ASSESSMENT AND INTERVENTION CENTER ANNUAL REPORT 2020-21

Assessment and Intervention Center

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2979 E. Pleasant Run Parkway NDR, Indianapolis, IN 46203

ASSESSMENT & INTERVENTION CENTER

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FOREWORD

Purpose of the Assessment and Intervention Center

The Assessment and Intervention Center (AIC) is a collaborative between the Office of Public Health and Safety (OPHS) for the City of Indianapolis and The Health and Hospital Corporation of Marion County. It is located at 2979 E. Pleasant Run Parkway NDR on the Community Justice Campus. It is two stories: the first floor focuses on assessments/evaluations; the second floor has 60 beds for short-term "housing" that allows individuals time to safely withdrawal from substances (if needed) and be linked to mental health or substance use services in the community.

On May 11, 2016, Mayor Joe Hogsett set Indianapolis on the path of holistic, data-driven criminal justice reform, creating the Criminal Justice Reform Task Force, with a mission focused on presenting recommendations to reform and optimize the county criminal justice system.

Sandra Eskenazi Mental Health Center was chosen to develop and operate on-site programming at the AIC.

The AIC focuses on quickly assessing and linking individuals with apparent mental health and/or substance use issues to appropriate community providers.

Year in Sum: Program Operations

The AIC opened December 1, 2020. Due to COVID-19 pandemic protocols and available funding, AIC opened at ½ capacity (30 beds). It has remained at 30-bed maximum capacity throughout 2021.

Quick Facts December 2020 through November 2021	
Referrals	2419 referrals
Top Referral Source: Emergency Rooms	33% of all referrals
Assessments (Individuals showing to AIC after referral)	1707 assessments
Show Rate: Individuals who showed for assessment after initial referral made.	70.6%
Average Daily Census	16
Admissions to 2nd Floor Housing Units	1481

Percentage of All Assessments admitted to 2nd Floor Housing Units	87%
Average Length of Stay for 2nd Floor Admissions	5.3 days
Connection to Recovery Housing/Addictions Treatment	25% of all admissions
Percentage of Clients Experiencing Homelessness or At-Risk of Homelessness at time of referral	65.8% of all referrals

Focus and Structure of this Year-End Report

This report focuses on the program operations of the AIC. It does not address business operations (such as budget, full time equivalents, expenses, etc.). It intends to give a clear overview of AIC throughput (referral-assessment-admission-linkage-discharge), as well as information on discharge dispositioning, treatment linkage, ancillary services, and demographics. The voices of the client and staff are also important, so client success stories and program challenges will also be presented.

Statement Regarding Data

The AIC uses a software package called "OpenCaseWare" as its record keeping system. There have been multiple issues over the last 12 months in both developing and optimizing the system for AIC use, especially as it relates to storing data in a manner that facilitates valid and reliable reporting. This report attempts to present data as accurately as possible but it is recognized that due to system-related issues, a few metrics—such as discharge dispositioning and ancillary treatment linkage—have some degree of error or null values in the data. Again, the data have been presented as fairly as possible to give a reasonable picture of the work that is being done at the AIC. Metrics related directly to throughput—referral, assessment, admission, census, discharge, and length of stay—are reliable and valid. Demographic, linkage, and disposition data are less so, though again what is presented gives a reasonable picture of these.

REFERRALS

The AIC receives referrals by either phone or walk-in to the AIC. The AIC records all referrals made in the OpenCaseWare case management system. Some data, such as demographic data, can be a challenge to get at referral as referral sources (such as medical staff in emergency rooms or law enforcement in the field) are tight on time or have limited information. What follow are solid data about number of referrals received, how many referrals by unique client, and the sources of referral to the AIC.

Referral Totals

The AIC received 2419 referrals from December 1, 2020 through November 30, 2021. These referrals were made either through telephone or AIC walk-in.

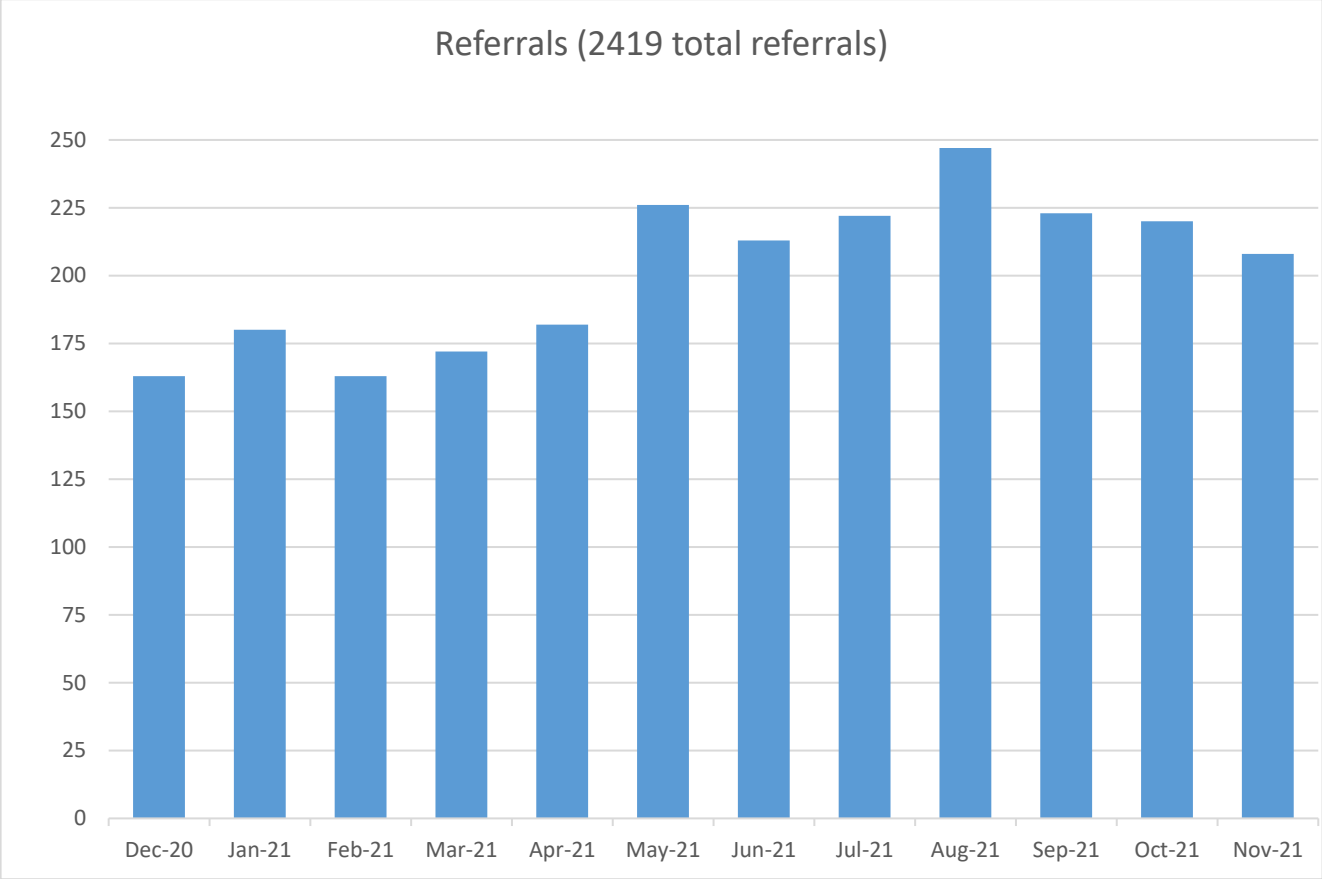
Of those 2419 referrals, there were 1724 unique clients (meaning that there were multiple referrals done throughout the year for some of those referred). Table 1 shows how many clients received more than one referral from December 1, 2020 through November 2021.

Table 1: Referrals Made for Each Unique Client December 2020 through November 2021

# of Referrals	Unique Clients
9	2
8	4
7	1
6	9
5	24
4	35
3	77
2	243
1	1329
Total Unique Clients	1724

The Chart 1 below details number of referrals by month from AIC open December 1, 2021 to November 30, 2021.

Chart 1: Referrals by month December 2020 through November 2021



Referral Sources

The following charts and tables delineate specifics regarding referral sources.

Chart 2: Referral Sources December 2020 through November 2021 by Provider Category

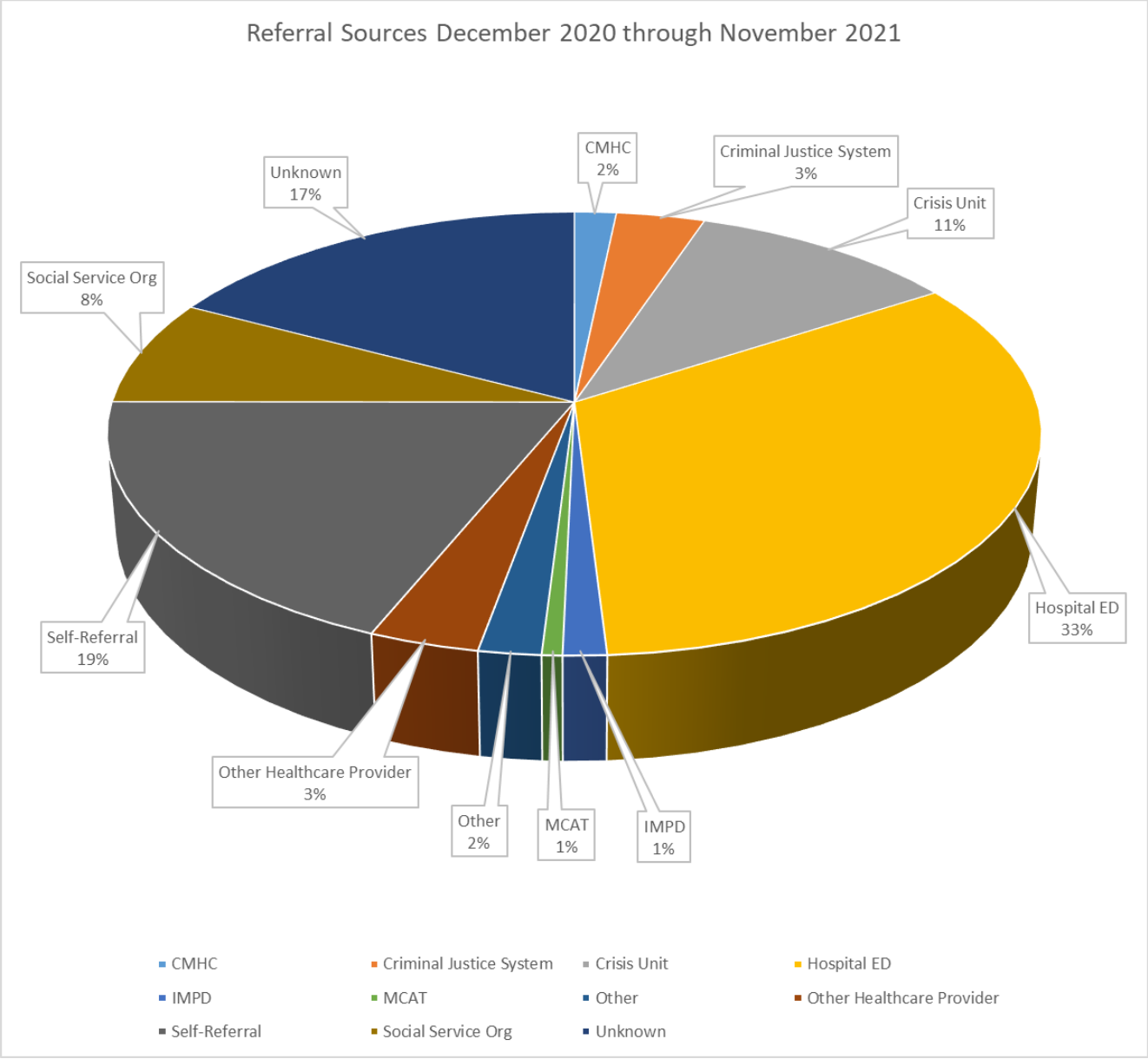


Table 2: Referral Sources December 2020 through November 2021 by Provider

Referrer	Category	Total
Self-Referral	Self-Referral	455
Not indicated	Unknown	418
Eskenazi Hospital	Hospital ED	346
CIU at Eskenazi	Crisis Unit	259
Methodist ER	Hospital ED	175
Community North	Hospital ED	114
Community East	Hospital ED	99
Horizon House	Social Service Org	52
Other	Other	46
Public Defender	Criminal Justice System	42
St Vincent ED	Hospital ED	34
IMPD	IMPD	32
Wheeler Mission (Men and Women)	Social Service Org	31
Adult and Child MHC	CMHC	28
Valle Vista	Other Healthcare Provider	27
Pedigo	Other Healthcare Provider	24
St. Francis	Hospital ED	22
MCAT	MCAT	15
Drug Court	Criminal Justice System	13
Pathway to Recovery	Social Service Org	13
Community Corrections	Criminal Justice System	11
St. Vincent Stress Center	Other Healthcare Provider	10
VA Hospital	Other Healthcare Provider	10
Behavioral Health Court	Criminal Justice System	9
Community South	Hospital ED	9
Nu Vision	Social Service Org	9
Sandra Eskenazi MHC	CMHC	8
Salvation Army ARC	Social Service Org	7
Damien Center	Social Service Org	7
Center of Hope	Social Service Org	6
Stagz	Social Service Org	6
Dove House	Social Service Org	6
Hickory House	Social Service Org	6
125 Ministries	Social Service Org	5
HVAF	Social Service Org	5
Probation	Criminal Justice System	4
Marion County Health Department	Other Healthcare Provider	4
Clean Slate	Social Service Org	4
Salvation Army Harbor Light	Social Service Org	4
Veteran's Court	Criminal Justice System	3
IU West	Hospital ED	3
Homeless Initiative Program	Social Service Org	3

Outreach Inc.	Social Service Org	3
Centerstone	CMHC	2
Aspire	CMHC	2
Parole	Criminal Justice System	2
IU Health Behavioral Care/Chemical Dependency	Other Healthcare Provider	2
Options	Other Healthcare Provider	2
Fairbanks	Other Healthcare Provider	2
PourHouse	Social Service Org	2
Buchner's Place	Social Service Org	2
Meet Me Under the Bridge	Social Service Org	2
Southeast Community Center	Social Service Org	2
Department of Correction	Criminal Justice System	1
Talbot House	Social Service Org	1
VOA	Social Service Org	1
IMPACT Southside	Social Service Org	1
Hope Center	Social Service Org	1
Partners in Housing	Social Service Org	1
DCS	Social Service Org	1
CORE	Social Service Org	1
PBSO	Social Service Org	1
Seeds of Hope	Social Service Org	1
Almost Home Sober Living	Social Service Org	1
Step Up	Social Service Org	1
Total		**2419**

ASSESSMENTS

Initial assessments are provided to all who show at AIC. Referrals are all the contacts made by community providers or the client through self-referral, regardless if they ever show to the AIC. Assessment data speak to those individuals that showed after a referral and were provided an initial assessment for further service or linkage.

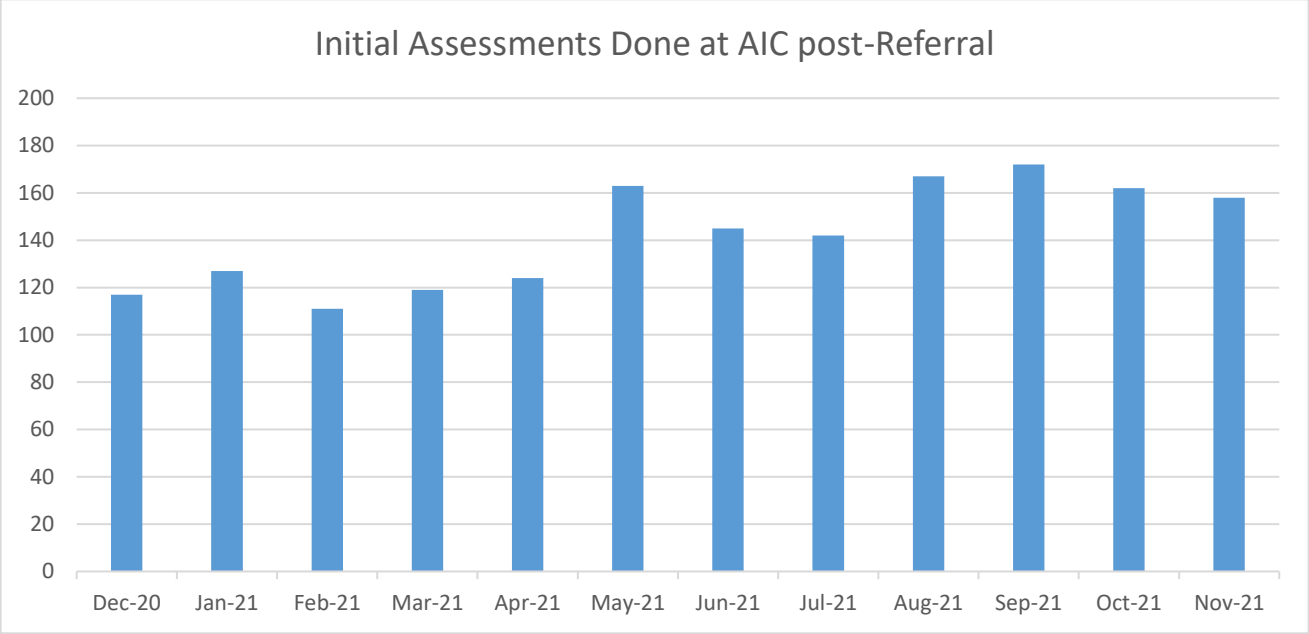
From December 2020 through November 2021 the AIC conducted 1707 initial assessments of the 2419 total referrals made. This was a show rate of 70.6% to the AIC post-referral. The 1707 initial assessments were conducted on 1264 unique clients. The chart below shows the number of individuals who received multiple initial assessments at the AIC.

Table 3: Initial Assessments Conducted for Each Unique Client December 2020 through November 2021

# of Assessments	Unique Clients
7	1
6	6
5	8
4	26
3	57
2	183
1	983
Total	1264

The chart below shows the number of assessments done per month at the AIC over the course of the AIC's first 12 months of operation.

Chart 3: Initial Assessments Conducted per Month December 2020 through November 2021



ADMISSIONS TO SECOND FLOOR 30-BED UNIT

Admissions to Second Floor: Explanation

The second floor of the AIC has two 30-bed units. As stated earlier in this report, AIC opened with and has maintained only 30 beds due to COVID protocols through December 2020 and 2021 overall. The second floor beds are for short-term stays to address withdrawal management and additional time required to link with direct service providers (such as recovery housing, community mental health treatment, etc.). This additional time to facilitate linkage could be due to a variety of factors, including homelessness, maintaining sobriety until recovery housing, or delays in available beds in recovery housing. During the initial assessment process, its determined if the client requires second floor housing. If the client does not require 2nd floor resources, they will be provided provider resources and sent back into the community.

Of the 1707 individuals who showed to the AIC for initial assessment, 1481 (or 86%) were admitted to the second floor 30 bed-unit. The difference of 226 between initial assessment and referral generally reflects one of three actions: (1) upon hearing that the AIC is not a shelter-only/housing resource, the client chooses to leave; or (2) the client presents as needing a higher level of care than the AIC can provide and is sent to a hospital (such as for withdrawal that cannot be safely managed at the AIC); or (3) the client was able to be provided resources at time of assessment thereby not requiring admission to the 2nd floor 30-bed unit.

Table 4: Admissions to Second Floor December 2020 through November 2021

Month/Year	Admitted	Not Admitted	Unknown	% Admitted
December 2020	106	7	4	90.6%
January 2021	106	18	3	83.5%
February 2021	99	12	0	89.2%
March 2021	111	7	1	93.3%
April 2021	113	4	7	91.1%
May 2021	144	13	6	88.3%
June 2021	129	14	2	89.0%
July 2021	116	24	2	81.7%
August 2021	143	21	3	85.6%
September 2021	146	24	2	84.9%
October 2021	129	30	3	79.6%
November 2021	139	18	1	88.0%
TOTAL	1481	192	34	100%

The daily average of admissions was 4.2 with a range of 1 to 15 per day.

Table 5: Average Daily Admissions to Second Floor December 2020 through November 2021

Month/Year	Average Admitted Daily per Month	Range of Daily Admissions per Month
December 2020	3.5	1 to 13
January 2021	3.5	1 to 10
February 2021	3.7	1 to 6
March 2021	3.7	1 to 7
April 2021	3.9	1 to 12
May 2021	4.6	1 to 10
June 2021	4.4	1 to 9
July 2021	4	1 to 9
August 2021	4.6	1 to 10
September 2021	5	1 to 15
October 2021	4.2	1 to 7
November 2021	4.8	1 to 9
Average Admissions Per Day for 12-Month Period	4.2	1 to 15

DISCHARGES FROM THE SECOND FLOOR 30-BED UNIT

Discharges from Second Floor: Explanation

The goal of the AIC is to connect individuals to treatment providers to address apparent mental health and/or substance use issues. The 2nd floor 30-bed unit allows the opportunity for individuals to successfully manage withdrawal and allow safe place to work on linkage and/or placement with other treatment providers. Successful discharges would be considered those that have left with some relevant and potentially impactful treatment linkage. As the AIC is a voluntary program, individuals can self-exit and this often happens, especially if not committed to the idea of change. Discharge statistics in this section reflect all discharges, regardless of disposition. Discharge dispositioning will be addressed in a separate section.

Average discharges from the 2nd floor 30-bed unit per day from December 2020 through November 2021 were 4.8 individuals per day.

Table 6: Discharges from Second Floor December 2020 through November 2021

Month/Year	Average Discharges per Day per Month	Range of Daily Discharges per Month
December 2020	3.6	1 to 7
January 2021	4.6	1 to 12
February 2021	4.0	1 to 11
March 2021	3.7	1 to 8
April 2021	4.6	1 to 10
May 2021	4.9	1 to 10
June 2021	5.3	1 to 10
July 2021	4.8	1 to 10
August 2021	5.3	1 to 9
September 2021	5.6	1 to 11
October 2021	5.2	1 to 10
November 2021	5.7	1 to 12
Average Discharges Per Day for 12 Month Period	4.8	1 to 12

DISCHARGE DISPOSITIONING AND TREATMENT LINKAGE/ANCILLARY SERVICES

The AIC program's mandate is to assist those with an apparent mental illness and/or substance use issue with appropriate treatment sources. This is typically done in two ways: discharge dispositioning and ancillary services. This section will discuss discharge dispositioning (with an emphasis on addiction recovery treatment locations as those are essential for most AIC clients who stay to be linked to services) and ancillary services.

A significant resource for discharges, ancillary services, and that has been used is the Comprehensive Opioid Abuse Program (COAP) grant through Indiana FSSA Division of Mental Health and Addiction that was originally awarded to the Reuben Engagement Center. This grant allows for more significant wraparound and financial funding for those individuals who have current or past history of opioid use. From December 2020 through November 2021, forty-one clients have been placed in substance use treatment facilities through COAP grant funds.

A Note on Transportation:

To make discharging dispositioning as low barrier as possible—in addition to ancillary services to be discussed in another section of this report—AIC staff (primarily peer recovery coaches) transport 100% of clients to their discharge disposition, in addition to other treatment related appointments they might have while on the 2nd Floor housing unit. Helping make this possible was the generous donation of a mini-van to AIC by the Central Indiana Community Foundation (CICF). This transportation piece is very challenging to manage, as AIC operations has had to be creative in how to facilitate this as no direct funding is attached to transportation in the current AIC budget.

Discharge Dispositioning

Discharge dispositioning involves planning the client's discharge to a physical address that preferably facilitates the client's treatment/recovery. Some clients will return home and be linked to outpatient community mental health and/or addictions treatments; others may go to recovery environments like an addictions treatment center. As the data below show, 53% of clients self-exit prior to discharge.

The greatest challenge with discharge dispositioning involves those individuals who self-exit prior to linkage with an appropriate treatment provider. Most individuals who self-exit discharge same day; others may grow frustrated during the wait to be linked with treatment or for treatment facility beds

to open. Much effort has been placed in decreasing self-exits including placing a peer recovery coach on the weekend, training all staff in Motivational Interviewing to facilitate more productive change-oriented conversations, and internally reviewing self-exit data monthly.

Chart 4: Discharge Dispositions December 2020 through November 2021

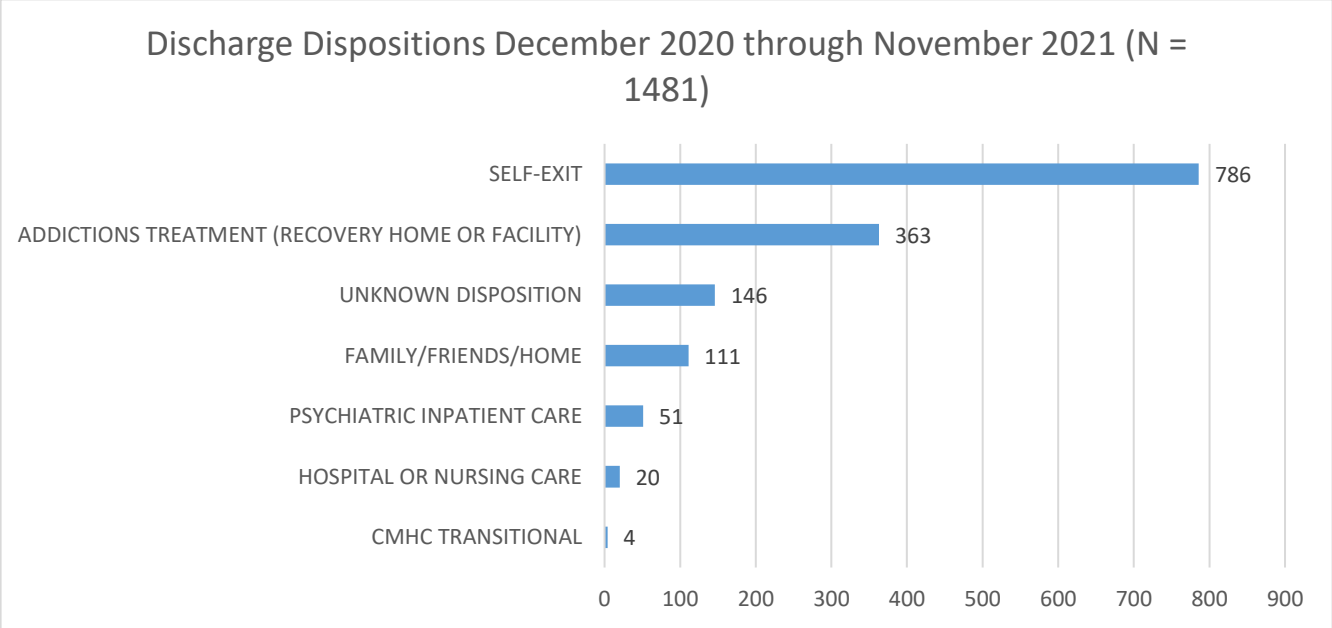
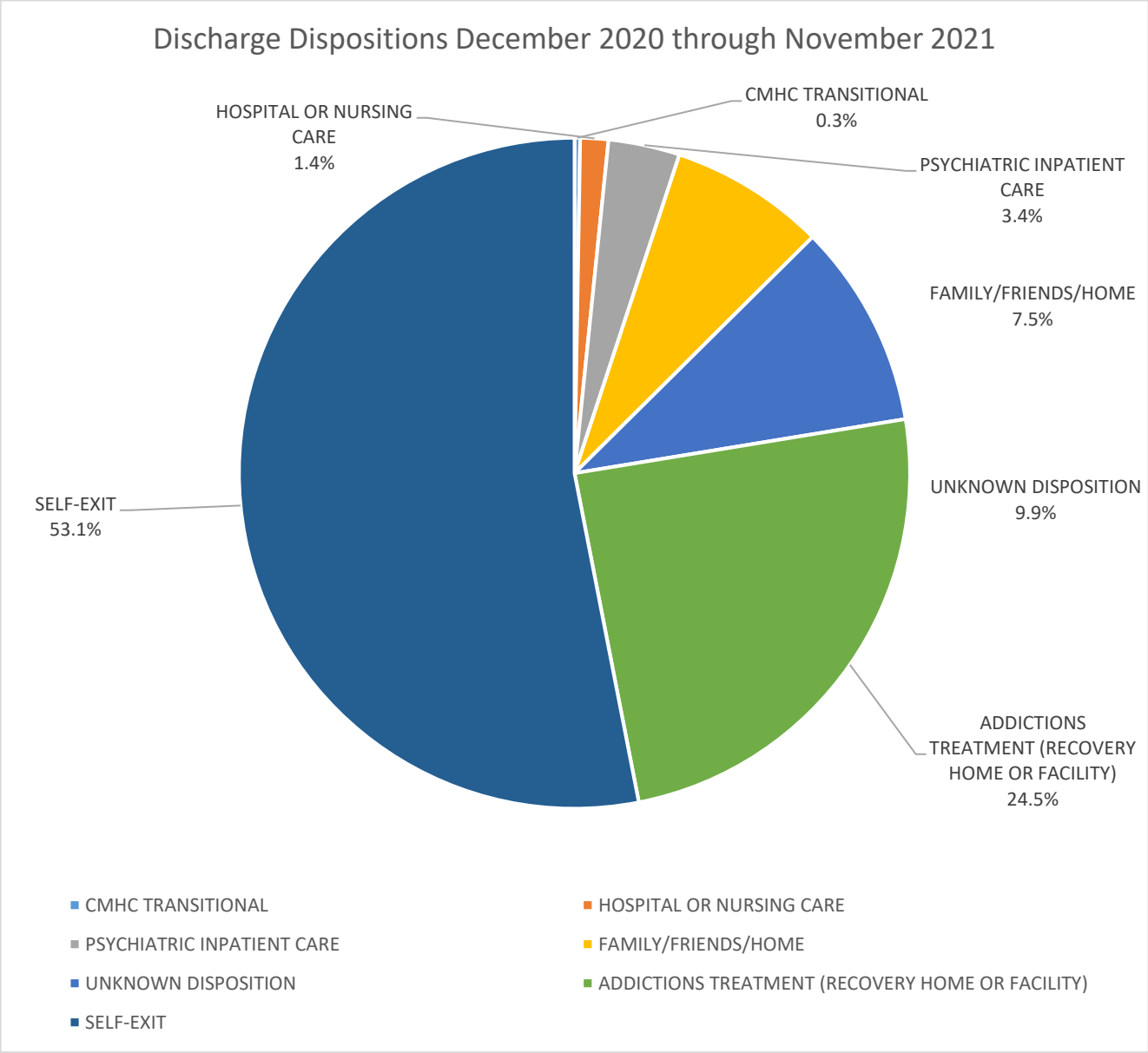


Chart 5: Discharge Dispositions (percentages) December 2020 through November 2021



Recovery Treatment Centers

The following chart lists the majority of recovery treatment centers and homes that have been used over the last 12 months in discharge dispositioning. The frequency of use is based upon provider bed availability, location, client need, and client desire.

Table 7: Recovery Treatment/Home Usage December 2020 through November 2021

Recovery Provider	Percentage of Discharges
Hickory Treatment Center	22.0%
Sober Living America	13.3%
Great Answers 4 U	9.0%
Steps 2 Life	5.9%
Stagz	3.9%
Valle Vista	3.9%
Wooded Glen	3.5%
Nu Vision	3.1%
Pathway to Recovery	2.7%
Together We Can	2.0%
Fairbanks	1.6%
Landmark Recovery	1.6%
Mockingbird Hill	1.6%
Salvation Army Harbor Light	1.6%
Truth Treatment Center	1.6%
ARC Meridian	1.2%
Other/Undefined	1.2%
Hebron	1.2%
Julian Center	1.2%
Options Behavioral Health	1.2%
Progress House	1.2%
Volunteers of America	1.2%
ChainBreakers Ministries	0.8%
Dove House	0.8%
New Day	0.8%
Odyssey House	0.8%
Our Brother's Place	0.8%
Oxford House	0.8%
Pathway to Success	0.8%
Talbott House	0.8%
Tara Treatment Center	0.8%

125 Ministries	0.4%
Across the Bridge	0.4%
Centerstone	0.4%
DOM Program	0.4%
Destination Recovery	0.4%
Grace House	0.4%
Halfway house	0.4%
Isiah House	0.4%
Legacy House	0.4%
Meridian ARC	0.4%
Nazareth House	0.4%
Project Safe Haven	0.4%
Queen of Peace	0.4%
RW Cambridge City	0.4%
Salvation Army ARC	0.4%
Sardis House	0.4%
Seeds of Hope	0.4%
The Waters	0.4%
Third Phase	0.4%

Treatment Linkage/Ancillary Services

Ancillary services are the treatment linkage to outpatient treatment services and other resources to which AIC clients are linked that will facilitate recovery and support in the community. These services can be provided by community mental health centers, peer recovery programs like Mobile Pathways, 12-step groups, and so on. This is an area of AIC service where the data is most lacking. Due to the construction of the OpenCaseWare system, any data pull specifically for this data is sorely incomplete. Other than through individual client chart reviews, no reliable quantitative metrics can be provided. Anecdotally, about 10-15% of all clients admitted to the 2nd floor housing unit have been linked to one of Marion County's four community mental health centers for mental health and/or substance use disorder outpatient treatment. A similar percentage have been linked to primary care. Nearly 100% of all clients receiving peer recovery services through either Mobile

Pathways (explained below) or AIC peer recovery coaches are provided additional information and support in linkage to peer-based community resources, such as 12-step programs.

A great outpatient resource to AIC clients who have current of past or current history of using opioids or stimulants is Mobile Pathways. Mobile Pathways is funded by Indiana as part of the Mobile Integrated Response System funded through the Indiana FSSA Division of Mental Health and Addiction State Opioid Response. Mobile Pathways is a peer recovery coach team that provides support, treatment navigation, and case management to the aforementioned clients who have current or past history of opioid or stimulant use. Mobile Pathways has worked closely with AIC (including embedding staff members throughout the work week at AIC) to provide the community support for the client to successfully complete recovery in an outpatient setting. Table 10 below shows Mobile Pathways referrals by month from January through November 2021. Thus far 215 AIC clients have received Mobile Pathways services.

Table 8: Referrals to Mobile Pathways January through November 2021

Month	Number of Referrals Made to Mobile Pathways
January 2021	3
February 2021	0
March 2021	0
April 2021	12
May 2021	16
June 2021	29
July 2021	25
August 2021	29
September 2021	31
October 2021	24
November 2021	46
Total	215

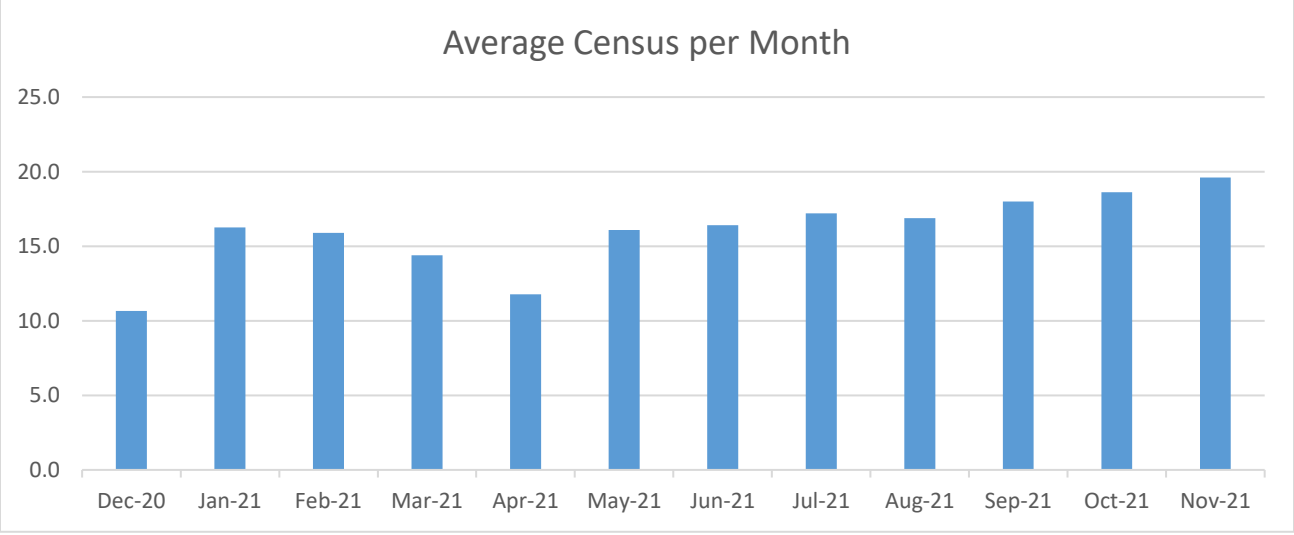
DAILY CENSUS AND LENGTH OF STAY

Below is the average daily census by month from opening in December 2020 through November 2021. The AIC daily census has seen a significant increase over the course of the year, increasing by 9 individuals per day over the course of 12 months. The census value is the number of individuals in an AIC bed at midnight on any given day.

Table 9: Average Daily Census December 2020 through November 2021

Month/Year	Average Daily Census
December 2020	10.7
January 2021	16.3
February 2021	15.9
March 2021	14.4
April 2021	11.8
May 2021	16.1
June 2021	16.4
July 2021	17.2
August 2021	16.9
September 2021	18.0
October 2021	18.6
November 2021	19.6
Average Daily Census for 12-Month Period	16

Chart 6: Average Daily Census December 2020 through November 2021



Length of stay (LOS) is calculated for those admitted to the 2nd floor 30-bed unit as the span of time between arrival at the AIC and discharge. As LOS of stay can cross across calendar months, the LOS for each month is based on those individuals discharged within that calendar month. The average LOS from December 2020 through November 2021 was 5.3 days.

Table 10: Average Length of Stay by month December 2020 through November 2021

Month/Year	Length of Stay (in days)	Range (in days)
December 2020	3.5	1 to 17
January 2021	5.34	1 to 20
February 2021	5.1	1 to 28
March 2021	3.9	1 to 17
April 2021	3.6	1 to 23
May 2021	3.3	1 to 15
June 2021	4.3	1 to 28
July 2021	4.9	1 to 23
August 2021	4	1 to 25
September 2021	3.9	1 to 40
October 2021	5	1 to 27
November 2021	4.8	1 to 39
Average LOS for 12-Month Period	5.3	1 to 40

THROUGHPUT: COMPARISON OF ADMISSIONS, DISCHARGES, CENSUS, AND LENGTH OF STAY

The following graph compares 2nd floor 30-bed unit admission, discharges, and LOS to average daily census to give a better overview of throughput. Please note the following.
Although there was a dip in average census March through April of 2021, daily census has steadily climbed throughout the last 12 months.

Average daily admissions and discharges tend to run in parallel with discharges slightly leading admissions. For example, for the last 12 months, admissions average 4.2 daily versus 4.8 daily discharges.

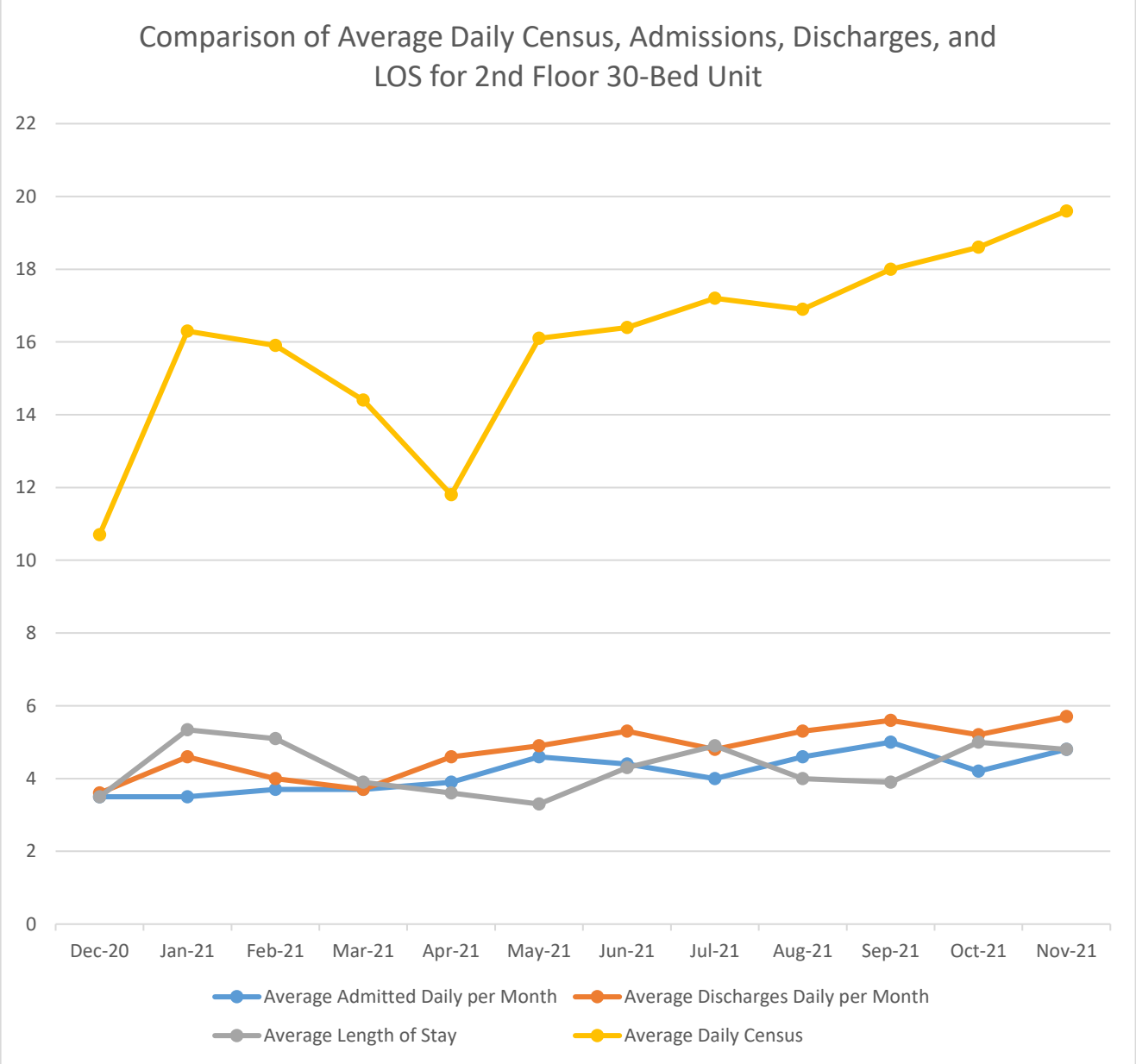
However, even though there are typically more discharges daily than admissions, the daily census has continued to increase. This is due in part to length of stay increasing over the course of the year (i.e., 3.5 days in December 2020, compared to 4.8 days in November 2021).
As the year progressed, the individual length of stays started to increase. For comparison, December 2020 and January 2020, the range of individual stays spanned from 1 to 17 and 1 to 20 respectively. For the last months of this past 12 months—October 2021 and November 2021—the length of stay ranged from 1 to 27 and 1 to 39 respectively. The monthly average length of stay has increased over the past 12 months directly affecting daily census, even when discharges outnumber admissions.

Reasons for increased lengths of stay include challenges with securing recovery housing (due to COVID protocols or complexity of client referred), inadequate availability of community mental health center residential beds, overall complexity of client needs, and increased number of referrals of individuals presenting primarily with a serious mental illness (e.g., schizophrenia). The latter issue is a challenge as it is hard to get a client into a community mental health center for an intake. And, if an intake is secured, there are delays in getting the individual connected and stabilized on meds, in addition to the dearth of mental health residential beds available in Marion County. These issues will be further addressed in the “Challenges” section of this report.

Regarding prognostication of 2022 throughput, if lengths of stay increase and admissions intensify, there will be issues in accessing 2nd floor 30-bed unit beds. Of course, opening the other 30-bed unit

can address that unless admissions increase at such an intensity to create such throughput issues for the second unit.

Chart 7: Comparison of Average Daily Census, Admissions, Discharges, and LOS for 2nd Floor 30-Bed Unit December 2020 through November 2021



DEMOGRAPHICS

The following race and gender data provide demographics at time of referral, assessment (i.e., client shows at AIC for an assessment post-referral), and admissions to the 2nd floor 30-bed unit. As will be observed there is no appreciable difference in terms of race and gender between referral, assessment, and admission (meaning that one group is neither more prone not to show nor be favored for admission). What can be gleaned from race and gender data is that white males are referred to the AIC (and subsequently assessed and admitted) than others.

Gender

Chart 8: Referrals December 2020 through November 2021: Gender Identification

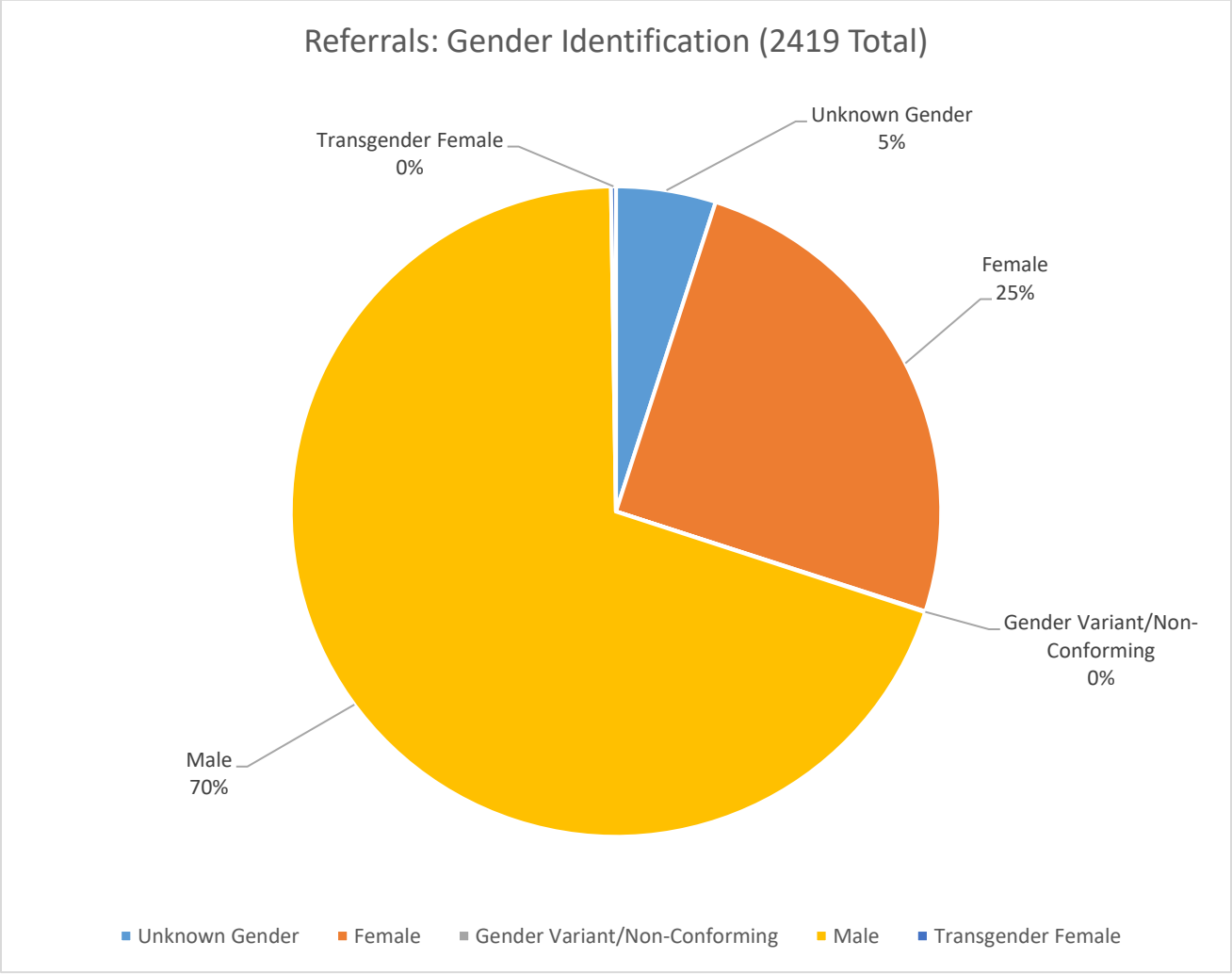


Chart 9: Assessments (Clients showing to AIC) December 2020 through November 2021: Gender Identification

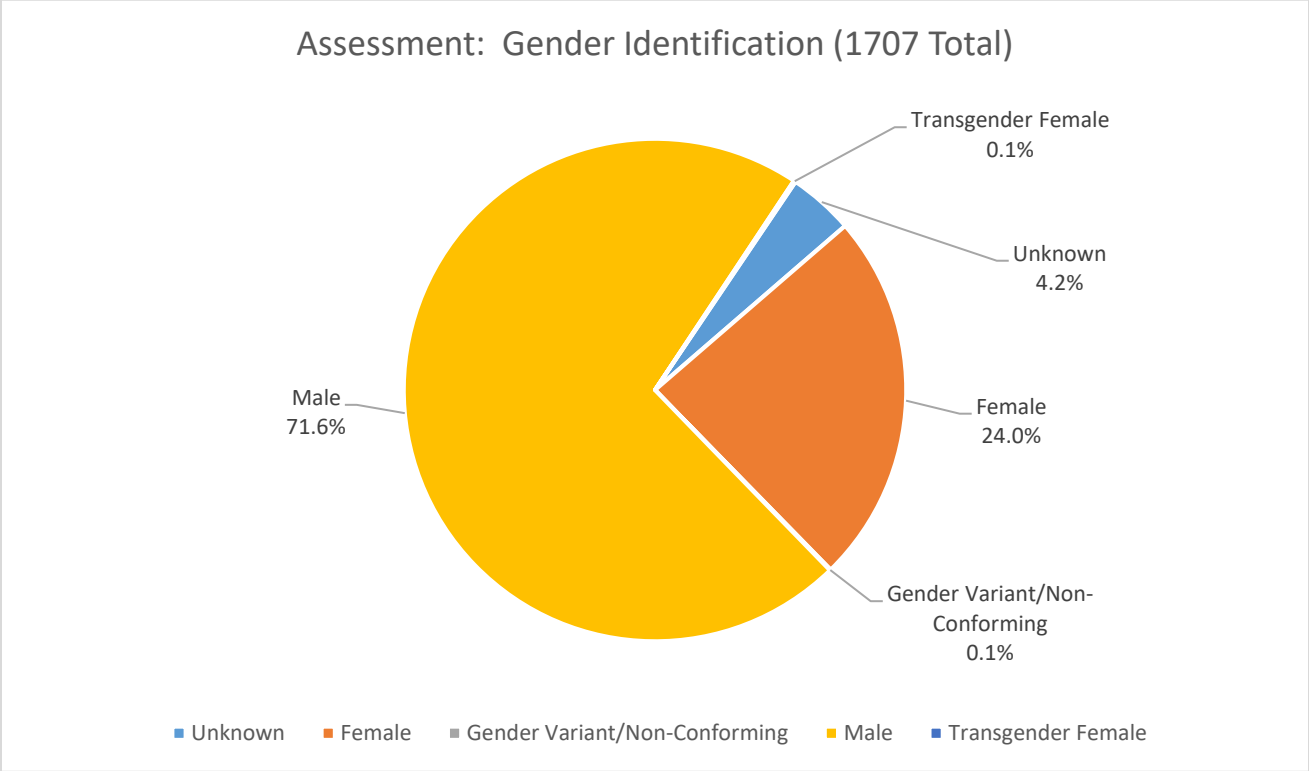
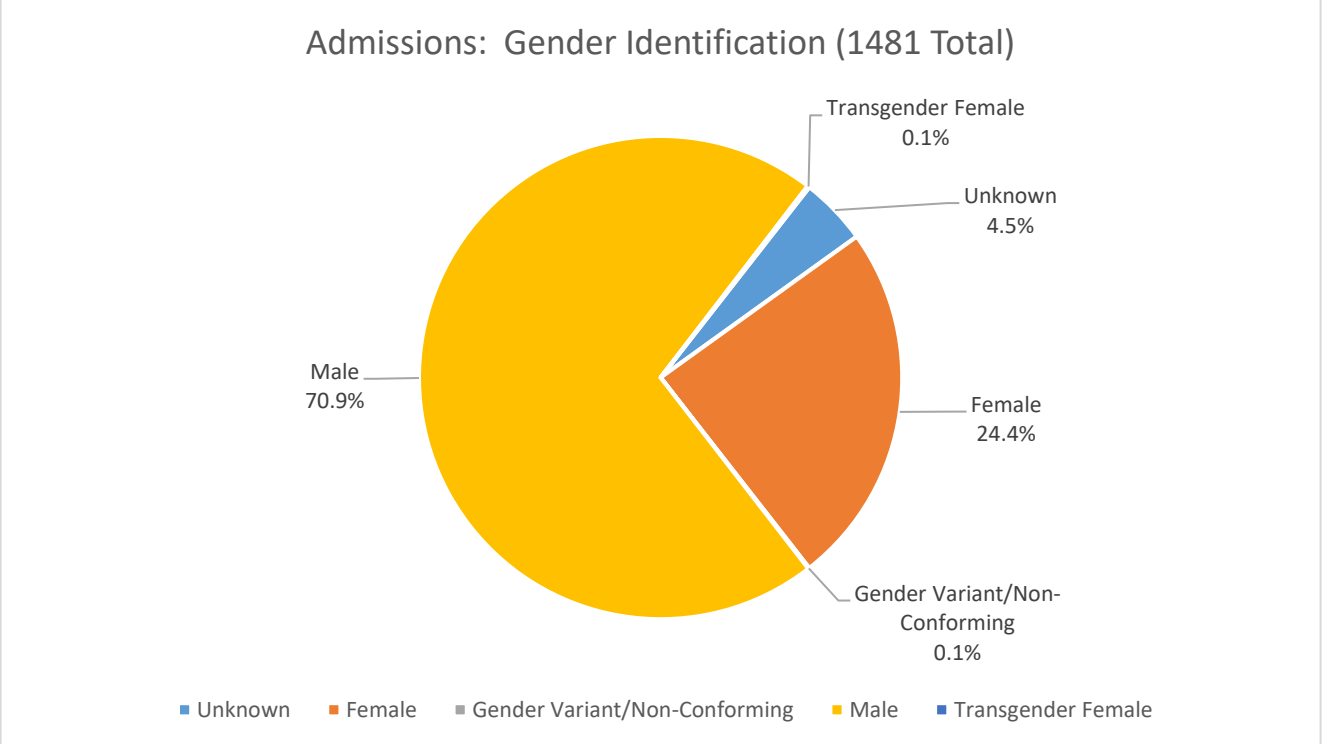


Chart 10: 2nd Floor Admissions December 2020 through November 2021: Gender Identification



Race

Chart 11: Referrals December 2020 through November 2021: Race Identification

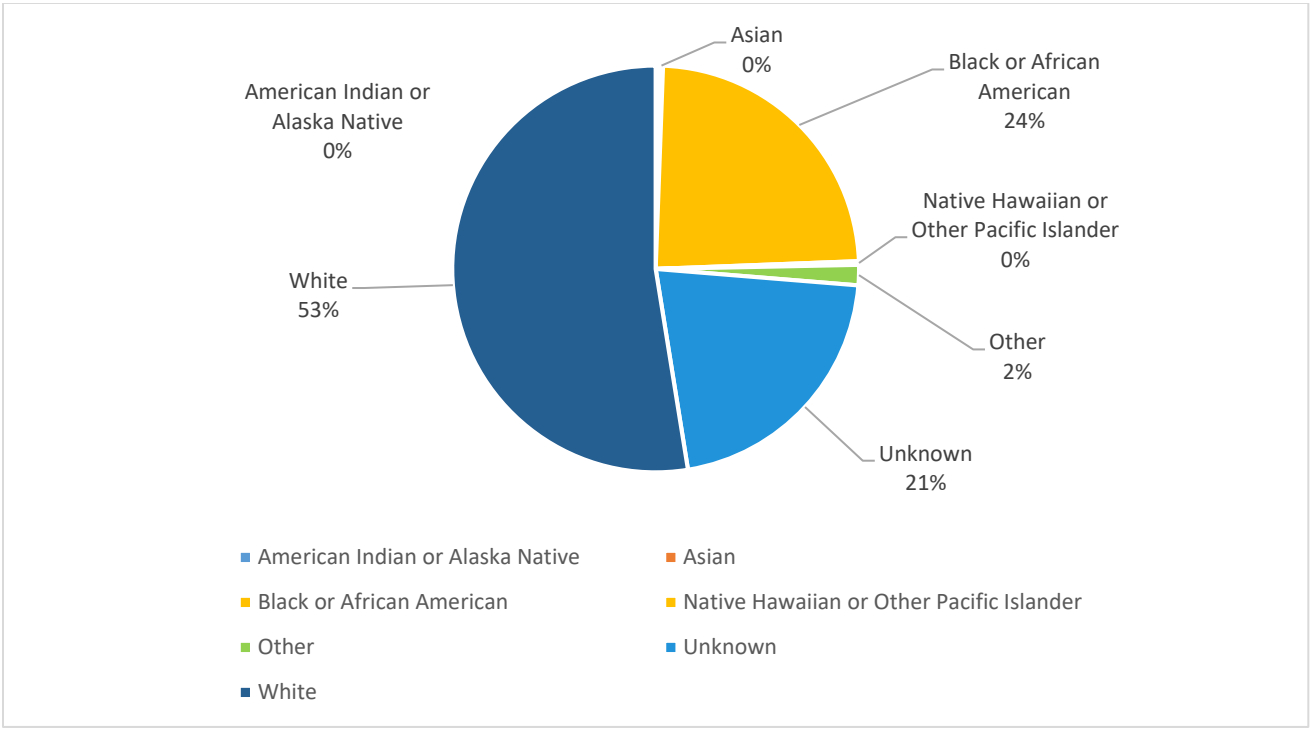


Chart 12: Assessments (Clients showing to AIC) December 2020 through November 2021: Race Identification

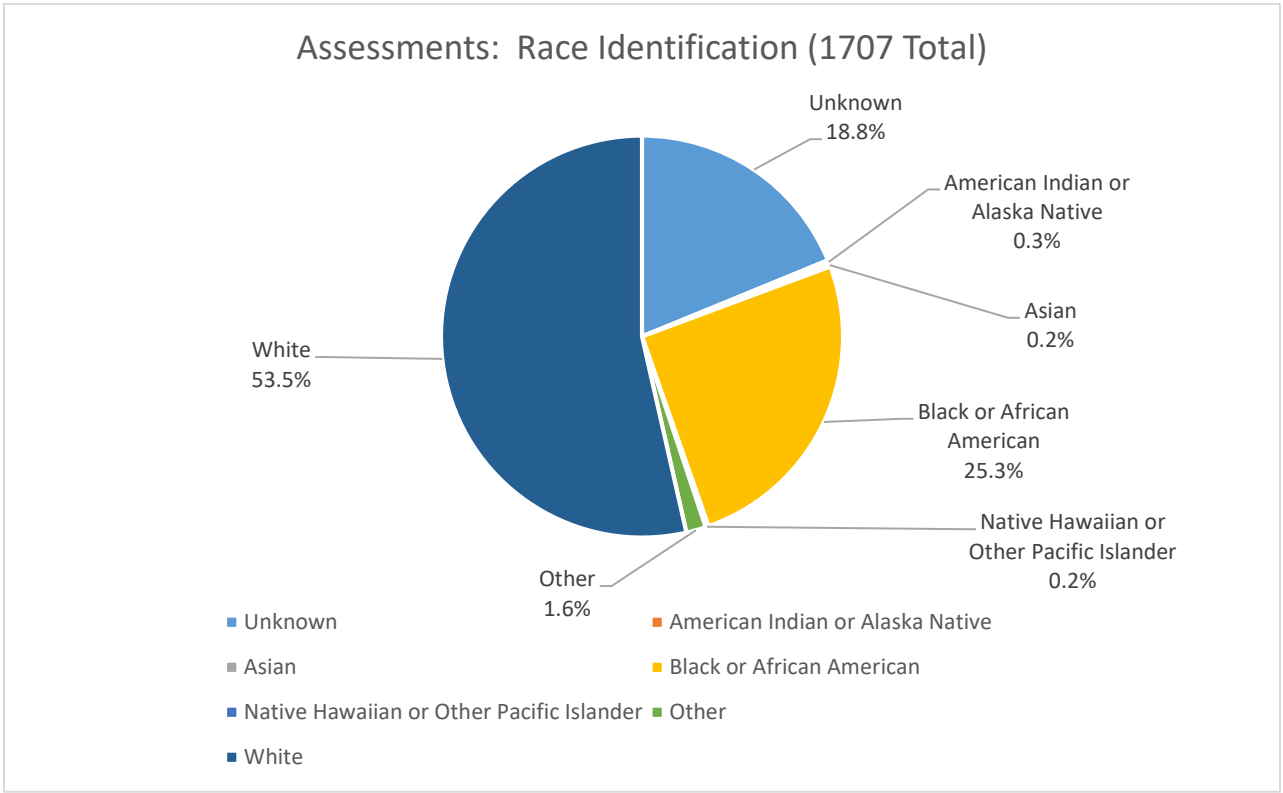
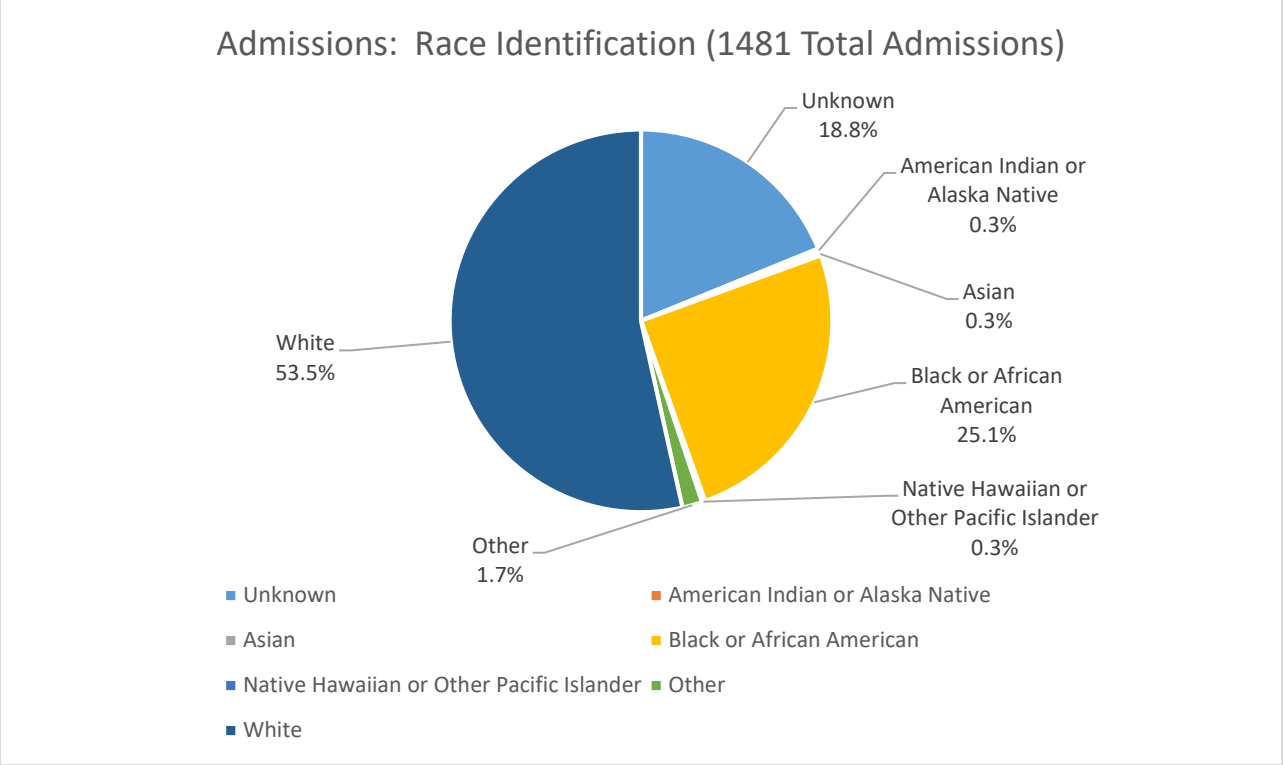
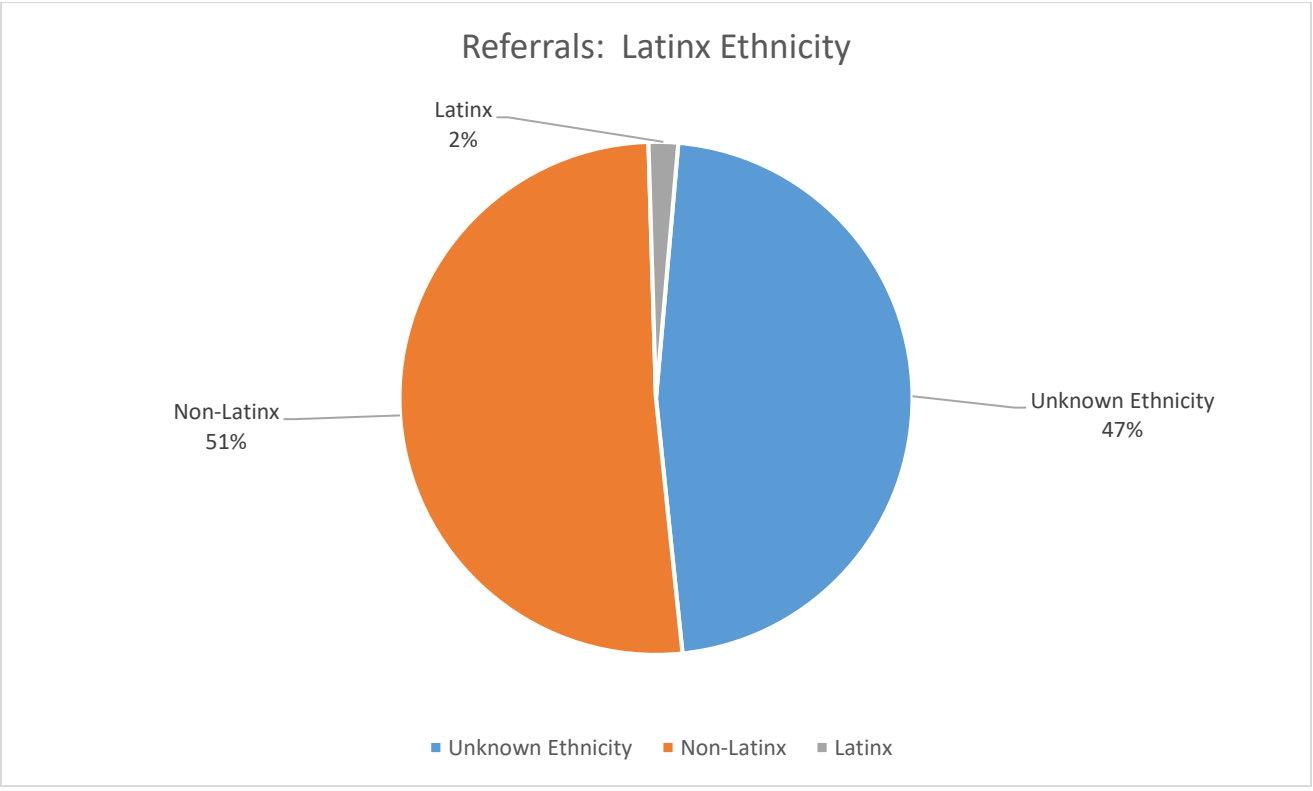


Chart 13: 2nd Floor Admissions December 2020 through November 2021: Race Identification



Latinx Ethnicity

Chart 14: Referrals December 2020 through November 2021: Latinx Ethnicity



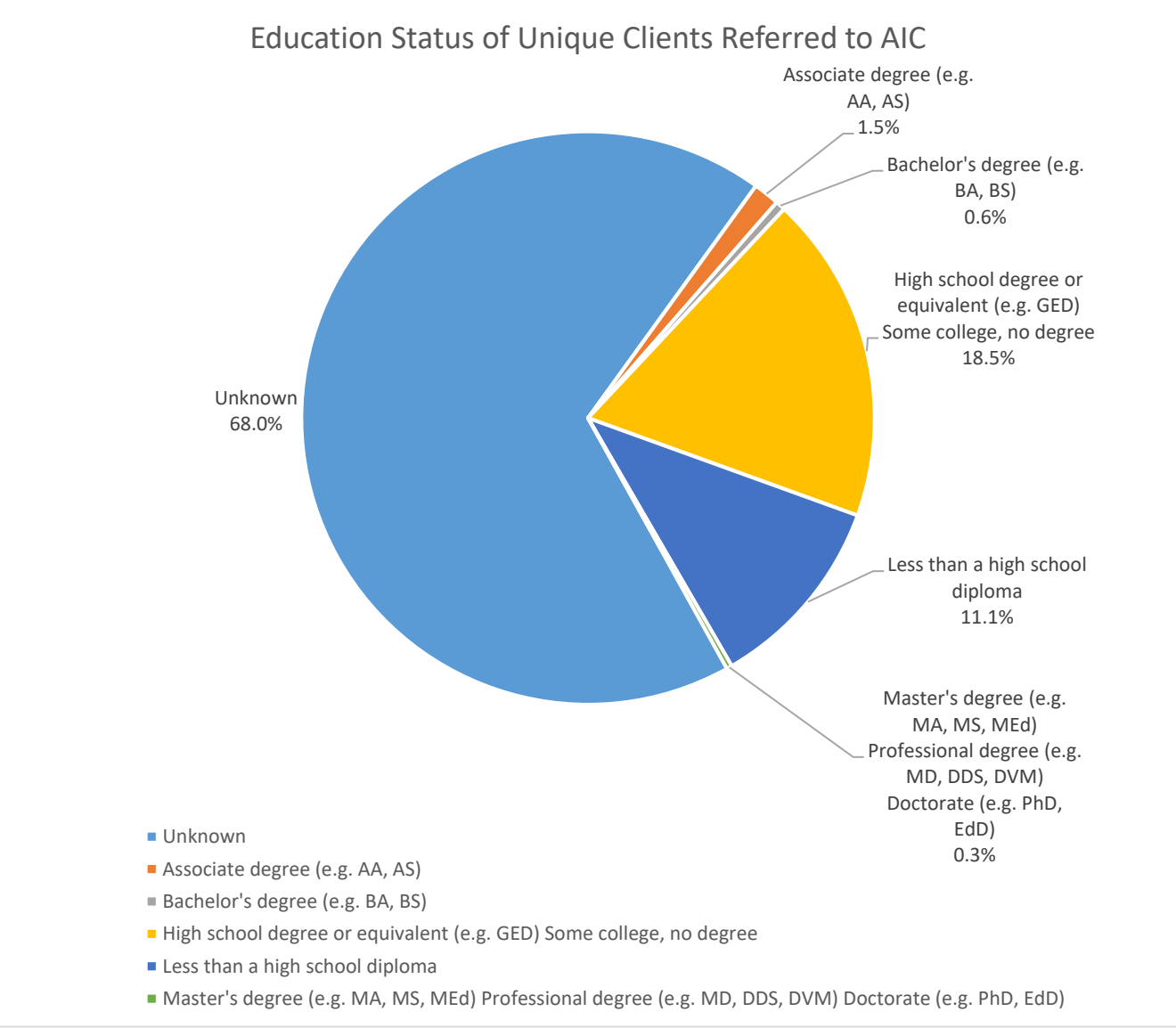
Age

Table 11: Age Information for all Unique Referred Clients December 2020 through November 2021

Statistic	Data
Range of Ages	19-75 years old
Average Age	41 years old
Mode Age (most frequent)	38 years old

Education

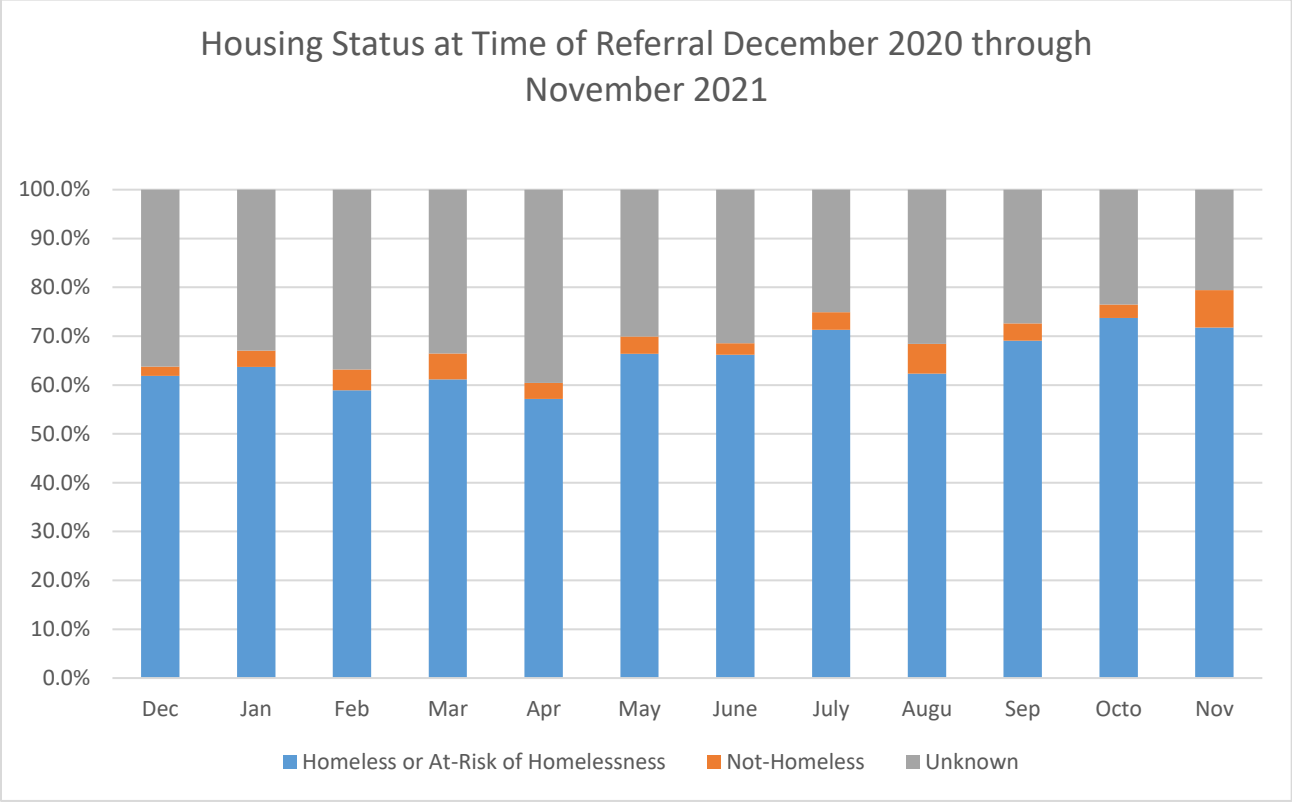
Chart 15: Education Status for all Unique Referred Clients December 2020 through November 2021



Housing Status

The following outlines by month those self-reporting as experiencing homelessness or at risk of homelessness at time of referral. For the time period of December 2020 through November 2021, 65.8% of all referrals (N = 2419) indicated that the client was experiencing homelessness or at risk of homelessness.

Chart 16: Housing Status at time of Referral December 2020 through November 2021

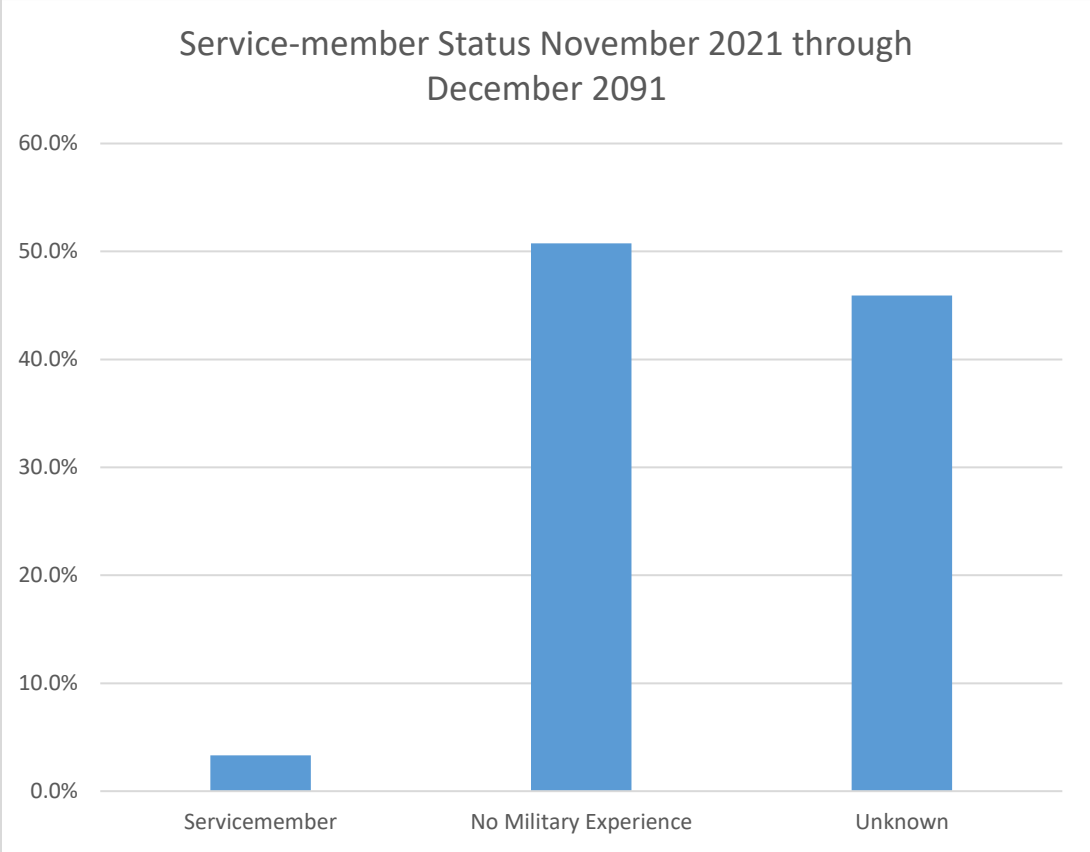


Veterans/Service-members

The following data indicate the percentage of individuals identifying as a service-member at time of referral. For the past 12-months, 3.3% of all referrals (N = 2417) identified as having been a service-member.

In April 2021 AIC altered its referral question from "Veteran: Yes or No?" to "Have you ever served in the military?" to ensure that those serving through the National Guard, or perhaps were dishonorably discharged, were not excluded. Given how often this question was not answered, the 3.3% figure could be higher.

Chart 17: Service-Member Status at Time of Referral December 2020 through November 2021



TREATMENT NEED

The goal of the AIC is to link clients presenting with substance use and/or behavioral health disorders to appropriate treatment. One of the core tools in helping determine client treatment need. The data that follow indicate substance use and behavioral health needs reported by the client or apparent to the clinician at time of the initial assessment by the clinician. No diagnosis is assigned to the client; however, the diagnostic impression aids in determining best treatment linkage and in referrals and "warm handoffs" to treatment providers.

Substance Use

The following data indicate the client's self-report of substance use at time of the AIC clinician's initial assessment. 91.5% of all clients given an initial clinical assessment identified some degree of substance use behavior. 40.5% of all clients reported some level of Alcohol use, followed by Stimulants at 41.2% and Opioids at 29.9%.

Table 12: Substances Use Identified by Clients December 2020 through November 2021

Substance	Percentage of Clients
Alcohol	40.5%
Stimulants	41.2%
Opioids	29.9%
Cannabinoids	21.3%
Benzodiazepines	1.8%
Hallucinogens	0.9%
Inhalants	0.2%
Barbiturates	0.1%
None Identified	8.5%

In terms of client identified primary substance use, alcohol is most common for 36.2% of those assessed. Stimulants are second at 27.5% and Opioids third at 25.8%

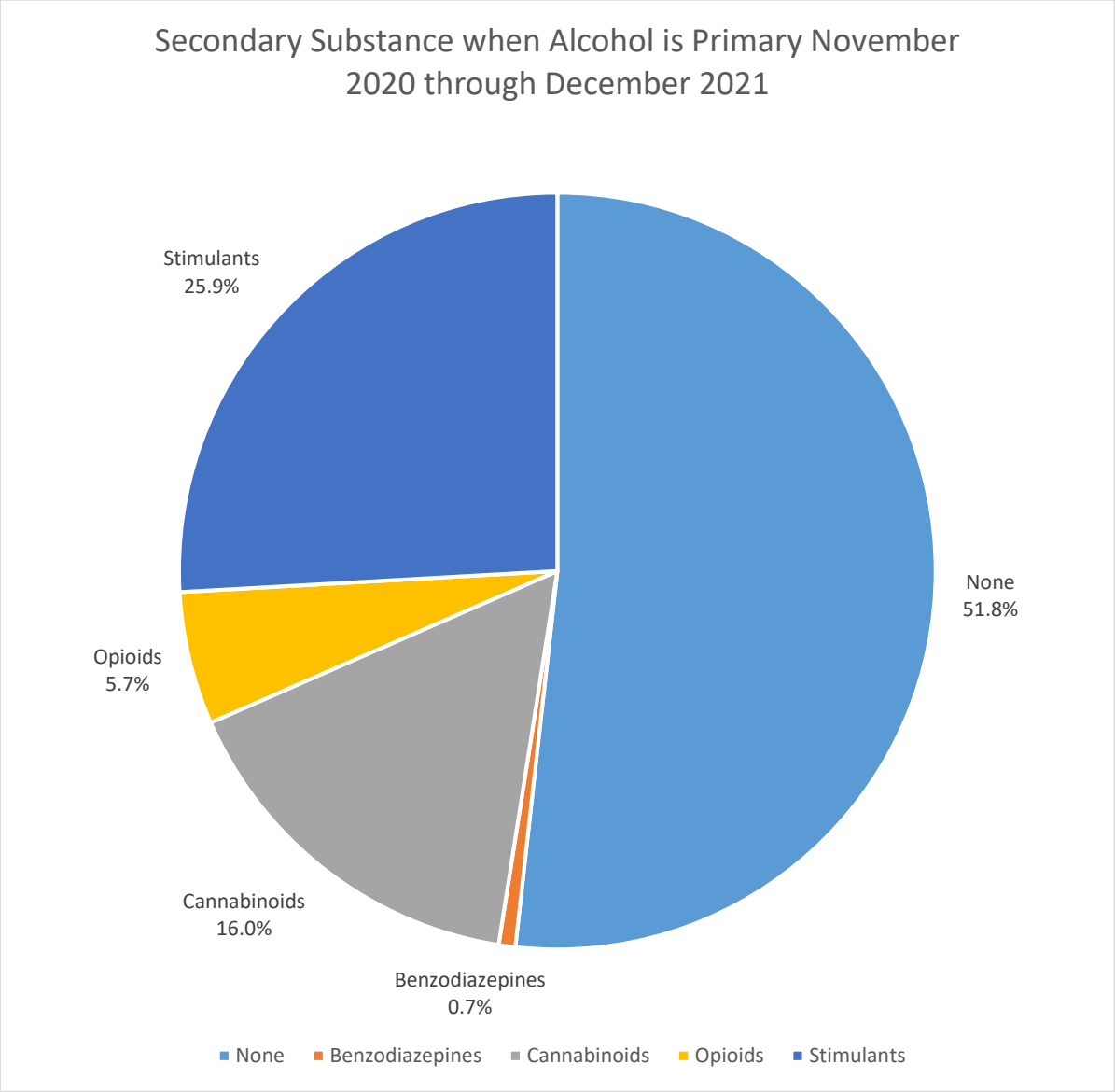
24.3% of those who identified having a primary substance did not identify having a secondary substance of choice (note: this was 32.4% of all individuals who had an initial clinician assessment). For the most common secondary substances, Stimulants account for 37.3% of those reported, followed by Cannabinoids (25.9%) and Opioids at 19.7%.

Table 13: Primary Substance Use Identified by Clients December 2020 through November 2021

Substance	Primary Substance	Secondary Substance (If Client Identified a Primary Substance)
Alcohol	33.1%	10.6%
Stimulants	25.1%	28.2%
Opioids	23.6%	15.0%
Cannabinoids	8.2%	19.6%
Benzodiazepines	0.7%	1.5%
Hallucinogens	0.7%	0.3%
Inhalants	0.0%	0.3%
Barbiturates	0.0%	0.2%
None Identified	8.6%	24.3%

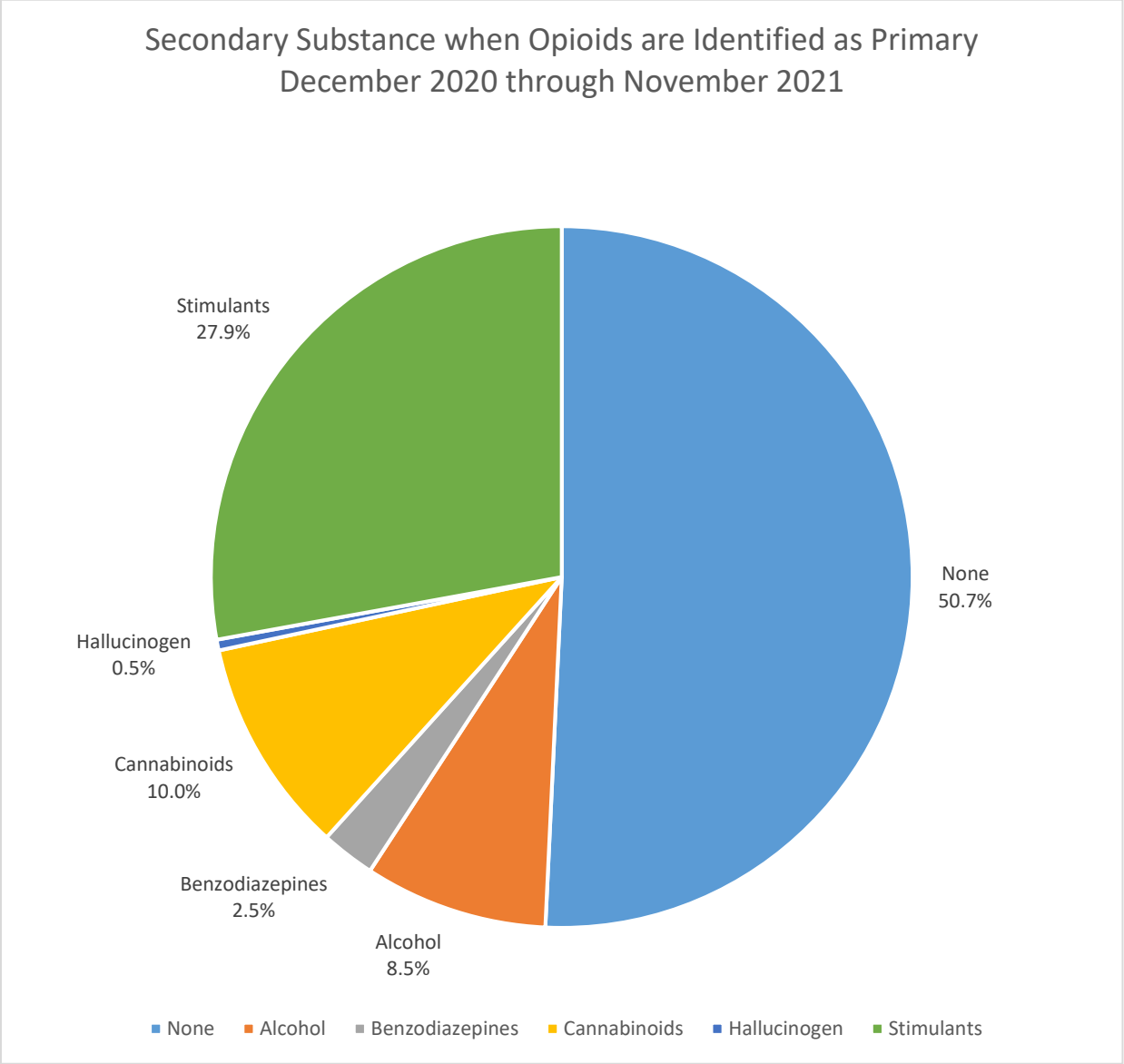
For those individuals who identified alcohol as their primary substance, 52% did not identify a second substance. For those that did, Stimulants led at 26%, followed by Cannabinoids at 16% and Opioids at 6%. One of out of four times, a stimulant will be the secondary substance when alcohol is identified as primary.

Chart 18: Secondary Substance when Alcohol identified as Primary Substance December 2020 through November 2021



Given the concerns regarding Opioid use in the Nation and Marion County specifically, the chart below shows what substance is most likely to be identified as the secondary substance for those who identify Opioids as primary. The data show 50.7% of all those who use Opioids report they do not use a second substance. Stimulants far outpace other substances as the preferred secondary substance at 27.9%.

Chart 19: Secondary Substance when Opioids are identified as Primary Substance December 2020 through November 2021



Behavioral Health

The following data indicate those individuals at time of the AIC clinician's initial assessment who either presented with or reported behavioral health issues or diagnoses.

Behavioral Health Disorder Prevalence

48.7% of those assessed presented to the AIC with a behavioral health issue. The table below outlines prevalence among the sample assessed.

Table 14: Behavioral Health Issue Prevalence either Observed or Reported at Time of AIC Clinician Assessment

Diagnostic Category	Behavioral Health Prevalence
Depression	17.7%
Anxiety	17.6%
Schizophrenia Spectrum	12.5%
Bipolar Disorder	9.8%
Post-Traumatic Stress	8.7%
Attention Deficit	2.9%
Borderline Personality Disorder	2.8%
Other Disorders	0.9%
No BH Issue Observed or Reported	51.3%

Depression was most common at 17.7%, followed by Anxiety (17.6%) and Schizophrenia Spectrum Disorders 12.5%). Individuals most often presented with multiple diagnoses, so percentages below do not reflect discreet, unique clients (so someone who reported Depression could have additionally reported PTSD and Anxiety, all three of which are included in the percentages provided below).

It should be noted that prevalence rates for some behavioral health disorders are higher than one would find in typical adult populations. The National Alliance on Mental Illness (2021), for example, reports that less than 1% of the adult U.S. population has Schizophrenia, yet 12.5% of those presenting to AIC have symptoms of a Schizophrenia Spectrum Disorder. Borderline Personality Disorder is twice the national prevalence rates at 2.8%. Post-Traumatic Stress and Depression are more than double the national prevalence rates. It should additionally be noted that national prevalence data indicate that 21% of U.S. adults experienced a mental illness in 2020; while 5.6% of U.S. adults experienced a serious mental illness (like Schizophrenia or Bipolar Disorder) in 2020.

Almost 50% of those showing to AIC presented with symptoms or history of a behavioral health disorder. Obviously the nature and purpose of AIC will result in serving citizens who more frequently than the general Marion County adult population present with a behavior health issue. What should be noted are the prevalence rates of certain disorders (such as Schizophrenia Spectrum Disorders)

that potentially create challenges in linkage to appropriate treatment and housing. And, as noted in the previous section, over 90% of those presenting to AIC engage in some level of substance use. This means that almost half of those with substance use related issues additionally have mental health concerns. The dual diagnosis of substance use disorder and behavioral health disorder can disqualify access to addiction treatment resources, like recovery housing.

COMMMUNITY ENGAGEMENT AND OUTREACH

To ensure that that Marion County partners and community members understand the purpose, function, and referral mechanism of the AIC, AIC and Sandra Eskenazi Mental Health Center leadership spent much time between December 2020 and November 2021 providing tours, interviews, consultations, team meetings, and a conference presentation. For example, in terms of AIC tours and program presentation, AIC leadership, including Sandra Eskenazi Mental Health Center CEO Dr. Ashley Overley, provided over 60 tours during that twelve month period. Response from the community and partners was very positive and resulted in either new or strengthened relationships with them. The table provides a partial overview of engagement and outreach activities during the aforementioned time period. The table names the group; the count are the number of tours, presentations, etc. provided.

Table 15: AIC Tours December 2020 through November 2021

Tours	Count	Tours	Count
Community members	2	Aspire/Community CMHC tour	1
Behavioral Health Academy	2	IMPD Chiefs	1
NAMI	1	Marion County RAP	1
IMPD	2	Prosecutor's Office	2
IU Police	2	Division of Mental Health and Addiction (Jay Chaudray and Rachel Halleck)	1
Sandra Eskenazi MHC	3	Tours for Opening of AIC	15
Community Corrections	2	Reuben Advisory Board	1
SEND	2	Greater Indianapolis Progress Committee	1
Mayor's Office	4	News Outlets	5+
Hickory Recovery Center	1	Minority Women's Business Group	1
Minority Women's Business Group	1	Behavioral Health Court	1
Behavioral Health Court	1	Eskenazi Health	1
Lt Governor Suzanne Crouch	1		
Central Indiana Community Leadership	1	Office of Public Health and Safety	2
Muncie Mayor's Office, Judges, and City Council	1	Keep Indianapolis Beautiful	1
State Suicide Director Chris Drapeau		Veteran's Administration	2
Turning Point	1	IU Physicians	1

Table 16: Presentations and Outreach December 2020 through November 2021

Presentations	Count	Community Outreach	Count
2021 NAMI Criminal Justice Summit	1	IMPD Roll Calls	All of them (every district; every shift)
INSTEP	1	Community Fair	1
Twin Air Neighborhood Coalition	1	AIC E-Learning Video by Dr. Overley	1

SUCCESSES

One of the greatest successes this past year was the addition of the peer recovery coaches to the AIC. Peer recovery has a strong emerging evidence base which fundamentally relies upon how a person with lived experience can leverage that experience to inspire and facilitate another's own recovery. The relationship between peer recovery coach and client is very unique and not the traditional staff role one would see in social work or medical models. It is the intentional use of self-disclosure and personal insight that undergirds any leverage one has in using their experience as a therapeutic tool. As the majority of individuals who come to the AIC are tentative and non-committal to starting their change process, peer recovery can be a very important intervention that assists and sustains the treatment linkage component of the AIC mandate.

The AIC peers help AIC as a program focus on client-level qualitative data, moderating any myopic focus on self-exiting clients. For every client that leaves prematurely, there is another that is starting their recovery journey. Success stories contextualize the data and speak directly to the impact AIC has made on client lives and recovery. These wonderful stories of recovery speak to the commitment of clients and staff in engaging in conversations that spark healing and forward motion.

From Lindsay, Peer Recovery Coach

I had the opportunity to work with a young woman who come to the AIC. This woman was right from the beginning engaged in groups and one on one appointments. After being here a few days she started to become antsy and came to the conclusion that her best option would be to leave the AIC before placement was put into place. When this client verbalized to me her desire to leave I worked quickly to talk with the resource coordinator who oversees the grant here at AIC. The resource coordinator found that this client would qualify for the grant and as soon as the client was placed on the grant, the team worked quickly to get her into placement same day. This client was able to leave AIC to go to a solid treatment option and knew she would be supported longer term as she has supports here at AIC and is receiving additional support through the COAP grant. When this client left the AIC she was optimistic about her on-going recovery and future.

From Kelly, Peer Recovery Coach

I had the privilege of working with this client, she came in broken and hopeless, she had the "gift of desperation". During her stay here, she opened up, participated in all the groups offered, and was a joy for me to watch her grow in this short time at the AIC. This client was transitioned into the Dove house, and has since now joined a home group, has a sponsor, and I get the privilege of watching her continue of her new journey.

From Michelle, Peer Recovery Coach

I have a client that started to take a lot of pain pills in 1994, eventually lived on the streets for 15 years & went to prison 6 times for a total of 5 ½ years. Client continued her substance abuse through these times and eventually began using heroin. . . longed for a fresh start and a new life, so she moved to Indianapolis in April of 2021. . . within 2 days was robbed of everything she owned but her clothes. Her medications were gone. . . Client felt she was at a rock bottom, empty, scared, terrified to go back to street living, upset, angry, violated, vulnerable, and alone. . .Crisis Intervention Unit at Eskenazi referred her to the AIC. . . The AIC provided her with a safe housing, she was able to start addressing her mental and physical health, learned coping skills, and client really appreciated not having to worry about someone hurting her on the streets. The AIC Resource Coordinators were able to place client at Hickory Treatment Center. . . It was at Hickory where client felt a fire for recovery was gifted to her and she was taught that she can be somebody just as she is without drugs and prostitution. . . When client left Hickory, she got another referral to come back to the AIC on June 7th so she could stay safe, and sober until her bed opened at The Amethyst House. Client shared "I have a pure and wonderful soul inside of me that makes me want to be generous and excited about everything in my life."

Resource Coordinators are the backbone of treatment/resource linkage. They have relationships with a multitude of treatment providers and recovery homes and can often place people quickly. Below is their report of one of the scenarios for which they always take great pride.

From Debra and Cindy, Resource Coordinators:

Worked with a Female client who was admitted to AIC at 8am and quickly worked to link to placement. Individual left for placement by noon the same day. This is not an uncommon success story.

CHALLENGES

Programmatic challenges encountered this year:

Mental Health Care

- Inability or slowness of linking clients with mental illness to Community Mental Health Centers
- Dearth of residential housing for clients with mental illness at Community Mental Health Centers
- Mental health prescriber schedules are full resulting in lengthy delays in evaluation for need for psychotropic medications

Substance Use Disorder Treatment

- Inability or slowness of linking addiction clients to Community Mental Health Centers
- Recovery homes sometimes will not accept a dually-diagnosed client (e.g., someone with opioid use disorder and schizophrenia)
- Some treatment centers will not accept an individual unless they've been stabilized on medication for 30-days (which can be a problem as 1) the challenges of getting a client in with a psychiatric prescriber, 2) obtaining the prescribed psychotropic medications, and 3) being able to stabilize them at AIC which is not a medical or psychiatric facility)

Medical and other Physical Health Issues

- As AIC is not a medical facility, clients referred to the AIC need to be medically stable (within parameters of withdrawal management protocols), able to transfer themselves, and ambulatory (or able to transport self). There have been occasions when individuals were referred to AIC that upon arrival it was apparent they required a higher level of medical care.
- Some individuals who have issues/problems in the community have been referred with issues that go beyond behavioral health or substance use. An example would be someone who is demonstrating early signs of dementia and may require specialized treatment settings.

Self-Exit

- There are times when referrers may not have adequately described the purpose of the AIC, resulting in the client choosing to exit AIC as soon as they have arrived (for example, someone who is only looking for housing and desires no substance use or behavioral health treatment linkage)
- Because of the time it sometimes takes for clients to be linked to treatment sources, they may leave early (often times resulting in a re-referral at another date)

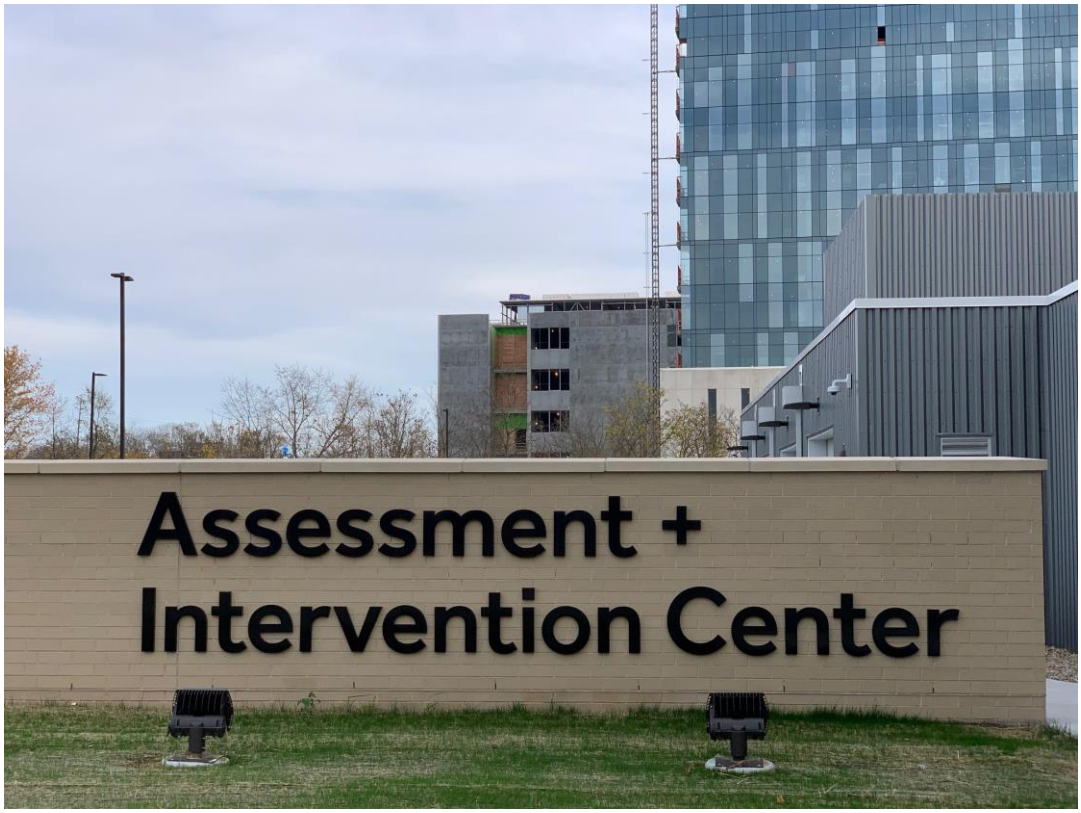
Housing

- AIC is not solely structured to provide housing only services. This is a misperception by some providers/referral sources in the community and can result in confusion when a client is referred. Often, when the client is told that our focus on linkage to treatment, the client will leave if treatment is not of importance to them at that time.

Client Insurance, Income, and Residency

- If the client does not have insurance or the appropriate insurance, this can limit available treatment options. This is when resource coordination looks for providers with sliding scales, pro bono services, or the internal or external grants that can help facilitate treatment.
- Lack of income can be a barrier to acquiring meds, housing, and other necessary resources for integration into the community. As previously stated, resource coordination works hard to identify community resources that can help fund these needs, but often this search requires more time dedicated to it and the ability to be mobile in the community. Resource coordinator staffing is not adequate to address all the case management needs that a client might have, which is why it is imperative clients are linked to external resources like community mental health centers who can assist the client in these areas.
- An additional challenge is when a client relocates to Indiana from out of state and has to get birth certificate, identification, insurance, etc. As previously stated, given the work involved in linking clients to treatment, the additional work required to match individuals with the additional resources they need lengthens the client's stay, complicates disposition, and stretches the bandwidth of resource coordination.

PHOTOS


Assessment +
Intervention Center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Ritter


ONE DAY AT A TIME!


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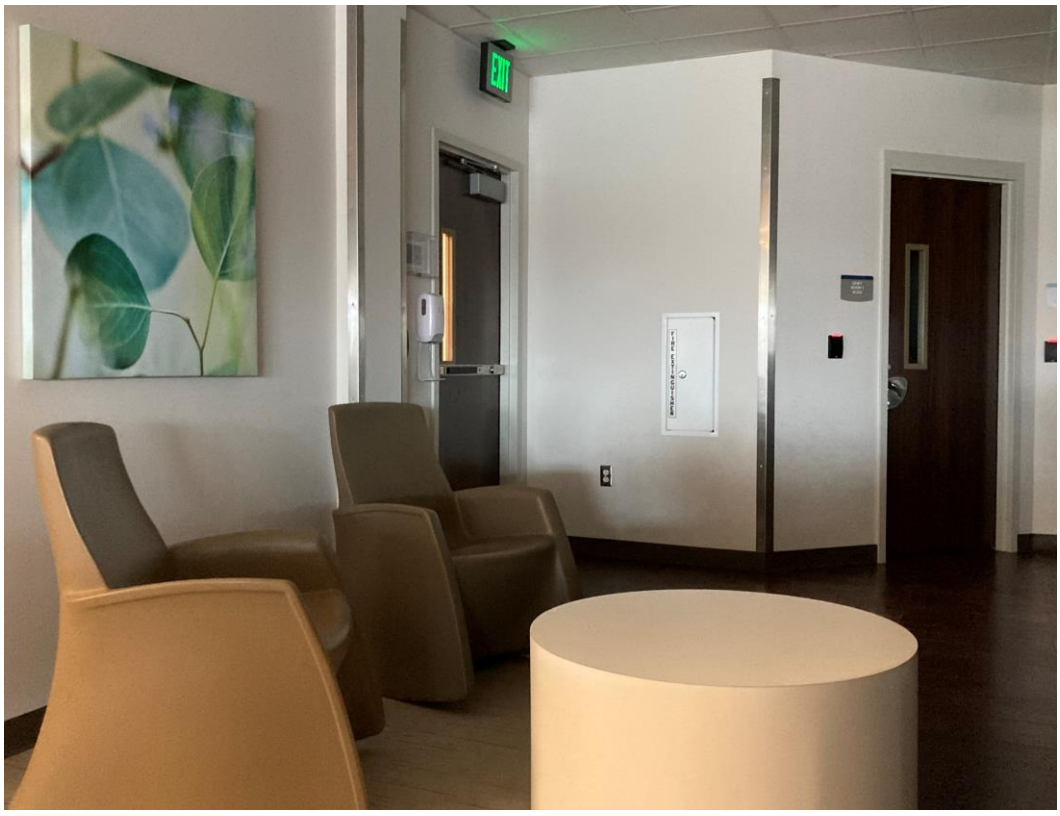
EXIT


RECOVERY
ROAD TO