Indiana's Opioid Settlements

The United States is in the **midst of a crisis** on its streets and in its communities as **overdoses, homelessness, and disorder reach record levels**. Yet settlement proceeds secured by the State of Indiana present an **unprecedented opportunity for generational investment** in treatment capacity for substance-use disorder (SUD) and severe mental illness (SMI).

Indiana is set to receive **more than $1 billion** (*$1,109,941,520.41*) in opioid settlement funds—equal to nearly one-third of the state's share of the monumental Tobacco Master Settlement Agreement.[1] With twenty-one separate settlements and payments spread out over decades, the funds are **at risk of being squandered** through ad-hoc allocations to **diffuse and disorganized efforts**.

The state must ensure that this opportunity for treatment investment does not go underutilized. **Indiana can make targeted investments in treatment capacity** that will **honor those who suffered** in the opioid crisis and **ensure accessible care** for decades to come.

Indiana splits all received settlement funds evenly between the state and subdivisions. The state's share (*$605,333,609.77*) is suballocated with 15 percent of all funds in an unrestricted account controlled by the state legislature and 35 percent of all funds in an abatement account controlled by the office of the secretary of the Family and Social Services Administration, with prior approval of a distribution plan by the budget committee.[2]

While this structure allows for some accountability and oversight, the state should amend IC 4-12-16.2-5 and **reserve all funds for appropriation by the legislature** in order to start prioritizing investments in priorities that will have the largest impact. It's not clear that funds are being spent responsibly. Indiana's reporting indicates nearly $1 million spent on harm reduction in 2024.[3] However, the bulk of the state's allocations do not provide detail and only indicate the "Exhibit E" qualifying strategy that most closely aligns with the allocation.

The state must rein in the potential misallocation of these funds and prioritize investments in comprehensive treatment networks. **Three priorities** (Certified Behavioral Health Clinics, secure psychiatric beds, and community SMI/SUD response) **will ensure these funds have the largest impact** on the state.

Certified Community Behavioral Health Clinics (CCBHCs)

CCBHCs are designed to ensure access to coordinated comprehensive behavioral health care and are stably-funded and supported by all recent presidential administrations. CCBHCs are a key response to

the opioid crisis and can augment other services such as police crisis response teams, homelessness outreach and services, and outpatient psychiatric commitment services.

- **Solution: Fund the development and expansion of CCBHCs.**
    - Expand the CCBHC footprint with an emphasis on a team-based approach to co-occurring disorders.
    - Create a stepped approach to SMI/CSA treatment with services provided by the CCBHCs.
    - Require CCBHCs to offer specific care pathways to meet the needs of individuals with co-occurring disorders.

State Psychiatric Hospitals

Inpatient beds in secure facilities are critical for serving the highest-acuity psychiatric patients. Indiana currently has only **9.1 state psychiatric beds** per 100,000 people available for civil patients.[4] [5] Treatment Advocacy Center recommends a rate of 30-60 beds per 100,000. Even counting non-public secure psychiatric beds, Indiana still falls short of the minimum.[6] Secure beds are costly, but a necessary expenditure to protect patients with severe psychiatric disorders and the public at large.

- **Solution: Fund the expansion of civil psychiatric beds.**
    - Invest in expanding state hospital capacity.
    - Move forensic (criminal) commitments to a jail-based restoration facility.
    - Apply for one of several Section 1115(a) waivers to expand Medicaid reimbursement for institutions for mental diseases (IMDs).

Inpatient Stabilization Centers and Mobile Crisis Teams

Emergency departments (EDs) are supposed to be a last-resort for times of true emergencies, but are increasingly used for all types of immediate-need medical care, especially true for low- to medium-acuity mental health crises. In order for the other two priorities to have the largest impact, there must be an immediate triage of low-acuity patients from higher-need patients, or else these investments will be drowned out, overburdened, and underutilized by those that need them most, just like emergency departments.

- **Solution: Fund community-based mental health response resources.**
    - Expand community-based recovery centers, including voluntary short-term respite housing, especially for young adults.
    - Leverage CCBHC resources to develop comprehensive mobile crisis response teams in conjunction with police crisis intervention teams (CIT).
    - Support integration with crisis networks such as the Lifeline to support those in need or provide guidance for concerned loved ones.

[1] KFF. "Actual Tobacco Settlement Payments Received by the States (in millions)." Accessed 8 September 2025. https://www.kff.org/health-costs/state-indicator/tobacco-settlement-payments.
[2] IC 4-12-16.2-5. Accessed 9 September 2025. https://iga.in.gov/laws/2025/ic/titles/4#4-12-16.2-5.
[3] Office of Drug Prevention, Treatment and Enforcement, "Annual Opioid Settlement Report." *Indiana Family and Social Services Administration*. 2024. https://www.in.gov/recovery/files/2024-Annual-Opioid-Settlement-Report.pdf.
[4] Treatment Advocacy Center, "Indiana Psychiatric Beds Report." 2023. https://www.tac.org/wp-content/uploads/2023/10/Indianabedsinformation.pdf.
[5] United States Census Bureau, "2023 American Community Survey – Total Population." https://data.census.gov/table/ACSDT1Y2023.B01003?q=population&t=Population+Total&g=010XX00US$0400000.
[6] Silver, Shanti, "Estimating Psychiatric Bed Need in the United States," p. 2-4. Treatment Advocacy Center Office of Research and Public Affairs. January 2024. https://www.tac.org/wp-content/uploads/2024/03/TAC_ORPA_ResearchSummary1.24.pdf.