

Kalamazoo County



Community Health
Needs Assessment
for **Behavioral
Health and
Developmental
Disabilities**

2021

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Feedback on this report and its content is welcome. Please send comments, questions, and requests for additional data to: agalick@iskzoo.org

LETTER FROM THE CEO

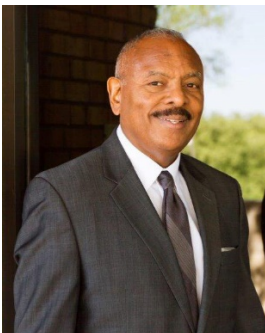
On behalf of Integrated Services of Kalamazoo, I am excited to announce the 2021 Community Health Needs Assessment for Behavioral Health and Developmental Disabilities. Residents and community leaders in Kalamazoo County are increasingly recognizing the central importance that mental health and behavioral health hold for the overall health of our community. This year, ISK is releasing our most comprehensive CHNA to date, which I am confident will provide a strong foundation for deeper understanding, collaborative action, and greater empowerment across the Kalamazoo community as we work together to better meet all of our health needs.

This achievement would not have been possible without the generous participation of many community stakeholders. I want to first thank the over two hundred and fifty respondents who shared their experiences and perspectives on the local behavioral health and developmental disabilities care system through ISK's community survey. Community members shared many honest and heartfelt accounts of trauma, seeking care, providing care, and struggling with unmet needs, and this wealth of diverse community wisdom truly formed the foundation for a responsive and relevant CHNA. I would like to further acknowledge the dozens of ISK staff who participated in ISK's internal CHNA focus groups, offering their time and subject-matter expertise to bring rich context and deeper understanding to each facet of the community's needs. Finally, I want to thank the ISK CHNA steering team, named below, for organizing and leading this effort:

CHNA Steering Team Members:

- Amy Galick, CHNA coordinator
- Carlos Brown
- Tracey Culpepper
- Sheila Hibbs
- Dusty Jepkema
- Chris Klinske
- Jackie Mitchell

This CHNA will be a valuable tool for ISK as we work to fulfill our mission, as well as for anyone hoping to improve behavioral health or developmental disabilities care locally. I look forward to collaborating with partners across Kalamazoo to turn these findings into positive action for our community.



A handwritten signature in black ink that reads "Jeff Patton".

Jeff Patton
CEO, Integrated Services of Kalamazoo

Introduction

“Behavioral health” is an umbrella term that refers to mental illness along with substance use disorders. In Michigan, the publicly funded behavioral health system is also responsible for providing services to individuals with developmental disabilities and is managed by the state’s Behavioral Health and Developmental Disabilities Administration (BHDDA). **Integrated Services of Kalamazoo** is the local governmental entity managing these services for Kalamazoo County, so this Needs Assessment focuses on these three areas that fall within ISK’s authority:

- Mental illness
- Substance use disorders
- Intellectual and developmental disabilities

Mental health is defined as a state of emotional, psychological, and social well-being in which an individual is able to realize their full potential, cope with the normal stresses of life, and contribute to their community. Mental health conditions are very common – about 20% of American adults experience some diagnosable mental health issue in any given year, and about 5% of people live with a serious mental illness, such as schizophrenia, bipolar disorder, or major depression. There are many factors that contribute to mental illness and mental health conditions, including biological factors such as genes or brain chemistry, and social factors such as experiencing trauma or abuse.¹

Substance use disorders (SUD) are complex conditions affecting a person’s brain and behavior. When a SUD is present, there is uncontrolled use of a substance such legal or illegal drugs, alcohol, or medications, despite harmful consequences like health issues or problems meeting daily responsibilities. An estimated 8% of all American adults experience a SUD each year, and about half of that population also experience a co-occurring mental illness.² Similarly to other mental health issues, substance use disorders can be caused by biological or genetic factors in combination with social or environmental factors.

Developmental disabilities are conditions that cause an impairment in physical, learning, language, or behavior areas, which are present at birth or begin during the developmental period. Common developmental disabilities include intellectual disabilities, learning disabilities, cerebral palsy, autism spectrum disorder, and Down syndrome. Developmental disabilities may impact day-to-day functioning, and often last throughout a person’s lifetime. About 17% of children age 3 through 17 have one or more developmental disabilities³, and it’s estimated that around 1% of adults have an intellectual or developmental disability that continues to cause specific limitations.⁴


With evidence-based treatments, services, and community support systems, people with a mental illness or a substance use disorder can get better, and many recover completely. People with intellectual and developmental disabilities can live active, meaningful lives and be fully included in their community.

This Community Health Needs Assessment will be a primary resource to help inform ISK strategic planning, program development, and system improvement. It is also intended to serve as a resource for other community organizations and individuals working to improve behavioral health or developmental disabilities services in Kalamazoo County.

About the system

In Michigan, the Behavioral Health and Developmental Disabilities Administration manages the provision of services for mental illness, substance use disorders, and developmental disabilities, by way of local, county-based entities called Community Mental Health Services Programs (CMHSPs). Integrated Services of Kalamazoo is the CMHSP responsible for administering these services within Kalamazoo County. ISK provides services directly and also maintains contract partnerships with other public and private health care providers.

The CMHSP system, including ISK, is operated based on the philosophy of Person-Centered Planning (PCP). Person-centered planning means that the individual who is receiving services sets their own goals that they want to achieve from treatment, and they take an active role in collaborating with the clinical treatment team to develop a treatment plan



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that will support accomplishing those goals. Services are provided in a way that supports individuals' full integration in and access to the broader community, including seeking employment and working, engaging in community life, independently managing personal resources, and enjoying other community benefits with the same degree of access as any individuals not receiving CMHSP services.⁵

Integrated Services of Kalamazoo provides a comprehensive range of services and supports, including outpatient therapy, case management, supports coordination, community living support, psychiatric services, home-based services, housing support, and 24-hour emergency and crisis response services. Beginning in late 2021, ISK will become a federally endorsed Certified Community Behavioral Health Center (CCBHC), and will now be able to offer mental health and substance use services to anyone in Kalamazoo County regardless of insurance coverage or ability to pay.

Outside of providing services to individuals, ISK also conducts and participates in other community efforts related to behavioral health and developmental disabilities. We are a leading partner for SPAN, the local Suicide Prevention Action Network⁶ which raises awareness, provides community training and education opportunities, and spearheads strategic planning and system change to reduce suicide in Kalamazoo County. We offer free Mental Health First Aid training throughout the county,⁷ which teaches community members the key skills for appropriately responding to signs of mental illness, including strategies to help someone in crisis and where to turn for help. ISK is the sponsoring partner for Kalamazoo WRAPS, a coalition of organizations and community members working to transform the way services and supports for youth are developed and provided in our local system of care.⁸ We are home to the Kalamazoo County Veteran Navigator program,⁹ which assists service members, veterans, and their families to identify and access resources related to mental health, housing, medical, education, employment, and veteran benefits. Beyond this, we also have a number of informal and semi-formal relationships and partnerships with other human service organizations in the area, collaborating to support community members in a variety of settings.

EXECUTIVE SUMMARY

Background

This Community Health Needs Assessment from Integrated Services of Kalamazoo (ISK) is our attempt to thoroughly analyze and illuminate the landscape of our community's needs related to behavioral health and intellectual/developmental disabilities, as well as barriers that make it difficult to meet those needs. The CHNA and this report are designed to supplement, not take the place of, other local CHNAs which have a broader scope covering all types of health. Because other local CHNAs frequently name mental health and/or substance use as a top area of concern^a, we believe a CHNA that focuses in more detail on these specific areas may be a valuable community resource.

Community input and analysis for this CHNA took place in four phases. First, an online Community Needs Survey gathered written comments from a broad cross-section of about 250 individual stakeholders, including behavioral health and developmental disability service professionals, recipients of services, family members and advocates, other human service professionals, and the general public. Second, a series of fifteen ISK staff workgroups met to discuss fifteen different themes that emerged from a qualitative analysis of the survey responses. These workgroups discussed the body of relevant responses, supplemented the survey data with more background and context, and worked towards a consensus view of the most important community needs related to each theme. Third, alongside the theme-specific workgroups, a cross-disciplinary CHNA workgroup reviewed secondary data sources and conducted primary data analysis to supplement the qualitative data from the survey. Finally, ISK senior leadership reviewed a brief summarized overview of findings, and voted to determine the top "strategic directions" that are recommended as actionable priorities to come out of the CHNA.

Building on the leadership of community partners who have greatly advanced Kalamazoo organizations' capacity to center equity concepts in discussions of health care and unmet health needs, ISK endeavored to conduct this CHNA from a foundational **equity framework**. This included conducting the CHNA process itself in an equity-focused manner, with the understanding that this makes it more likely that the outcome of the process will be just and equitable. It also means that the results and findings are presented with an emphasis on systems thinking and root-cause analysis, and the acknowledgement of systemic oppression itself as an important "root cause" that has significant consequences reverberating throughout the community, including in health care systems and in community members' experiences with health.

^a Bronson CHNA for Kalamazoo County, 2016: "Mental health treatment and support"

www.bronsonhealth.com/app/files/public/2302/BMH-Community-Health-Needs-Assessment-Report.pdf;

Ascension Borgess CHNA for Kalamazoo County, 2019: "Mental health assistance and access"

healthcare.ascension.org/-/media/Healthcare/Compliance-Documents/Michigan/2019-Ascension-Borgess-CHNA-Report.pdf;

Bronson CHNA for Kalamazoo County, 2019: "Mental health and substance abuse – Access to services, Experiences of stress and trauma" www.bronsonhealth.com/app/files/public/8108/chna-kalamazoo-county-2019-final.pdf;

Kalamazoo County 2017 Maternal and Child Health Needs Assessment: "Child/adolescent mental health" www.kalcounty.com/hcs/datahub/files/news/2017%20MCH%20Assessment%20Final%20Report%201.9.pdf;

Kalamazoo County Older Adults 2020 Needs Assessment: "Geriatric-focused behavioral health services" https://www.kalcounty.com/hcs/aaa/pdf_files/AAA%20Community%20Needs%20Assessment%202020.pdf

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Unmet need

There is a growing awareness of the mental health impacts of the ongoing coronavirus pandemic, as communities across the world grapple not just with the virus itself and the millions of serious illnesses and fatalities, but also isolation, job loss, economic upheaval, and fear. New research is continuing to uncover the extent and severity of these emerging mental health risks, from a surge in the presence of anxiety and depression symptoms¹⁰ to an estimated 10% to 60% increase in so-called “deaths of despair”¹¹, a term referring to deaths by suicide, alcohol and drug use, or overdose. Unfortunately, these increasing mental health and behavioral health needs are adding pressure to a behavioral health care system that was already stretched to the breaking point for a long time before the pandemic.

The pre-covid landscape was already one where large numbers of Americans were experiencing mental illness, substance addiction, trauma, or emotional distress, but where a majority of individuals with diagnosable conditions were not receiving *any* care at all for those conditions. Recent estimates from 2019 were that among all adults, about 21% experienced any mental illness and 5% had a serious mental illness during the year — and of all these people with a mental illness, only 45.5% received any mental health care at all. Thus, about a 55% majority of people with mental illnesses went completely untreated. Among youth, about 16% reported having a major depressive episode during the year, and again, less than half of these youth (43%) received any depression care. Substance addictions that are serious enough to qualify as a substance use disorder (SUD) are also fairly common: 7.4% of all people age 12 and older had a diagnosable SUD in 2019, including nearly 15% of young adults aged 18–25. With only about 21% of these individuals with an SUD receiving any substance use treatment, a staggering nearly 80% majority lived with their substance use disorder going completely untreated.^{2,12}

Comprehensive data that is specific to Kalamazoo is not available, but extrapolating national and regional prevalence estimates^{2,13–15} to our local population can offer a rough approximation of the likely sizes of relevant populations within Kalamazoo County:

- At least **40,000** adults with any mental illness
- About **10,000** adults with a serious mental illness
- Over **10,000** youth under age 18 with mental, emotional, developmental or behavioral problems
- Over **15,000** adults and nearly **1,000** youth with a substance use disorder
- About **9,500** adults and **2,500** youth who seriously consider suicide each year
- About **1,000** adults and **1,000** youth who experience an actual suicide attempt each year
- Up to **2,000** adults with an intellectual/developmental disability, many of whom have co-occurring behavioral health needs

It is also safe to assume that in Kalamazoo County, as in most other locations around the country, the majority of individuals with behavioral health conditions are likely not receiving any behavioral health treatment at all.

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When people cannot access behavioral health care that they need, difficulties often worsen over time and sometimes devolve into a serious behavioral health crisis. Because Kalamazoo County has large numbers of people living with mental health or substance use concerns, and the majority of them lack access to adequate treatment, crisis situations are all too common. Such crisis situations can cause enormous trauma and disruption for the individual and their family or community, and providing effective treatment can also become even more difficult once a behavioral health need has progressed into becoming a crisis. Local data shows that behavioral health–related crises in Kalamazoo County are frequent and widespread:

- ISK and our provider network make about **200 crisis contacts per week**, a total of over 10,000 contacts per year
- Medicaid covered over **12,000 days of hospitalization** related to behavioral health in Kalamazoo County in 2020, which constituted at least 15% of all Medicaid-paid hospitalization days¹⁶
- In 2020, County Dispatch handled over **fifteen thousand 911 calls** that had mental illness or substance use as a contributing factor, making up approximately 10% of all 911 calls received^{17,18}

This ongoing surge of crisis situations presents a significant challenge to a behavioral health system that is already overwhelmed. When the demand for routine behavioral health care as well as the level of crisis needs exceeds the capacity of the behavioral health system so greatly, the unfortunate result is that addressing these needs falls to other, non-behavioral health focused service systems such as schools, homeless shelters and housing services, and the criminal justice system. In fact, the criminal justice system acts as the behavioral health provider of last resort to such a degree in America that some authors have dubbed jails and prisons “the new asylums.”¹⁹ This model is, of course, very harmful to individuals with behavioral health needs, but it also puts unreasonable expectations on other human service professionals, who do not have appropriate training and are not well equipped to handle psychiatric or emotional crises.

Homeless shelters and housing services are another sector that frequently ends up taking responsibility for significant behavioral health care needs in the absence of adequate coverage by the behavioral health system, and homelessness deserves special mention when discussing unmet behavioral health needs. Among all of the adults with mental illness served by ISK, a staggering 22% reported one or more episodes of homelessness in a year-long time frame, representing over 1000 individuals. The difficulty of accessing care, widespread stigma and criminalization against behavioral health conditions, and a lack of affordable housing and specialized supportive housing options all contribute to the community crisis of homelessness among individuals with mental illness or substance use disorders.

“We are still trying to invent our community mental health system forty years after de-institutionalization. Hundreds of people with mental health challenges are left to fend for themselves on our streets. We have to name this — and call it the failure that it is. Our police departments, the Kalamazoo Gospel Mission and Ministry With Community should not be covering as much need and picking up as much load as they are.

—A housing services professional

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Racism and poverty and their impacts

ISK forms part of the social safety-net system, and the vast majority (about 98%) of individuals we serve are either Medicaid recipients, qualifying due to poverty and/or disability, or uninsured. Meanwhile, in the general population, adults living below the poverty line are nearly twice as likely to have a serious mental illness, and nearly twice as likely to experience serious thoughts of suicide.²⁰ Because of the deep connection between poverty and behavioral health conditions or disabilities, **a clear analysis of poverty is absolutely essential** for understanding the needs of these service populations.

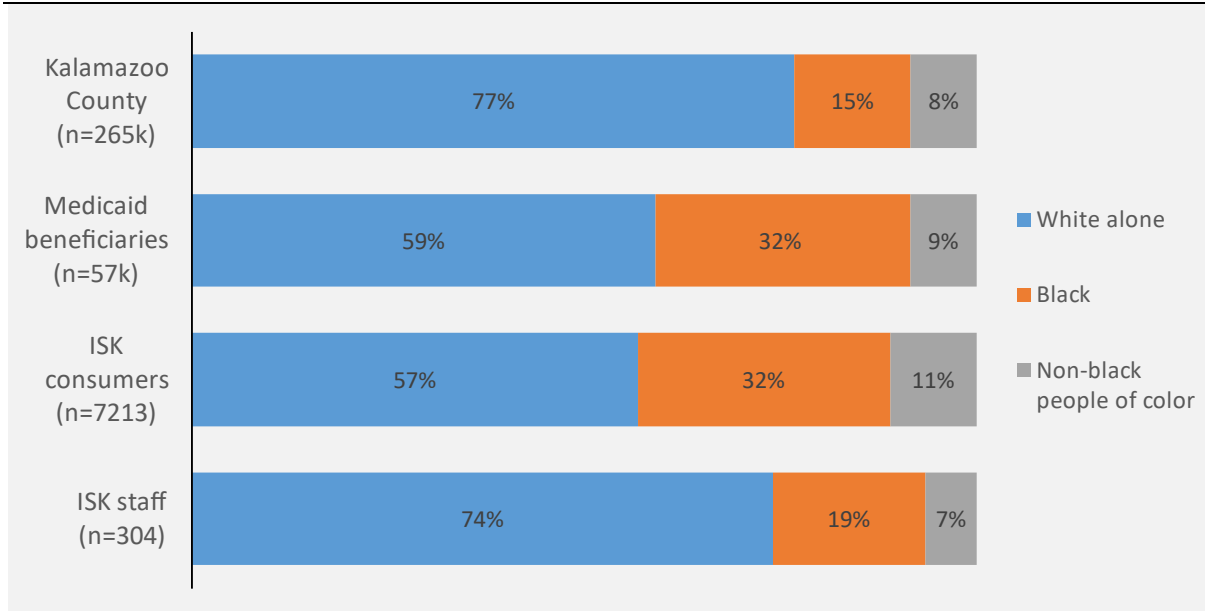
Kalamazoo County is home to approximately 35,000 individuals who are below the poverty line (about 13% of the total population), including about 17,000 individuals living in so-called “deep poverty” — below 50% of the federal poverty level.²¹ Living in poverty generally constitutes a **traumatic experience** that causes mental and emotional distress and can lead to the development of mental illness, including severe mental illnesses and substance use disorders. The end result is that individuals living in poverty are more likely to need some type of behavioral health care, and because they are living in poverty, they are also likely to rely on safety-net providers such as ISK.

It is also important to understand that **poverty is highly racialized**. While 12% of white residents in Kalamazoo County live below the poverty line, the rate is 17% for Native American residents, 21% for Hispanic/Latino residents, and 29% for Black residents.²² There is also a geographical concentration of poverty within the City of Kalamazoo, which largely came into existence in conjunction with the racial disparity — both of these phenomena are outcomes of generations of racist and segregationist policies and practices that expropriated resources from communities of color while at the same time limiting people of color’s access to residential areas. One well-known example of such a policy was residential redlining, a federal policy which severely limited the ability of Black people to obtain mortgage loans and build wealth through homeownership, while also effectively segregating neighborhoods by race.

An important consequence of this connection between behavioral health needs, poverty, and race, which was mentioned frequently by stakeholders participating in this Needs Assessment, is the demographic mismatch that is present between providers of behavioral health care and those seeking treatment. Using ISK as an example, our staff population closely matches the racial diversity of Kalamazoo County overall, which by itself seems appropriate and would not be assumed to be a cause of inequity. However, because of the racialized nature of poverty, the local population of Medicaid recipients has a much higher proportion of people of color (especially Black people) than the County overall. This naturally carries through to the ISK service population as they are overwhelmingly Medicaid recipients. The result is that even in the presence of apparently equitable hiring practices, there is a dramatic difference between the racial profiles of ISK staff and ISK consumer populations: while staff are about 26% people of color, consumers of services are a much greater 43% people of color. (See figure next page)

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Figure 1: Demographic comparison of populations, 2020



This demographic reality creates a systemic inequity, where consumers of color are less likely to be able to find a mental health provider who shares their cultural background. A number of respondents named this inequity as a significant barrier to receiving effective treatment, for example:

“When working with providers who do not have a historically marginalized identity, I have found that I spent more time explaining my experience as a person of color than receiving actual care.
—A consumer of behavioral health services

In summary, poverty itself creates trauma and adverse experiences that can often cause or exacerbate mental or behavioral health problems. The trauma of poverty is a significant driver of mental health needs generally, and it affects nearly all ISK consumers. For people of color there are further impacts: first, due to longstanding institutional racism they are much more likely to experience poverty in the first place; then, racial trauma along with the trauma of poverty can cause or exacerbate mental health struggles; finally, those who seek treatment often must navigate cultural and/or language barriers while they are trying to receive care, since such a large majority of providers are white.

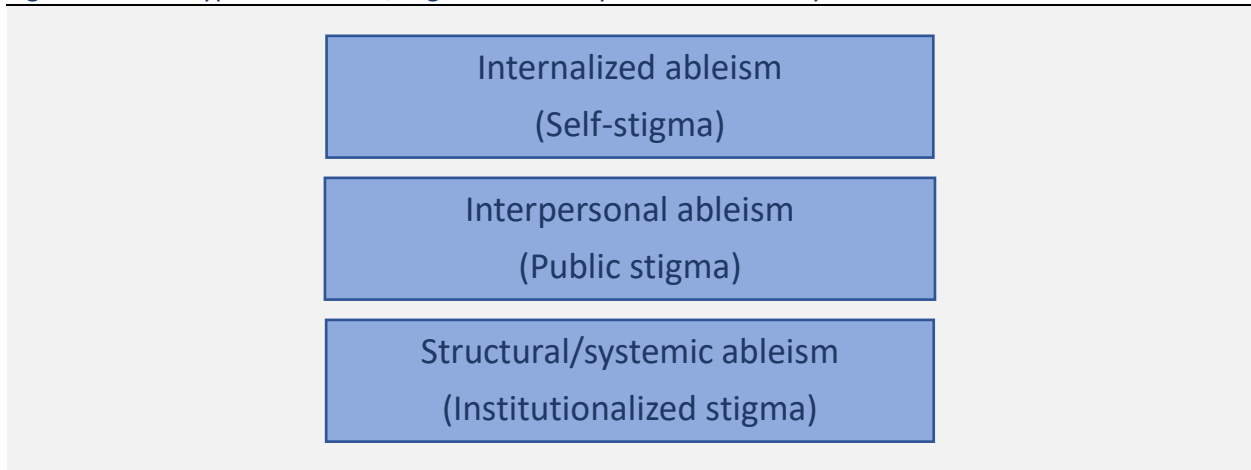
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Ableism and stigma and their impacts

Ableism is a second system of oppression that plays a foundational role in communities not meeting most of the needs of individuals with mental illness, substance use disorders, or intellectual/developmental disabilities. Ableism, simply defined, is discrimination or social prejudice against people with disabilities based on the belief that typical abilities, or people who have typical abilities, are superior.²³ All types of disability can be the target of ableist responses, including physical disabilities, sensory disabilities, chronic illnesses, cognitive disabilities, and psychiatric disabilities or mental illnesses. For the individuals served by ISK, common forms of ableism include stigma against mental illnesses, criminalization of substance use disorders, and exclusion or devaluing of people with intellectual/developmental disabilities.

The American Psychiatric Association identifies three types of stigma that affect people with mental health conditions. Ableism and stigma are often enacted at an individual level, but similarly to racism and other systems of oppression, ableism can also take the form of ableist beliefs and priorities that are embedded into institutions and social systems – i.e., *systemic ableism* or *structural ableism*.

Figure 2: Three types of ableism/stigma defined by the American Psychiatric Association²⁴



Interpersonal ableism has many detrimental effects. Much of American society holds negative beliefs about disabilities, such as that people with mental illness are dangerous or unreliable, that people with intellectual/developmental disabilities are incompetent, or that people with substance use disorders have chosen to be addicted — all beliefs that are incorrect as well as harmful. When family and friends hold such attitudes, an individual with these conditions may become socially isolated and lose important social supports that were necessary to their well-being. When negative beliefs like these are held by employers, landlords, health care providers, public safety officials, and other individuals in a position of power, people with disabilities and behavioral health conditions can end up being treated in a traumatizing or disparaging way, and can even be denied access to essential resources just based on their disability.

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While less commonly recognized than interpersonal ableism, **systemic ableism or structural ableism** causes some of the most far-reaching and damaging impacts. One notable way that systemic ableism is expressed is through funding. Mental health–related concerns account for about 15% of the total disease burden in the United States, but research is underfunded, with only 10% of funds at the National Institutes of Health (NIH) earmarked for behavioral health, and service provision is dramatically underfunded, with a measly 5% of national health care spending going towards behavioral health.^{25–27}

This **pervasive, systemic underfunding** is not always recognized specifically as an expression of ableism, but doing so is accurate. Funding structures are formed via law and policy, and many of these policies (past and current) were developed from a point of view that devalues people with disabilities, including mental illnesses or intellectual/developmental disabilities. Funding choices have been based on an ableist attitude that equal resources do not need to be spent on disabled individuals and the treatment they need, because it is assumed that their lives have lesser value. The underfunding of the system is thus a prime example of systemic ableism.

The lack of resources in the system impacts all facets of behavioral health and intellectual/developmental disabilities care. Some significant consequences of lacking adequate funding include:

- Due to generations of underspending on research, there are many types of behavioral health need that do not have evidence-based practices (EBPs) available to address them.
- As legislators and administrators try to stretch a totally inadequate pool of resources to meet all needs, the system suffers from overcomplexity and constant structure changes. This presents a significant barrier to accessing care, as people who want treatment are often stymied by the overwhelming task of simply navigating the system.
- Behavioral health careers are underfunded, which means salaries are low for all kinds of jobs within the system. This includes staff providing personal care services in residential settings, who often earn not much above minimum wage; clinical social workers, who have a median salary below the national median for all jobs, despite needing a master’s degree to enter the field; and psychiatry, which is one of the least well-paid medical specialties.^{28–31}

The unattractive salary landscape is one of the main causes of a pervasive unmet need, which is the fact that **there are simply not enough workers overall**. The negative impacts of this workforce shortage on individuals needing care and treatment can hardly be overstated. People who need services often struggle to even find a provider who has openings to see them; this barrier to access can be another reason that individuals go without any treatment until their difficulties become a crisis. Having too few staff also directly contributes to high caseloads, which has implications for the quality of service, and also increases the risk of compassion fatigue and burnout for the providers themselves.

For decades, this shortage of professionals has been recognized as one of the most difficult constraints in behavioral health care systems across the country. Because the need is so longstanding, having too few workers in the sector may sometimes appear to be a natural state of affairs — but the truth is that such shortages are greatly driven by low pay levels, and that underfunding these systems of care and these careers so severely is a collective choice that has been made, one that is rooted in ableism.

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Prioritized strategic directions

The final phase of the CHNA attempted to discover what strategies are most promising for ISK and the behavioral health system as a whole to better meet the community's needs, in the face of overwhelming systemic problems. ISK leadership considered seven possible "strategic directions" that were compiled based on stakeholder feedback, ranging from externally-focused strategies (like advocacy towards higher-up entities for systems change) to fully internal strategies (internal process improvement). To select the top most promising strategies, the leadership team rated each of the seven possibilities on three domains:

- What is the *importance* of this strategy? How many people would be affected, and how dramatic would the impacts be?
- What are the *equity/inequity* implications of the strategy?
- What is the *feasibility* of the strategy? To what degree can ISK realistically have an effect?

When the overall combined ratings were tallied, the strategy that emerged as the clear first choice for prioritization was **workforce development and hiring**. This strategy can be implemented both externally and internally to ISK, and is also an excellent area of opportunity for other community partners who wish to take action to support behavioral health care needs.

The two needs that this strategy would primarily address are (1) not having enough workers overall, and (2) the available workforce not matching the demographics of the consumer population. There are many potential approaches to shoring up the behavioral health and disability care workforce; as ISK explores specific actions we could take, we may take inspiration from a four-pillar workforce development framework that researchers from the University of Michigan³² recently proposed to help the health care sector respond to staff shortages exacerbated by the COVID-19 pandemic. Their four proposed pillars are:

- *Production*: Efforts that influence individuals choosing to enter a health career in the first place
- *Distribution*: The way that an available workforce is matched to populations needing service
- *Maximization*: Finding efficiencies that can be gained within a workforce already in place
- *Resilience*: Supporting and protecting the workforce in an ongoing fashion

The second strategic direction that ISK leadership prioritized highly was **internal process improvement**. This is a recognition that while we are significantly constrained by regulatory requirements and financial limitations, we do have some degree of administrative choice over the way we do business and that ISK can make a noticeable difference for the community depending on different organizational decisions we may take. Our agency serves a large number of individuals and influences the employment of a large number of professionals, so the impact of our administrative choices should not be underestimated. It is also important to value the *feasibility* of internal process improvement as a strategy. Some externally-focused strategies have significant barriers to progress, while focusing on ISK's own internal operations is much more within our locus of control and still has the potential to result in concrete improvements to the system and tangible value.

CHNA methodology

The 2021 Community Health Needs Assessment was a collaborative, multiphase organizational learning process that involved staff across all departments and at all levels of Integrated Services of Kalamazoo, as well as significant input from stakeholders outside the agency.

First, ISK conducted a Community Needs Survey with targeted respondents including ISK staff, other behavioral health and developmental disabilities service providers, other health and human services professionals, service consumers, families and advocates, as well as the general public. The survey asked for participants' perspectives on the most significant community needs related to behavioral health or developmental disabilities, as well as (where applicable) their own experience with the system. Due to the COVID-19 pandemic all responses were collected online, and the survey was available to respondents in English and Spanish.

All survey questions were open-ended, so the analysis of this data was qualitative in nature. Specifically, all survey responses were stored to a database and coded for mentions of specific themes, and the most common themes were then identified. For each theme, a workgroup made up of ISK staff with subject-matter expertise was convened to discuss the body of relevant responses, supplement the survey data with more background and context, and work towards a consensus view of the most important community needs related to the specific theme. These workgroup sessions were recorded and the main findings were summarized for communication outside the group.

Alongside this, a cross-disciplinary CHNA steering team of seven ISK staff members reviewed secondary data from reports and publications of various local healthcare organizations and other entities, with the goal that our CHNA for Behavioral Health and Developmental Disabilities would build on the wealth of existing community knowledge instead of starting from scratch. Where there were gaps in available secondary data for a theme or need that was identified as important, the steering team recommended and/or conducted primary data analysis to try to fill in these gaps.

Finally, ISK leadership reviewed a summary of the findings in order to recommend the top strategies that the system should prioritize at this time for responding to unmet needs. These are outlined and discussed in this report's section titled "Priority areas."

A core priority in planning the CHNA was to undergird this learning with a foundational **equity framework**. We endeavored to conduct the CHNA process itself in an equity-focused manner, with the understanding that this makes it more likely that results and outcomes of the process will be just and equitable. An equity focus was embedded in the process in the following ways: (1) Outreach for the community survey, to get as much input as possible from historically disadvantaged/disconnected populations; (2) Survey questions specifically asking the respondents to share their perspectives with respect to equity, inequity, or unfairness in the system; (3) Each staff workgroup including participants from multiple racial backgrounds; (4) Focus questions used in all ISK staff workgroups asking the participants to discuss the workgroup's theme from an equity/inequity angle; (5) Considering equity/inequity as a main factor to determine priority areas (in combination with impact and feasibility).

Local needs

There has not been any thorough research into the extent specifically within Kalamazoo County of mental health conditions, substance use disorders, or intellectual/developmental disabilities. However, by extrapolating national and regional prevalence estimates, we can obtain an approximate idea of how many residents in our local community might be experiencing these conditions.

Kalamazoo County is home to 265,066 individuals, of which 208,054 are adults. Given the accepted national and regional prevalence estimate of 20%, we can assume there are at least 40,000 adults residing in Kalamazoo County who will experience some type of mental illness in a year-long timeframe. This includes about 17,000 adults experiencing a depressive episode, about 9,500 having serious thoughts of suicide, and over 1,000 actually attempting suicide in a year. The number of adults experiencing a serious mental illness (a mental illness that results in a significant impairment) is likely about 10,000.^{33,34}

Among youth, an estimated 23.1% have one or more reported mental, emotional, developmental or behavioral problems; this equates to over 10,000 children age 3–17 in Kalamazoo County. This estimate includes over 4,000 youth with ADHD or ADD, and about 1,300 with autism spectrum disorder (ASD).^{13,34} Emotional difficulties like depression and anxiety become more common as youth grow older. National youth surveys by the CDC suggest that about 36% of high-school students had an episode of feeling sad or hopeless during the year, which would be about 4,500 youth in Kalamazoo County out of the approximately 12,600 who are high-school aged (from 14 to 17). There are probably between 2,000 and 2,500 high-school aged youth in the county who seriously consider suicide in a year, and nearly 1,000 who make an actual attempt.^{14,34}

The prevalence of a substance use disorder is estimated at 7.6% among adults and 4.0% among youth age 12 to 17, meaning that in any given year about 15,700 adults and over 700 youth could be affected locally in Kalamazoo County. The vast majority of people suffering from a substance use disorder do not receive adequate treatment for it; extrapolating from statewide estimates, there may be about 15,000 Kalamazoo County residents lacking specialized substance use care that they need.^{33,34}



For the population of adults with intellectual or developmental disabilities (IDD), there are unfortunately no comprehensive national research surveys being conducted at this time. This research gap limits our understanding of unmet needs for the population. One barrier is that there is no commonly accepted definition of IDD in adults; the exact meaning may vary depending on the source of the information. The best smaller-scale research studies that are available, and which use a definition for IDD that is comparable to the MDHHS interpretation, have estimated IDD prevalence at between 0.5% and 1.0% of the entire adult population. This would correspond to between about 1,000 and 2,000 adults in Kalamazoo County.^{4,15,34}

Systemic and societal barriers to meeting community needs

Understanding unmet needs, health inequities, and gaps in the system begins with understanding the historical and social context within which these issues arise. The present section outlines some of this context that is necessary background for a deep understanding of behavioral health needs.

This outline is a synthesis of findings from discussions in a number of staff workgroups that each explored one specific area of need. In each workgroup, an informal root-cause analysis was prompted by asking the participants to discuss any historical and social context relevant to the area of need. Followup questions were posed asking what the underlying causes were of each successive layer of explanatory phenomena. Looking across the many different workgroups examining different areas of identified need, there seem to be two phenomena that are **root causes** at the most fundamental level, which act individually and in combination to create the barriers that prevent people's needs from being met in the areas of behavioral health and developmental disability care. These two identified root causes are (1) Racism, social inequity, and poverty; and (2) Ableism and stigma against mental illness, substance use disorders, and intellectual/developmental disabilities.

Below, a brief overview is provided for each of these root-cause phenomena. The third section describes some of the systemic effects of these root causes which are relevant to understanding the behavioral health and developmental disabilities health landscape.

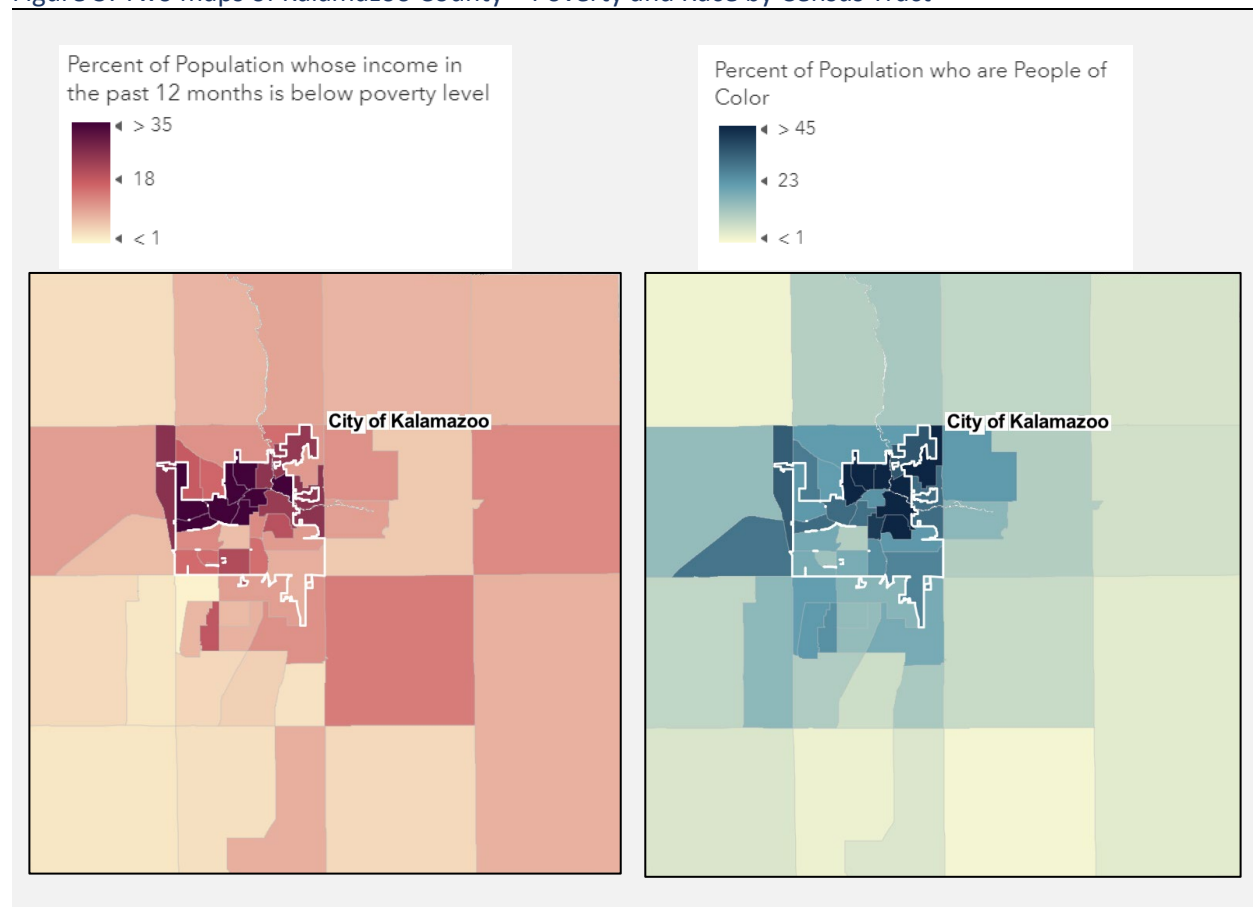
❖ Racism, social inequity, and poverty

Kalamazoo County, like most of the United States, exhibits a high degree of social inequality, with different people experiencing vastly different levels of access to the resources that sustain and enhance life. The estimated poverty rate in Kalamazoo County is 13.4%, representing the percentage of the population with income below the Federal Poverty Level based on a family's size (in 2019, this level was \$13,300 for a single adult or \$26,172 for a family of four).^{21,31} While the poorest 10% of Kalamazoo County households have incomes below \$15,000, the top 10% household income level is over \$150,000, more than ten times greater.³⁵

Again similarly to the rest of the country, this resource inequity tends to correlate with the boundaries of race; poverty is highly racialized. The 5-year estimated poverty rate among non-Hispanic white Kalamazoo County residents is 11.8%, while for Hispanic/Latino residents the poverty rate is a much higher 20.8% and for African-American residents it is a staggering 28.9%.²² Kalamazoo County's poverty is also highly concentrated within the City of Kalamazoo itself; the poverty rate within the City is 28.4%, while outside the City it is only 7.2%. This represents about 21,000 people in poverty within the City of Kalamazoo, and about 13,000 people in poverty elsewhere in the County. At the same time as poverty is concentrated within the City, Kalamazoo County's communities of color also tend to be geographically segregated there: while only 23.6% of white Kalamazoo County residents reside within the City, among people of color the proportion is 45.9%.³⁶

The maps on the next page illustrate this racial segregation and concentration of poverty in the County.

Figure 3: Two maps of Kalamazoo County – Poverty and Race by Census Tract



This segregation is not due to personal choice or individual differences, but is caused by large-scale institutional and policy decisions that did not or do not affect everyone in the same way.

One of the most clear examples of such a policy with unjust effects is the practice of redlining that drove the development of the nationwide housing landscape to a significant extent starting in the 1930s and lasting about 30 years.

The map on the next page is the Residential Security Map for the City of Kalamazoo, produced by the Home Owners Loan Corporation (HOLC) in 1937. The Federal Housing Administration (FHA) commissioned the drawing of these color-coded maps, using various data to assign ratings to different neighborhoods that designated them as a higher or lower “risk” for investment. The green areas were rated “A” and considered the best or safest investments, followed by blue areas (“B” rating). The yellow-shaded areas (“C”) were marginal, and finally the red-lined areas, rated “D”, were determined to be the highest risk and therefore not good areas to invest in.

One of the major criteria for coding an area red (“redlining”) or yellow was the presence of black people and/or immigrants living there, or data that led HOLC to believe they would move there soon.

It was also considered a “favorable influence” that could help an area into the blue or green categories if the neighborhood had racially restrictive covenants in place — formal agreements laid out in property deeds that barred the sale or rental of a home to black people, immigrants, or other groups.

Banks used the A/B/C/D ratings as part of their decisions to make or deny mortgage loans for purchasing real estate. The FHA would not insure loans made in redlined areas; banks also saw the yellow C-rated areas as somewhat risky and were therefore more reluctant to make loans in those neighborhoods.

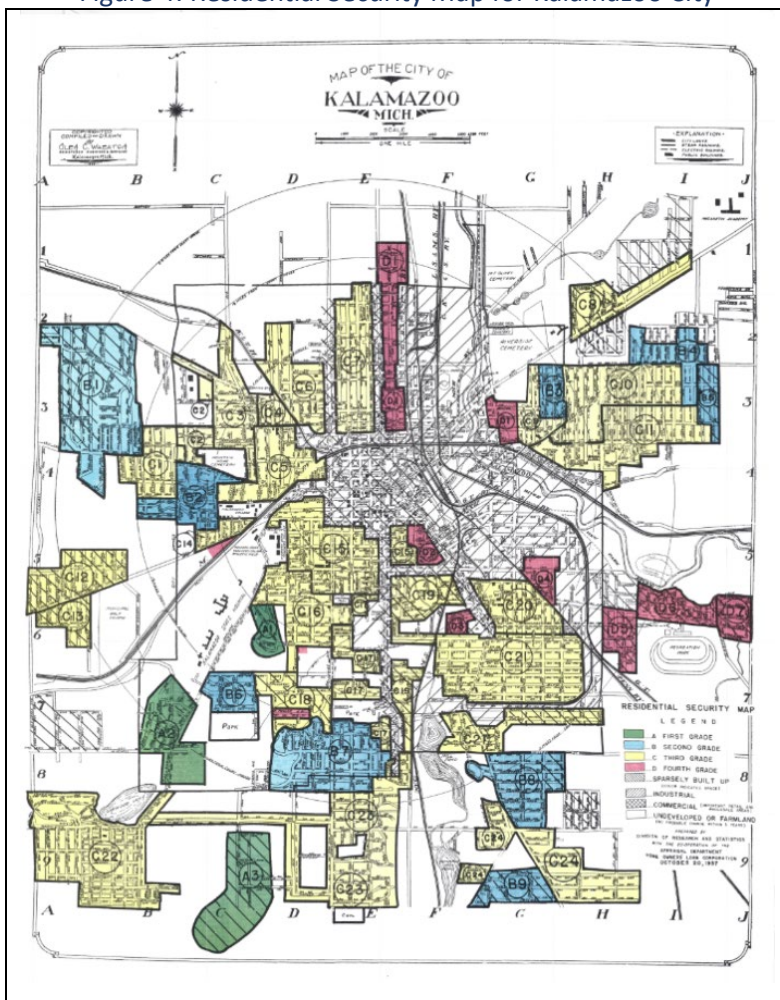
This put homeownership out of reach of many Kalamazoo residents as mortgages were more expensive to take out, or simply unavailable. The lack of access to mortgage funding, combined with racial restrictions in many areas, trapped most black residents into renting within a few “undesirable” areas of the city. Meanwhile, many white residents were able to buy homes and build up wealth that would be passed down through generations.

The effects of this segregationist policy are still apparent today, generations later. The Northside and Edison neighborhoods, two areas with notable redlining in 1937, are still disproportionately populated by people of color and still experience much of Kalamazoo’s concentrated poverty.

Some of the blue and green areas such as Winchell and Milwood neighborhoods are today much wealthier, with high homeownership rates, and predominantly white. Overall, white residents of Kalamazoo have on average much greater wealth and a much higher homeownership rate than black residents, regardless of neighborhood.

As demonstrated in this report as well as other Needs Assessments, there are major health disparities based on geography within Kalamazoo County. In order to build a just and equitable health care system, we need to deeply understand the forces that led to unfairness in the system in the first place. This means continuing to study and analyze historical realities such as redlining, along with present-day policies and forces that are still causing harm today.

Figure 4: Residential Security Map for Kalamazoo City



❖ Ableism, stigma against behavioral health conditions and developmental disabilities

Ableism is defined as a set of beliefs or practices that devalue and discriminate against people with physical, intellectual, or psychiatric disabilities. Ableism is rooted in assumptions that typical abilities are superior, that it is better to be non-disabled than to be disabled, or that disabled people are fundamentally defined by their disabilities.²³ Disability is a normal part of the human experience and can be celebrated as a valuable dimension of human diversity, but societal ableism wrongly teaches us instead that disability is a problem to be fixed or eliminated.

Stigma, defined as negative stereotypes attributed to people when their characteristics or behaviors are viewed as different from or inferior to social norms,³⁷ is one specific manifestation of societal ableism. When a person has a disability, because of ableism they may encounter inaccessible environments, be socially excluded, be treated paternalistically, or be discriminated against due to unfair assumptions about them based on their disability. When a condition is stigmatized, the person may additionally face negative, disparaging beliefs about their disability or themselves as a person. Some of these commonly-held stigmatizing beliefs are that people should be blamed for their condition, or that they may be untrustworthy, unreliable, or even dangerous, just based on their condition or disability. Among the most highly stigmatized groups in society are people with serious mental illness or substance use disorders, who are often stigmatized to the point of being treated as inherently criminal.

Stigma is the biggest barrier in my opinion. That's hard to counter. We as a community have to keep working at it.

—An ISK staff member

These social judgments are inaccurate as well as harmful. People do not choose to develop mental illnesses or substance use disorders; these conditions are caused by complex, interacting factors including past and current traumatic experiences, genetic predisposition, and environmental stressors – all factors over which a person has little to no control.^{1,38} People with intellectual and developmental disabilities, people with behavioral health conditions, and people in recovery can and do maintain productive employment, volunteer commitments, family responsibilities, and other valuable contributions to the community. It is extremely rare for a mental illness, even a severe mental illness, to cause a person to behave violently, and in fact people with severe mental illness are at a greatly increased risk of being the *victim* of violence, not the perpetrator.³⁹

Ableism and stigma are ubiquitous around the world; global surveys have found no country, society or culture where people with mental illness have the same social access, social inclusion, and perceived social value as people without a mental illness.⁴⁰ There are many systems and social practices that contribute to the creation and perpetuation of ableism and stigma. Media coverage related to mental illness is often sensationalist and imprecise, and strengthens negative stereotypes. Diagnostic terms are casually used in everyday language, such as figuratively describing a situation or person as “schizophrenic” or “bipolar” — and genuine ableist slurs are unfortunately just as commonplace. Lastly, large numbers of people with disabilities or mental illnesses have historically been institutionalized and forcibly separated from the rest of society, and due to this separation, inaccurate stereotypes flourished in the absence of real experience and contact with these individuals.

Similar to other discriminatory social systems, ableism and stigma can be enacted at the individual level and also at a larger institutional or societal scale. Researchers have delineated three different arenas where stigma plays out: socially, individually/internally, and institutionally. In social contexts, “public stigma” is the phenomenon where a person with mental illness or a developmental disability is faced with negative and discriminatory attitudes from others. At the individual level, “self-stigma” refers to internalized stigmatizing ideas that a person holds towards themselves or their own condition or disability. Finally, “institutional stigma” is the force that shapes the policies and practices of governments, nonprofits, or private organizations in ways that intentionally or unintentionally limit opportunities for people with mental illnesses or disabilities.²⁴

The lives of people with developmental disabilities or behavioral health conditions are profoundly impacted by this ableism and stigma, in multifaceted ways. Stigmatizing beliefs are commonly held by employers, landlords, social service workers, educators, and even mental health professionals themselves,⁴⁰ which can lead to the unjust exclusion of people from participating in activities and services that others have full access to. Social stigma from family and friends can damage relationships and make it harder to maintain a support network. Fear of all these repercussions and/or internalized self-stigma causes many people to avoid or delay seeking treatment that they need. Stigma also continues to have negative impacts on people who do seek treatment, with high levels of self-stigma associated with less favorable treatment outcomes in numerous research studies.⁴¹

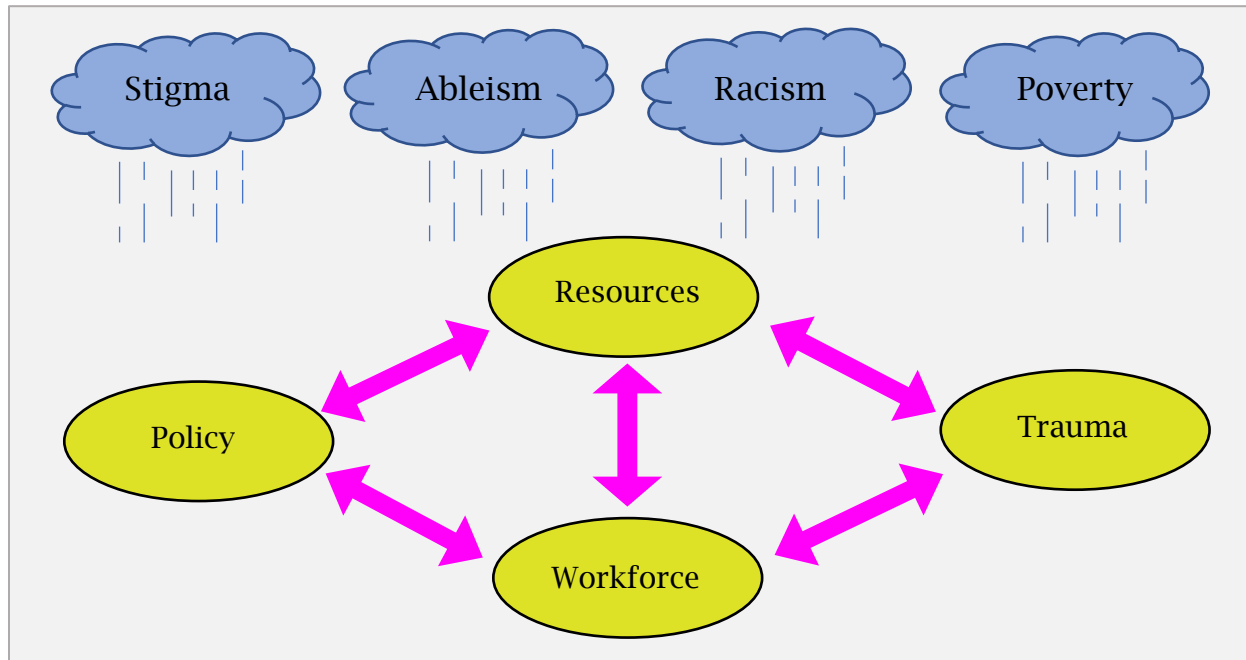
At a broader societal level, *institutional stigma* is a main force causing the overall undervaluing and underfunding of behavioral health research, behavioral health service systems, and behavioral health careers. To quantify, the Global Burden of Disease Project estimated in 2019 that mental health–related concerns account for about 15% of the total disease burden in the United States²⁵, but other research has found that mental health and substance use care together only account for around 5% of national health care spending per year²⁶, and the National Institutes of Health (NIH) appropriations send only 10% of total funds to institutes that focus on researching mental health and addiction science.²⁷ Furthermore, insurance reimbursement rates for behavioral health office visits are, on average, nearly 20% lower than the rates for physical health visits.²⁶ This pervasive state of underfunding makes behavioral health care much harder to access for those who need it, and makes it difficult for the system to provide high quality care when people do receive services.

In spite of the harm caused by these forces in the lives of vulnerable community members, ableism and stigma tend to receive relatively little attention from community leaders. Community Health Needs Assessments and similar projects, locally and around the country, will very frequently name mental health and behavioral health as a top concern or area of need, but few include a thorough analysis of the origins or impacts of mental health stigma, and it is rare to even hear mention of the word “ableism.”

In order to develop a health care system, including behavioral health and developmental disabilities services, that functions equitably for all, Kalamazoo community leaders must understand ableism as a fundamental social system of inequity, and recognize the negative impacts that ableism has on so many Kalamazoo residents — whether directly, through interpersonal/social ableism or internalized ableism and stigma, or indirectly and at a larger scale through systemic ableism.

❖ Systems overview of unmet needs

The current reality is that behavioral health and developmental disabilities service needs are going unmet to a serious extent, both locally in Kalamazoo County and across the country. This section will describe, at a high level, some of the most evident unmet needs, and outline some of the context and history behind those gaps and ways that systems are interacting to make it difficult to meet needs.



As mentioned in the previous section, institutional ableism and stigma affects policy decisions at the federal and state levels such that all systems for delivering behavioral health and developmental disabilities **services are dramatically underfunded**. The Community Mental Health Association of Michigan (CMHAM) reported in 2019 that due to inadequate and restricted state funding, there is a statewide deficit of over \$130 million per year in Michigan’s public mental health system.⁴²

One notable direct result of systemic underfunding is that careers in behavioral health and developmental disabilities care are usually very low-paying. For example, the nationwide median salary for mental health or substance use social workers and counselors is only about \$48,000 annually, despite the majority of these jobs requiring a master’s degree.^{28,29} Direct support professionals, who help individuals with disabilities to manage personal care and activities of daily living, have median earnings of only \$27,000 a year,³⁰ just barely above the federal poverty level for a family of four.⁴³

This unattractive salary landscape is one of the main causes of a pervasive unmet need, which is the fact that **there are simply not enough behavioral health workers overall**. The Health Resources and Services Administration (HRSA), working from national estimates of current unmet need along with projections of changing supply and demand, estimated that in 2025 there could be a nationwide shortage of 57,000 psychologists, 48,000 mental health social workers, and over 15,000 psychiatrists.⁴⁴

Kalamazoo County is relatively fortunate in terms of our local professional labor force, with an estimated 1 mental health professional for every 250 residents in the county (compared to 1 per 360 in Michigan overall⁴⁵ and only 1 per 372 nationwide⁴⁶). Additionally, Kalamazoo is one of only 20 counties out of the 83 counties in Michigan that do not have a county-wide HRSA-designated shortage of psychiatrists. (However, the HRSA does identify Kalamazoo County's low-income population as having insufficient access to psychiatrists — about 3.2 additional FTE psychiatrists would need to be serving that population in order to meet its estimated need.⁴⁷) Nevertheless, even though the need in other geographic areas may be still more dire, hiring and retaining an adequate workforce locally is a serious challenge and was frequently cited by CHNA participants as a significant barrier to meeting community needs.

The system-wide severe underfunding has major impacts on more than just the behavioral health career landscape. Systemic underfunding also causes a tendency towards complex and arcane policy strategies as funding entities, administrators, and providers attempt to cover all needs with inadequate resources. As an example illustrating this complexity, the Michigan Medicaid Provider Manual requires 213 pages to outline policy for the behavioral health and developmental disabilities system, compared to 113 pages for hospitals and just 26 pages for Federally Qualified Health Centers (FQHCs).⁴⁸ There is also not yet any nationwide consensus on how to structure behavioral health and developmental disabilities services in the wake of deinstitutionalization in the latter half of the 20th century. In fact, in 2009 the President's New Freedom Commission on Mental Health summarized the overall state of the American system as "fragmented and in disarray."⁴⁹ As various legislators, administrative bodies, and funders all attempt to innovate the next iteration of the system, experimental policy adjustments and constant pilot tests of new frameworks are the norm. In the end, the result is a behavioral health and developmental disabilities care **system that is very complicated and undergoes dramatic changes frequently.**

Understanding this context, that we are operating within a care system that is exceedingly complicated and constantly changing, makes it easier to understand one of the community needs that came through most strongly in ISK's survey of Kalamazoo County: Unless they are already connected with the system, **community members generally don't know what services are available**, how they could get started seeking services, or how to find out if they qualify for public services. This is the predictable result when the system is so difficult to understand and when new changes are so frequent. It is not feasible for ISK or other agencies to keep comprehensive information about the system up to date and make it available to the public, and even our own staff will often struggle to keep up with all the changes and details. Misinformation and confusion about services then spreads in the community, which presents a substantial access barrier for individuals who need care.

So, the overcomplexity stemming from underfunding means that people don't have access to good information about how the system works, they struggle to even get started, and once somebody does seek services it can be hard for them to produce required documentation and meet eligibility requirements. On the other hand, the overall lack of providers (also primarily caused by underfunding) means that even if the system were accessible and easy to navigate, there is simply not enough capacity to serve all individuals who want treatment. The end result of these twin influences is that **many people who would benefit from services are not receiving any behavioral health care at all.**

The whole system is intimidating and confusing, and **I put off seeking care** for many years because I was just too overwhelmed and anxious.

—A consumer of behavioral health services

People lacking care that they would benefit from is a serious enough problem on its own, but it also causes additional secondary consequences. In particular, when a person is not easily able to receive services that they would benefit from, there is an increased risk that their difficulties may develop into a crisis situation. This can create enormous trauma and disruption for the individual and their family or community, and can also make it much harder to provide effective treatment. Partially due to the difficulty of accessing comprehensive, quality preventive care, **crisis situations are all too common**, and managing them adequately presents a serious challenge to a behavioral health care system that is already stretched.

A number of resource gaps and systemic weaknesses become especially stark within the context of crisis care. While there are not enough behavioral health workers overall, an adequate crisis workforce is even more difficult to maintain, because 24/7 coverage is required and the work of handling these crises is so exhausting. And many psychiatric hospitals are specifically excluded from being reimbursed by Medicaid (the only type of medical care subject to such an exclusion),⁵⁰ meaning that all across the country, there are not nearly enough psychiatric hospital beds available to meet the demand for this type of service. Adults and youth experiencing a crisis often have to “board” in an emergency department for days or even weeks (often with no access to behavioral health professionals during that time); they may have to be sent out of state for an available hospital bed; and some never receive the needed crisis care at all.

We have, what, eight hospitals in Michigan we can call for youth [in crisis]? And you have fifty counties calling those eight hospitals. We have some kids who are in some pretty serious crises, needing inpatient services, who will sit for two weeks. We have had a kid sit for six weeks in the ED waiting for a hospital bed. ... When we need a bed, a place for this youth to be safe, there is no bed except the ED. And that is **heartbreaking** for families.

—A crisis services professional

In the absence of enough behavioral health professionals and enough hospital beds or equivalent safe locations, a great deal of difficult, crisis-level **behavioral health management falls to other human service systems** without behavioral health expertise. These include, prominently, homeless shelters and the criminal justice system, including jails and prisons. Recent research by the Bureau of Justice Statistics estimated that 54% of prison inmates have a past or current mental health problem⁵¹; past research has found the proportion to be even higher in local jails.⁵² In fact, the criminal justice system acts as the behavioral health provider of last resort to such a degree that some authors have dubbed jails and prisons “the new asylums.”¹⁹ This model is, of course, very harmful to people with behavioral health needs, but it also puts unreasonable expectations on the criminal justice system and criminal justice professionals, who do not have appropriate training and are not equipped to handle psychiatric or emotional crises.

In addition to police, jails, and prisons, the housing system and homeless shelters also frequently have to pick up the pieces when the behavioral health care system isn't able to meet people's needs. A behavioral health crisis that isn't managed well can cause a person to lose their housing, or a traumatic experience such as domestic violence can be the independent cause of homelessness as well as mental health problems at the same time. The stress of lacking shelter can, in turn, seriously exacerbate behavioral health issues, creating a vicious cycle. Providing services to an individual experiencing homelessness can be very complex, and adequate care is difficult to implement and coordinate because of the disconnection at all levels between housing funders and health care funders. Overall, the existence and frequency of **homelessness is one of the greatest difficulties** facing the behavioral health care system.

We are still trying to invent our community mental health system 40 years after de-institutionalization. Hundreds of people with mental health challenges are left to **fend for themselves** on our streets.

We have to name this – and call it the failure that it is. Our police departments, the Kalamazoo Gospel Mission and Ministry with Community should not be covering as much need and picking up as much load as they are. We have to **fund and build hundreds of subsidized housing units** for people living on <\$800 per month and surround these people with professionalized supportive services.

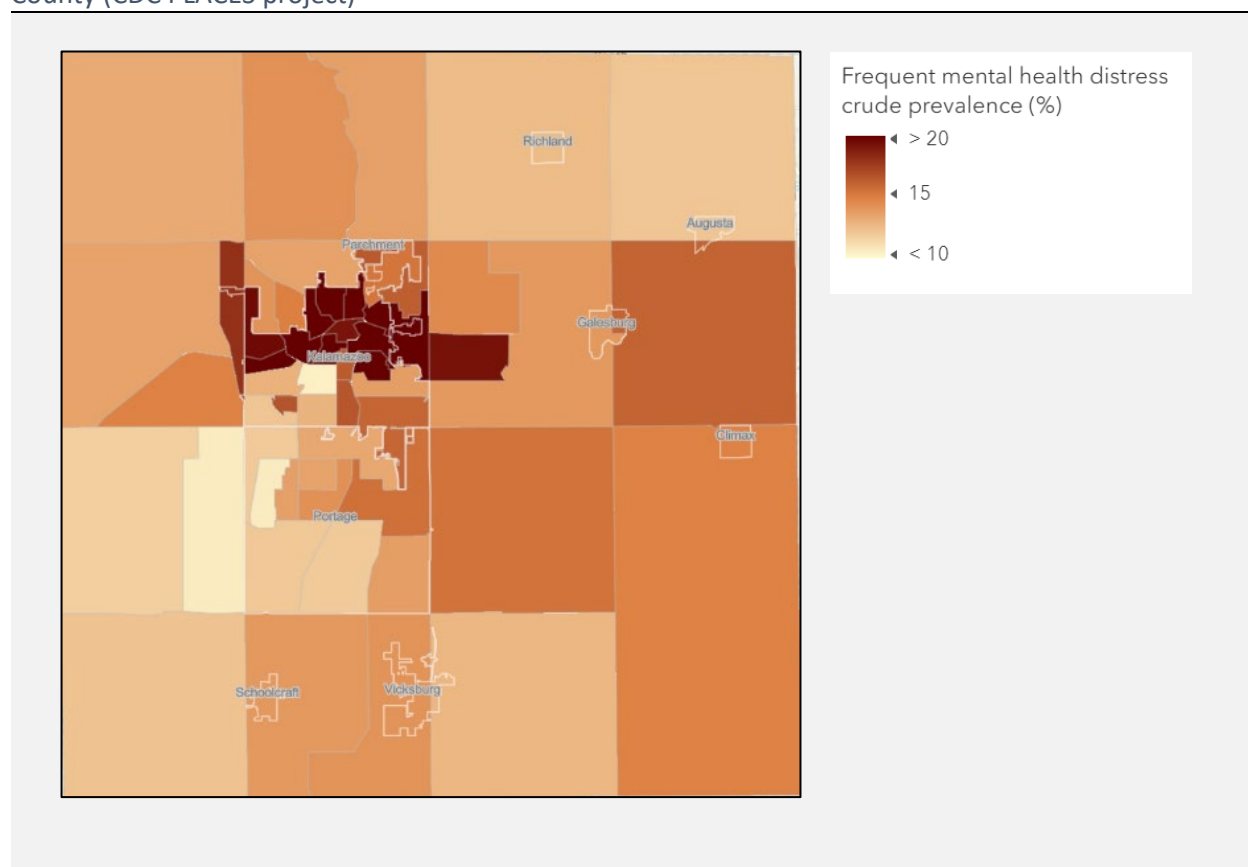
—A housing services professional

The high prevalence of homelessness among people with behavioral health conditions is deeply rooted in social and institutional stigma. The original vision of deinstitutionalization in the late twentieth century was that people with disabilities or mental illness could be integrated into society and receive community-based care, rather than being segregated into hospitals. But in practice, local communities have not always accepted people with severe mental illnesses or substance use disorders as neighbors. Early on, many local governments even attempted to deploy zoning strategies that would legally limit the provision of housing options such as group homes and specialized residential programs with embedded behavioral health care.⁵³ Adding to the crunch, the closure of many public housing and subsidized private housing projects meant that the overall pool of affordable housing options decreased at the same time.

On a more individual level, the stigma and criminalization against mental illness and substance use disorders can directly cause people to lose their apartments or housing vouchers, and the financial disruption of a behavioral health condition can make it impossible to keep up with rent. Even once a person is connected with housing assistance, the lack of options can mean that they end up placed in a setting that isn't a good match for their needs. While there are individuals who truly just need access to an apartment that is affordable to them, there are many others for whom a robust supportive housing environment, with comprehensive wraparound services provided from a harm-reduction paradigm, is essential. Currently, **the range of available housing options does not correspond to people's actual need**, and when out of desperation a person is placed in whatever is available, this can create different problems later (such as new involvement with the criminal justice system when police are called at the housing site).

Homelessness is one of the most severely traumatic experiences for people, and ISK has found homelessness to be the factor most strongly associated with a number of adverse behavioral health outcomes.⁵⁴ But even more modest levels of housing stress, and poverty in general, still have measurable health impacts. Within the marginalized core neighborhoods in the City of Kalamazoo where poverty rates are higher, there also tend to be more households that are considered rent-burdened⁵⁵ and higher rates of people living doubled-up with relatives other than a spouse or parent.⁵⁶ And, via their PLACES project, the CDC estimates a higher prevalence of frequent mental health distress in these same neighborhoods. While the most at-risk neighborhoods are estimated to have rates of mental health distress that are 25%–60% higher than the county average, regions within and outside the City where poverty rates are lower are estimated to have rates 25%–50% lower than the county average.⁵⁷

Figure 5: Estimated (model-based) prevalence of frequent mental health distress within Kalamazoo County (CDC PLACES project)



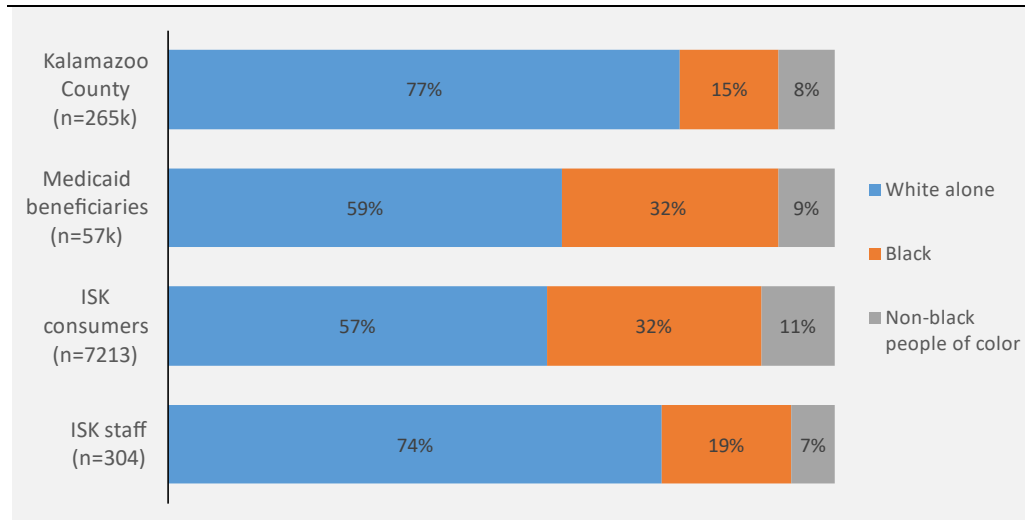
This geographic concentration of poverty, high risk, and high need is due to the interaction of a number of past and current policies (including redlining as mentioned previously), and also to a certain extent follows the contours of racial segregation. Previously we named poverty and racism as another “root cause” that, along with ableism and stigma, has negative impacts reverberating across the behavioral health care landscape. While poverty and racism are not completely equivalent social phenomena, we mention them together because of how closely they are intertwined: One of the most universal impacts of racism on people’s lives is the experience of poverty, and simultaneously, societal racism is one of the primary motivators for policy decisions that perpetuate the existence of poverty among all races.

Understanding poverty is essential for analyzing the public behavioral health and developmental disabilities care system; it is a safety-net system, and as such the great majority of individuals who we serve are experiencing generational or situational poverty. This is significant first because **traumatic experiences, including poverty-based trauma and racial trauma**, are prominent causal factors for serious mental illness, mild-to-moderate mental health problems, and substance use disorders. Even when an individual household's income is held constant, living in more impoverished neighborhoods has been shown to cause more mental health and behavioral problems.⁵⁸

Trauma is defined as the response to any deeply distressing or disturbing event that overwhelms an individual's ability to cope or causes feelings of helplessness. The same events can be experienced by different people as traumatizing or not traumatizing, but there are some common experiences that are highly likely to cause trauma: being the victim of or a witness to violence, including domestic violence, community violence, and political violence; physical, sexual, or emotional abuse or neglect; and natural disasters and severe accidents.⁵⁹ Behavioral health authorities such as the Substance Abuse and Mental Health Services Administration (SAMHSA) now recognize trauma itself as a widespread public health problem and acknowledge that "addressing trauma requires a multi-pronged, multi-agency public health approach" in a community context that is *trauma-informed* — "based on knowledge and understanding of trauma and its far-reaching implications."⁶⁰

Because of the relationship that exists between poverty and racism, the pervasiveness of poverty within the population served by safety-net systems also has implications for the racial demographics of that population. Consumers of services from ISK and our provider network are much more likely to be Black than the general population of Kalamazoo County. While ISK takes a serious approach to hiring a diverse staff and our internal staff population demographics do match the diversity of Kalamazoo County overall, the high-poverty profile of the people we serve means that **staff and provider populations do not match the consumer population demographically**. The ISK staff population is about 26% people of color (slightly higher than the County overall), while among people who receive services from us the proportion is 43% people of color (similar to the overall population of people with Medicaid).

Figure 6: Demographic comparison of populations, 2020



This demographic mismatch already creates inequities in care by itself — consumers of color have a harder time finding a provider who shares their cultural background, and frequently have to “code-switch” or otherwise navigate cultural or language barriers at the same time they are trying to receive treatment, something that white and English-speaking consumers generally would not have to worry about. This level of inequity will be present as long as the provider population does not match the consumer population, regardless of how careful individual white providers are to treat individual consumers of color fairly. But further injustice is being caused by the fact that behavioral health and developmental disabilities care workers can be affected by implicit bias⁶¹ that does cause them to unknowingly treat people differently based on race or culture. Having few treatment options other than working with professionals from the dominant white and middle-class background becomes a burden beyond merely that of continually having to navigate cross-cultural interactions, when misunderstandings and/or biased assumptions affect the care that an individual receives or even cause them to be denied services altogether.

When working with providers who do not have a historically marginalized identity, I have found that I spent more time **explaining** my experience as a person of color than **receiving actual care**.

—A consumer of behavioral health services

The system as a whole is also subject to **institutional bias** that plays out on a larger scale than individual interactions. Governing authorities generally require providers to deliver types of treatment that are grounded in a European medical tradition, while at the same time service models based in other cultural traditions are comparatively neglected — sometimes to the point where it is practically impossible to fund and maintain such program options. Furthermore, some of the most common referral sources for the public behavioral health system are police departments, schools, and foster care, all systems that are known to be still fighting to overcome their own histories of institutional bias and racism. Enduring inequities in those systems can lead to inequities in access to behavioral health care, for example when some individuals are directed towards jail or school disciplinary action while others in the same situation would be referred for behavioral health treatment.

When the system responds to or treats individuals inequitably, the impacts go beyond just failing to provide quality care for that individual at that moment in time. Biased treatment can cause consumers of services to become traumatized by the system itself, and we must be aware that such trauma will affect the way people interact with behavioral health care for years to come. Current consumers may also still be affected by such **institutional trauma** from negative experiences they may have had with the system in the past, including bias, racism, stigmatization, overall poor treatment, and/or institutionalization. When community members seeking help are traumatized by the system itself, this also greatly diminishes the trust level that the community holds for ISK, the behavioral health system in general, or the broader network of health and human service systems that coordinate social services in the County.

Negative views of the system and stories of specific bad experiences spread by word of mouth, with the result that many people in the community do currently seriously **distrust ISK or “the system” as a whole**. This distrust is born from many of the issues raised previously: institutional bias and direct trauma from the system, whether past or recent; service quality issues stemming from lack of funding, the shortage of behavioral health professionals, and/or the complexity and difficulty of navigating the system; and a

general environment of misinformation and confusion about services and eligibility, which can lead to people holding expectations of the system that it cannot meet. When trust is damaged by any of these factors, this impacts people's willingness to obtain services, and as mentioned above, this can lead to more crisis situations later — which creates even greater strain on the system and makes it even harder to make the improvements necessary to regain trust.

All of these interacting phenomena have been outlined in order to illustrate clearly that the ongoing presence of serious unmet behavioral health needs in the community is in fact due to multiple systemic failures — it is not caused by poor decisions or a lack of effort at the individual level. We have in Kalamazoo County hundreds of extremely dedicated, caring, and professional individuals who are on the front lines of delivering the best care possible under impossible constraints. They are frequently paid less in the public system than they could earn by leaving for private sector healthcare or for other industries, and while working in the public system they are responsible for the care of individuals with some of the most challenging situations, while also having to keep up with the frightening complexity and crushing administrative burdens that come with public funding. Caseloads are high, the jobs are difficult, and staff are constantly experiencing secondary trauma from engaging closely with consumers' trauma, meaning that **burnout is all too common among workers** in the behavioral health and developmental disabilities care system. This contributes to staffing turnover, which disrupts the care of people receiving treatment and also tightens the squeeze of workforce shortages in a vicious cycle.

To conclude, it is clear that in order to truly meet the needs of the Kalamazoo County community related to mental health, substance use, and intellectual/developmental disability care, many fundamental structural changes would be required. This level of change is not likely to be able to be implemented by ISK alone, or even by a strong coalition of local organizations, because the most necessary changes are related to policy and resource allocation at the state and national level. Nevertheless, we have community members who require services and supports right now, and we must do what is in our power to meet those needs as much as possible.

ISK is using this Needs Assessment and other resources to carefully decide where we think we can feasibly make the most beneficial impact within the constraints we are operating under. Our efforts can be multiplied and help more of our community, the more partners we have working alongside us towards the same goals. Behavioral health and developmental disabilities organizations can make efforts to support their staff as much as possible, to help alleviate the pressures imposed by the system and reduce burnout. Social service agencies and other organizations can work to become more trauma-informed, and adjust the way they operate accordingly. Any individuals or institutions can join ISK and our partners in advocating at higher levels for necessary system change. Finally, everyone in Kalamazoo County can play a part in reducing racism, ableism, and stigma in our community. This will truly make a difference, as these societal forces are the root causes of many of the problems in the system.

Priority areas

For this Needs Assessment, ISK held fifteen internal staff discussion groups, each of which focused on one specific theme that was identified from responses to the Community Needs Survey. These groups included members of the cross-disciplinary CHNA Team as well as subject-matter experts in the theme area, who worked towards a consensus understanding of the most significant needs related to the theme and also began suggesting concrete actions that ISK could take to respond to those needs. These preliminary action suggestions from all 15 groups were compiled and categorized into seven proposed **strategic directions** that ISK could choose to emphasize.

Figure 7: Seven strategic directions considered by ISK leadership

Advocacy towards higher-up entities for systems change	Advocacy towards peer and local entities	Public relations and marketing	Workforce development and hiring	Programmatic changes	Staff training and support	Internal process improvement
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ISK senior leadership then met to discuss the proposed strategic directions and choose the subset of them that should be most emphasized, given that resource constraints would prevent the agency from fully executing all seven. To select this subset, the seven strategic directions were scored on a scale of 1 to 5 by each member of leadership on the following three domains:

- What is the **importance** of this strategy? How many people would be affected, and how dramatic would the impacts be?
- What are the **equity/inequity** implications of the strategy?
- What is the **feasibility** of the strategy? To what degree can ISK realistically have an effect?

All individual ratings were averaged together within these three domains, and the three domains' average scores were multiplied together to give one overall score for each proposed strategic direction. The two strategic directions with the highest overall scores, which the leadership team collectively agreed should be highlighted as the agency's current top priority areas, were (in decreasing order of total score):

Figure 8: Top two strategic directions selected by ISK leadership

1. Workforce development and hiring	2. Internal process improvement
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The following sections will briefly discuss each of these strategic directions and some of their implications for ISK, the behavioral health system, the individuals we serve, and the Kalamazoo County community as a whole. Formulating a detailed strategic plan is outside the scope of the Needs Assessment, and so specific recommendations are not made at this time but will come from future ISK planning initiatives.

❖ Workforce development and hiring

The professionals providing behavioral health and developmental disabilities care constitute the backbone of the system, and developing this workforce was the clear first choice of ISK leadership as the strategic direction that is most necessary to focus on. The primary unmet needs related to workforce development are (1) not having enough workers overall, and (2) the available professional workforce not matching the demographics of individuals who receive services.

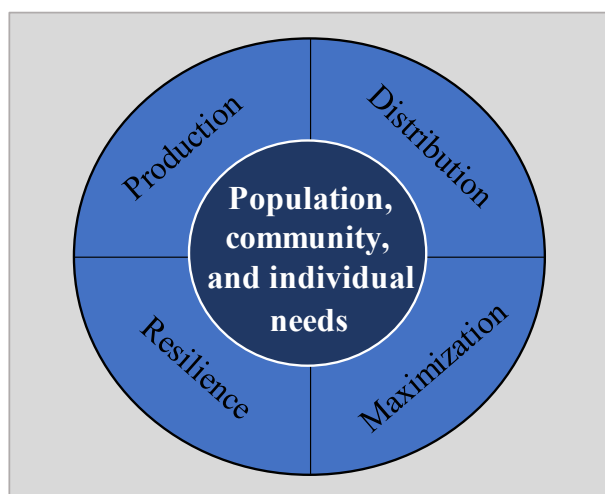
An overall shortage of behavioral health and developmental disabilities service providers has been a nationwide issue for a long time. Included already in the landmark 1980 Mental Health Systems Act was an acknowledgement that “because of the rising demand for mental health services ... there is a shortage in the medical specialty of psychiatry and there are also shortages among the other health personnel who provide mental health services.”⁶² Later, in 2003, the President’s New Freedom Commission on Mental Health “heard consistent testimony from consumers, families, advocates, and public and private providers about the ‘workforce crisis’ in mental health care.”⁴⁹ More recently, the American Hospital Association stated that “behavioral health needs are reaching a crisis point rising amid gaps in the behavioral health workforce[...] The stresses of the COVID-19 pandemic have compounded these concerns.”⁶³ There is, of course, a direct association that can be drawn between the longstanding lack of funding to the system, and the struggle to recruit and train enough qualified workers.

The negative impacts of this shortage of workers on individuals needing care and treatment can hardly be overstated. First, people who need services often struggle to even find a provider who has openings to see them. This barrier to access can mean that individuals go without any treatment until their difficulties become a crisis. Second, having too few staff contributes directly to high caseloads. This has implications for the individuals receiving services, who often cannot get as much focused individual attention from their provider and may even be seen less frequently than is necessary. The professionals themselves are also affected, having a higher risk of burnout the more excessive their caseload becomes.

The demographic mismatch between providers and consumers is another issue. Because consumers of behavioral health services are more likely to be poor, and at the same time poverty is highly racialized in America, people of color and especially Black people are highly over-represented in the population of ISK consumers (compared to the overall county population). The diversity of the staff population tends to match the county overall, which means people of color have less opportunities to be treated by a provider who shares their cultural background. This is a serious inequity, since recipients of services then have to navigate cultural and/or language barriers at the same time they are trying to receive treatment, something that white consumers generally would not have to worry about. There is also a significant risk of harm from a predominantly white staff lacking the necessary cultural humility to adequately treat individuals from marginalized communities.

A team of researchers from the University of Michigan Behavioral Health Workforce Research Center (BHWRC) recently proposed a policy framework for growing and reshaping the health workforce in order to address unmet needs in the wake of the COVID-19 pandemic.³² The four pillars of their framework are *production*, *distribution*, *maximization*, and *resilience*. While the framework was designed with an eye towards policy intervention at the federal and state levels, thinking in terms of these different intervention settings may also be useful inspiration for ISK and local partners to explore effective actions we could take within current policy constraints.

Figure 9: BHWRC Health workforce policies framework³²



The “production” pillar proposed by the BHWRC team refers to efforts that influence individuals choosing to enter into a health career in the first place, with the goal of increasing the number and the diversity of this population. Initiatives aiming to impact production might try to get more people to see health care as an attractive career choice or job option, or encourage more people to enter into and complete relevant education pathways. Efforts could be targeted towards specific demographic groups in order to help increase the overall diversity of the workforce.

The second pillar, “distribution,” refers to the way that an available workforce is matched to populations needing service. The goal is to shift workers away from areas where the workforce is already more than adequate to meet needs, and towards areas with the most unmet need. The most obvious tactics have to do with geography (e.g., initiatives to make providers more available in rural areas, which tend to have far too few), but distribution can also be thought of in terms of other dimensions. Some examples are different provider specialization areas which address different types of need; different levels of acuity (i.e., routine preventive services versus acute or crisis services); or different service settings, such as onsite, telehealth, or home-based services. Along any dimension, shifting the workforce towards the areas with greater needs will improve the system’s ability to effectively serve the consumer population.

The third pillar named by the researchers is “maximization” and has to do with finding efficiencies that can be gained within a workforce that is already in place. There are a few patterns of potential workforce efficiency that are common to different innovative service delivery models, such as: having staff with lower levels of training and credentials help to augment service provision; expanding staff responsibilities to encompass all functions allowed within their scope of practice; directing consumers to the appropriate level of care; using technology to extend provider reach; and increasing the capacity for behavioral health concerns to begin being treated outside of behavioral health–specific settings.⁶⁴

The fourth and final pillar of the framework, named “resilience”, focuses on efforts that are needed to support the workforce in an ongoing fashion. Hiring people into the system is not the end of the challenge; attention to workplace safety, clinician mental health, financial security, and other ongoing support is needed to help protect staff against the burnout and high turnover that are all too common in behavioral health and developmental disability care professions.

This framework, and the numerous potential approaches it suggests, may offer useful inspiration to ISK and our partners as we plan how to execute a strategy to help develop and hire our local workforce. This broad theme of **workforce development** is the strategy that ISK leadership proposes as the single most important strategy at this time for making a difference in meeting the behavioral health and intellectual/developmental disability care needs of our community.

❖ Internal process improvement

Working to optimize our own internal processes was the second strategic direction that ISK leadership prioritized highly for the agency to emphasize, a recognition that while we are significantly constrained by regulatory requirements and financial limitations, we do have some degree of administrative choice over the way we do business and that ISK can make a noticeable difference for the community depending on different organizational decisions we may take. Internal process improvement as a strategy gained an overall higher rating than most other strategies because of its balanced potential in each of the three prioritization domains of importance, equity, and feasibility.

First, the importance and the number of people impacted by ISK's administrative choices should not be underestimated. Each year we and our provider network serve nearly 8,000 individuals, including many of Kalamazoo County's residents with the very greatest behavioral health challenges, and this number is set to increase significantly in the next few years as we become the Certified Community Behavioral Health Center (CCBHC) for all of Kalamazoo County. Process improvements that make care easier to access, support effective care coordination between agencies, and/or increase the typical quality of care that people receive, will create immediate positive changes as well as potentially having helpful impacts over the longer term (for example, by preventing the emergence of crisis situations by ensuring individuals have better access to routine, preventive care).

ISK also directly employs over 300 professionals at time of writing, and has contract relationships with dozens of local providers of behavioral health and developmental disabilities services, meaning that a sizeable portion of the entire workforce is impacted by actions taken by ISK. For example, process improvements that reduce administrative burdens would in turn help to alleviate staff burnout, one of the top difficulties facing the system.

Next, we should recognize the great potential that internal process improvement holds for impacting equity, a key value and a strategic imperative for ISK. Every administrative decision that ISK makes is an opportunity to either advance equity and justice, or create or perpetuate inequity and injustice. Both ISK itself and external evaluators have already identified a number of health disparities and inequities in Kalamazoo County's behavioral health and developmental disabilities care system, and targeted performance improvement efforts to erase those inequities could turn out to be some of the most transformative projects that ISK can take on.

Finally, it is important to value the feasibility of internal process improvement as a strategy. While some other more externally focused strategies were rated a bit more highly on importance and/or equity impacts, their notably lower ratings for feasibility indicate ISK leadership's collective estimation that agency effort in those directions is less likely to overcome the significant barriers to progress that are known to exist. In contrast, focusing on ISK's own internal operations is much more within our locus of control, while still having the potential to result in concrete improvements to the system and tangible value for people needing behavioral health or developmental disability care and the rest of the Kalamazoo community.

Secondary data and analysis

This section is based on a number of publicly available data sets and reports, as well as some basic original analysis by ISK from two confidential raw data sources: Medicaid claims from beneficiaries residing in Kalamazoo County, and ISK's own data from our electronic health record.

❖ Data sources overview

Many of the following maps and tables include reference data from the **2019 American Community Survey (ACS)**³⁴ 5-year estimates provided by the US Census Bureau. The ACS is an annual survey that is used to supplement data from the decennial census, so that estimates can be updated continually between census years. At the time of writing this report, the 2020 Census had been completed, but full data had not yet been released by the Census Bureau.

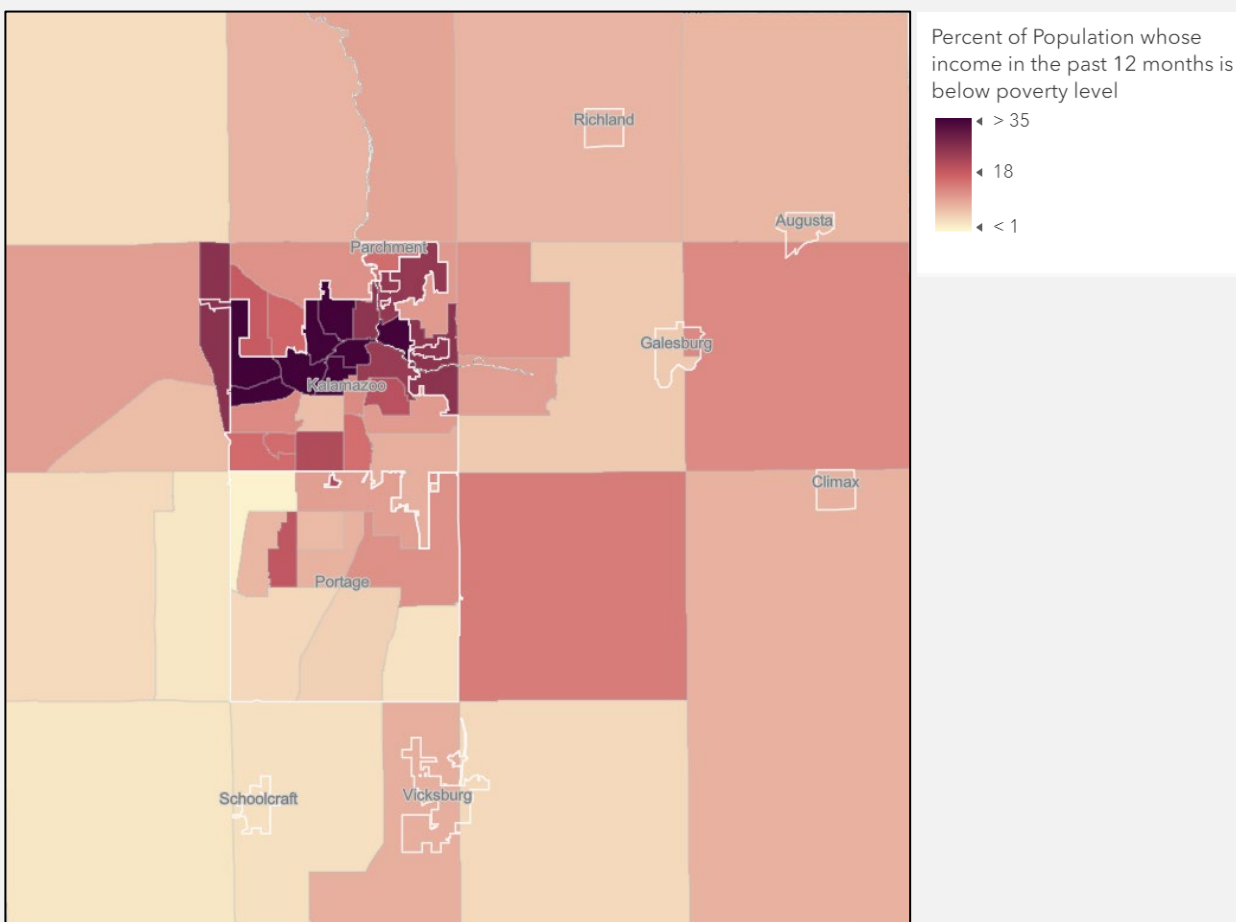
The **PLACES Project**⁶⁵ is a collaboration between the CDC, the CDC Foundation, and the Robert Wood Johnson Foundation. It is based on data from the CDC's Behavioral Risk Factor Surveillance System (BRFSS), which asks respondents a number of questions about physical and mental health, and health-related behaviors. The project uses statistical modeling methods to generate "small area estimates" for 27 measures; that is, measure estimates by census tract were calculated by starting with the county-wide measure average, and adjusting for differences between census tracts, such as age, race, and poverty rate, that are known to correlate with the measure.

The **CareConnect360 Medicaid claims database (CC360)**¹⁶ is a data feed of complete, individually identifiable healthcare claims which MDHHS collects from every provider who bills to Medicaid. As a governmental entity, ISK is permitted to access almost all such claims that are connected to a Medicaid beneficiary who resides in Kalamazoo County. The findings from this data set are only based on the county's Medicaid population and cannot be generalized to the rest of the population without Medicaid. However, as a safety-net provider, ISK's consumer population is dominated by Medicaid beneficiaries and this is our primary population of focus, so CC360 is still a highly relevant and valuable data set for this needs assessment. There are two limitations to this data to be aware of. First, due to extra privacy protections that are afforded by law to individuals receiving substance use treatment, no claims are available to ISK from a service where the primary concern (primary diagnosis) was a substance use diagnosis. Second, there is a sizable portion of the Medicaid beneficiary population (about 10%) who are also dually enrolled in Medicare, and since CC360 includes Medicaid claims only, when these individuals have services paid for by Medicare those services will not appear in the CC360 record.

❖ Poverty and health geography

Poverty rate (Census)

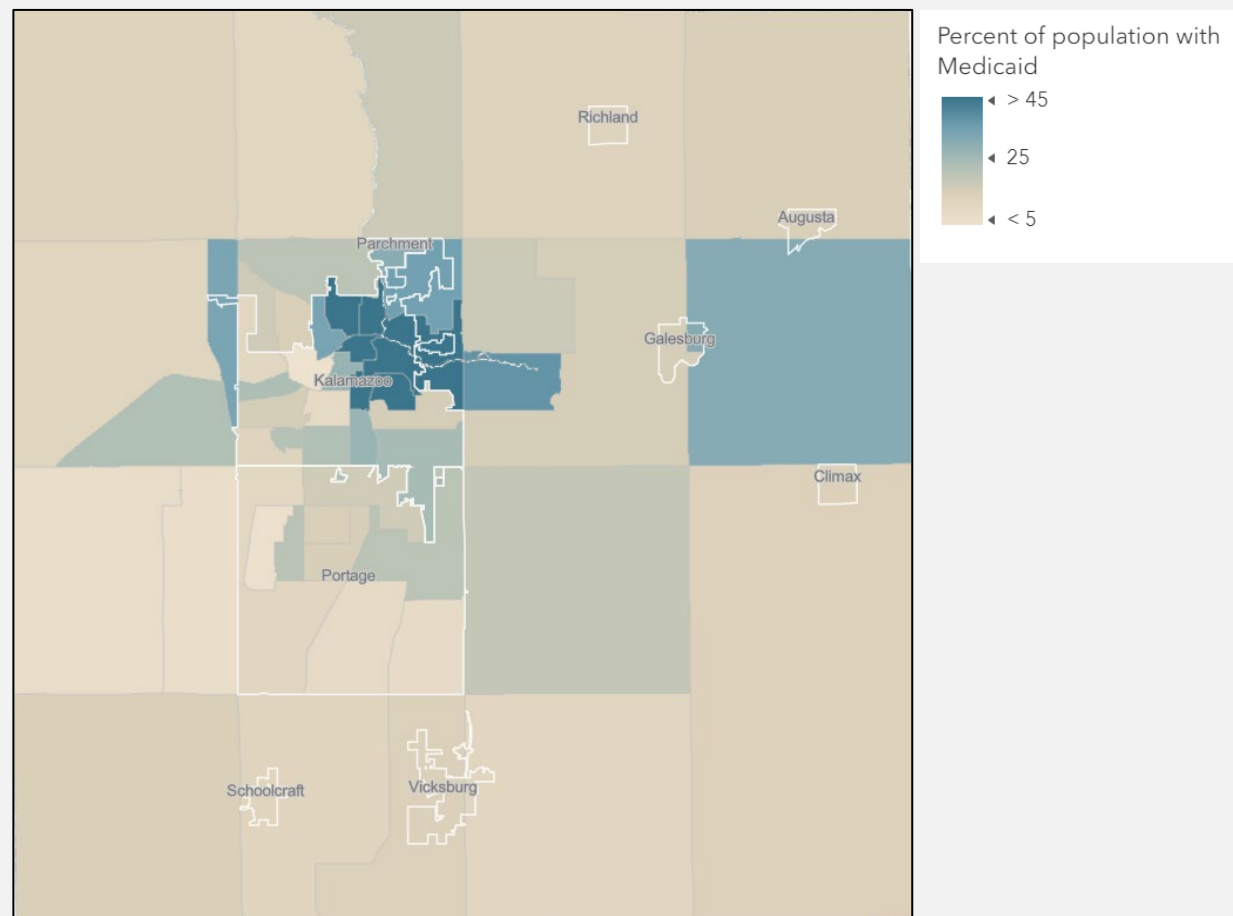
Figure 10: Kalamazoo County poverty rates by census tract



Poverty is an important influence on physical, mental, and behavioral health. Within Kalamazoo County, poverty is most highly concentrated in the City of Kalamazoo. High poverty rates in the western areas of the City are largely attributable to situational poverty connected with the presence of large student populations near WMU. In contrast, the high poverty rates in the northern and eastern areas of the City are more often from the presence of generational poverty.

Percent of population with Medicaid (CC360)

Figure 11: Kalamazoo County Medicaid enrollment rates by census tract

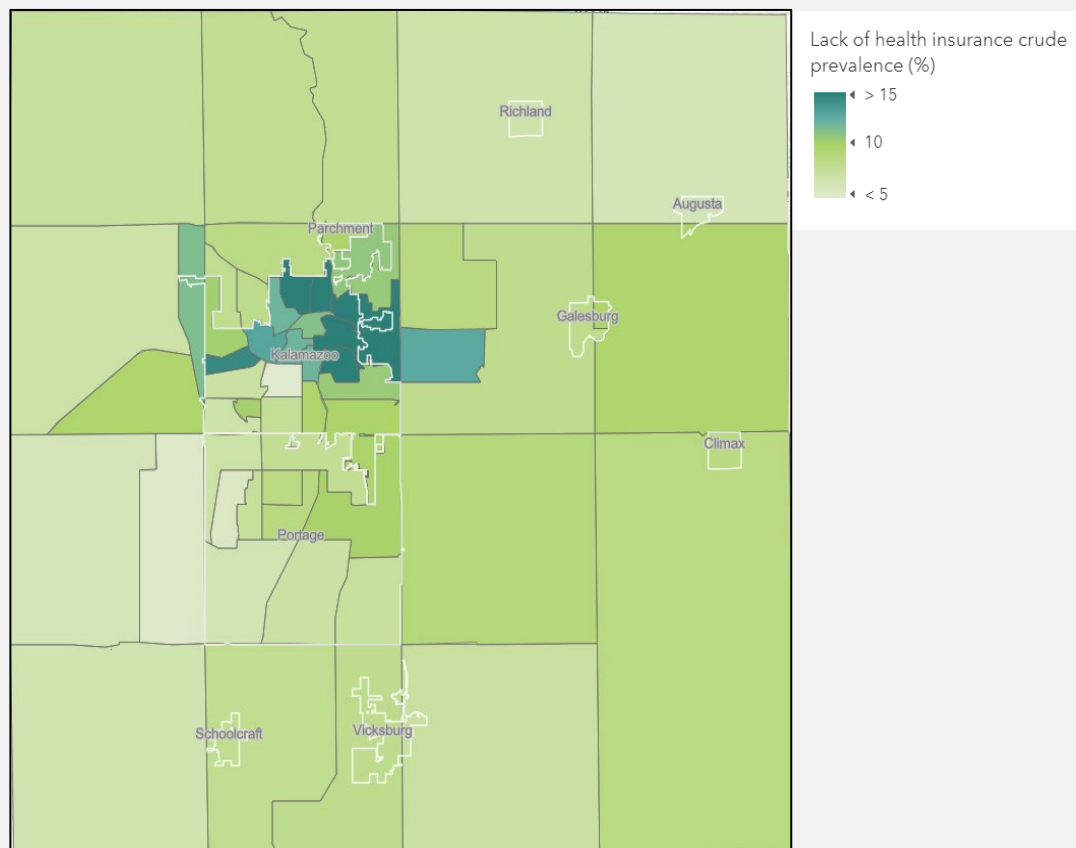


The utilization of Medicaid is an important metric for ISK, as Medicaid recipients constitute our primary target population. The types of services relevant to ISK (such as mental health treatment, substance use treatment, residential and personal care services, and long-term services and supports) are also disproportionately funded through Medicaid, compared to other types of health care spending.⁶⁶

Medicaid eligibility is usually based on poverty, so the geography of Medicaid coverage largely tracks the geography of poverty displayed previously. The exception is in the areas of the City of Kalamazoo near WMU – while these areas have high poverty rates, many of the individuals below the poverty line have low incomes only because they are currently students, not because they are living in generational poverty. Most students have access to other types of health insurance, so Medicaid enrollment rates in those areas are fairly low.

Estimated rate of lacking health insurance (PLACES)

Figure 12: Kalamazoo County uninsured rates by census tract

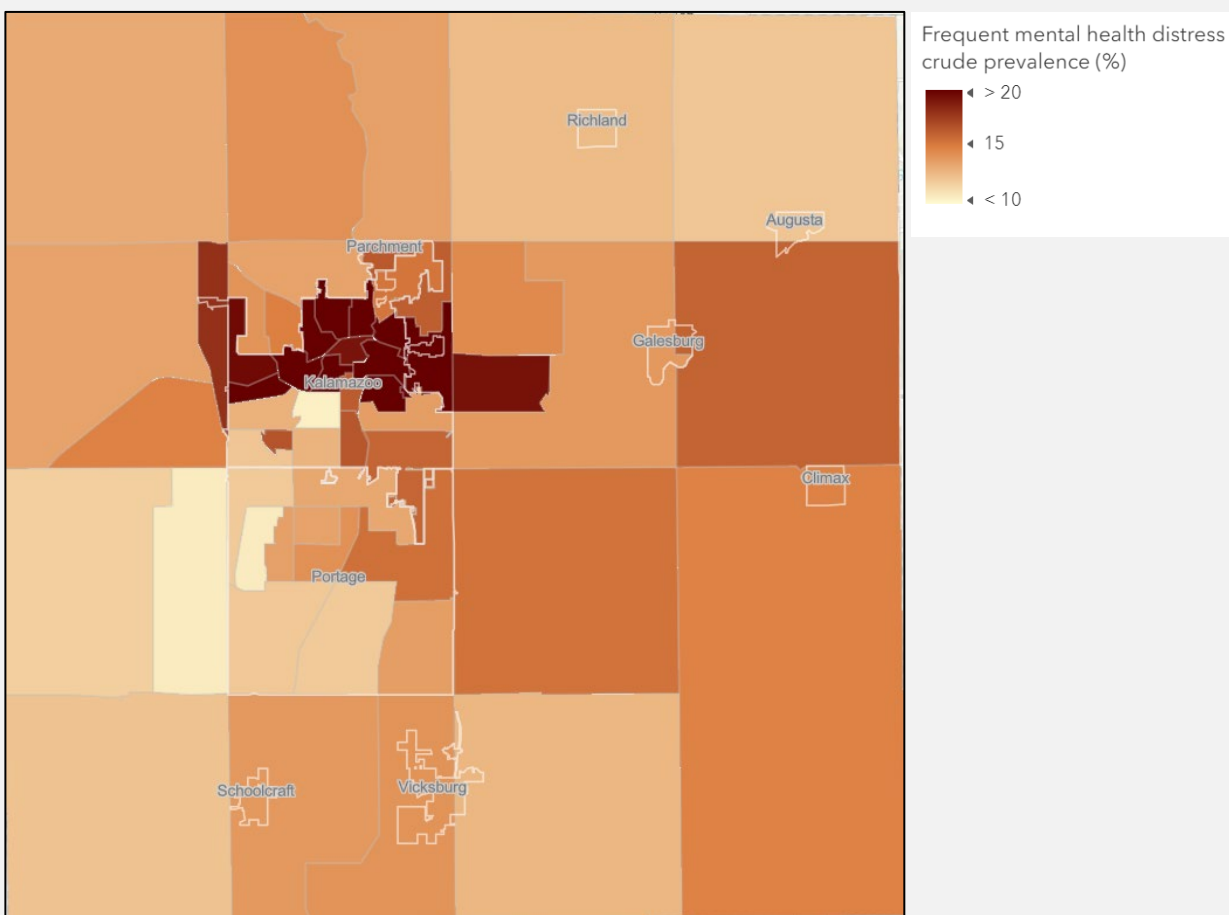


The BRFSS asked respondents whether they had any kind of healthcare coverage, including private plans, government plans like Medicare or Medicaid, or other types of coverage. People age 65 and older are not included in the denominator, since they automatically qualify for Medicare. In Kalamazoo county overall, the percent of adults age 18 to 64 who reported no health insurance coverage was 9.3%, which represents about 15,500 individuals. This data is from the BRFSS survey conducted in 2018. This is similar to the Census Bureau 2019 ACS estimate of 14,178 uninsured individuals.

Statewide, young adults are more likely to be uninsured than older adults; Black, Hispanic, and multiracial adults are more likely to be uninsured than White adults; and especially, people with low incomes are more likely to be uninsured. The PLACES project therefore estimates the uninsured rate to be higher in those geographic areas that have more young people and/or more people of color residing there, or which have a higher poverty rate. The areas with the highest estimated rates are the City of Kalamazoo's marginalized core neighborhoods: Northside, Eastside, and Edison. Not far behind are Knollwood (west of WMU) and the eastern piece of Kalamazoo Township (just outside city lines). All of these areas have an estimated 15% or more of their population uninsured. Even in the areas with the lowest rates, there are still meaningful numbers of uninsured people. The lowest rate is 5.2%, in the Oakland/Winchell and Westnedge Hill area.

Estimated prevalence of frequent mental health distress (PLACES)

Figure 13: Kalamazoo County rates of frequent mental health distress by census tract

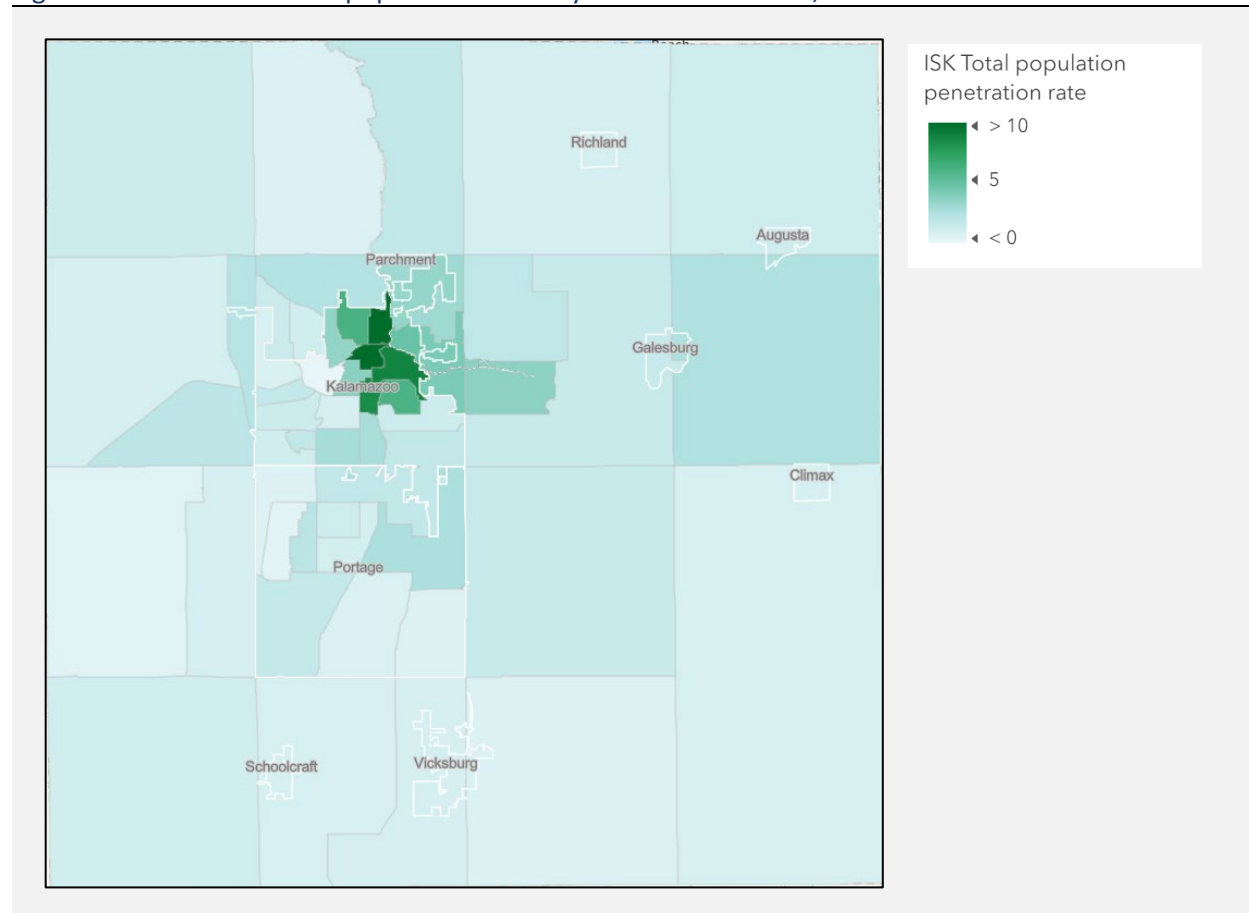


The BRFSS asked respondents to report approximately how many days during the preceding 30 days their mental health was “not good,” including stress, depression, and problems with emotions. If a person reports 14 days or more, the CDC categorizes this as “frequent” mental health distress. In Kalamazoo county overall, the percent of adults reporting frequent mental health distress was 14.8%, which represents about 30,400 individuals. This data is from the BRFSS survey conducted in 2018.

Statewide, young adults are more likely to report frequent mental health distress, as are people with low incomes. The PLACES project therefore estimates the uninsured rate to be higher in those geographic areas that have more young people and/or a higher poverty rate. The areas with the highest estimated rates are those with the most significant college-student populations (WMU, Knollwood, Westwood, Vine, and West Douglas) and those with the highest poverty rates (Northside, Eastside, Edison, eastern Kalamazoo Township and Comstock, and the Central Business District). All of these areas have an estimate of at least 19% of their population having frequent mental health distress. Even in the areas with the lowest rates, there is still a sizable population estimated to have frequent mental health distress. The lowest predicted rate is 10.5%, in the Oakland/Winchell and Westnedge Hill area.

ISK service population

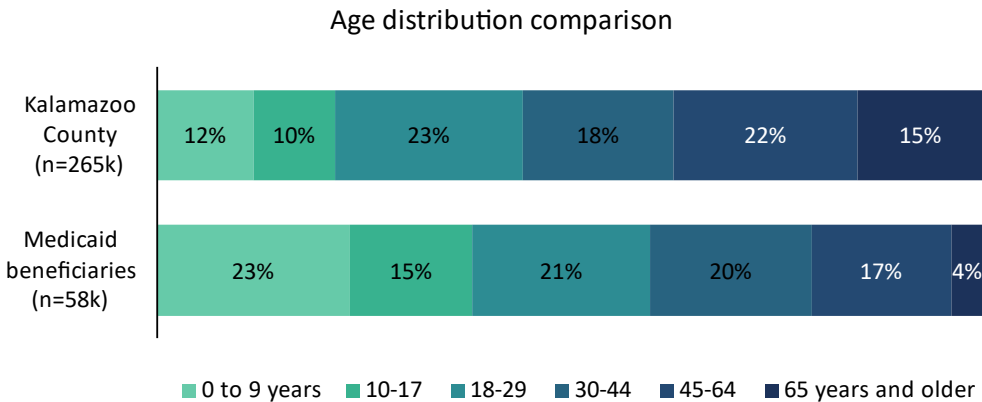
Figure 14: Percent of entire population with any ISK service contact, 2020



Not surprisingly, the proportion of the population who is served by ISK varies greatly by neighborhood demographics, from less than half a percent in some census tracts with less poverty and fewer Medicaid beneficiaries, to over ten percent of the entire population in some tracts with the greatest concentration of poverty and homelessness. The areas with the highest proportions of the population who are ISK consumers tend to be the core neighborhoods of the City of Kalamazoo that have high poverty rates, high rates of Medicaid enrollment, larger populations lacking health insurance, and higher estimated rates of mental health distress.

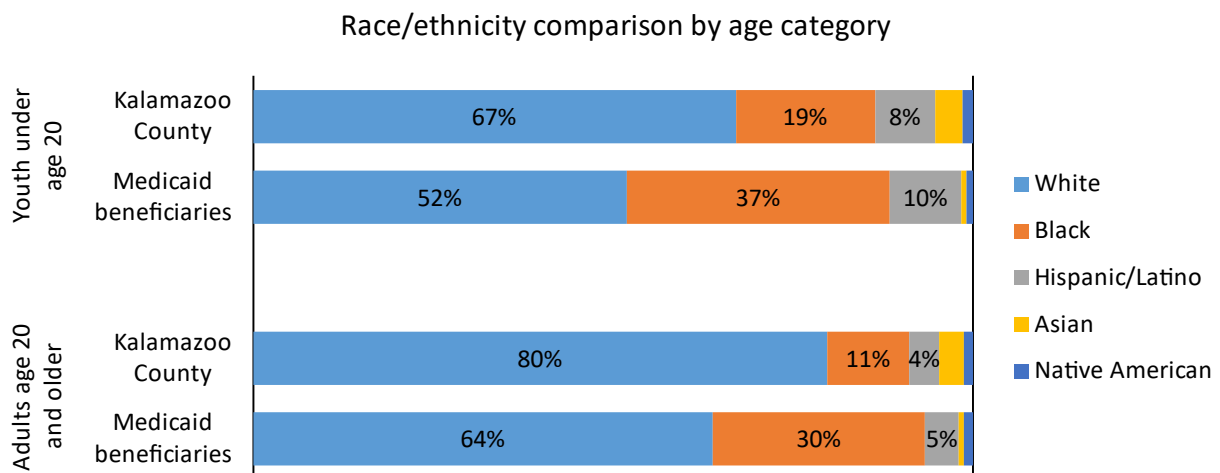
❖ Medicaid beneficiary population

The Medicaid population is notably younger than Kalamazoo County's population overall. While only 12% of the general population is young children under 10 years old, they make up fully 23% of the Medicaid population. On the other end, 15% of Kalamazoo County is age 65 or older, but only 4% of people with Medicaid are in that age group.

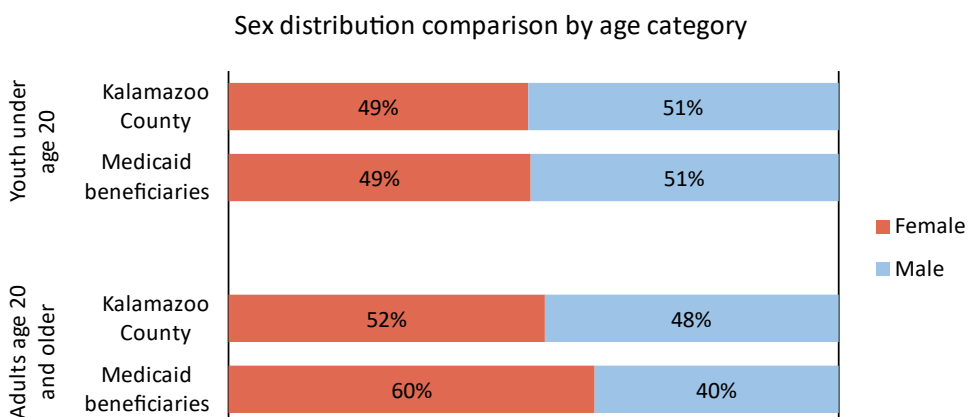


Across the country, younger age groups tend to be more often people of color compared to older age groups. This is the case as well for both the Kalamazoo County general population and the Medicaid population — 67% of all County youth are white, compared to 80% of all County adults; and 52% of Medicaid youth are white, compared to 64% of Medicaid adults.

Additionally, black residents are extremely over-represented in the Medicaid population among both adults and youth. Black people make up 19% of all youth, but 37% of youth in Medicaid; they make up only 11% of all adults, but 30% of adults in Medicaid.



Kalamazoo County overall is about evenly split along gender lines, with female individuals making up 49% of all youth and 52% of all adults. In contrast, within the Medicaid population there is a gender imbalance among adults such that the population is 60% female.



❖ Prevalence of behavioral health conditions / developmental disabilities

Diagnoses that indicate behavioral health conditions:

Anxiety or major depression	Bipolar disorder
PTSD	Schizophrenia and other psychotic disorders
Personality disorders	Substance use disorders
Eating disorders	Mental illness due to physiological conditions
ADHD (for youth)	Conduct disorders (for youth)

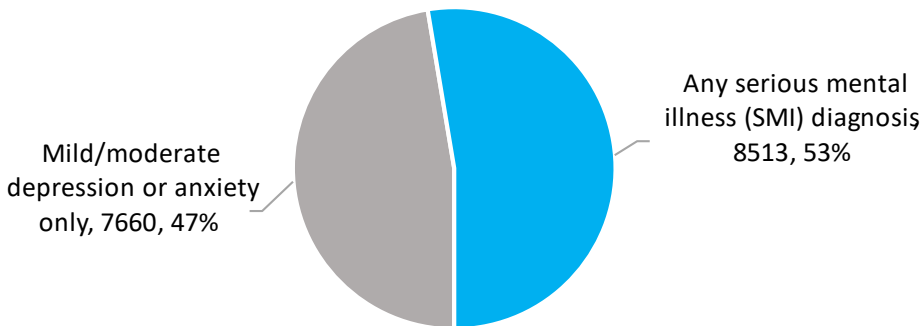
There were 16,173 adults over age 18 with any behavioral health diagnosis during the year (45% of all Medicaid adults), and 4,888 youth with any behavioral health diagnosis (22% of all Medicaid youth).

Diagnoses that are likely indicators of a intellectual/developmental disability:

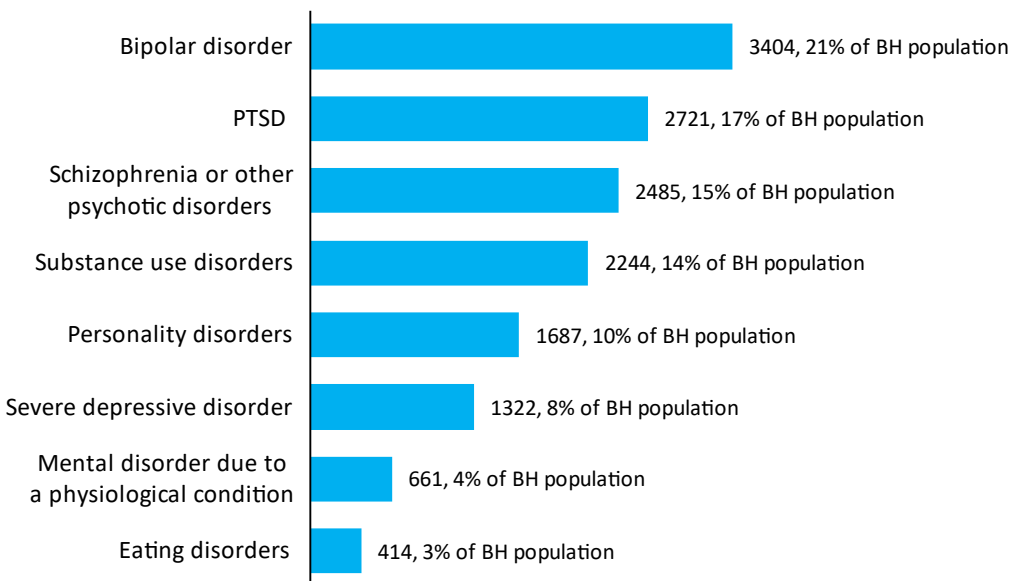
Moderate/severe intellectual disabilities	Chromosomal abnormalities
Some congenital disorders	Autism spectrum disorder
Other pervasive developmental disorders (for youth)	
Some specific learning disabilities (for youth)	

Diagnoses indicating a likely developmental disability were found for 1194 adults over age 18 (3.3% of all Medicaid adults), and for 1091 youth (4.9% of all Medicaid youth).

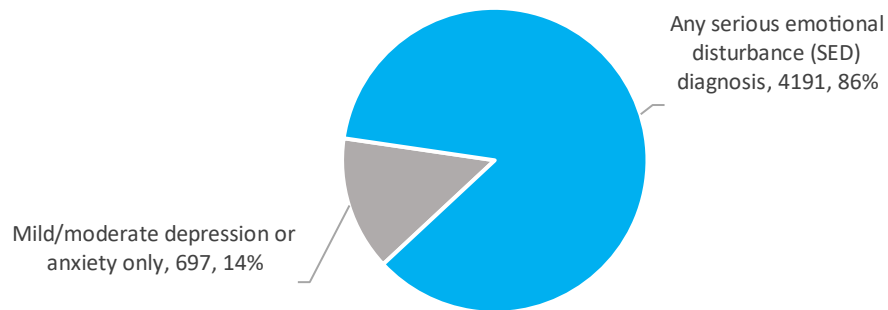
Adults types of BH diagnoses



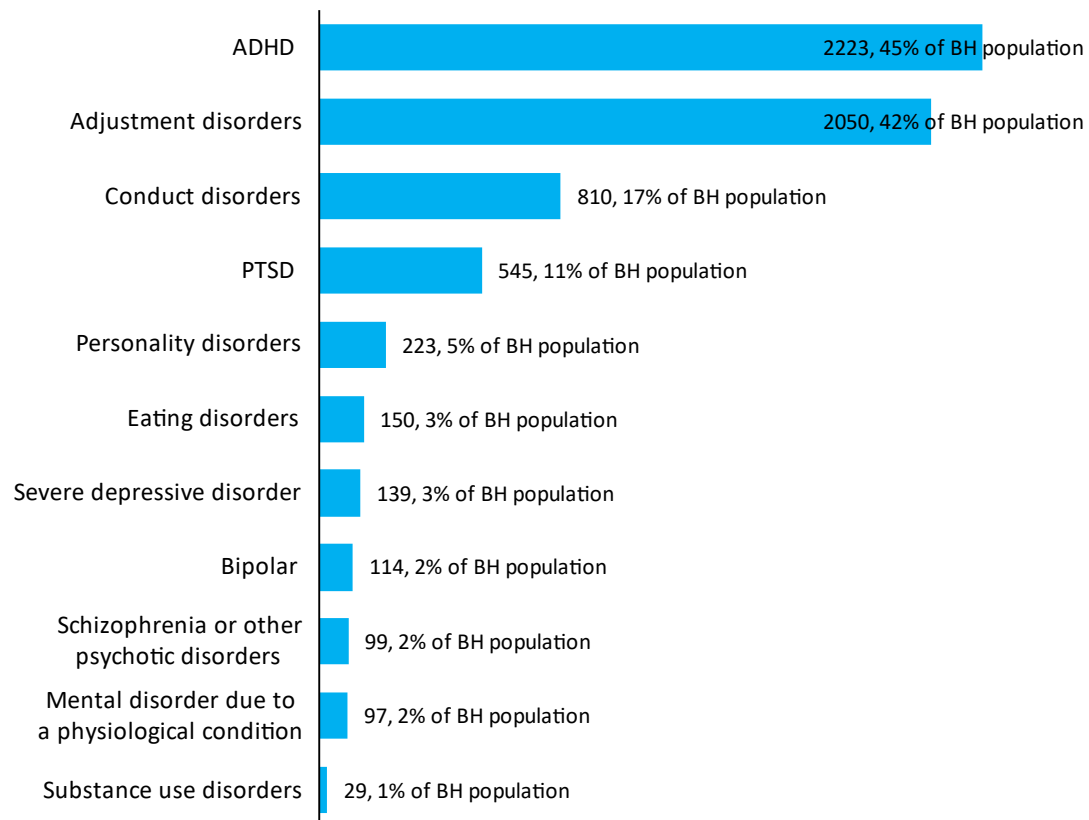
Frequency of SMI categories within adult Medicaid population



Youth types of BH diagnoses



Frequency of SED categories within youth Medicaid population



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