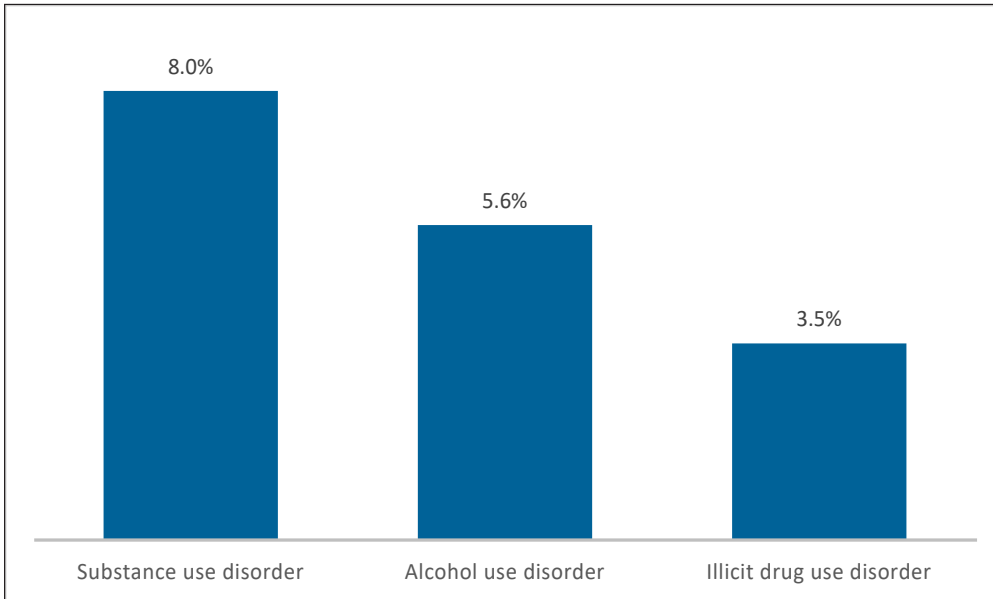
Additionally, 7.5% of Indiana residents aged 12 and older needed but did not receive treatment at a specialty facility for their SUD; again, the rate was highest for those between the ages of 18 and 25 (14.6%) (SAMHSA, 2018-2019).

Nearly one-in-four (22.3%) Indiana adults aged 18 or older had some type of mental illness in the past year, and 5.4% experienced a serious mental illness (SMI). Nearly 17% of Indiana adults received services for their mental health condition. (SAMHSA, 2018-2019). **See Figure 2**.

Figure 2. Prevalence of experiencing any mental illness or serious mental illness in the past year among Indiana adults aged 18 and older (NSDUH, 2018-2019)
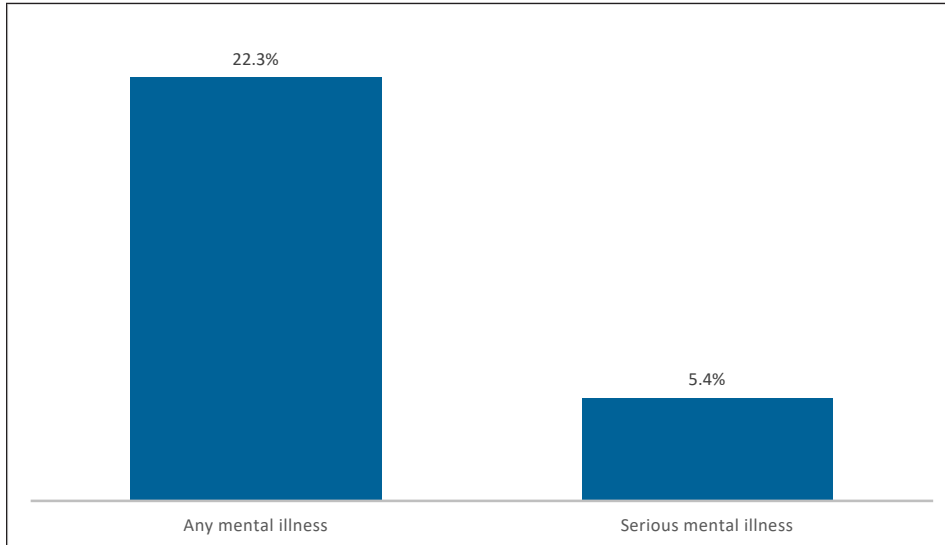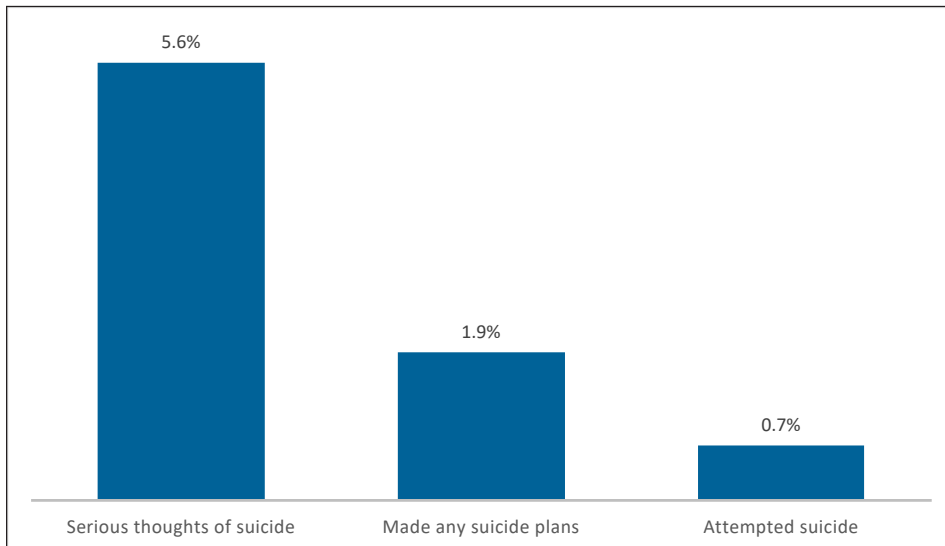

In terms of suicidal behaviors, 5.6% of Indiana adults had serious thoughts of suicide, 1.9% made any suicide plans, and 0.7% attempted suicide in the past year (SAMHSA, 2018-2019). **See Figure 3**.

Figure 3. Prevalence of engaging in suicidal behaviors in the past year among Indiana adults aged 18 and older (NSDUH, 2018-2019)

Available data on mental health conditions among children are limited, especially at the state or community level. Among Indiana children between the ages of 3 and 17 years, 28.2% have one or more reported mental, emotional, developmental, or behavioral problem; 14.2% have attention deficit hyperactivity disorder (ADHD); and 2.6% have autism (Data Resource Center for Child & Adolescent Health, 2020).

Mental health estimates in Marion County

When we apply the above-referenced Indiana-level prevalence rates to the general adult population[2] in Marion County, we estimate that in the past year:

Substance use disorders
- 58,476 adults had an alcohol and/or illicit drug use disorder

Mental illness
- 163,003 adults had some type of mental illness
- 39,472 adults had a serious mental illness

Suicidal thoughts and behaviors
- 40,934 adults had serious thoughts of suicide
- 13,888 adults made a suicide plan
- 5,117 adults attempted suicide

Vulnerable groups

Specific populations have been identified in the literature as particularly vulnerable in terms of experiencing mental health conditions and/or having access to treatment services. County- or even state-level data are frequently not available for these populations, therefore, we relied on national data sources for estimates.

LGBTQ+ community: Among U.S. adults who identify as LGBTQ+, rates of substance use and mental health concerns are higher compared to the general population. It is estimated that 44% (or 5.7 million adults) experienced some type of mental illness, nearly 17% (or 2.1 million adults) had an SUD, and 12% (or 1.5 million adults) had a co-occurring disorder of both mental illness and SUD (SAMHSA, 2018).

Justice-involved populations: While it is difficult to measure the exact rates of inmates who have an SUD, some research shows that an estimated 65% percent of the U.S. prison population have an active SUD and an additional 20% percent do not meet SUD criteria but were under the influence of alcohol or drugs at the time of their crime (National Institute on Drug Abuse, 2020; National Center on Addiction and Substance Abuse, 2010). Furthermore, an estimated 44% of those in jail and 37% of those in prison have a mental illness (Bureau of Justice Statistics, 2017).

People experiencing housing instability / homelessness: Estimating the prevalence of mental health conditions among people with housing instability is difficult and available data are sparse. According to the 2016 Annual Homeless Assessment report, 75% of adults in permanent supportive housing had a

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[2]According to the U.S. Census Bureau, the estimated adult population aged 18 and older in Marion County was 730,956 in 2021.

mental health condition, substance abuse issue, or a co-occurring disorder (U.S. Department of Housing and Urban Development, 2017).

Communities of color: Estimates of past-year illicit drug use among Americans aged 12 or older were highest for people reporting two or more races (28.5%), American Indian or Alaska Native people (25.9%), and Black people (20.8%) compared with the estimates for people in all other racial/ethnic groups. Similarly, the rates for illicit drug use disorder in the past year were also highest for people reporting two or more races (5.0%) and American Indian or Alaska Native people (4.8%), followed by Black people (3.4%) (SAMHSA, 2021).

Drug intoxication and suicide deaths in Marion County
In 2021, there were 826 drug intoxication deaths in Marion County. This represents a 24% increase from the previous year. Most of these deaths (799) were classified as accidental. Of the total number of drug intoxication deaths, 83% (683 deaths) involved an opiate, primarily fentanyl (641 deaths). These fatalities mostly involved residents who were white (559 deaths), male (559 deaths), and those ages 30 to 39 (224 deaths). In Marion County, drug intoxication was the top cause of death in 2021, even surpassing cardiovascular fatalities (511 deaths) for the second year (Marion County Coroner's Office, 2021).

Among all deaths in 2021, 188 deaths have been classified as suicide. This represents a 5% increase from the previous year. Firearms were the leading cause of death for all suicides (59%), followed by hanging/ligature (22%) and drug intoxication (10%) (Marion County Coroner's Office, 2021).

Community Mental Health Centers in Marion County
Community Mental Health Centers (CMHCs) in Indiana provide comprehensive mental health services to individuals who suffer from mental illness and/or substance use disorders. CMHCs specifically offer services to Hoosiers who are most in need, focusing on economically disadvantaged individuals and those who typically encounter difficulties accessing care.

Sites and services
Based on the most recent data from state fiscal year (SFY) 2022[3], the four Marion County CMHCs, Sandra Eskenazi Mental Health Center, Community Fairbanks Behavioral Health, Aspire Indiana Health, and Adult and Child Health combined have:

• 28 outpatient sites
• 179 school sites

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[3]State fiscal year (SFY) 2022 was from July 1st, 2021, through June 30th, 2022.

- 225 inpatient beds
- 700 residential beds

Also, Marion County residents have regional access to at least 58 more group home beds, 98 SUD residential beds, and 33 cluster apartments.

Overall, the CMHCs utilized 60 different evidence-based practices; supported 54 jail diversion programs; conducted or participated in 75 research projects pertaining to psychiatric or integrated care; engaged in 303 community outreach events, sponsorships of events, community meetings, presentations, and media events; and provided nearly $20.8 million in charity care.

The four CMHCs currently employ 2,267 clinical and support staff. However, the CMHCs still experience a combined staff vacancy of 381.0 FTE, this means that 278,000 hours of direct client service are lost per year due to staff vacancies.

Persons served

During SFY 2022, a total of 56,524 persons were served by the four CMHCs in Marion County. Of these, a total of 27,233 were persons registered through the Indiana Division of Mental Health and Addiction (DMHA), with 13,565 adults (50%) receiving services for serious mental illness (SMI) and 3,775 adults (14%) for substance use disorders (SUD), as well as 9,893 youth (36%) receiving services for severe emotional disturbance (SED).

Treatment gap: Based on data from the National Survey on Drug Use and Health (SAMHSA, 2018-2019), we estimated that approximately 39,472 adults in Marion County had a serious mental illness (SMI) and 58,476 adults had a substance use disorder (SUD) in the past year. Comparing this to data provided by the four CMHCs, that show that 13,565 adults received SMI services and 3,775 adults received SUD services in the past year, we estimate that 25,907 adults needed but did not receive SMI treatment and 54,701 needed but did not receive SUD treatment in Marion County. [We acknowledge that this presents a good-faith estimate, since Marion County residents may have received needed services outside of a CMHC or without being DMHA-registered.]

Nearly one-third (30%) of adult CMHC clients had a primary diagnosis that fell into the "depressive disorders" category. This was followed by substance use and anxiety disorders. **See Figure 4**.

Figure 4. Primary diagnosis in adult CMHC patients
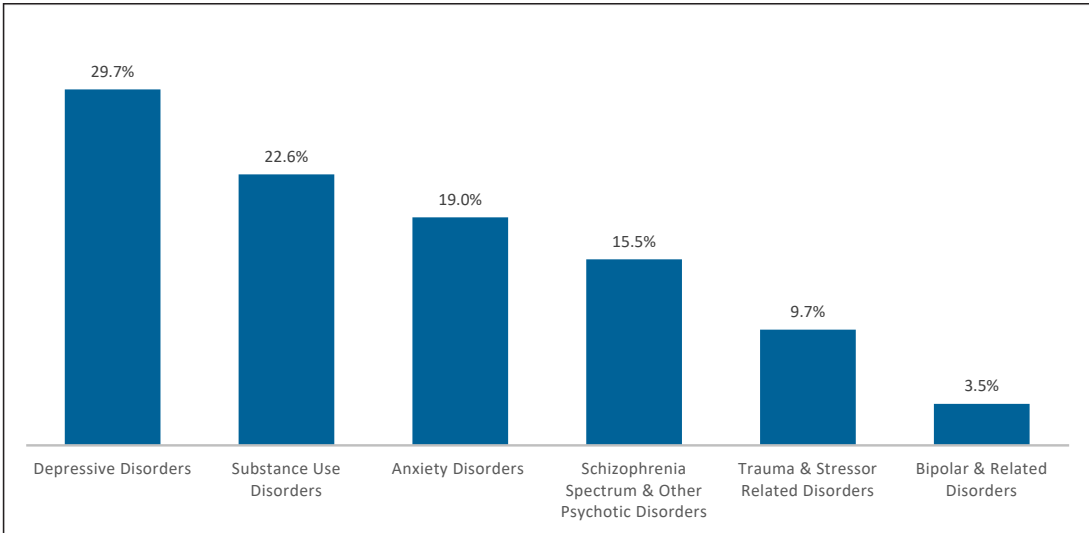
Note: A person can be counted in multiple diagnostic categories, as the primary diagnosis may change during the course of treatment or upon repeated episodes.

Over one-fourth (27%) of the youth CMHC population had a primary diagnosis of disruptive, impulse-control, or conduct disorder. This was followed by depressive and anxiety disorders. Furthermore, 15% of youth had a neurodevelopmental disorder; this category also includes attention deficit/hyperactivity (ADHD) diagnoses. **See Figure 5**.
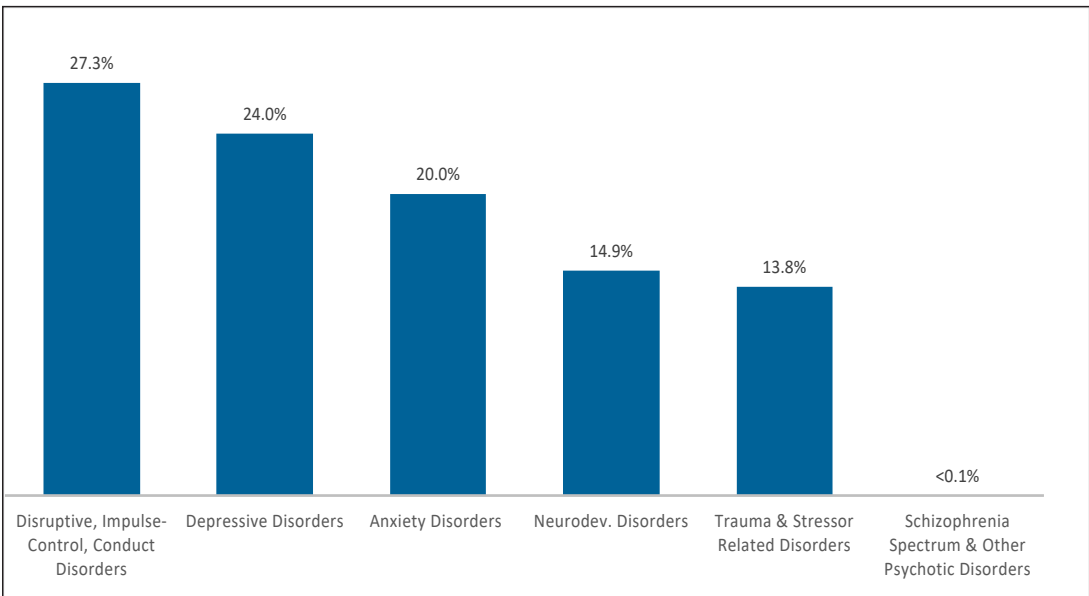
**Figure 5. Primary diagnosis in youth CMHC patients**

Notes: A person can be counted in multiple diagnostic categories, as the primary diagnosis may change during the course of treatment or upon repeated episodes. The neurodevelopmental disorders category includes diagnoses for ADHD.

The most common substances used by CMHC clients receiving SUD services were alcohol and cannabis. **See Figure 6**.

Figure 6. Types of substances used in CMHC patients
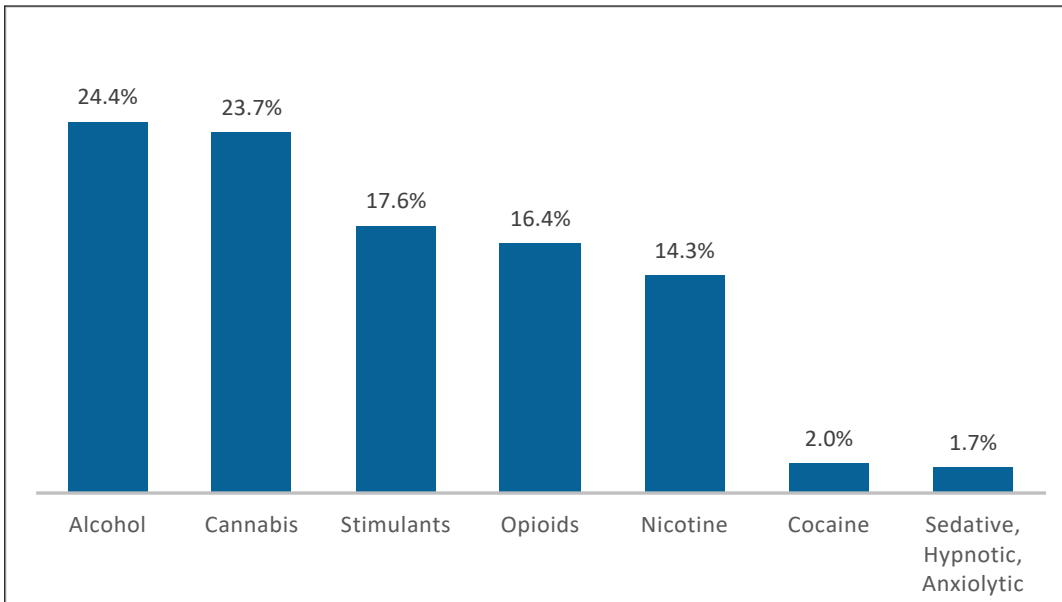
Note: The CMHC data on substances used are based on the primary reason why patients are seeking treatment, or selected from the diagnostic list during services. As such, nicotine is likely underreported in the data set.

Nearly one-third (32%) of CMHC clients experienced housing instability, meaning they were currently homeless or at risk of becoming homeless. Furthermore, 28% had some type of justice involvement.

Racial and ethnic composition
The percentage of African Americans working at a CMHC in Marion County was comparable to the percentage of African Americans within the general population, but lower than the percentage of African Americans receiving services at a CMHC. [African Americans make up about 28% of the Marion County population but represent nearly 37% of CMHC clients.]

The percentage of CMHC staff identifying as Hispanic was below the percentage of Hispanic individuals within the general as well as the CMHC client population. **See Table 1**.

Table 1. Percentage of population by race and ethnicity

		Marion County general population	CMHCs' client population	CMHCs' staff population
Race	Black / African American	27.5%	36.5%	24.5%
	White / Caucasian	53.9%	54.7%	70.2%
	Asian	3.9%	1.0%	1.6%
	American Indian / Alaska Native	0.3%	0.3%	0.2%
	Hawaiian/ Pacific Islander	0.0%	0.6%	< 0.1%
	Other single race	5.6%	3.2%	0.4%
	Two or more races	8.8%	3.8%	3.1%
Ethnicity	Hispanic (of any race)	11.3%	12.5%	2.2%

Note: We do not have information on race and ethnicity for all staff members or clients; some declined to report, and some data are missing.

As mentioned before, almost 4% of households in Marion County have limited English proficiency (LEP), making it difficult to communicate effectively in English. To circumvent the language barrier, CMHCs offer interpreter services supporting over 200 languages. The most utilized languages are Spanish, Haitian Creole, Arabic, French, Swahili, Kinyarwanda, Yoruba, Tigrinya, Burmese, and Punjabi.

Needed services

The CMHCs identified the most needed evidence-based services that should be offered to clients but are currently missing or are provided only at limited capacity, due to resource constraints. These services fall within the categories of: Levels of care, evidence-based treatments, and services for special populations.

- Services covering all levels of care, including prevention and education, sub-acute levels of care, partial hospitalization, and residential programs.
- Evidence-based treatments, including assertive community treatment (ACT), electroconvulsive therapy (ECT), supportive employment, and family therapies.
- Services that address the needs of special populations, including re-entry services for justice-involved individuals, services for individuals with comorbidities or dual diagnosis, and services for individuals with developmental disorders.

Key Informant Interviews

We conducted 7 focus groups and 19 in-depth interviews with key informants, speaking with a total of 52 individuals. Key informants included persons served at CMHCs and their family members, clinical and administrative CMHC professionals, community stakeholders, and representatives from statewide agencies or organizations.

> **We want to point out that these are the views and opinions expressed by our key informants and may or may not reflect the views of the sponsors of the report. Furthermore, much of the discussion is in reference to the "behavioral health system at large" and not in regard to CMHCs or individual providers.**

CMHC clients and family members

We conducted four focus groups with clients or family members of clients, one group at each CMHC. Each focus group represented a different CMHC population, including: Men recovering from substance abuse, individuals with SMI, residential clients, and family members of children who receive services at the CMHC.

The primary information we aimed to obtain from the client focus groups were issues related to: Access to care, satisfaction with services, and gaps in programs and services.

Access to care

Most clients in our focus groups indicated that it was not difficult obtaining treatment at their respective CMHC. Some were able to complete an intake over the phone and then schedule a visit within a few days. In other cases, where the client was previously incarcerated, a coordinator at the jail was able to secure a treatment place. However, another client had a different experience and described the lack of

coordination between the jail release and treatment. One person explained that they had overdosed and woke up in the ED, when they were asked if they are interested in receiving treatment (*"And I was like, "Yeah, I'll give it a shot."*). These examples highlight the **importance of collaboration between the individual systems** (e.g., jails, hospitals, and community mental health) to provide clients with a "warm handoff" and increase the likelihood that a person will be able to access needed services.

Some clients also mentioned that getting into treatment this time around was easy, but that has not always been the case. Previous attempts had been unsuccessful because of a lack of open beds. Other challenges and barriers that clients faced over the years when attempting to get into treatment included:

- Treatment center-specific obstacles (e.g., only accepting clients who have a "dirty" drug screen or who have been previously in treatment; too much emphasis on medications to treat their SUD)
- Personal and societal obstacles (such as poverty, lack of transportation, lack of social support, stigma)

"If you have cancer, everybody rallies around you, but if you have a mental health issue, they go away."

Satisfaction with services

The clients we spoke with in these focus groups were not a homogenous group, but came from various backgrounds, had different mental health disorders, and, therefore, received diverse types of services.

Regardless of the setting, **clients generally were satisfied with the services** they received at their respective CMHC. When we followed up with the question, what specifically do you like about the program, the responses we heard primarily described the positive aspects of the program and the incredible work of the clinical staff, but also fellowship with other clients (meeting new people and socializing with others) was an important theme that emerged. The comments made about the program and staff included:

- Clients appreciate learning new things and life skills
- Clients feel safe
- Many of the staff are in long-term recovery themselves and can relate to clients' experiences
- Staff and doctors are committed to their clients and easily accessible
- Medication management (finding the "*right mix*" of medications for clients)
- Program provides structure and stability to clients' lives
- Appropriate level of freedom in the program, allowed to work outside of the program

"I really like that they let us work, because I feel like that's a great way to start integrating us back in society. Because we could stay here and do this all day long, but when we get thrown back into the real world, we're like a fish out of water."

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"I would be lost in the world if it wasn't for the mental health doctors and the nurses and the staff and the places that we could go to get help. Imagine if we didn't have none of that, nowhere to go get help at. You know, a lot of us would be dead. We'd probably just kill ourselves, you know. So, I thank God so much. I've been homeless before. If they didn't have mental health, I would be homeless."

Gaps in programs and services

Though comments were predominantly positive, clients also had suggestions on how CMHCs could improve their services including:

- **Staff spending more time with clients**
  Most recommendations centered around staff spending more time with clients. This included listening to what clients want or need, being more patient with them, spending more one-on-one time, or going on outings with them.
- **Hiring more mental health staff**
  Clients seemed to realize that staff's high workload and turnover rates were a concern, some suggested hiring more mental health staff.
- **Providing transportation services**
  Clients suggested providing transportation services ("*we don't have our van drivers anymore*").
- **Additional treatment options and follow-up**
  Some clients proposed offering additional treatment options to what is currently available. A few clients mentioned that some of the programs do not follow-up when a person stops treatment, which makes it easy "*to fall through the cracks*."

Family members' concerns

During the focus group with family members, the following concerns were brought up:

- **"The larger system"**
  The system has not always been helpful in addressing the family situation. This was not in reference to a specific CMHC or any of the mental health services provided, but in response to the larger system, including law enforcement, the school system, and the Department of Child Services (DCS).
- **Workforce shortages in partner agencies**
  Workforce shortages in partner agencies such as DCS make it difficult to give appropriate care and services to children in need.
- **Caretakers often feel overwhelmed and helpless**
  Especially in crisis situations, caretakers feel overwhelmed and do not always get the assistance they need.
- **Need to invest in mental health and our children**
  The systematic challenges that were experienced by family members were linked to a lack of resources because "*...let's just be honest. We don't invest in the state of mental health and our children.*"

- **A more diverse system**
  Another important theme that was brought up was the need for the system to be more diverse and representative of the community it serves.

  "...when you have little brown babies that come into therapeutic situations and the other person doesn't look like you...that's an additional hurdle. You have to prove yourself. Before we even get down to what my problem is, I'm coming in this room not trusting you. And to be honest with you, we have, as Americans, we have the history...like the stuff we have done to African American families in this country."

CMHC professionals

We interviewed the CEOs of the four CMHCs. Additionally, we conducted three focus groups with clinical staff from all four CMHCs. Each focus group focused on staff from different service areas such as (1) ED, crisis, and mobile response teams, (2) ambulatory child services, and (3) ambulatory adult services. Their responses were aggregated into four domains: Access to care, gaps in programs and services, vulnerable groups and unmet needs, and challenges.

Access to care

When asked if it is easy to get access to community mental health services, the majority of respondents stated "no", or in some instances, mentioned that it is dependent on a person's insurer (public or commercial) and on the level of severity of their mental health condition.

Several reasons were listed why getting access to care can be challenging for clients. Most of these categories were recurring themes that were repeated throughout the interviews:

- **Workforce shortages**
  Workforce shortage is a major concern, not enough staff are going into and staying in community mental health. Furthermore, a big part of the current workforce is aging out. Having fewer staff, limits an organization's capacity to provide needed services. This can lead to long wait times for clients, especially for those who need to see a psychiatrist.

  "Well, for sure, there's a workforce development issue ... Even with all the positions that we all have budgeted or funded, you know, the percentage of those that are actually filled are pretty low for what the need is, so that impacts it a lot."

- **Limited diversity among providers**
  Related to the workforce shortage, at least in part, is the limited diversity among providers. CMHCs are aware of the importance of having a workforce that represents their client population and are actively pursuing greater staff diversity; however, this is not always an option.

"We get a lot of calls from individuals that want to work from a therapeutic perspective, want to work with someone who's the same race or/and ethnicity as they are, and we can't accomplish… We do our best, right? But there's a lot of times we can't accommodate that, because we don't have the capacity to. So, I think that's another huge barrier, and especially as it relates to reducing health disparities."

- **Complexity of the mental health system and administrative burden**
  The mental health system is complex and actually consists of multiple interacting systems with different gatekeepers (e.g., Division of Mental Health and Addiction, Department of Child Services, Indianapolis Housing Agency, criminal justice system). Respondents felt that "*there's not enough coordination across systems.*" This complexity is confusing even for CMHC staff, but especially difficult to navigate for clients who would benefit from "*community navigators.*"

  Additionally, the administrative burden ("*the amount of paperwork*") puts a strain on staff and clients alike, often leading to long intake processes, which can be "*re-traumatizing*" for clients.

- **Lack of transportation or internet connection and equipment**
  Clients may not be able to see a therapist because they have no access to transportation. Telehealth is in some cases a viable option, however, not all services can be delivered virtually and not all clients have a laptop or computer or a stable internet connection.

Gaps in programs and services

The four CMHCs provide a wide array of essential mental health services, including suicide prevention. Some of these services are provided at specific CMHC locations, others are delivered directly in the community (e.g., school-based programs, homeless outreach).

We asked respondents what they perceive to be the gaps in services. Here is a list of programs that they suggested should be implemented or expanded:

- Group homes and youth shelters
- Specialized care for people with complex needs and for pregnant women
- School-based services
- Certified peer recovery support and community navigators
- Crisis stabilization and crisis alternatives
- Transitional levels of care
- 1-day respite care
- Faster transfers to state hospitals

"I would think in almost every service, A to Z, whether it's mental health or addictions, or more social determinant oriented type services, every service could be increased. There's no shortage of referrals. Capacity is always outgunned, outmanned. And so, there's not anything that we do that we couldn't do more of, have a saner workload for staff. Everything is in too short of supply."

Vulnerable groups and unmet needs

Our respondents identified the following groups as the most vulnerable in terms of being able to access mental health care in Marion County.

- People who are experiencing homelessness
- People who have several comorbidities (e.g., individuals with autism, cognitive or intellectual disabilities in addition to mental illness or substance use disorders)
- Individuals with lower incomes, especially if they have commercial insurance
- Individuals from the LGBTQ+ community, especially youth
- People who are or have been involved with the justice system
- Pregnant females
- Children, especially those involved in foster care
- People of color, especially if they are non-English speakers

"I think...our black and brown community within the city. We know there is a lack of services there. And then the systemic, historically systemic oppression of them puts them in those spaces, right? They're more likely to be homeless and more likely to be in some of these other circumstances...And then we also lack staff that look like those clients, that reflect that diversity. I know we're all trying to do different things about that, but that's a huge piece of it. So, we might get them in the door, but they might not want to stay because they don't feel seen or as supported as they need to be."

We then discussed what interviewees believed were the areas of greatest unmet need in terms of providing mental health services:

- **Workforce**
  The workforce shortage was identified as an unmet need by all CMHCs.

- **CMHC funding and reimbursement rates**
  All respondents mentioned the difficult funding situation and that Medicaid/Medicare reimbursement rates have not kept up with the costs of providing services.

  "Our government payer rates, Medicaid, Medicare, haven't adjusted since the late nineties, and if, you know, commercial insurance pegs their rates to the government rate, they have no incentives on increasing their rates to what they pay us."

- **Safe affordable housing, residential or group homes**

  "We think the biggest unmet need has to do with housing. So safe and affordable housing for individuals who are recovering with substance use disorder."

- **Geriatric psychiatry**
  Some respondents mentioned that CMHCs are not equipped to deal with an aging population who is experiencing both serious mental illness and physical ailments, and that nursing homes or assisted living facilities often will not take people who are actively psychotic.

- **Specific programs and services**
  Several programs and services were listed by our respondents such as prevention, outreach, and education; expanding the peer workforce; IOP for co-occurring disorders mental health and substance use disorders; sub-acute care; and helping clients transition from one level of care to the next.

  "I think one of the greatest areas of needs is building up the peer workforce. I don't think we have enough, again, services before a crisis, acute care that could stabilize individuals to help bridge over that. And I know the 988 and the plans, the state, they hope to build more out in front of crisis. Again, sub-acute. There is a big gap in sub-acute."

Challenges

We also asked our participants what they see as major challenges to the mental health care system at large. Many of the issues raised were recurring themes that had been mentioned as gaps or unmet needs previously. The primary challenges reported by participants were sustainable funding for CMHCs and workforce shortages, two issues that are difficult to tease apart since they are highly interrelated.

Sustainable funding for CMHCs
Medicaid/Medicare reimbursement rates are low and have not been updated since the 1990's. The current funding model cannot attract and retain an adequate workforce, because it does not allow CMHCs to pay a competitive salary.

Low reimbursement rates hinder the sustainability of many programs and services, including competency trainings for staff. This means that CMHCs often have to apply for external grant funding "…*to make sure that staff get ongoing training.*"

Also, some needed services are either not covered by the current fee-for-service structure or not reimbursed well. This includes residential services, group homes, and peer services.

> *"Like our group homes, we receive zero funding; today we only have fee-for-service kind of processes to draw in funding for that; we get no per-diem room and board to care for these individuals."*

Another challenge that was mentioned involved the Medicaid Rehabilitation Option (MRO), which reimburses for services to clients who meet DMHA's specific diagnosis and level-of-need criteria. Depending on clients' current ANSA (Adult Needs and Strengths Assessment) or CANS (Child and Adolescent Needs and Strengths) score, clients may lose their MRO package and their continuity of care is disrupted.

Commercial insurance was also listed as a concern "*because it usually doesn't support the range of services needed for individuals with severe mental illness and addiction,*" unless individuals are able to pay out-of-pocket for these services.

Workforce shortages

Recruiting and retaining staff has been difficult, largely due to CMHCs not being able to pay a competitive salary. Turnover rates among staff have been high ("*CMHCs experienced a 46% turnover rate last year*"), with heavy workloads and administrative burdens often leading to staff burnout.

> *"And so, we're losing a lot of really good dedicated "I've been here eighteen years, and I can't do this anymore" staff. So, it's the money for our young staff. For our older, passionate staff, it's just burnout from COVID and from just the increase in need of services and the lack of staff to provide them."*

Having more diverse staff, especially in higher-degree positions, was also recognized as a challenge.

> *"I have more diversity in my staff population in Marion County than say, Hamilton County or Boone County… And that's appropriate. But we still don't have enough, especially in those higher-degree, physicians, nurse practitioners, social workers, psychologists."*

Workforce shortages and staff turnover also exist in partner agencies, such as the Department of Child Services. This can be critical, especially when working with children who have experienced severe trauma.

> *"…some of our kids that have the most trauma, their DCS workers change way too often…and these are the most critical kids who really need that consistency, and they'll [DCS workers] change over five times in a month, and that really puts a lot of struggle and barrier on us to work with them."*

Community stakeholders

We conducted 10 interviews with representatives from agencies or community organizations who often interact, or whose mission is driven by, individuals with mental health conditions. The following sectors were represented:

- Public health (Marion County Public Health Department)
- Public safety (Office of Public Health and Safety, Indianapolis Metropolitan Police Department)
- Justice system (Marion County Superior Court)
- Youth-serving agencies (Department of Child Services, Indianapolis Public Schools)
- Mental health advocacy (Mental Health America of Indiana, National Alliance on Mental Illness Indiana)
- Housing (Coalition for Homelessness Intervention & Prevention)
- Community engagement (Community Solutions)

Their responses were aggregated into four domains: Most significant concerns, vulnerable groups and unmet needs, services and resources, and challenges.

Most significant concerns

When asked to name their most significant concerns regarding the mental health system in Marion County, our participants responded in a variety of ways. Due to the differing foci of each community organization, these differences are not unexpected. Three major themes emerged: Access to care, workforce shortages, and substance use and its consequences.

Access to care

Multiple community organizations mentioned they were concerned about not having enough treatment options, particularly to treat substance use disorders. As one respondent stated: "*I think the lack of access to treatment across the board, regardless of what your crisis point is, is a major issue, but I think it's "easier" if you have a mental health diagnosis and not a substance use diagnosis to access treatment.*"

Some of our community informants were concerned about specific subpopulations being able to access needed services. Particular concerns were voiced for: Children, pregnant women and their babies, immigrants, people living in poverty, and people experiencing homelessness.

Workforce shortages

The current mental health workforce shortages seem to be consistent with the workforce concerns of other industries, especially since the start of the COVID-19 pandemic. Though respondents were also concerned that shortages were due to, at least in part, licensing restrictions put in place by commercial insurance companies. This lack of qualified providers has led to long waitlists, particularly for youth services. Many respondents also emphasized that they are concerned about a lack of diversity in the workforce compared to the community they are serving.

Substance use and its consequences

Respondents frequently brought up substance use and its consequences, such as overdose, accidental death, or HIV and hepatitis A or C infections, as major concerns. Furthermore, stigma surrounding substance use and addiction was mentioned by a few community organizations as a reason that individuals might not get needed treatment.

Vulnerable groups and unmet needs

In terms of being able to access treatment, our respondents identified the following as the most vulnerable or disparate groups in Marion County:

- Racial and ethnic minority groups
- Individuals experiencing homelessness
- People with co-occurring mental health and substance use disorders
- Justice-involved individuals
- Children who have experienced trauma (adverse childhood events)
- LGBTQ+ youth

When asked about the areas of greatest unmet need, the following themes emerged:

- Availability of specific services, such as continuity of care, especially for justice-involved or homeless individuals; and partial hospitalization options
- Additional support for schools and parents, such as mental health training for school staff, early school-based prevention/intervention programs, and resources for parents
- Addressing social determinants of health, especially stable and safe housing, and transportation

Mental health services and community resources

We asked community informants (a) if they believe that there are enough mental health services available to meet the need in Marion County and (b) if Marion County has sufficient support and resources to provide adequate mental health services to the community.

Many of our community informants felt that the need for mental health and substance use treatment exceeds the services that are currently provided ("...*you don't have enough services.*"). One of the most common reasons stated by our informants was the workforce shortage in the mental health field ("*I think that workforce is definitely an issue. We don't have enough providers...*").

Some interviewees mentioned that often people who need mental health services do not know how to get them, or that clients are frequently lost to follow-up and "*fall through the cracks*" when visiting multiple different health systems. However, once people can connect with the correct services, they are able to get

quality care.

A few of our participants emphasized the need for more programs and interventions addressing children and youth. This could include training for teachers and other school staff to be able to recognize and deal with mental health issues in their student population. Also, for mental health providers to offer services to youth early on, "*...intervening in a manner to help that child when they're younger...[before] they come to a point where they're so challenging that it's almost like there's not an answer...*".

Most community informants stated that Marion County currently does not have sufficient support and resources to address the need in their client population. Workforce shortages, lack of adequate funding as well as low reimbursement rates for services were frequently cited reasons.

> *"Workforce is such an issue even in Marion County. I think that we do need way more funding, because one of the reasons why we have a workforce issue is because we have a reimbursement issue, and rates are very low for mental health."*

Challenges

Community informants discussed what they perceive to be major obstacles to accessing mental health services. The primary challenges mentioned were:

- **Transportation**
  Multiple community informants discussed how transportation was one of the biggest challenges they see. If a client cannot get to their appointments, they will not be successful in their treatment.

- **Stigma**
  The second most mentioned challenge was stigma. Interviewees mentioned that stigma is still heavily present across all populations, but more prominently in minoritized communities.

  > *"I will just say, even culturally, our Hispanic families, almost when I first started, almost always would turn down mental health referral. They just were not interested in that. And thankfully, we've seen a big uptick, and that which I'm so grateful for, and I'm not sure exactly what that's attributed to, but we'll take it."*

- **Housing**
  Having safe and affordable housing was often cited as essential to treatment success and considered by some a form of health care.

  > *"Housing is the way that you can keep people safe, and you can improve health outcomes, and people can start to address, you know, mental health issues that they might be struggling with or substance use."*

- **Minoritized populations, especially immigrant and non-English speaking groups**

  "...if you aren't documented...it's very difficult to get mental health services. We can get you some emergency services, but once you're past the emergency services, it's difficult to get ongoing. ...if you speak in a language that's different than English, sometimes that's a barrier too. So, we will have kiddos who speak pretty good English, but then their parents speak no English, and regardless of documentation or not, that's a barrier. We do use the Language Line, but there's a lot of stuff that's lost in translation when you're talking about mental health."

- **Navigating the mental health system**
  Community informants also mentioned that it can be difficult for clients to navigate the mental health system and that there are not enough community navigators to help connect individuals to services.

- **Children**
  Children face a variety of challenges when it comes to mental health care. Multiple interviewees discussed how we are limited on the number of services for children, especially for severe mental health disorders.

Representatives from statewide agencies and organizations

To gain a greater context, we conducted interviews with five representatives from state-level agencies and organizations: the Division of Mental Health and Addiction, part of Indiana's Family and Social Services Administration; the Governors' office; Indiana Council of Community Mental Health Centers; Indiana Primary Health Care Association; and the Indiana Hospital Association.

Our questions targeted the following areas: Status of mental health care in Indiana, access to care, and vulnerable groups. The responses are not focused on Marion County specifically, but provide a statewide perspective.

Status of mental health care in Indiana

When asked what was going well with mental health care in the state, all respondents commended the CMHCs for providing essential services. One said, "*I do think our community mental health centers are maybe the best-kept secret in Indiana*." Respondents also stated that Indiana is in a good position for the CCBHC model due to work that has already been done to build the networks. The increasing normalization of mental health care and decreasing stigma around receiving care was also cited as a positive change in the state. Other encouraging developments the interviewees mentioned included:

- Expansion of ways providers can offer medication-assisted treatment
- Evidence-based treatment trainings offered by DMHA

- Strong collaborations between the treatment system and criminal justice
- Efforts on the 988 Suicide and Crisis hotline
- Indiana Recovery Network's recovery cafes and hubs
- NAMI in the Lobby

When asked what was missing from the mental health system in Indiana, the respondents agreed that improvements could be made to ensure all levels of care are provided ("*continuum of care*") and better coordination between systems.

Respondents mentioned other gaps as well, such as a need for expanded service hours, a need to fund SMI treatment beyond skills training, the ability to address housing and transportation issues, and consistent integration of mental health with primary care, especially for youth.

Access to care

Interviewees were asked to identify barriers to accessing mental health care and how those barriers might be addressed.

Workforce

Respondents all mentioned workforce shortages as the biggest barrier to access. These limitations make it hard for people to receive care in a timely manner. First, CMHCs struggle to staff extended hours or same-day appointment slots to help people when they are in crisis ("*If we can't provide services at the moment when they're ready to seek them, then we've lost them until that next opportunity comes around.*") And second, there are not enough providers to meet demand, leading to long waitlists for appointments. The interviewees reported that they do not see a good short-term solution. One suggested redefining the mental health workforce to include non-licensed roles such as community health workers in addition to licensed providers. Respondents also suggested looking at ways to increase reimbursement rates to be able to adequately pay providers in a way that can attract and maintain a sufficient workforce. Another suggested looking for ways to fund graduate medical education and psychiatric residency programs to increase the workforce over time.

Health insurance coverage

Interviewees pointed out that health insurance changes often affect the consistency and quality of care. Adults on Medicaid are frequently reassessed for eligibility and might "*roll on and off coverage*" when living arrangements or employment change, which interrupts care.

> "*Access for those with Medicaid, because of our great system, is pretty good. But if you have commercial insurance, that is really where people are struggling with getting plugged in.*"

"What we really end up with is two systems in this state. We have a system for people who qualify for our community mental health centers, and we have people who can pay for private behavioral health. What we really need is much like our physical health system. We need a full continuum, we need a system that pays everyone for the work they're doing."

Vulnerable groups

Participants identified the following as the most vulnerable groups in terms of getting access to mental health services (this is from a statewide perspective, not focusing on Marion County):

- People experiencing homelessness
- Justice-involved individuals
- Migratory and undocumented populations
- Youth (especially those on commercial insurance)
- The quickly growing aging population
- Rural populations (because of geographic and cultural barriers to access)

It was also mentioned that greater care coordination, increasing mental health literacy and culturally appropriate services, and expanding insurance coverage would help address the needs of these groups.

Recommendations

Certain key issues were consistently identified by all participants in the interviews and focus groups. We summarized these key issues and the resulting recommendations that were made, and aggregated them into five categories: Funding, Workforce, Access, Coordination, and Stigma. It is important to note that these recommendations are not meant as the sole responsibility of the CMHCs but should be viewed in the larger context of the community and the mental health system.

Sustainable funding for CMHCs

CMHCs are over-burdened and under-resourced. Although costs have increased over the years, reimbursement rates have not been updated in decades.

It is recommended to: Increase the state budget and raise Medicaid/Medicare reimbursement rates to adequately fund CMHCs. Change the current reimbursement model from fee-for-service to whole-person care, and for commercial insurance to reimburse case management. Adopt the federal Certified Community Behavioral Health Center (CCBHC) Model.

Workforce development (recruitment and retention)

We have a workforce shortage and there are not enough CMHC staff to address the community's

mental health needs. Working long hours and dealing with substantial administrative requirements and restrictions, many staff members are overwhelmed and experience burnout. With sustainable funding, CMHCs will be better able to provide a competitive salary to recruit and retain the workforce.

It is recommended to: Hire more staff, update licensure requirements, and reduce the administrative burden to help reduce staff burnout. Create a career pipeline, starting in college or even high school, to prepare future mental health providers. Aim to increase diversity, equity, and inclusion (DEI) within the workforce, especially in higher-level and leadership roles.

Treatment access and services

Access to treatment is often dependent on a person's insurance (public or commercial) and the severity of their mental health condition. Individuals with commercial insurance, who are not able to pay for non-reimbursable services out-of-pocket often "fall through the cracks." Also, people who need mental health services may not know how to navigate the complex system. Furthermore, Social determinants of health also play a significant role; they may increase a person's risk of developing a mental health or substance use disorder and can make it more difficult to obtain services and remain in treatment.

It is recommended to: Expand access to mental health services and help clients (or potential clients) to navigate the system. This can be accomplished by hiring more staff, increasing the peer workforce, and providing more community navigators. Furthermore, expand wrap-around youth services and improve transitional services and care for those coming out of incarceration. Also, provide support services to address the social determinants of health and help individuals meet their basic needs (e.g., food and affordable housing) and offer transportation to and from their place of treatment.

System coordination

The mental health system is complex and fragmented, with multiple, interacting systems and different gatekeepers.

It is recommended to: Provide opportunities for stakeholders of the mental health system and the adjoining agencies, such as the Department of Child Services, Criminal Justice and the Courts, and the school system, to come together and increase coordination. Promote policy changes to improve the upstream conditions (e.g., risk factors and social determinants of health) and address the drivers of substance use and mental illness early on with effective prevention and outreach.

Stigma reduction

Stigma is still a considerable barrier to accessing mental health services, especially in communities of color.

It is recommended to: Increase awareness and reduce stigma in the community. Promote use of non-stigmatizing language. Educate communities in culturally appropriate ways to normalize mental health and substance use disorder treatment.

> *"If we got rid of that stigma for substance abuse as well as mental health, first of all, people would be more willing to come and seek that care. But also, I think, if people realize how important it is, we wouldn't be arguing or having an issue about providing the resources, right?"*

Afterword

In September 2022, the Indiana Behavioral Health Commission published a report on the mental health and wellbeing of Hoosiers, including recommendations on building a sustainable behavioral health infrastructure and developing a strong workforce in our state. The report was known to and referenced by many of our key informants.

The work completed by the Indiana Behavioral Health Commission also served as the impetus for Senate Bill 1 - Behavioral Health Matters, the first time in Indiana history that a mental health bill had been designated a legislative priority. The focus of SB 1 was to (1) build a solid crisis response system, including the 988 Suicide & Crisis Lifeline, clinician-led mobile teams, and crisis receiving and stabilization units, and (2) adopt the Certified Community Behavioral Health Clinic (CCBHC) model to provide comprehensive and integrated mental health and substance use services.

Though the bill passed, it did not receive the full $130 million funding requested but instead were given $100 million for the biennium (or $50 million per year).

References

Bureau of Justice Statistics. (2017). *Indicators of Mental Health Problems Reported by Prisoners and Jail Inmates, 2011-12*. U.S. Department of Justice. Retrieved January 12, 2023, from https://bjs.ojp.gov/content/pub/pdf/imhprpji1112.pdf

Data Resource Center for Child & Adolescent Health. (n.d.) *National Survey of Children's Health, 2020*. Retrieved May 31, 2023, from https://www.childhealthdata.org/

Indiana Behavioral Health Commission. (2022). *Indiana Behavioral Health Commission Report*. Retrieved December 28, 2022, from https://www.in.gov/fssa/dmha/files/INBHC-Report.pdf

Indiana Family and Social Services Administration. (n.d.). *Indiana 211*. Retrieved February 28, 2023, from https://in211.communityos.org/

Marion County Coroner's Office. (2021). *2021 Annual Report*. Retrieved February 20, 2023, from https://media.graphassets.com/THdo4cntQwyGT8RCdmus?

National Center on Addiction and Substance Abuse. (2010). *Behind bars II: Substance abuse and America's prison population.*

National Institute on Drug Abuse. (2020). *DrugFacts: Criminal Justice*. Retrieved January 12, 2023, from https://nida.nih.gov/publications/drugfacts/criminal-justice#:~:text=There%20are%20high%20rates%20of%20substance%20use%20within,higher%20risk%20for%20overdose%20following%20release%20from%20incarceration.

Substance Abuse and Mental Health Services Administration. (2021). Racial/ethnic differences in substance use, substance use disorders, and substance use treatment utilization among people aged 12 or older (2015-2019). Publication No. PEP21-07-01-001. Retrieved January 12, 2023, from https://www.samhsa.gov/data/sites/default/files/reports/rpt35326/2021NSDUHSUChartbook.pdf

Substance Abuse and Mental Health Services Administration. *(2018-2019). 2018-2019 National Survey On Drug Use And Health: Model-Based Prevalence Estimates (50 States And The District Of Columbia)*. Retrieved December 26, 2022, from https://www.samhsa.gov/data/report/2018-2019-nsduh-state-prevalence-estimates

Substance Abuse and Mental Health Services Administration. (2018). *2018 National Survey on Drug Use and Health: Lesbian, Gay, & Bisexual (LGB) Adults*. Retrieved January 12, 2023, from https://www.samhsa.gov/data/sites/default/files/reports/rpt23252/7_LGB_2020_01_14_508.pdf

University of Wisconsin, Population Health Institute. (2023). *County Health Rankings*. Retrieved May 18, 2023, from https://www.countyhealthrankings.org/explore-health-rankings/indiana/marion?year=2023

U.S. Census Bureau. (2021). *QuickFacts Marion County, Indiana*. Retrieved December 23, 2022, from https://www.census.gov/quickfacts/fact/table/marioncountyindiana/PST045221#PST045221

U.S. Census Bureau. (2021). *American Community Survey 1-Year Estimates*. Retrieved May 16, 2023, from https://data.census.gov/table?q=Language+Spoken+at+Home&g=050XX00US18097&tid=ACSST1Y2021.S1602

U.S. Department of Health and Human Services. (n.d.). *Social Determinants of Health*. Retrieved December 23, 2022, from https://health.gov/healthypeople/priority-areas/social-determinants-health

U.S. Department of Housing and Urban Development. (2017). *The 2016 Annual Homeless Assessment Report (AHAR) to Congress*. Retrieved January 12, 2023, from https://www.huduser.gov/portal/sites/default/files/pdf/2016-AHAR-Part-2.pdf

U.S. Health Resources & Services Administration. (n.d.). *Workforce shortage areas*. Retrieved May 16, 2023, from https://bhw.hrsa.gov/workforce-shortage-areas