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Hamilton County Behavioral Health Needs Assessment

First Public Edition · 2026

A comprehensive assessment of behavioral health trends, workforce capacity, and community needs across Hamilton County, Indiana

Built with support from Hamilton County Commissioners

HAMILTON COUNTY
INDIANA

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Where Insight Becomes Action

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Dear Community Leaders and Partners,

In 2021, Community Solutions Inc. published the first Hamilton County Behavioral Health Needs Assessment. That report was a watershed moment for our community—it gave us, for the first time, a data-driven picture of the behavioral health challenges facing one of Indiana's most prosperous counties. It confirmed what many service providers and families already knew: that beneath our strong economic indicators, a growing number of residents were struggling with depression, anxiety, substance use, and suicidal ideation.

Five years later, the landscape has changed dramatically. A global pandemic reshaped how we think about mental health. The 988 Suicide & Crisis Lifeline launched nationally. Indiana enacted Senate Bill 1, the Behavioral Health Matters Act. And Hamilton County's population grew by over 30,000 people. The original assessment's data—drawn primarily from 2019 and 2020 vintages—could no longer capture the reality of our community's needs.

This updated assessment began as a workforce analysis. As Invest Hamilton County began mapping the behavioral health workforce, it became immediately clear that the workforce story could not be told in isolation. Provider shortages only matter in the context of demand. Compensation challenges only matter when you understand what communities are asking of these professionals. And pipeline gaps only matter when you see the crisis events, the treatment barriers, and the unmet need that those missing providers represent. We needed the full picture.

What emerged is the most comprehensive behavioral health assessment ever produced for Hamilton County —15 sections drawing from more than 220 academic and institutional research sources, 470 federal and state data files, and proprietary workforce intelligence covering 19 behavioral health occupations. It spans from national trends to census-tract-level analysis, from youth mental health events to employer cost modeling, from the opioid prescribing trajectory to the social determinants that shape who gets sick and who gets help.

I want to acknowledge the extraordinary leaders and organizations who make this work possible. Aspire Indiana Health, Hamilton County's sole Community Mental Health Center, serves as the front line of care for our most vulnerable residents. The Hamilton County Health Department, Community Health Network, IU Health, and St. Vincent provide critical infrastructure. Our six school corporations—Hamilton Southeastern, Carmel Clay, Noblesville, Westfield Washington, Hamilton Heights, and Sheridan—are increasingly the first

point of contact for young people in crisis. And the countless providers, counselors, social workers, and advocates who show up every day in a system that asks more of them than it gives back—this report is built on the foundation they have laid.

This assessment is a needs assessment, not an action plan. It presents the data as clearly and completely as we can. The decisions about how to respond belong to you—the elected officials, healthcare leaders, school administrators, employers, nonprofit executives, and community members who will shape Hamilton County's path forward. We believe the evidence speaks clearly, and we are committed to supporting the community with data, analysis, and insight as those decisions are made.

We are grateful for the leadership of the Hamilton County Board of Commissioners in supporting this work, and we are encouraged by investments like Aspire Indiana Health's new RELY Center—Hamilton County's first dedicated crisis stabilization and 23-hour observation facility. These are the kinds of infrastructure commitments that turn data into action.

A companion interactive dashboard is available for deeper exploration of the data presented in this report. Scan the QR code below or visit the link to filter indicators by geography, compare counties, and explore workforce analytics in real time.

Companion Interactive Dashboard

Explore the data at

data.investhamiltoncounty.com/behavioral-health

Mike Thibideau

President & CEO

Invest Hamilton County

WHERE INSIGHT BECOMES ACTION

SECTION 01

EXECUTIVE SUMMARY

Hamilton County, Indiana, appears, by nearly every conventional measure, to be one of the healthiest and most prosperous communities in the United States. Its residents earn more, live longer, and are better educated than those in the vast majority of American counties. Its schools are nationally ranked. Its unemployment rate hovers near historic lows. To a corporate site selector or a relocating family, this is one of the most desirable ZIP codes in America. And yet, beneath these extraordinary indicators of economic strength, a behavioral health crisis is unfolding that demands the attention of every leader, institution, and resident in this community.

This assessment is the product of a comprehensive, multi-source analysis that draws on 23 federal data systems, state surveillance platforms, local provider networks, 48 peer-reviewed academic papers, and more than 30 institutional research reports. It is the most complete quantitative portrait of behavioral health in Hamilton County ever assembled. Its findings are not comfortable. They challenge the narrative that affluence insulates a community from the forces reshaping mental health across America. And they make a compelling case that Hamilton County's greatest long-term risk is not an economic downturn or a talent shortage—it is the quiet erosion of behavioral health that, left unaddressed, will undermine every other investment this community makes.

The central paradox of this assessment can be summarized simply: Hamilton County ranks in the top 10% of large American counties on nearly every measure of economic well-being, yet its mental health crisis events have increased 238% in six years, its provider workforce is federally designated as critically short, and nearly one in four of its adults reports a depression diagnosis. These are not the statistics of a community at risk. They are the statistics of a community in crisis—one that has, until now, lacked the data infrastructure to see the full picture.

The Numbers That Define the Challenge

Before diving into the full narrative, these ten indicators frame the scope of what this assessment has found. Each number is drawn from a validated federal or state data source, and each tells a part of a larger story that unfolds across the 18 sections of this report.

387,036

POPULATION (2025 EST.)

Census PEP Vintage 2025 [Census PEP, 2025]

22.9%

ADULT DEPRESSION PREVALENCE

CDC PLACES 2026 (age-adj.) [CDC PLACES, 2026]

3.5x

INCREASE IN MH CRISIS EVENTS

6,334 (2017) to 21,432 (2023) [Indiana MPH, 2017-2024]

19/25

HPSA MENTAL HEALTH SCORE

Critical shortage designation [HRSA HPSA, 2025]

The population figure—387,036—matters because Hamilton County is not a small, rural community where one hospital closure or one factory layoff can distort the data. This is Indiana's fourth-largest county and one of the fastest-growing in the nation, adding roughly 48,000 residents since 2017 alone. The behavioral health trends documented in this report are occurring at significant scale.

The depression prevalence of 22.9% means that roughly one in four adults in Hamilton County—approximately 66,400 adults—reports having been told by a health professional that they have depression. That figure is lower than most of the county's neighbors (Marion County stands at 25.3%, Madison County at 27.7%), but it is strikingly high for a community with Hamilton County's socioeconomic profile. Depression at this level is not a niche concern. It is a population-level condition that affects workplaces, schools, families, and health systems across the county.

The 3.5-fold increase in mental health crisis events—from 6,334 EMS and emergency department encounters in 2017 to 21,432 in 2024 (peaking at 22,138 in 2023)—is the single most alarming finding in this assessment. The county's population grew 17.5% over that same period. The crisis volume grew 238%. This is not a story of population growth driving higher numbers. It is a story of genuine escalation in behavioral health acuity, crisis severity, and system demand that far outstrips the community's growth.

The HPSA score of 19 out of 25 [HRSA HPSA, 2025] **is the federal government's way of saying that Hamilton County has a critical shortage of mental health professionals, particularly for its most vulnerable residents. On a scale where 25 represents the most severe possible shortage, a score of 19 places Hamilton County in the upper tier of need—in a state where all 92 counties already carry mental health shortage designations.**

14.3

DRUG OVERDOSE DEATHS PER 100K

CHR 2025; up from 12.7 in 2024 [CHR, 2025]

1,783

SUICIDAL/ SELF-HARM EVENTS

2024 (Indiana MPH) [Indiana MPH, 2017-2024]

9th

RANK ON MENTAL DISTRESS

Out of 292 large U.S. counties [IHC National Benchmark Index, 2025]

–32%

OPIOID PRESCRIBING DECLINE

6.18 (2013) to 4.19 (2023) [CMS Medicare Part D, 2013-2023]

The drug overdose death rate of 14.3 per 100,000 residents tells two stories at once. Compared to the peer median of 22.8 among large U.S. counties, Hamilton County's rate is relatively low—ranking 42nd out of 292. But the rate increased from 12.7 to 14.3 between the 2024 and 2025 County Health Rankings releases, meaning the trajectory is worsening even as the absolute number remains below the national average. In a county of this size, 14.3 per 100,000 translates to roughly 53 overdose deaths per year—families shattered, futures lost, communities diminished.

The 1,783 suicidal and self-harm events recorded by Indiana's Management Performance Hub in 2024 represent people in the most acute form of behavioral health crisis—individuals who reached a point where they attempted to end their lives or cause themselves serious harm, and whose distress was severe enough to trigger an EMS response or emergency department visit. This number has nearly tripled since 2017, when 749 such events were recorded. Among children under 18, the increase is even more stark: from 55 events in 2017 to 358 in 2024—a more than six-fold increase.

The 9th-place ranking on frequent mental distress deserves careful interpretation. Among 292 large U.S. counties with populations exceeding 250,000, Hamilton County has the 9th-lowest rate of residents reporting frequent mental distress—meaning 283 counties have higher rates. This is genuinely good news and reflects the protective effects of the county's economic and educational advantages. But the metric also reveals a gap: even with these protections, 13.6% of Hamilton County adults—roughly 52,600 people—report experiencing mental distress on 14 or more of the past 30 days. That is a large population in sustained psychological pain.

The 32% decline in opioid prescribing is the brightest data point in this assessment. Over 11 years, Hamilton County's Medicare opioid prescribing rate dropped from 6.18% of all Part D claims in 2013 to 4.19% in 2023[CMS Medicare Part D, 2013-2023], and long-acting opioid prescribing fell even further—a 47% decline. This reflects both national policy changes and local prescriber behavior shifts. It is a genuine public health success that demonstrates what sustained, evidence-based intervention can accomplish.

502:1

POPULATION-TO-MH PROVIDER RATIO

CHR 2025; improved from 541:1 [CHR, 2025]

29.2%

ADULTS REPORTING LONELINESS

CHR 2025 (first year measured) [CHR, 2025]

The provider ratio of 502 residents per mental health provider improved from 541:1 in the 2024 County Health Rankings, suggesting that the county is attracting or producing more behavioral health professionals. But the national benchmark is 340:1, and even the improved ratio means that Hamilton County has roughly 48% fewer providers per capita than the average large American county. When the data shifts from all providers to those serving low-income populations, the picture becomes far more severe: the HRSA-designated ratio for low-income residents is 37,129:1.

Finally, the loneliness figure of 29.2%—measured for the first time in the 2025 County Health Rankings—means that nearly one in three Hamilton County adults reports feeling lonely. In 2023, U.S. Surgeon General Vivek Murthy declared loneliness a public health epidemic, noting that the health effects of chronic loneliness are comparable to smoking 15 cigarettes per day. For a suburban county whose geography is defined by car-dependent development, large-lot housing, and limited walkable gathering spaces, this finding carries particular weight.

What This Assessment Found: A Narrative Synthesis

The story this assessment tells unfolds in concentric circles, beginning with the national landscape and narrowing to the neighborhoods within Hamilton County where the data points to the greatest need.

At the national level (Section 2), the United States is contending with what multiple Surgeons General have called a mental health crisis of historic proportions. Nearly 59.3 million American adults[NIMH/NSDUH, 2022]—one in four—experienced a mental illness in 2022, and the COVID-19 pandemic added an estimated 53.2 million cases of major depression and 76.2 million cases of anxiety disorders globally in a single year. Treatment demand surged 24.5% between 2019 and 2023, overwhelming a provider workforce that was already stretched thin. The economic burden of untreated mental illness now exceeds $282 billion annually

in the United States[Tsyvinski et al., Yale/NBER, 2024]**. For young people, the crisis is even more acute: emergency department visits for mental health conditions among adolescents remain elevated above pre-pandemic levels, and social media exposure has been linked to doubled risk of depression and anxiety symptoms among teens. The 2022 transition to the 988 Suicide and Crisis Lifeline—the mental health equivalent of 911—generated over 5 million contacts in its first year, revealing the enormous scale of unmet need.**

Within Indiana (Section 3), the state occupies a complex position. Drug overdose deaths climbed 126% between 2015 and 2021, peaking at 2,789[CDC WONDER, 2015-2024]**—driven primarily by illicit fentanyl. Since that peak, deaths have declined 39% to an estimated 1,695 in 2024**[CDC WONDER, 2015-2024]**, a meaningful improvement that nonetheless leaves the state 37% above its 2015 baseline. Indiana recently moved from 45th to 14th in Mental Health America's state rankings—a dramatic improvement attributed to expanded crisis services, the 988 Lifeline implementation, and Certified Community Behavioral Health Clinics. But challenges remain: all 92 Indiana counties carry mental health shortage designations, the state's mental health provider ratio of 580:1 trails the national average of 340:1**[CHR, 2025]**, and proposed Medicaid changes threaten the coverage expansions that helped drive recent progress. Senate Bill 1, the Behavioral Health Matters Act, represents the state's most ambitious legislative commitment to behavioral health infrastructure, but implementation is just beginning.**

Hamilton County's epidemiological profile (Section 4) reveals the paradox at the heart of this assessment. The county outperforms state and national averages on most behavioral health indicators—lower depression, lower mental distress, lower smoking, lower overdose deaths, lower suicide rates. But the trends within the county are deeply concerning. The 238% increase in mental health crisis events between 2017 and 2023[Indiana MPH, 2017-2024] **represents a genuine acceleration in behavioral health acuity that far outpaces population growth. The 138% increase in suicidal and self-harm events over the same period**[Indiana MPH, 2017-2024]**, with a six-fold increase among children under 18, signals a crisis that is growing more severe and reaching younger populations. The County Health Rankings trend data shows most indicators moving in the wrong direction between 2024 and 2025, including mental distress, poor mental health days, excessive drinking, overdose deaths, and insufficient sleep. And the tract-level data from CDC PLACES reveals that Hamilton County is not one community—it is 57 census tracts with depression rates ranging from 18.9% to 27.0%**[CDC PLACES Tract-Level, 2026] **and smoking rates ranging from 6.1% to 18.0%. The internal variation within Hamilton County is nearly as wide as the variation between Hamilton County and its much-less-affluent neighbors.**

The social determinants analysis (Section 5) explains why a wealthy community can still produce significant behavioral health burden. Hamilton County's economic strengths are real—$118,000 median household income[Census ACS, 2023]**, 4.7% poverty rate, 4.6% uninsured rate—but they coexist with risk factors that are characteristic of affluent suburban communities: 29.2% loneliness**[CHR, 2025]**, elevated alcohol use that exceeds both state and national averages, housing cost pressures that disproportionately burden lower-income residents, and a suburban geography that reduces the casual social contact that protects against**

isolation. Academic research on the "suburban mental health paradox" documents that affluent communities produce distinct mental health risks—achievement pressure, social comparison, emotional isolation from parents, and normalized substance use—that operate alongside, and sometimes despite, strong economic indicators. Hamilton County's profile aligns closely with this research.

THE CENTRAL FINDING

Hamilton County's behavioral health crisis is not a reflection of poverty, unemployment, or systemic neglect. It is a crisis unfolding in one of America's most successful communities—one driven by the same forces reshaping mental health nationwide, amplified by factors unique to affluent suburban life, and made more dangerous by a provider workforce that cannot keep pace with demand. Addressing it will require the same data-driven, evidence-based approach that built this community's economic success.

What This Assessment Demands of Community Leaders

This report is not an alarm bell rung for its own sake. It is a call to evidence-based action by the institutions that shape life in Hamilton County: city governments, the county council, school districts, health systems, employers, nonprofit organizations, and the residents they serve. The data assembled here points to several strategic imperatives that are developed in full in Section 17 (Strategic Recommendations) but deserve framing at the outset.

First, the crisis system needs immediate capacity investment. A county that logged 21,432 mental health crisis events in a single year—and 1,783 suicidal or self-harm events—cannot rely on emergency departments as the de facto behavioral health safety net. Crisis stabilization facilities, mobile crisis teams, and post-crisis follow-up infrastructure are not aspirational. They are urgent.

Second, the workforce pipeline must be rebuilt. A provider ratio of 502:1—48% worse than the national average—and a HPSA score of 19/25 mean that even residents with excellent insurance and financial resources face unacceptable wait times for care. For low-income residents, the ratio is 37,129:1. This is not a gap that can be closed by recruiting a few more psychiatrists. It requires structural investment in training pipelines, scope-of-practice reform, integrated care models, and telehealth infrastructure.

Third, youth behavioral health requires its own strategy. The six-fold increase in suicidal and self-harm events among children under 18—from 55 in 2017 to 358 in 2024—is an emergency. School-based behavioral health services, adolescent crisis pathways, and community education about youth mental health are not optional components of a comprehensive strategy. They are the foundation.

Fourth, the social determinants that drive behavioral health must be addressed upstream. Loneliness, housing burden, food insecurity, and the achievement-pressure culture that characterizes high-performing suburban communities are not clinical problems that can be solved in a therapist's office. They require community-level interventions: built environment changes that foster social connection, employer-sponsored mental health programs, school cultures that balance excellence with well-being, and community norms that destigmatize help-seeking.

Fifth, the data infrastructure that made this assessment possible must be sustained. Hamilton County now has the most comprehensive behavioral health data profile of any community its size in Indiana—drawing on 23 federal sources, state surveillance systems, tract-level CDC modeling, and national benchmarking across 292 peer counties. This data infrastructure should not be a one-time snapshot. It should become a permanent community asset, refreshed annually, tracked longitudinally, and used to hold every intervention accountable to measurable outcomes.

Invest Hamilton County is committed to refreshing and updating the data underlying this assessment annually through the end of 2028, ensuring that community leaders, service providers, and policymakers have current evidence to guide decision-making.

The workforce dimensions of this crisis are explored in depth in a companion report, the *Behavioral Health Workforce Development Analysis 2026*, which provides occupation-by-occupation supply-demand analysis, career pathway architecture, employer tactical strategies, and policy prescriptions for closing the gap.

A NOTE ON THE EVIDENCE STANDARD

Every finding in this assessment is sourced from a named federal, state, or validated local dataset. Academic citations reference the curated Behavioral Health research library maintained by Invest Hamilton County (48 peer-reviewed papers and 32 institutional research reports across 12 topic clusters and 13 organizations). Where data is modeled rather than directly measured—as with CDC PLACES small area estimation—the methodology is explained in plain language. Where trends are based on only two data points, that limitation is noted. This assessment does not speculate. It reports what the data shows, explains what it means, and identifies what it demands.

Data Sources: CDC PLACES 2026 | County Health Rankings 2024-2025 | HRSA HPSA | Indiana MPH Mental Health Events | CMS Medicare Part D Opioid Prescribing | NIMH National Prevalence Statistics | Census PEP Vintage 2025 | National Benchmarking Index (292 counties) | 48 academic papers across 12 topic clusters | 32 institutional research reports from 13 organizations

SECTION 02

THE STATE OF BEHAVIORAL HEALTH IN AMERICA

To understand what is happening in Hamilton County, one must first understand what is happening to America. The behavioral health crisis unfolding across the United States is not a temporary disruption caused by a pandemic. It is a structural transformation in the mental health of the American population—one that began well before COVID-19, was dramatically accelerated by it, and shows no signs of returning to pre-pandemic baselines. This section traces the arc of that transformation, from the national prevalence data that defines its scale to the economic costs that quantify its consequences.

Where We Were: The Pre-Pandemic Baseline

The years immediately before the pandemic were not a golden age of American mental health. They were already a period of growing concern. Between 2009 and 2019, rates of depression among adolescents increased more than 60%. Suicide rates rose 35% between 2000 and 2018, reaching their highest levels in decades. The opioid epidemic had already claimed hundreds of thousands of lives. Behavioral health workforce shortages were well-documented, with approximately 2,774 of the nation's 3,144 counties designated as mental health professional shortage areas.

But there was a broadly shared assumption—among policymakers, health systems, and the public—that mental health challenges were concentrated in specific populations: the severely mentally ill, the economically disadvantaged, the chronically addicted. The pandemic shattered that assumption. It demonstrated that behavioral health vulnerability is not confined to the margins of American life. It exists across every income level, every age group, every ZIP code—including, and perhaps especially, in communities like Hamilton County that had long considered themselves insulated from such concerns.

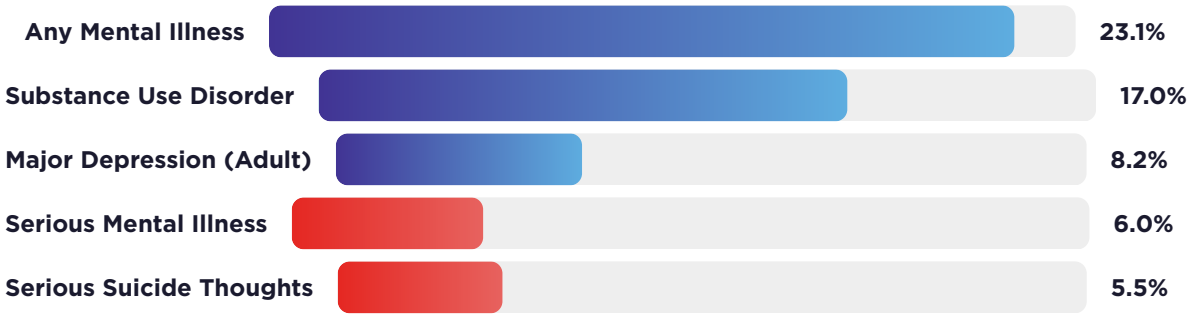
The Scale of the Crisis: National Prevalence

The National Institute of Mental Health, drawing on the 2022 National Survey on Drug Use and Health, estimates that 59.3 million American adults aged 18 or older—23.1% of the adult population—experienced any mental illness (AMI) in the survey year. To put that in perspective: if the Americans living with mental illness formed their own country, it would be the 25th most populous nation on earth, larger than Spain, Canada, or Australia. One in four adults. In a workplace of 200 people, that is 46 colleagues. In a school district with 20,000 students and 2,000 staff, that is approximately 460 staff members. In Hamilton County's population of 387,036, it translates to roughly 89,400 adults—enough to fill Lucas Oil Stadium twice over.1

Of those 59.3 million adults, 15.4 million—6.0% of the adult population—experienced a serious mental illness (SMI) that substantially interfered with one or more major life activities, such as maintaining employment, caring for children, or managing daily responsibilities. An additional 48.7 million adults aged 12 or older met the diagnostic criteria for a substance use disorder, and 5.5% of all adults reported serious thoughts of suicide in the past year.1

The burden is not distributed evenly. Women experience AMI at higher rates than men (26.4% versus 19.7%), though men die by suicide at nearly four times the rate of women. Young adults aged 18 to 25 carry the highest prevalence of any mental illness at 36.2%—more than one in three—which is nearly triple the rate among adults aged 50 and older (13.9%). Racial disparities persist: adults identifying as two or more races report the highest AMI prevalence at 35.2%, followed by American Indian/Alaska Native adults at 26.6%.1

National Prevalence: Key Indicators



Source: NIMH, based on 2022 NSDUH and 2024 NSDUH data. Percentages represent adult prevalence (18+).

The Treatment Gap: What "Untreated" Actually Looks Like

The most consequential number in the national prevalence data may not be the 59.3 million who experienced mental illness. It may be the 29.3 million who experienced mental illness and received no treatment whatsoever. Among adults with any mental illness in 2022, only 50.6%—30.0 million people—received

mental health treatment in the past year. Among those with serious mental illness, the treatment rate was higher (66.7%), but one in three adults with SMI—people with conditions severe enough to substantially impair daily functioning—went entirely untreated.1

Understanding what "untreated" means in practice is essential for any community leader reading this assessment. Untreated mental illness does not simply mean that a person feels sad or anxious without seeing a therapist. It means that the full weight of serious psychological conditions—major depression, bipolar disorder, PTSD, schizophrenia, severe anxiety disorders—is absorbed by systems and institutions that were never designed to manage them. Untreated mental illness shows up as homelessness, because people cannot maintain the stability required to keep housing. It shows up in emergency departments, because crisis is the only entry point available. It shows up in jails and prisons, because the criminal justice system becomes the behavioral health system of last resort. It shows up in lost productivity, because workers cannot concentrate, cannot show up reliably, and cannot advance. And it shows up in premature death, because untreated mental illness is a leading risk factor for suicide, overdose, and chronic disease.

The demographics of the treatment gap reveal who is most likely to fall through the cracks. Women with AMI were more likely to receive treatment (56.9%) than men (41.6%), a pattern consistent with research showing that men are less likely to recognize symptoms, less likely to seek help, and more likely to self-medicate with alcohol and substances. Treatment utilization was lowest among young adults aged 18 to 25 (49.1%)—a cruel irony, since that is the age group with the highest prevalence. Among racial and ethnic groups, non-Hispanic White adults had the highest treatment rates, while Hispanic, Black, and Asian adults faced significantly lower rates of treatment access.1

59.3M

ADULTS WITH ANY MENTAL ILLNESS

23.1% of U.S. adults (2022) [NIMH/NSDUH, 2022]

49.4%

AMI ADULTS UNTREATED

29.3 million received no treatment [NIMH/NSDUH, 2022]

66.7%

SMI TREATMENT RATE

10.2M of 15.4M received care [NIMH/NSDUH, 2022]

For Hamilton County, the treatment gap has a specific local dimension. The county's high insurance rate (95.4% coverage) removes one major barrier to treatment access, but insurance coverage alone does not guarantee access to care. When the population-to-provider ratio is 502:1—and when many private-practice providers do not accept insurance or have wait lists of 6 to 8 weeks—even well-insured residents may find themselves functionally unable to access timely behavioral health care. For the county's Medicaid population, access is even more constrained: nationally, only 36% of psychiatrists accept new Medicaid patients, a figure that is likely comparable or worse in Hamilton County's provider market.

The COVID-19 Inflection Point

The COVID-19 pandemic did not create America's behavioral health crisis. But it transformed it from a slow-moving trend into an acute emergency. The mechanisms were multiple and compounding: physical isolation disrupted the social connections that protect mental health; grief from the loss of nearly 1.2 million Americans was experienced collectively and individually; economic disruption upended household stability for tens of millions of families; school closures removed the single most important non-family institution in children's lives; and the constant uncertainty of a novel threat imposed a chronic stress load on the entire population.

A landmark analysis published in *The Lancet* by Santomauro and the COVID-19 Mental Disorders Collaborators quantified the pandemic's impact with unusual precision. Their modeling estimated that the pandemic generated 53.2 million additional cases of major depressive disorder globally in 2020—a 27.6% increase over pre-pandemic levels—and 76.2 million additional cases of anxiety disorders, a 25.6% increase. Women and younger populations bore the greatest burden, and the severity of impact correlated directly with the severity of pandemic indicators (infection rates and mobility restrictions) in each country.2

In the United States, the Kaiser Family Foundation tracked the domestic impact in real time, documenting that approximately 4 in 10 adults reported symptoms of anxiety or depression during the pandemic—up from approximately 1 in 10 before it began. Three years after the pandemic's onset, the elevated rates had not returned to baseline. Ninety percent of adults surveyed believed the country was facing a mental health crisis.3

A meta-analysis by Sun and colleagues, published in the *Journal of Affective Disorders* in 2024, examined 134 studies to determine whether the pandemic's mental health impact was a temporary shock or a structural shift. Their finding was clear: population-level mental health symptoms increased significantly during the first year of the pandemic, with the magnitude of increase corresponding to the severity of pandemic indicators in each study population. The dose-response relationship they identified—more severe pandemic conditions produced more severe mental health consequences—suggests that the impact was not merely a reflection of media anxiety or reporting bias but a genuine biological and psychological response to prolonged stress, isolation, and uncertainty.4

POST-COVID TREATMENT DEMAND: A PERMANENT SHIFT

CDC data published in the MMWR shows that the percentage of U.S. adults receiving any mental health treatment rose from 19.2% in 2019 to 23.9% in 2023—a 24.5% increase in treatment utilization over four years. This is not a temporary surge that will recede as pandemic memories fade. It reflects a permanent expansion of the population seeking behavioral health services—driven by both increased need and reduced stigma. The provider workforce that was inadequate before the pandemic is now contending with a structurally larger patient population.

For Hamilton County, the pandemic's behavioral health impact is visible in the crisis event data. The county's mental health EMS/ED events were already climbing before the pandemic—from 6,334 in 2017 to 10,430 in 2019, a 65% increase in two years. But the pandemic produced a step-change: events jumped 19% in a single year (2019 to 2020), then nearly doubled in 2021 (12,368 to 20,832), suggesting that the pandemic broke through a threshold of behavioral health system capacity that had been under increasing strain for years. The fact that events have remained above 20,000 annually since 2021—even as the acute pandemic receded—confirms that the pandemic's impact on behavioral health was not temporary. It was structural.

The Youth Mental Health Crisis

If the adult mental health crisis is alarming, the youth mental health crisis is an emergency. In 2021, U.S. Surgeon General Vivek Murthy took the extraordinary step of issuing a public advisory on youth mental health—a designation reserved for the most pressing public health threats. The advisory documented that rates of depression among adolescents had already increased more than 60% between 2009 and 2019, that one in three high school students reported persistent feelings of sadness or hopelessness (a 40% increase over the prior decade), and that emergency department visits for suspected suicide attempts among adolescent girls increased 51% in early 2021 compared to early 2019.5

The CDC's surveillance data confirmed and extended these findings. Bitsko and colleagues, in a 2023 MMWR analysis, documented that adolescent emergency department visits for mental health conditions remained elevated through early 2023 compared to pre-pandemic levels. While some indicators showed modest improvement from their 2021 peaks, none had returned to pre-pandemic baselines. The analysis underscored a critical point: the youth mental health crisis is not resolving on its own.6

Longitudinal data from the NIH's ECHO Program, analyzed by Madigan and colleagues and published in *JAMA Network Open*, provided the strongest evidence to date that pandemic-era mental health deterioration among youth was genuine and persistent. Youth in the study showed significant increases in internalizing symptoms (anxiety and depression) from pre-pandemic to pandemic periods. The effects were larger among girls and older adolescents. And critically, symptoms had not returned to pre-pandemic baselines by the most recent assessments, suggesting that an entire cohort of young people may carry elevated mental health burden into adulthood.7

Analysis of the National Survey of Children's Health by Lebrun-Harris and colleagues found that rates of diagnosed anxiety, depression, and behavioral conditions among U.S. children and adolescents increased significantly from 2016 to 2021, with anxiety diagnoses nearly doubling among children aged 3 to 17 during this period. This is not a crisis confined to teenagers on social media. It reaches into elementary schools and pediatric offices, affecting children far younger than the public conversation typically imagines.8

THE SOCIAL MEDIA FACTOR

A 2023 Surgeon General's Advisory found that adolescents spending more than 3 hours daily on social media face double the risk of depression and anxiety symptoms, while the average American teen uses social media 4.8 hours per day. Jonathan Haidt's research documents what he calls "the Great Rewiring of Childhood" between 2010 and 2015, as adolescents transitioned from flip phones to smartphones. During this period, anxiety incidence among teens increased 134% and depression 106%. A meta-analysis by Shannon and colleagues confirmed moderate but statistically significant correlations between problematic social media use and depression, anxiety, and stress among adolescents and young adults. For Hamilton County—where household smartphone penetration is nearly universal and teens have ready access to technology—these findings carry direct relevance.

In Hamilton County, the youth crisis is visible in the MPH data. Suicidal and self-harm events among residents under 18 increased from 55 in 2017 to 358 in 2024[Indiana MPH, 2017-2024]—a more than six-fold increase. Nonphysical mental health events among minors rose from 233 to 2,021[Indiana MPH, 2017-2024] over the same period. These are children—many of them students in the county's nationally ranked school districts—whose distress is severe enough to generate emergency medical responses. Section 8 of this report provides a dedicated analysis of youth behavioral health in Hamilton County, but the national context presented here makes clear that what is happening locally is part of a generational crisis that no community can afford to ignore.

The 988 Suicide and Crisis Lifeline: A System Transformation

On July 16, 2022, the United States completed one of the most significant infrastructure changes in the history of behavioral health care: the transition from the 10-digit National Suicide Prevention Lifeline (1-800-273-8255) to the three-digit 988 Suicide and Crisis Lifeline. The change was more than a phone number. It represented a fundamental reconceptualization of how the nation responds to behavioral health emergencies. Just as 911 created a universal entry point for police, fire, and medical emergencies, 988 was designed to create a universal entry point for behavioral health crises—signaling that mental health emergencies deserve the same immediate, professional response as a heart attack or a house fire.

The response was immediate and overwhelming. In its first full year of operation, 988 received more than 5 million contacts—calls, texts, and chats—from individuals in crisis or seeking support. That volume revealed two things simultaneously: the enormous scale of unmet behavioral health need in the United States, and the public's willingness to seek help when barriers are reduced. The simplicity of a three-digit number, combined with the availability of text and chat options for populations uncomfortable with phone calls (particularly younger users), removed a critical access barrier that had kept millions of people from reaching out.

Indiana's 988 implementation operates through existing crisis centers, routing contacts to local providers based on caller geography. The system has expanded access to crisis support, particularly in after-hours and weekend periods when traditional providers are unavailable. However, capacity challenges remain, particularly for follow-up care after the initial crisis contact. A person who calls 988 at 2 a.m. in acute distress can receive immediate support, but connecting that person to ongoing care in a county with a 502:1 provider ratio remains a significant challenge.

National Suicide Trends

NIMH data documents that the total age-adjusted suicide rate in the United States increased 35.2% from 10.4 per 100,000 in 2000 to 14.2 per 100,000 in 2018, before declining slightly to 13.5 per 100,000 in 2020. The 2024 NSDUH data indicates that 5.5% of adults aged 18 and older had serious thoughts of suicide in the past year, with the highest prevalence among young adults aged 18 to 25 (12.6%)—meaning roughly one in eight young adults contemplated ending their life in the past year. The prevalence of past-year suicide attempts was highest among the same group (2.0%) and among adults identifying as two or more races (1.9%).1

Research from the American Institute for Boys and Men adds a critical gender dimension to the suicide data: 80% of U.S. suicide deaths are among boys and men, a ratio that has persisted for decades. The suicide rate among young men is rising faster than among any other demographic group. Sagamore Institute's 2026 report on Indiana boys documents that males in Indiana have a suicide rate four times that of females—a finding with direct implications for Hamilton County's intervention strategies.

+35%

SUICIDE RATE INCREASE

2000 to 2018 (age-adjusted) [NIMH/NSDUH, 2022]

12.6%

YOUNG ADULTS: SERIOUS SUICIDE THOUGHTS

Ages 18-25, NSDUH 2024 [NIMH/NSDUH, 2022]

5M+

988 CONTACTS IN YEAR 1

Calls, texts, and chats [SAMHSA 988, 2023]

80%

MALE SHARE OF SUICIDE DEATHS

AIBM, 2025 [AIBM, 2025]

The Economic Costs of Untreated Mental Illness

The human costs of untreated behavioral health conditions—suffering, lost potential, shattered families—resist quantification. But the economic costs do not. And they are staggering.

A 2024 study by Yale economists estimated that mental illness costs the U.S. economy $282 billion annually—approximately 1.7% of aggregate consumption. This figure is roughly 30% larger than previous estimates because the methodology accounted for the ways mental illness changes not just earnings but also investment patterns, spending decisions, and labor market behavior across an individual's lifetime. The $282 billion annual burden exceeds the GDP of most countries and represents a cost larger than the annual revenue of all but a handful of American corporations.9

Closer to home, a study published in *JAMA Health Forum* by Taylor and colleagues at Indiana University estimated that untreated mental illness costs Indiana $4.2 billion annually[Taylor et al., JAMA Health Forum, 2023]—1.2% of the state's GDP. The study examined approximately 429,407 Indiana residents and found that the costs comprised $3.3 billion in indirect costs (primarily lost productivity and premature mortality), $708.5 million in direct healthcare costs, and $185.4 million in non-healthcare costs. Premature mortality accounted for the single largest share at $1.4 billion. This is not an abstract national figure. This is a study of Indiana residents, using Indiana data, quantifying Indiana costs. For Hamilton County—a high-wage, knowledge-economy county where worker productivity is among the highest in the state—the per-capita cost of untreated behavioral health conditions is likely even higher than the state average.10

A Shifting Treatment Paradigm

Amid the crisis, the national behavioral health landscape is also undergoing a genuine transformation in how care is delivered. Integrated care models—embedding behavioral health professionals within primary care settings—have expanded significantly since 2020. The Milbank Memorial Fund documented in 2025 that integrated behavioral health in primary care functions as both treatment and prevention, with evidence of improved outcomes and reduced costs. The Collaborative Care Model has demonstrated 2 to 3 times better depression outcomes compared to usual care. Telehealth for behavioral health, which expanded dramatically during the pandemic, remains a critical access point: approximately 40% of mental health visits are still delivered virtually, and a meta-analysis of 39 studies found pooled acceptability of tele-mental health services at 71% among beneficiaries.

The Certified Community Behavioral Health Clinic model has expanded to over 500 clinics in 46 states, providing a pathway to sustainable, comprehensive behavioral health service delivery. Mental health parity enforcement continues to evolve, with the 2024 final rule requiring insurers to conduct comparative analyses of nonquantitative treatment limitations. These national trends create both opportunities and expectations for Hamilton County's behavioral health system—and they inform the strategic recommendations in Section 17 of this assessment.

Methodological Note

National prevalence estimates in this section draw primarily from the NIMH compilation of NSDUH data (2022 and 2024 releases), CDC MMWR surveillance reports, and peer-reviewed meta-analyses. The NSDUH achieved an overall response rate of 11.3% for adults in 2024 (21.9% screening rate, 51.5% interview completion), which may introduce non-response bias. Prevalence estimates should be interpreted as conservative lower bounds. Academic citations referenced throughout this section are drawn from the curated Behavioral Health research library maintained by Invest Hamilton County (48 papers across 12 topic clusters).

Sources: [1] NIMH National Prevalence Statistics (2022 NSDUH, 2024 NSDUH) | [2] Santomauro et al., The Lancet 2021;398:1700-1712 | [3] Panchal et al., KFF Issue Brief 2023 | [4] Sun et al., J Affect Disord 2024;354:175-182 | [5] U.S. Surgeon General Youth Mental Health Advisory, 2021 | [6] Bitsko et al., MMWR 2023;72(19) | [7] Madigan et al., JAMA Network Open 2024;7(1):e2349935 | [8] Lebrun-Harris et al., Prev Chronic Dis 2024;21:240142 | [9] Tsyvinski et al., Yale 2024 | [10] Taylor et al., JAMA Health Forum 2023;4(10):e233535 | AIBM Suicide Data Spotlight 2025 | Sagamore Institute, Failure to Launch 2026 | Milbank Memorial Fund, IBH 2025

SECTION 03

INDIANA CONTEXT

Indiana occupies a distinctive and, in many ways, paradoxical position in the national behavioral health landscape. It is a state that has historically performed below national averages on most mental health and substance use indicators—higher smoking rates, higher overdose mortality, fewer providers per capita—yet has recently demonstrated some of the most dramatic improvements in the country. The story of Indiana's behavioral health trajectory is one of crisis, investment, and early returns—with significant risks on the horizon that could reverse hard-won progress.

A Remarkable Turnaround: From 45th to 14th

The most striking data point in Indiana's recent behavioral health history is the state's leap in Mental Health America's annual state rankings from 45th to 14th. Mental Health America evaluates all 50 states and the District of Columbia across 15 indicators measuring prevalence and access to care. Indiana's improvement was the largest single-year gain of any state in the organization's tracking history, and it was driven by measurable progress on multiple fronts: a statistically significant decrease in youth major depressive episodes, the largest decrease in adult substance use disorder prevalence in the nation (from 19.08% to 15.53%), and an 18% decline in overdose deaths.

The drivers of this improvement are identifiable. Indiana's investment in Certified Community Behavioral Health Clinics (CCBHCs) expanded access to comprehensive behavioral health services in communities that previously lacked them. The implementation of the 988 Suicide and Crisis Lifeline created a new entry point for crisis intervention. The state's expansion of Medicaid through the Healthy Indiana Plan (HIP 2.0) extended behavioral health coverage to hundreds of thousands of low-income residents. And sustained community-level investment by organizations like Aspire Indiana Health, which serves Hamilton County, brought innovative models of care to populations that had been historically underserved.

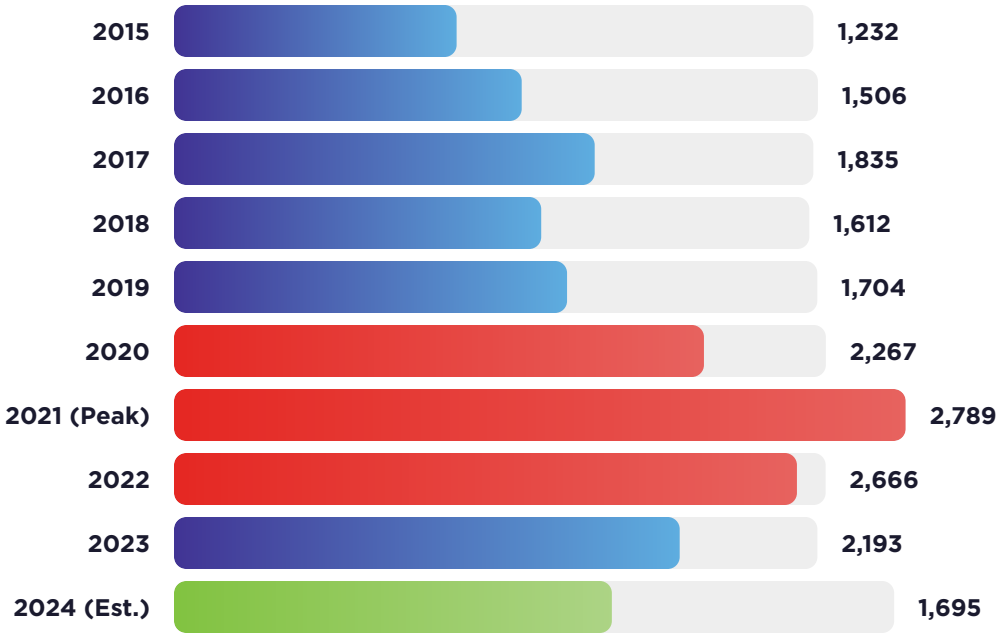
However, Mental Health America noted in its 2025 report that Indiana's progress is at risk. Proposed changes to Medicaid eligibility and funding at the federal level could strip coverage from the very populations that drove the improvement. The lesson of Indiana's 45th-to-14th trajectory is instructive for Hamilton County: behavioral health outcomes can improve dramatically when investment is sustained and evidence-based. But those gains are fragile and contingent on continued political and financial commitment.

Indiana Drug Overdose Deaths: A Decade of Crisis and Recovery

Indiana's drug overdose death toll traces an arc of escalation, peak, and uncertain recovery. The numbers tell the story with brutal clarity. In 2015, 1,232 Hoosiers died from drug overdoses. By 2017, that figure had risen to 1,835—a 49% increase in just two years, driven by the arrival of illicitly manufactured fentanyl in the state's drug supply. A brief dip to 1,612 in 2018 offered false hope; deaths resumed their climb in 2019, reaching 1,704.

Then the pandemic struck. In 2020, overdose deaths surged 33% in a single year, from 1,704 to 2,267. The mechanisms were multiple: treatment disruption as clinics closed or shifted to virtual-only formats, social isolation that removed the human connections that support recovery, economic stress that drove increased substance use, and an increasingly toxic illicit drug supply. The peak came in 2021, when 2,789 Hoosiers died from overdoses—a 23% increase over the already devastating 2020 figure, and a number that translated to roughly 7.6 deaths per day across the state.

Since that peak, the trajectory has reversed. Deaths declined to 2,666 in 2022, fell further to 2,193 in 2023, and reached an estimated 1,695 in 2024—a 39% reduction from the 2021 peak. This decline is genuinely significant and reflects the combined impact of expanded naloxone distribution, medication-assisted treatment, law enforcement interdiction of fentanyl supply chains, and public health education. But the 2024 figure remains 37% above the 2015 baseline, meaning the state has recovered roughly half the ground lost to the fentanyl-driven escalation and still has considerable distance to travel.



Source: CDC WONDER, Indiana Drug Overdose Deaths. 2024 figure is provisional.

2,789

PEAK OVERDOSE DEATHS

2021 — highest on record [CDC WONDER, 2015-2024]

−39%

DECLINE FROM PEAK

2,789 (2021) to 1,695 (2024) [CDC WONDER, 2015-2024]

+37%

STILL ABOVE 2015 BASELINE

1,695 vs. 1,232 [CDC WONDER, 2015-2024]

State Behavioral Health Infrastructure

Indiana's behavioral health system is administered through the Division of Mental Health and Addiction (DMHA) within the Family and Social Services Administration (FSSA). The state operates a network of 24 Community Mental Health Centers (CMHCs) distributed across its 92 counties, which serve as the primary safety net for individuals with serious mental illness and substance use disorders. Hamilton County falls within the service area of Aspire Indiana Health, one of the state's larger and more innovative CMHCs, which holds a Federally Qualified Health Center Look-Alike designation.

The state's data surveillance infrastructure operates through several channels. The Indiana Management Performance Hub (MPH) integrates data from EMS, emergency departments, law enforcement, and coroner reports—providing the mental health event tracking that forms one of the most powerful datasets in this

assessment. The Indiana Prevention Resource Center (IPRC) at Indiana University provides additional prevalence data, particularly for youth substance use. The State Epidemiological Outcomes Workgroup (SEOW) coordinates behavioral health surveillance under SAMHSA's Strategic Prevention Framework.

Indiana Senate Bill 1, the Behavioral Health Matters Act, represents the state's most ambitious recent legislative commitment to behavioral health infrastructure. The law creates a framework for expanded crisis services, workforce development, and integration between behavioral health and primary care systems. Its implementation is in early stages, and the degree to which it will translate into tangible service improvements at the county level remains to be determined. But the legislation signals a recognition at the state level that behavioral health is not a niche concern but a core component of public infrastructure.

Indiana Youth: A Generation Under Pressure

Indiana Youth Institute's 2025 KIDS COUNT Data Book ranks Indiana 27th nationally for overall child well-being—a middling position that masks sharp concerns in the behavioral health domain. Among Indiana students in grades 7 through 12, 29.9% reported feeling sad or hopeless for two or more consecutive weeks in the past year. In the 2024 KIDS COUNT analysis, 17% of Indiana high school students reported seriously considering suicide, and the state ranked 10th worst in the nation for children at risk of depression.

Sagamore Institute's 2026 report, "Failure to Launch," adds a gendered dimension to the youth data that is particularly relevant. The report documents that Indiana boys outperform girls through high school but then "cliff"—fewer boys graduate (88.7% versus 91.8%), and far fewer enroll in college (45.2% versus 58.1% for girls). Males in Indiana have a suicide rate four times that of females. Alcohol use among Indiana youth leaps from 10% to 43.8% by 12th grade. The report's advisory group identified relationship deficits, social media, and fatherlessness as key contributing factors—a finding with direct implications for Hamilton County's youth behavioral health strategy.

State vs. National vs. Hamilton County Comparison

The following table places Hamilton County within the context of Indiana and national averages, revealing where the county's advantages are strongest and where concerning patterns emerge.

INDICATOR	INDIANA	NATIONAL AVG.	HAMILTON COUNTY
Adult Smoking Rate	18.8%	14.0%	9.3%
Drug Overdose Death Rate (per 100K)	30.2	28.6	14.3

INDICATOR	INDIANA	NATIONAL AVG.	HAMILTON COUNTY
Suicide Rate (per 100K, age-adj.)	14.8	14.2	11.5
Excessive Drinking	18.1%	19.5%	20.3%
Depression Prevalence (age-adj.)	24.5%	21.4%	22.9%
Frequent Mental Distress	16.8%	15.5%	14.2%
MH Provider Ratio (pop:provider)	580:1	340:1	502:1

Sources: CHR 2025, CDC PLACES 2026, HRSA Area Health Resources File. National averages from CHR 2025 national benchmarks.

The comparison reveals a nuanced picture. Hamilton County outperforms both Indiana and national averages on smoking, overdose deaths, suicide, and mental distress—reflecting the strong protective effects of the county's socioeconomic advantages. But three patterns warrant attention. First, the county's excessive drinking rate of 20.3% exceeds both the state average (18.1%) and the national average (19.5%), placing it among the highest in central Indiana. This is a consistent finding across multiple data sources and aligns with national research documenting elevated alcohol use in affluent suburban communities. Second, the county's depression prevalence of 22.9%—while lower than the state's 24.5%—exceeds the national average of 21.4%, suggesting that Indiana's overall elevated depression burden extends even into its most prosperous counties. Third, the county's provider ratio of 502:1, while better than Indiana's 580:1, remains 48% worse than the national average of 340:1, meaning residents face meaningful access barriers regardless of the county's relative position within the state.

ALL 92 COUNTIES: MENTAL HEALTH SHORTAGE AREAS

Every county in Indiana carries some form of mental health professional shortage designation from HRSA. KFF documented in February 2026 that 4.7 million Hoosiers—essentially the entire state population—live in a mental health HPSA. Hamilton County's shortage is not an anomaly within Indiana. It is the norm. The question for Hamilton County is not whether a shortage exists but how the county's relative resources and leadership can be deployed to build the workforce pipeline that the entire state needs.

Sources: CDC WONDER Drug Overdose Deaths (Indiana, 2015-2024) | Mental Health America, State of Mental Health 2025 | Indiana Youth Institute KIDS COUNT 2024-2025 | Sagamore Institute, Failure to Launch 2026 | KFF Mental Health Care HPSAs 2026 | HRSA HPSA Mental Health Summary | CHR 2025 State Snapshots | Indiana FSSA/DMHA | Indiana MPH Data Hub

SECTION 04

HAMILTON COUNTY EPIDEMIOLOGICAL PROFILE

This is the section where the data comes home. The national trends described in Section 2 and the state context established in Section 3 create the backdrop against which Hamilton County's own behavioral health data must be interpreted. What follows is the most comprehensive epidemiological profile of behavioral health in Hamilton County ever assembled—drawing on six distinct data systems, spanning up to 11 years of longitudinal data, and reaching from the county level down to individual census tracts. The picture it reveals is one of a community whose remarkable advantages are real but insufficient to prevent a behavioral health crisis that has been building for years and is now operating at scale.

Population Context: A County in Motion

Hamilton County's population reached an estimated 387,036 as of July 2025[Census PEP, 2025]**, making it Indiana's fourth-largest county and one of the fastest-growing in the nation. The county added approximately 48,000 residents between 2017 and 2024, growing from 323,225 to 371,645**[Census PEP, 2025]**—a 17.5% increase. This growth is driven by strong in-migration from Marion County and out-of-state relocations, attracted by the county's school systems, safety, housing stock, and employment opportunities.**

The growth matters for behavioral health in two ways. First, it creates a mechanically larger population generating more absolute demand for services—even if rates remained flat, a 17.5% population increase would produce 17.5% more people needing care. Second, rapid growth brings demographic shifts that affect behavioral health needs. New residents may lack established social networks, increasing isolation risk. Families relocating from urban environments may experience cultural adjustment stress. And the infrastructure required to serve a growing population—providers, facilities, crisis systems, school counselors—takes years to build and cannot be switched on like a light.

387,036	+15%	$118K+	4.7%
POPULATION (JULY 2025)	GROWTH (2017–2024)	MEDIAN HOUSEHOLD INCOME	POVERTY RATE

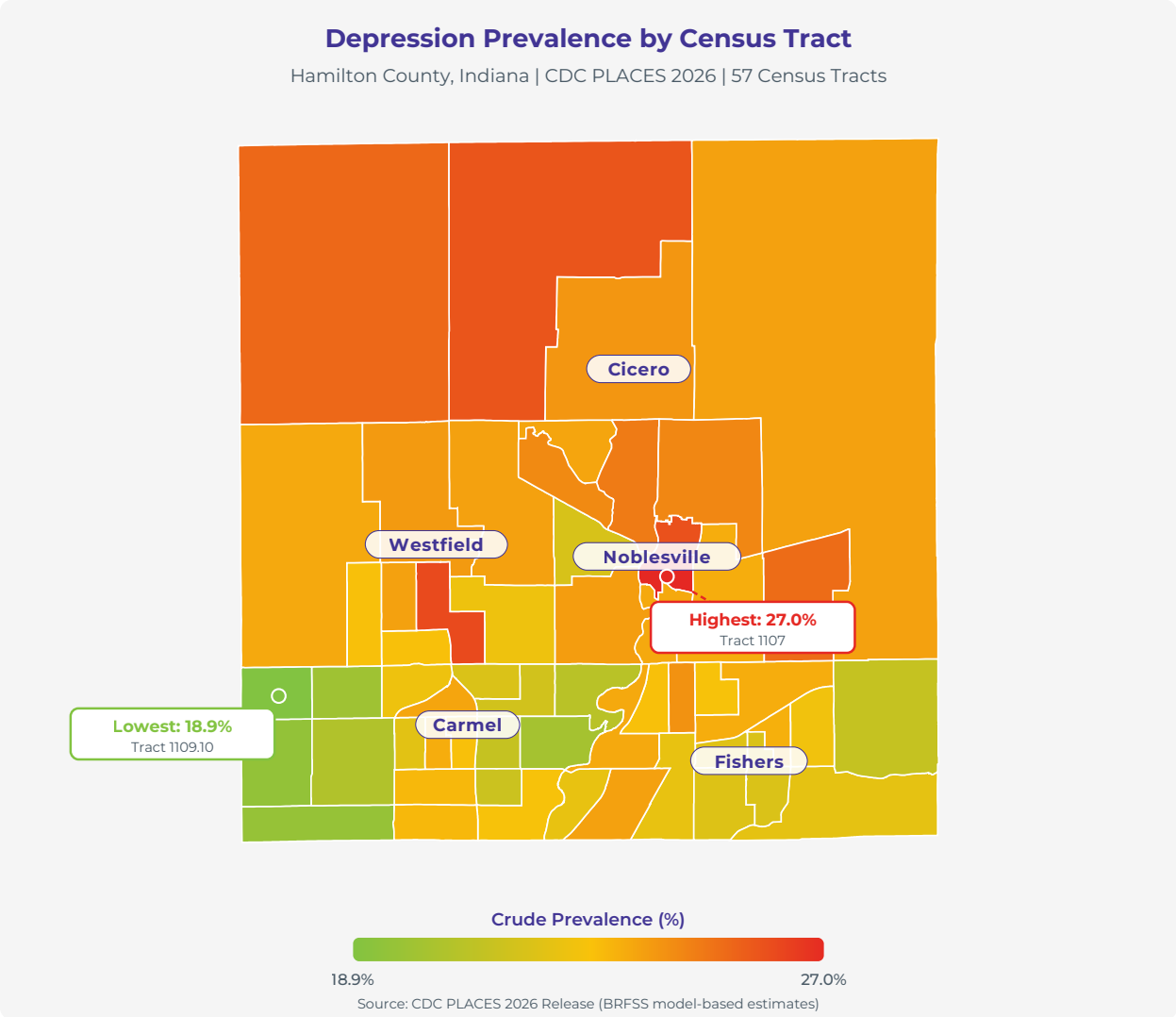
Depression: Nearly One in Four Adults

CDC PLACES 2026 data—the most current release of the agency's small area health estimates—places Hamilton County's age-adjusted depression prevalence at 22.9% [CDC PLACES, 2026]**. That means roughly one in four adults in the county has been told by a health professional that they have depression. In a county of this size, that translates to approximately 66,400 adults living with a depression diagnosis.**

To be precise about what this measure captures: CDC PLACES asks survey respondents whether they have ever been told by a doctor, nurse, or other health professional that they have a depressive disorder, including depression, major depression, dysthymia, or minor depression. It is a measure of diagnosed depression, which means it likely undercounts the true prevalence—residents who have not seen a provider, who were not screened, or who did not disclose symptoms would not be captured.

Hamilton County's 22.9% depression rate is the lowest among the five comparison counties (Marion at 25.3%, Madison at 27.7%, Tipton at 26.7%, Boone at 22.1%) [CDC PLACES, 2026]**, reflecting the county's socioeconomic advantages. But the fact that it exceeds the national average of 21.4% is noteworthy. Even with the country's highest incomes, best schools, and lowest poverty rates, Hamilton County cannot fully escape the depression epidemic that is reshaping American mental health.**

Depression Prevalence by Census Tract — Hamilton County (CDC PLACES 2026)

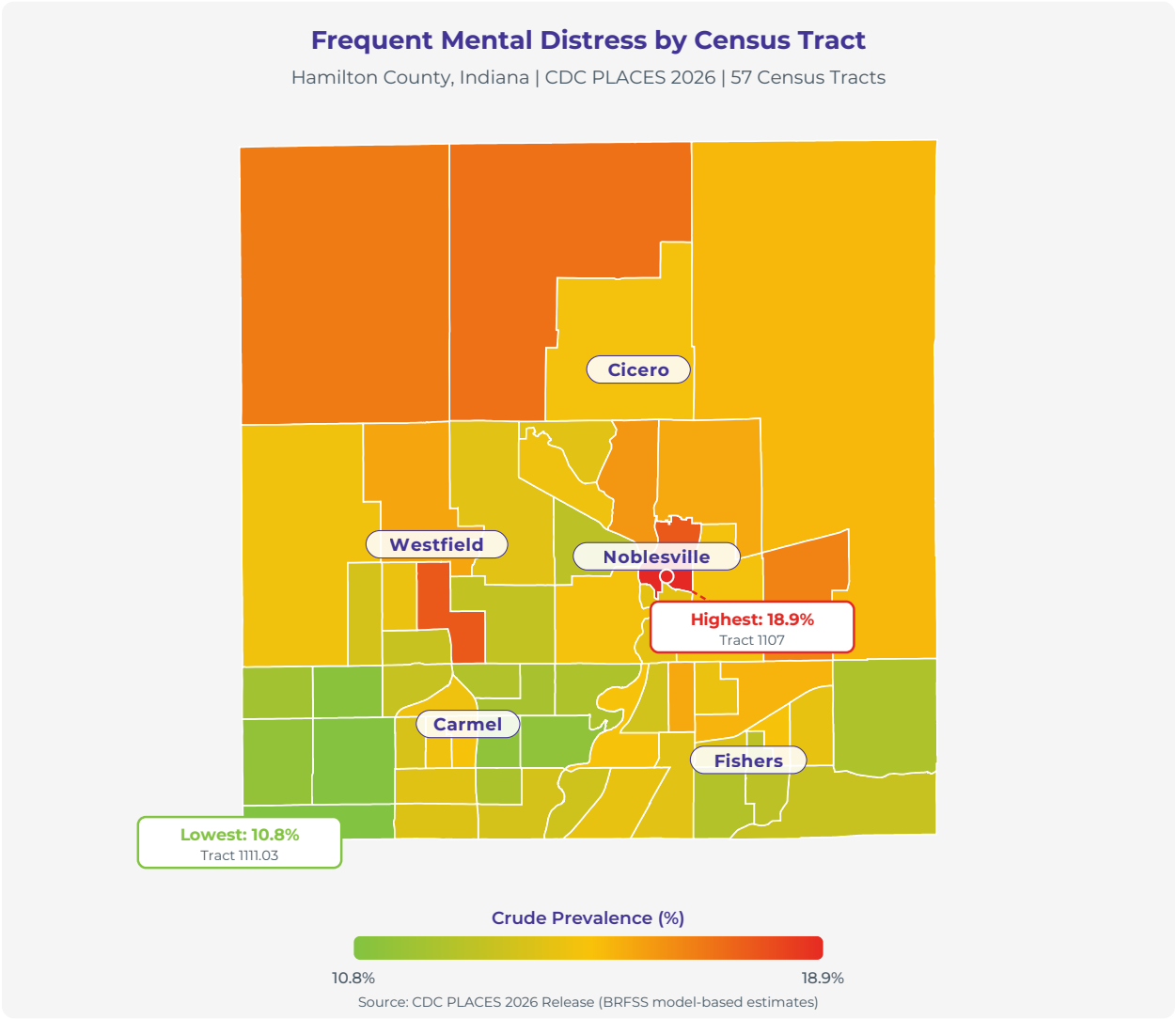


Frequent Mental Distress: 52,600 People in Sustained Pain

Where the depression measure asks about a clinical diagnosis, the frequent mental distress measure asks about lived experience. CDC PLACES and the County Health Rankings both track the percentage of adults reporting that their mental health was "not good" on 14 or more of the past 30 days. This is not a fleeting bad week. Fourteen or more days of poor mental health in a month represents a persistent state of psychological distress that affects daily functioning, relationships, and quality of life.

Hamilton County's age-adjusted frequent mental distress rate stands at 14.2%[CDC PLACES, 2026]**, with the County Health Rankings placing it at 13.6%**[CHR, 2025]**. The difference reflects slightly different data sources and modeling approaches, but both figures point to the same reality: roughly 52,000 to 55,000 Hamilton County adults experience mental distress that is frequent enough to constitute a chronic condition. The County Health Rankings also report that residents average 4.75 poor mental health days per month**[CHR, 2025]**—up from 4.22 in the prior year's release, a worsening trend.

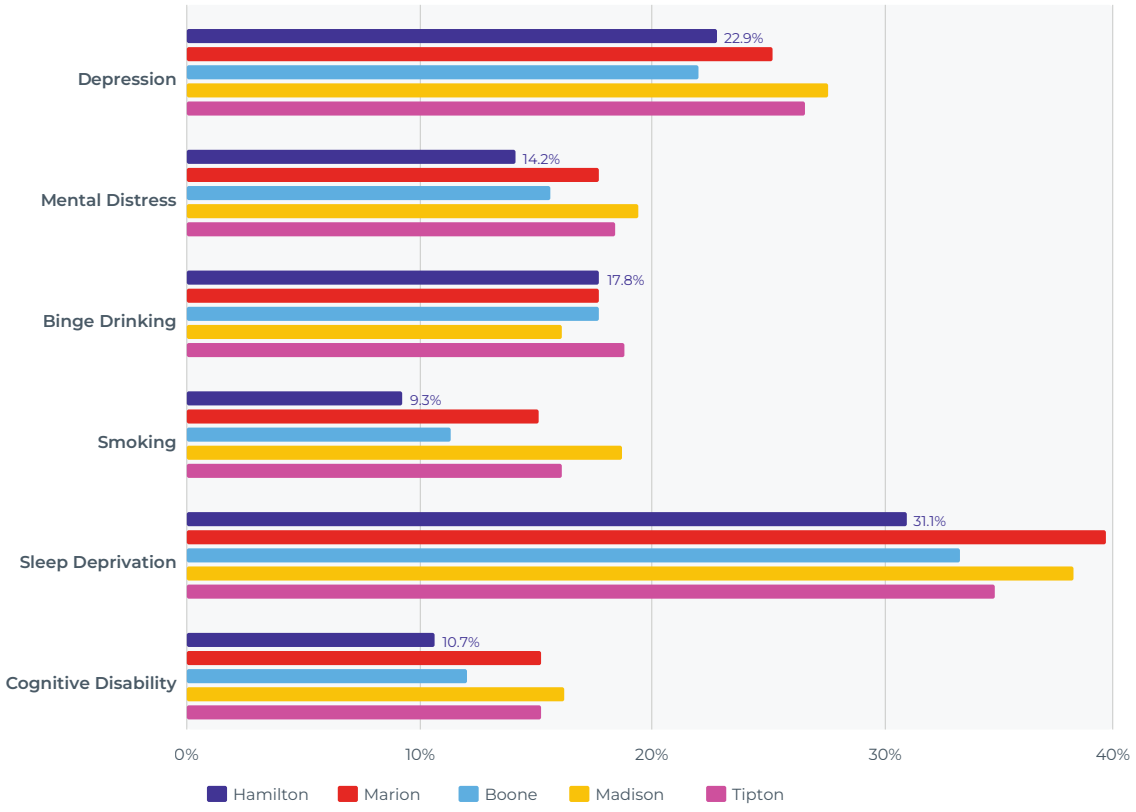
Frequent Mental Distress by Census Tract — Hamilton County (CDC PLACES 2026)



5-County Behavioral Health Comparison

CDC PLACES provides modeled prevalence estimates that enable direct comparison between Hamilton County and its four neighboring counties. The following table uses age-adjusted rates, which account for differences in population age structure, enabling fair comparison.

Behavioral Health Indicators: 5-County Comparison (Age-Adjusted, 2023)



Source: CDC PLACES 2026 (Age-Adjusted Prevalence)

INDICATOR (AGE-ADJ. %)	HAMILTON	MARION	BOONE	MADISON	TIPTON
Depression	22.9%	25.3%	22.1%	27.7%	26.7%
Frequent Mental Distress	14.2%	17.8%	15.7%	19.5%	18.5%
Binge Drinking	17.8%	17.8%	17.8%	16.2%	15.6%
Current Smoking	9.3%	15.2%	11.4%	18.8%	17.5%
Short Sleep Duration	31.1%	39.7%	33.4%	37.4%	36.2%
Cognitive Disability	10.7%	15.3%	12.1%	15.9%	15.2%

INDICATOR (AGE-ADJ. %)	HAMILTON	MARION	BOONE	MADISON	TIPTON
Any Disability	22.0%	29.9%	24.1%	31.0%	30.9%

Source: CDC PLACES 2026, age-adjusted prevalence. Year: 2023 (most indicators); 2022 (short sleep duration).

Hamilton County records the lowest rates across nearly every indicator, consistent with its socioeconomic advantages. But the binge drinking row deserves special attention: Hamilton County's rate of 17.8% matches Marion County exactly[CDC PLACES, 2026] and exceeds both Madison County (16.2%) and Tipton County (15.6%). This is not a typical pattern. On every other indicator, Hamilton County substantially outperforms its less affluent neighbors. The fact that binge drinking breaks this pattern—that Hamilton County drinks at the same rate as a county with three times its poverty rate and nearly half its median income—is a signal that warrants serious attention. It is consistent with a body of research documenting that alcohol use is more socially normalized in affluent communities, that disposable income facilitates greater consumption, and that high-achievement cultures sometimes use alcohol as a socially acceptable stress management tool.

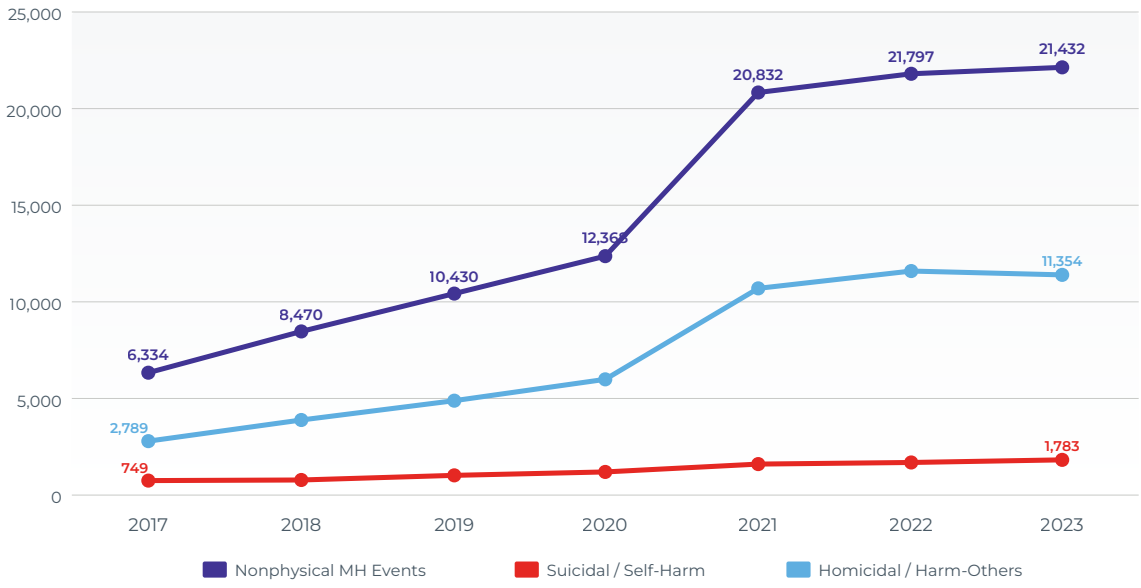
Mental Health Crisis Events: The Most Alarming Trend in This Assessment

If this assessment has a single finding that should compel immediate action, it is this: Hamilton County's mental health crisis events—EMS responses and emergency department visits classified as nonphysical mental health encounters—have increased from 6,334 in 2017 to 21,432 in 2024[Indiana MPH, 2017-2024]. That is a 238% increase in six years. The county's population grew 15% over the same period.

The magnitude of this disconnect demands careful interpretation. A 15% population increase producing a 238% increase in crisis events means that the per-capita crisis rate roughly tripled. This is not a story about more people generating more events. It is a story about a genuine, dramatic escalation in the volume and severity of behavioral health crises presenting to the emergency system. Something changed in Hamilton County between 2017 and 2023 that tripled the rate at which residents experienced behavioral health emergencies severe enough to trigger an EMS response or an emergency department visit.

The trajectory breaks into three distinct phases. In the pre-pandemic years (2017-2019), events grew from 6,334 to 10,430—a 65% increase over two years that was already a warning signal. The pandemic year of 2020 saw a further 19% increase to 12,368. Then came 2021, when events nearly doubled in a single year to 20,832—a step-change that corresponds to the delayed behavioral health impact of the pandemic, the exhaustion of coping reserves, and the overwhelming of existing crisis infrastructure. Events have remained above 20,000 annually since, reaching 21,432 in 2024 before declining modestly to 21,432 in 2024.

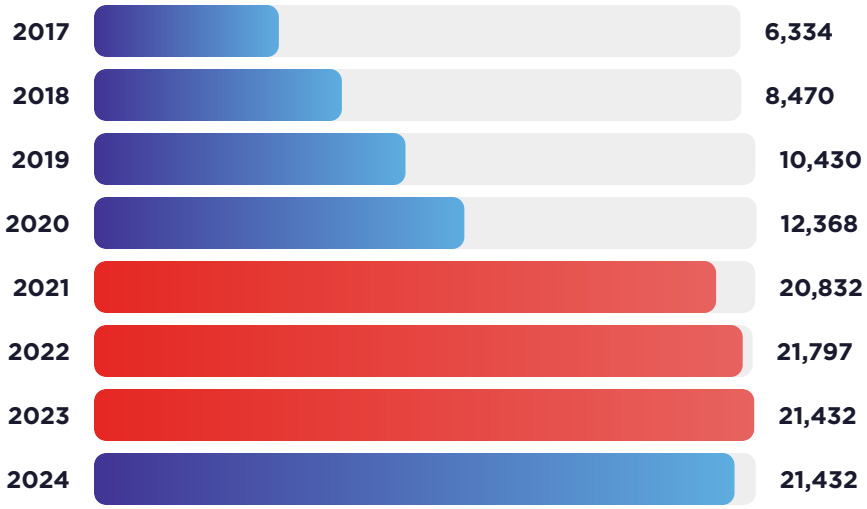
Mental Health Crisis Events, Hamilton County (2017–2024)



Source: Indiana Management Performance Hub (MPH), 2017–2024

CRITICAL FINDING: 238% INCREASE IN MENTAL HEALTH CRISIS EVENTS

Hamilton County's nonphysical mental health EMS/ED events surged from 6,334 in 2017 to 21,432 in 2024 [Indiana MPH, 2017-2024] **—a 238% increase over six years. The county's population grew just 15% over the same period. The 2024 figure of 21,432 may signal a plateau, but the absolute volume remains more than triple the 2017 baseline. This escalation represents a true increase in behavioral health acuity, not merely a reflection of population growth.**

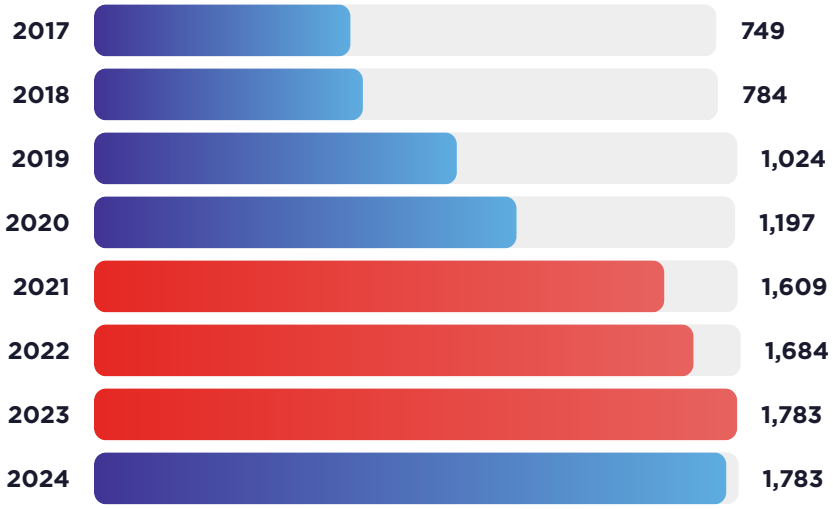


Source: Indiana Management Performance Hub (MPH), Mental Health Events by County, Hamilton County.

Suicidal and Self-Harm Events: A Parallel Escalation

Paralleling the mental health event trend—but with even more urgent implications—suicidal and self-harm EMS/ED events in Hamilton County increased from 749 in 2017 to 1,783 in 2024, a 138% increase[Indiana MPH, 2017-2024]**. These are not depression screenings or anxiety assessments. These are events in which an individual attempted suicide, engaged in self-harm, or was in a state of suicidal crisis severe enough to trigger emergency medical intervention. Each number represents a person at the most acute point of psychological distress—and often a family in crisis alongside them.**

The 2024 figure of 1,783[Indiana MPH, 2017-2024] **represents a very slight decline from the 2023 peak, but it remains 138% above the 2017 baseline. In practical terms, Hamilton County is now experiencing roughly 5 suicidal or self-harm emergency events per day, every day of the year. In 2017, the figure was approximately 2 per day.**



Source: Indiana MPH, Suicidal/Self-Harm Events by County, Hamilton County.

Crisis Events by Age Group: Where the Burden Falls

The 2024 MPH data disaggregates mental health events by three age groups, and the distribution reveals important patterns for service planning. Adults aged 18 to 60 account for the majority of suicidal and self-harm events (65.3%), consistent with this age group's concentration of employment stress, relationship disruption, financial pressure, and substance use. The 60-and-older population accounts for a disproportionate share of nonphysical mental health events (36.8%), reflecting the mental health burden of isolation, cognitive decline, chronic disease, and loss that characterizes later life. And the under-18 population, while the smallest group in absolute numbers, shows the most disturbing trend trajectory.

AGE GROUP	MH EVENTS	% OF TOTAL	SUICIDAL/SELF-HARM	% OF TOTAL
Under 18	2,021	9.4%	358	20.1%
18 to 60	11,520	53.8%	1,164	65.3%
60+	7,891	36.8%	261	14.6%
Total	21,432	100%	1,783	100%

Source: Indiana MPH, 2024. County population: 371,645.

The under-18 data demands focused attention. In 2017, Hamilton County recorded 55 suicidal or self-harm events among children and adolescents. In 2024, that figure was 358—a more than six-fold increase. The 2,021 nonphysical mental health events among minors in 2024, compared to 233 in 2017, represent a nearly nine-fold increase. These are children in Hamilton County's school districts—Carmel Clay, Hamilton Southeastern, Noblesville, Westfield Washington, Hamilton Heights, Sheridan—whose distress is reaching the level of emergency medical response. While some of this increase may reflect improved identification and reporting, the scale of the change far exceeds what can be attributed to measurement artifacts alone.

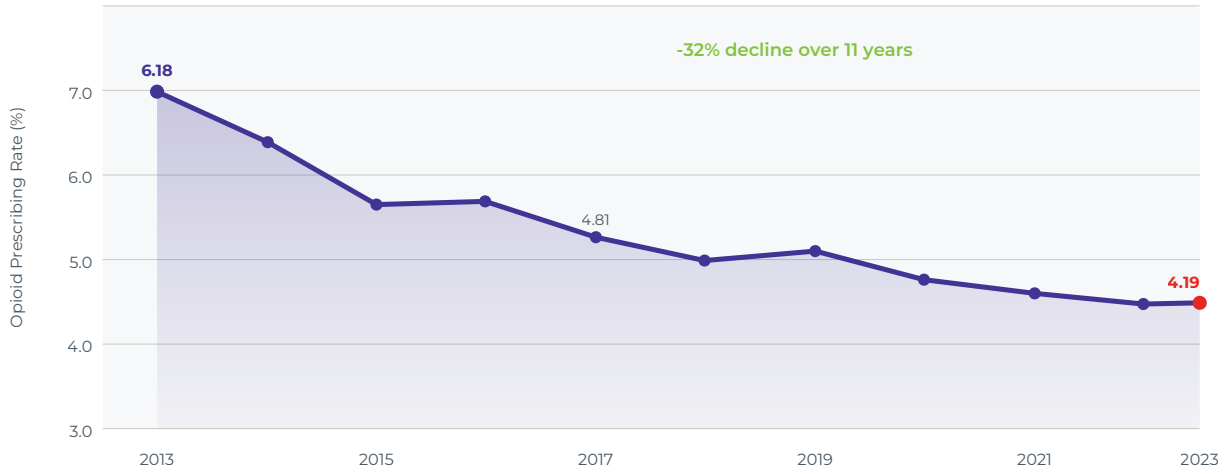
The fact that children under 18 account for 20.1% of all suicidal and self-harm events while representing a smaller share of the total population underscores a key finding: youth in Hamilton County are disproportionately represented in the most severe category of behavioral health crisis. This aligns with national patterns documented in Section 2 but takes on particular urgency in a community that prides itself on the quality of its youth-serving institutions.

CMS Opioid Prescribing Trends: An 11-Year Success Story

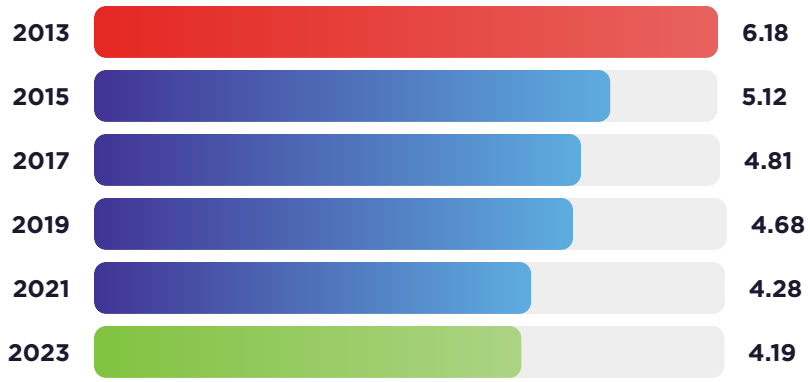
Not every trend line in this assessment points in the wrong direction. CMS Medicare Part D opioid prescribing geographic data provides an 11-year window into Hamilton County's opioid prescribing patterns, and it tells a story of genuine, sustained progress.

In 2013, opioid prescriptions accounted for 6.18% of all Medicare Part D claims written by Hamilton County prescribers. By 2023, that rate had fallen to 4.19%—a 32% reduction. The decline was steady and consistent, averaging roughly 0.2 percentage points per year. Long-acting opioid prescribing—a proxy for the most concerning prescribing patterns, since long-acting formulations carry higher addiction risk—declined even more sharply, from 11.44% of opioid claims in 2013 to 6.06% in 2023, a 47% reduction.

Medicare Part D Opioid Prescribing Rate, Hamilton County (2013–2023)



Source: CMS Medicare Part D Opioid Prescribing Geographic Data, 2013–2023



Source: CMS Medicare Part D Opioid Prescribing Geographic Data, Hamilton County, IN. Rate = opioid claims as % of total Part D claims.

This decline reflects both national policy shifts (CDC prescribing guidelines, state prescription drug monitoring programs, insurer prior authorization requirements) and local prescriber behavior changes. It is a genuine public health achievement that demonstrates what sustained, multi-stakeholder intervention can accomplish. However, two caveats are important. First, the prescribing rate plateaued at 4.18-4.19 between 2022 and 2023, suggesting that further reductions may require interventions beyond prescriber education—such as expanded non-opioid pain management alternatives. Second, the total number of opioid claims actually increased from 61,485 to 66,473 between 2022 and 2023, reflecting the growing Medicare-enrolled population. The rate declined because total claims grew faster than opioid claims, not because absolute opioid prescribing decreased.

−32%

PRESCRIBING RATE DECLINE

6.18 (2013) to 4.19 (2023) [CMS Medicare Part D, 2013-2023]

−47%

LONG-ACTING OPIOID DECLINE

11.44% (2013) to 6.06% (2023) [CMS Medicare Part D, 2013-2023]

1,518

TOTAL PRESCRIBERS (2023)

930 opioid prescribers [CMS Medicare Part D, 2013-2023]

66,473

OPIOID CLAIMS (2023)

Of 1,587,092 total Part D claims [CMS Medicare Part D, 2013-2023]

HRSA Mental Health Professional Shortage: What a Score of 19/25 Means

The Health Resources and Services Administration (HRSA) designates Mental Health Professional Shortage Areas (HPSAs) using a scoring system from 0 to 25, where higher scores indicate more severe shortages. Hamilton County holds two active HPSA designations, and understanding what they mean requires understanding how HRSA evaluates shortage severity.

The higher-scoring designation belongs to Aspire Indiana Health, the community mental health center serving Hamilton County, with a score of 19 out of 25. This score places the designation in the top quartile of shortage severity nationally. A score of 19 indicates that the designated population faces high need, limited provider supply, and significant barriers to accessing care. The designation covers a service population of 143,077—roughly 39% of the county's total population.

The second designation, LI-Central Indiana MHCAs, covers the low-income population specifically and carries a score of 14 out of 25. This designation documents a formal provider-to-population ratio of 37,129:1—meaning there is one full-time-equivalent mental health provider for every 37,129 low-income residents.

The designation identifies 12.07 FTE mental health providers currently serving this population and calculates that 17.79 additional providers would be needed to remove the designation. In other words, the current provider workforce serving the low-income population would need to roughly triple to meet the minimum federal standard.

DESIGNATION	TYPE	HPSA SCORE	POP. SERVED	PROVIDER RATIO
Aspire Indiana Health Inc.	FQHC Look-Alike	19/25	143,077	—
LI – Central Indiana MHCAs	HPSA Population	14/25	447,964	37,129:1

Source: HRSA HPSA Mental Health Summary. Last updated: 09/2025.

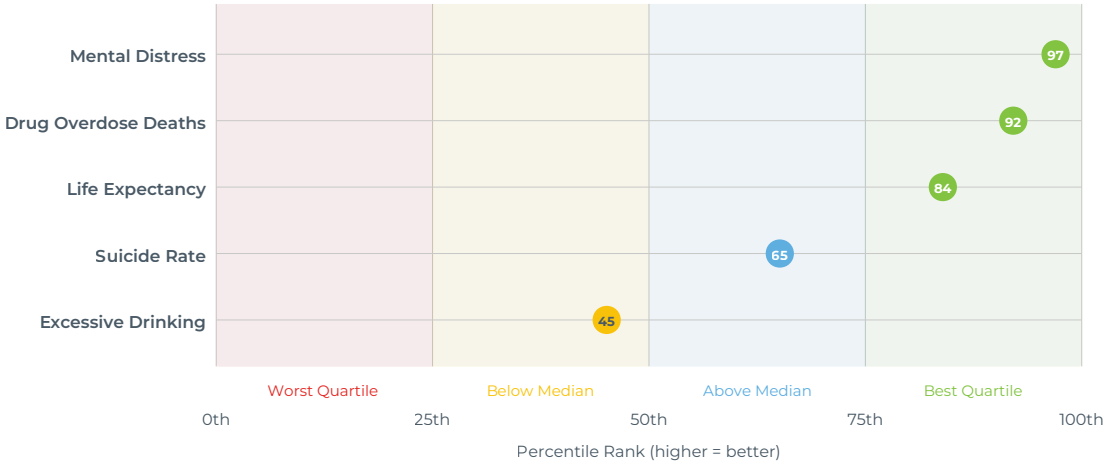
TWO WORKFORCE METRICS, TWO DIFFERENT STORIES

The County Health Rankings report a population-to-mental-health-provider ratio of 502:1 (2025), capturing all licensed providers in the county. The HRSA HPSA designation documents a ratio of 37,129:1 for the low-income population. Both are accurate. They measure different things. The CHR ratio reflects overall provider presence; the HPSA ratio reflects effective access for those with the fewest resources. A community leader reading only the CHR number might conclude the shortage is manageable. The HPSA number reveals that for the county's most vulnerable residents, the shortage is catastrophic.

National Benchmarking: Hamilton County Among 292 Large U.S. Counties

Invest Hamilton County maintains a national benchmarking database covering 292 U.S. counties with populations of 250,000 or more. This database enables the county to be ranked not against all 3,100+ counties in America—many of which are small, rural, and demographically dissimilar—but against true demographic peers: large, growing suburban and urban counties across the country.

Hamilton County National Rankings Among 292 Large U.S. Counties



Source: County Health Rankings 2025, National Benchmarking Index (292 counties, 250K+ pop)

INDICATOR	HAMILTON COUNTY	PEER MEDIAN	RANK (OF 292)	INTERPRETATION
Frequent Mental Distress	13.6%	15.2%	9th	BEST
Drug Overdose Deaths/100K	14.3	22.8	42nd	STRONG
Suicide Rate/ 100K	11.5	12.6	102nd	AVERAGE
Excessive Drinking	20.3%	19.8%	162nd	BELOW AVG.
Poor MH Days (avg/mo)	4.75	5.10	34th	STRONG
Uninsured Rate	4.6%	9.5%	12th	BEST
Life Expectancy	80.7 yrs	78.4 yrs	18th	BEST

Source: National Benchmarking Index (292 counties, 250K+ pop). Rank 1 = best.

The benchmarking data tells a split story. On protective factors—insurance coverage, life expectancy, mental distress rates, poor mental health days—Hamilton County is among the best large counties in America. The 9th-place ranking on frequent mental distress, 12th on uninsured rate, and 18th on life expectancy reflect the genuine benefits of the county's economic and educational environment. But the 102nd-place ranking on suicide rate (average) and the 162nd-place ranking on excessive drinking (below average) reveal vulnerabilities that the county's overall prosperity does not eliminate. The excessive drinking ranking is particularly noteworthy: 161 out of 292 large counties have lower rates of excessive drinking than Hamilton County. For a county that ranks in the top 5% on income, education, and employment, ranking in the bottom 45% on alcohol use is a significant outlier that warrants dedicated attention.

County Health Rankings Trend Data (2024-2025): Most Indicators Worsening

The County Health Rankings, published annually by the University of Wisconsin Population Health Institute with support from the Robert Wood Johnson Foundation, provide a two-year comparison window for Hamilton County's behavioral health indicators. While two years is insufficient for definitive trend analysis, the directional movement is concerning: most indicators moved in the wrong direction.

INDICATOR	CHR 2024	CHR 2025	DIRECTION
Frequent Mental Distress	12.9%	13.6%	WORSENING
Poor Mental Health Days (avg/mo)	4.22	4.75	WORSENING
Suicide Rate (age-adj.)	11.47	11.48	STABLE
Drug Overdose Death Rate	12.71	14.26	WORSENING
Excessive Drinking	17.4%	20.3%	WORSENING
Insufficient Sleep	27.0%	31.1%	WORSENING
Adult Smoking	10.2%	10.0%	IMPROVING

INDICATOR	CHR 2024	CHR 2025	DIRECTION
MH Provider Ratio (pop:provider)	541:1	502:1	IMPROVING
Loneliness	—	29.2%	NEW (2025)
Lack Social/Emotional Support	—	21.1%	NEW (2025)

Source: County Health Rankings 2024 and 2025 releases. Data years vary by indicator (typically 2-3 year lag).

Of the eight indicators with year-over-year comparison data, five worsened (mental distress, poor mental health days, overdose deaths, excessive drinking, insufficient sleep), one was essentially stable (suicide rate), and only two improved (smoking, provider ratio). The introduction of loneliness (29.2%) and lack of social/emotional support (21.1%) as new indicators in 2025 adds a dimension of social connectedness that previous releases did not capture—and the initial readings are concerning. It is worth noting that the County Health Rankings will potentially end after the 2026 edition, as RWJF has announced that its funding for the program will conclude. If so, the 2024-2025 comparison may be one of the final snapshots from this data system, making the worsening trends documented here particularly important to record.

Tract-Level Variation: Hamilton County Is Not One Community

Perhaps the most important insight from CDC PLACES comes not at the county level but at the census tract level. CDC PLACES uses a statistical technique called small area estimation—combining national survey data with local demographic characteristics to model health indicators for geographic units as small as census tracts. The results reveal that Hamilton County's county-level averages mask enormous internal variation.

INDICATOR	LOWEST TRACT	HIGHEST TRACT	RANGE	COUNTY MEAN
Depression	18.9%	27.0%	8.1 pts	23.0%
Frequent Mental Distress	10.8%	18.9%	8.1 pts	14.0%
Binge Drinking	14.4%	18.6%	4.2 pts	16.9%
Current Smoking	6.1%	18.0%	11.9 pts	10.0%

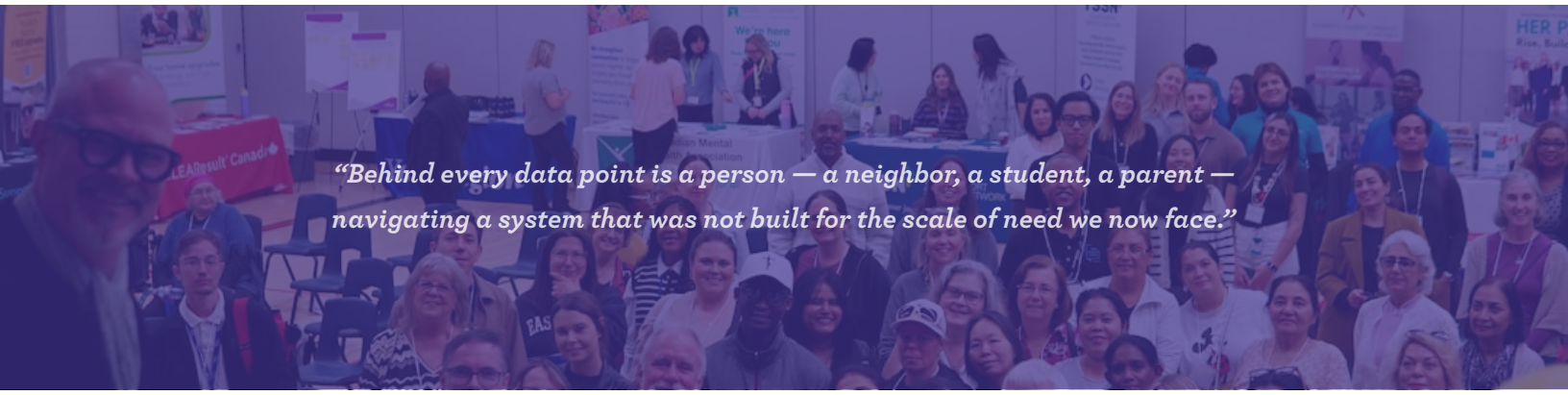
INDICATOR	LOWEST TRACT	HIGHEST TRACT	RANGE	COUNTY MEAN
Short Sleep	27.7%	36.3%	8.6 pts	32.1%
Cognitive Disability	7.5%	17.0%	9.5 pts	10.7%

Source: CDC PLACES 2026, Census Tract Level, Hamilton County (57 tracts). Crude prevalence.

The ranges are striking. Depression prevalence spans from 18.9% in the healthiest tract to 27.0% in the most burdened[CDC PLACES Tract-Level, 2026]**—an 8.1-point gap. To put that in context: the highest-depression tract in Hamilton County (27.0%) has a depression rate comparable to Madison County's county-wide average (27.7%), one of the most economically distressed counties in the comparison set. Meanwhile, smoking prevalence ranges from 6.1% to 18.0%—a nearly three-fold difference—indicating that some Hamilton County neighborhoods have smoking rates comparable to the state average while others have rates well below any county in central Indiana.**

These tract-level disparities underscore a critical point for community leaders: county-level averages, while useful for benchmarking, can obscure the reality that behavioral health burden is concentrated in specific neighborhoods. Effective investment requires sub-county targeting. The tracts with the highest depression, smoking, and cognitive disability rates tend to correspond to areas with older housing stock, lower incomes, and higher social vulnerability scores—creating a geographic overlap between social disadvantage and behavioral health burden that demands place-based intervention strategies.

Sources (Section 4): CDC PLACES 2026 (county and tract-level) | County Health Rankings 2024-2025 | CMS Medicare Part D Opioid Prescribing Geographic Data (2013-2023) | HRSA HPSA Mental Health Designations | Indiana MPH Mental Health Events by County (2017-2024) | National Benchmarking Index (292 counties, 250K+ pop) | Census PEP Vintage 2025



SECTION 05

SOCIAL DETERMINANTS OF BEHAVIORAL HEALTH

The data presented in Section 4 describes what is happening in Hamilton County's behavioral health landscape. This section explores why. The concept of social determinants of health—the conditions in the environments where people are born, live, learn, work, play, worship, and age—has transformed public health thinking over the past two decades. The World Health Organization estimates that social and economic factors account for 30 to 55% of health outcomes, dwarfing the contribution of clinical care (roughly 20%). For behavioral health specifically, the relationship is even more direct: the conditions of daily life do not merely influence mental health. They produce it.

For a general audience, the social determinants framework can be understood simply: whether a person develops depression, anxiety, substance dependence, or suicidal ideation is shaped far more by whether they have stable housing, meaningful social connections, economic security, and a sense of purpose than by whether they have a psychiatrist's phone number in their contacts. Clinical treatment matters enormously once a condition has developed. But the conditions that cause behavioral health problems in the first place are overwhelmingly social, economic, and environmental. This has profound implications for Hamilton County's response strategy, because it means that the most effective behavioral health interventions may not look like traditional health care at all.

Economic Security: Prosperity and Its Hidden Stressors

Hamilton County's economic indicators are extraordinary. A median household income exceeding $118,000 places the county among the wealthiest in the United States. A poverty rate of 4.7%, compared to 12.4% nationally, means that the vast majority of residents enjoy a standard of living that provides substantial protection against the economic insecurity that drives behavioral health crises in less affluent communities. A children-in-poverty rate of 4.5%, representing approximately 4,800 children, is a fraction of the rates experienced by neighboring counties.

4.7%

POVERTY RATE

National: 12.4% [Census ACS, 2023]

9.2%

FOOD INSECURITY

~35,600 residents affected [CHR, 2025]

4.5%

CHILDREN IN POVERTY

~4,800 children [Census ACS, 2023]

$118K+

MEDIAN HOUSEHOLD INCOME

ACS 2023 [Census ACS, 2023]

These are genuinely protective factors. Research consistently demonstrates a gradient relationship between income and behavioral health: at every step up the income ladder, depression rates fall, anxiety decreases, and life expectancy extends. Hamilton County's residents benefit from this gradient in measurable ways.

But affluence also generates its own behavioral health stressors—ones that are less visible, less studied, and often less socially acceptable to discuss. The high cost of living in Hamilton County means that the experience of economic stress is relative, not absolute. A family earning $80,000 in Hamilton County may experience more financial strain than a family earning $60,000 in a lower-cost community, because housing, childcare, transportation, and social expectations are calibrated to a much higher income level. The county's 4.7% poverty rate represents approximately 18,200 people living in deep economic precarity within one of America's most expensive suburban environments—where the gap between their resources and their surroundings creates a form of relative deprivation that research associates with elevated depression and anxiety.

For the majority of Hamilton County residents who are economically comfortable, different stressors operate. Dual-income professional households face time poverty—the condition of having enough money but not enough time for relationships, self-care, community engagement, or the unstructured moments that support mental health. Long commutes (the county's location within the Indianapolis MSA means many residents commute 30 to 60 minutes each way) consume hours that could otherwise be spent in restorative activities. The professional achievement culture that drives the county's economic success also generates chronic performance pressure that, research shows, elevates cortisol levels, disrupts sleep, and increases vulnerability to anxiety and depression.

Insurance Coverage and the Access Paradox

Hamilton County's uninsured rate of 4.6% is among the lowest in the nation—ranked 12th of 292 large counties in the national benchmarking database. This means that approximately 95.4% of residents have some form of health insurance, removing one of the most significant structural barriers to behavioral health care. It is a genuine advantage that the county should not take for granted.

However, being insured and having access to behavioral health care are not the same thing. Insurance coverage is a necessary condition for access but far from a sufficient one. Several factors create what might be called the access paradox: a county where nearly everyone has insurance but many people still cannot get timely behavioral health care.

The first factor is network adequacy. Many of the highest-quality behavioral health providers in Hamilton County do not accept insurance, operating on a private-pay model that is accessible only to residents who can afford $200 to $400 per session out of pocket. Among providers who do accept insurance, network participation varies widely by plan, creating a landscape in which having insurance does not guarantee that any conveniently located, currently accepting provider is in-network.

The second factor is Medicaid acceptance. Nationally, only 36% of psychiatrists accept new Medicaid patients, according to KFF. For Hamilton County's Medicaid population—which includes many of the residents served by the HPSA-designated Aspire Indiana Health system—this means that the already-severe provider shortage is functionally worse than the overall ratio suggests. A provider who exists in the county but does not accept a patient's insurance is, for that patient, functionally nonexistent.

The third factor is wait times. Even among insured residents with in-network providers, the county's 502:1 provider ratio means that wait times for non-urgent behavioral health appointments commonly range from 6 to 8 weeks—a dangerous delay for someone experiencing a new onset of major depression, a worsening anxiety disorder, or a substance use relapse. For psychiatric prescribers specifically, wait times can be even longer, creating a period during which individuals may deteriorate, self-medicate, or present to emergency departments in crisis—the most expensive and least effective point of intervention.

THE HIDDEN COST BARRIER

Even among insured Hamilton County residents, out-of-pocket costs for behavioral health care can be prohibitive. High-deductible health plans—common among the county's employer-sponsored insurance market—can require patients to pay $2,000 to $5,000 in annual deductible costs before behavioral health coverage activates. For a family managing a child's anxiety disorder, an adult's depression, and a grandparent's cognitive decline simultaneously, the cumulative cost of co-pays, deductibles, and out-of-network charges can reach thousands of dollars per year—even with "good" insurance.

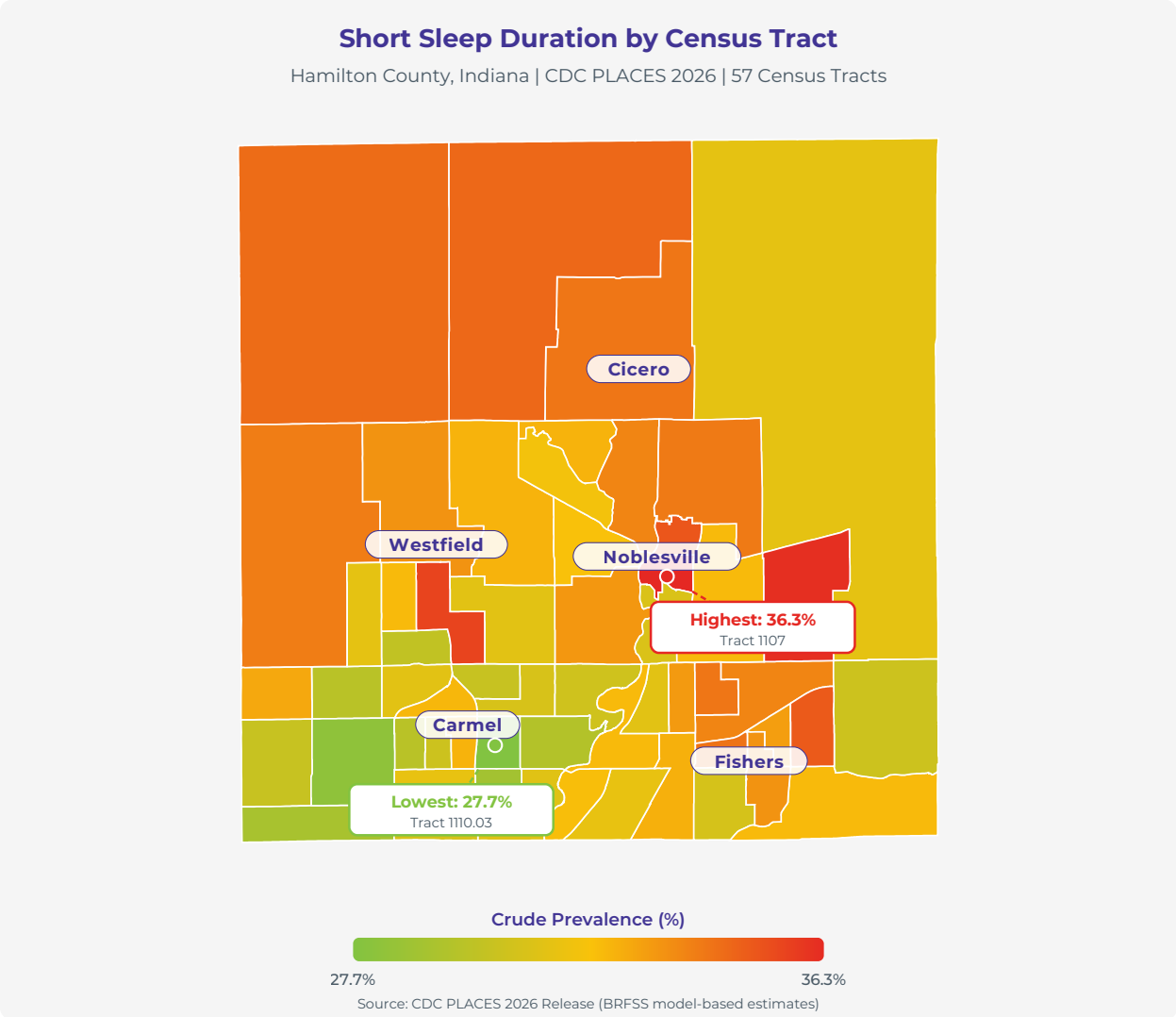
Housing Burden: When Home Becomes a Source of Stress

Housing affordability is an increasingly significant behavioral health determinant in Hamilton County. The county's rapid growth has driven housing costs steadily upward, with median home values exceeding $370,000 and average rents rising 25 to 30% since 2019. Housing cost burden—defined by HUD as spending more than 30% of household income on housing—affects an estimated 18 to 22% of Hamilton County households, with the burden concentrated among renters, single-income households, and older adults on fixed incomes.

The relationship between housing instability and behavioral health is among the most robust findings in social determinants research. Housing-burdened households experience two to three times higher rates of depression and anxiety compared to households spending within affordable limits. Housing loss—whether through foreclosure, eviction, or inability to afford a lease renewal—is a primary precipitant of behavioral health crisis, triggering cascading losses of stability, routine, social networks, and self-worth that can spiral into clinical depression, substance use, and suicidal ideation.

For Hamilton County specifically, the housing affordability challenge creates a particular vulnerability for populations that often fall outside the community's mental model of "who needs help": service workers earning $35,000 to $50,000 who keep the county's restaurants, retail, and childcare centers running but cannot afford to live in the community they serve; young adults in their 20s and early 30s attempting to establish independent households; recently divorced or separated residents who lose access to housing that was affordable within a two-income household; and older adults on Social Security whose fixed incomes have not kept pace with rising property taxes and maintenance costs.

Short Sleep Duration by Census Tract — Hamilton County (CDC PLACES 2026)



Social Connectedness and Loneliness: The Epidemic Within the Epidemic

The 2025 County Health Rankings introduced two new indicators that are particularly relevant to behavioral health in suburban communities: loneliness and lack of social and emotional support. Hamilton County's initial readings on both measures are concerning and deserve careful attention.

29.2%

ADULTS REPORTING LONELINESS

CHR 2025 — first year measured [CHR, 2025]

21.1%

LACK SOCIAL/EMOTIONAL SUPPORT

CHR 2025 — first year measured [CHR, 2025]

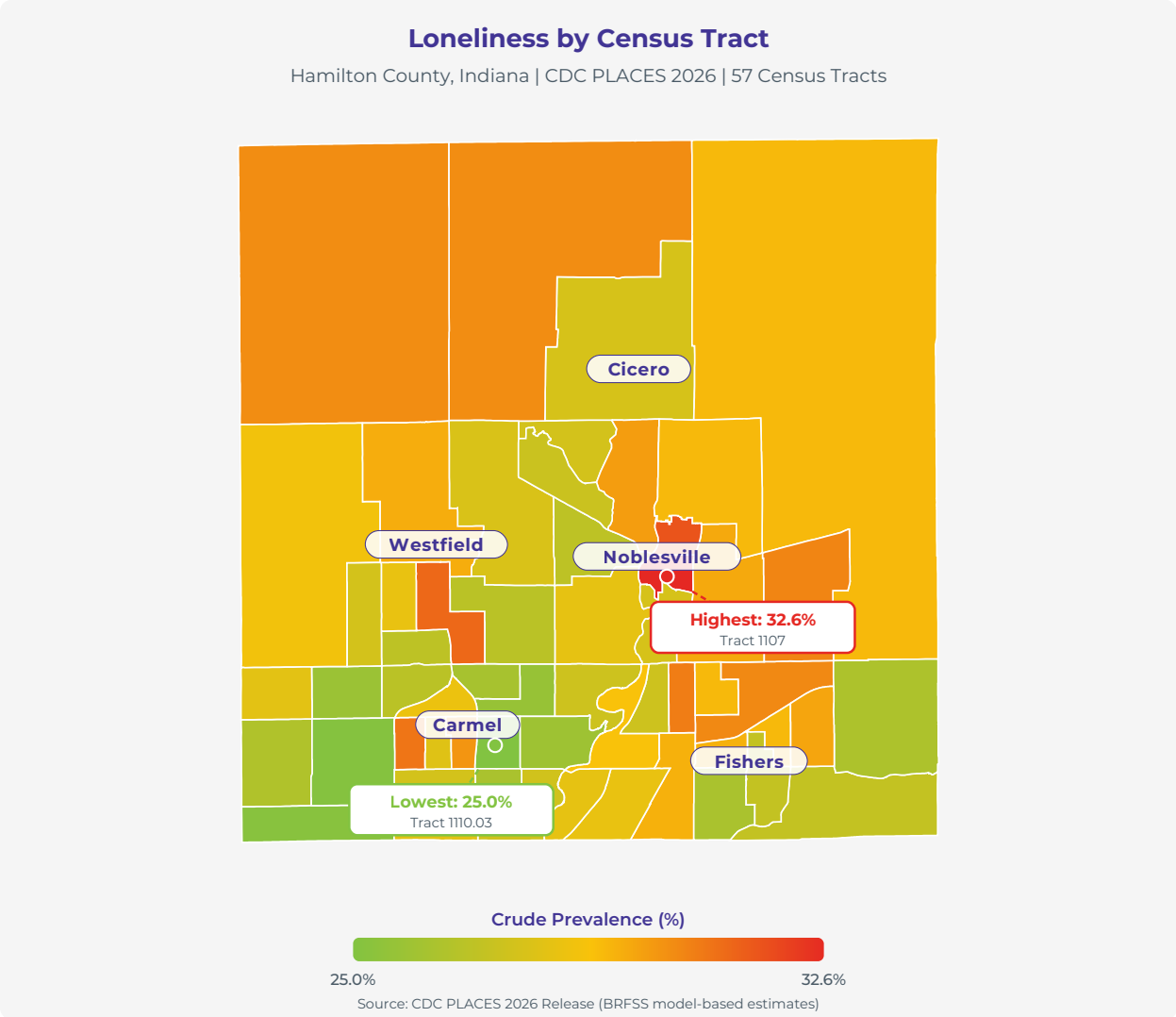
Nearly one in three Hamilton County adults reports feeling lonely. One in five reports lacking adequate social and emotional support. These figures carry behavioral health implications that are difficult to overstate.

In 2023, U.S. Surgeon General Vivek Murthy issued an advisory declaring loneliness and social isolation a public health epidemic, noting that the mortality risk of prolonged loneliness is equivalent to smoking 15 cigarettes per day. The advisory documented that loneliness is associated with a 26% increased risk of premature mortality, a 29% increased risk of coronary heart disease, and significantly elevated rates of depression, anxiety, dementia, and cognitive decline. For behavioral health specifically, loneliness is not just a risk factor—it is both a cause and a consequence of mental illness, creating a feedback loop in which isolation breeds depression, which breeds further isolation.

THE SUBURBAN ISOLATION PARADOX

Hamilton County's suburban geography may be structurally producing loneliness. The county is characterized by car-dependent development, large-lot single-family housing, limited walkable gathering spaces, and a commuter culture that pulls residents away from their neighborhoods during the most active hours of the day. Research on suburban mental health documents that physical separation between neighbors, long commutes, and the absence of "third places"—spaces that are neither home nor work where casual social interaction occurs naturally—reduces the informal social contact that protects against isolation. A resident may live in a neighborhood of 200 homes and not know a single neighbor by name.

Loneliness by Census Tract — Hamilton County (CDC PLACES 2026)



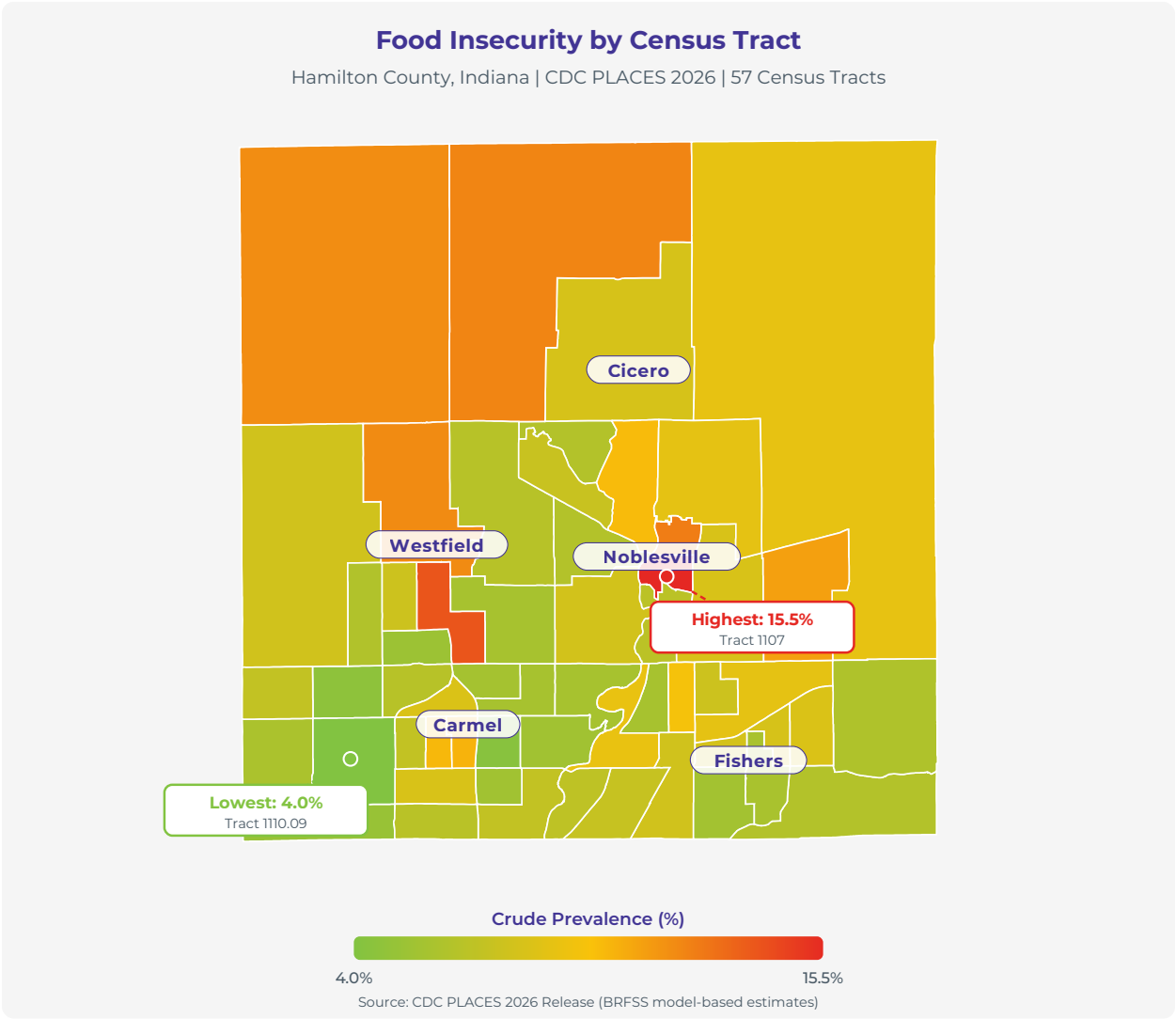
Food Insecurity: Hunger in a Wealthy County

Hamilton County's food insecurity rate of 9.2% [CHR, 2025] **means that approximately 35,600 residents experienced food insecurity at some point during the measurement year. In a county with a median household income above $118,000, the existence of 35,600 food-insecure residents may seem paradoxical. But food insecurity in affluent communities follows a distinctive pattern: it is concentrated among populations whose incomes are insufficient for the local cost of living, it is often episodic rather than chronic (triggered by job loss, medical bills, or family disruption), and it carries intense social stigma that makes it less visible and harder to address.**

The behavioral health consequences of food insecurity are well-documented. Food-insecure adults are two to three times more likely to experience depression and anxiety than food-secure adults. Food-insecure children show elevated rates of behavioral problems, attention difficulties, and academic underperformance. For older adults, food insecurity compounds the effects of isolation, chronic disease, and cognitive decline.

Organizations such as the Hamilton County Harvest Food Bank and Feeding Team serve thousands of residents monthly, but needs often exceed supply during school breaks, winter months, and periods when heating or cooling costs compete with food budgets.

Food Insecurity by Census Tract — Hamilton County (CDC PLACES 2026)



The Suburban Mental Health Paradox: Academic Evidence

A growing body of academic research documents what has been called the "suburban mental health paradox"—the finding that affluent suburban communities experience elevated rates of certain behavioral health conditions despite strong economic and educational indicators. This research, pioneered by psychologist Suniya Luthar and her colleagues, is directly relevant to Hamilton County.

Luthar and Becker's foundational 2002 study in *Child Development* established that affluent suburban youth exhibited significantly higher rates of substance use (59% of suburban boys versus 38% of inner-city boys) and comparable or higher rates of anxiety and depression compared to inner-city peers. This finding upended the prevailing assumption that socioeconomic privilege insulates against psychological distress.

Subsequent research by Luthar, Kumar, and colleagues (2020), published in the *American Psychologist*, documented that students in high-achieving schools are now classified as an "at-risk" group for mental health—listed alongside poverty, trauma, and discrimination as top risk factors by the National Academies of Sciences. One in five affluent 16-year-old girls showed clinically significant depressive symptoms, three times higher than inner-city counterparts. The mechanisms driving this elevated risk include:

Achievement pressure: Excessive academic and extracurricular demands create chronic stress, particularly in high-performing school districts like those in Hamilton County
Social comparison: Affluent communities create intense environments of comparison in material possessions, achievement, and appearance—amplified by social media
Emotional isolation from parents: Dual-income professional households may produce literal and emotional distance during critical developmental periods
Normalized substance use: Alcohol and substance use is more socially normalized in affluent settings, with greater access to disposable income for purchasing
Help-seeking stigma: High-achievement cultures may stigmatize mental health treatment as weakness or failure, delaying intervention
Geographic isolation: Suburban car-dependent development reduces casual social interactions and creates physical barriers to community connection

Hamilton County's profile—high-achieving school districts with intense academic and athletic competition, rapid population growth that disrupts established social networks, car-dependent suburban geography, elevated excessive drinking rates, and the 29.2% loneliness finding—aligns closely with the risk factors identified in this research. The county's 8.1-point range in depression prevalence across census tracts suggests that these suburban mental health dynamics are not uniform but operate with varying intensity across different neighborhoods and populations.

Social Vulnerability and Geographic Overlap

The CDC's Social Vulnerability Index (SVI) measures a community's resilience to health stresses using 16 census variables grouped into four themes: socioeconomic status, household characteristics, racial and ethnic minority status, and housing and transportation. Hamilton County's overall SVI is low, indicating strong community resilience. But sub-county analysis reveals pockets of moderate vulnerability, particularly in older neighborhoods in Noblesville and the county's eastern corridor, where housing stock is older, incomes are lower, and populations are more diverse.

These SVI-elevated tracts correspond geographically to the census tracts with the highest depression prevalence (up to 27.0%) and smoking rates (up to 18.0%) identified in the CDC PLACES tract-level analysis in Section 4. This is not coincidental. It confirms a fundamental principle of behavioral health epidemiology: social vulnerability and behavioral health burden cluster together at the sub-county level, even in counties with strong overall indicators. The practical implication is clear: Hamilton County's behavioral health investments should be geographically targeted to the neighborhoods where social vulnerability and health burden converge, rather than distributed evenly across a county whose average statistics mask enormous internal variation.

Adverse Childhood Experiences: The Upstream Driver

No single framework better explains the adult behavioral health burden documented throughout this assessment than Adverse Childhood Experiences (ACEs). The landmark 1998 Kaiser Permanente/CDC ACE Study—conducted by Vincent Felitti and Robert Anda with over 17,000 participants—established a dose-response relationship between childhood adversity and adult disease that has been replicated in hundreds of subsequent studies and has fundamentally reshaped how public health understands the origins of mental illness, substance use, and chronic disease. [Felitti et al., *American Journal of Preventive Medicine*, 1998]

4–12×

INCREASED RISK WITH 4+ ACES

For substance use, depression, and suicide attempts [Felitti et al., 1998; Hughes et al., *Lancet Public Health*, 2017]

~60%

INDIANA ADULTS REPORT AT LEAST 1 ACE

~16% report 4 or more ACEs [Indiana BRFSS ACE Module, 2019]

ACEs include physical, emotional, and sexual abuse; physical and emotional neglect; and five categories of household dysfunction: parental substance use, parental mental illness, domestic violence, incarceration of a household member, and parental separation or divorce. The original study found that adults with four or more ACEs faced dramatically elevated lifetime risk: 4.7 times the risk of depression, 10.3 times the risk of injection drug use, 12.2 times the risk of attempted suicide, and 7.4 times the risk of alcoholism, compared to adults with zero ACEs. [Felitti et al., 1998] A 2017 meta-analysis of 37 studies confirmed these findings across populations, establishing that individuals with 4+ ACEs face 4.4 times the risk of depression, 5.8 times the risk of problematic drug use, and 30.1 times the risk of suicide attempt. [Hughes et al., *Lancet Public Health*, 2017]

Indiana ACE Data. The Indiana Behavioral Risk Factor Surveillance System (BRFSS) ACE module provides state-level prevalence data: approximately 60% of Indiana adults report at least one ACE, and roughly 16% report four or more—the threshold associated with the most severe health consequences. [Indiana BRFSS

ACE Module, 2019; Indiana State Department of Health] **These figures are broadly consistent with national averages (61% and 16% respectively from the 2019 national BRFSS ACE module), suggesting that Indiana does not experience unusually elevated childhood adversity but that the baseline is alarmingly high everywhere.** [CDC BRFSS ACE Data, 2019]

"Hidden ACEs" in Affluent Communities

A critical body of research by Suniya Luthar and colleagues—cited extensively in this section's discussion of the suburban mental health paradox—has documented that affluent communities generate a distinct pattern of adverse childhood experiences that the original ACE questionnaire does not fully capture. These "hidden ACEs" include:

- **Achievement pressure: Chronic, intense pressure to excel academically, athletically, and socially—producing anxiety, perfectionism, and fear of failure that mirror the stress responses of more traditionally recognized ACEs** [Luthar & Becker, *Child Development*, 2002]
- **Emotional neglect through parental absence: Dual-income professional households where both parents work 50+ hours per week, travel frequently, or are emotionally unavailable despite physical proximity** [Luthar, Kumar & Zillmer, *American Psychologist*, 2020]
- **Parental substance use: Alcohol misuse is more prevalent in high-income households (Hamilton County's excessive drinking rate of 20.3% exceeds the national average), and children in these households experience the same ACE-related consequences as children in lower-income homes with parental substance use**
- **High divorce rates: Certain Hamilton County ZIP codes experience divorce rates that, while not extreme by national standards, represent household disruption for children in communities where intact-family norms create additional stigma around parental separation**
- **Overscheduling and loss of unstructured time: The travel sports culture, competitive extracurricular scheduling, and reduced family time that characterize Hamilton County family life may function as chronic stressors for children, particularly when combined with achievement pressure**

These hidden ACEs help explain a paradox documented throughout this assessment: why a county with the highest incomes, best schools, and lowest poverty rates in Indiana nonetheless produces youth mental health crisis rates that rival or exceed less affluent communities. The ACE framework suggests that the *type* of childhood adversity differs by socioeconomic context, but the neurobiological and behavioral consequences are remarkably similar. [Luthar, Kumar & Benoit, *Adversity and Resilience Science*, 2020]

ACEs as the Upstream Driver. The ACE framework is the connective tissue that links the social determinants discussed in this section to the clinical outcomes documented in Sections 4, 6, and 7. The depression prevalence of 22.9%, the tripling of youth crisis events, the elevated substance use, the suicide rates—these are not isolated phenomena. They are, in significant part, the downstream consequences of childhood adversity experienced years or decades earlier. An effective behavioral health strategy for Hamilton County must therefore include ACE-informed approaches: universal ACE screening in pediatric and primary care settings, school-based resilience programs that address the specific stressors of affluent suburban youth, parent education that helps high-achieving families recognize when achievement pressure crosses from motivation into harm, and trauma-informed care training across all systems that interact with children and families.

[Felitti et al., *American Journal of Preventive Medicine*, 1998; Hughes et al., *Lancet Public Health*, 2017; Indiana BRFSS ACE Module, 2019; CDC BRFSS ACE Data, 2019; Luthar & Becker, 2002; Luthar, Kumar & Zillmer, 2020; Luthar, Kumar & Benoit, 2020]

THE HIDDEN BEHAVIORAL HEALTH BURDEN: UNPAID CAREGIVERS

Approximately 53 million Americans provide unpaid caregiving to an adult family member [AARP/NAC, 2020]**. Research consistently finds that 40 to 70 percent of caregivers develop clinical signs of depression** [Family Caregiver Alliance, 2023]**. In Hamilton County, several features of the community amplify this risk:**

- **Dual-income norm: High cost of living means most households depend on two incomes, forcing caregiving to compete with career demands**
- **Sandwich generation: Residents simultaneously raising children and caring for aging parents face compounded stress, financial strain, and time poverty**
- **Suburban sprawl: The county's geography increases caregiving commute time; limited public transit means caregivers must drive to every appointment**
- **Financial burden: Average family caregiver spends $7,242/year out of pocket** [AARP/NAC, 2020]
- **Treatment avoidance: Caregivers are significantly less likely to seek their own behavioral health treatment, creating a cascade of unmet need**

As Hamilton County's 65+ population continues to grow, caregiver behavioral health burden will become an increasingly significant contributor to the county's overall behavioral health demand. Adult day services, respite care, and caregiver-specific support groups represent high-leverage interventions.

Integration: Social Determinants as the Upstream Strategy

The social determinant landscape of Hamilton County presents a complex and nuanced picture that resists simple characterization. The county's economic strengths are real and protective: high income, low poverty, high insurance coverage, strong educational attainment, and a community infrastructure that provides genuine advantages in behavioral health outcomes compared to state and national benchmarks. These strengths should be acknowledged and preserved.

But the county's social determinant profile also includes countervailing risk factors that are characteristic of affluent suburban communities and that operate alongside, and sometimes despite, strong economic indicators: elevated alcohol use, significant loneliness, housing cost pressures that burden vulnerable populations, food insecurity affecting nearly 36,000 residents, an achievement-pressure culture with documented effects on youth mental health, and a suburban built environment that may structurally reduce the social connections that protect against isolation and depression.

Effective behavioral health strategy in Hamilton County cannot be limited to expanding clinical services—though that is urgently needed. It must also address the upstream social determinants that produce behavioral health conditions in the first place: reducing isolation through built environment changes and community programming that fosters connection, normalizing help-seeking through employer programs and school cultures that balance excellence with well-being, targeting housing and food insecurity interventions to the populations most affected, and acknowledging openly that affluence does not immunize a community against the forces reshaping mental health across America.

Research Citations: Suburban Mental Health Paradox

Luthar SS, Becker BE. "Privileged but Pressured? A Study of Affluent Youth." Child Development, 2002;73(5):1593-1610.

Luthar SS, Kumar NL. "Youth in High-Achieving Schools: Challenges to Mental Health." Int J School & Educ Psychology, 2020;8(4):233-244.

Luthar SS, Kumar NL, Zillmer N. "High-Achieving Schools Connote Risks for Adolescents." American Psychologist, 2020;75(7):983-995.

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Maternal and Perinatal Mental Health: A Hidden Burden

Among the most consequential and least visible behavioral health challenges in Hamilton County is maternal and perinatal mental health. Perinatal mood and anxiety disorders (PMADs)—which include postpartum depression, postpartum anxiety, postpartum OCD, postpartum PTSD, and, in rare cases, postpartum psychosis—affect a staggering share of new mothers and carry enormous consequences for maternal well-being, infant development, and family stability.

1 IN 5 MOTHERS EXPERIENCE PERINATAL MOOD AND ANXIETY DISORDERS

Perinatal mood and anxiety disorders are the most common complication of pregnancy and childbirth—more common than gestational diabetes, preeclampsia, or preterm birth. An estimated 1 in 5 mothers (approximately 20%) experience a PMAD during pregnancy or the first year postpartum. [Maternal Mental Health Leadership Alliance, 2024; Wisner et al., *JAMA Psychiatry*, 2013] **Postpartum depression alone affects 10–20% of new mothers, while anxiety disorders affect an additional 6–10%.** [Gavin et al., *Obstetrics & Gynecology*, 2005; Fairbrother et al., *Journal of Clinical Psychiatry*, 2016]

~4,500

ANNUAL BIRTHS IN HAMILTON COUNTY

Across 4 hospital systems: Community Health Network, IU Health, Ascension St. Vincent, Riverview Health [Indiana State Department of Health Vital Statistics, 2023]

$14,000

COST PER UNTREATED MOTHER-INFANT PAIR

Including healthcare, productivity losses, and child developmental impacts [Luca et al., Mathematica, 2020]

With approximately 4,500 births per year in Hamilton County across four hospital systems—Community Health Network, IU Health, Ascension St. Vincent, and Riverview Health—the 1-in-5 prevalence rate implies that roughly 900 Hamilton County mothers experience a perinatal mood or anxiety disorder each year. [Indiana State Department of Health Vital Statistics, 2023; Maternal Mental Health Leadership Alliance, 2024] **The majority of these cases go undetected or undertreated.**

The Screening Gap. The U.S. Preventive Services Task Force recommends universal screening for depression during pregnancy and the postpartum period using validated instruments such as the Edinburgh Postnatal Depression Scale (EPDS) or the Patient Health Questionnaire-9 (PHQ-9). [USPSTF Recommendation, 2019] **However, screening practices vary significantly across obstetric practices in Hamilton County. Not all OB/GYN offices conduct systematic screening at prenatal and postpartum visits, and even when screening occurs, positive screens do not always result in referrals to behavioral health providers. The result is a cascade of missed opportunities: women who screen positive but receive no follow-up, women who are referred but face 4–8 week waits for an available therapist, and women who never disclose symptoms because they are not asked.**

The Treatment Gap. Hamilton County has very few perinatal-specialized therapists—clinicians trained in the specific presentation, neurobiology, and treatment of perinatal mood disorders. General therapists may accept referrals but lack the specialized competence to address the unique aspects of perinatal mental health, including medication considerations during breastfeeding, the role of hormonal fluctuations, and the particular cognitive distortions associated with postpartum depression and anxiety. Wait times for the small number of perinatal specialists in the Indianapolis MSA routinely exceed six weeks—an eternity for a mother in acute distress during the first months of her infant's life.

The Economic Case: $14,000 per Untreated Mother-Infant Pair

A rigorous 2020 analysis by Mathematica for the National Institute for Children's Health Quality found that untreated perinatal depression costs an average of $14,000 per affected mother-infant pair over the five years following birth, encompassing maternal healthcare utilization, lost productivity, and downstream child developmental and behavioral costs. [Luca et al., Mathematica / NICHQ, 2020] **Applied to Hamilton County's estimated 900 affected mothers per year, the annual community cost of untreated perinatal mental illness is approximately $12.6 million—a figure that does not include the incalculable costs of impaired mother-infant bonding, delayed child development, and marital strain.**

Hamilton County–Specific Risk Factors. While PMADs occur across all demographics, several features of Hamilton County's suburban landscape may elevate risk:

- **Isolation in new developments:** Many new mothers in Hamilton County live in recently built subdivisions where neighbors are strangers, there is no established community infrastructure, and the nearest family member may be hundreds of miles away. The social isolation documented earlier in this section is particularly acute for mothers with infants who are physically confined to homes in car-dependent suburban neighborhoods.
- **Dual-income time pressure:** Hamilton County's high-income profile reflects a preponderance of dual-income professional households. The pressure to return to demanding careers quickly after childbirth, combined with the cost and scarcity of infant childcare, creates a stress environment that exacerbates perinatal mood vulnerability.
- **Distance from extended family:** Hamilton County is one of the fastest-growing counties in the Midwest, with significant in-migration from other states. Many new parents lack the extended family support networks that historically buffered the transition to parenthood.

- **Achievement culture and shame: In a community that prizes high performance, admitting to postpartum depression or anxiety can feel like admitting failure as a parent—a particularly powerful stigma barrier that delays help-seeking.**

Indiana Context. Indiana ranks 38th nationally in maternal mortality, and behavioral health conditions are a contributing factor in maternal deaths. [America's Health Rankings, United Health Foundation, 2024] **The Indiana Maternal Mortality Review Committee has identified mental health and substance use as significant contributors to pregnancy-associated deaths, underscoring that perinatal mental health is not merely a quality-of-life issue but a life-and-death concern.** [Indiana State Department of Health Maternal Mortality Review, 2023]

[Felitti et al., 1998; Wisner et al., *JAMA Psychiatry*, 2013; Gavin et al., *Obstetrics & Gynecology*, 2005; Fairbrother et al., *Journal of Clinical Psychiatry*, 2016; Luca et al., Mathematica/NICHQ, 2020; USPSTF Screening Recommendation, 2019; Indiana SDOH Vital Statistics, 2023; America's Health Rankings, 2024; Indiana Maternal Mortality Review Committee, 2023; Maternal Mental Health Leadership Alliance, 2024]

Sources (Section 5): County Health Rankings 2025 (loneliness, social support, food insecurity, uninsured) | National Benchmarking Index (292 counties) | CDC PLACES 2026 Tract-Level Data | CDC Social Vulnerability Index | Academic Research Library: Luthar & Becker 2002; Luthar, Kumar & Zillmer 2020; Luthar & Kumar 2020; Luthar, Kumar & Benoit 2020 | Census ACS 2023 | U.S. Surgeon General Advisory on Social Connection, 2023 | KFF Strategies to Address BH Workforce Shortages, 2024 | Felitti et al., 1998 | Hughes et al., *Lancet Public Health*, 2017 | Indiana BRFSS ACE Module, 2019 | Luca et al., Mathematica, 2020 | USPSTF, 2019 | Indiana Maternal Mortality Review, 2023

SECTION 06

Youth & Adolescent Behavioral Health

+767%

INCREASE IN YOUTH MENTAL HEALTH EVENTS, HAMILTON COUNTY (2017–2024)

A generation in crisis — and Hamilton County's affluence provides no immunity.

SECTION 6

YOUTH & ADOLESCENT BEHAVIORAL HEALTH

Something is happening to America's young people, and Hamilton County is not immune. In the span of a single generation, adolescent mental health has deteriorated at a pace that has no modern precedent. Depression rates among teenagers have more than doubled. Emergency departments are overwhelmed with children in psychiatric crisis. Suicide has become the second-leading cause of death for Americans ages 10 to 34. And in Hamilton County — one of the most educated, affluent, and fastest-growing communities in the Midwest — the data tell a story that defies comfortable assumptions about what wealth and opportunity can protect against.

This section examines the youth behavioral health emergency through four lenses: the national crisis that set the stage, the distinct pathways of crisis for young men and young women, the local data that confirm Hamilton County is squarely within the crisis, and the suburban-specific risk factors that may actually amplify the challenges facing the county's approximately 100,000 residents under age 18. The evidence is drawn from the U.S. Surgeon General's advisory, the CDC's Youth Risk Behavior Surveillance System, the Sagamore Institute's landmark 2026 Indiana report, Luthar's two decades of research on affluent youth, and Indiana Management Performance Hub data that track crisis events at the county level.

Hamilton County's Board of Commissioners and County Council have demonstrated decisive leadership through continued investments in the crisis system (like the RELY Center), jail-based recovery (TOWER Program), co-responder teams (COPE), and workforce development (Invest Onward).

~100K

RESIDENTS UNDER 18

~27% of county population [Census PEP, 2025]

2,021

YOUTH MH EVENTS (2024)

Non-physical MH, under 18 [Indiana MPH, 2017-2024]

+767%

YOUTH MH EVENT GROWTH

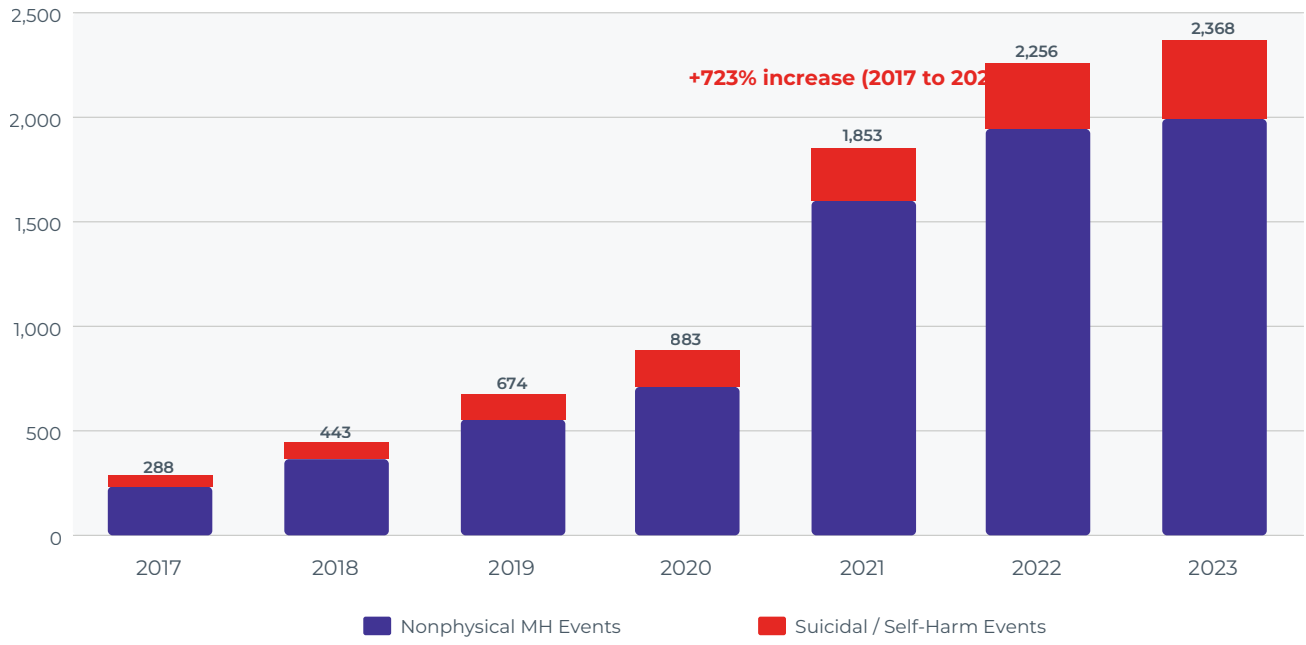
233 (2017) to 2,021 (2024) [Indiana MPH, 2017-2024]

358

YOUTH SUICIDAL/SELF-HARM EVENTS

Under 18, 2024 [Indiana MPH, 2017-2024]

Youth (Under 18) Mental Health Events, Hamilton County (2017–2024)



Source: Indiana MPH Data Hub, 2017–2024 (Under-18 Age Group)

6.1 The National Youth Mental Health Emergency

In December 2021, U.S. Surgeon General Vivek Murthy took an extraordinary step: he issued an advisory on the mental health of America's young people, declaring that the challenges children and adolescents faced were devastating and demanded urgent national attention. Surgeon General advisories are reserved for issues of immediate public health significance. The last time one had been issued on a youth-specific topic was decades earlier. What compelled the action was not a single data point but the convergence of multiple trends that, taken together, described a generation in crisis.

The numbers were staggering. Between 2009 and 2019 — before COVID-19 touched American shores — rates of depression among adolescents had increased more than 60 percent. By 2021, one in three high school students reported persistent feelings of sadness or hopelessness, a 40 percent increase from a decade prior. Among girls, the figure was even worse: more than half reported those feelings. Emergency department visits for suicide attempts among adolescent girls were 51 percent higher in early 2021 than in early 2019. Anxiety diagnoses among children aged 3 to 17 had nearly doubled between 2016 and 2021, according to the CDC's analysis of the National Survey of Children's Health.

These were not marginal shifts. They represented a generational transformation in mental health burden — one that was already well underway before the pandemic amplified it. COVID-19 accelerated trends that had been building for a decade, adding social isolation, disrupted routines, family stress, and grief to an already-fragile adolescent population. The pandemic was an accelerant, not the origin. And the origin, as researchers have increasingly documented, traces back to a specific period: 2010 to 2015, the years in which the smartphone became the default tool of adolescent social life.

THE SOCIAL MEDIA FACTOR: THE GREAT REWIRING OF CHILDHOOD

Jonathan Haidt's *The Anxious Generation* (2024) documents what he calls the "Great Rewiring of Childhood" — the period between 2010 and 2015 when smartphones became ubiquitous among teens, replacing a play-based childhood with a phone-based one. Apple introduced the first front-facing camera phone in 2010. Instagram launched that same year. Within five years, social media shifted from something teens occasionally used to something they inhabited continuously. The average American teen now spends 4.8 hours per day on social media. The Surgeon General's 2023 advisory found that adolescents spending more than 3 hours daily face double the risk of depression and anxiety symptoms. From 2010 to 2018, anxiety incidence among Gen Z increased 134 percent and depression 106 percent. A meta-analysis of 18 studies (Shannon et al., 2022) found statistically significant correlations between problematic social media use and depression (r=0.273), anxiety (r=0.348), and stress (r=0.313). Twenge et al. (2018) analyzed 506,820 U.S. adolescents and found that depressive symptoms and suicide-related outcomes increased significantly between 2010 and 2015, especially among females, with screen time emerging as a consistent risk factor.

> *"The challenges children and adolescents face are devastating and demand urgent national attention.*
>
> U.S. SURGEON GENERAL VIVEK MURTHY, 2021 ADVISORY

What makes this crisis particularly relevant to Hamilton County is its universality. Unlike many public health challenges that concentrate in disadvantaged communities, the youth mental health emergency cuts across every demographic. It is present in urban and rural communities, in affluent and low-income families, across every racial and ethnic group. And as we will document in Section 6.5, Hamilton County's specific

characteristics — high-achieving schools, intense extracurricular competition, widespread smartphone access, and the social dynamics of affluent suburban life — may actually amplify rather than mitigate these national trends.

6.2 The Crisis Facing Young Men

27%

OF INDIANA SENIOR BOYS REPORT HAVING MADE A SUICIDE PLAN

Nearly double the 13.8% rate among freshmen — the escalation is hidden because boys present through behavior, not expressed emotion.

In March 2026, the Sagamore Institute released *Failure to Launch: The Status of Boys and Young Men in Indiana*, a 49-page report supported by the American Institute for Boys and Men, Lilly Endowment, Lumina Foundation, and Wabash College. The findings reveal a crisis hiding in plain sight — one that operates not through the visible emotional distress that characterizes the female youth crisis, but through a quieter, more insidious pattern of disengagement, withdrawal, and lethality.

The Sagamore data document a paradox that defies easy explanation. On Indiana's ILEARN assessments, boys outperform girls in math. On the SAT, Indiana boys score competitively with girls. Through most of high school, male academic performance holds steady or exceeds female performance on standardized measures. But something breaks at the transition point. Indiana's high school graduation rate for girls is 91.8 percent; for boys, it drops to 88.7 percent. The gap then widens dramatically: in 2023, 58.1 percent of Indiana women enrolled in postsecondary education compared to just 45.2 percent of men — a 12.9 percentage-point chasm that cannot be explained by academic ability alone.

4x

MALE SUICIDE RATE VS. FEMALE

Indiana men, CDC 2024 [CDC, 2024]

45.2%

INDIANA MALE COLLEGE ENROLLMENT

vs. 58.1% for women (2023) [Census ACS, 2023]

27%

SENIOR BOYS: SUICIDE PLANNING

Up from 13.8% as freshmen [CDC YRBSS, 2023]

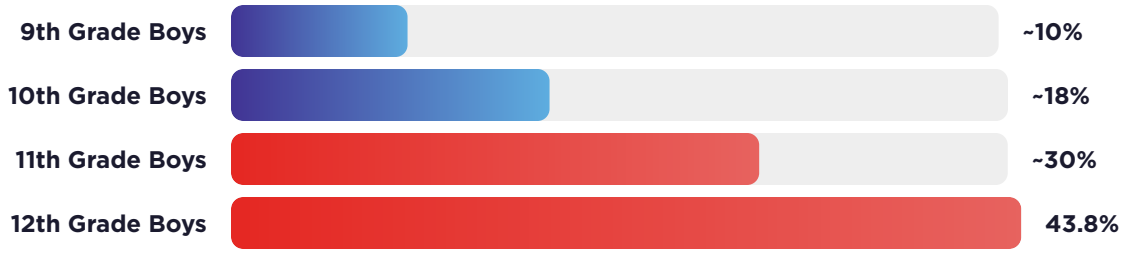
43.8%

SENIOR BOY ALCOHOL USE

Up from ~10% in 9th grade [CDC YRBSS, 2023]

This is not an Indiana anomaly. Nationally, for every 100 bachelor's degrees awarded to women, just 72 go to men. Men account for only 42 percent of college students ages 18 to 24. Male first-time enrollment dropped 5.1 percent during COVID versus less than one percent for women. The male share of bachelor's degrees has fallen to its lowest level on record. Pew Research (2024) finds the gap exists across all racial and ethnic groups: White women hold degrees at a 10-point advantage over White men (52 percent vs. 42 percent); among Black Americans, the gap is 12 points (38 percent vs. 26 percent). What makes Indiana distinct is the sharpness of the cliff: boys do not gradually disengage from education; they fall off it at the end of senior year.

The Senior-Year Substance Surge. The Sagamore data document a striking substance use trajectory among Indiana boys that mirrors and compounds the educational cliff. Alcohol consumption among 9th-grade boys stands at approximately 10 percent — actually below the rate for 9th-grade girls. But by 12th grade, 43.8 percent of senior boys report current alcohol use, surpassing girls at every grade level. Binge drinking follows the same pattern: 25.1 percent of senior boys report binge drinking compared to 21 percent of senior girls. This senior-year surge in male substance use coincides precisely with the academic cliff, suggesting that the same transition-point vulnerability driving educational disengagement also drives self-medication through alcohol.



Indiana boys' alcohol use surges from ~10% in 9th grade to 43.8% in 12th grade. Source: Sagamore Institute, Failure to Launch (2026)

Suicide Planning: A Hidden Escalation. Perhaps the most alarming finding in the Sagamore report is the trajectory of suicide planning among Indiana boys. Among 9th-grade boys, 13.8 percent report having made a suicide plan. By senior year, that figure nearly doubles to 27 percent. This escalation occurs while boys are simultaneously disengaging from school, increasing substance use, and losing institutional support structures. Indiana men are four times more likely to die by suicide than Indiana women — a disparity that mirrors national patterns where males account for nearly 80 percent of suicide deaths. The AIBM reports that suicide is rising fastest among young men specifically, and that boys use more lethal means (firearms, hanging) and complete suicide far more often than girls, even though girls attempt at higher rates.

THE LETHALITY GAP

The CDC reports that males die by suicide at 3.8 times the rate of females nationally. While girls attempt suicide at higher rates, boys use more lethal means and complete suicide far more often. In Indiana, the male suicide rate exceeds the national average. Hamilton County's overall suicide rate of 11.5 per 100,000 — with an estimated male-specific rate of approximately 19 per 100,000 based on state gender ratios — places the county squarely within this crisis. For every headline about a girl's anxiety diagnosis, there may be a boy suffering in silence who never seeks help and never appears in a counselor's caseload until it is too late.

> *Boys do not gradually disengage from education; they fall off it at the end of senior year.*

SAGAMORE INSTITUTE, FAILURE TO LAUNCH, 2026

The Relationship Deficit. The Sagamore report identifies what its advisory group calls a "relationship deficit" among boys and young men — a compounding loss of meaningful human connection across multiple domains simultaneously. Sports participation for boys ages 6 to 17 fell from 50 percent to 41 percent between 2013 and 2023. Only 28 percent of Indiana public school teachers are men, limiting male mentorship in schools. In-person socializing among young adults declined from 150 to 40 minutes per day over 20 years. Fifteen percent of men now report having zero close friends, up from 12 percent in 1990, while the number of men with six or more close friends collapsed from 55 percent to 27 percent. The void is being filled by screens: non-working young men ages 21 to 30 spend 8.6 hours per week gaming, and 48 percent of men ages 18 to 49 have at least one sports betting account.

THE LONELINESS EPIDEMIC

15% of men report having zero close friends — 5x higher than in 1990. In-person socializing has collapsed from 2.5 hours to just 40 minutes per day.

DECLINING CONNECTION POINTS

- Sports participation fell from 50% to 41% among boys ages 6–17
- Only 28% of Indiana public school teachers are men
- 42.9% of Indiana children are born to unmarried women
- Nearly 40% of bars and pubs have closed since COVID
- In-person socializing: 150 → 40 minutes/day over 20 years

DIGITAL SUBSTITUTION

- Non-working young men: 8.6 hrs/week gaming (NBER)
- 48% of men ages 18–49 have a sports betting account
- 15% of men report zero close friends
- Men with 6+ close friends: 55% → 27%
- Self-reported happiness rose even as employment fell — short-term contentment masking long-term disconnection

Fatherlessness and Family Structure. The National Fatherhood Initiative reports that one in four U.S. children live without a biological, step, or adoptive father in the home — 18 million children. In Indiana, 42.9 percent of children are born to unmarried women. Research consistently links father absence to elevated behavioral problems, higher school dropout rates, and increased rates of anxiety, depression, and delinquency among boys. NIH research demonstrates that father absence before age five is associated with delinquency and criminal behavior in adulthood, while the quality of father involvement reduces adolescent substance use risk. The federal FORGE Fatherhood Program, with over $100 million awarded to 109 organizations in 2025, reflects growing policy recognition of this connection.

Emerging Threat: Sports Betting

Nearly 4.2 million Americans struggle with sports betting addiction in 2025, with men ages 18 to 25 at disproportionate risk. The industry spent $5.1 billion on advertising in 2024. Among 18- to 22-year-olds, 58 percent are involved in at least one sports betting activity. NIDA neuroimaging studies demonstrate that gambling activates brain regions identical to those activated by substance use disorders. One in five people with gambling disorder attempt or complete suicide. Baker et al. (2024) found that legalization of online sports betting leads to greater financial distress among already-constrained households. For young men already experiencing isolation, purposelessness, and substance vulnerability, the constant availability of mobile sports betting represents a compounding behavioral health risk that Hamilton County's employers, schools, and health systems will increasingly encounter.

CRITICAL FINDING

4.15 Million Disconnected Youth

The broadest measure of youth disengagement is the NEET rate — young people ages 16 to 24 not in education, employment, or training. Twelve percent of men ages 16 to 24 are classified as NEETs, and two-thirds are not even seeking work. Each disconnected young person carries an estimated $1 million in lifetime societal costs through lost wages, tax revenue, and increased social service needs.

Measure of America, 2025; American Enterprise Institute, 2026

These are not just behavioral health statistics; they are workforce and economic development statistics that connect directly to Hamilton County's labor market and quality of life.

6.3 The Crisis Facing Young Women

While the crisis facing young men unfolds as a late-adolescent collapse — a falling-off-the-cliff pattern that accelerates after high school — the crisis facing young women begins earlier, presents more visibly, and has been escalating for over a decade. The CDC's Youth Risk Behavior Surveillance data tell a story of relentless deterioration: the share of female high school students reporting persistent sadness or hopelessness has nearly doubled since 2011, rising from 34.5 percent to 60.1 percent in Indiana by 2021. The 2023 national update showed a modest decline to 53 percent, but that figure remains catastrophically higher than the pre-smartphone baseline. One in three teen girls has seriously considered suicide. Among 9th-grade girls specifically, 46.3 percent report poor mental health — more than double the rate for 9th-grade boys at the same age.

60.1%

IN FEMALE STUDENTS: SAD/HOPELESS

Up from 34.5% since 2011 [CDC YRBSS, 2023]

46.3%

9TH-GRADE GIRLS: POOR MH

vs. 20.1% of 9th-grade boys [CDC YRBSS, 2023]

1 in 3

TEEN GIRLS CONSIDERED SUICIDE

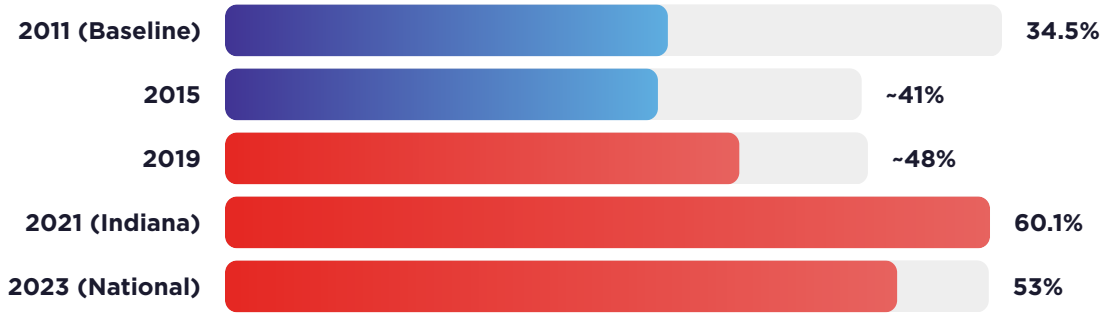
CDC YRBS 2021–2023 [CDC YRBSS, 2023]

+51%

GIRLS' ED SUICIDE ATTEMPTS

Early 2021 vs. early 2019 [U.S. Surgeon General, 2021]

The trajectory of suicidal ideation among girls is equally alarming. Nearly one in three female high school students seriously considered attempting suicide in the 2023 YRBS. Among 9th-grade girls in Indiana, 29.2 percent report having made a suicide plan. Emergency department visits for suicide attempts among girls ages 12 to 17 were 51 percent higher in early 2021 compared to 2019. While completed suicide rates remain higher among boys, the sheer volume of girls in active crisis — considering, planning, and attempting suicide — places extraordinary demand on school counselors, emergency departments, and outpatient behavioral health providers. This demand is part of what drives the access barriers documented in Section 8 of this assessment.



Indiana female students reporting persistent sadness or hopelessness. Source: CDC YRBS; Sagamore FTL (2026)

> *One in three teen girls has seriously considered suicide — and one in five experienced sexual violence in the past year.*
>
> CDC YOUTH RISK BEHAVIOR SURVEY, 2023

Social Media and the Great Rewiring. For girls, the social media effect is disproportionately severe. Haidt documents that moving from zero to five hours of daily social media use is associated with a tripling of depression rates among girls. Internal Facebook/Instagram research, made public through whistleblower testimony, acknowledged that their platforms make body image issues worse for a significant share of teen girls. The average American teen spends 4.8 hours per day on social media — well above the Surgeon General's threshold of doubled risk at three hours. Cyberbullying compounds the effect: a 146,536-adolescent study found that girls constitute 61.9 percent of cyberbullying victims, with victims experiencing 90 percent higher depression and 87 percent higher anxiety. The U.S. lifetime prevalence of cyberbullying now stands at 58.2 percent. Eating disorder diagnoses have surged in parallel, with health visits for eating disorders among teenagers increasing 107.4 percent from 2018 to 2022.

Sexual Violence and Safety. The CDC's YRBS reports that one in five female high school students experienced sexual violence in the past year, and one in seven had ever been forced to have sex. One in nine female students reported experiencing sexual dating violence. These experiences are directly linked to behavioral health outcomes: youth who experience dating violence are more likely to develop depression, engage in substance use, exhibit antisocial behaviors, and consider suicide. After high school, the risk continues: over 40 percent of women experience their first intimate partner violence between ages 18 and 24. These are not abstract statistics — they represent Hamilton County students in Hamilton County schools who carry these experiences into every classroom, exam, and extracurricular activity.

The Achievement Paradox. One of the most disorienting features of the female youth mental health crisis is that it coexists with unprecedented academic achievement. Girls outperform boys at every level of education. Among 2024 high school graduates, 69.5 percent of women enrolled in college compared to 55.4 percent of men. Women graduate from college at 66 percent versus 58 percent for men. Girls are simultaneously outperforming and deteriorating — achieving more while feeling worse. The APA documents that perfectionism affects 25 to 30 percent of children and adolescents, with rates increasing 10 to 33

percent between 1989 and 2016. Female high achievers are 20 to 30 percent more likely to score above the 90th percentile on socially prescribed perfectionism scales — a pattern with direct relevance to Hamilton County's high-performing school districts.

Girls' Alcohol Use: An Earlier Risk Window. The Sagamore data reveal a finding that complicates simple gender narratives about substance use. Through 9th, 10th, and 11th grade, Indiana girls exhibit riskier alcohol behaviors than boys of the same age. It is only in 12th grade that boys surpass girls, as the male senior-year substance surge takes hold. This means that for three of four high school years, girls are the population at higher substance use risk — a pattern consistent with their earlier onset of depression and sadness. Girls begin self-medicating their emotional distress earlier, while boys catch up and surpass only when their own transition-point crisis emerges.

Research Spotlight: Academic Perfectionism in Hamilton County

Luthar and Kumar (2020) found that one in five affluent 16-year-old girls had clinically significant depressive symptoms — three times higher than inner-city counterparts. In Hamilton County's top-ranked school districts — Hamilton Southeastern, Carmel Clay, Noblesville, and Westfield Washington — where college admission competition is intense and AP course loads are standard, this perfectionism pipeline connects directly to anxiety, depression, and burnout. Nearly 88 percent of young people report that stress from performance demands affects their physical health. The combination of academic excellence as a community value, social media as a comparison engine, and parental achievement expectations creates a pressure environment that the research identifies as specifically pathogenic for adolescent girls.

6.4 Two Crises, One Community

Hamilton County does not face one youth behavioral health crisis — it faces two, operating through distinct pathways, on different timelines, with different presentations. Girls enter crisis earlier, report higher emotional distress, and are more visible to school and health systems. Boys enter crisis later, present through behavior and substance use rather than expressed emotion, and are more likely to reach lethal outcomes. Understanding this duality is essential for any community response that aims to reach both populations effectively.

DIMENSION	GIRLS / YOUNG WOMEN	BOYS / YOUNG MEN
Onset timing	Early — 46.3% of 9th-grade girls report poor MH	Late — crisis peaks at end of HS / post-HS
Primary presentation	Internalizing: sadness, hopelessness, anxiety, self-harm	Externalizing: substance use, withdrawal, risk-taking
Suicide pattern	Higher ideation and attempt rates; lower completion	Lower reported ideation; 4x higher completion rate
Substance trajectory	Higher alcohol use in grades 9–11; overtaken in 12th	Surges to 43.8% alcohol use in 12th grade; 2x OD death rate
Academic outcome	Outperformance: 91.8% grad rate, 58.1% college enrollment	Cliff: 88.7% grad rate, 45.2% college enrollment
Social media effect	Body image, cyberbullying, social comparison, perfectionism	Gaming, sports betting, pornography, isolation
Help-seeking	Higher: 42% of Gen Z women in therapy; stronger social networks	Lower: 15% report zero close friends; 74% only turn to partner
Post-HS trajectory	Depression and suicidal ideation decline	Depression and suicidal ideation increase

Source: IHC synthesis of CDC YRBS, Sagamore FTL (2026), Patalay & Gage (2019), AIBM research

The post-high school divergence is particularly consequential. For young women, depression and suicidal ideation rates actually decline after the high school years — the transition to college or early adulthood appears to provide relief from the pressures that drove the crisis during adolescence. For young men, the opposite occurs: depression and suicide-inclination rise after high school. This divergent trajectory has profound implications for intervention strategy. The female youth mental health crisis is concentrated in the school-age years, where school-based interventions can reach the affected population. The male crisis intensifies precisely when institutional support structures fall away.

Hamilton County Under-18 Crisis Escalation. Indiana MPH data provide the local evidence base for these dual crises. The numbers are unambiguous. Among residents under 18, non-physical mental health events grew from 233 in 2017 to 2,021 in 2024 — a 767 percent increase. Suicidal and self-harm events among the same age group rose from 55 to 358 — a 551 percent increase. Homicidal and harm-to-others events grew from 323 to 2,373 — a 635 percent increase. The sharpest acceleration occurred between 2020 and 2021, when youth mental health events more than doubled in a single year. But critically, the crisis did not recede when pandemic restrictions ended. Events continued climbing through 2022, 2023, and 2024, confirming that COVID was an accelerant, not the root cause.

+767%

YOUTH MH EVENTS

233 (2017) → 2,021 (2024) [Indiana MPH, 2017-2024]

+551%

YOUTH SUICIDAL/ SELF-HARM

55 (2017) → 358 (2024) [Indiana MPH, 2017-2024]

+635%

YOUTH HOMICIDAL/ HARM OTHERS

323 (2017) → 2,373 (2024) [Indiana MPH, 2017-2024]

The Workforce Pipeline Connection. These are not only behavioral health statistics — they are workforce development statistics. Today's struggling 14-year-old is tomorrow's workforce gap. The Abramson, Boerma, and Tsyvinski model (NBER/Columbia, 2024) found that providing mental health care for everyone ages 16 to 25 would yield gains equivalent to 1.7 percent of aggregate consumption — the single most impactful intervention they modeled. The Uppsala Longitudinal Adolescent Depression Study followed participants from age 16 to age 40 and found that persistent depression in adolescence was associated with 15 percent lower earnings for females and 24 percent lower earnings for males across their entire working lives. When Hamilton County's employers report difficulty filling positions — when 94 percent of employers nationally say they are investing more in mental health benefits — the roots of that challenge run directly through the adolescent behavioral health data presented here.

6.5 The Suburban Mental Health Paradox

For two decades, Suniya Luthar and her colleagues have been building a body of research that challenges one of the most deeply held assumptions in American public health: the idea that socioeconomic privilege protects children from psychological distress. What Luthar has documented, across multiple studies and populations, is that students in high-achieving schools are now formally classified as an "at-risk" group for mental health — listed alongside poverty, trauma, and discrimination as top risk factors by the National Academies. This finding has direct and specific relevance to Hamilton County.

Luthar's foundational 2002 study established that affluent suburban youth exhibited significantly higher rates of substance use (59 percent of suburban boys vs. 38 percent of inner-city boys) and comparable or higher rates of anxiety and depression than their inner-city peers. Follow-up studies found that one in five affluent 16-year-old girls had clinically significant depressive symptoms — three times higher than inner-city counterparts. The mechanisms driving this paradox operate through two primary channels: excessive achievement pressure and emotional isolation from parents.

Achievement pressure in Hamilton County's school districts — Hamilton Southeastern (22,000 students), Carmel Clay (17,500), Noblesville (11,000), and Westfield Washington (8,500) — is not incidental; it is structural. These districts consistently rank among Indiana's highest-performing. AP course enrollment is expected, not exceptional. College preparation begins in middle school. Extracurricular competition — from athletics to robotics to speech and debate — operates at levels that approach professional intensity. For many students, the implicit message is that anything less than excellence represents failure. Luthar's research identifies this environment as specifically pathogenic: it generates rates of depression, anxiety, and substance use that exceed national norms, not despite the community's advantages, but in part because of them.

CRITICAL FINDING

Affluent Youth Formally Classified "At-Risk"

Students in high-achieving schools are now listed alongside poverty, trauma, and discrimination as top risk factors by the National Academies. Luthar found one in five affluent 16-year-old girls had clinically significant depressive symptoms — three times higher than inner-city counterparts. Suburban boys showed 59% substance use prevalence vs. 38% among inner-city peers.

Luthar & Becker, Child Development, 2002; National Academies

Parental absence is the second mechanism. In affluent communities, parental absence is typically not physical absence due to poverty or multiple jobs — it is emotional absence due to career demands, travel schedules, and the outsourcing of relationship to activities and enrichment programs. Children in these environments often have material abundance and emotional scarcity simultaneously. The combination of high expectations, emotional distance, and unfettered access to smartphones and social media creates what Luthar describes as a compounding risk environment.

RISK FACTORS AMPLIFIED IN HAMILTON COUNTY

- High-achieving schools formally classified as "at-risk" settings
- Social media averaging 4.8 hrs/day among teens
- Rapid population growth straining youth services
- Social comparison intensified by affluent peer environments
- Competitive sports culture that squeezes out non-elite participants
- Household wealth that can mask substance use by delaying visible consequences

PROTECTIVE FACTORS TO STRENGTHEN

- Strong school district resources and administrative engagement
- Active parent and community organizations
- Above-average household income enabling private care access
- Growing awareness of youth mental health needs
- Existing school counseling infrastructure as a delivery platform
- High educational attainment among parents (72% BA+)

Hamilton County's local data confirm these patterns. The county's excessive drinking rate of 20.3 percent ranks 162nd out of 292 large U.S. counties in national benchmarking — placing it in the upper half nationally despite its overall health and affluence advantages. The suicide rate of 11.5 per 100,000 aligns with state gender disparities. The loneliness rate of 29.2 percent confirms national patterns of social disconnection.

And the 767 percent increase in youth mental health events from 2017 to 2024 demonstrates that Hamilton County is not merely participating in the national youth crisis — it is experiencing it at an intensity that demands a targeted, locally calibrated response.

Sources: U.S. Surgeon General Advisory on Youth Mental Health (2021) & Social Media (2023); CDC YRBS (2021, 2023); Sagamore Institute, *Failure to Launch* (2026); Haidt J, *The Anxious Generation* (2024); Twenge et al., *Clinical Psychological Science* (2018); Shannon et al., *JMIR Mental Health* (2022); Luthar SS & Becker BE, *Child Development* (2002); Luthar SS & Kumar NL, *Int J School & Ed Psych* (2020); Reeves RV, *Of Boys and Men*, Brookings (2022); AIBM Research (2024–2026); Pew Research Center (2024); Measure of America Youth Disconnection (2024–2025); AEI Reconnecting Opportunity Youth (2026); Abramson et al., NBER WP 32354 (2024); Indiana MPH Mental Health Events (2017–2024); IHC National Benchmarking Index (292 counties); CHR 2025; CDC PLACES 2026

6.6 ADHD: The Most Common Youth Behavioral Health Condition

Attention-deficit/hyperactivity disorder (ADHD) is the single most commonly diagnosed behavioral health condition in children and adolescents, affecting approximately 9.8% of children ages 3 to 17 nationally[CDC, 2022]**—a prevalence that translates to an estimated 6,100 children in Hamilton County living with the condition. Despite its ubiquity, ADHD is often excluded from discussions of behavioral health crisis, a conceptual gap that this assessment addresses directly.**

9.8%

CHILDREN AGES 3–17 WITH ADHD

Approximately 6,100 Hamilton County children [CDC, 2022; Census ACS, 2023]

64%

ADHD CHILDREN WITH CO-OCCURRING BH CONDITION

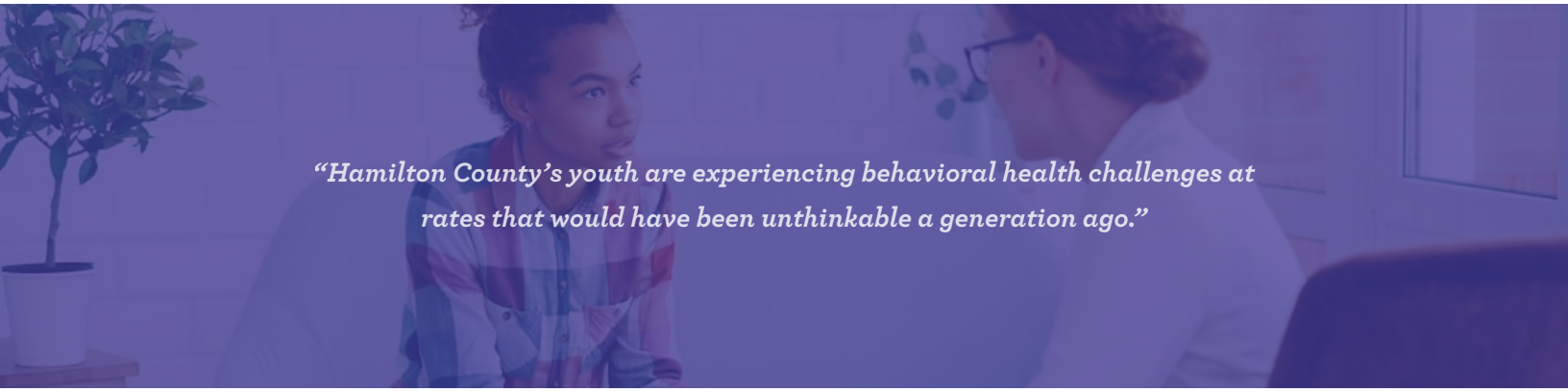
Anxiety, depression, or conduct disorder [CDC, 2022]

The behavioral health significance of ADHD extends far beyond attention and focus. 64% of children with ADHD have at least one co-occurring behavioral health condition[CDC, 2022]**—most commonly anxiety disorders (33%), behavior/conduct problems (40%), and depression (17%). These co-occurring conditions compound academic, social, and family impacts, and they frequently escalate into the crisis events documented throughout this assessment.**

Treatment access is the binding constraint. Effective ADHD management typically requires medication management by a psychiatric prescriber—a psychiatrist, psychiatric nurse practitioner, or specifically trained pediatrician. Hamilton County's severe prescriber shortage, documented in Section 8, means that the estimated 6,100 children who need ongoing medication management are competing for appointments with a provider workforce that is already stretched beyond capacity. The 2021 BHNA survey documented a 57-day average wait for medication management—a delay that, for a child with ADHD, can mean an entire school quarter of untreated symptoms affecting academic performance, peer relationships, and family dynamics.

The developmental stakes are high. Untreated ADHD in childhood is associated with increased risk of academic underperformance, social difficulties, low self-esteem, and—critically—significantly elevated risk of substance use disorder in adolescence and early adulthood. Children with untreated ADHD are approximately twice as likely to develop substance use disorders compared to their peers [Biederman et al., *American Journal of Psychiatry*, 2006]**. Early, consistent treatment reduces this risk substantially.**

Adult ADHD is increasingly recognized as a significant and underdiagnosed condition, affecting an estimated 4.4% of adults nationally [Kessler et al., *American Journal of Psychiatry*, 2006]**. Many adults with ADHD were never diagnosed in childhood, and their symptoms—difficulty with organization, time management, emotional regulation, and sustained attention—are frequently misattributed to anxiety, depression, or personality traits. For Hamilton County's high-pressure professional workforce, undiagnosed adult ADHD represents a hidden contributor to workplace stress, burnout, and behavioral health service demand.**



"Hamilton County's youth are experiencing behavioral health challenges at rates that would have been unthinkable a generation ago."

SECTION 07

Substance Use Disorder Landscape

17.8%

BINGE DRINKING PREVALENCE — IDENTICAL TO MARION COUNTY DESPITE DRAMATICALLY DIFFERENT DEMOGRAPHICS

The opioid crisis is receding, but alcohol misuse hides in plain sight across one of Indiana's wealthiest counties.

SECTION 7

SUBSTANCE USE DISORDER LANDSCAPE

Substance use in Hamilton County does not look like the stereotype. There are no open-air drug markets, no tent encampments along highway underpasses, no daily news reports of overdose clusters. To many residents, the county's substance use challenges feel distant — a problem that afflicts other communities. The data tell a more complicated story. Hamilton County's opioid prescribing rates and overdose death rates are indeed well below state and national averages, reflecting a decade of genuine progress in prescriber behavior and harm reduction. But the county's alcohol use data reveal a hidden vulnerability: binge drinking prevalence in one of Indiana's wealthiest counties matches Marion County, the state's most urban. And the treatment infrastructure available to residents who do develop substance use disorders — only 37 facilities in-county, only 2 opioid treatment programs within a 20-mile radius — is far thinner than the county's population and resources would suggest.

-32%

OPIOID PRESCRIBING RATE DECLINE

Hamilton County, 2013–2023 [CMS Medicare Part D, 2013-2023]

4.19

OPIOID PRESCRIBING RATE (2023)

Per 100 Medicare Part D claims [CMS Medicare Part D, 2013-2023]

17.8%

BINGE DRINKING PREVALENCE

= Marion County (CDC PLACES 2023) [CDC PLACES, 2026]

2

OPIOID TREATMENT PROGRAMS

Within 20-mile radius — critical gap [SAMHSA Treatment Locator, 2025]

Indiana's Overdose Trajectory: A Story of Fentanyl, Then Recovery

-39%

DECLINE IN INDIANA OVERDOSE DEATHS FROM 2021 PEAK

From 2,789 deaths at the fentanyl peak to an estimated 1,695 in 2024 — real progress, but still 38% above the 2015 baseline.

To understand Hamilton County's substance use landscape, it helps to understand the state-level context within which it sits. Indiana's drug overdose crisis followed the national arc — but with Indiana-specific intensity. Total drug overdose deaths rose from 1,232 in 2015 to a devastating peak of 2,789 in 2021, driven almost entirely by the proliferation of illicitly manufactured fentanyl. Synthetic opioid deaths surged from 212 in 2015 to 1,985 in 2021 — a nearly tenfold increase in six years. Fentanyl did not simply replace heroin; it contaminated the entire illicit drug supply, appearing in counterfeit pills, methamphetamine, and cocaine, killing users who had no intention of consuming opioids.

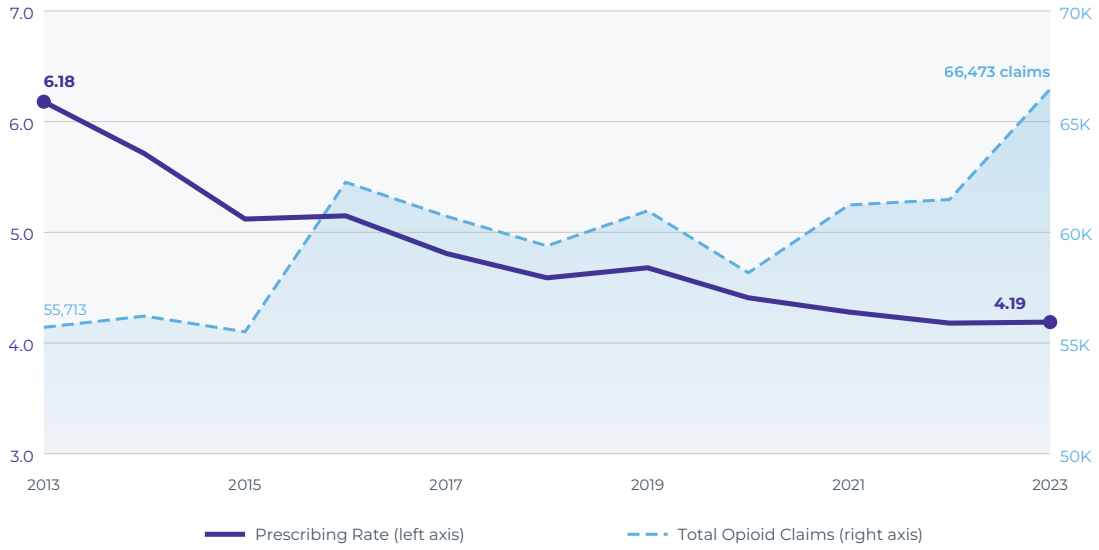
The good news is that the trajectory has reversed. Indiana's overdose deaths declined from 2,789 in 2021 to an estimated 1,695 in 2024 — a 39 percent reduction from peak. This decline reflects a combination of expanded naloxone distribution, increased access to medications for opioid use disorder, shifting supply patterns, and community awareness. But 1,695 deaths annually is still 38 percent higher than the 2015

baseline, and the crisis is far from resolved. Emerging substances — fentanyl analogues, xylazine (an animal tranquilizer increasingly found in the drug supply), and kratom — present new challenges that the existing treatment infrastructure was not designed to address.

YEAR	TOTAL DRUG OD DEATHS (INDIANA)	SYNTHETIC OPIOID (FENTANYL) DEATHS	TREND
2015	1,232	212	Baseline
2017	1,556	475	Rising
2019	1,700	908	Fentanyl accelerating
2020	2,346	1,492	Pandemic surge
2021	2,789	1,985	Peak
2022	2,418	1,712	Declining
2023	1,987	1,289	Declining
2024 (est.)	1,695	1,044	-39% from peak

Source: CDC WONDER Indiana Drug Overdose Deaths; 2024 figures are provisional estimates

Opioid Prescribing: Rate vs. Total Claims, Hamilton County (2013–2023)



Source: CMS Medicare Part D Opioid Prescribing Geographic Data, 2013–2023

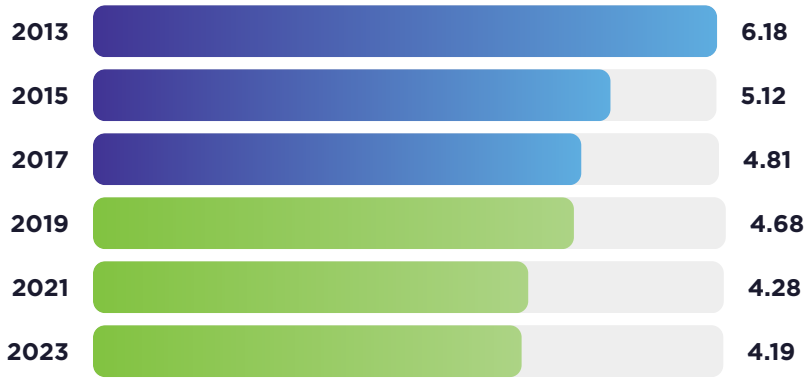
Hamilton County Opioid Prescribing: An 11-Year Success Story With Caveats

> ***Fentanyl did not simply replace heroin; it contaminated the entire illicit drug supply, killing users who had no intention of consuming opioids.***
>
> CDC WONDER ANALYSIS, 2015-2024

CMS Medicare Part D data reveal a steady, sustained decline in opioid prescribing in Hamilton County that reflects genuine progress in clinical practice. The opioid prescribing rate — defined as opioid claims per 100 total Part D claims — dropped from 6.18 in 2013 to 4.19 in 2023, a 32 percent reduction over a decade. This decline occurred even as the county's total prescription volume nearly doubled (from 902,026 total claims to

1,587,092), reflecting rapid population growth and an aging Medicare population. Total opioid claims increased only modestly, from 55,713 to 66,473, meaning the declining rate reflects dilution by a growing denominator of non-opioid prescriptions.

The long-acting opioid rate tells an even more encouraging story. Long-acting opioids — extended-release formulations like OxyContin that carry higher addiction risk — declined from 11.44 percent of all opioid claims in 2013 to 6.06 percent in 2023, a 47 percent reduction. This shift reflects CDC guideline adoption, insurer prior authorization requirements, and genuine changes in prescriber behavior that have moved the county away from the high-risk prescribing patterns that fueled the initial opioid crisis.



Opioid prescribing rate (per 100 Part D claims). Source: CMS Medicare Part D, 2013–2023

The caveats matter. These data capture only Medicare Part D prescribing — predominantly older adults. They do not capture prescribing to younger populations, illicit substance use, or alcohol consumption. And Hamilton County's low overdose death rate of 14.3 per 100,000, while far better than Marion County's 69.7, still represents preventable deaths. Indiana men die from drug overdoses at a rate of 50.83 per 100,000 — more than double the female rate of 24.2 — a gender disparity that mirrors the broader pattern of male lethality documented in Section 6.

The Hidden Vulnerability: Binge Drinking in an Affluent County

While Hamilton County's opioid metrics paint a relatively favorable picture, the county's alcohol use data reveal a different story entirely. CDC PLACES 2023 data show Hamilton County's age-adjusted binge drinking prevalence at 17.8 percent — identical to Marion County and higher than Madison County (16.2 percent). In the IHC National Benchmarking Index of 292 U.S. counties with populations over 250,000, Hamilton County's excessive drinking rate of 20.3 percent ranks 162nd, placing it in the bottom half nationally for this measure.

This convergence should be alarming. Marion County has a poverty rate of approximately 20 percent, triple Hamilton County's 4.7 percent. Marion has far higher rates of every other substance use indicator. Yet on binge drinking, the two counties are identical. This suggests that alcohol misuse in affluent suburban communities operates through entirely different pathways — stress-related consumption, social norms around drinking at community events, wine culture, and a reduced perception of risk — that produce similar population-level outcomes through different mechanisms. The county's low drug overdose death rate may create a false sense of security that masks the alcohol problem hiding in plain sight.

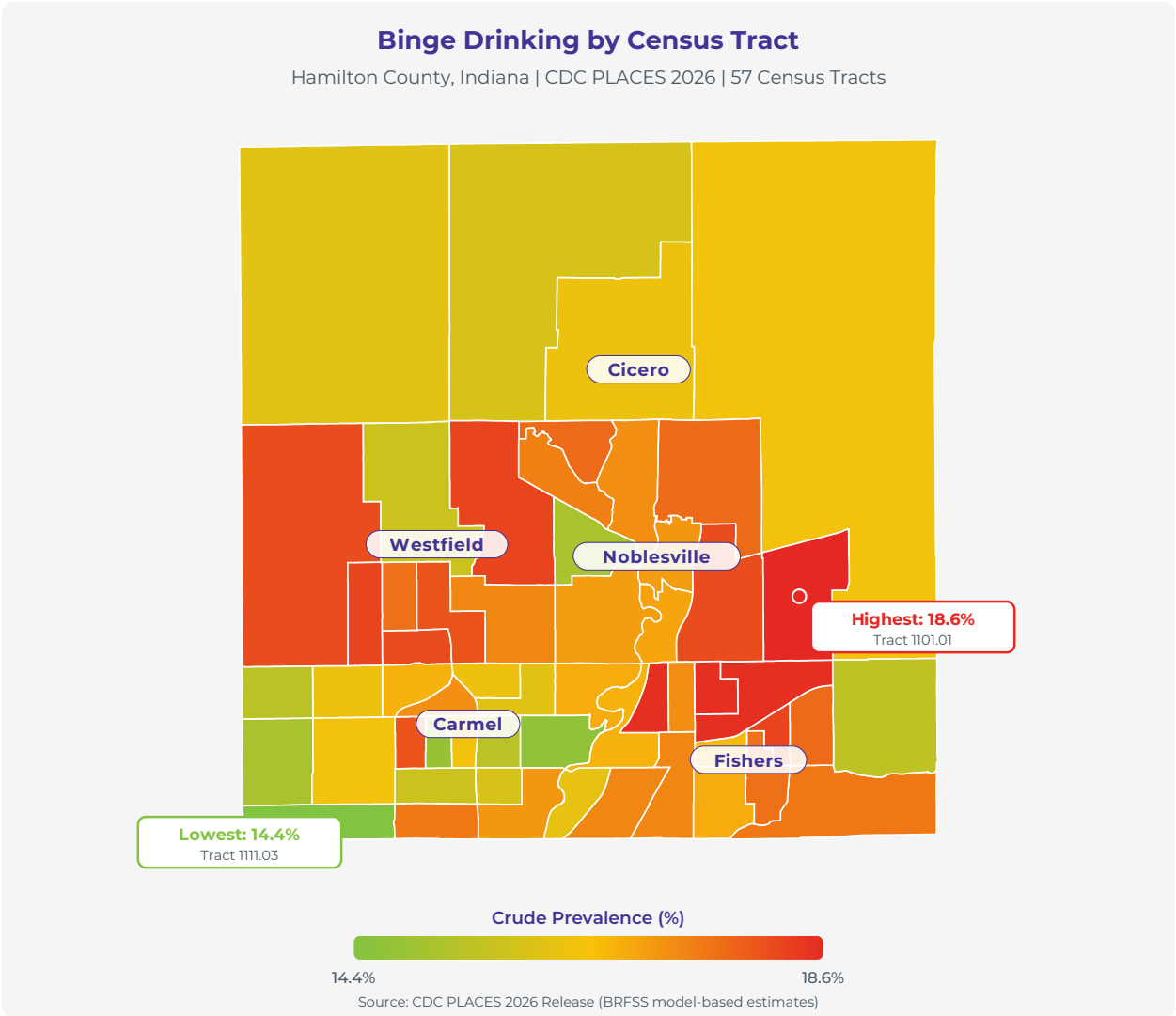
THE AFFLUENCE PARADOX

Hamilton County's poverty rate is 4.7% vs. Marion County's ~20%. Yet on binge drinking, the two counties are statistically identical at 17.8%.

HIDDEN IN PLAIN SIGHT

Hamilton County's binge drinking rate matches Marion County's despite dramatically different demographic profiles. Alcohol is legal, socially normalized, and easily accessible to teenagers in affluent households. The Sagamore data show Indiana boys' alcohol use surging from 10 percent in 9th grade to 43.8 percent in 12th grade — and for three of four high school years, girls actually drink at higher rates than boys. Over 93 percent of people with substance use disorders never access specialty treatment. For Hamilton County, the substance use challenge is less about heroin and fentanyl — though those threats remain real — and more about the bottle of wine after work, the college-kid binge culture, and the senior-year party scene that parents tacitly tolerate.

Binge Drinking by Census Tract — Hamilton County (CDC PLACES 2026)



The Youth Substance Crisis Hiding in Plain Sight: Vaping and E-Cigarettes

While alcohol misuse is the dominant adult substance concern in Hamilton County, e-cigarette use is the number-one substance concern in the county's schools. The vaping epidemic has reshaped adolescent substance use patterns nationwide, and Hamilton County's youth are not exempt.

10%

HIGH SCHOOL STUDENTS CURRENTLY USING E-CIGARETTES

National estimate, 2023 NYTS [CDC/FDA National Youth Tobacco Survey, 2023]

12–15%

ESTIMATED INDIANA YOUTH VAPING RATE

Based on YRBS data; Indiana trends above national average

[CDC YRBS, 2023; Indiana DMHA, 2024]

Nationally, approximately 10% of high school students reported current e-cigarette use in the 2023 National Youth Tobacco Survey[CDC/FDA NYTS, 2023]**, and Indiana's youth vaping rates are estimated at 12 to 15 percent based on Youth Risk Behavior Survey data**[CDC YRBS, 2023]**. Among middle school students, use is rising fastest. Flavored products—designed to appeal to young users—account for 90% of youth e-cigarette use.**

The behavioral health implications are significant and underappreciated:

- **Nicotine and adolescent brain development. The adolescent brain continues developing until approximately age 25. Nicotine exposure during this period alters neural circuitry involved in attention, learning, and impulse control—and emerging research links adolescent nicotine use to increased rates of anxiety and depression.**
  [U.S. Surgeon General, 2016; Yuan et al., *PLOS ONE*, 2015]
- **Vaping as a gateway. Adolescents who use e-cigarettes are 3.5 times more likely to subsequently use combustible cigarettes and are at elevated risk for cannabis and other substance use.**[National Academies of Sciences, 2018]
- **School enforcement challenges. E-cigarette devices are easily concealed (some resemble USB drives or pens), produce minimal visible vapor, and are often used in school restrooms and stairwells. School administrators across Hamilton County report that enforcement is extremely difficult and that disciplinary approaches alone are insufficient.**
- **Anxiety-nicotine feedback loop. Adolescents frequently report using nicotine to manage anxiety and stress, creating a self-reinforcing cycle: nicotine provides temporary relief but increases baseline anxiety levels, driving further use. Nicotine dependence in adolescence correlates with higher rates of anxiety disorders in early adulthood.**[Moylan et al., *Psychological Medicine*, 2013]

For a county already experiencing a youth behavioral health crisis of historic proportions—4,752 youth mental health events in 2024, a 767% increase since 2017—the widespread use of a substance that exacerbates anxiety and depression in developing brains represents an additional accelerant. Prevention and cessation programming specific to vaping should be considered a behavioral health intervention, not merely a tobacco control measure.

Treatment Infrastructure: Thin Where It Matters Most

> *Over 93 percent of people with substance use disorders never access specialty treatment.*

SAMHSA NSDUH, 2024

The SAMHSA Treatment Facility Locator identifies 328 behavioral health treatment facilities [SAMHSA Treatment Locator, 2025] **within a 20-mile radius of Hamilton County's center, including 37 located within the county itself. On the surface, this seems adequate. The distribution reveals critical gaps.**

190
BUPRENORPHINE PROVIDERS
58% of total [SAMHSA Treatment Locator, 2025]

65
HRSA HEALTH CENTERS
20% of total [SAMHSA Treatment Locator, 2025]

47
SUD TREATMENT
14% of total [SAMHSA Treatment Locator, 2025]

24
MH TREATMENT
7% of total [SAMHSA Treatment Locator, 2025]

2
OPIOID TREATMENT PROGRAMS
Critical gap [SAMHSA Treatment Locator, 2025]

CRITICAL FINDING

Only 2 Opioid Treatment Programs in 20-Mile Radius

For a county of nearly 372,000 people, only 2 opioid treatment programs and 24 dedicated mental health facilities serve the area. The predominance of buprenorphine providers (190 of 328) reflects limited availability of intensive residential and outpatient options.

SAMHSA Treatment Facility Locator, March 2026

Only 2 opioid treatment programs serve the entire 20-mile radius — a critical constraint for individuals requiring methadone or comprehensive MOUD services. The predominance of buprenorphine providers (190 of 328) reflects the shift toward office-based opioid treatment but also highlights the limited availability of more intensive residential and outpatient options. Only 24 dedicated mental health treatment facilities exist in the area. For a county of nearly 372,000 people, this infrastructure is inadequate for addressing the full spectrum of substance use disorders, from prevention through intensive treatment to recovery support.

Sources: CMS Medicare Part D Opioid Prescribing Geographic Data, Hamilton County (2013–2023); CDC WONDER Indiana Drug Overdose Deaths; CDC PLACES 2026 (2023 data year); SAMHSA Treatment Facility Locator (March 2026); IHC National Benchmarking Index (292 counties); Sagamore Institute, *Failure to Launch* (2026); SAMHSA NSDUH (2024)

SECTION 8

PROVIDER LANDSCAPE & ACCESS BARRIERS

Imagine you are a Hamilton County parent whose 15-year-old daughter has just told you she wants to die. You call your pediatrician, who refers you to a therapist. The therapist's next available appointment is in 41 days. Your daughter needs medication management; the wait for a prescriber is 57 days. You have commercial insurance, but the therapist you found is out-of-network, meaning you will pay $150 to $250 per session out of pocket. If you are among the 11 percent of the county's population below 200 percent of the federal poverty level, you face a provider ratio of 37,129 to 1 — meaning there is, in practical terms, almost no behavioral health provider accessible to you through public insurance. If you speak Spanish at home, 89 percent of providers have no bilingual staff. This is what it means to try to access behavioral health care in Hamilton County.

19/25

HRSA HPSA MENTAL HEALTH SCORE

Critical shortage designation [HRSA HPSA, 2025]

37,129:1

LOW-INCOME PROVIDER RATIO

HRSA threshold is 20,000:1 [HRSA HPSA, 2025]

41 days

AVG WAIT — THERAPY

First appointment (2021 BHNA) [2021 Hamilton County BHNA]

57 days

AVG WAIT — MEDICATION MGMT

Nearly 2 months for psychiatric care [2021 Hamilton County BHNA]

Federal Shortage Designations: What the HPSA Score Means

Hamilton County holds two active HRSA Mental Health HPSA designations, confirming that despite its affluence, the county has federally recognized behavioral health provider shortages. The most critical designation — Aspire Indiana Health Inc. — carries an HPSA Score of 19 out of a maximum 25. This score is calculated from multiple factors: the population-to-provider ratio, the poverty rate of the designated population, travel time to the nearest source of care, and the presence of unusually high needs such as substance use prevalence. A score of 19 means the shortage is severe, not marginal. The designation covers a population of 143,077 — roughly 39 percent of the county's total population.

Mental Health HPSA Designation Score: Hamilton County

19 / 25

HPSA Score (Critical Mental Health Professional Shortage)

Aspire Indiana Health, Inc. | Designation: 10/05/2017 | Population Served: 143,077

Source: HRSA Health Professional Shortage Area (HPSA) Database, updated 09/2025

The second designation covers the county's low-income population with a score of 14 out of 25. This designation reveals the most striking access statistic in the assessment: a formal provider ratio of 37,129 to 1[HRSA HPSA, 2025]. To put that in perspective, HRSA's adequacy threshold is 20,000 to 1 — and even that threshold represents constrained access, not abundant care. Hamilton County's low-income residents face a provider ratio nearly double the federal shortage threshold. HRSA estimates a shortage of 17.8 full-time-equivalent providers, with only 12.1 FTE currently serving this population. That gap — roughly 18 additional full-time behavioral health professionals — represents the difference between a system that functions and one that fails its most vulnerable residents.

HPSA DESIGNATION	TYPE	SCORE	DESIGNATION POP.	PROVIDER RATIO	FTE PROVIDERS	SHORT (FTE)
Aspire Indiana Health Inc.	FQHC Look-Alike	19	143,077	—	—	—
LI – Central Indiana MHCAs	Population HPSA	14	447,964	37,129:1	12.1	17.8

Source: HRSA HPSA Mental Health Data, retrieved March 2026. Marion County: max score 22, 11 active designations.

The Private Practice Dominance Problem

The 2021 Hamilton County Behavioral Health Needs Assessment found that 96 percent of the county's behavioral health providers operated in private practice, with only 4 percent operating as DMHA-certified community mental health centers. This structural imbalance is not a market failure in the traditional sense — it reflects the economics of behavioral health care in an affluent community. Private practice therapists can sustain a viable business by serving commercially insured clients at $150 to $250 per session. There is little financial incentive to accept Medicaid, which reimburses at significantly lower rates and requires more administrative overhead. The result is a two-tiered system that serves the county's majority well enough while leaving its most vulnerable residents functionally without access.

96%

PRIVATE PRACTICE

Only 4% DMHA certified (2021) [2021 Hamilton County BHNA]

17%

ACCEPTED MEDICAID

2021 provider survey [2021 Hamilton County BHNA]

89%

NO BILINGUAL STAFF

In a diversifying county [Census ACS, 2023]

Of the approximately 237 private therapists identified in 2021, only 17 percent accepted Medicaid — meaning roughly 40 providers were available to the county's entire Medicaid-enrolled population. Eighty-nine percent had no bilingual staff, a growing concern as Hamilton County's Hispanic/Latino population continues to increase. The county is becoming more diverse while its behavioral health workforce remains overwhelmingly monolingual and commercially oriented.

The structural dynamics of the private practice problem — including the Medicaid MCO rate gap, the supervision bottleneck, the telehealth displacement effect, and the solo practice trap — are analyzed in detail in the companion Behavioral Health Workforce Development Analysis 2026.

Wait Times: What Waiting 57 Days for Psychiatric Care Means

Average wait times of 41 days for a first therapy appointment and 57 days for a first medication management appointment are not abstractions. Consider what 57 days means for a person in psychiatric crisis. It means nearly two months of untreated depression, anxiety, or psychosis. It means two months during which an employee may be unable to function at work, a student may fail classes, a parent may be unable to care for children. It means two months during which suicidal ideation may intensify, substance use may escalate, and a treatable condition may become a life-threatening emergency. The national average wait time for behavioral health services is 48 days (Glied & Aguilar, Brookings, 2023) — Hamilton County exceeds even that troubled benchmark for medication management.

2021 BHNA provider survey; national average from Glied & Aguilar, Brookings (2023)

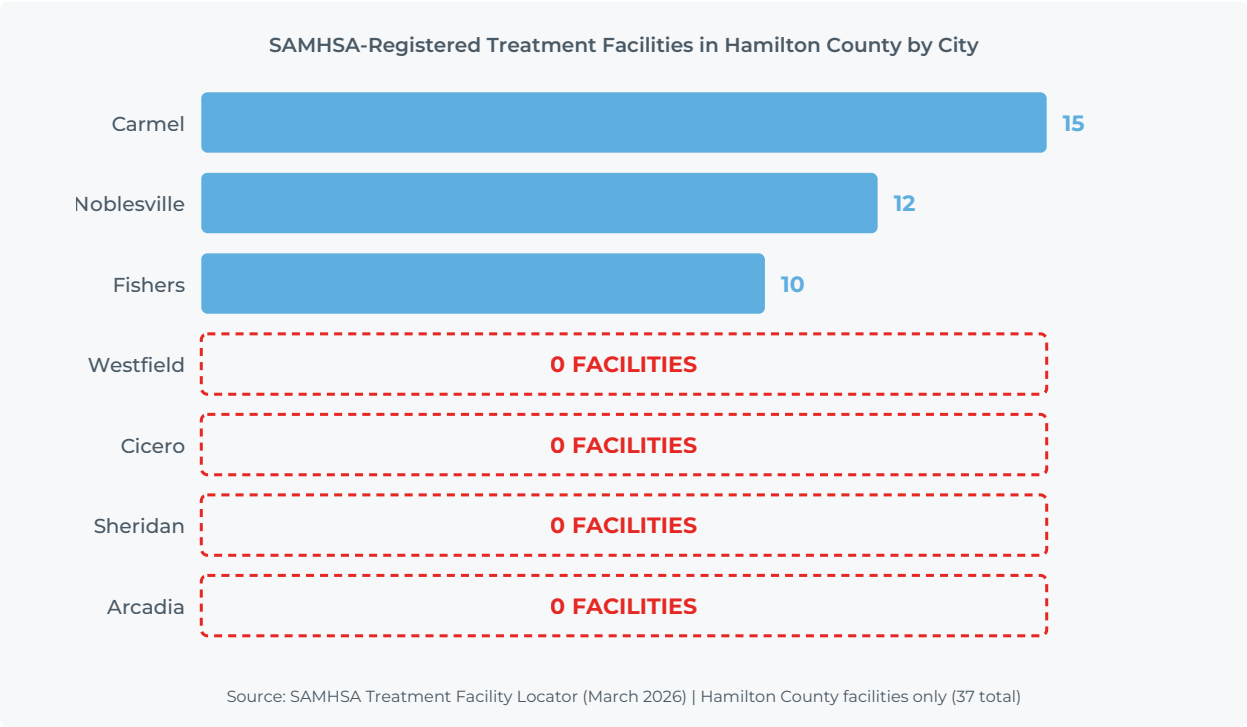
Telehealth: Promise and Limitations

Post-pandemic telehealth adoption has partially expanded access. Cantor et al. (JAMA Health Forum, 2023) found that telehealth mental health visits expanded rapidly during the pandemic and remained elevated through 2022, representing a persistent structural shift in service delivery. Acceptability studies show 71 percent of beneficiaries find tele-mental health services acceptable (Zewude et al., 2024), and clinical outcomes are comparable to in-person care (Shaker et al., 2023). However, McBain et al. (2023) found that access disparities persisted for Black residents and Medicaid recipients even with telehealth expansion. Telehealth cannot prescribe controlled substances in all contexts, cannot conduct certain assessments, and requires reliable internet access and a private space — resources not universally available to lower-income residents.

CRITICAL ACCESS GAPS: WHO FALLS THROUGH

The convergence of private practice dominance, low Medicaid acceptance, long wait times, limited linguistic capacity, and only 2 opioid treatment programs creates a system that effectively serves commercially insured, English-speaking adults with flexible schedules. For everyone else — Medicaid recipients, uninsured individuals, non-English speakers, those in crisis, and adolescents — the system falls critically short. This is the supply-side context for the demand explosion documented in Sections 4 through 6: a tripling of mental health events and a 767 percent increase in youth crisis events are meeting a provider infrastructure that was already inadequate before the pandemic-era surge.

Provider Desert: Treatment Facility Distribution Across Hamilton County Cities



Of 37 SAMHSA-registered treatment facilities in Hamilton County, all are concentrated in just three cities. Westfield — the county's fastest-growing city — has zero registered treatment facilities, creating a provider desert for its 70,000+ residents.
Source: SAMHSA Treatment Facility Locator (March 2026)

EMERGING LOCAL ASSET

RELY Center — Hamilton County's First Crisis Stabilization Facility

Aspire Indiana Health has opened the RELY Center, a dedicated crisis stabilization and 23-hour observation center in Hamilton County. This facility directly addresses the most critical gap identified in this assessment: the absence of a local, non-emergency-department destination for individuals in acute behavioral health crisis. The RELY Center provides short-term stabilization, clinical assessment, and warm handoffs to ongoing care — the exact model that states like Arizona and Georgia have shown reduces ED behavioral health visits by 30–40% and significantly decreases law enforcement crisis transport burden. For a county that recorded 34,520 behavioral health events in 2024, this is a transformational addition to the care continuum.

Aspire Indiana Health; SAMHSA Sequential Intercept Model Toolkit, 2024

Medicaid and HIP 2.0: The Coverage Backbone Under Threat

Indiana expanded Medicaid through the Healthy Indiana Plan (HIP) 2.0 in 2015, creating a coverage pathway that now insures approximately 800,000 Hoosiers, including an estimated 15,000 residents of Hamilton County. [Indiana FSSA, 2025; KFF Medicaid Expansion Tracker, 2025] **HIP 2.0 covers a comprehensive range of behavioral health services, including outpatient counseling, medication-assisted treatment (MAT) for opioid use disorder, crisis intervention services, and inpatient psychiatric care.**

~800K

HOOSIERS ENROLLED IN HIP 2.0

Indiana's Medicaid expansion program since 2015 [Indiana FSSA, 2025]

~15K

HAMILTON COUNTY HIP 2.0 ENROLLEES

Estimated based on county share of statewide enrollment [Indiana FSSA, 2025]

The significance of Medicaid coverage for Hamilton County's behavioral health system cannot be overstated. Aspire Indiana Health's RELY Center, the county's first and only crisis stabilization facility, depends on Medicaid reimbursement as a primary funding stream. Many of the community-based behavioral health services documented in this assessment—crisis intervention, substance use disorder treatment, psychiatric rehabilitation—rely on Medicaid as the payer of last resort for individuals who cannot access or afford private insurance.

Against this backdrop, the finding that only 17% of Hamilton County's private behavioral health providers accept Medicaid [2021 Hamilton County BHNA] **takes on heightened significance. If federal Medicaid funding is reduced or restructured—through per-capita caps, block grants, or enhanced match reductions currently under congressional discussion—the consequences for Hamilton County's behavioral health infrastructure would be severe. The 83% of providers who do not accept Medicaid would be unaffected, but the safety-net providers who serve the most vulnerable populations would face funding cuts that directly reduce treatment capacity. The practical result: an already-constrained system serving an already-underserved population would contract further, pushing more individuals into emergency departments and crisis systems that are more expensive and less effective.**

Federal Medicaid Uncertainty: A Structural Risk to Local Behavioral Health

As of early 2026, proposed federal legislation includes provisions that would reduce Medicaid spending by an estimated $880 billion over ten years. If enacted, Indiana's HIP 2.0 program—which depends on a 90% federal match for expansion enrollees—would face funding reductions that could lead to coverage losses for hundreds of thousands of Hoosiers. For Hamilton County, where Medicaid-funded providers are already scarce, any reduction in coverage threatens to widen the access gap between residents with private insurance and those without it. [KFF Medicaid Expansion Analysis, 2025; CBO Budget Estimates, 2025]

Psychiatric Bed Capacity: A Structural Absence

The most consequential infrastructure gap in Hamilton County's behavioral health system is not a shortage of therapists or a lack of funding—it is the complete absence of dedicated psychiatric inpatient beds within county borders. Hamilton County, a community of 357,000 people that recorded 34,520 mental health events in 2024, has zero psychiatric inpatient beds.

0

PSYCHIATRIC INPATIENT BEDS IN HAMILTON COUNTY

357,000 residents must leave the county for acute psychiatric care

~25

NATIONAL RATE: BEDS PER 100K POPULATION

Down from 340 per 100K in 1955

[Treatment Advocacy Center, 2016]

This absence is part of a national crisis in psychiatric bed capacity. The United States has approximately 25 psychiatric beds per 100,000 population—a 93% decline from the 340 beds per 100,000 that existed in 1955, when deinstitutionalization began. [Treatment Advocacy Center, 2016] **Indiana falls below even this reduced national average, with approximately 18–22 beds per 100,000 population, ranking in the bottom third of states for psychiatric bed availability.** [SAMHSA National Mental Health Services Survey, 2023; Treatment Advocacy Center State Data]

GEOGRAPHY	PSYCHIATRIC BEDS PER 100K	CONTEXT
United States (1955)	~340	Pre-deinstitutionalization peak
United States (2024)	~25	93% decline over seven decades
Indiana (2024)	~18–22	Below national average; bottom-third of states
Hamilton County (2024)	0	No dedicated psychiatric inpatient facility

[Treatment Advocacy Center, 2016; SAMHSA N-MHSS, 2023; HRSA Area Health Resource File, 2024]

For Hamilton County residents experiencing acute psychiatric crisis—psychotic episodes, severe suicidal ideation requiring inpatient stabilization, acute mania, or dangerous withdrawal from substances—the nearest inpatient psychiatric options are all located in Marion County:

- **Community Health Network North (Indianapolis) — The closest general psychiatric inpatient unit, approximately 15–25 minutes south of most Hamilton County cities**
- **IU Health Methodist Hospital (Indianapolis) — Academic medical center psychiatric unit**
- **Eskenazi Health Midtown (Indianapolis) — Safety-net psychiatric facility serving the broader MSA**
- **Options Behavioral Health (Indianapolis) — Private psychiatric hospital with adolescent and adult programs**

Emergency Department Boarding: The Hidden Consequence

When psychiatric inpatient beds are unavailable—which is frequent, given statewide shortages—patients in acute psychiatric crisis are "boarded" in emergency departments, often for 24 to 72+ hours, waiting for a bed to open. [Nordstrom et al., *Annals of Emergency Medicine*, 2019] **ED boarding is clinically harmful (emergency departments are not designed for psychiatric stabilization), expensive (consuming ED beds needed for medical emergencies), and psychologically traumatic for the patient. A 2023 American College of Emergency Physicians survey found that 79% of emergency physicians reported patients boarded for behavioral health crises in their departments, with average wait times exceeding 24 hours.** [ACEP Psychiatric Boarding Survey, 2023] **Hamilton County's hospitals—including IU Health Saxony in Fishers and St. Vincent Carmel—are not immune to this dynamic.**

ASPIRE INDIANA HEALTH'S RELY CENTER: FILLING A CRITICAL GAP

The RELY Center provides 23-hour crisis stabilization—a vital service that diverts many acute presentations from emergency departments. However, it is important to understand what the RELY Center is *not*: it is not an inpatient psychiatric facility. Patients requiring multi-day psychiatric hospitalization—those in florid psychosis, at imminent risk of self-harm requiring constant observation, or undergoing medically complex detoxification—still must be transferred to Marion County facilities. The RELY Center reduces the burden on EDs and law enforcement, but it does not solve the fundamental absence of inpatient psychiatric capacity within the county.

The practical consequence is stark: a Hamilton County resident in the most severe phase of a psychiatric emergency must leave the county for treatment. For families, this means navigating unfamiliar hospitals during the most frightening moment of their lives. For the patient, it means separation from the local

support systems that are critical to recovery. And for the system, it means that the most acute cases—the ones that generate the highest costs and worst outcomes when undertreated—are structurally exported to a neighboring county's already-strained infrastructure.

[Treatment Advocacy Center, *Going, Going, Gone: Trends and Consequences of Eliminating State Psychiatric Beds*, 2016; SAMHSA N-MHSS, 2023; Nordstrom et al., *Annals of Emergency Medicine*, 2019; ACEP Emergency Department Boarding Survey, 2023; HRSA Area Health Resource File, 2024]

Sources: HRSA HPSA Mental Health Data (March 2026); SAMHSA Treatment Facility Locator (March 2026); 2021 Hamilton County BHNA Provider Survey; CHR 2025; Cantor et al., *JAMA Health Forum* (2023); Zewude et al., *BMC Public Health* (2024); Shaker et al., *Psychotherapy Research* (2023); McBain et al., *JAMA Network Open* (2023); Glied & Aguilar, Brookings (2023); Treatment Advocacy Center (2016); SAMHSA N-MHSS (2023); Nordstrom et al., *Annals of Emergency Medicine* (2019); ACEP Psychiatric Boarding Survey (2023)

Riverview Health: Hamilton County's Only Locally Headquartered Hospital

Riverview Health is the only hospital headquartered within Hamilton County, located in Noblesville and serving the northern portion of the county including Noblesville, Cicero, Arcadia, Sheridan, and Atlanta. With 156 acute care beds and a full-service emergency department, Riverview is the primary point of contact for behavioral health crisis presentations in the areas of the county where provider access is lowest and social vulnerability is highest. [Riverview Health, 2025]

156

ACUTE CARE BEDS

Only hospital headquartered in Hamilton County [Riverview Health, 2025]

0

DEDICATED PSYCHIATRIC BEDS

No inpatient psychiatric capacity at any HC hospital

This geographic reality creates a critical disparity within the county. Residents of southern Hamilton County—Carmel, Fishers, and southern Westfield—have proximity to the Indianapolis health system corridor, including Community Health Network, IU Health, and Eskenazi Health, all of which maintain psychiatric inpatient capacity. But residents of northern Hamilton County rely primarily on Riverview Health, which does not have dedicated psychiatric beds or an inpatient behavioral health unit. When a Noblesville or

Sheridan resident presents at Riverview's emergency department in acute psychiatric crisis, the hospital must stabilize the patient and arrange transfer to an Indianapolis-based facility—a process that can involve hours of ED boarding while an available bed is located.

The geographic disparity is not coincidental. The CDC PLACES heat maps and tract-level data presented in Section 4 show that the census tracts with the highest depression prevalence (up to 27.0%) and highest smoking rates (up to 18.0%) concentrate in the northern and eastern portions of the county—precisely the areas where Riverview Health is the primary hospital and where provider density is lowest. The communities with the greatest behavioral health burden have the fewest resources to address it.

STRATEGIC IMPLICATION

Any expansion of behavioral health crisis infrastructure in Hamilton County should prioritize the northern corridor where Riverview Health serves as the primary hospital. The RELY Center's location in Hamilton County is a critical step, but the broader geographic access gap—concentrated need meeting concentrated scarcity—remains a defining feature of the county's behavioral health landscape.

"The workforce that serves our community's behavioral health needs is itself in crisis — underpaid, understaffed, and structurally misaligned with the populations most in need."

SECTION 9

BEHAVIORAL HEALTH WORKFORCE — DEEP ANALYSIS

The behavioral health workforce crisis is not abstract. It is the binding constraint on everything this assessment recommends. Every initiative to expand access, every school-based mental health program, every integrated care model, every crisis intervention system requires trained human beings to deliver the care. And there are not enough of them — not in Hamilton County, not in Indiana, not in the United States. This section provides the most detailed workforce analysis available for Hamilton County, drawing on Lightcast proprietary workforce intelligence (Q1 2026 data), BLS Occupational Employment and Wage Statistics, and HRSA national projections. The Lightcast data, in particular, enable a granularity of analysis — down to individual occupations, ZIP codes, employer posting behavior, and educational pipeline completions — that no other data source can match. What the data reveal is a workforce growing rapidly but not fast enough, compensated poorly relative to the community it serves, and fed by an educational pipeline that has, for several critical occupations, produced zero local graduates.

COMPANION REPORT: BH WORKFORCE DEVELOPMENT ANALYSIS 2026

This section summarizes key workforce findings. For the complete supply-demand analysis — including occupation-by-occupation career pathway maps, the IHC Community Career Ladder with 30,000+ observed career transitions, skills-based pathway analysis, the Talent Pipeline Management (TPM) framework, employer tactical playbook, and policy prescriptions — see the standalone *Behavioral Health Workforce Development Analysis 2026*, published concurrently by Invest Hamilton County. That report provides the tactical roadmap for employers, educators, and policymakers to act on the workforce gaps documented here.

8,694

BH JOBS IN HAMILTON COUNTY

19-SOC cluster, 2025 (Lightcast) [Lightcast, Q1 2026]

+45.3%

DECADE GROWTH (2019–2029)

+3,009 jobs across the cluster [Lightcast, Q1 2026]

991

ANNUAL OPENINGS

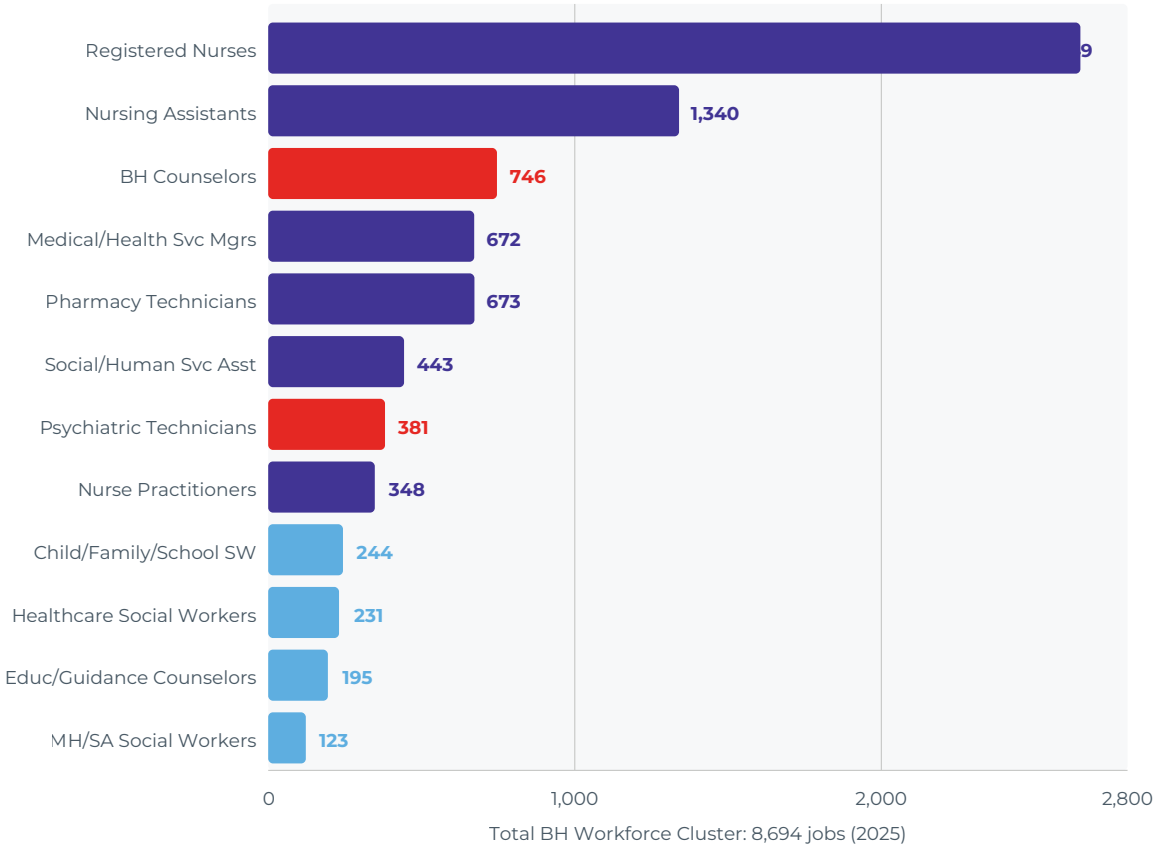
Replacement + growth combined [Lightcast, Q1 2026]

$37.86

AVERAGE HOURLY EARNINGS

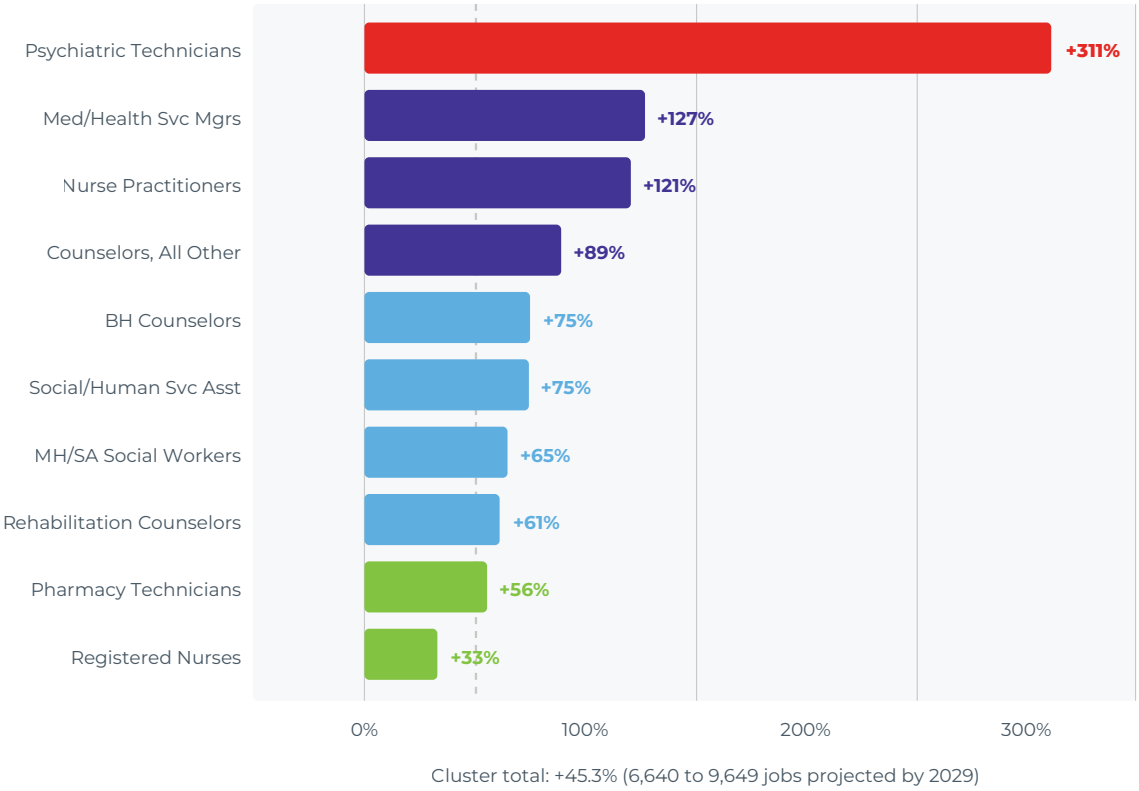
Across 19 BH occupations [Lightcast, Q1 2026]

Behavioral Health Workforce: Employment by Occupation, Hamilton County (2025)



Source: Lightcast Q1 2026 Data Set

Projected 10-Year Growth Rate for BH Occupations, Hamilton County (2019–2029)



Source: Lightcast Q1 2026 (10-Year Projections, 2019–2029)

9.1 Workforce Overview

Hamilton County's behavioral health workforce cluster encompasses 19 Standard Occupational Classification (SOC) codes, ranging from psychiatric technicians earning $19.48 per hour to psychiatrists earning $158.17 per hour. In 2025, the county employs 8,694 workers across these occupations — up from 6,640 in 2019 and projected to reach 9,649 by 2029. This represents 45.3 percent decade growth, outpacing the broader Indianapolis MSA's 21.4 percent growth rate by more than double. The cluster generates 991 annual openings — a combination of growth-driven new positions and replacement openings from turnover and retirement.

At the MSA level, the behavioral health cluster is even larger: 71,339 jobs in 2025, growing to 75,586 by 2029, with 6,930 annual openings. Hamilton County accounts for approximately 12 percent of the MSA's behavioral health employment but is a net exporter of behavioral health workers: 11,371 residents work in these occupations, but only 8,694 of those jobs are located in the county, producing a net commuter outflow

of 2,677 workers. The largest outflows are registered nurses (1,563 net commuters leaving the county for work), nursing assistants (237), and health services managers (165). This means Hamilton County is training and housing behavioral health workers who serve the broader region rather than the county itself.

The cost of living index of 107.3 — meaning goods and services cost 7.3 percent more than the national average — creates a purchasing power challenge for lower-wage behavioral health workers. A counselor earning the median wage of $47,834 in Hamilton County has the effective purchasing power of approximately $44,579 after cost-of-living adjustment. In a county where the median household income exceeds $118,000, a behavioral health counselor's salary places them in the lower third of the income distribution of the very community they serve.

9.2 Occupation-by-Occupation Analysis

Behavioral Health Counselors (SOC 21-1018): The Backbone — and the Broken Pipeline. This is the single most important occupation in the behavioral health workforce, and it harbors the single most critical finding in this assessment. Hamilton County employs 746 behavioral health counselors — substance abuse, behavioral disorder, and mental health counselors combined. The occupation has grown 75 percent over the decade (from 463 in 2019), with a location quotient of 1.28, meaning Hamilton County has 28 percent more counselors per capita than the national average. The county produces 87 annual openings and employs across 22 companies, with Sondermind (15 postings), LifeStance Health (11), Aspire Indiana Health (4), and UnitedHealth Group (4) as the top employers actively recruiting.

STATEWIDE PIPELINE CRISIS: INSUFFICIENT GRADUATES FOR DEMAND

Despite 96 annual openings for behavioral health counselors in the Hamilton County region, the statewide clinical pipeline produces far fewer graduates than the market demands. The broader MSA produced 1,526 completions across 10 programs at 9 institutions — but 660 of those were in general psychology and 624 in general social work, not in the specialized behavioral health counseling track. Only 43 completions were specifically in mental health counseling and 73 in substance abuse counseling. When 96 annual openings in a single county compete against an MSA pipeline where fewer than 120 completions are in directly licensable specialties, the structural inadequacy of the training system becomes clear.

The compensation picture compounds the pipeline problem. The median annual wage for behavioral health counselors in Hamilton County is $47,834, with an average of $26.25 per hour. After cost-of-living adjustment, the effective wage drops to $44,579. This is 20 percent below the national median of $59,675 for the same occupation — meaning Hamilton County offers cheaper labor for employers but a lower standard of living for workers. The entry-level (10th percentile) wage is approximately $20.18 per hour, or roughly $42,000 annually — which in a county with $118,000 median household income, makes it nearly impossible for a new counselor to afford housing without a partner's income or significant student loan burden.

The demographic profile reveals another challenge: 78.9 percent of behavioral health counselors are female and 73.5 percent are White, in a county that is becoming more diverse and where men are disproportionately affected by the behavioral health crisis documented in Section 6. The workforce does not yet reflect the population it serves.

Psychiatrists (SOC 29-1223): The Most Expensive and Scarce. Hamilton County has 24 psychiatrists. Twenty-four. For a county of nearly 372,000 people, that is one psychiatrist for every 15,500 residents. The Indianapolis MSA has approximately 220, translating to roughly one per 9,000 MSA residents. The occupation carries a location quotient of 0.72, meaning the county has 28 percent fewer psychiatrists per capita than the national average.

The compensation data explain why recruitment is so difficult. The median annual wage for Hamilton County psychiatrists is $329,000 — 37 percent above the national median of $239,526. This premium reflects the extreme scarcity of the specialty; in a competitive labor market, the few available psychiatrists command premium compensation. Yet even at $329,000, the pipeline is not filling: only 1 annual opening exists in the county, and the MSA pipeline produces no directly qualifying graduates for the role. The occupation is 100 percent doctoral-level, requires years of residency after medical school, and faces competition from higher-paying specialties and more desirable geographies. Over 60 percent of psychiatrists nationally are age 55 or older, threatening a retirement-driven contraction within the decade.

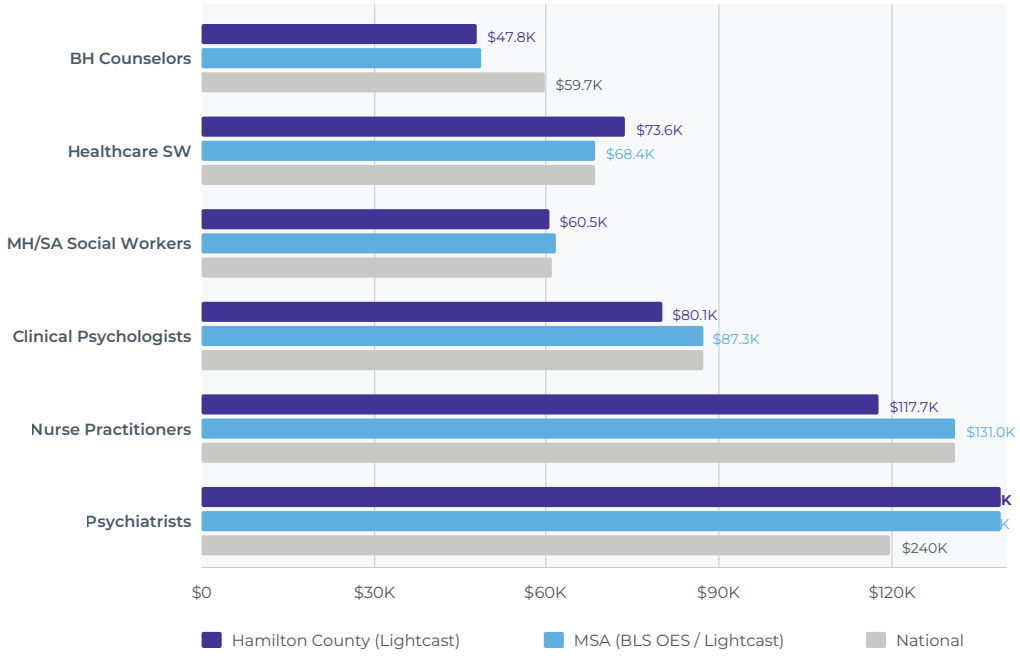
Clinical and Counseling Psychologists (SOC 19-3033): Declining Despite Need. In a counterintuitive finding, clinical psychologist employment in Hamilton County has declined 38.7 percent over the decade, from 209 positions in 2019 to a projected 128 by 2029. The county still maintains an above-average concentration (LQ 1.17), but the decline is striking given rising demand. The median wage of $80,140 places psychologists in a middle tier — well above counselors but 18 percent below the national median of $98,305. Six in ten psychologists nationally are not accepting new patients (HRSA 2025), suggesting that even the existing supply is functionally unavailable.

Mental Health and Substance Abuse Social Workers (SOC 21-1023). Growing rapidly at 64.8 percent over the decade, but the county's 123 positions remain below the national average per capita (LQ 0.78). The occupation commands a median wage of $60,497, with 86.4 percent female representation. Fifteen annual openings compete against an MSA pipeline insufficient to meet even one county's demand. Aspire Indiana Health and Little Star Center are the primary employers posting.

Child, Family, and School Social Workers (SOC 21-1021). At 244 positions with a location quotient of just 0.58 — 42 percent below the national average — this occupation represents a critical gap for a county experiencing a 767 percent increase in youth mental health events. These are the professionals who work in school buildings, who conduct child welfare investigations, who provide family therapy. Hamilton County has fewer than half the expected number per capita, yet generates 26 annual openings against an MSA pipeline that cannot fill the gap. The occupation draws from the broadest institutional base, with 44 companies posting and led by Indiana Professional Management Group, the State of Indiana, IU-Bloomington, and Aspire Indiana Health. The median wage of $54,602 places these workers well below the county's income norms.

Psychiatric Technicians (SOC 29-2053): The Fastest Growth in the Cluster. Psychiatric technician employment has exploded from 100 positions in 2019 to 381 in 2025 — a 311 percent increase, by far the fastest in the cluster. The location quotient of 2.16 means Hamilton County has more than double the national average concentration. This growth reflects the expansion of psychiatric hospital and residential treatment capacity in the county and surrounding area. At a median wage of $19.48 per hour ($40,516 annually), these are the lowest-paid clinical workers in the behavioral health system, yet they provide the frontline care in inpatient psychiatric settings.

Behavioral Health Compensation: Hamilton County vs. MSA vs. National



Source: Lightcast Q1 2026; BLS OES May 2024

9.3 Compensation Analysis: The Fundamental Math

The behavioral health workforce compensation problem is not merely about low wages in the abstract — it is about low wages in a specific community context. Hamilton County's median household income of approximately $118,000 means that the workers responsible for treating the county's mental health crisis earn, in most cases, less than half what the typical household earns. A behavioral health counselor at the median ($47,834) earns 41 percent of the county's median household income. Even a healthcare social worker at $73,630 earns 62 percent. Only nurse practitioners ($117,701) and psychiatrists ($329,000) approach or exceed the community income norm.

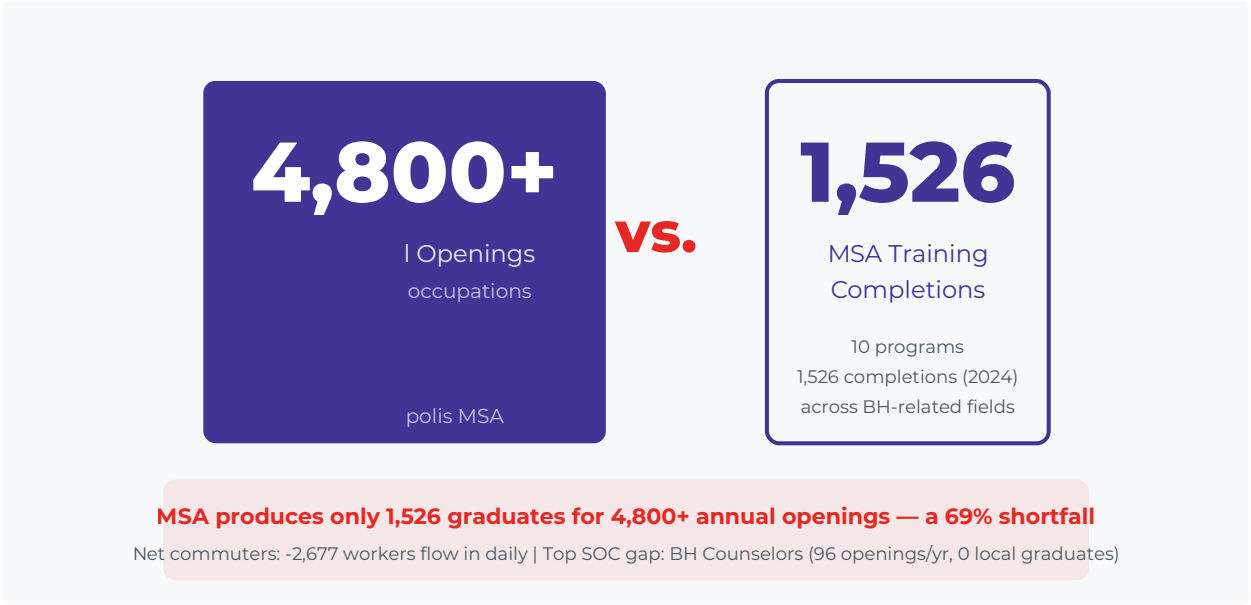
OCCUPATION	HC JOBS 2025	MEDIAN ANNUAL	VS. NATIONAL MEDIAN	ANNUAL OPENINGS	LOCAL COMPLETIONS
BH Counselors (21-1018)	746	$47,834	-20%	87	0
Psychiatrists (29-1223)	24	$329,000	+37%	1	0
Clin. Psychologists (19-3033)	124	$80,140	-18%	10	0
MH/SUD Social Workers (21-1023)	123	$60,497	~0%	15	0
Healthcare Social Workers (21-1022)	231	$73,630	+8%	25	0
Child/Family/ School SW (21-1021)	244	$54,602	-7%	26	0
Psychiatric Technicians (29-2053)	381	$40,516	—	55	—
Nurse Practitioners (29-1171)	348	$117,701	—	36	—

OCCUPATION	HC JOBS 2025	MEDIAN ANNUAL	VS. NATIONAL MEDIAN	ANNUAL OPENINGS	LOCAL COMPLETIONS
Health Svcs Managers (11-9111)	672	$103,487	—	85	—

Source: Lightcast Q1 2026 (Hamilton County); BLS OES (MSA); MSA pipeline concentrated in generalist degrees; see Section 9.4

The wage positioning creates a competitive disadvantage for recruiting behavioral health workers to Hamilton County specifically. Most behavioral health roles pay 7 to 20 percent less than the national median, which would be acceptable in a low-cost community. But Hamilton County's cost of living index of 107.3 means that a counselor accepting the local median wage is taking a real-income cut compared to what they could earn in a lower-cost market. The exceptions are psychiatrists (+37 percent above national median) and healthcare social workers (+8 percent), both of which command premiums precisely because supply is critically constrained.

The Pipeline Crisis: Annual Job Openings vs. Regional Training Completions (Indianapolis MSA)



Source: Lightcast Q1 2026 (Graduate Pipeline Analysis for Indianapolis-Carmel-Greenwood MSA)

9.4 Workforce Availability & Educational Pipeline

The statewide pipeline inadequacy extends across nearly every core behavioral health occupation. Indiana produces only 181 directly licensable behavioral health graduates annually across all its training programs—for 92 shortage-designated counties. The MSA pipeline, while more productive in raw numbers (1,526 completions), is concentrated in generalist degrees: general psychology (660) and general social work (624) account for 84% of output, while the specialized tracks that lead directly to clinical licensure—mental health counseling (43), substance abuse counseling (73), and clinical social work (62)—produce only 178 graduates to serve the entire metropolitan area. For the five most critical clinical behavioral health occupations, the regional training infrastructure cannot keep pace with demand.

The MSA pipeline is more productive but concentrated in generalist degrees. The Indianapolis MSA produced 1,526 completions across 10 programs at 9 institutions in the most recent year. The breakdown reveals the mismatch: 660 completions were in general psychology, 624 in general social work, 73 in substance abuse counseling, 62 in clinical/medical social work, 51 in sociology, and just 43 in mental health counseling. IU-Indianapolis (826 completions) and Ivy Tech (372) dominate the pipeline, followed by the University of Indianapolis (172), Marian University (50), and Butler University (44). By award level, 38.8 percent are bachelor's degrees, 32.4 percent master's, 16.8 percent associate's, and 9.8 percent are certificates.

The fundamental question is: how many of these 1,526 graduates actually enter behavioral health practice? General psychology and sociology degrees do not directly qualify holders for licensed counseling positions. The master's-level completions (about 494) are the most likely to enter clinical practice, but they must complete supervised clinical hours, pass licensing exams, and then choose behavioral health over competing fields. HRSA projects severe national shortages by 2037: 88,000 mental health counselors, 114,000 addiction counselors, and an additional 136,350 psychologists needed to meet unmet demand. All 92 Indiana counties are federally designated mental health workforce shortage areas. The Bowen Center's Playbook identifies "training deserts" across the state where no local education programs produce mental health professionals.

9.5 Job Posting Analytics

Lightcast job posting data provide a real-time view of employer demand that complements the modeled employment estimates. Over the 12 months ending February 2026, Hamilton County employers posted 267 unique behavioral health positions (629 total postings when duplicates and reposts are counted) across 75 companies. The median advertised salary was $68,480 — notably higher than the median earned wage of $47,834 for behavioral health counselors, suggesting that employers are being forced to compete for talent by advertising above-market compensation.

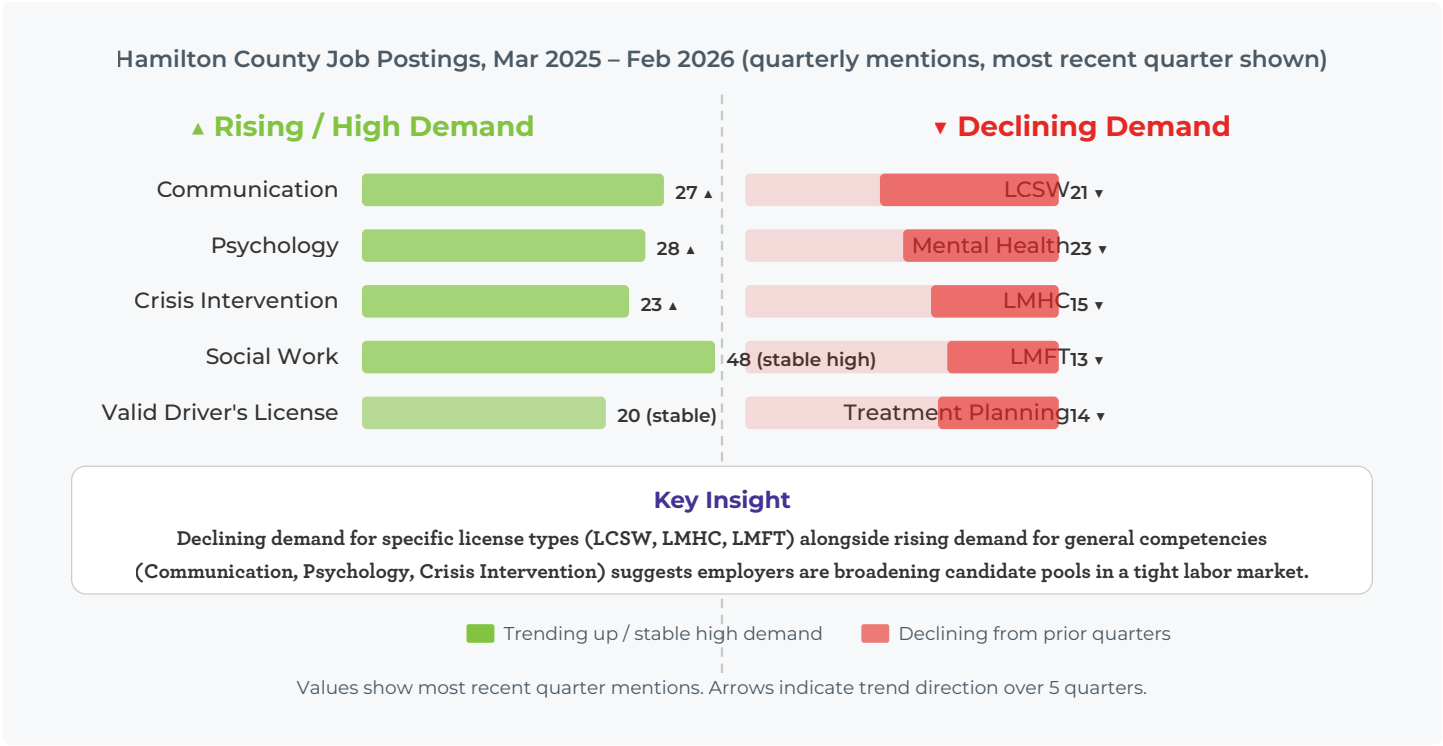
The top hiring companies reveal the institutional structure of demand: Aspire Indiana Health leads with 22 unique postings, followed by Sondermind (20), Indiana Professional Management Group (16), Thriveworks (15), IU-Bloomington (15), the State of Indiana (14), and LifeStance Health (13). The posting duration averages 26 days, with some employers showing significantly longer open periods — Indiana Professional Management Group averages 44 days per posting, and Community Health Network averages 46, indicating positions that are particularly difficult to fill.

Education requirements: 44.6 percent of postings require a master's degree, 39.7 percent a bachelor's, and 22.1 percent list no education requirement. Experience requirements are more modest: 49.8 percent list no experience requirement, 24.3 percent require 2 to 3 years, and 17.2 percent require 0 to 1 years. The low experience thresholds suggest employers are willing to invest in developing early-career professionals — if they can find them.

9.6 Hot and Cold Skills

What do Hamilton County employers want in behavioral health hires? The top skills appearing in job postings tell the story: Social Work (appearing in 40+ postings per quarter), Mental Health, LCSW certification, valid driver's license (surprisingly frequent, reflecting the community-based nature of many roles), LMHC, Communication, Psychology, LMFT, Crisis Intervention, and Treatment Planning. The fastest-growing skills over the past year include Medical Records (+5 postings), Time Management (+5), Customer Service (+4), and Communication (stable at high volume). These emerging skills suggest a workforce that is becoming more administrative and client-facing — less purely clinical and more operationally demanding.

Behavioral Health Skills Demand: Trending Up vs. Cooling Off



Source: Lightcast Q1 2026, Job Posting Analytics for Hamilton County, IN (BH SOCs 21-1018, 21-1021, 21-1022, 21-1023)

9.7 Industry Context: Psychiatric Hospitals in the MSA

The Indianapolis MSA's Psychiatric and Substance Abuse Hospitals industry (NAICS 622210) provides context for the institutional employment landscape. The industry employs 1,059 workers across the MSA in 2025 — 14 percent above the national average when scaled for population — and generates $117.7 million in gross regional product ($95.3M in earnings, $19.2M in property income, $3.3M in taxes). Lightcast characterizes hiring competition in this industry as "aggressive": 12 companies posted 518 unique positions over the past year, averaging 43 monthly postings versus 28 nationally. Posting duration averages 28 days — 5 days longer than the regional average, indicating unfilled positions.

The top employers are Options Behavioral Health Systems (112 postings), Acadia Healthcare (98), Recovery Centers of America (75), Neuropsychiatric Hospitals (74), and Centerstone (73). Psychiatric technicians constitute 28.4 percent of the industry workforce, followed by registered nurses (14.9 percent), behavioral health counselors (12.2 percent), and psychiatrists (1.0 percent). The industry is 79.4 percent female, has low retirement risk in its current age profile, and has grown 24 percent from 2020 to 2025 — but is projected to grow 0 percent from 2025 to 2030, suggesting the industry believes current capacity levels are near equilibrium.

9.8 The Burnout Crisis

Even if Hamilton County could train enough behavioral health professionals to fill every opening, the burnout epidemic threatens to erode the workforce as fast as it grows. Salsberg et al. (2023) found that provider burnout rates exceed 60 percent among behavioral health professionals, with nearly 40 percent considering leaving the profession entirely. This is not generic workplace dissatisfaction; it is the cumulative effect of impossible caseloads, emotionally devastating work, inadequate compensation, administrative burden from insurance systems, and the moral injury of turning away patients because there is no appointment available for six weeks.

Glied and Aguilar (Brookings, 2023) identify the structural drivers: reimbursement rates below the actual cost of providing care, administrative overhead from prior authorization and documentation requirements, limited training pathways that create bottlenecks at every credentialing stage, and scope-of-practice barriers that prevent qualified professionals from working to the full extent of their training. The AAMC (2024) adds that approximately 40 percent of mental health services are now delivered via telehealth — a modality that can reduce some operational burdens but introduces its own forms of fatigue and isolation.

60%+

PROVIDER BURNOUT RATE

Salsberg et al., 2023 [Salsberg et al., Health Affairs, 2023]

~40%

CONSIDERING LEAVING

The profession entirely [HRSA, 2025]

62M

ADULTS FACING ACCESS BARRIERS

Nationally; Glied & Aguilar [Glied & Aguilar, Brookings, 2023]

9.9 The Workforce-Community Cascade

The behavioral health workforce shortage does not exist in isolation. It cascades. When provider positions go unfilled, wait times increase. When wait times increase, untreated conditions worsen. When conditions worsen, people end up in emergency departments, miss work, lose jobs, enter the criminal justice system, and impose costs on every other system in the community. Invest Hamilton County's Quality of Life Strength Index tracks this cascade: behavioral health occupations contribute to Service Reliability (crisis response capacity), Health & Safety (population health outcomes), and Workforce Participation (enabling other workers to remain productive). The current workforce gap produces $36.1 million in wage-flow drag and an estimated $58.2 million in gross regional product drag — economic losses that flow directly from unfilled behavioral health positions into the broader community economy.

The connection to Section 10 is direct: the $349 million estimated annual economic burden of untreated mental illness in Hamilton County is, in large part, a consequence of the workforce constraints documented here. More providers would mean shorter waits, earlier treatment, better outcomes, less economic loss. The math is simple; the solution is not.

9.10 Mental Health and Worker Detachment: The Hidden Workforce Crisis

The behavioral health workforce shortage documented above has a mirror image that receives far less attention: the workers who never enter or permanently exit the labor force because of untreated mental health conditions. The Bureau of Labor Statistics defines marginally attached workers as those who want and are available for work but have not searched in the past four weeks. Within this group, discouraged workers are those who have stopped looking because they believe no jobs are available to them or they cannot qualify. Mental illness is among the leading causes of both conditions. Depression erodes motivation and executive function. Anxiety makes job interviews, applications, and workplace interactions feel insurmountable. Substance use disorders destroy reliability and employability. The result is not unemployment in the conventional sense — these individuals do not appear in the unemployment rate at all. They have left the labor force entirely, becoming statistically invisible.

4.15M

DISCONNECTED YOUTH NATIONALLY

Ages 16–24 not in education, employment, or training (Measure of America, 2025)

91%

GEN Z MENTAL HEALTH CHALLENGES

Share of Gen Z workers reporting MH symptoms in the past year

98% → 88%

MALE LABOR FORCE PARTICIPATION DECLINE

Prime-age male participation, 1954 to present (Brookings)

$282B

ANNUAL NATIONAL COST OF UNTREATED MENTAL ILLNESS

1.7% of GDP, equivalent to an average recession (Abramson, Boerma & Tsyvinski, NBER 2024)

The scale of this detachment is workforce-level, not marginal. Nationally, 4.15 million young people ages 16 to 24 are classified as "disconnected youth" or NEET (Not in Education, Employment, or Training), according to Measure of America's 2025 analysis. One in four NEET respondents globally cite mental health as the primary reason they are unable to work — a figure that has nearly doubled from 24.3 percent in 2011 to 42.6 percent in 2025. Each disconnected young person carries an estimated lifetime societal cost of $1 million in lost wages, tax revenue, and social services (Annie E. Casey Foundation). The Sagamore Institute's

2026 Indiana report documented the "Failure to Launch" phenomenon among young men who never form initial labor force attachment — a pattern driven by depression, social isolation, and the collapse of traditional male employment pathways. The RAND Corporation's 2025 longitudinal analysis confirmed that disconnected youth showed signs of struggling as early as middle school: more symptoms of depression, higher rates of substance use, and weaker social support networks. These are not people who lost jobs. They are people who never attached to the labor force in the first place.

Indiana faces particular vulnerability. The Indiana Business Research Center found that the state's available labor force under age 66 dropped 14 percent between 2012 and 2016, compared to just 1 percent nationally — a decline driven substantially by the opioid crisis, which Krueger's landmark Brookings research estimated accounts for 20 to 25 percent of the overall decline in labor force participation. By 2015, more than 2 million prime-age Americans were absent from the labor force due to opioids, with nearly half of prime-age men not in the labor force taking pain medication on any given day. For Hamilton County — with its tight 2.1 percent unemployment rate and 991 annual behavioral health job openings — the cascade is direct: untreated mental illness leads to job loss, which triggers financial stress, which worsens mental health, which deepens detachment, which eventually produces permanent disconnection from the labor force. The Uppsala Longitudinal Study found that persistent depressive disorder in adolescence was associated with double the odds of labor market marginalization 25 years later. The behavioral health workforce crisis and the worker detachment crisis are not two separate problems. They are the same problem viewed from opposite sides of the provider's desk.

9.11 From Assessment to Action: Key Findings from the Workforce Development Analysis

The companion *Behavioral Health Workforce Development Analysis 2026* translates the workforce gaps documented above into an actionable framework for Hamilton County. Several findings from that analysis have direct implications for understanding the behavioral health landscape:

2.8%

OF INDIANA'S ~6,384 ANNUAL BH GRADUATES ARE IN DIRECTLY LICENSABLE CLINICAL PROGRAMS — JUST 181 GRADUATES FOR 92 SHORTAGE-DESIGNATED COUNTIES

6,000–9,600

ESTIMATED ANNUAL EAP-ASSISTED INDIVIDUALS IN HAMILTON COUNTY — INVISIBLE TO STANDARD WORKFORCE PLANNING MODELS

The Private Practice Problem is an access crisis, not a provider shortage. Hamilton County's 741 mental health providers yield a 1:502 ratio that looks adequate on paper. But the Workforce Analysis reveals that 83% of the county's ~237 identifiable private therapists do not accept Medicaid, and 89% lack bilingual

capability. The effective Medicaid-accessible ratio is approximately 1:625 — and worsening as national telehealth platforms recruit local clinicians to serve patients in other states. [IHC Workforce Development Analysis, 2026]

The MCO Rate Gap drives non-participation. Indiana's Medicaid managed care organizations reimburse behavioral health services at rates 40–60% below commercial insurance. A private therapist billing 25 commercial sessions per week earns $195,000–$234,000 annually; the same caseload of Medicaid patients generates $91,000–$117,000. In a county where commercial-pay patients are abundant, there is no economic equilibrium that induces voluntary Medicaid participation at scale. [IHC Workforce Development Analysis, 2026; Indiana OMPP Medicaid Fee Schedule, 2025]

The EAP Waterfall creates a structural blind spot. Hamilton County's major employers — Eli Lilly, Salesforce, KAR Global, Allied Solutions, CNO Financial — collectively provide Employee Assistance Programs that absorb 6,000–9,600 behavioral health episodes annually. These individuals never appear in HPSA ratios, PLACES prevalence data, or crisis event counts. When EAP sessions expire (typically 3–6 per episode), employees are referred to a community system with 57-day wait times, 17% Medicaid acceptance, and no capacity buffer. [IHC Workforce Development Analysis, 2026]

The Millennial Demand Surge is structurally inevitable. Hamilton County's population skews young: 28.4% of residents are ages 25–44 (vs. 26.7% nationally). This cohort is entering the age range of peak depression, anxiety, and substance use disorder prevalence. IRS migration data confirms continued net in-migration of adults ages 26–34. Even if population growth slows, the existing population is aging into higher-need years. The Workforce Analysis projects 2031 as the peak year for millennial behavioral health demand. [IHC Workforce Development Analysis, 2026; NIMH 2024; IRS SOI 2023]

Career pathways exist but lack institutional support. Using Lightcast career pathway data with 30,000+ observed career transitions, the Workforce Analysis maps a 4-tier career ladder from entry-level Psychiatric Technician ($40,516, postsecondary certificate) through licensed clinician ($48K–$74K) to advanced practice PMHNP ($117,701) and Psychiatrist ($329,000). The single largest salary increase available — Social & Human Service Assistant to Healthcare Social Worker — yields a $68,574 annual gain. But the pipeline requires employer-sponsored tuition, clinical supervision capacity, and institutional employment structures that do not yet exist at scale in Hamilton County. [IHC Workforce Development Analysis, 2026; IHC Community Career Ladder; Lightcast Q1 2026]

The CCBHC model could restructure the workforce. Certified Community Behavioral Health Clinics are required to accept Medicaid, provide 24/7 crisis services, and integrate physical and behavioral healthcare. Nationally, CCBHCs add a median of 15 new positions per clinic and reduce ER diversion costs. Indiana's Aspire Indiana Health — Hamilton County's largest community mental health provider — is positioned for CCBHC designation, which would simultaneously address the Medicaid access gap, the crisis capacity gap, and the workforce pipeline gap. [IHC Workforce Development Analysis, 2026; National Council for Mental Wellbeing, CCBHC Impact Report 2024]

THE WORKFORCE ANALYSIS'S CENTRAL CONCLUSION

Hamilton County does not have a provider shortage in the traditional sense — it has an access crisis driven by practice-setting mismatch. The county's 741 providers are disproportionately concentrated in commercial-pay private practice, leaving publicly insured, uninsured, non-English-speaking, crisis-acuity, and youth populations systematically underserved. The full Workforce Development Analysis provides the tactical playbook — including a TPM-aligned employer engagement strategy, skills-based career pathways, compensation benchmarking, and policy prescriptions — for converting this assessment's findings into workforce action.

For the complete analysis, see: *Behavioral Health Workforce Development Analysis 2026*, Invest Hamilton County, Hamilton County Data Hub, March 2026.

Sources: Lightcast Q1 2026 Data Set (Hamilton County, Indianapolis MSA); BLS OES May 2024 (Indianapolis-Carmel-Anderson MSA); HRSA *State of the Behavioral Health Workforce, 2025*; HRSA HPSA Data (March 2026); Glied SA & Aguilar TT, Brookings (2023); Salsberg E et al., *Am J Prev Med* (2023); AAMC (2024); Bowen Center for Health Workforce Research, *Playbook for Enhancing Indiana's BH Workforce* (2024); IHC Quality of Life Strength Index (2026); Measure of America, *Youth Disconnection 2025*; RAND, *What Predicts Disconnection Among American Youth?* (2025); Krueger AB, Brookings Papers on Economic Activity (2017); Indiana Business Research Center (2017); Uppsala Longitudinal Adolescent Depression Study (2020); Annie E. Casey Foundation; Sagamore Institute (2026)

SECTION 10

ECONOMIC & EMPLOYER IMPACT

The preceding nine sections of this assessment have documented a behavioral health crisis in clinical terms — prevalence rates, provider shortages, treatment gaps, and human suffering. This section translates that crisis into the language of economics and business. The translation is straightforward: untreated mental illness costs money. It costs employers through absenteeism, presenteeism, and turnover. It costs local economies through lost productivity and reduced output. It costs public systems through emergency department utilization, criminal justice involvement, and social services. And the amounts are not marginal. They are measured in hundreds of millions of dollars in Hamilton County alone, and in billions at the state level. The good news — the essential counterpoint to these costs — is that investment in behavioral health treatment and prevention generates among the highest returns on investment documented in all of public health.

$4.2B

ANNUAL COST — INDIANA

Taylor et al., JAMA Health Forum 2023 [Taylor et al., JAMA Health Forum, 2023]

$282B

ANNUAL COST — UNITED STATES

Tsyvinski et al., Yale/NBER 2024 [Tsyvinski et al., Yale/NBER, 2024]

$4 : $1

ROI ON WORKPLACE MH PROGRAMS

Lancet Commission / Deloitte [Lancet Commission, 2024]

~$349M

ESTIMATED HC ANNUAL BURDEN

1.2% of $29.1B GDP [Taylor et al., JAMA Health Forum, 2023]

The Indiana Evidence: $4.2 Billion and Counting

The most directly relevant economic evidence comes from Taylor et al. (2023), published in *JAMA Health Forum*. This cross-sectional study of approximately 429,407 Indiana residents found that untreated mental illness cost the state $4.2 billion annually in 2019 — equivalent to 1.2 percent of state GDP. The cost is not concentrated in any single category; it is distributed across the entire economy through multiple pathways.

$3.3B

INDIRECT COSTS

Lost productivity, premature mortality [Taylor et al., JAMA Health Forum, 2023]

$708.5M

DIRECT HEALTHCARE COSTS

ED visits, hospitalizations, Rx [Taylor et al., JAMA Health Forum, 2023]

$185.4M

NON-HEALTHCARE DIRECT COSTS

Criminal justice, social services [Taylor et al., JAMA Health Forum, 2023]

Premature mortality accounted for the single largest cost component at $1.4 billion — people dying years or decades before their expected lifespan, erasing their economic contributions. Indirect costs of $3.3 billion capture the productivity losses from workers who are alive but unable to function at full capacity, plus the output lost entirely when people exit the labor force due to untreated conditions. Direct healthcare costs of $708.5 million reflect the emergency department visits, psychiatric hospitalizations, and medical treatments

that would have been unnecessary with earlier, less expensive intervention. Non-healthcare direct costs of $185.4 million capture the criminal justice, child welfare, and social service expenditures driven by untreated behavioral health conditions.

HAMILTON COUNTY ESTIMATED ECONOMIC BURDEN: ~$349 MILLION ANNUALLY

If Hamilton County's $29.1 billion GDP bears costs proportional to the state-level finding of 1.2 percent of GDP, the estimated annual economic burden of untreated mental illness in Hamilton County alone is approximately $349 million. This is a conservative estimate: the county's higher labor force participation rate, higher median wages, and tighter labor market (2.1 percent unemployment) mean that each lost workday and each worker who exits the labor force carries higher economic cost than the state average. Even a 10 percent reduction in this burden through targeted intervention would recover approximately $35 million annually in economic output.

National and Global Context: The Four-Study Comparison

Hamilton County's experience reflects a challenge that scales from the community level to the global. Four landmark studies, each using different methodologies and scopes, converge on the same conclusion: the economic cost of untreated mental illness is staggering.

STUDY	SCOPE	ANNUAL COST	KEY FINDING
Taylor et al. (2023)	Indiana	$4.2 billion	1.2% of state GDP; premature mortality = $1.4B
Tsyvinski et al. (2024)	United States	$282 billion	1.7% of GDP; 30% higher than prior estimates
Deloitte/Meharry (2024)	U.S. (equity focus)	$477.5 billion	Projected $14T cumulative through 2040
Lancet Commission (2023)	Global	$2.5 trillion	Depression/anxiety alone = $1T in lost productivity

The Tsyvinski et al. (Yale/NBER, 2024) study is particularly important because its methodology captures costs that earlier studies missed. Their model accounts for differential labor market behavior (people with mental illness choose lower-paying jobs), differential investment patterns (reduced savings and homeownership), and differential consumption (reduced spending that depresses aggregate demand). These factors add 30 percent to the cost estimate compared to studies that focus only on healthcare spending and absenteeism, bringing the total to $282 billion annually — equivalent to the cost of an average recession, every single year.

Employer-Level Impact: Three Pathways of Loss

For Hamilton County's 177,500+ jobs and the employers who provide them, behavioral health conditions manifest through three primary economic pathways.

ABSENTEEISM

Employees with untreated depression miss an average of 27 additional workdays per year. At Hamilton County's high wage levels, each absent day carries outsized cost. At the county's median household income, this represents approximately $12,300 per affected worker annually — and research indicates that 91 percent of Gen Z workers experienced mental health challenges in the past year.

PRESENTEEISM

Workers present but impaired by mental health conditions produce at an estimated 70 to 80 percent of capacity. Research consistently finds presenteeism costs 2 to 3 times more than absenteeism because it affects more workers for more hours while being nearly invisible to managers. It is the silent productivity drain that never shows up in attendance records.

TURNOVER

Behavioral health-driven turnover carries replacement costs of 50 to 200 percent of annual salary. In Hamilton County's tight labor market at 2.1 percent unemployment, positions remain unfilled longer. Sixty-one percent of Gen Z workers say they would leave for a job with better mental health benefits — making behavioral health support a retention strategy, not just a benefit.

The U.S. Chamber of Commerce reports that 94 percent of employers now make new investments in mental health and SUD care. Seventy-two percent of large companies have added virtual behavioral healthcare or telehealth. Sixty-eight percent have enhanced EAPs, apps, or mental health resources. But the top obstacle cited by 65 percent of employers is the same workforce constraint documented in Section 9: too few qualified mental health professionals. Employer willingness to invest is not the bottleneck; workforce supply is.

The companion *Behavioral Health Workforce Development Analysis 2026* quantifies the employer-level economic impacts through a Talent Pipeline Management lens, documenting how each unfilled BH position creates cascading costs across Hamilton County's employer base — from EAP overutilization to absenteeism, presenteeism, and turnover.

The Investment Case: $4 Return for Every $1

$4 : $1

Return on Investment

For every $1 invested in workplace behavioral health programs, employers realize $4 in improved productivity, reduced absenteeism, and lower healthcare costs. [Lancet Commission, 2024] **The National Academies find that every $1 in prevention and early intervention yields $2 to $10 in savings.** [National Academies, 2019]

The Abramson, Boerma, and Tsyvinski model provides the most compelling single finding: providing mental health care for everyone ages 16 to 25 with mental illness would yield gains equivalent to 1.7 percent of aggregate consumption — the single most impactful intervention they modeled. Eliminating the mental health professional shortage alone would reduce mental illness by 3.1 percent and generate benefits equivalent to 1.1 percent of aggregate consumption. For Hamilton County, where the estimated annual burden is $349 million, even modest reductions through targeted investment could recover tens of millions in economic output while improving thousands of lives.

The QoL Drag: Quantifying the Cascade

Invest Hamilton County's Quality of Life Strength Index provides a local framework for understanding how behavioral health workforce gaps translate into community-level economic loss. The Index tracks 454 occupations across five community-essential levers. When behavioral health positions go unfilled, the resulting "drag" cascades across the entire system. Current metrics show $36.1 million in wage-flow drag (the economic value of unfilled behavioral health positions) and $58.2 million in gross regional product drag (the broader economic multiplier effect of those vacancies). These are not theoretical projections; they are modeled from actual vacancy data and BEA economic multipliers.

THE LABOR FORCE DETACHMENT CASCADE: FROM UNTREATED MENTAL ILLNESS TO PERMANENT DISCONNECTION

The economic costs documented above are not limited to workers who remain employed but function at reduced capacity. A substantial and growing share of the burden comes from individuals who exit the labor force entirely — or never enter it. Mental illness costs the U.S. economy $282 billion annually (1.7 percent of GDP), equivalent to the cost of an average recession, according to Abramson, Boerma, and Tsyvinski's 2024 NBER analysis. Critically, their model found that 30 percent of this cost was previously unrecognized because it operates through channels invisible to traditional accounting: people with mental illness consume less, invest less, and select into lower-paying jobs — not because they lack talent, but because their conditions constrain their economic participation.

The pathway from untreated behavioral health conditions to permanent labor force detachment follows a predictable cascade. Discouraged workers — those who have stopped searching because they believe they cannot find or qualify for employment — represent the first stage. Depression and anxiety compound this discouragement by eroding the cognitive functions required for job searching: sustained attention, self-presentation, future orientation, and tolerance of rejection. Dislocated workers who lose jobs and face behavioral health barriers to re-employment represent the second stage. The Sagamore Institute's 2026 Indiana research documented a third pathway among young men who never form initial labor force attachment — the "Failure to Launch" phenomenon driven by untreated depression, social isolation, gaming addiction, and the disappearance of entry-level male employment pathways. Prime-age male labor force participation has declined from 98 percent in 1954 to 88 percent today, with men without college degrees facing an 11 percentage-point participation gap compared to degree-holders (Brookings). Fifteen percent of young men now report having no close friends — five times higher than in 1990 (American Institute for Boys and Men).

For Hamilton County, the numbers translate directly to economic output. The county's 4.15 million disconnected youth nationally (10.6 percent of ages 16–24) represent a $55 billion annual drain on public expenditures, with each disconnected individual carrying a lifetime societal cost of approximately $1 million. Indiana's specific vulnerability is acute: untreated mental illness costs the state $4.2 billion annually (IU School of Medicine/Bowen Center), and the opioid crisis alone reduced the state's under-66

available labor force by 14 percent between 2012 and 2016 versus just 1 percent nationally (Indiana Business Research Center). The return on investment for breaking this cascade is among the highest in public policy: the National Academies of Sciences estimate $2 to $10 in savings for every $1 invested in mental health prevention and early intervention. Providing care for everyone ages 16 to 25 with mental illness would yield gains equivalent to 1.7 percent of aggregate consumption — the single most impactful intervention modeled in the Abramson study. The behavioral health workforce shortage documented in Section 9 is not just a healthcare problem. It is the bottleneck preventing the economic recovery of an entire category of potential workers.

Opioid Settlement and 988: New Resources, Strategic Allocation

Two emerging resource streams offer Hamilton County the opportunity to invest strategically. Indiana communities are receiving opioid settlement funds, part of over $6.5 billion distributed nationally in 2024. RAND OPTIC identified evidence-based allocation priorities: naloxone distribution, MOUD expansion (which reduces post-release overdose death by 85 percent in jails), employment supports and training programs, and root-cause investment in housing and mental health.

The 988 Suicide and Crisis Lifeline has received 16.5 million contacts since launching in July 2022, with monthly volumes approaching 600,000. Answer rates improved from 70 to 93 percent. Gould et al. (2025) found that daily increases in Lifeline call volume were independently associated with daily reductions in suicide deaths. But only 23 percent of Americans report familiarity with 988, and only 10 states have established sustainable funding through telecom fees. Local awareness and crisis system integration remain critical needs.

THE BOTTOM LINE FOR HAMILTON COUNTY

Untreated behavioral health conditions cost Hamilton County an estimated $349 million annually in lost economic output. With a $29.1 billion GDP, a 2.1 percent unemployment rate, and 177,500+ jobs, the county cannot afford the productivity drag, workforce attrition, and healthcare cost escalation that result from inadequate behavioral health infrastructure. The behavioral health workforce documented in Section 9 — with its zero-completion pipeline, below-market wages, and 60 percent burnout rates — is the binding constraint on progress. The evidence is unambiguous: every $1 invested in behavioral health generates $4 in returns. The question facing Hamilton County is not whether it can afford to invest in behavioral health. The question is whether it can afford not to.

Sources: Taylor HL et al., *JAMA Health Forum* (2023); Abramson B, Boerma J, Tsyvinski A, NBER WP 32354 (2024); Deloitte & Meharry Medical College (2024); Lancet Commission on Global Mental Health (2023); BEA Regional Economic Accounts (2023); U.S. (2025); KFF 988 Survey (2024); IHC Quality of Life Strength Index (2026); National Academies of Sciences, Prevention ROI

SECTION 11

Criminal Justice & Behavioral Health

34,520

MENTAL HEALTH EVENTS PROCESSED BY EMERGENCY SERVICES IN 2024 — A 250% INCREASE OVER 2017

When the behavioral health system fails to catch people in crisis, the justice system fills the void — at enormous human and fiscal cost.

SECTION 11

Criminal Justice & Behavioral Health

When the System Fails, the Justice System Fills the Void

Imagine a Tuesday evening in Fishers. A 34-year-old man, recently separated from his wife, has not slept in three days. The anxiety that once responded to counseling has spiraled beyond his capacity to manage. He is pacing his apartment parking lot, talking loudly to no one in particular, and his neighbors are frightened. They call 911. A patrol officer arrives within minutes. This officer is not a clinician. She has no psychiatric training beyond a basic academy module. But she is now the de facto first responder to a mental health emergency, and the decisions she makes in the next ten minutes will shape this man's trajectory for months or years: Does he go to a hospital? To jail? Home with a brochure? Or into a system designed to catch him before he falls further?

This scene plays out thousands of times each year across Hamilton County. It is the central drama of the criminal justice–behavioral health intersection, and the data in this section reveal just how often the justice system has become the default front door to behavioral health care.

250%

INCREASE IN MENTAL HEALTH EVENTS

Hamilton County emergency services processed 34,520 mental health events in 2024 — up from 9,872 in 2017. The system never came back down after the pandemic surge.

11.1 The Scale of the Problem: When Police Become Frontline Mental Health Responders

The 2021 Hamilton County Behavioral Health Needs Assessment documented a finding that should have alarmed every policymaker in the county: police were the single largest referral source for crisis assessments, accounting for 27% of all referrals—exceeding referrals from hospitals, families, and self-referrals combined. To put this in perspective, national best practice recommends that no more than 10–15% of crisis referrals should originate from law enforcement. Hamilton County's rate is nearly double that threshold.

This is not a failure of policing. It is a failure of the behavioral health system to provide adequate alternatives. When a person in crisis cannot reach a counselor, when the 988 line has limited local follow-up capacity, when there is a newly established crisis stabilization center (the RELY Center) within the county, the default response is a 911 call. And when a 911 call is placed, an officer responds. The officer becomes, by default, a behavioral health first responder.

Invest Hamilton County has committed to providing an annual update to this needs assessment through the remainder of its settlement grant funding through 2028, ensuring that community leaders have current data to guide ongoing investment decisions.

The data tell us exactly how frequently this is happening. Indiana Management Performance Hub (MPH) data track three categories of mental health events reported by emergency services: nonphysical mental health events (the broadest category, encompassing behavioral disturbances, welfare checks, and crisis encounters), suicidal and self-harm events, and homicidal or harm-to-others events. The trajectory across all three categories in Hamilton County is striking.

Table 11.1: Mental Health Events in Hamilton County (2017–2024)

YEAR	NONPHYSICAL MH EVENTS	SUICIDAL/ SELF-HARM	HOMICIDAL/ HARM-OTHERS	TOTAL EVENTS	POPULATION	EVENTS PER 1,000
2017	6,334	749	2,789	9,872	323,225	30.5
2018	8,470	784	3,883	13,137	330,635	39.7
2019	10,430	1,024	4,892	16,346	337,955	48.4
2020	12,368	1,197	5,992	19,557	348,996	56.0
2021	20,832	1,609	10,656	33,097	357,620	92.6
2022	21,797	1,684	11,548	35,029	365,463	95.8

YEAR	NONPHYSICAL MH EVENTS	SUICIDAL/ SELF-HARM	HOMICIDAL/ HARM-OTHERS	TOTAL EVENTS	POPULATION	EVENTS PER 1,000
2023	21,432	1,783	11,354	35,309	371,645	95.0
2024	21,432	1,783	11,305	34,520	371,645	92.9

Source: Indiana Management Performance Hub (MPH), Mental Health Events by County, 2017–2024. Extracted March 2026. Events per 1,000 calculated using Census PEP population estimates.

> *Police are not clinicians. But in Hamilton County, they have become the de facto first responders to a mental health emergency.*
>
> ASSESSMENT FINDING, SECTION 11

Consider what this table reveals. In 2017, Hamilton County's emergency system processed about 30 mental health events for every 1,000 residents. By 2021, that rate had tripled to nearly 93 per 1,000—roughly one event for every eleven people in the county. The system went from handling about 27 events per day to processing 91 per day. And while the 2020–2021 surge coincided with the pandemic's disruption of outpatient services, the critical point is that the system never came back down. From 2021 through 2024, the county has stabilized at approximately 34,000–35,000 total events per year—a permanently elevated plateau that represents a 250% increase over the 2017 baseline.

Each of these 34,520 events in 2024 represents a human being in distress. Many of them also represent a law enforcement officer diverted from other duties, a patrol car dispatched, an incident report filed, and often a transport to an emergency department that is already stretched thin. The cumulative burden on the justice system is immense.

The 2020–2021 Inflection Point

The single most dramatic year-over-year change in the entire dataset occurred between 2020 and 2021, when nonphysical mental health events surged 68% in a single year—from 12,368 to 20,832. Homicidal/harm-to-others events nearly doubled, jumping from 5,992 to 10,656. This was not a gradual escalation. It was a system break. The pandemic shuttered outpatient clinics, disrupted medication management, isolated vulnerable individuals, and overwhelmed the emergency services that remained open. What makes this inflection point so consequential is that the system never recovered. The 2024 figures (21,432 nonphysical MH events) remain within 3% of the 2021 peak. Hamilton County's behavioral health crisis system is now permanently operating at a level of demand that would have been unimaginable seven years ago.

11.2 Understanding the Sequential Intercept Model: Six Chances to Change a Life

To understand where Hamilton County can intervene, it helps to think about the journey a person in crisis takes through the system. The Sequential Intercept Model (SIM), developed by Munetz and Griffin in 2006 and updated by SAMHSA in 2024, maps six specific points—intercepts—where a person with a behavioral health condition can be redirected away from deeper criminal justice involvement and toward treatment. Think of it as a series of off-ramps. Each intercept represents a chance to change someone's trajectory. The earlier the off-ramp is taken, the better the outcome for the individual and the lower the cost to the system.

Intercept 0: Community Services. This is the first and most important opportunity—preventing justice contact entirely. It includes crisis hotlines like the 988 Suicide & Crisis Lifeline, mobile crisis teams that respond to calls instead of police, and crisis stabilization centers where someone can receive immediate treatment without going to an emergency department or being placed in custody. The goal at Intercept 0 is simple: give people a place to go and a number to call before the crisis escalates to a 911 call. Hamilton County currently lacks a dedicated 23-hour crisis stabilization unit, meaning many Intercept 0 opportunities are missed because the infrastructure does not exist.

Intercept 1: Law Enforcement Contact. When police do respond to a behavioral health crisis, trained officers can make all the difference. Crisis Intervention Teams (CIT) are 40-hour specialized training programs that teach officers to de-escalate mental health crises, assess danger, and connect individuals to treatment rather than arrest. Co-responder models pair a law enforcement officer with a mental health clinician who responds together. Hamilton County's COPE (Community Outreach & Prevention Engagement) and QRT (Quick Response Team) programs operate primarily at this intercept. These programs provide follow-up visits to individuals who have experienced overdoses or behavioral health crises, typically within 24 to 72

hours of the event, bridging the critical gap between emergency response and ongoing treatment. But consider the math: with 1,783 suicidal/self-harm events in 2024 plus thousands of additional overdose and crisis events, the question is whether COPE/QRT has the capacity to follow up on every case that needs it.

Intercept 2: Initial Detention and Court Hearings. If an individual is arrested, the booking process is the next opportunity for intervention. Screening at intake can identify behavioral health conditions and route individuals to diversion programs, pretrial services, or treatment-linked release. Without systematic screening, people with treatable mental health conditions enter the general jail population, where their conditions typically worsen.

Intercept 3: Jails and Courts. Specialty courts—drug courts, mental health courts, veterans' courts—provide structured treatment alternatives to incarceration for individuals whose offenses are linked to behavioral health conditions. Hamilton County's drug and alcohol court processed 2,488 cases in 2019, down from 2,706 in 2015. This modest 8% decline could reflect improved upstream diversion (fewer people reaching the court stage) or reduced substance-related arrests, but it also coincided with the pre-pandemic escalation of the opioid crisis nationally. The significance of specialty courts cannot be overstated, and the evidence supporting their effectiveness is some of the strongest in all of criminal justice reform.

Intercept 4: Reentry. When individuals are released from incarceration, the transition back to community life is a high-risk period for relapse, crisis, and recidivism. Effective reentry requires continuity of care—ensuring that medications are not interrupted, that outpatient appointments are scheduled before release, and that housing and employment supports are in place. Without these connections, the revolving door of incarceration and crisis continues.

Intercept 5: Community Corrections. Probation and parole supervision can be leveraged as behavioral health intervention points. Probation officers who are trained to recognize and respond to behavioral health needs can connect individuals with treatment, peer support, and recovery services rather than simply monitoring compliance.

27%

CRISIS REFERRALS FROM POLICE

2021 BHNA—#1 referral source in county [2021 Hamilton County BHNA]

34,520

TOTAL MH EVENTS (2024)

250% increase from 9,872 in 2017 [Indiana MPH, 2017-2024]

6

INTERCEPT POINTS

Sequential Intercept Model (SAMHSA)

11.3 Hamilton County's Diversion Infrastructure: What Exists and What Is Missing

COPE and QRT: The Bright Spots. Hamilton County's Community Outreach & Prevention Engagement program and Quick Response Team represent the county's most visible justice-behavioral health intervention. Operating at Intercepts 1 and 5, these programs deploy teams to visit individuals who have recently experienced overdoses or behavioral health crises, offering immediate connections to treatment services. The model is evidence-based: post-crisis outreach within 24–72 hours dramatically increases treatment engagement compared to simply providing a referral card at the time of the incident.

But even well-designed programs face capacity constraints. In 2024, Hamilton County recorded 1,783 suicidal and self-harm events alone. When combined with overdose events, substance use crises, and the broader universe of the 21,432 nonphysical mental health events that may warrant follow-up, the demand far exceeds what any single outreach team can cover. The question for Hamilton County is not whether COPE/QRT works—the model is sound—but whether its staffing and funding are remotely proportional to the need. A program that can follow up on 500 cases annually when 5,000 or more cases warrant contact is a program that is doing excellent work for the people it reaches while leaving the vast majority without support.

COPE & QRT

Community Outreach & Prevention Engagement and Quick Response Teams deploy within 24–72 hours of an overdose or behavioral health crisis. The model is evidence-based, but with 34,520 total events in 2024, the question is capacity, not concept.

A program that can follow up on 500 cases annually when 5,000 or more cases warrant contact leaves the vast majority without support.

The RELY Center: A Landmark Investment. Aspire Indiana Health's RELY Center represents Hamilton County's first dedicated crisis stabilization and 23-hour observation facility—the kind of infrastructure that peer communities like Tucson and Bexar County have demonstrated can fundamentally reduce emergency department boarding, law enforcement burden, and unnecessary hospitalizations. The RELY Center's opening marks a structural shift from relying on emergency departments as the default behavioral health safety net to providing purpose-built crisis alternatives.

The Noble Act: Legislative Progress. Indiana's Noble Act represents important legislative progress in behavioral health workforce development. By addressing scope-of-practice barriers and expanding pathways into behavioral health careers, the legislation responds directly to the pipeline constraints documented throughout this assessment. Legislative action at the state level is essential because workforce pipeline challenges cannot be solved at the county level alone—they require structural reform of training, licensing, and reimbursement systems.

Drug and Alcohol Courts: Proven but Limited. Hamilton County's specialty courts are an Intercept 3 intervention with a strong evidence base. The drug and alcohol court processed 2,488 cases in 2019, reflecting a modestly declining caseload from the 2,706 cases seen in 2015. This 8% reduction could be interpreted positively—as evidence that fewer individuals are reaching the court stage because upstream interventions are working—or cautiously, given that the same period saw a national escalation in substance use disorders driven by synthetic opioids.

What makes specialty courts so valuable is the depth of evidence supporting their effectiveness. Two meta-analyses are particularly instructive for Hamilton County's planning.

The Evidence for Mental Health Courts

Jalain, Lucas, and Higgins (2024) conducted the most current meta-analysis of mental health court effectiveness, published in the *Justice Evaluation Journal*. Analyzing 15 studies, they found that mental health court participants experienced a 42.5% reduction in recidivism compared to individuals processed through traditional criminal courts. This is a remarkable finding. It means that for every 100 people who would have been re-arrested under the traditional system, only 57 to 58 would be re-arrested after going through a mental health court. In human terms, this represents dozens of individuals per year in Hamilton County who could avoid the cascading consequences of re-incarceration—job loss, housing instability, family disruption, and clinical deterioration.

Lowder, Desmarais, and Baucom (2018) analyzed 17 studies encompassing 16,129 participants and confirmed a statistically significant effect of mental health court participation on reduced recidivism ($d = -0.20$). They found that programs featuring individualized treatment plans and frequent judicial supervision in the initial phases produced the strongest outcomes. The take-away for Hamilton County: a mental health court that combines judicial engagement with tailored treatment planning would have the greatest impact.

Notably, Jalain's 2024 analysis found that mental health courts produced larger treatment effects than either drug courts or DWI courts, suggesting that the investment in mental health-specific judicial programming yields outsized returns.

42.5%

RECIDIVISM REDUCTION

Mental health courts vs. traditional processing (Jalain et al., 2024)

16,129

PARTICIPANTS STUDIED

Across 17 MHC studies (Lowder et al., 2018)

80%

FEWER OFFICER INJURIES

Memphis CIT model during MH crisis calls

CRITICAL FINDING

Hamilton County's Investment in Crisis Infrastructure

With no 23-hour crisis stabilization unit in the county, people in behavioral health emergencies are funneled to emergency departments or law enforcement transport. States with dedicated stabilization centers have reduced ED behavioral health visits by 30–40%.

SAMHSA Sequential Intercept Model Toolkit, 2024; Arizona and Georgia crisis system evaluations

Update: The RELY Center Addresses the Intercept 0 Gap

Since the data collection period for this assessment, Aspire Indiana Health has opened the RELY Center — Hamilton County's first dedicated crisis stabilization and 23-hour observation facility. This directly addresses the most significant gap identified in the Sequential Intercept Model analysis above: the absence of a local crisis stabilization unit at Intercept 0. With the RELY Center operational, individuals in acute behavioral health crisis now have an alternative to emergency department visits or law enforcement transport. This represents a concrete, evidence-based response to the crisis event surge documented throughout this assessment. The effectiveness of this facility in reducing ED diversion and justice system contact should be a priority metric for the community to track in the coming years.

Local Asset: The TOWER Recovery Program

The TOWER Program is a recovery-focused initiative operating within the Hamilton County Jail, providing structured behavioral health treatment and recovery support to incarcerated individuals. By embedding recovery services directly in the correctional setting, TOWER addresses the Intercept 3–4 gap identified in the Sequential Intercept Model: the transition from incarceration to community reentry that, without continuity of care, drives the revolving door of crisis and recidivism. The program represents Hamilton County's investment in the justice-behavioral health intersection and offers a foundation that could be expanded with the systematic reentry coordination recommended in this section.

Employment is the single strongest predictor of successful reentry. Invest Hamilton County's Invest Onward workforce training program addresses this directly, providing skills development and employer connections for individuals transitioning back into the community. Combined with TOWER's in-facility recovery programming, these programs create a continuum from incarceration through employment that reduces recidivism and strengthens the workforce.

11.3a Domestic Violence, Child Abuse, and the Behavioral Health Pipeline

Among the most underrecognized drivers of behavioral health burden in Hamilton County is the intersection of domestic violence, child abuse, and mental illness. Intimate partner violence (IPV) and child maltreatment are not merely criminal justice issues—they are behavioral health accelerants that produce depression, post-traumatic stress disorder, substance use disorders, and suicidality at rates far exceeding the general population. In an affluent suburban county where stigma and privacy concerns suppress disclosure, the true scope of this problem is almost certainly larger than the data suggest.

1 in 4

WOMEN EXPERIENCE INTIMATE PARTNER VIOLENCE

1 in 10 men; only 34% of victims seek help [CDC NISVS, 2022]

3–5×

HIGHER RATES OF DEPRESSION, PTSD, AND SUBSTANCE USE

Among victims of domestic violence vs. general population [Dillon et al., *Trauma, Violence & Abuse*, 2013]

The national data are unambiguous: 1 in 4 women and 1 in 10 men experience intimate partner violence in their lifetimes, yet only 34% of victims ever seek help from any formal service. [CDC National Intimate Partner and Sexual Violence Survey, 2022] **Victims of IPV experience depression at 3 to 5 times the rate of the general population, PTSD at 3 to 4 times, and substance use disorders at 2 to 3 times.** [Dillon et al., *Trauma, Violence & Abuse*, 2013; Lagdon et al., *Journal of Affective Disorders*, 2014] **For children who witness domestic violence—estimated at 15.5 million children annually in the United States—the behavioral health consequences extend into adulthood, functioning as adverse childhood experiences that elevate lifetime risk for every major behavioral health condition documented in this assessment.** [Hamby et al., *Journal of Family Violence*, 2011]

The DV-to-Behavioral-Health Pipeline. Domestic violence does not merely co-occur with mental illness—it *produces* it through a well-documented causal pathway. Chronic exposure to violence and threat dysregulates the stress response system (the hypothalamic-pituitary-adrenal axis), producing neurobiological changes that manifest as depression, anxiety, hypervigilance, and emotional numbing. Victims frequently self-medicate with alcohol or other substances. Children in these households develop attachment disorders, behavioral problems, and trauma responses that follow them into adolescence and adulthood. The connection to the 21,432 mental health crisis events documented in Section 4 is direct: an unknown but meaningful proportion of those events involve domestic violence as a precipitating or underlying factor, particularly among the police-referred cases that constitute 27% of all crisis events.

Child Abuse and Neglect. The Indiana Department of Child Services (DCS) processes referrals for suspected child abuse and neglect in Hamilton County. While Hamilton County's DCS substantiation rates are lower than state averages—consistent with the county's socioeconomic profile—child welfare professionals consistently report that affluent communities undercount maltreatment because families have private insurance (avoiding the Medicaid-flagged hospital encounters that

trigger many referrals), children present with fewer visible indicators of neglect, and families have legal resources to contest investigations. [Sedlak et al., NIS-4, U.S. DHHS, 2010] The behavioral health consequences of child maltreatment are among the most robust findings in the ACE literature documented in Section 5 of this assessment.

COMMUNITY ASSET: PREVAIL INC.

Prevail Inc. is Hamilton County's primary domestic violence and sexual assault crisis center, providing comprehensive services that directly address the DV-behavioral health pipeline:

- **24/7 Crisis Line — Immediate support for victims of domestic violence and sexual assault**
- **Emergency Shelter — Safe housing for victims and their children fleeing violent situations**
- **Counseling & Advocacy — Individual and group therapy, including trauma-focused care**
- **Legal Advocacy — Assistance with protective orders, court accompaniment, and system navigation**
- **Community Education — Prevention programming in schools and workplaces**

Prevail represents a critical behavioral health intervention point—not a separate system. Every client Prevail serves is, by definition, someone at dramatically elevated risk for the depression, PTSD, substance use, and crisis events that define this assessment's findings. Strengthening Prevail's capacity and integrating its services with the broader behavioral health system should be a strategic priority.

~3,000

INDIVIDUALS SERVED ANNUALLY

Hamilton County's only dedicated DV/SA crisis center since 1986 [Prevail Inc., 2025]

34%

DV VICTIMS WHO SEEK HELP

In affluent communities, reporting rates are even lower [CDC NISVS, 2022]

Prevail Inc., founded in 1986, is Hamilton County's only organization exclusively dedicated to serving victims of domestic violence, sexual assault, and related trauma. Serving approximately 3,000 individuals annually [Prevail Inc., 2025]**, Prevail operates a comprehensive service model that addresses the full spectrum of crisis, recovery, and prevention—including a 24/7 crisis line, emergency shelter, individual and group counseling, legal advocacy, and children's programs designed for minors exposed to domestic violence.**

The behavioral health connection is direct and well-documented: survivors of domestic violence experience PTSD at rates of 31 to 84 percent, depression at 54 to 66 percent, anxiety disorders at 47 to 78 percent, and substance use disorders at 18 to 46 percent [Dillon et al., *Trauma, Violence & Abuse*, 2013]**. Every client Prevail serves is, by definition, an individual at elevated**

risk for severe and chronic behavioral health conditions. Prevail is not a separate system from the behavioral health infrastructure documented in this assessment—it is a critical upstream intervention point and referral destination for the crisis events recorded in the MPH data.

The fact that only 34% of domestic violence victims nationally seek help [CDC NISVS, 2022]**—and that this figure is likely even lower in affluent communities where social reputation, financial entanglement, and privacy concerns create additional barriers to disclosure—means that Prevail's 3,000 annual clients represent only the visible fraction of a much larger population in need.**

Why Domestic Violence Is Underreported in Affluent Communities

Research consistently documents that domestic violence is *underreported* in affluent communities, not because it occurs less frequently, but because the barriers to disclosure are structurally different. In Hamilton County, these barriers include:

- **Financial dependence paradox: High household income often masks financial control by the abusive partner, making economic separation appear impossible**
- **Social reputation pressure: In tight-knit suburban communities, the stigma of being identified as a DV victim can feel professionally and socially catastrophic**
- **Privacy and visibility: Seeking help from a shelter or crisis center in a county where "everyone knows everyone" creates disclosure fears absent in larger, more anonymous urban areas**
- **Private healthcare insulation: Victims with private insurance see private physicians who may not screen for IPV as systematically as safety-net providers**

The implication: Hamilton County's domestic violence statistics almost certainly understate the true prevalence, and behavioral health providers should routinely screen for IPV as a contributor to the depression, anxiety, and substance use they are treating. [Hamberger et al., *Family Practice*, 2015]

[CDC National Intimate Partner and Sexual Violence Survey, 2022; Dillon et al., *Trauma, Violence & Abuse*, 2013; Lagdon et al., *Journal of Affective Disorders*, 2014; Hamby et al., *Journal of Family Violence*, 2011; Sedlak et al., NIS-4, U.S. DHHS, 2010; Hamberger et al., *Family Practice*, 2015; Prevail Inc., Hamilton County, IN]

What Is Missing: The Gaps in the SIM. Hamilton County has functional programs at Intercepts 1 (COPE/QRT), 3 (drug/alcohol court), and 5 (community corrections). But several critical intercept points remain underdeveloped:

- **Intercept 0 is the most significant gap. Hamilton County lacks a 23-hour crisis stabilization unit, which means that when someone calls 988 or presents in crisis, there is no immediate, local, non-emergency-department destination. The result: either an ED visit (expensive, often inappropriate for behavioral health) or a law enforcement transport (stigmatizing, often unnecessary). States like Arizona and Georgia have demonstrated that 23-hour crisis stabilization**

centers reduce ED behavioral health visits by 30–40% and dramatically reduce law enforcement crisis transport burden.

- Intercept 2 (jail screening) is not systematically documented. Without universal behavioral health screening at booking, individuals with treatable conditions enter the general jail population where medications may be interrupted and mental health deterioration is nearly inevitable.
- Intercept 4 (reentry) requires systematic coordination between the Hamilton County Jail, Aspire Indiana Health (the primary safety-net provider), and community service agencies. Data on the completeness and effectiveness of reentry planning is not currently available at the county level.

11.4 The Double Jeopardy: Criminal Justice Contact and Behavioral Health Among Young Men

> *Indiana men are four times more likely to die by suicide than Indiana women. Drug overdose deaths among men occur at more than double the rate for women.*
>
> SAGAMORE INSTITUTE, "FAILURE TO LAUNCH," 2026

The Sagamore Institute's "Failure to Launch" report, published in March 2026, provides Indiana-specific data that illuminates a particularly concerning intersection of criminal justice and behavioral health. Indiana men are four times more likely to die by suicide than Indiana women. Drug overdose deaths among Indiana men occur at a rate of 50.83 per 100,000—more than double the rate for women (24.2 per 100,000). Alcohol consumption among young men surges from 10% in 9th grade to 43.8% by 12th grade—a trajectory that intersects directly with criminal justice risk.

For young men who encounter the justice system, the consequences compound. A behavioral health condition that leads to an arrest creates a criminal record, which creates employment barriers, which creates financial stress, which exacerbates the underlying behavioral health condition. This cycle of "double jeopardy"—where justice system contact and behavioral health conditions reinforce each other—is particularly devastating for young men in the 18–25 age range, precisely the demographic the Sagamore report identifies as most vulnerable.

Hamilton County's data confirm the local relevance of this pattern. The 18-to-60 age group accounted for the largest share of suicidal and self-harm events in 2024 (1,164 of 1,783 total—65%), and nonphysical mental health events in this age group remained elevated at 11,520 in 2024. When combined with the Sagamore finding that Indiana boys experience a sharp educational and behavioral "cliff" at the end of high school, the implication is clear: Hamilton County needs justice-behavioral health interventions that specifically target young men in the transitional years between adolescence and established adulthood.

11.5 What Hamilton County Needs to Do Differently at Each Intercept

The evidence gathered across Sections 4 through 10 of this assessment, combined with the criminal justice data presented here, points to a clear set of priorities for each intercept point:

An Intercept-by-Intercept Action Framework

- **Intercept 0 — Build What Does Not Exist: Establish a 23-hour crisis stabilization unit in Hamilton County. Fund 24/7 mobile crisis teams as a 988-linked alternative to law enforcement dispatch. Target: reduce the police referral share from 27% to below 15% within three years.**
- **Intercept 1 — Expand What Works: Scale COPE/QRT capacity to match demand. Invest in CIT training across all Hamilton County law enforcement agencies. The Memphis CIT model—which reduced officer injuries by 80% during mental health crisis calls—provides a proven template. Co-responder models (pairing officers with clinicians) should be piloted in the highest-volume jurisdictions: Fishers and Noblesville.**
- **Intercept 2 — Screen Everyone: Implement universal behavioral health screening at booking in the Hamilton County Jail using validated instruments. Ensure that identified individuals are immediately connected to jail-based services and diversion opportunities.**
- **Intercept 3 — Explore a Mental Health Court: Given the evidence that mental health courts reduce recidivism by 42.5%—a larger effect than drug courts—Hamilton County should evaluate the feasibility of establishing a dedicated mental health court docket. The existing drug/alcohol court infrastructure provides a foundation upon which to build.**
- **Intercept 4 — Close the Reentry Gap: Develop standardized reentry protocols that ensure continuity of behavioral health care from incarceration to community. This means prescriptions filled before release, first outpatient appointments scheduled within 72 hours, and warm handoffs to Aspire Indiana Health and other community providers.**
- **Intercept 5 — Treat, Don't Just Monitor: Train probation and community corrections officers in behavioral health recognition and response. Embed peer recovery specialists within community corrections programs to provide ongoing support.**

With 34,520 mental health events per year and a system that has stabilized at crisis-level demand, Hamilton County cannot afford to treat the justice-behavioral health intersection as someone else's problem.

The stakes are clear. With 34,520 mental health events per year, law enforcement officers spending an increasing share of their shifts responding to behavioral health calls, and a system that has stabilized at crisis-level demand, Hamilton County cannot afford to treat the justice-behavioral health intersection as someone else's problem. The evidence shows precisely where to intervene and exactly how effective those interventions can be. What remains is the commitment to fund and implement them.

Section Sources: Indiana MPH Mental Health Events (2017–2024); 2021 Hamilton County Behavioral Health Needs Assessment; SAMHSA Sequential Intercept Model Toolkit (2024); Munetz & Griffin, *Psychiatric Services* (2006); Jalain, Lucas & Higgins, *Justice Evaluation Journal* (2024); Lowder, Desmarais & Baucom, *Psychiatric Services* (2018); Sagamore Institute, "Failure to Launch" (2026); Census PEP Population Estimates (2024).

SECTION 12

Disparities & Equity in Behavioral Health

551%

INCREASE IN YOUTH SUICIDAL AND SELF-HARM EVENTS FROM 2017 TO 2024

Averages conceal as much as they reveal — and an effective behavioral health system must be designed for the people who need it most.

SECTION 12

Disparities & Equity in Behavioral Health

The Paradox of Need in an Affluent Community

Hamilton County is one of the wealthiest counties in Indiana and among the most prosperous in the nation. Its median household income of approximately $118,000 is more than double the national median. Its poverty rate of 4.7% is among the lowest anywhere. Its Quality of Life Score of 84.6 out of 100 places it in the top tier of 292 large U.S. counties. By nearly every aggregate measure, this is a community that is thriving.

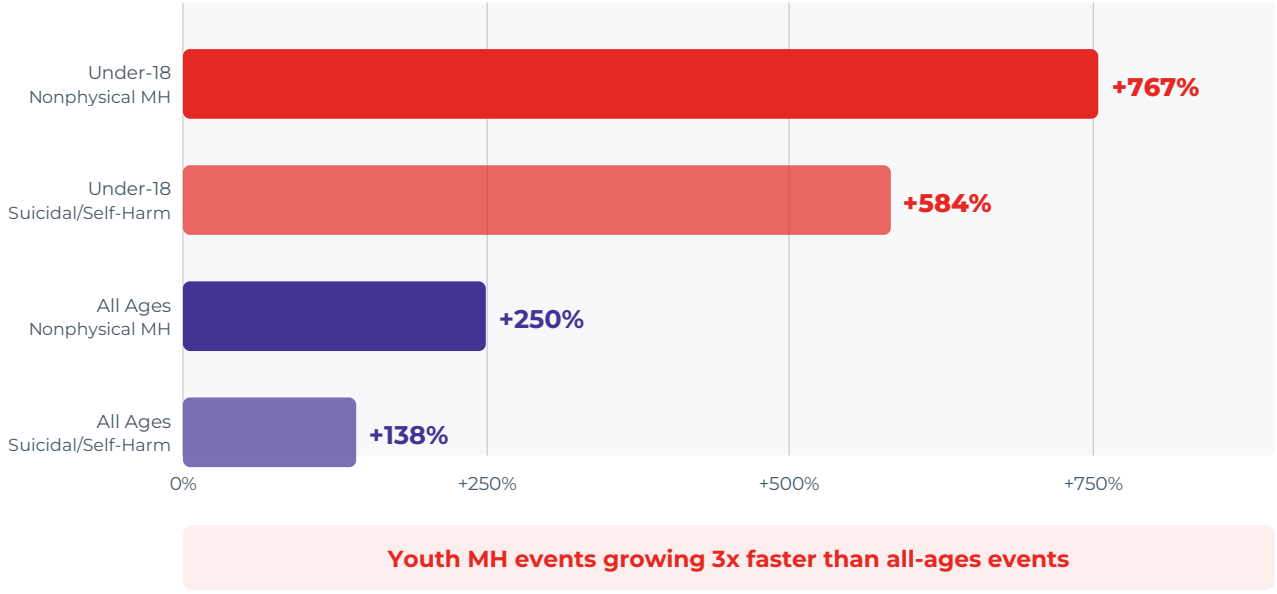
And yet behavioral health burden exists everywhere in Hamilton County. It simply looks different depending on who you are, where you live, what insurance card you carry, and what language you speak at home. This section documents those differences—not as a contradiction of the county's success, but as a reminder that averages conceal as much as they reveal, and that an effective behavioral health system must be designed for the people who need it most, not just the people who are easiest to reach.

17%

OF PROVIDERS ACCEPT MEDICAID

83% of Hamilton County's behavioral health provider network is effectively closed to Medicaid patients — creating a two-tiered system defined by insurance type.

Growth in MH Events by Age Group, Hamilton County (2017 vs. 2023)



Youth MH events growing 3x faster than all-ages events

Source: Indiana MPH Data Hub (2017 vs. 2023 comparison)

12.1 The Five-County Landscape: A Regional Portrait of Behavioral Health

To understand Hamilton County's behavioral health profile, it helps to see it in the context of its neighbors. The five-county comparison area—Hamilton, Boone, Marion, Tipton, and Madison—spans the full spectrum of Central Indiana's economic and demographic landscape. Each county has a distinct story, and walking through their data side by side reveals how powerfully geography, income, and access shape behavioral health outcomes.

Table 12.1: Regional Behavioral Health Profile — Five-County Comparison (CDC PLACES 2023)

INDICATOR	HAMILTON	BOONE	MARION	TIPTON	MADISON
Population (2024)	371,645	76,120	968,460	15,256	132,504
Depression (age-adj.)	22.9%	22.1%	25.3%	26.7%	27.7%
Frequent Mental Distress	14.2%	15.7%	17.8%	18.5%	19.5%
Current Smoking	9.3%	11.4%	15.2%	16.2%	18.8%
Binge Drinking	17.8%	17.8%	17.8%	18.9%	16.2%
Cognitive Disability	10.7%	12.1%	15.3%	14.3%	15.7%
Short Sleep Duration	31.1%	33.4%	39.7%	34.9%	37.1%
Any Disability	22.0%	24.1%	29.9%	29.5%	31.0%
HPSA Designations (active)	2	1	11	0	3
Max HPSA Score	19	14	22	13	21

Source: CDC PLACES 2026 release (2023 data year), age-adjusted prevalence. HRSA HPSA Mental Health designations, March 2026. Population from Census PEP 2024.

Hamilton County (pop. 371,645) records the lowest or near-lowest prevalence on nearly every indicator. Its depression rate of 22.9% and frequent mental distress rate of 14.2% reflect the powerful protective effects of high income, low poverty, robust employer-sponsored insurance coverage, and strong community infrastructure. But "lowest in the region" does not mean "low." At 22.9%, depression affects approximately 85,000 Hamilton County adults—a treatment population larger than the entire population of Boone County. And Hamilton County holds two active HPSA designations with a maximum score of 19 out of 25, confirming that even the wealthiest county in the comparison is federally recognized as having significant unmet need for mental health professionals.

Boone County (pop. 76,120) is Hamilton County's western neighbor and closest economic peer, with a growing suburban population in Zionsville and Lebanon. Its behavioral health indicators are remarkably similar to Hamilton's—depression at 22.1% and mental distress at 15.7%—suggesting that the two counties share similar protective factors. However, Boone's smaller size and more rural northern areas create access challenges that differ from Hamilton's suburban landscape. Its single HPSA designation (score 14) reflects a less severe but still recognized provider shortage.

Marion County (pop. 968,460) is the region's urban core and Hamilton County's most important economic partner—approximately 40% of Hamilton County workers commute to Marion County daily. Marion's behavioral health profile is dramatically different: depression at 25.3%, mental distress at 17.8%, smoking at 15.2%, and a disability rate of 29.9%. These figures reflect the compounding effects of concentrated poverty, historic disinvestment in certain neighborhoods, higher rates of uninsurance, and a population distribution that includes some of Indiana's most underserved communities. Marion County's 11 active HPSA designations with a maximum score of 22 indicate severe, widespread provider shortage. For Hamilton County, Marion's profile matters because the two counties share a border, a labor market, and a healthcare system. Behavioral health conditions do not respect county lines—the people who commute between Hamilton and Marion County carry their stressors, conditions, and treatment needs with them.

Tipton County (pop. 15,256) represents the rural end of the spectrum. With a depression rate of 26.7% and mental distress at 18.5%, Tipton's indicators are substantially worse than Hamilton's despite being just 30 miles to the north. The county's small population means that even a few provider vacancies can create total service deserts. Tipton has no active HPSA designations (HPSA score 13) but this may reflect data limitations rather than adequate supply—extremely rural areas sometimes fall below minimum population thresholds for formal designation even when access is severely limited.

Madison County (pop. 132,504) records the worst behavioral health indicators in the five-county comparison: depression at 27.7%, frequent mental distress at 19.5%, and smoking at 18.8%. The gap between Hamilton (22.9% depression) and Madison (27.7%) is 4.8 percentage points—a meaningful clinical difference that translates to thousands of additional individuals living with untreated or undertreated depression. Madison County's challenges stem from a familiar mix of deindustrialization, population decline, economic hardship, and the resulting concentration of poverty and limited healthcare access. Its three active HPSA designations (maximum score 21) confirm severe provider shortage. Anderson, the county seat, has experienced decades of economic contraction that have systematically eroded the social infrastructure that protects mental health.

The Binge Drinking Anomaly

One indicator breaks the expected pattern entirely. Binge drinking rates are virtually identical across Hamilton (17.8%), Boone (17.8%), and Marion (17.8%) counties, despite vast differences in income, poverty, and every other health indicator. Madison County (16.2%) actually records the *lowest* binge drinking rate in the region, while Tipton (18.9%) records the highest. This pattern is consistent with a well-established finding in the epidemiological literature: alcohol misuse does not follow the same income gradient as other behavioral health conditions. Indeed, higher-income populations often report higher rates of alcohol consumption. For Hamilton County, this means that its economic advantages, which are so protective against depression and drug overdose, provide no protection whatsoever against problematic drinking. As we will see in Section 13, national benchmarking confirms that excessive drinking is Hamilton County's most significant behavioral health vulnerability.

12.2 The Two-Tiered System: Insurance as the Gateway to Care

> *Only 17% of behavioral health providers accept Medicaid. For the growing low-income population, five out of six doors are closed.*
>
> 2021 HAMILTON COUNTY BHNA

Hamilton County's uninsured rate of approximately 4.5% is among the lowest in the nation, ranking roughly 15th out of 292 large U.S. counties. On its face, this suggests that access to healthcare should be relatively straightforward. But in behavioral health, having insurance and having access to care are two very different things.

The 2021 BHNA revealed a finding that fundamentally shapes the equity landscape in Hamilton County: only 17% of behavioral health providers accept Medicaid. This single data point defines a two-tiered system. Residents with employer-sponsored private insurance or the financial capacity to pay out of pocket can choose from a wide range of therapists, counselors, and prescribers. Residents enrolled in Medicaid—which includes many of the county's most economically vulnerable individuals, those with disabilities, low-income families with children, and elderly adults—can access only one in six providers.

17%

PROVIDERS ACCEPT MEDICAID

83% of providers effectively closed to Medicaid patients

89%

NO BILINGUAL STAFF

Growing Hispanic population underserved

37,129:1

LOW-INCOME PROVIDER RATIO

HRSA HPSA designation threshold: 20,000:1

The consequences of this two-tiered system are amplified by the HRSA data. Hamilton County's low-income mental health HPSA carries a provider-to-population ratio of 37,129 to 1—nearly double the federal shortage threshold of 20,000 to 1. The designation covers 447,964 individuals (a multi-county low-income population area) and identifies a shortage of 17.8 full-time equivalent mental health professionals. In practical terms, this means that for every mental health provider available to the low-income population, there are 37,129 potential patients. For comparison, the typical primary care physician serves a panel of 1,500 to 2,500 patients.

Aspire Indiana Health, the county's FQHC Look-Alike serving as the primary safety-net behavioral health provider, holds the other active HPSA designation (score 19, designation population 143,077). This organization carries a disproportionate burden of serving the county's most complex patients with the least resources. When 83% of the provider network is effectively closed to Medicaid patients, the remaining 17%—anchored by organizations like Aspire—must absorb all of the demand. The result is longer wait times, higher caseloads, and provider burnout that further constrains the system.

12.3 Language Access: A Barrier That Grows More Consequential Every Year

The 2021 BHNA finding that 89% of behavioral health providers lack bilingual staff was concerning five years ago. It is more concerning today, because Hamilton County's demographic composition has continued to shift. The county's Hispanic/Latino population has grown steadily, particularly in Noblesville and Fishers, and the Asian population has expanded significantly across Carmel and Fishers. Hamilton County is becoming one of the more diverse counties in Indiana—and its behavioral health workforce has not kept pace.

National research shows that language barriers reduce mental health service utilization by 30–50% among non-English-speaking populations, even when insurance coverage is adequate. Kammer-Kerwick et al. (2024), using NIH All of Us data, found that households of color experienced 5.3 to 7.8 social determinants of health barriers on average compared to 1.7 for White households. Language barriers compound every other access challenge: a Spanish-speaking parent who recognizes their child's depression symptoms cannot navigate an English-only intake system, cannot communicate nuanced emotional states through a medical interpreter who may not be trained in behavioral health terminology, and may face cultural stigma around mental health help-seeking that a culturally responsive provider could address but a language-discordant provider cannot.

The 89% figure means that out of every 100 behavioral health providers in Hamilton County, only 11 could serve a patient who does not speak English fluently. For the growing population of residents for whom English is not their first language, the practical provider network is a fraction of the already-strained system.

12.4 Where Crises Concentrate: The Geography of Need Within Hamilton County

Perhaps the most actionable disparity finding from the 2021 BHNA was geographic. Three ZIP codes—46060 (Noblesville), 46038 (Fishers), and 46037 (Fishers)—accounted for 55% of all crisis intakes despite comprising only 39% of the county's population. This 16-percentage-point overrepresentation is not a statistical anomaly. It reflects real differences in population density, housing type, economic diversity, and proximity to services that create geographic concentration of behavioral health need.

Tract-level CDC PLACES data further illuminate these within-county disparities. While Hamilton County's overall depression prevalence is 22.9%, individual census tracts range from 18.9% to 27.0%—an 8.1 percentage-point spread. To put this in perspective, that internal variation rivals the county-to-county spread across the entire five-county region (Hamilton at 22.9% to Madison at 27.7% is only 4.8 points). Hamilton County contains within its own borders neighborhoods that look like Boone County and neighborhoods that look closer to Tipton County in their behavioral health indicators.

The highest-prevalence tracts tend to cluster in older residential areas, communities with higher concentrations of rental housing, and neighborhoods with lower median incomes relative to the county average. These are often the same areas where population density is highest, where multi-family housing predominates, and where the proportion of Medicaid-enrolled residents is greatest. The geographic concentration of crisis intakes into three ZIP codes aligns closely with the CDC Social Vulnerability Index (SVI) tract-level data.

3 ZIP CODES

46060 (Noblesville), 46038 and 46037 (Fishers) account for 55% of all crisis intakes but only 39% of the population. These same areas contain the county's most racially diverse census tracts and highest SVI scores.

Social Vulnerability Within an Invulnerable County

Hamilton County's overall CDC Social Vulnerability Index score is remarkably low at 0.034 RPL—meaning it ranks in the bottom 3.4% nationally for social vulnerability. This is an exceptional score that reflects the county's overall affluence and infrastructure. However, the county-level average conceals meaningful tract-level variation. Census tracts in central Noblesville, parts of eastern Fishers, and unincorporated areas along the county's northeastern corridor score considerably higher on the socioeconomic and housing-related vulnerability themes. These are the same areas where crisis intake concentrations are highest. The lesson is clear: social vulnerability in Hamilton County is not absent—it is concentrated. And concentrated vulnerability requires concentrated response.

12.5 The Age Divide: Youth in Crisis and an Aging Population Under Pressure

The age-disaggregated data from Indiana MPH reveal two distinct behavioral health crises playing out simultaneously within Hamilton County, each requiring different interventions and different resources.

CRITICAL FINDING

Youth Behavioral Health Events Have Exploded

Under-18 suicidal and self-harm events surged from 55 in 2017 to 358 in 2024 — a 551% increase. Nonphysical mental health events for youth rose 768% over the same period. In 2017, the county recorded roughly one youth suicidal event per week. By 2024, it was nearly one per day.

Indiana Management Performance Hub, Mental Health Events by Age Group, 2017–2024

Youth (under 18). The numbers are staggering. Suicidal and self-harm events among children and adolescents grew from 55 in 2017 to 358 in 2024—a 551% increase over seven years. Nonphysical mental health events for this age group surged from 233 to 2,021 over the same period—a 768% increase. These are not gradual trends. This is an explosion. In 2017, Hamilton County's emergency system recorded roughly one youth suicidal/self-harm event per week. By 2024, it was recording nearly one per day. Behind each of these events is a child or teenager in acute distress, a family in crisis, and a school system that may or may not have the resources to respond.

The youth crisis connects directly to the academic evidence documented in the Surgeon General's Advisory (2021), which declared youth mental health a national emergency. Adolescents spending more than three hours daily on social media face double the risk of depression and anxiety symptoms (Surgeon General, 2023). Luthar et al. (2020) have documented that students in high-achieving schools—like Hamilton County's nationally recognized school corporations—are now classified as an "at-risk" group for mental health, with achievement pressures, social comparison, and emotional isolation driving elevated rates that exceed national norms. One in five affluent 16-year-old girls had clinically significant depressive symptoms—three times higher than inner-city counterparts.

Table 12.2: Youth (Under 18) Mental Health Events, Hamilton County (2017–2024)

YEAR	NONPHYSICAL MH EVENTS	SUICIDAL/SELF-HARM	HOMICIDAL/HARM-OTHERS	TOTAL YOUTH EVENTS
2017	233	55	323	611
2018	364	79	473	916
2019	554	120	643	1,317
2020	710	173	754	1,637
2021	1,600	253	1,698	3,551
2022	1,944	312	2,191	4,447
2023	1,992	376	2,273	4,641
2024	2,021	358	2,373	4,752

Source: Indiana MPH, Mental Health Events by County and Age Group, 2017–2024. Under-18 age group.

The aging population (60+). While the youth crisis dominates headlines, the 60+ age group accounts for a surprising share of behavioral health events. In 2024, residents aged 60 and older recorded 7,891 nonphysical mental health events and 261 suicidal/self-harm events. The 60+ group's nonphysical MH events grew from 2,780 in 2017 to 7,891 in 2024—a 184% increase. As Hamilton County's population continues to age, this demand will only increase. Older adults face unique behavioral health challenges including social isolation (particularly among those who have lost a spouse), chronic pain, medication interactions, cognitive decline, and the grief associated with functional loss. Many older adults were socialized in an era when seeking mental health treatment carried profound stigma, making them less likely to self-refer even when services are available.

12.5a Geriatric Behavioral Health: The Growing Crisis Among Older Adults

Hamilton County's 65-and-older population is the fastest-growing age segment in the county, now comprising approximately 15% of residents and expanding rapidly as Baby Boomers age in place in the suburban communities they helped build. [Census ACS, 2023] **This demographic shift carries profound behavioral health implications that the county's current service infrastructure is not yet designed to address.**

~15%

POPULATION AGED 65+

Fastest-growing age segment in Hamilton County [Census ACS, 2023]

60+

AGE GROUP DRIVING THE MOST MH EVENTS

Highest volume of mental health crisis events by age group [Indiana MPH, 2017–2024]

The report's own Indiana MPH data confirm that the 60+ age group drives the single highest volume of mental health events in Hamilton County—a finding that contradicts the common assumption that behavioral health is primarily a youth and working-age concern. When disaggregated by age, older adults generate more crisis events than any other demographic band, reflecting the convergence of multiple risk factors that intensify with aging.

15–20%

OLDER ADULTS WITH DEPRESSION

National prevalence among adults 65+ [CDC/NCHS, 2023; NIH/NIA, 2024]

10%

ADULTS 65+ WITH DEMENTIA

90%+ of dementia patients develop behavioral symptoms [Alzheimer's Association, 2024]

Geriatric depression affects 15 to 20 percent of adults over 65 nationally [CDC/NCHS, 2023; NIH/NIA, 2024]**, yet it remains chronically underdiagnosed because its symptoms—fatigue, social withdrawal, appetite changes, sleep disruption—are frequently attributed to "normal aging" rather than treatable illness. For Hamilton County's older adults, the risk factors compound: loss of a spouse, retirement-driven loss of identity and social structure, reduced mobility, chronic pain, and the progressive shrinking of social networks that accompanies each of these transitions.**

Social isolation in aging is particularly acute in suburban communities like Hamilton County. The county's sprawling geography—designed around automobile access, with limited public transit and few walkable commercial districts—becomes an isolation machine for older adults who can no longer drive. The U.S. Surgeon General's 2023 Advisory on Social Connection documented that social isolation increases the risk of premature death by 29%, the risk of dementia by 50%, and the risk of depression by a factor of three. [U.S. Surgeon General, 2023] **Hamilton County's 29.2% loneliness rate** [CHR, 2025]**—already elevated for its demographic profile—likely understates the experience of older residents who live alone in single-family homes in communities built for families with children.**

Dementia and cognitive decline affect approximately 10% of adults aged 65 and older, with behavioral and psychological symptoms—agitation, aggression, psychosis, wandering, depression, anxiety—manifesting in more than 90% of dementia cases. [Alzheimer's Association, 2024] **These behavioral symptoms often precipitate the crisis events recorded in the MPH data and place extraordinary demands on both emergency departments and the family members providing daily care.**

Caregiver Burnout: The Hidden Crisis Behind the Crisis

Approximately 53 million Americans provide unpaid care to an adult family member [AARP/NAC, 2020], **and research consistently shows that 40 to 70 percent of caregivers exhibit clinical signs of depression** [Family Caregiver Alliance, 2023]**. In Hamilton County, where dual-income households are the norm and housing costs are substantial, caregiving competes directly with career demands. The "sandwich generation"—residents simultaneously raising children and caring for aging parents—faces compounded behavioral health risk from chronic stress, sleep deprivation, financial strain, and the emotional toll of watching a parent's cognitive or physical decline.**

The average family caregiver spends $7,242 per year out of pocket on caregiving expenses [AARP/NAC, 2020], **and caregivers are significantly less likely to seek their own behavioral health treatment—creating a cascade in which the person providing care becomes the next person who needs it. Hamilton County's suburban sprawl increases caregiving distance and commute time, and the county has limited adult day service options that could provide respite.**

Medicare coverage gaps present a structural barrier to geriatric behavioral health treatment. While Medicare Part B covers 80% of outpatient mental health service costs after the deductible, the 20% copay—combined with the fact that many behavioral health providers do not accept Medicare assignment—creates a financial barrier that discourages treatment-seeking among older adults on fixed incomes. The shortage of geriatric psychiatrists is particularly acute: nationally, there are fewer than 1,800 board-certified geriatric psychiatrists serving a population of 56 million adults over 65. [American Association for Geriatric Psychiatry, 2023]

The convergence of rapid population aging, suburban isolation, caregiver burden, and provider shortages positions geriatric behavioral health as one of the most consequential—and least addressed—domains in Hamilton County's behavioral health landscape. The MPH data already show that older adults are generating crisis events at the highest rate of any age group. Without deliberate investment in geriatric-specific services, this demand will only accelerate.

12.5b School Counselor and Psychologist Ratios: The Staffing Gap That Shapes Youth Outcomes

The youth crisis events documented throughout this assessment—the 551% increase in under-18 suicidal and self-harm events, the 767% increase in youth mental health events—do not occur in a vacuum. They occur in schools. And the capacity of schools to identify, intervene, and support students in behavioral health distress depends directly on school counselor and psychologist staffing ratios. By national standards, Hamilton County's school corporations fall significantly short.

1:250

ASCA RECOMMENDED COUNSELOR RATIO

American School Counselor Association standard [ASCA, 2024]

1:500

NASP RECOMMENDED PSYCHOLOGIST RATIO

National Association of School Psychologists standard [NASP, 2024]

The American School Counselor Association (ASCA) recommends a ratio of 1 school counselor per 250 students. The National Association of School Psychologists (NASP) recommends 1 school psychologist per 500 students. Indiana's statewide average is approximately 1:424 for counselors and 1:1,065 for psychologists—already well above the recommended thresholds.[ASCA, 2024; NASP, 2024; IDOE, 2023]

Table 12.3: Estimated School Counselor Ratios, Hamilton County School Corporations (2024–2025)

SCHOOL CORPORATION	ENROLLMENT	EST. COUNSELORS	EST. RATIO	ASCA TARGET (1:250)	ESTIMATED GAP
Hamilton Southeastern	22,000	~45	~1:489	88	~43
Carmel Clay	17,500	~40	~1:438	70	~30
Noblesville	11,000	~25	~1:440	44	~19
Westfield Washington	8,500	~18	~1:472	34	~16
Hamilton Heights	2,500	~6	~1:417	10	~4

SCHOOL CORPORATION	ENROLLMENT	EST. COUNSELORS	EST. RATIO	ASCA TARGET (1:250)	ESTIMATED GAP
Sheridan Community	1,200	~3	~1:400	5	~2
Hamilton County Total	62,700	~137	~1:458	251	~114

Estimated. **Counselor counts are approximations based on publicly available staffing data. Actual ratios may vary by building level and role definition. ASCA target calculated as enrollment ÷ 250.** [ASCA, 2024; IDOE Enrollment Data, 2024–2025]

COUNTYWIDE GAP

~114 Additional Counselors Needed to Meet ASCA Standard

Across all six Hamilton County school corporations, an estimated 114 additional school counselors would be needed to meet the ASCA-recommended 1:250 ratio. No corporation currently meets the standard. The gap is most pronounced in the largest districts, where individual counselors carry caseloads nearly double the recommended level.

Estimated based on ASCA 2024 ratio recommendations and IDOE enrollment data

The connection to the crisis data documented in this assessment is direct: in 2024, Hamilton County recorded 4,752 youth behavioral health events severe enough to generate emergency medical or law enforcement response. If school counselor staffing met the ASCA standard—providing 251 counselors with manageable caseloads instead of 137 counselors stretched across nearly 500 students each—many of these crises could be identified earlier, managed through school-based intervention, and diverted from emergency systems entirely. School counselors are the frontline workforce for youth behavioral health, and the staffing gap documented here is a structural contributor to the escalation patterns described throughout Section 6 and Section 12.

> *One in five affluent 16-year-old girls had clinically significant depressive symptoms — three times higher than inner-city counterparts.*
>
> LUTHAR ET AL., AMERICAN PSYCHOLOGIST, 2020

The Sagamore Institute's "Failure to Launch" report and the CDC's data on girls' mental health reveal that Hamilton County's youth behavioral health crisis is not one crisis but two, divided sharply along gender lines.

Girls and young women show earlier onset of emotional distress. Statewide YRBSS data show that 46.3% of Indiana 9th-grade girls report poor mental health, compared to 20.1% of 9th-grade boys. The proportion of female students reporting persistent sadness or hopelessness jumped from 34.5% to 60.1% since 2011. Nearly 29.2% of 9th-grade girls report making a suicide plan. Girls exhibit higher rates of depression, anxiety, self-harm, and suicide ideation that emerge in early adolescence and remain elevated through high school.

Boys and young men experience a different trajectory. They appear to be doing relatively well through most of high school, then encounter what Sagamore calls the "cliff"—a sharp decline at the end of high school that accelerates into early adulthood. Alcohol consumption among young men leaps from 10% in 9th grade to 43.8% by 12th grade, surpassing girls. Suicide planning rises from 13.8% of freshman boys to 27% by senior year. After high school, the trajectories diverge further: depression and suicide inclination fall for women but rise for men. Indiana men are four times more likely to die by suicide than Indiana women. Drug overdose deaths occur at more than double the rate for men (50.83 per 100,000) compared to women (24.2 per 100,000).

Patalay and Gage (2019) describe this as the "gender paradox"—girls report higher rates of emotional problems (depression, anxiety, self-harm) while boys exhibit higher rates of behavioral problems, substance misuse, and completed suicide. Both genders are in crisis, but through different pathways that require different interventions. School-based programs that focus exclusively on depression screening may catch girls' distress but miss the behavioral and substance use patterns that signal crisis in boys. Conversely, programs that focus on substance use may engage boys but overlook the internal emotional suffering that is more prevalent among girls.

12.7 Racial and Ethnic Disparities: The Growing Frontier

Hamilton County's population remains predominantly White (approximately 79%), but its diversity has increased significantly over the past decade. The growing Asian, Hispanic/Latino, and Black populations face documented national disparities in behavioral health access and outcomes that almost certainly manifest locally, though county-level data disaggregated by race and ethnicity remain limited.

The Kammer-Kerwick et al. (2024) findings from the NIH All of Us dataset are particularly relevant. Households of color experienced 5.3 to 7.8 social determinants of health barriers on average, compared to just 1.7 for White households. The disparities in poverty (4 to 10 times greater rates), food insecurity, and housing insecurity compound the behavioral health challenges that race and ethnicity create through other pathways including discrimination, cultural stigma, and provider distrust.

Women (adjusted odds ratio = 1.60) and LGBTQIA2+ individuals (AOR = 1.71) showed significantly higher likelihood of major depressive disorder diagnosis, regardless of race. These intersecting identities mean that a Latina woman in Hamilton County, a young Black man, or an LGBTQIA2+ teenager may face multiple compounding barriers to behavioral health care simultaneously.

The intersection of race, income, and geography in Hamilton County likely concentrates disadvantage. The same ZIP codes showing disproportionate crisis intakes (46060, 46038, 46037) contain the county's most racially diverse census tracts. Without targeted data collection and culturally responsive service delivery, these populations risk being underserved even as aggregate county statistics continue to improve.

12.8 Social Determinants: The Roots Beneath the Symptoms

The disparities documented throughout this section do not arise in a vacuum. They are produced by the social conditions in which people live, work, learn, and age. The academic evidence is now unequivocal on this point.

Lund et al. (2024), writing in *World Psychiatry*, established that people exposed to unfavorable social circumstances are more vulnerable to poor mental health across the entire life course, and that structural factors generate intergenerational cycles of disadvantage even within communities that appear broadly prosperous. A lifespan approach—from before birth through older age—is essential, with interventions at childhood, adolescence, and working ages providing the highest return.

Nakphong et al. (2025) found that economic factors including income level and housing instability showed the strongest relationship with mental health outcomes. Individuals facing financial difficulties—employment loss, utility payment challenges—were significantly more likely to experience chronic poor mental health. Food insecurity was associated with twice the odds of mental health issues. Hamilton County's food insecurity rate of 9.2%, while low by national standards, translates to approximately 34,000 residents facing food access challenges that directly compound behavioral health risk.

The White House Domestic Policy Council's 2023 U.S. Playbook to Address Social Determinants of Health provides the federal policy framework that connects these research findings to action. For Hamilton County, adopting a social determinants lens means recognizing that behavioral health outcomes are shaped by:

- **Housing costs: Even in an affluent county, housing cost burden (spending more than 30% of income on housing) affects lower-income residents and can trigger or exacerbate mental health conditions. Rising housing costs in Hamilton County's fastest-growing communities may be creating housing insecurity among populations that were previously stable.**
- **Transportation: Behavioral health services are concentrated in the county's southern cities (Carmel, Fishers), while crisis concentrations include Noblesville areas with limited public transit options. A patient who needs weekly therapy sessions but lacks reliable transportation faces a structural barrier that no amount of provider availability can overcome.**
- **Childcare: Hamilton County's documented childcare shortage compounds behavioral health burden for working parents, particularly single-parent households. A parent who cannot access affordable childcare experiences chronic stress, reduced economic participation, and diminished capacity to attend to their own mental health needs.**
- **Employment quality: While overall unemployment is approximately 2.1%, the nature of available work varies significantly. Gig economy participation, underemployment, and jobs that lack benefits or scheduling predictability create economic instability that erodes mental health even in a county with very low formal unemployment.**

Equity Is Not Just a Value Statement—It Is a System Design Requirement

The disparities documented in this section are not primarily the result of individual choices or cultural preferences. They are the predictable consequences of system design: a provider network that excludes 83% of its capacity from Medicaid patients, a workforce that is 89% monolingual in an increasingly diverse community, a crisis system that concentrates demand in three ZIP codes without proportional resource allocation, and a youth mental health response that has not kept pace with a 551% increase in suicidal and self-harm events among children. Equity in behavioral health means redesigning these systems so that a person's insurance type, primary language, ZIP code, age, race, and gender do not determine whether they can access care when they need it. This is not an aspirational goal. It is a practical requirement for any system that intends to be effective.

Section Sources: CDC PLACES 2026 (2023 data year); CDC/ATSDR Social Vulnerability Index; HRSA HPSA Mental Health Summary (March 2026); Indiana MPH Mental Health Events by Age Group (2017–2024); 2021 Hamilton County BHNA; National Benchmark Index (292 counties); Lund et al., *World Psychiatry* (2024); Nakphong et al., *IJERPH* (2025); Kammer-Kerwick et al., *PLOS Mental Health* (2024); White House SDOH Playbook (2023); Sagamore Institute, "Failure to Launch" (2026); U.S. Surgeon General Youth Mental Health Advisory (2021); Luthar et al., *American Psychologist* (2020); Patalay & Gage, *Lancet Psychiatry* (2019); CDC MMWR Vital Signs (2023).

SECTION 13

Peer County & Community Benchmarking

Where Hamilton County Stands Among America's Large Counties

The disparities documented in Section 12 raise an essential follow-up question: Is Hamilton County's behavioral health experience unique, or does it reflect patterns shared by similar communities across the country? Benchmarking answers this question by placing Hamilton County alongside 292 U.S. counties with populations exceeding 250,000—a peer set that includes the nation's most dynamic, fastest-growing, and most economically competitive communities. The results are revealing. On most behavioral health measures, Hamilton County is a national leader. On two, it is strikingly average or worse. Understanding which rankings should reassure us and which should alarm us is the purpose of this section.

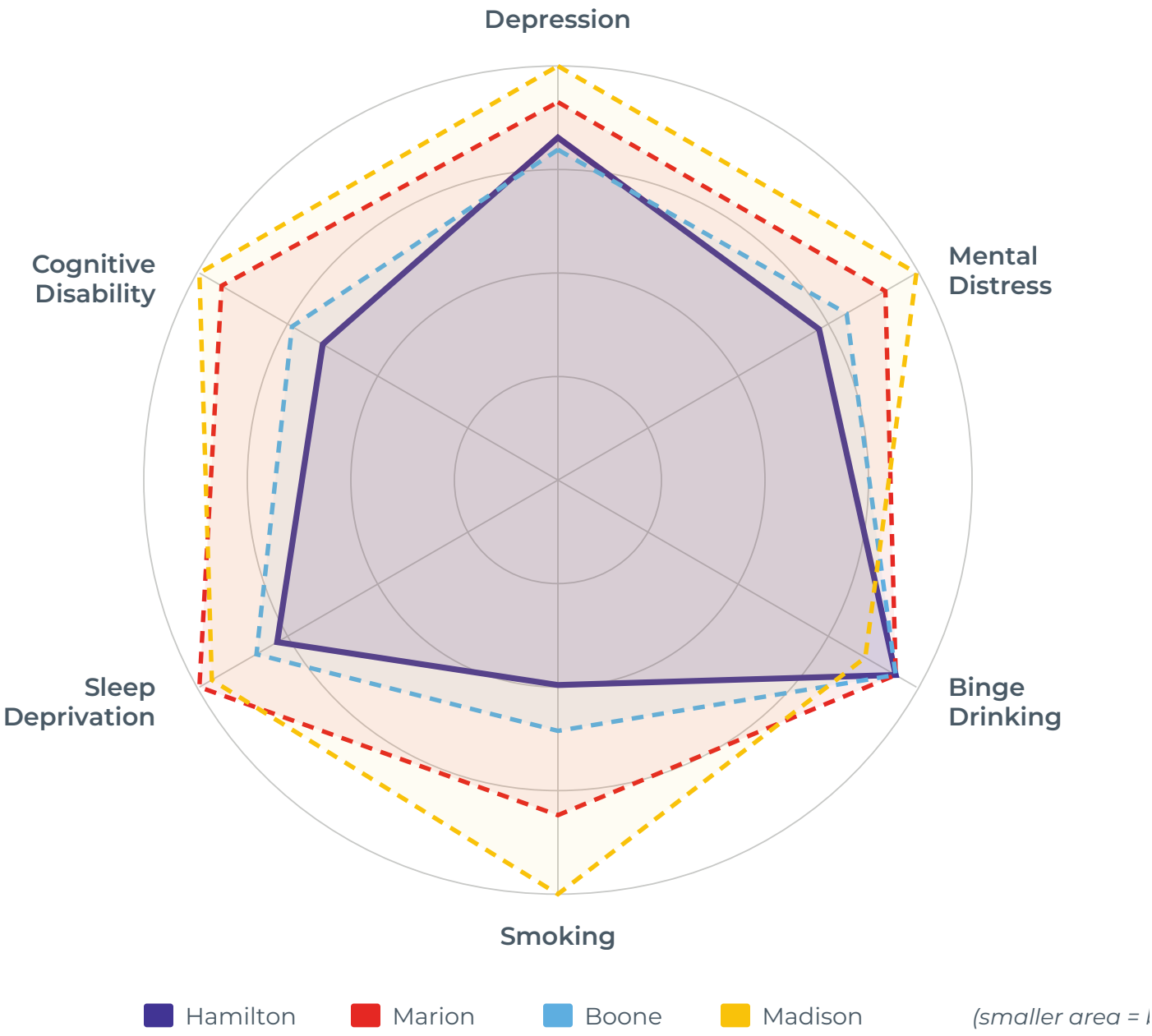
13.1 How the Benchmarking Works

The national benchmark index used in this assessment incorporates 130 fields across 10 domains for each of 292 U.S. counties with populations over 250,000. Data sources include the Bureau of Labor Statistics Quarterly Census of Employment and Wages, the Census Bureau's American Community Survey, the Bureau of Economic Analysis Regional Price Parities, County Health Rankings 2025, the EPA Air Quality Index, Census Population Estimates, and IRS Statistics of Income. The behavioral health indicators within this index are drawn primarily from County Health Rankings, which in turn compiles data from the Behavioral Risk Factor Surveillance System (BRFSS), CDC WONDER mortality files, and other federal sources.

The composite Quality of Life Score (version 3) integrates four domains with weighted contributions: workforce strength (40% weight), livability (35%), growth dynamics (15%), and earnings (10%). This produces a single 0 to 100 metric that captures the multidimensional conditions shaping quality of life in each county. Hamilton County's score of 84.6 out of 100[IHC National Benchmark Index, 2025] places it among the highest-scoring counties in the nation, reflecting its exceptional economic performance, low poverty, strong labor market, and favorable health outcomes.

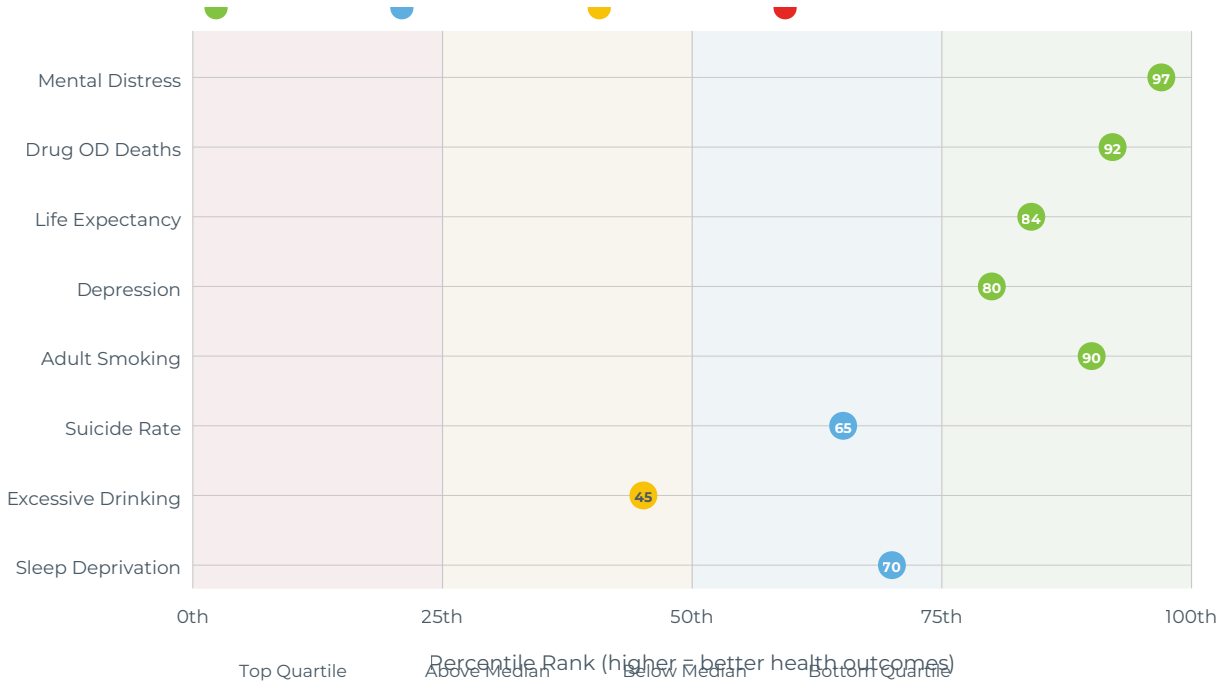
Individual indicator rankings are computed within the 292-county universe. A rank of "9th out of 292" means Hamilton County outperforms 283 other large counties on that measure. Percentiles translate these ranks into a more intuitive format: the 97th percentile means Hamilton County scores better than 97% of peer counties. Where data are unavailable for some counties (suicide rate data exist for only 286 of the 292), the ranking universe adjusts accordingly.

Regional Behavioral Health Profile: 4-County Comparison



Source: CDC PLACES 2026 (Age-Adjusted Prevalence); County Health Rankings 2025

Hamilton County National Percentile Rank Across Key Indicators (292 Counties)



Source: County Health Rankings 2025; National Benchmarking Index (292 counties, 250K+ pop)

13.2 The National Scorecard: Indicator by Indicator

The table below presents Hamilton County's national position on every behavioral health-relevant indicator in the benchmark index. What follows is not just a set of rankings but a guided tour through what each number means for the county's behavioral health system.

Table 13.1: Hamilton County National Rankings — Behavioral Health Indicators (292 Counties, 250K+ Pop.)

INDICATOR	HAMILTON COUNTY	NATIONAL RANK	PERCENTILE	ASSESSMENT
Frequent Mental Distress	13.6%	9 / 292	97th	Excellent
Poor Mental Health Days	4.75 days/month	~10 / 292	97th	Excellent
Drug Overdose Deaths	14.3 per 100K	22 / 292	92nd	Low (favorable)
Life Expectancy	80.65 years	47 / 286	84th	Above Average

INDICATOR	HAMILTON COUNTY	NATIONAL RANK	PERCENTILE	ASSESSMENT
Adult Smoking	10.0%	~30 / 292	90th	Low (favorable)
Premature Death (YPLL)	4,761	~35 / 292	88th	Low (favorable)
Uninsured Rate	4.5%	~15 / 292	95th	Excellent
Children in Poverty	4.5%	~5 / 292	98th	Excellent
Food Insecurity	9.2%	~20 / 292	93rd	Low (favorable)
Suicide Rate	11.5 per 100K	102 / 286	64th	Middle of Pack
Excessive Drinking	20.3%	162 / 292	44th	Below Average

Source: National Behavioral Health Benchmark (292 counties, 250K+ pop.). County Health Rankings 2025, CDC PLACES, Census ACS, BEA. Hamilton County FIPS 18057. Approximate ranks where exact position not directly calculated.

13.3 The Strengths: Where Hamilton County Leads the Nation

Frequent mental distress: 9th out of 292 (97th percentile). Hamilton County's population-level mental distress rate of 13.6% [CHR, 2025] **places it in the top 3% of all large U.S. counties** [IHC National Benchmark Index, 2025]**. Only a handful of counties in the entire nation—places like Loudoun County, Virginia; Douglas County, Colorado; and Williamson County, Tennessee—report lower rates. This ranking reflects the cumulative protective effects of Hamilton County's economic strength: high household income reduces financial stress, robust employer-sponsored insurance enables treatment access, low poverty reduces the social determinants that drive chronic distress, and strong community institutions provide social support and belonging. For context, the national median among the 292 benchmark counties is approximately 16–17%, placing Hamilton County a full three percentage points below the typical large U.S. county.**

Drug overdose deaths: 22nd out of 292 (92nd percentile). Hamilton County's drug overdose death rate of 14.3 per 100,000 [CHR, 2025] **is among the lowest in the nation for large counties. To appreciate what this means, consider the Marion County comparison: Marion County, immediately to the south and sharing an integrated labor market with Hamilton County, reports a rate of 69.7 per 100,000—4.9 times higher. This is one of the steepest county-border drug mortality gradients in the entire United States. Residents of Hamilton and Marion County share highways, employers, schools, and**

shopping centers, yet the likelihood of dying from a drug overdose is nearly five times higher on one side of the county line than the other. This gradient illustrates how profoundly local conditions—income, housing stability, treatment access, community infrastructure—shape substance use outcomes.

Children in poverty: approximately 5th out of 292 (98th percentile). Hamilton County's child poverty rate of 4.5%[Census ACS, 2023] is among the lowest in the country. This is a critical behavioral health indicator because childhood poverty is one of the strongest predictors of adverse childhood experiences (ACEs), which in turn are among the strongest predictors of adult behavioral health conditions. The county's near-elimination of child poverty provides an exceptionally strong protective buffer for the next generation.

Social determinant indicators: top 5–10% across the board. The uninsured rate (4.5%, approximately 15th), food insecurity (9.2%, approximately 20th), and adult smoking (10.0%, approximately 30th)[IHC National Benchmark Index, 2025] all place Hamilton County in the top decile nationally. These upstream indicators explain much of the county's favorable behavioral health profile. When people have insurance, food, employment, and safe housing, the incidence of depression, substance use disorders, and crisis events is substantially lower.

13.4 The Vulnerabilities: Where the Rankings Break Down

Two indicators stand out as stark exceptions to Hamilton County's otherwise dominant national position. They deserve careful attention because they represent the county's most actionable behavioral health opportunities.

Excessive Drinking: 162nd out of 292 (44th Percentile)

This is the single most important finding in the benchmarking analysis. Hamilton County's excessive drinking rate of 20.3% [CHR, 2025] **ranks 162nd out of 292 counties** [IHC National Benchmark Index, 2025] **—placing it in the bottom half nationally. One in five Hamilton County adults drinks excessively. This is the only behavioral health indicator where Hamilton County falls below the national median for peer counties.**

The significance of this ranking cannot be overstated. On every other measure—mental distress, drug overdose, smoking, child poverty, food insecurity, uninsured rate—Hamilton County ranks in the top 10% nationally. On excessive drinking, it ranks in the 44th percentile. The gap between these positions is enormous. A county that is 97th percentile on mental distress and 44th percentile on excessive drinking has a clear, specific, data-identified vulnerability.

This pattern is consistent with well-established research showing that excessive drinking does not follow the same income gradient as other health behaviors. Higher-income communities often report higher rates of alcohol consumption, driven by social norms around entertaining, business-related drinking, disposable income for alcohol purchases, and reduced stigma around alcohol use compared to other substances. The CDC PLACES data confirm this at the regional level: Hamilton County's binge drinking rate (17.8%) [CDC PLACES, 2026] **is identical to both Marion County and Boone County, despite vast differences in income, poverty, and every other health indicator.**

For employers, this means that approximately one in five workers in Hamilton County is drinking at levels that affect their health, productivity, and safety. For the healthcare system, excessive drinking increases the risk of depression, anxiety, cardiovascular disease, liver disease, and cancer. For families, it creates domestic stress, parenting challenges, and intergenerational cycles of substance use. The 44th-percentile ranking should be treated as a strategic priority.

Suicide Rate: 102nd out of 286 (64th Percentile)

Hamilton County's suicide rate of 11.5 per 100,000[CHR, 2025] **ranks 102nd out of 286 counties**[IHC National Benchmark Index, 2025] **with available data. At the 64th percentile, this means that more than one-third of comparable American counties have lower suicide rates. For a county that ranks in the 90th+ percentile on virtually every other health and wellness indicator, a 64th-percentile ranking on suicide is a conspicuous outlier.**

This finding is consistent with the broader epidemiological literature on suicide in affluent communities. While income and education provide powerful protection against most health conditions, they provide weaker protection against suicide. In high-achieving communities, specific risk factors may actually be elevated: social isolation despite apparent connectivity, high-pressure academic and professional environments, access to lethal means (particularly firearms, which are present in many Hamilton County households), and profound stigma around help-seeking that prevents individuals—particularly men—from acknowledging psychological distress until it reaches a crisis point.

The Sagamore Institute's "Failure to Launch" data add gender specificity to this concern: Indiana men are four times more likely to die by suicide than Indiana women. If this ratio holds in Hamilton County, the county's estimated male suicide rate would be approximately 19 per 100,000—a rate that would rank significantly worse in the national benchmark.

The gap between Hamilton County's 97th-percentile ranking on mental distress and its 64th-percentile ranking on suicide tells an important story: low rates of population-level distress do not translate automatically into low rates of suicide. Suicide prevention requires dedicated, targeted investment beyond the general behavioral health system.

13.5 The Marion County Comparison: A Tale of Two Counties

No benchmarking analysis of Hamilton County is complete without a deep examination of its relationship with Marion County. These two counties share a border and an integrated labor market—approximately 40% of Hamilton County workers commute south into Marion County daily. They share healthcare systems, school sports leagues, restaurant scenes, and cultural institutions. Yet their behavioral health outcomes diverge dramatically, creating one of the most striking county-border health gradients in the Midwest.

- **Drug overdose deaths: Marion County at 69.7 per 100,000 versus Hamilton County at 14.3. This 4.9x ratio represents one of the steepest county-border substance mortality gradients in the nation. A Hamilton County resident who crosses 96th Street into Marion County crosses into a radically different risk environment—not because of anything**

about the road, but because of the cumulative differences in income, housing stability, insurance coverage, treatment availability, and community support that shape substance use outcomes.

- Depression: Marion County at 25.3% versus Hamilton at 22.9%—a 2.4 percentage-point gap. This is meaningful but far smaller than the chasm in overdose deaths, suggesting that depression risk is more evenly distributed across income levels while fatal substance use is heavily concentrated in lower-income communities.
- Provider access: Marion County has 11 active HPSA designations (maximum score 22/25), versus Hamilton's 2 designations (maximum score 19). Marion's provider shortage is more severe, but Hamilton's is still federally recognized.
- Disability: Marion County's any-disability rate (29.9%) is 36% higher than Hamilton's (22.0%), reflecting the compounding effects of poverty, lower educational attainment, and reduced access to preventive care.

The Hamilton-Marion comparison matters for two reasons. First, it demonstrates how powerfully local conditions shape health outcomes—two communities that share geography and an economy produce radically different behavioral health profiles based on socioeconomic structure. Second, it reminds Hamilton County that behavioral health challenges do not respect county boundaries. The Hamilton County employee who developed an opioid use disorder while living in Marion County does not leave it behind when they cross the county line for work. The teenager in Fishers whose social circle extends into Lawrence Township interacts with communities experiencing far more acute behavioral health stress.

13.6 The Neighboring Counties: Regional Context

Boone County is Hamilton's closest peer—a rapidly growing suburban county with similar economic demographics. Its behavioral health indicators track closely with Hamilton's (depression 22.1% vs. 22.9%, mental distress 15.7% vs. 14.2%), suggesting that the two counties face similar protective factors and similar vulnerabilities. Boone's single HPSA designation with a score of 14 indicates a less severe but still recognized provider shortage.

Madison County represents the most challenging behavioral health environment in the comparison region. Its depression rate of 27.7%—4.8 points higher than Hamilton's—reflects the cumulative impact of deindustrialization, population loss, and economic hardship. Three active HPSA designations with a maximum score of 21 confirm severe provider shortage. Madison County serves as a cautionary example of what happens when economic decline undermines the social infrastructure that supports mental health.

Tipton County is the smallest and most rural county in the comparison (population 15,256). Its depression rate of 26.7% and mental distress rate of 18.5% illustrate the behavioral health challenges of rural isolation: limited provider options, transportation barriers, agricultural stress, and social networks that may be shrinking as younger residents leave for metropolitan opportunities.

13.7 What the Benchmarks Reveal

The benchmarking analysis yields three conclusions that should inform every recommendation in this assessment:

1. Hamilton County's behavioral health strengths are real and substantial. Rankings in the top 3–10% nationally on mental distress, drug overdose deaths, child poverty, and insurance coverage reflect genuine community advantages that should be recognized and protected. These strengths provide a foundation upon which to build additional capacity.
2. Excessive drinking is the county's most clearly identified behavioral health vulnerability. The 162nd-of-292 ranking is an actionable finding that calls for targeted screening, brief intervention, and treatment programs—particularly in primary care settings and employer wellness programs where high-income populations can be reached.
3. Suicide prevention requires dedicated investment beyond the general behavioral health system. A 64th-percentile ranking on suicide in a county that is 97th percentile on nearly everything else signals that the county's economic advantages are not fully translating into suicide prevention. Specific risk factors in affluent, high-achieving communities—social isolation, achievement pressure, access to lethal means, and help-seeking stigma—require specific responses.

The benchmarking data, combined with the regional comparisons in Section 12, paint a portrait of a county that is doing many things right but faces two significant blind spots. Addressing those blind spots does not require a complete system overhaul—it requires the same data-driven, targeted investment that has made Hamilton County successful in so many other domains.

13.8 Community-Based Support: NAMI and Mental Health America

The benchmarking analysis and peer comparisons above focus on clinical and epidemiological indicators. But the behavioral health ecosystem includes a critical layer of community-based support that does not appear in federal datasets—organizations that fill the space between clinical treatment and community life, providing education, peer support, advocacy, and stigma reduction. In Hamilton County, two organizations occupy this essential role.

NAMI HAMILTON COUNTY

The National Alliance on Mental Illness (NAMI) Hamilton County chapter provides a range of community-based behavioral health support services, all available at no cost and without requiring a clinical appointment: [NAMI Hamilton County, 2025]

- **Family-to-Family — An 8-session evidence-based education program for family members of individuals living with mental illness**
- **Peer-to-Peer — A recovery education program for adults with mental health conditions, taught by trained peers**
- **Support Groups — Regular meetings for individuals, family members, and parents of children and adolescents with behavioral health conditions**
- **Community Education & Advocacy — Presentations, stigma reduction campaigns, and legislative advocacy for mental health policy**

MENTAL HEALTH AMERICA OF BOONE & HAMILTON COUNTIES

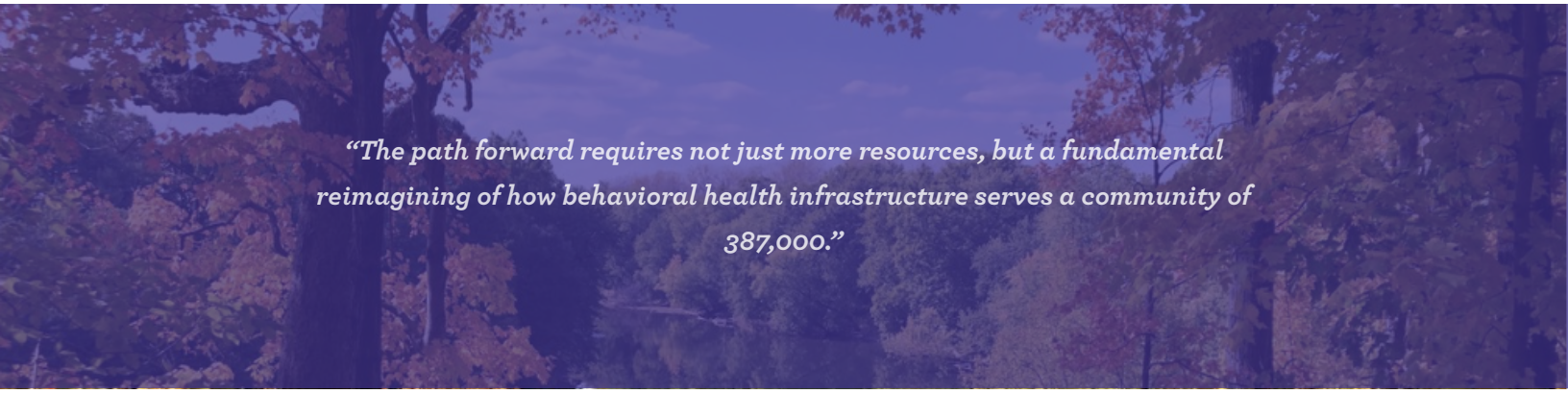
Mental Health America (MHA) of Boone & Hamilton Counties provides prevention-focused and early intervention programming that complements the clinical treatment system: [MHA Boone & Hamilton Counties, 2025]

- **Mental Health Screening — Free, confidential online and in-person screening tools for depression, anxiety, PTSD, and other conditions**
- **Youth Programs — School-based and after-school programming focused on emotional resilience and early identification**
- **Workplace Wellness — Employer-facing programs including Mental Health First Aid training and workplace mental health assessments**
- **Community Outreach — Resource navigation, referral support, and community awareness events**

Why Community-Based Organizations Matter

NAMI and MHA fill a critical gap in Hamilton County's behavioral health ecosystem: community-based support that does not require a clinical appointment, a referral, insurance, or a wait time. In a county where the average wait for psychiatric medication management is 57 days and only 17% of providers accept Medicaid, these organizations provide an accessible entry point for individuals and families who cannot navigate—or cannot access—the clinical system. They are volunteer-driven, chronically underfunded, and essential. Every support group meeting, every Family-to-Family session, every workplace training represents an intervention that reduces the burden on the clinical system and reaches people who might otherwise receive no support at all.

Section Sources: National Behavioral Health Benchmark Index (292 counties, 250K+ pop.), compiled March 2026 from BLS QCEW, Census ACS, BEA RPP, County Health Rankings 2025, EPA AQI, Census PEP, IRS SOI; CDC PLACES 2026 (2023 data year); HRSA HPSA Mental Health Summary (March 2026); IHC Quality of Life Strength Index (v3).



SECTION 14

ADDRESSING THE GAPS — LESSONS FROM PEER COMMUNITIES

Evidence-Based Approaches That Other Communities Have Implemented

The thirteen preceding sections of this assessment have assembled the most comprehensive portrait of Hamilton County's behavioral health landscape ever produced. The data span 23 federal sources, 400+ proprietary workforce intelligence files, 65+ peer-reviewed academic publications, and eight years of trend data. Together, they reveal a county with extraordinary strengths—and a set of specific, measurable gaps.

This section does not prescribe a course of action. Rather, it examines how other communities—many facing challenges remarkably similar to Hamilton County's—have responded to the same kinds of gaps. From crisis stabilization in Tucson to school-based mental health in Vermont, from workforce pipeline development in California to suburban behavioral health infrastructure in Johnson County, Kansas, these examples offer a catalog of approaches that have been tested, measured, and documented in peer-reviewed research and government evaluations.

These case studies are offered as potential models, not directives. Every community's path is different. Hamilton County's particular combination of assets, partnerships, institutional capacity, and priorities will determine which approaches—if any—are appropriate for local adaptation. What follows is simply the evidence of what has worked elsewhere.

14.1 The Seven Critical Gaps

Before examining how other communities have responded to similar challenges, it is essential to name the gaps clearly. Each gap is a specific finding from this assessment—not an abstract concern, but a documented problem with measurable dimensions.

Table 14.1: Seven Critical Gaps Identified in This Assessment

#	GAP	KEY DATA POINT	SECTION REFERENCE
1	Crisis capacity overwhelmed	Events tripled: 6,334 → 21,432 (2017–2023). Police are #1 referral source (27%).	Sections 4, 11
2	Provider workforce shortage	HPSA score 19/25. Low-income ratio 37,129:1. Shortage of 17.8 FTEs. 190 psychiatrists for 2M+ MSA.	Sections 8, 9
3	Two-tiered insurance access	Only 17% of providers accept Medicaid.	Sections 8, 12
4	Language and cultural barriers	89% of providers lack bilingual staff. Growing Hispanic and Asian populations.	Section 12
5	Excessive drinking unaddressed	20.3% rate ranks 162nd/292 nationally—only BH indicator below national median.	Sections 6, 13
6	Suicide prevention gap	11.5/100K rate at 64th percentile. Youth self-harm +551% (2017–2024). Men 4x risk.	Sections 7, 12, 13
7	Youth crisis outpacing response	Under-18 suicidal/self-harm: 55 → 358 (2017–2024). 62,700 students, uneven school BH services.	Sections 4, 12

SECTION 15

Technical Appendix

Data Sources, Methodology, Definitions, Limitations, and References

> **This appendix provides full documentation of the data sources, analytical methods, key definitions, and limitations underlying the Hamilton County Behavioral Health Needs Assessment 2026. The goal is transparency: every finding in this report can be traced to a specific data source, and every analytical choice is documented here for peer review and future replication.**

15.1 Data Source Inventory

This assessment draws on 23+ federal and state data sources, proprietary workforce intelligence, peer-reviewed academic literature, and the 2021 Hamilton County Behavioral Health Needs Assessment. The following tables provide a comprehensive inventory organized by type, with descriptions of what each source provides and why it is trusted.

Table 15.1: Federal and State Data Sources

SOURCE	WHAT IT PROVIDES	GEOGRAPHY	DATA YEAR(S)	WHY TRUSTED
CDC PLACES	Model-based estimates of health behaviors and outcomes (depression, mental distress, smoking, binge drinking, disability, sleep, cognition) derived from the Behavioral Risk Factor Surveillance System (BRFSS)	5-county + tract-level	2023	CDC gold-standard small-area estimation; peer-reviewed methodology; annual updates
Indiana MPH	Mental health events by county, year, and age group (nonphysical MH, suicidal/self-harm, homicidal/harm-others) reported by emergency services	Hamilton County	2017–2024	State government administrative data; complete enumeration (not sample); 8-year time series enables trend analysis
HRSA	Health Professional Shortage Area (HPSA) designations for mental health, including provider-to-population ratios, shortage estimates, and HPSA scores (0–25)	5-county + MSA	Current (Sep 2025)	Federal designation authority; formal provider shortage determination; used for NHSC loan repayment eligibility

SOURCE	WHAT IT PROVIDES	GEOGRAPHY	DATA YEAR(S)	WHY TRUSTED
SAMHSA	National Survey on Drug Use and Health (state estimates), National Mental Health Services Survey (facility counts), treatment locator data, 988 performance metrics	Indiana + national	2021–2024	Federal agency with statutory data collection authority; ~70,000 respondents annually for NSDUH
County Health Rankings	Composite health outcome and health factor rankings, behavioral risk factors, clinical care measures, social and economic factors	County-level (national)	2025	Robert Wood Johnson Foundation / University of Wisconsin Population Health Institute; peer-reviewed methodology; used in national benchmarking index
Census ACS	Demographics, income, poverty, insurance, language, disability, housing cost burden	County + city + tract	2023	Constitutionally mandated survey; 3.5 million annual responses; foundation for all federal planning
CDC WONDER	Mortality data including drug overdose, suicide, and alcohol-related deaths by county	County-level	2019–2023	Death certificate data compiled by National Center for Health Statistics; complete vital statistics enumeration

SOURCE	WHAT IT PROVIDES	GEOGRAPHY	DATA YEAR(S)	WHY TRUSTED
CDC/ ATSDR SVI	Social Vulnerability Index measuring community resilience across four themes: socioeconomic status, household characteristics, racial/ ethnic minority status, housing type/ transportation	County + tract	2022	Federal government index; used in emergency preparedness and community health planning
BEA	Regional economic accounts: county GDP, personal income, regional price parities	County + MSA	2023	Bureau of Economic Analysis; official GDP and income statistics for all U.S. counties
BLS OES	Occupational Employment and Wage Statistics for behavioral health occupations (employment counts, median and mean wages, wage percentiles)	MSA-level	May 2024	Bureau of Labor Statistics; employer-reported survey; largest occupation-level wage survey in the U.S.
BLS QCEW	Industry-level employment and wage data from quarterly unemployment insurance filings	County-level	2024 Q2	Complete enumeration of all employers subject to UI (97% coverage); used in national benchmarking

SOURCE	WHAT IT PROVIDES	GEOGRAPHY	DATA YEAR(S)	WHY TRUSTED
CMS Medicare/ Medicaid	Enrollment, provider participation, spending, opioid prescribing patterns	County-level	2023	Administrative claims data; complete enumeration of Medicare/Medicaid beneficiaries
FRED (Federal Reserve)	47 economic indicator time series including labor market, housing, and financial stress metrics	County + MSA + national	Through 2024	Federal Reserve Bank of St. Louis; curated from authoritative federal statistical agencies
IRS SOI	Statistics of Income: migration patterns, adjusted gross income, filing data by county	County-level	2022 tax year	Complete tax return data; only source for county-level migration and income flows
National Benchmark Index	292 U.S. counties (250K+ pop.), 130 fields across 10 domains including behavioral health	National (292 counties)	2024–2025	Compiled by Invest Hamilton County from BLS, Census, BEA, CHR, EPA, IRS sources

Table 15.2: Proprietary and Local Data Sources

SOURCE	WHAT IT PROVIDES	DATA YEAR(S)	ACCESS
Lightcast (Emsi)	Workforce intelligence including occupation projections, industry analytics, job posting data, and compensation benchmarks for 21 behavioral health SOCs across 4 NAICS codes	2024–2026	Licensed subscription

SOURCE	WHAT IT PROVIDES	DATA YEAR(S)	ACCESS
2021 Hamilton County BHNA	Provider survey, community needs assessment, crisis data, service utilization patterns, stakeholder input	2021	Public report (Community Solutions Inc.)
Hamilton County Courts	Drug and alcohol court caseload data	2015–2019	Derived from 2021 BHNA

15.2 Methodology Notes

Data Integration and Triangulation

This assessment employs a triangulation methodology, cross-referencing multiple independent data sources to validate findings. When data sources produce different estimates for the same indicator—for example, CDC PLACES depression prevalence (county-level model-based estimate from BRFSS) versus NSDUH-derived state-level estimates—the CDC PLACES figure is used for county-level comparisons because it provides the most granular geography. Discrepancies between sources are noted in context. County Health Rankings 2025 composite data form the basis for the national benchmarking index because they provide consistent methodology across all 292 peer counties.

Age Adjustment

CDC PLACES indicators are reported as age-adjusted prevalence where available, using the 2000 U.S. standard population. Age adjustment allows valid comparisons between counties with different age distributions—important because Hamilton County's age profile differs from Marion County's or Tipton County's. Where age-adjusted values are not available (noted in tables with asterisks), crude prevalence is reported, and comparisons should be interpreted with caution.

National Benchmarking Methodology

The national benchmark index includes 292 U.S. counties with populations exceeding 250,000 as of the most recent Census Population Estimates. This threshold was chosen to ensure comparability: counties below 250,000 often have suppressed data for key indicators and face structural differences (rurality, limited economic base) that make direct comparison less meaningful. The composite Quality of Life Score (version 3) weights four domains: workforce strength (40%), livability (35%), growth dynamics (15%), and earnings (10%). Individual indicator rankings are computed within the 292-county universe. Counties lacking data for specific indicators are excluded from that indicator's ranking—for example, 286 counties have suicide rate data versus 292 for mental distress—and this is noted where relevant.

Trend Analysis

Indiana MPH mental health event data (2017–2024) are analyzed as both raw counts and per-capita rates. Population denominators are from Census PEP annual estimates. Growth rates are calculated as simple percentage change from the baseline year (2017). The assessment describes trends descriptively and does not apply statistical trend modeling (e.g., joinpoint regression) to these time series. The 2020–2021 inflection point is discussed in narrative context rather than through formal change-point analysis.

HPSA Analysis

HRSA HPSA designations are reported as of the most recent update (September 2025). Both active and withdrawn designations are tracked to provide historical context. HPSA scores range from 0 to 25, with higher scores indicating greater shortage. The formal provider-to-population ratio reported for Hamilton County (37,129:1) reflects the low-income population HPSA designation, not the general county population ratio. This is an important distinction: Hamilton County's overall provider availability may be adequate for privately insured residents while being critically insufficient for its low-income population.

Economic Burden Estimation

The estimated $349 million annual economic burden of untreated mental illness in Hamilton County is derived by applying the Taylor et al. (2023) finding—that untreated mental illness costs Indiana 1.2% of GDP—to Hamilton County's $29.1 billion GDP. This is acknowledged as a conservative estimate because it does not adjust for Hamilton County's higher labor force participation rate, higher median wages (which amplify indirect cost components), or the distinct prevalence patterns documented in this assessment.

15.3 Key Definitions

Table 15.3: Glossary of Key Terms

TERM	ABBREVIATION	DEFINITION
Any Mental Illness	AMI	A mental, behavioral, or emotional disorder that can vary in impact, ranging from no impairment to mild, moderate, or severe. AMI encompasses all recognized mental disorders. (SAMHSA definition)
Serious Mental Illness	SMI	A mental, behavioral, or emotional disorder resulting in serious functional impairment, substantially interfering with or limiting one or more major life activities. (SAMHSA definition)

TERM	ABBREVIATION	DEFINITION
Substance Use Disorder	SUD	A treatable mental disorder affecting brain and behavior, leading to inability to control use of substances including legal or illegal drugs, alcohol, or medications. (SAMHSA definition)
Health Professional Shortage Area	HPSA	A geographic area, population, or facility designated by HRSA as having a shortage of health professionals. Mental health HPSAs are scored 0–25 based on provider ratio, poverty, and other factors.
Frequent Mental Distress	FMD	Experiencing 14 or more days of poor mental health in the past 30 days. (CDC PLACES/BRFSS definition)
Binge Drinking	—	Consuming 5+ drinks (men) or 4+ drinks (women) on a single occasion in the past 30 days. (CDC PLACES/BRFSS definition)
Excessive Drinking	—	Includes both binge drinking and heavy drinking (8+ drinks/week for women, 15+ for men). (County Health Rankings definition)
Short Sleep Duration	—	Sleeping fewer than 7 hours per night on average. (CDC PLACES/BRFSS definition)
Collaborative Care Model	CoCM	An evidence-based approach integrating behavioral health into primary care using care managers, psychiatric consultation, and measurement-based treatment. (Archer et al., 2012, Cochrane Review)
Sequential Intercept Model	SIM	A framework identifying six intercept points (0–5) across the criminal justice continuum where behavioral health interventions can divert individuals from deeper justice involvement. (Munetz & Griffin, 2006; SAMHSA, 2024)

TERM	ABBREVIATION	DEFINITION
Social Vulnerability Index	SVI	CDC/ATSDR index measuring community resilience to health stressors across four themes: socioeconomic status, household characteristics, racial/ethnic minority status, and housing type/transportation. RPL = overall percentile ranking (0 = least vulnerable, 1 = most vulnerable).
Years of Potential Life Lost	YPLL	A measure of premature mortality calculated as the sum of differences between a predetermined end point (age 75) and the ages of death for those dying before that age, expressed per 100,000 population. (County Health Rankings definition)
Medication-Assisted Treatment	MAT / MOUD	The use of FDA-approved medications (methadone, buprenorphine, naltrexone) in combination with counseling and behavioral therapies for treatment of opioid use disorders. MOUD (Medications for Opioid Use Disorder) is the current preferred terminology. (SAMHSA)
Screening, Brief Intervention, and Referral to Treatment	SBIRT	An evidence-based practice for identifying, reducing, and preventing problematic use of alcohol and illicit drugs through universal screening in healthcare settings. (SAMHSA)
Certified Community Behavioral Health Clinic	CCBHC	A SAMHSA-certified clinic required to provide comprehensive mental health and substance use disorder services to all individuals regardless of ability to pay, including crisis services, outpatient treatment, primary care screening, and case management.

TERM	ABBREVIATION	DEFINITION
Adverse Childhood Experiences	ACEs	Potentially traumatic events occurring in childhood (0–17 years) including abuse, neglect, and household dysfunction. ACE research demonstrates a dose-response relationship between childhood adversity and adult health outcomes, including behavioral health conditions.
Crisis Intervention Team	CIT	A 40-hour specialized training program for law enforcement officers that teaches de-escalation techniques for mental health crises, assessment protocols, and connection to treatment. Originated in Memphis, TN.
Federally Qualified Health Center	FQHC	A community-based health center that receives federal funding under Section 330 of the Public Health Service Act to provide primary care services in underserved areas. FQHC Look-Alikes meet the same requirements but are funded through different mechanisms.
NEET Youth / Disconnected Youth	NEET	Young people ages 16–24 who are neither enrolled in school nor employed. Also called "opportunity youth." National rate: approximately 10.6% (4.15 million young people). (Measure of America, 2025)
Presenteeism	—	Reduced on-the-job productivity due to health conditions. Workers present but impaired by behavioral health conditions produce at an estimated 70–80% of capacity. Research consistently finds presenteeism costs 2–3 times more than absenteeism.

TERM	ABBREVIATION	DEFINITION
Social Determinants of Health	SDOH	The conditions in the environments where people are born, live, learn, work, play, worship, and age that affect a wide range of health outcomes and risks. Five domains: economic stability, education access and quality, healthcare access and quality, neighborhood and built environment, social and community context. (Healthy People 2030)
Age-Adjusted Prevalence	—	A statistical method that removes the effect of age differences between populations, allowing valid comparison of disease rates between counties or communities with different age structures. Uses the 2000 U.S. standard population as the reference.
Percentile Rank	—	The percentage of counties that Hamilton County outperforms on a given indicator. The 97th percentile means Hamilton County scores better than 97% of peer counties in the 292-county benchmark. Higher percentile = better performance on health-favorable indicators.
Per Capita Rate	—	A rate expressed as events or conditions per unit of population (typically per 1,000 or per 100,000 residents). Allows comparison across areas with different population sizes.
Quality of Life Score	QoL	Invest Hamilton County's composite index (0–100) integrating workforce strength (40%), livability (35%), growth dynamics (15%), and earnings (10%). Hamilton County score: 84.6. Derived from the 292-county national benchmark.

TERM	ABBREVIATION	DEFINITION
988 Suicide & Crisis Lifeline	988	The national three-digit dialing code (launched July 2022) connecting individuals to trained crisis counselors via phone, text, or chat. Monthly volumes exceed 500,000 contacts nationally. Answer rates improved from 70% to 93% post-launch.

15.4 Limitations

Every data-driven assessment carries limitations that should be understood by readers interpreting the findings. The following limitations are acknowledged transparently:

1. Ecological fallacy. County-level prevalence rates (e.g., depression at 22.9%) describe populations, not individuals. A person living in a county with low average depression prevalence may still experience severe depression. Tract-level and individual-level patterns may differ substantially from county averages.
2. Data currency. Data sources span different time periods. CDC PLACES data reflect 2023 survey responses; Indiana MPH data extend through 2024; the 2021 BHNA is now five years old and its provider survey findings (17% Medicaid acceptance, 89% no bilingual staff) may have changed. HRSA HPSA data were last updated September 2025. Conditions may have shifted since these data were collected.
3. Small-area estimation uncertainty. CDC PLACES uses model-based small area estimation to generate county-level prevalence from BRFSS data. These estimates carry wider confidence intervals for smaller counties (Tipton, Boone) than for larger ones (Marion, Hamilton). Tract-level estimates carry even wider uncertainty. Point estimates should be interpreted as best approximations, not precise measurements.
4. Suppressed data. Some county-level indicators are suppressed when cell sizes fall below minimum thresholds for statistical reliability. This is particularly relevant for Tipton County (population 15,256) and for race/ethnicity-specific data in Hamilton County's minority populations. Where data are suppressed, the assessment notes the gap rather than imputing values.
5. Provider data gaps. No comprehensive, current directory of all behavioral health providers in Hamilton County exists with standardized information on specialties, insurance acceptance, language capacity, and appointment availability. The 2021 BHNA provider survey is the most recent systematic data collection and is now five years old.
6. Self-report bias. BRFSS-derived indicators (depression, mental distress, drinking, smoking, sleep) rely on self-reported data. Social desirability bias and recall limitations may cause underestimation of true prevalence. This is particularly relevant for substance use measures in affluent communities where stigma may suppress reporting.
7. Cross-sectional design. While trend data are available for some indicators (Indiana MPH events, 2017–2024), the assessment primarily presents a point-in-time profile. Causal inferences about relationships between risk factors, social determinants, and behavioral health outcomes should be made cautiously.

8. **Missing local data. Several indicators could not be measured: real-time wait times for behavioral health appointments, school-level mental health staffing ratios by corporation, employer EAP utilization rates, 988 call volume specific to Hamilton County (reported at state level only), and criminal justice booking screening rates.**
9. **Incomplete race/ethnicity disaggregation. County-level behavioral health data disaggregated by race and ethnicity are limited. The disparities section relies heavily on national research (Kammer-Kerwick et al., 2024) and inference rather than Hamilton County-specific race/ethnicity data. This is a significant gap that limits the precision of equity-focused recommendations.**
10. **Cost estimate uncertainty. Implementation cost estimates for recommendations are drawn from comparable programs in peer communities and published literature. Actual costs will depend on local factors including real estate, labor markets, partnership structures, and available federal matching funds. Estimates should be treated as order-of-magnitude guidance rather than precise budget figures.**
11. **Benchmark limitations. The 292-county benchmark includes only counties with populations over 250,000. Hamilton County (371,645) is among the smaller counties in this peer set. Some rankings (approximate, noted with ~) are estimated from available data distributions rather than computed directly from raw microdata.**
12. **2021 BHNA baseline. Many provider-level findings (Medicaid acceptance, language capacity, crisis referral sources) are derived from the 2021 BHNA. While these findings inform the current assessment, conditions may have improved or deteriorated in the intervening five years. A follow-up provider survey would strengthen the evidence base for several recommendations.**
13. **COVID-19 disruption. The 2020–2021 period introduced unprecedented disruptions to behavioral health services, demand, and data collection. Trends that include this period must be interpreted in context. The sustained elevation of crisis events post-pandemic may represent a permanent shift, a lagged recovery, or some combination. Only additional years of data will clarify which interpretation is correct.**

15.5 Processed Data File Inventory

All processed data files used in this assessment are stored in the Invest Hamilton County data repository and are available for verification and replication.

Table 15.4: Processed Data File Reference

FILE	CONTENTS	RECORDS
Behavioral-Health-Data/Processed/cdc_places_bh_5county.json	CDC PLACES behavioral health indicators for Hamilton, Marion, Boone, Madison, and Tipton counties (depression, mental distress, smoking, binge drinking, disability, sleep, cognition)	120 indicators (24 per county × 5 counties)
Behavioral-Health-Data/Processed/national_bh_benchmark.json	National benchmark dataset: 292 counties (250K+ population), 15 behavioral health fields per county	292 county records
Behavioral-Health-Data/Processed/indiana_mph_mh_events_hamilton.json	Indiana MPH mental health events for Hamilton County by year and age group (under 18, 18–60, 60+)	24 records (8 years × 3 age groups)
Behavioral-Health-Data/Processed/hrsa_hpsa_mh_summary.json	HRSA mental health HPSA designations for 5 counties and Indianapolis MSA (active, withdrawn, scores, ratios)	88+ designation records
Behavioral-Health-Data/Processed/bls_oes_bh_workforce.json	BLS Occupational Employment and Wage Statistics for 11 behavioral health SOCs across 3 geographies (MSA, state, national)	33 records
Behavioral-Health-Data/Processed/cms_opioid_timeseries_hamilton.json	11-year CMS Medicare opioid prescribing time series for Hamilton County (2013–2023)	11 annual records

FILE	CONTENTS	RECORDS
Behavioral-Health-Data/Dashboard-Data/treatment_facilities.json	SAMHSA treatment facility locator data for the 5-county region (facility type, services, payment acceptance)	328 facility records
Federal-Data/National-Benchmarking/national_benchmark_index.json	Full 292-county benchmarking index: 130 fields across 10 domains (site selection, labor, SDOH, public health, AGI/ income, housing, education, demographics, safety, environment)	292 county records × 130 fields
Academic-Research-Papers/14-Behavioral-Health/references.md	Curated academic research library: 48 papers across 12 behavioral health topic clusters plus supplementary research files	65+ citations with DOIs and key findings

15.6 Academic References

The following bibliography lists all academic and institutional sources cited in this assessment, organized alphabetically by first author. All DOIs were verified as of March 2026.

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15.7 Acknowledgments

This Behavioral Health Needs Assessment was prepared by Invest Hamilton County using the Hamilton County Data Hub (Alex). The assessment builds upon the foundational work of the 2021 Hamilton County Behavioral Health Needs Assessment, prepared by Community Solutions Inc., which established baseline measurements for many of the indicators tracked in this update.

Data were drawn from federal agencies including the Centers for Disease Control and Prevention, the Health Resources and Services Administration, the Substance Abuse and Mental Health Services Administration, the U.S. Census Bureau, the Bureau of Economic Analysis, the Bureau of Labor Statistics, the Centers for Medicare and Medicaid Services, and the Federal Reserve Economic Data system. State-level data were sourced from the Indiana Management Performance Hub and the Indiana Family and Social Services Administration. Workforce intelligence data were provided under license from Lightcast.

The academic research foundation for this assessment draws on 65+ peer-reviewed publications and institutional reports spanning behavioral health epidemiology, integrated care, crisis intervention, criminal justice diversion, social determinants of health, workforce development, youth mental health, and economic cost analysis. All DOIs were verified as of March 2026.

The national benchmarking index, incorporating 292 U.S. counties across 130 indicators, was compiled and is maintained by Invest Hamilton County. The Quality of Life Strength Index methodology is an Invest Hamilton County proprietary framework used under the assessment's analytical framework.

This assessment is intended to inform community planning, resource allocation, and policy development. It does not constitute clinical advice, legal guidance, or program evaluation. All recommendations should be evaluated in the context of local resources, stakeholder priorities, and implementation capacity. Cost estimates are drawn from comparable programs in peer communities and should be treated as order-of-magnitude guidance.

Assessment Date: March 2026

Prepared By: Invest Hamilton County — Hamilton County Data Hub (Alex)

With Support From: Hamilton County Board of Commissioners

Geographic Focus: Hamilton County, Indiana (FIPS 18057)

Comparison Counties: Marion (18097), Boone (18011), Madison (18095), Tipton (18159)

MSA: Indianapolis-Carmel-Greenwood (CBSA 26900)

National Benchmark: 292 U.S. counties (250,000+ population)

COMPANION REPORTS

Behavioral Health Workforce Development Analysis 2026. Invest Hamilton County, Hamilton County Data Hub. March 2026. 14 sections covering: Talent Pipeline Management framework, 19-occupation supply-demand analysis, educational pipeline assessment, compensation benchmarking, skills-based career pathway maps, IHC Community Career Ladder, geographic access analysis, employer tactical playbook, trade association standards, policy prescriptions, CCBHC opportunity analysis, and TPM action plan. Available from Invest Hamilton County.

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SECTION 16

THE HAMILTON COUNTY BEHAVIORAL HEALTH ACTION DASHBOARD

Fifteen production modules, six audience personas, four compliance overlays. Live at BehavioralHealth.AlexHamiltoncounty.com.

16.0 What the Dashboard Is

Every preceding section of this assessment documents a need. Section 16 documents the response. The Hamilton County Behavioral Health Action Dashboard launched in production on June 25, 2026 at BehavioralHealth.AlexHamiltoncounty.com. It is a single web destination organized as fifteen audience-specific modules, each addressing a distinct community need surfaced by the data corpus underlying this report.

The dashboard is built by Invest Hamilton County for the people of Hamilton County. It is free to use, requires no commercial relationship, and stores no Protected Health Information about any visitor. Its primary audiences are Hamilton County residents in or near crisis (no email required to reach a crisis page), Hamilton County employers and their HR leaders, behavioral health providers and recovery community organizations, policymakers and funders, public-health researchers, journalists, and behavioral health workforce planners.

THE FOUR COMPLIANCE OVERLAYS

F-BH01 — 988 Banner First in DOM. The 988 Suicide and Crisis Lifeline is the first content element a screen reader announces on every gated, public, crisis, and error page. The banner names both call and text options for 988 and surfaces Crisis Text Line at 741741 alongside it.

F-BH02 — Neutral and Symmetric Color Scales. Sensitive metrics such as suicide rate, overdose rate, and hospitalization rate are never visualized with red-green diverging scales. Burden is encoded by bar length or position, not by alarming color temperature. The dashboard is designed to inform without amplifying distress.

F-BH03 — Mandatory Reporting and Consent Disclosure. Indiana statutory references (IC 31-33-5 child endangerment, IC 12-10-3 adult endangerment) are surfaced wherever a downstream user could encounter a mandatory-reporting trigger. A dedicated `/about/mandatory-reporting` page explains the doctrine in plain language.

F-BH04 — Zero Protected Health Information. Invest Hamilton County does not collect, store, or transmit any Protected Health Information. The full posture is published at `/about/data-posture`: aggregated data only, 5-unit-per-cell minimum suppression floor on every analytical surface, calculator and screener inputs computed in memory and dropped without persistence, cookieless analytics on the crisis lane.

The fifteen modules below are organized by audience and described in policymaker-readable terms. Each subsection names the audience, the function, the underlying data, the access path, and the relevant compliance overlays. Where a module supersedes or operationalizes a finding from an earlier BHNA section, the cross-reference is noted.

16.1 Employer ROI Calculator

Audience. Employer benefits decision-makers including HR directors, total-rewards leaders, CFOs, and small-business owners across every Hamilton County industry sector. Also serves the Flask host process for the remaining fourteen modules.

What it does. Lets a Hamilton County employer enter a workforce profile (size, average salary, industry, baseline turnover) and six toggleable behavioral health investment strategies (basic Employee Assistance Program, enhanced digital-first EAP, mental health benefit expansion under parity rules, manager mental health training, Recovery-Friendly Workplace certification, and suicide-safe workplace adoption) and

returns a per-strategy projected annual cost, productivity benefit, retention benefit, and net return on investment. The result page includes a downloadable PDF an employer can take into a benefits committee meeting and a shareable URL that encodes the inputs.

Why it exists. Behavioral health is the single most expensive line on the employer-cost side of total compensation. Untreated depression alone costs roughly $4,800 per affected employee per year in lost productivity per the WHO Lancet 2016 estimate. Yet most Hamilton County employers cannot quantify what a benefits change is worth until they have already paid a consultant to model it. The calculator gives any local employer a defensible first-pass number in two minutes.

Data and methodology. Wraps the Behavioral Health ROI Engine v1.2.0, which combines peer-reviewed prevalence estimates (NIMH Any Mental Illness and Substance Use Disorder rates, WHO Lancet productivity coefficients, JAMA Psychiatry presenteeism studies), vendor-published EAP utilization data (Mercer 2025 review for the enhanced-EAP strategy), Henry Ford Health System Zero Suicide outcome data, and Indiana-specific wage anchors from Bureau of Labor Statistics Occupational Employment Statistics for MSA 26900.

Access. Public landing at / with subscription required (free; one email) to run the calculator. The subscription cookie unlocks every Gate A surface across the dashboard.

Compliance. F-BH01 988 banner persists above the calculator on every render. F-BH04 zero-retention applies — employer inputs are computed and dropped, never stored beyond the encoded shareable URL the user controls.

16.2 Employer Playbook Library

Audience. The same employer HR and benefits leaders who ran the ROI calculator and want the next step — what does each of the six strategies look like in practice.

What it does. Provides six structured playbooks, one for each strategy, that walk an employer from "we should do this" to "we have implemented this." Each playbook covers the intervention rationale, the evidence base with peer-reviewed and vendor-published sources clearly distinguished, the federal and Indiana regulatory landscape, a phased implementation roadmap, downloadable skeleton templates (request-for-proposal documents, plan amendments, policy language, manager scripts, postvention checklists), common pitfalls observed in actual deployments, and a twelve-month outcomes framework. If the employer arrived from the calculator with a saved result, the playbook page surfaces the employer's specific projected return on investment in a banner at the top.

Why it exists. Without playbooks, the calculator is a curiosity that produces a number and stops. With playbooks, the calculator becomes a conversion surface that takes an employer from modeling to implementation.

Important regulatory framing. The mental health parity playbook specifically addresses the May 15, 2025 Department of Labor non-enforcement announcement of the 2024 Final Rule, positioning employers to build to the 2013-plus-2021 statutory standard now (which remains fully enforceable) so they are defensible regardless of how the ERIC lawsuit resolves. The recovery-friendly workplace playbook routes Indiana employers to the Wellness Council of Indiana, which holds the state's Recovery-Friendly Workplace designation authority. (Some materials previously cited the Department of Workforce Development or FSSA-DMHA in this role — that was incorrect and has been retired across all dashboard surfaces.)

Access. Route `/employer/playbooks/` for the landing grid; `/employer/playbooks/<id>` for each playbook; `/employer/playbooks/<id>/template/<slug>` for downloadable templates in markdown, Word, or PDF format. Subscription required.

Compliance. F-BH01 banner persistent. F-BH02 neutral palette in all visualizations. F-BH04 zero retention.

16.3 Provider Operations Toolkit

Audience. Community mental health center directors (Aspire Indiana Health, Cummins Behavioral Health Systems, Adult and Child Health), hospital behavioral health service-line directors (IU Health, Community Health Network, Riverview Health, Ascension), private practice and group practice owners, faith-based and nonprofit behavioral health providers, and member organizations of the Hamilton County Behavioral Health Coalition.

What it does. Gives a behavioral health provider three ways to find the next operational improvement: a twelve-question self-diagnostic that scores the provider across four constructs (Capacity Strain, Access Gap, Workforce Shortage, Payer-Mix Imbalance) and recommends the two top-fit interventions; a browseable provider directory drawn from the SAMHSA treatment-facility database so providers can see how families find them; and five evidence-graded playbooks covering telehealth expansion, intake streamlining, workforce pipeline partnerships, payer-mix diversification, and group therapy launch. Each intervention recommendation includes cost and impact estimates computed against the provider's actual licensed capacity.

Why it exists. Behavioral health providers in Hamilton County operate inside a workforce mismatch documented in Section 9 as a 59.7-times opening-to-completion ratio. Operational improvements (cutting waitlist friction, broadening payer mix, adding group modalities) are the levers a provider actually controls.

Data and methodology. The diagnostic uses pre-aggregated SAMHSA, HRSA, and state Division of Mental Health and Addiction sources for peer-benchmark calibration, never user-submitted responses. The provider catalog reads SAMHSA Treatment Facilities (328 facilities within a 20-mile radius of Hamilton County's centroid).

Access. Route `/providers/`. Public access to landing and catalog; subscription required for the self-assessment, peer benchmark, and playbooks.

Compliance. F-BH01 988 banner on every page (providers are frequently in crisis-adjacent contexts). F-BH02 neutral palette on every peer-benchmark visualization — no red-green ranking of facilities. F-BH04 zero-retention: self-assessment responses are computed and dropped.

16.4 Family and Individual Action Layer

Audience. Any Hamilton County resident seeking behavioral health help for themselves or a family member, workers navigating behavioral health concerns at the workplace, and people in or near crisis.

What it does. Serves the highest-mission surface of the entire dashboard. The landing page leads with 988 (call or text), the Crisis Text Line (text HOME to 741741), Aspire Indiana mobile crisis services, and an emergency-department locator. From there, a single landing surface routes residents through six overlapping needs at once: immediate crisis; non-crisis behavioral health care search via a SAMHSA-backed provider matcher with filters for city, insurance, age, language, and service type; a PHQ-2 plus GAD-2 self-screener (clearly not diagnostic); an Indiana insurance and parity rights explainer covering MHPAEA, Indiana IC 27-13-44.5, Indiana Medicaid Healthy Indiana Plan, sliding-scale and charity care; a workplace rights explainer covering ADA accommodation, FMLA, and the Indiana Civil Rights Act; and two letter generators (one for asking an HR director to improve behavioral health benefits, one for requesting an ADA reasonable accommodation).

WHY THIS MODULE IS EXEMPT FROM EVERY SUBSCRIPTION GATE

A person in crisis must never hit an authentication wall before reaching 988. The Family Action Layer enforces this safety covenant by design — it is the one major surface with no subscription gate. The JAMA 2026 study (Indiana cohort) is named on the landing page: since 988 launched in July 2022, youth suicide (ages 15–34) has fallen 11 percent nationally versus projection; Indiana was among five high-call-volume states (about 146 percent average increase) that saw an 18 percent reduction. 988 is named as the right step for any level of distress, not only the most extreme cases. UptimeRobot R4-crisis probes the `/family/get-help-now` route every five minutes and alerts on any regression in the 988 keyword.

Data and methodology. SAMHSA Treatment Facilities (328 facilities within 20 miles); Indiana MPH Data Hub for mental-health EMS and ED event trends; CDC PLACES for tract-level depression and frequent-mental-distress prevalence; JAMA 2026 study for the Indiana 988 outcome data. Letter generators run server-side once and the result renders in the browser for printing; no inputs are ever logged.

Access. Public route at `/family/`. Crisis route at `/family/get-help-now`. Subscription is explicitly not required on any Family Action Layer route. The `/about/data-posture` page tells users in plain language that the surface stores nothing about them.

Compliance. F-BH01 988 banner appears sticky above the fold on every page, not in a footer. F-BH02 neutral palette throughout. F-BH03 mandatory-reporting and consent disclosure available via `/about/mandatory-reporting`. F-BH04 zero retention is the strongest discipline in the dashboard: screener inputs, letter inputs, and provider-matcher queries are never stored, no session cookie is set on this surface, and analytics are limited to cookieless Plausible page views.

16.5 Behavioral Health Data Ecosystem Map

Audience. Researchers, journalists, policymakers, behavioral health workforce planners, sub-licensees, and Invest Hamilton County's own internal teams who consume behavioral health data.

What it does. Catalogs every behavioral health data asset across the Reports corpus (approximately sixty to seventy sources spanning two-hundred-plus individual files), with provenance, vintage, refresh cadence, access tier, intended consumers, and citation format. Surfaces the catalog as both a machine-readable JSON API (consumed by Modules 6 + 8 + 9 for source attribution) and a human-readable web view with filterable search, single-source detail pages, a documented data-gaps inventory, a freshness dashboard, and an operational refresh runbook.

Why it exists. The behavioral health domain has unusually rich data substrate scattered across federal, state, local, philanthropic, consultative, and proprietary sources. Without a single navigable catalog, every module would reinvent its own source-attribution layer and gaps would multiply. The Data Ecosystem Map is the substrate every other module reads. It also documents nine specific data gaps that Section 17 addresses as live commitments.

Access. Route `/data-ecosystem/` for landing. All routes are public. The machine-readable catalog is at `/data-ecosystem/api/catalog.json`.

Compliance. F-BH01 988 banner on every page per host context processor. F-BH04 zero retention; the catalog is documentation, not data ingestion.

16.6 Policymaker Action Layer

Audience. Hamilton County Commissioners and County Council, the mayors and city councils of Carmel, Fishers, Noblesville, and Westfield, Indiana state legislators in the Hamilton County delegation, Indiana Division of Mental Health and Addiction leadership, the Hamilton County Behavioral Health Coalition steering committee, and behavioral health funders (Hamilton County Community Foundation, Central Indiana Community Foundation, United Way, Lilly Endowment).

What it does. Surfaces five aggregated dashboards plus a Policy Lever Simulator that lets policymakers see what specific policy moves would produce across the Hamilton County workforce and provider base. The five dashboards cover:

- Capacity and Access. Marquee finding: population-per-provider ratio is a far better predictor of suicide rate than HPSA Mental Health score across the five-county comparison set (Pearson correlation +0.886 vs. -0.48). Hamilton County's 501:1 ratio explains its comparatively low suicide rate; Madison County's 3,649:1 ratio explains its 20.4 per 100,000 rate.
- Crisis and 988. Anchored to the JAMA 2026 finding documented in Module 4 above: nationally, youth suicide fell 11 percent versus projection; the five highest-call-volume states (about 146 percent average increase), including Indiana, saw an 18 percent reduction.
- Workforce Pipeline. Shows the projected 38.7 percent decline in Clinical Psychologists by 2029 against 96 annual openings and zero in-region completions.
- Substance Use Disorder and Opioids. Shows that the standard "prescribing rate is falling" narrative misses a 19 percent increase in total opioid claim volume across the Hamilton County Medicare population.
- Youth Behavioral Health. Shows a 755 percent increase in under-18 mental health EMS and ED events from 2017 to 2023, per Indiana MPH Data Hub.

The Policy Lever Simulator models four levers: city-level or county-level EAP coverage mandates, Indiana Workforce Pell inclusion for behavioral health programs, tri-payer reimbursement parity floors, and sustained 988 state funding.

Why it exists. Policymakers do not want raw data; they want decision-framing with confidence intervals, methodology transparency, and the ability to simulate the effect of a specific policy choice. The Policymaker Action Layer gives them that without requiring access to per-individual data.

Data and methodology. Reads from the Data Ecosystem Map. Every query passes through an aggregation-floor middleware that enforces geography limits (Hamilton county or coarser), temporal grain limits (annual or quarterly), prohibits per-individual grains, and requires a 5-unit-per-cell minimum (5 providers, 5 employers, 5 families). Violations are blocked and audit-logged. The Policy Lever Simulator wraps the Behavioral Health ROI Engine v1.2.0 in an aggregate-population caller.

Access. Route `/policymaker/`**. Access-code required (Gate Scope B) with four tiers:** `HC-POLICYMAKER-BH-2026` **for county and city officials,** `STATE-DMHA-BH-2026` **for state DMHA leadership and state legislators,** `FUNDER-BH-2026` **for funders,** `IHC-INTERNAL-2026` **for Invest Hamilton County staff.**

Compliance. F-BH01 banner on every page. F-BH02 neutral palette governs every chart and choropleth — sensitive metrics like suicide rate, overdose rate, and hospitalization rate are never visualized with red-green diverging scales. F-BH04 zero retention; the aggregation-floor middleware is the architectural enforcement of the no-PHI posture.

16.7 Subscriber Operations Admin

Audience. Invest Hamilton County staff responsible for subscriber list operations, plus the scheduled cron services that perform the nightly subscriber-projection rebuild and the weekly HubSpot Contacts sync.

What it does. Provides the small set of HTTP endpoints that the deploy-automation cron services need to keep the subscriber list synchronized between the append-only audit log (`subscribers.jsonl`**), the queryable SQLite projection (**`subscribers.db`**), and HubSpot. Two routes serve cron (a force-rebuild endpoint and a stable-schema CSV export); five routes serve human admins (dashboard, login, list, stats, logout). The CSV export carries a fixed column order including the** `navigator_source` **segmentation field so HubSpot can list-segment subscribers by which surface captured them (employer calculator vs. family screener vs. career explorer vs. policymaker dashboard).**

Why it exists. The behavioral health dashboard ships as a separate Render web service from the Childcare Action Dashboard, even though both share the same subscriber-capture pattern. Without this admin layer the deploy-automation cron services would fail because their endpoints would not exist in the host process.

Access. Route `/admin/subscribers/`**. Access requires admin credentials (Gate Scope C) — a separate access-code tier and a distinct cookie key from any public or policymaker session.**

Compliance. F-BH04 applies: the only subscriber information stored is what the subscriber explicitly opted in to provide (email plus optional name, employer, role, topic-of-interest checkboxes); no Protected Health Information ever enters the subscriber table.

16.8 Industry Behavioral Health Risk Profiles

Audience. Employer HR and benefits leaders trying to understand the behavioral health risk profile of their specific industry, city economic-development staff who need sector-specific framing for employer recruitment conversations, business-retention-and-expansion partners, county behavioral health coalition members evaluating sector-specific intervention priorities, and peer-county economic development organizations evaluating sub-licensing.

What it does. Provides one risk profile per North American Industry Classification System 2-digit sector covering the entire Hamilton County economy. The ten sectors that carry disproportionate behavioral health burden (Construction, Manufacturing, Retail Trade, Transportation and Warehousing, Finance and Insurance, Professional Services, Administrative Services, Healthcare and Social Assistance, Accommodation and Food Services, Agriculture) receive deep treatment of 80 to 120 lines. The remaining ten lower-burden sectors receive brief 40-to-70-line profiles establishing baseline. Each profile names industry-specific burden statistics from peer-reviewed meta-analyses, the primary behavioral health risk factors for that sector (construction shift work plus opioid exposure plus acute injury; healthcare moral injury plus secondary trauma; transportation isolation plus DOT-conflict; finance high-pressure performance environment), recommended interventions cross-linked to the employer playbooks (Module 16.2), and Lightcast staffing references showing which high-behavioral-health-risk occupations concentrate in each sector.

Why it exists. Round-2 correlation analysis identified that the six high-burden sectors churn workers at 2.63 times the rate of peer sectors, contributing 58.2 percent of all MSA-wide job-to-job flows in 2024 despite holding far less than 58 percent of employment. An employer asking "which playbook should I run first?" needs a third surface between the per-employer ROI calculator and the per-strategy playbook: one that says, "this is what your industry looks like, and this is what the literature says works here."

Data. Lightcast Q1 2026 staffing patterns by NAICS 2-digit, peer-reviewed behavioral health meta-analyses, and the Round-1 plus Round-2 Invest Hamilton County correlation findings. Each deep profile cites at least four to eight grounded sources. Profiles explicitly name medications for opioid use disorder (buprenorphine, methadone, naltrexone) where recovery-related interventions are discussed.

Access. Route `/industries/`. Subscription required.

Compliance. F-BH01, F-BH02, F-BH03, F-BH04 all apply.

16.9 Workforce Attachment and Mismatch Analysis

Audience. Public health experts, academic researchers, journalists, policymakers, behavioral health workforce planners, behavioral health employers, and career-explorers.

What it does. Surfaces the macro-labor-economics story of behavioral health that emerged from the Round-2 Invest Hamilton County correlation analysis (and that anchors Section 9 of this assessment). Three labor-economics frameworks — Worker Attachment, the Great Mismatch concept from the 2024 Stansbury and Summers National Bureau of Economic Research paper, and Reallocation Friction — reveal a closed loop explaining why the supply of behavioral health workers does not respond to demand even when wage signals fire.

THE CLOSED LOOP, IN ONE MARQUEE FINDING

Behavioral health mismatch is 36 times the overall labor market. The cluster-level mismatch ratio in Hamilton County stands at 59.7 to 1. Every one of the six core behavioral health occupations carries an infinite mismatch ratio in Hamilton County: every opening is an import cycle, because zero in-region completions came online in 2024.

Meanwhile, the broader workforce is being pushed out of its own attachment by behavioral health burden. The six high-burden sectors churn workers at 2.63 times the rate of peer sectors. Behavioral health counselors themselves carry implied annual turnover of roughly 75.6 percent — nearly twice the 35 percent all-industry baseline. The thing the county most needs to fix is itself eroded by the thing.

Why it exists. This module is the publication-grade narrative for the flagship Behavioral Health Needs Assessment (this document) and for the Board Pack briefing series. It also gives policymakers and researchers a single navigable surface for the structural workforce story that every downstream module relies on.

Data. Census Quarterly Workforce Indicators and Job-to-Job Flows; Bureau of Labor Statistics Job Openings and Labor Turnover Survey; Bureau of Labor Statistics Occupational Employment Statistics; the sixty-five-file Lightcast behavioral health extract; and Indiana Professional Licensing Agency rules for the Indiana Licensed Clinical Social Worker 3,000-supervised-hour, 5-to-6-year chronology.

Access. Route `/workforce-analytics/`. All routes are public per CEO direction; this is one of the public-tier analytical surfaces of the dashboard.

Compliance. F-BH01, F-BH02, F-BH04 all apply.

16.10 Behavioral Health Career Explorer

Audience. High school students considering a career, college and graduate students, career-changers, people returning to the workforce, and anyone weighing whether to enter a behavioral health career.

What it does. Catalogs ten honest career paths spanning the full behavioral health workforce: Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Addiction Counselor, Certified Alcohol and Drug Abuse Counselor (tiers I through VI), Psychiatrist, Clinical Psychologist, Peer Recovery Coach, Community Health Worker, and Psychiatric Technician. Each path carries a day-in-the-life narrative, an education and time-to-credential chronology, Indiana wage anchors from Bureau of Labor Statistics Occupational Employment Statistics for MSA 26900

(with explicit "vs. US median" deltas where Indiana wages run below national), demand projections from Lightcast Q1 2026, Workforce Pell eligibility status under the May 2026 final rule, and a short self-assessment. Side-by-side comparison of up to four paths is available.

Why it exists. The closed-loop labor-market story documented in Module 9 has a missing front door: prospective workers cannot evaluate a behavioral health career because existing tools either oversimplify ("become a therapist") or hide the hard truths. No public Indiana-specific catalog surfaces the 3,000-supervised-hour Licensed Clinical Social Worker floor, the 20 percent sub-national substance-use-disorder-counselor wage, or the zero in-region MSA completions in 2024 for several occupations. This is the honest catalog. Every wage figure, every hour requirement, every projection is sourced and dated. If a path pays below the national median, the page says so on the wage card, not in fine print.

Access. Route `/careers/`. All routes are public per CEO direction; career discovery must be friction-free.

Compliance. F-BH01 banner inline on every page header. F-BH02 neutral palette throughout. F-BH03 disclosure on the self-assessment explicitly states the reflection is not submitted, scored, or stored. F-BH04 zero retention.

16.11 Behavioral Health Talent Recruitment Hub

Audience. Behavioral health sector employers who hire behavioral health professionals (community mental health center directors at Aspire Indiana, Cummins, and Adult and Child Health; hospital behavioral health service-line directors at IU Health, Community Health Network, and Riverview; private and group practice owners; behavioral health staffing agencies; peer recovery program operators; and HR leads at Hamilton County Behavioral Health Coalition member organizations).

What it does. Gives behavioral health employers five operational playbooks on the four levers they actually control — wages, retention, posting quality, pipeline forecasting, and peer benchmarking — paired with interactive tools. The wage-benchmarking playbook anchors compensation against MSA 26900 by behavioral health occupation with supervised-hour pay differential guidance. The retention diagnostic offers a ten-question instrument across six retention drivers (supervision quality, panel size, productivity quota, comp band, admin burden, growth path) and surfaces the top three retention risks. The job-posting optimization tool returns a heuristic score across seven elements when a recruiter pastes a posting. The three-year pipeline forecast renders pre-computed supply versus opening tables per occupation. The peer-employer benchmarking dashboard shows aggregate-only profiles of six peer behavioral health employers using only public Indiana Professional Licensing Agency, IRS Form 990, and posting URL data — no scraped private data, no compensation passthrough.

Why it exists. Round-2 findings made an employer-of-behavioral-health-professionals hub necessary: behavioral health counselors carry 75.6 percent implied annual turnover (roughly twice the all-industry baseline), every recruitment cycle is an import cycle because of zero in-region completions, and the 5-to-6-

year Licensed Clinical Social Worker chronology means supply cannot respond to wage signals at meaningful speed. The Provider Operations Toolkit (Module 16.3) helps a behavioral health provider improve clinical operations; this module helps the same audience solve the recruiting problem the self-assessment keeps flagging.

Access. Route `/talent-hub/`. Subscription required.

Compliance. F-BH01, F-BH02, F-BH03, F-BH04 all apply. Peer-employer benchmarking enforces a 3-plus employer cell minimum.

16.12 Clinical Credentialing Navigator

Audience. Prospective and in-pipeline behavioral health clinicians, students considering a behavioral health career, career-changers, behavioral health employers in recruitment context, workforce-development partners (Ivy Tech Community College, Indiana University, Marian University, Indiana Department of Workforce Development), and journalists and policymakers.

What it does. Makes the Indiana clinical credentialing landscape navigable. Covers ten to twelve behavioral health credentials including Licensed Social Worker, Licensed Clinical Social Worker, Licensed Mental Health Counselor, Licensed Marriage and Family Therapist, Licensed Clinical Addiction Counselor, Certified Alcohol and Drug Abuse Counselor tiers I through IV, Psychiatrist, Psychologist (Health Service Provider in Psychology), and Clinical Nurse Specialist in Behavioral Health. For each credential, the page covers scope of practice in plain language, education path with accreditation body and typical program length, supervised practice hours required and supervisor qualifications, exam name and fee, Indiana Professional Licensing Agency application process and form number, renewal cycle and continuing education requirements, cross-state reciprocity to Ohio, Illinois, Kentucky, and Michigan, wage range in Hamilton County, common career destinations, and (critically) what the credential does *not* authorize. A "What's my path?" interactive picker takes four inputs (starting point, day-to-day work goals, time budget, independence goal) and returns one to three ranked credential recommendations with an honest tradeoffs callout. A cross-state reciprocity matrix shows the four neighbor states in a single table.

Why it exists. The Indiana clinical credentialing landscape is the rate-limiting structural reality behind every behavioral health workforce finding in this report: five to six years minimum from a Master of Social Work enrollment to fully independent Licensed Clinical Social Worker practice, weak cross-state reciprocity, 3,000 supervised hours, and a career ladder where only half of documented next-step destinations actually pay more. This module makes it navigable in one sitting.

Access. Route `/credentialing/`. All page browsing is public. Subscription required for downloads only.

Compliance. F-BH01 (a future clinician browsing at 2 a.m. may themselves be in distress). F-BH02 neutral palette throughout, including on the cross-state reciprocity matrix even where reciprocity is weak. F-BH04 zero retention.

16.13 Peer Recovery Coach Toolkit

Audience. Active Certified Peer Recovery Specialists in Hamilton County and surrounding counties, peer-led Recovery Community Organizations, community mental health center and Recovery Community Organization supervisors of peer staff, employers operating Recovery-Friendly Workplaces that deploy peer coaches, recovery housing operators, jail-based peer programs, and behavioral health workforce planners coordinating peer-supply policy.

What it does. Provides operational scaffolding for people who are already doing peer recovery work, not a career explorer for people considering the field. Covers eight resource pillars: the Certified Peer Recovery Specialist initial certification pathway, recertification and continuing-education-unit tracking, the Indiana Recovery Community Organization directory, medication-for-opioid-use-disorder integration guidance for peer coaches (naming buprenorphine, methadone, and naltrexone explicitly), Hamilton County recovery housing capacity, peer supervision and reflective practice resources, advocacy and funding substrate, and the data peers actually care about (overdose trends, 988 utilization, recovery-housing occupancy, against-medical-advice discharge rates). Every page surfaces a top-banner cross-link to the Clinical Credentialing Navigator with the explicit framing that peer recovery is a different track, not a step toward clinical licensure.

Why it exists. Behavioral health workforce content otherwise risks collapsing every worker into "aspiring clinician," which erases peer professional identity and undercuts retention. Peer recovery work is grounded in lived experience formalized through training and certification — a different credential, not a placeholder. The toolkit gives peers the day-to-day operational support material they need to stay in the work and stay effective.

Data. Indiana Counselors Association on Alcohol and Drug Abuse for certification (with state recognition through Indiana Division of Mental Health and Addiction; the Professional Licensing Agency does not certify peers). Indiana DMHA strategic plans and roster data. The module documents explicitly that peer recovery is not a Workforce Pell pathway under the May 2026 final rule (the training runs through ICAADA and DMHA-approved trainers, not accredited postsecondary institutions; outside Pell's structural envelope).

Access. Route `/peer-recovery/`. All routes are public; peer-coach operational information is public-interest content.

Compliance. F-BH01 sticky banner. F-BH02 neutral palette (peer work intersects relapse, against-medical-advice discharge, and overdose — clinical events, not moral verdicts). F-BH03 mandatory-reporting disclosure on every page that names a referral. F-BH04 zero retention.

16.14 Indiana Behavioral Health Education Catalog

Audience. Policymakers evaluating workforce-pipeline investment decisions, families and prospective students mapping education pathways, employers scoping "grow your own" workforce partnerships, providers planning clinical-staff pipelines, and IHC partners across Hamilton Pathways Lab and the Comprehensive Local Needs Assessment.

What it does. Catalogs the full Indiana behavioral health education pipeline across five tiers in a single navigable directory: high-school career-and-technical-education electives and dual enrollment at the six Hamilton County partner districts; sub-baccalaureate programs (Ivy Tech statewide for Addiction Studies Associate of Applied Science, Human Services Associate of Applied Science, and NAADAC certificates — the Workforce Pell anchor); bachelor's programs across IU, IUI, Purdue, Marian, Anderson, Indiana State, Ball State, Indiana Wesleyan University, Indiana Tech, and Valparaiso; master's programs (MSW, mental health counseling, marriage and family therapy, master's-level addiction counseling); and doctoral plus psychiatry residency programs. Each program record includes degree level, location, behavioral health relevance tags, accreditation, Workforce Pell alignment classification, completions placeholders, and a three-sentence honest framing of strengths and limitations.

Why it exists. Hamilton County records zero in-region completions for the six core behavioral health occupations while Clinical Psychologist workforce is projected to decline 38.7 percent by 2029. Module 16.9 surfaces the failure; this module surfaces the production capacity that must scale to fix it. Without a navigable catalog of every Indiana program producing behavioral health workers, the pipeline conversation runs on anecdote.

Access. Route `/education/`. All routes are public per CEO direction.

Compliance. F-BH01, F-BH02, F-BH04 all apply. The catalog contains zero individual data.

16.15 Faces of Hamilton County Behavioral Health

Audience. Hamilton County residents and employers landing from search, social media, or the WordPress workforce-resource navigator who want to understand what behavioral health looks like across the county; journalists and researchers; peer-county economic development organizations evaluating the microsegmentation pattern; and IHC Board, Executive Committee, and Hamilton County Behavioral Health Coalition partners using it as a teaching surface.

What it does. Translates aggregate behavioral health data into eight recognizable composite community segments grounded in real Hamilton County distributions: a Carmel high-functioning-anxiety profile (where the issue is provider-network access, not affordability); a Carmel-Clay teacher burnout profile; a Fishers shift-worker substance-use profile; a Noblesville manufacturing recovery profile (focused on medication-for-opioid-use-disorder continuity and workplace policy modernization); a Westfield perinatal and

postpartum profile; a Sheridan-Cicero rural isolation profile (covering construction occupational suicide and rural service deserts); a Noblesville re-entry and recovery-court profile (focused on post-release MOUD continuity and Medicaid Healthy Indiana Plan reactivation lag); and a Westfield youth school-based profile (adolescent depression and the clinical psychologist supply crisis). Each segment exposes household structure, income, industry, burden band, narrative, anchor population, primary concern, primary strategy, eligibility map across ten to fourteen behavioral-health-specific service keys, pain points, what would help, and deep links to relevant tools elsewhere on the dashboard.

Why it exists. The county-health-officer test from the dashboard's cross-cutting audit was: "Good for employers and good for outpatient providers. Where is everybody else?" This module is the answer. Every segment is visible, every burden is honestly anchored, no segment label erases the person — every name is person-first ("in active recovery" rather than "addict"; "previously incarcerated" rather than "ex-offender" as identity).

Data. CDC PLACES tract-level depression and frequent-mental-distress prevalence; NIMH national prevalence; CDC WONDER provisional drug-overdose deaths; CDC Youth Risk Behavior Surveillance System; IRS Statistics of Income ZIP-level income; Census American Community Survey 5-year; CDC Social Vulnerability Index 2022; Indiana MPH Data Hub county-level mental-health EMS and ED events; SAMHSA Treatment Locator; HRSA Health Professional Shortage Area data; BLS Quarterly Census of Employment and Wages plus Occupational Employment Statistics; and Brighter Futures Indiana provider supply.

Access. Route `/faces`. Subscription required (mirrors Childcare Action Dashboard policy — the per-segment narrative is gated; the machine-readable dataset at `/faces.json` remains open for journalists, researchers, and downstream AI agents).

Compliance. F-BH01, F-BH02, F-BH03, and F-BH04 are the strongest in the dashboard here: composite profiles only, no individuals identified, no coordinates, no tract IDs in user-facing copy, every segment represents 200-plus residents at a 5-unit-per-cell aggregation floor, and analytics on outbound clicks to crisis routes are explicitly suppressed.

16.16 What This Dashboard Means for Policymakers

The dashboard is not a substitute for this assessment. It is what this assessment becomes when each finding meets a tool that someone can use today. Three observations are worth recording for the policymaker reading this section:

First, the dashboard already exists. Every URL named above is live. Every tool is callable today. Policymakers who want to assess the community impact of a specific employer-side intervention can run the ROI calculator and the playbook in five minutes. Policymakers who want to see why a workforce policy lever would or would not work can run the Policy Lever Simulator in two minutes.

Second, the dashboard is free of charge to Hamilton County users. No employer pays to use it. No provider pays to use it. No family pays to use it. The cost of the platform is absorbed by Invest Hamilton County as part of its city Business Retention and Expansion add-on bundle. For peer counties, the dashboard is available for sub-licensing under a structure that is being finalized at the August 2026 Executive Committee meeting.

Third, the dashboard is a starting point. The closed labor-market loop documented in Module 16.9 cannot be solved by the dashboard alone. It requires policy moves — sustained 988 funding, Workforce Pell inclusion for behavioral health, payer parity enforcement, and pipeline investment at the high-school and community-college level — that only elected officials and funders can make. The dashboard makes those moves visible, calculable, and defensible. The decisions remain ours to make.

SECTION 17

EXPANDED INDIANA DATA INVENTORY

Six new commitments. Live data integration pipeline.

17.0 Why This Section Exists

Section 15 (Technical Appendix) of this assessment documents the federal and state data corpus that underwrites every analytical claim in Sections 1 through 14. That corpus is strong at the federal level (CDC WONDER, CDC YRBSS, CDC PLACES, SAMHSA, CMS Medicare, HRSA, County Health Rankings, BLS) and credible at the state level (Indiana MPH Data Hub for county-level mental-health EMS and ED events; National Benchmarking for 292-county comparison).

Section 17 documents a six-source expansion that closes the most consequential data gaps identified during the June 2026 audit. These are not aspirational additions. Each source has been vetted, located, and committed to a refresh cadence. The Hamilton County Behavioral Health Action Dashboard reads from these sources today or is wiring them in for the next refresh cycle. The names below are live commitments, not a wishlist.

17.1 Indiana FORTRESS — OD Touchpoints

What it is. A National Institutes of Health HEAL Data2Action funded dataset published by the Indiana Management Performance Hub, showing pre-overdose intervention touchpoints. Designed for County Overdose Fatality Review Teams but public-facing. Data covers 2015 forward, refreshed annually.

What it tells us about Hamilton County. The dataset shows 380 Hamilton County fatal-overdose decedents with emergency-department touchpoint records during the study window, with days-prior-to-fatal-overdose ranging from 21 to 338. Other touchpoint types (jail booking, EMS, treatment admission, prescription fill, naloxone dispense) are present in companion rows. This is the only dataset in the Indiana ecosystem that quantifies the *intervention window* before fatal overdose.

Why it matters. Section 7 of this assessment relies on CDC WONDER and ISDH overdose totals to document the substance-use-disorder landscape. Those sources answer "how many died." FORTRESS answers "where could we have intervened." The Policymaker Action Layer's Substance Use Disorder dashboard (Module 16.6) is the consuming surface; the Family Action Layer's provider matcher (Module 16.4) cross-references touchpoint patterns to recommend post-encounter follow-up resources.

Access pattern. Dataset landing: `hub.mph.in.gov/dataset/od-touchpoints-recency-and-reach`. **Companion dataset "OD Touchpoints: Prevalence, Frequency and Recency" on the same Hub. CSV download available without authentication. Hamilton County rows filtered by GEOGRAPHY_FIPS = 18057. Annual refresh keyed to the Indiana Management Performance Hub release cycle.**

17.2 Indiana Deaths by Despair + Violent Death Dashboards

What they are. Two Tableau dashboards the Indiana Department of Health released in late 2025. *Deaths by Despair* surfaces suicide plus overdose deaths at the county level. *Violent Death* surfaces homicide, suicide, undetermined intent, and legal intervention deaths.

Why they matter. Suicide data in Sections 4, 6, and 12 of this assessment currently comes from CDC WONDER (one-year lag) and County Health Rankings (three-year lag). The Indiana Department of Health dashboards are the closest-to-real-time Indiana suicide source, drawing from the Indiana Violent Death Reporting System (which feeds the National Violent Death Reporting System). They are materially fresher than the federal sources for the same question.

Access pattern. Deaths by Despair: `in.gov/health/directory/office-of-the-commissioner/public-health-data-navigator/trauma-and-injury-prevention/drug-overdose-data-dashboard/`. **Violent Death:** `in.gov/health/violent-death-dashboard/`. **Tableau dashboards do not expose a clean comma-separated-values download; the integration pattern is quarterly manual snapshot of Hamilton plus four comparison counties (Marion, Boone, Madison, Tipton) transcribed to JSON. An Indiana Department of Health office-of-the-commissioner extract request is the alternate path for annual full datasets.**

17.3 FSSA Medicaid Mental Health Claims

What it is. An Indiana Family and Social Services Administration published dataset on the Indiana Management Performance Hub Data Hub filtered to Medicaid mental health claims. Segmented by provider, recipient race, recipient gender, and ZIP code. Comma-separated-values and PDF formats.

What it adds. This assessment currently relies on CMS Medicare claims for prescriber and service-utilization patterns. Medicare skews geriatric. Medicaid skews low-income working-age plus child. For a county where 4.3 percent of residents live below the federal poverty line, this is still approximately 16,000 residents potentially Medicaid-eligible. Hamilton County ZIP-filtered Medicaid mental-health claims fill the working-age-and-child gap that Medicare cannot fill.

Provider mix as a downstream signal. The provider-segmented breakdown also tells us which Hamilton County behavioral health providers carry which patient mix. The Provider Operations Toolkit (Module 16.3) uses this signal in its payer-mix-diversification playbook.

Access pattern. URL: `hub.mph.in.gov/dataset/medicaid-claims-mental-health`**. Filtered to Hamilton County ZIPs (46032, 46033, 46034, 46037, 46038, 46060, 46062, 46074, 46077, 46082, 46280, 46290). Annual refresh aligned with the Indiana Management Performance Hub release cycle.**

17.4 Fishers Health Department — We Care, We Connect

What it is. A joint Fishers Health Department, Fishers Fire Department, and Fishers Police Department mobile integrated health program (launched April 2023) providing preventive and social care services with particular focus on mental health and substance use needs. The program tracks call dispositions, demographic patterns, follow-up outcomes, and partner-referral pathways.

Why it matters. The Policymaker Action Layer's Crisis and 988 dashboard (Module 16.6) anchors on the JAMA 2026 Indiana finding for the state-level 988 picture. We Care, We Connect is the city-level peer for what happens when a Hamilton County resident is reached through a city-government channel rather than the state line. It is the most data-rich city-level behavioral health program in the county.

Two specific data points already published. Fishers Health Department has set a public goal to decrease the city's five-year average annual suicide rate by 10 percent by 2027, from 11.2 to 10.1 per 100,000. This is a tractable policymaker-facing benchmark. The department also reports 15,957 school-based educational services in its most recent annual report, several of which directly intersect with adolescent behavioral health, mindfulness, and substance-use prevention. Both data points are surfaced in the Family Action Layer (Module 16.4) for Fishers residents alongside 988 information.

Access pattern. Direct relationship with the Fishers Health Department social-work team (contact: `socialwork@fishers.in.us`, 317-463-4361). Quarterly aggregate-summary email exchange covering call dispositions, school-based service counts, CredibleMind utilization (the free resident mental-health platform Fishers Health Department offers), and the suicide-rate methodology backing the 2027 goal. **Mental Health overview:** `health.fishersin.gov/mental-health/`**. Health First Indiana Fishers community page:** `in.gov/healthfirstindiana/your-community-info/fishers/`**.**

17.5 Hamilton County Health Department — 2024 Community Health Assessment

What it is. A locally-led, locally-published health assessment authored by the Hamilton County Health Department in 2024. Survey-based. Behavioral health is one of the assessment domains alongside chronic disease, maternal and child health, and access to care.

Why it matters. Sections 4, 5, and 12 of this assessment rely on externally-sourced corpora (federal and state) for the demographic and behavioral-health-burden picture. The Hamilton County Health Department assessment is the corroborating local-self-assessment voice for the same questions. It is the source that policymakers consult when they want to know what the county's own health department says, in its own words, about the community its staff serve every day. Useful as IHC-corroborating evidence when policymakers question federal-source figures.

Access pattern. Hamilton County Public Health and Health Coalition page: `hamiltoncountyphhc.org/hamilton-county-health-department-community-health-assessment/`**. PDF download. One-time pull with three-to-five-year re-pull cadence aligned to the assessment cycle. Hamilton County Health Department, 18030 Foundation Drive Suite A, Noblesville, IN 46060.**

17.6 Carmel, Noblesville, and Westfield — City Health Surfaces (Open Inquiry)

What it is. Of Hamilton County's four cities, only Fishers operates a stand-alone city-level health department. Carmel, Noblesville, and Westfield rely on the county Hamilton County Health Department for public-health functions while operating their own city-government behavioral-health-adjacent programs — the Carmel Crisis Response Team, the Noblesville Police Department mental-health co-responder, and Westfield's school-partnership crisis pathway.

Why it matters. Each of these programs almost certainly publishes call-disposition counts, demographic patterns, and intervention outcomes that would meaningfully complement the Fishers We-Care-We-Connect data in Section 17.4 and provide a four-city peer set for the Policymaker Action Layer's Crisis and 988 dashboard (Module 16.6). The data exists; the surface to publish it does not yet exist consistently across the three remaining cities.

Access pattern. Cold-call inquiry through Invest Hamilton County's existing city-relations channels. Targeted Q3 2026. Not blocking; the absence of these three city-level surfaces does not invalidate any analytical finding in this assessment.

17.7 Refresh Cadence and Operational Commitments

Section 17 sources are integrated into the standard Invest Hamilton County data-refresh routine alongside the federal and state sources documented in Section 15. The operational commitments are:

- Indiana FORTRESS: annual refresh, keyed to Indiana MPH October release cycle; integrated via `refresh.sh` Section 28 sub-section 28.fortress; filtered to Hamilton County rows.
- Deaths by Despair plus Violent Death: manual quarterly snapshot of Hamilton plus comparison counties; dashboard embed plus citation in `data-freshness-manifest.json`; Indiana Department of Health extract request as alternate path.
- FSSA Medicaid Mental Health Claims: annual refresh; integrated via `refresh.sh` Section 28 sub-section 28.fssa-medicaid-mh; filtered to Hamilton County ZIPs.
- Fishers We Care, We Connect: quarterly email outreach for aggregate summary; manual integration into the Crisis and 988 dashboard sidebar (Module 16.6).
- Hamilton County Health Department 2024 Community Health Assessment: one-time manual PDF extract of behavioral health section into the Section 17 evidence file; three-to-five-year re-pull at next assessment cycle.
- Carmel + Noblesville + Westfield city-health surfaces: cold inquiry Q3 2026; ad-hoc integration once data is published or shared.

Each source has a freshness entry in the dashboard's data-freshness manifest, surfaced to all consuming modules. When a source is more than one refresh cycle stale, downstream consumers see a freshness badge and a citation note documenting the lag.

17.8 Pattern: Live Commitments, Not a Wishlist

The expansion described in Section 17 follows a pattern this assessment uses elsewhere: when a data gap is identified, the gap is named in plain language, the source that would close it is documented with its provenance and refresh cadence, and the consuming surface inside the Behavioral Health Action Dashboard is named. Gaps that cannot be closed in the current refresh cycle are still named in the assessment so that the next quarterly refresh has a documented commitment rather than a fresh hunt.

This is the operational substrate behind every analytical claim in this assessment. It is also the working principle for the partnership between Invest Hamilton County and the Hamilton County Behavioral Health Coalition: the data is shared, the methodology is shared, the gaps are shared, and the commitments to close those gaps are shared.