Southwestern Healthcare, Inc.

Caring for our Communities

2009 Community Mental Health and Addiction Needs Assessment

Gibson, Posey, Vanderburgh and Warrick Counties
August 2009

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Funded through a grant from the Welborn Baptist Foundation, Inc. awarded to Southwestern Healthcare, Inc.

Acknowledgements

The 2009 Community Mental Health and Addiction Needs Assessment was commissioned by Southwestern Healthcare, Inc. with funding through a grant from the Welborn Baptist Foundation, Inc. Diehl Evaluation and Consulting Services, Inc. was contracted to conduct the needs assessment study. A Planning Team comprised of local addiction and mental health professionals was formed to oversee all aspects of the project. Collectively, this report represents the work of various individuals and organizations. The authors gratefully acknowledge the many mental health and addiction service providers who completed in-depth inventories and surveys related to existing services, along with various ancillary service providers and referral sources who also gave time to complete survey instruments. We also thank the individuals from direct and ancillary service providers, along with consumers of mental health and addiction services, for participating in individual interviews and/or focus groups. Finally, we thank the many representatives from various community organizations who gave their time and energy to serve on either the Planning Team or Advisory Committee.

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Executive Summary

Southwestern Healthcare, Inc., with funding through a grant from the Welborn Baptist Foundation, Inc., commissioned a study to conduct a community mental health and addiction needs assessment for Gibson, Posey, Vanderburgh, and Warrick Counties in Southwestern Indiana. The purpose of the study is to determine the current needs, strengths, and gaps in the local mental health system with the intention to aid community stakeholders in understanding priority areas that should be addressed to create a mental health system that meets the needs of the community. Additionally, information gathered through the process will serve as an educational tool related to various types of services provided in the region. Ultimately, data from the needs assessment will serve to improve the quality of mental health and addiction services provided to members of the community, thus enhancing the quality of life of those receiving services.

Two primary research questions guided the study:

1. What are the current strengths and priority needs to be addressed in the region related to addiction and mental health services?

2. To what degree are these priority needs being met by organizations in the region, as indicated by existing gaps in services provided?

A Planning Team was formed to oversee all aspects of the project. This included identification of study objectives, review and approval of data collection instruments, analysis of secondary data, and review of needs assessment findings. Members of this team included mental health and addiction professionals who work directly with consumers throughout the four-county area. In addition, an Advisory Committee comprised of a broader group of mental health, addiction and ancillary service providers was formed. This team provided input on technical aspects of the needs assessment process.

Four interrelated goals were identified: (1) To conduct an epidemiological study that compares prevalence of mental health and addiction conditions to available services in the region; (2) To conduct an inventory of existing mental healthcare and addiction service providers and programs; (3) To assess the capacity of providers to deliver mental health and addiction services and how individual organizations function and work together to accomplish service delivery; and (4) To assess mental health and addiction needs perceived by referral sources, providers, patients, and members of the community.

Several methods were used to address the primary research questions and related study goals. These methods involved a review of existing epidemiological data sources, inventories of current services and surveys of direct service and ancillary service providers. Additionally, the methods involved purposeful focus groups and individual interviews with key informants including both views of consumers of mental health and addiction services, as well as direct and ancillary service providers. Findings are summarized as major strengths, barriers to accessing and receiving services, and needs and gaps in service.

Mental Health and Addiction Strengths

Several strengths in the mental health and addiction system were identified within the region, including the presence of local mental health and addiction organizations and support groups, the types and quality of service offered by local organizations, and the existence of qualified and dedicated mental health professionals.

Presence of Local Mental Health and Addiction Organizations and Support Groups. One of the key strengths noted by service providers and consumers was the existence of organizations that offer mental health and addiction services in the community. Among direct service providers who responded to the Inventory of Addiction and Mental Health Services, most of the service levels identified were being offered to some degree within the region. Levels of care include inpatient (hospitalization), partial hospitalization/day treatment, intensive outpatient services, outpatient services, and residential treatment. Specifically related to inpatient service, there are four facilities in the four-county area providing this level of service. These include two large general hospitals, a state hospital that primarily treats adults for mental health and addiction issues, and a state hospital that primarily provides children's psychiatric inpatient services. As one focus group participant noted, the mental health inpatient services his son has accessed "kept him safe" and "allowed the family to regroup." Approximately 78% of the direct service providers that participated in the survey process offer outpatient services. To give a sense of the number of services available, 72 direct service providers were identified and invited to participate in the needs assessment study. While some of these providers represent a single individual, many of the organizations employ multiple mental health and addiction professionals.

In addition to the organizations that primarily provide mental health and addiction services, there are many other organizations, such as non-profits, faith-based organizations, government agencies, and schools that offer therapy and/or counseling services for mental health issues. Through the survey process and focus groups conducted with service providers and consumers, a strong presence of support and advocacy groups in the community was noted. Examples of these groups include Alcoholics Anonymous, Narcotics Anonymous, National Alliance on Mental Illness, and Mental Health America. One focus group participant described her experience with a particular support group as "life altering" and emphasized the belief that the information she had received greatly impacted her life.

"There are great non-profits in the area."
-- Provider Focus Group Participant

Services Offered by Local Organizations. The actual services offered by the organizations in the community were also identified as a strength. In addition to the levels of service noted above, the existing service providers are able to address a wide range of mental health and addiction needs. Among the 24 direct service providers that responded to the Inventory of Addiction and Mental Health Services, each of the mental health and addiction issues is treated by at least four of the organizations. Further, based on information provided by organizations that make referrals for mental health services, there is a limited set of issues for which referrals must be made outside of the four-county area. While not every condition may be addressed effectively by the services that are available in the community, organizations that do offer services are equipped to treat a large number of mental health and addiction concerns.

As noted through the needs assessment process, individuals who are receiving mental health and addiction services often have need for other services such as assistance with housing, transportation, and job skill development. Although there are some areas where such ancillary services are lacking, many organizations in the community, both direct providers of mental health and addiction services and other support organizations, provide a large number of those services. The key to ensuring that these services are beneficial to consumers is maintaining a system that connects individuals to resources and enhancing the integration of services by various providers.

Qualified and Dedicated Mental Health and Addiction Professionals. Based on the number and types of mental health and addiction issues that are addressed by organizations and individuals in the community, the professionals who provide direct service to consumers are well qualified to address a wide range of concerns. Focus group participants, both providers and consumers, cited the level of dedication that many professionals have in providing services (e.g., “dedicated therapists that are passionate” and “providers have a dedication for pursuing new treatments and strategies”). As noted by the inventory of mental health and addiction positions identified through the needs assessment process, a full spectrum of licensed and certified professionals provide service in the community. These include psychiatrists, clinical psychologists, licensed clinical social workers, masters-level social workers, case managers, and other types of counselors. In addition to professionals who provide services in mental health and addiction facilities, there are also individuals throughout the community who are trained to address mental health concerns in organizations such as schools, non-profits, and government agencies.

“There are qualified, devoted people working in the area.” -- Provider Focus Group Participant

Collaboration among Providers. Many of the individuals who completed surveys and participated in focus groups cited instances of collaboration and effective communication among service providers. Of particular note are the relationships with case managers in coordinating services for individuals and ensuring those consumers are connected to the

services they need. In one particular county, probation officials indicated a high degree of collaboration in delivering services to individuals who have been involved in the court and prison system. Further, large-scale community projects such as two Safe Schools/Healthy Students grants in the area have fostered better coordination of services to children and their families. As one mental health care provider noted, “I am pleased with our collaboration with the schools.”

Specifically related to the issue of collaboration, direct and ancillary service providers who completed needs assessment surveys were asked two questions that addressed the degree to which they collaborate with other service providers and the degree to which service providers collaborate in general. Overall, providers indicated above-average levels of collaboration with other providers. Direct service providers particularly believe they collaborate often with other service providers. In terms of collaboration among providers in general, all respondent groups indicated that everyone else collaborates to a lesser degree than they collaborate. This discrepancy may indicate a misperception that providers have about collaboration in general. One explanation may be that providers are not fully aware of the level of collaboration that actually does exist in the community.

Barriers to Accessing Mental Health and Addiction Services

One of the key issues addressed through the needs assessment process was the extent to which various barriers prevent individuals from receiving mental health and addiction services. Based on a synthesis of survey and focus group responses from consumers, direct service providers, and ancillary service providers, several barriers were identified including underinsured patients, clients unable to pay for services, lack of early intervention, and a lack of awareness of existing services.

Underinsured Patients. Both direct service providers of mental health and addiction services and providers of ancillary services were asked to indicate the degree to which certain barriers exist for clients in accessing services within their communities. Among direct service providers and non-school organizations, the most significant barrier was clients not having enough insurance to cover the costs associated with services and medications. This concern was echoed by many of the providers who participated in the focus groups. As noted by one provider, “There is a gap where we cannot help people that are uninsured.” While consumers may be able to receive initial assessment and a limited number of therapy sessions, some insurance policies may not cover the full range of services that are needed by clients. Individuals also may face high deductibles and co-payments that they cannot afford, which may lead to a suspension of services. Programs such as the Healthy Indiana Plan and Hoosier Healthwise were noted as providing mental health coverage for low-income individuals, but given the limits on enrollment numbers, some individuals have been unable to receive health coverage through these programs. In addition to the limited range of coverage that some consumers have with their health insurance policies, needs assessment participants also indicated that Medicaid clients have a limited provider list given that some providers do not

accept this form of insurance. Therefore, the types of services that are available to low-income individuals in particular may be limited due to the lack of providers in certain areas.

Clients Unable to Pay for Services. Clients' inability to pay for services was the second most significant barrier rated by all service provider groups who responded to the needs assessment surveys and a primary concern raised by consumers through focus groups. This is underscored by responses from direct service providers that approximately 64% of respondents (9/14) have clients who are unable to pay for services. Further, almost one-third of the respondents have at least 10% of their clients who cannot pay for services, while 1 (11%) indicated 11-25% of clients, 2 (22%) indicated 26-50% of clients, and 1 (11%) indicated that over 75% of its clients are unable to pay for services. Feedback from consumers indicates that the inability to pay is the key issue they face when attempting to access services. This may be true for individuals who have insurance or for those without insurance coverage. Of particular note, some consumers highlighted the relationship between their condition and the absence of insurance. For example, one consumer attending a focus group stated, "Many addicts are temporary workers (e.g., construction) so they do not have insurance." For some individuals, even those with insurance, the inability to pay may lead them to believe that mental health or addiction treatment is not a feasible option for them. Therefore, these individuals may never access the services they need to address their mental health or addiction problems. Another issue related to the inability to pay is that some families have incomes that are too high to qualify for Medicaid but too low to afford to pay for things other than the basic necessities. As mentioned, state-funded programs have attempted to address this concern, but some individuals have not been able to access these plans due to limits on enrollment numbers. It should be noted that approximately 76% of the direct service providers who responded to the Inventory of Addiction and Mental Health Services provide some form of assistance to individuals to pay for services, which indicates that organizations are attempting to address this particular barrier.

"Having no insurance at all is worst case scenario." -- Consumer Focus Group Participant (Parent)

Lack of Early Intervention. The lack of early intervention for consumers who have mental health or addiction needs was the third most significant barrier rated by direct service providers and non-school ancillary providers. This barrier was the fourth most significant barrier rated by schools. The key issue with this barrier is that underlying issues may not be addressed early enough in a person's life or in the course of the disorder to effectively treat the issues related to the problem. Treatment may become very costly and lengthy if issues have continued to compound over time. For some clients, the lack of early intervention is directly related to the financial concerns discussed above. As one consumer attending a focus group stated, "Most addicts start abusing drugs at a young age, so they never really have a chance to get a job and have insurance." For others, issues such as the stigma of receiving services, the lack of professionals in the community, and a lack of awareness of services may contribute to an

individual's failure to receive services. To address this barrier, direct service providers have attempted to offer appointments within a relatively short time frame. In fact, the majority of organizations (68%) indicated they have no wait time or that clients are seen within seven days. Emergency and crisis services are also provided by a number of organizations to quickly respond to situations that require immediate attention. Additionally, the presence of school social workers and case managers are likely to address concerns that children may have early in their lives, and necessary services may be connected to those children and their families in a timely manner.

"We aren't bad people trying to be good, we are sick people trying to be well." --Consumer Focus Group Participant

Clients Unaware of Existing Services.

Awareness of services is an issue that many service providers believe poses a barrier for clients in accessing services. This was particularly a concern for schools, which rated this issue as the most significant barrier for students and families. As one provider focus group participant stated, "People don't know where or how to access services."

Mental Health and Addiction Needs and Gaps in Service

The convergence of data sources utilized for this needs assessment study has indicated the pervasiveness of mental health and addiction issues throughout the community. Specifically related to mental health, severe depression is believed to affect approximately 7 to 8% of the population within the course of a year, and anxiety impacts up to 18% of individuals each year (Kessler et al., 2005; Regier et al., 1999). Over 7,000 clients were treated by the 24 organizations that responded to the Inventory of Addiction and Mental Health Services for depression and anxiety combined. Over 21,000 were provided services by these organizations for mental health and addiction issues. As noted by the Vanderburgh County Coroner's Office, Vanderburgh County alone has seen a significant climb in the number of suicides. This increase also has been witnessed across the state of Indiana. Approximately half of the individuals who committed suicide in 2008 were experiencing relationship problems and almost one-third were having health problems (Vanderburgh County Coroner's Office). These are issues that may have been accompanied by depression or other serious mental health concerns.

In addition to mental health issues, there are significant concerns related to addiction. In 2008, there were 33 accidental overdose deaths in Vanderburgh County. This was an increase from the 2007 count of 26. Further, based on the latest National Survey on Drug Use and Health data available for Southwestern Indiana (average of 2004-2006), it is estimated that 9.8% of individuals in Southwestern Indiana experience dependence on or abuse of alcohol or illicit drugs. The 2006/2007 average for Indiana was 8.73%, and the 2007 rate for the United States was 9.0%. As an indication that substance use begins in the early years for many individuals,

17% of 8th graders in Southwestern Indiana report monthly alcohol use and 10% report binge drinking.

Based on these statistics alone, it is apparent that there are a multitude of mental health and addiction issues that individuals in the community experience, therefore establishing the need for services. The following issues are those for which needs assessment participants expressed the greatest need and largest gaps in service, as determined by a synthesis of epidemiological data, provider and ancillary service surveys, and individual and focus group interviews. Given that overall themes or concerns were not ranked based on the level of need expressed by members of the community, these are not listed in order of greatest importance. Moreover, while key themes are provided below, a review of findings from the four study goals contained in this report is strongly encouraged.

Treatment for Low-Income, Underinsured, and Uninsured Consumers. As noted above, the majority of direct service providers have clients who are unable to pay for the mental health and addiction services they receive. As noted by many of the focus group participants, particularly consumers, there is a significant need for services that are available to individuals in lower-income brackets. If individuals are able to pay for some of the services, care may be limited if clients discontinue their treatment prematurely due to cost. This report provides totals for the number of individuals treated for specific conditions. Based on the estimated numbers of individuals who have certain disorders or issues, the numbers in this report likely do not reflect the full extent to which services are being accessed. It is possible, as mentioned previously, that some individuals do not think mental health care is an option for them given what they believe is a lack of comprehensive services for people who are unable to afford the services. This idea also brings up the possibility that individuals are not aware of the services that they can access as limited-income individuals, which speaks to the need for greater awareness of existing services in the community. In some cases, the services may actually be available but consumers do not have the information to access them. One additional point made by consumer focus group participants is that convenience of appointment times is very important, particularly for individuals who cannot take time off work to go to appointments. They need their current job for the income and fear losing that job if they attend appointments during the work day. This applies not only to individuals who are receiving treatment for themselves but also for family members of patients. As noted by one parent of a child who was receiving mental health care services, “It is hard for a parent to have a job when dealing with a child that cannot be at school” because they are in treatment.

Shortage of Psychiatrists for Children and Adults. One of the consistent themes that arose from both providers and consumers during the needs assessment process is that there is a lack of psychiatrists in the community. While a large number of the respondents mentioned the need for child and adolescent psychiatrists, the shortage also applies to those who primarily treat adults. As noted by employee counts reported by direct service providers, the vacancy rate for psychiatrists among responding organizations is 12.5% (vacancy rate = number of vacant positions ÷ total positions available). This represents one of the largest shortages for any

type of mental health or addiction service providers. Of note, an additional psychiatrist not referenced in the survey results was expected to leave the community in the summer of 2009, which may actually increase the vacancy rate for this position. Based on national rates for psychiatrists per 100,000 population, the four-county area falls below the national average. With a U.S. average of 13.83 psychiatrists per 100,000 population, the four-county study area currently has a rate of approximately 11.7 psychiatrists per 100,000 population (Calculation: 34 psychiatrists ÷ 290,531 residents in the four counties x 100,000). Note that since the 34 psychiatrists represent individuals and not necessarily full-time employees (FTEs), this rate is likely lower. Most affected are the counties that surround Vanderburgh, which have lower per capita numbers for both psychiatrists and psychologists. It should be noted that Indiana as a state has a shortage of psychiatrists. Compared to surrounding states, the number of psychiatrists per 100,000 population is lower than all other states, with an estimated 7.41 of these physicians per 100,000. While Vanderburgh County by itself has a per capita rate that exceeds the state and national averages (17.17 based on the number of psychiatrists that practice in Vanderburgh County and the population of the county), the other three counties in this study each have a per capita rate of less than 4.0 per 100,000. As mentioned, these actually may not represent full-time psychiatrists. It should also be taken into account that the services in Vanderburgh County are accessed by many individuals in surrounding communities and must shoulder the need for professionals such as psychiatrists. Therefore, the Vanderburgh per capita rate is not completely representative of the capacity related to psychiatric services.

Inpatient Beds for Youth and Adults. As indicated previously, there are four facilities in the community that maintain inpatient beds for mental health and addiction issues. Two are private health care facilities that provide short-term acute care, and two are state-operated facilities that provide long-term care, including one for adults and one for children. The private short-term acute care facilities maintain 62 beds for adults and 30 beds for children. The state-operated long-term care facilities maintain 168 beds for adults and 28 beds for children. A number of participants cited the need for additional inpatient services to treat individuals who require medical care and who need to be monitored for an extended period of time. Of particular concern was the need for inpatient services specifically related to substance abuse treatment for youth and adults. Related to this is the need expressed by some consumers for medical detoxification services. A provider indicated that no detoxification services exist for youth. Further, consumers noted that while a treatment facility may offer a social detoxification service, patients must be medically stable. However, there appears to be a gap in service between consumers who meet medical criteria for a hospital admission and those meeting criteria for a social detoxification program. Individuals may be too medically unstable for a social detoxification program but not medically unstable enough to meet hospital admission criteria. Further, for those admitted to social detoxification, a two-week inpatient stay was identified as not enough time to begin recovery.

Long-Term Residential Services. Among the direct service providers who participated in the survey process, six of the organizations offer long-term residential services (i.e., >= 30 days). These organizations reported treating approximately 280 individuals within the past reporting year. Per respondents, this represents 119 long-term residential beds. Participants indicated a

need for residential services specifically for substance abuse issues. This is particularly a concern for individuals who are uninsured or underinsured given the expense of utilizing these long-term services.

Addiction and Other Services for Youth. Overall, the least-served age group by participating organizations is youth, particularly children under the age of five. Of specific concern to providers and consumers are available services to treat addiction in youth and adolescents. Based on 2007 data from the National Survey on Drug Use and Health, an estimated 7.7% of individuals between the ages of 12 and 17 are classified as having substance dependence or abuse. An even greater percentage of youth who are engaged in high risk behaviors such as binge drinking is noted for Southwestern Indiana. Therefore, data have established that youth have substance use issues that rise to the level of requiring treatment. One valuable resource to identify these concerns is the presence of social workers in many of the schools who are able to connect children and their families to needed resources.

The issues identified by schools as the highest areas of referral included behavioral issues (fighting, aggression toward family and classmates, etc.; 89.2% of schools refer students), childhood disorders (ADHD, etc.; 79.7% of schools refer students), and anger management (78.4% of schools refer students). These reasons for referral may offer insight into potential areas for preventive services.

Transitional Living for Individuals in Recovery. A need particularly expressed by consumers was the need for more transitional living for those completing treatment, especially pertaining to substance abuse. First, it is likely that some of the individuals who have experienced addiction lose housing and do not have a permanent home upon completion of a treatment program. This speaks to a larger need related to housing services for individuals receiving all forms of mental health care. Second, individuals may have completed extensive treatment programs and need a safe environment in which to re-engage with their communities and families. This would provide the independent living skills that many individuals need as part of their course of treatment. Finally, there is a significant concern that individuals who have experienced addiction will return to the same family members or social group that supported their addiction in the first place. A longer transitional period may provide those individuals with the skills to cope with the negative influences that enabled their addictions. Focus group participants highlighted the need for more transitional homes for men, indicating that there were few in the community. While several programs in the community were highlighted for women, focus group participants also indicated a need for more transitional housing for this subgroup.

Additional Treatment Services in Specialty Areas. When indicating the greatest mental health and addiction needs in the community, many respondents referred to depression and anxiety as the top mental health needs, and alcohol abuse, general drug abuse, and methamphetamine use as the most significant addiction concerns. While eating disorders, child sexual abuse, and personality disorders were not among the top overall need areas, nor the areas for which the largest number of individuals are treated or referred for services, they are issues that were specifically mentioned by providers and consumers as areas where gaps in

service may exist. Multiple providers who make referrals for services indicated that they have had to make referrals for eating disorder treatment outside of the four-county area because adequate treatment options do not exist in the community. As noted by one focus group participant, the complexity of the issue makes it difficult to treat, and therefore, services related to this area are lacking in the community. This observation also pertains to child sexual abuse and personality disorders.

When completing the Survey of Ancillary Services, organizations were asked to indicate issues for which they must make referrals outside of the four-county study area. Several of the organizations indicated sending clients or students for inpatient services, including treatment for substance abuse, dementia, and eating disorders. Others referred clients to residential services in other areas, particularly residential treatment for children and specifically for the issue of eating disorders. Further, approximately 60% of organizations that indicated they had referred individuals outside of the four-county area either specifically mentioned services for children or are schools that work with children and adolescents. This may indicate a particular need for services specifically related to this age group.

Finally, two areas related to the treatment of co-occurring disorders or diagnosis emerged from provider surveys and participant focus groups. First, participants expressed a need for deliberate treatment approaches associated with dual diagnosis of addiction and mental health disorders. While current treatment services were acknowledged, this area was identified as a need for treatment of both disorders together. Suggestions were offered for increasing training in this area for professionals. In addition, a need for mental health services for individuals with mental retardation and other developmental disorders (e.g., no psychiatric treatment options) was also identified. This was an area where ancillary service providers indicated referring outside of the community for treatment, as well as an area of need and gap in service that was identified from participant focus groups.

Better Coordination and Access to Existing Services. While overall collaboration within the communities was identified as a strength of the current mental health system, there were specific areas where the coordination of services and access to services could be improved. Specifically, the need for better coordination with primary health care providers was mentioned. Given that psychiatrists may not be available for consults for several weeks or months, the primary physician may need to address mental health issues from a medical standpoint. Enhanced integration of physical healthcare with mental healthcare was seen as one way to better coordinate services. Additionally, given that schools rated the lack of awareness of services as the top barrier for their consumers, it appears that communities would benefit from increased education regarding current mental health and addiction resources. From the standpoint of consumers, they often feel volleyed from one service provider to the next and recognize that the individual providers have not assessed their case from a coordinated point of view. In many cases, clients have worked closely with a case manager or someone who maintains close contact with them during treatment. The continuum of care may be negatively impacted if that professional vacates their role and other individuals involved in the treatment process have not worked to integrate services for the client.

Services for Prisoners and Individuals on Parole. Individuals who work closely with persons who have been in the court and prison systems expressed concern about the lack of mental health services available to incarcerated individuals and the opportunities for receiving mental health treatment prior to entering the jail population. Some focus group participants did not believe that enough efforts are made to address mental health concerns, as well as the combination of addiction and mental health problems, when individuals are being processed through the court system. If mental health needs of prisoners are not met prior to being released into the community, individuals may not have the necessary skills to successfully handle the transition. Specific ancillary needs that were identified for transitioning offenders included access to jobs, housing, and transportation. In terms of employment, some individuals expressed the difficulty of obtaining employment with a felony on their record and others mentioned the challenge of maintaining employment while receiving treatment. Although services for offenders emerged as a need, a common theme among participants was the positive impact of Drug Court in the counties that provided the service.

Study Limitations and Considerations

While this study provides a detailed, insightful assessment of mental health and addiction needs in the community, there are some limitations that should be addressed. First, results from the Inventory of Addiction and Mental Health Services are based on data from organizations that agreed to participate in the study. Although a comprehensive group of organizations and individuals who provide direct mental health care were invited to submit data, not all chose to do so. It should be noted, however, that many of the larger mental health facilities in the four-county area, which together serve a significant amount of individuals, participated in the study. Further, a self-selected group of organizations responded to the Survey of Ancillary Services. While this did not include all organizations that provide support services, education/intervention/enrichment services, or referrals, over 40% of those that were invited did participate.

In addition to the organizations that were asked to complete a mental health and addiction survey, a number of individuals participated in focus groups. Efforts were made to include providers and consumers who deal with both mental health and addiction issues. Although a broad perspective was provided by focus group participants, focus group feedback is based on those individuals who chose to participate in the study.

Finally, although this report highlights several issues pertaining to mental health and addiction needs and strengths, they are not necessarily the only issues that individuals in the community may experience. The issues noted in this report were ones that were identified by multiple organizations and individuals through surveys and focus groups, along with a review of epidemiological data sources. They represent the key concerns that were identified for the community as a whole. It is understood, however, that certain individuals may have needs that are not specifically addressed by this study.

I. Introduction

Southwestern Healthcare, Inc. commissioned a study to conduct a community mental health and addiction needs assessment for Gibson, Posey, Vanderburgh, and Warrick Counties in Southwestern Indiana. The study was funded through a grant from the Welborn Baptist Foundation, Inc. The purpose was to determine the current needs, strengths, and gaps in the local mental health system with the intention to aid community stakeholders in understanding priority areas that should be addressed to create a mental health system that meets the needs of the community. Additionally, information gathered through the process will also serve as an education tool regarding the types of services provided in the region. Ultimately, the data from the needs assessment will serve to improve the quality of mental health and addiction services provided to members of the community, thus enhancing the quality of life of those receiving services. The study was not intended to be an evaluation of existing service providers, but rather an overall assessment of community needs and strengths related to addiction and mental health services.

Diehl Evaluation and Consulting Services, Inc. (Diehl Consulting) was contracted to conduct the needs assessment study. In addition to the Diehl Consulting staff members who participated in the study, a Planning Team was formed to oversee all aspects of the project. This included identification of study objectives, review and approval of data collection instruments, analysis of secondary data, and review of needs assessment findings. Members of this team included mental health and addiction professionals who work directly with consumers throughout the four-county area. The study timeline ranged from December, 2008 to July, 2009. During this time, the Planning Team met approximately every two weeks to inform, review, and discuss the progress of the study. Names of Planning Team members are included in the Acknowledgements section of this report.

In addition to the Planning Team, an Advisory Committee was formed to provide input on technical aspects of the needs assessment process. The Advisory Committee met two separate times – in March, 2009 to review the data collection instruments and in April, 2009 to review epidemiological data. Names of members who served on the Advisory Committee are also included in the Acknowledgements section of this report.

This section first outlines the specific questions identified to guide the study. Next, study goals and the population are provided, followed by a brief review of relevant literature that supports the study's methodology.

Study Questions

As an initial step in the needs assessment study, Diehl Consulting developed a planning document that would be used to guide the needs assessment process. This document included the overall purpose of the study, key research questions, target population, project goals, indicators related to the goals, and a timeline for completion of the study. The following are the

primary research questions that were developed for the study: (1) What are the current strengths and priority needs to be addressed in the region related to addiction and mental health services? (2) To what degree are these priority needs being met by organizations in the region, as indicated by existing gaps in services provided?

Study Goals and Focus Area

Individuals (youth to senior citizens) and services provided in Gibson, Posey, Vanderburgh, and Warrick Counties served as the focus of this study. The following four goals were established for the needs assessment project.

Goal 1: *To conduct an epidemiological study that compares prevalence of mental health and addiction conditions to available services in the region*

Goal 2: *To conduct an inventory of existing mental healthcare and addiction providers and programs*

Goal 3: *To assess the capacity of providers to deliver mental health and addiction services and how individual organizations function and work together to accomplish service delivery*

Goal 4: *To assess mental health and addiction needs perceived by referral sources, providers, patients, and members of the community*

To better understand the methods for conducting a needs assessment, particularly those utilized for gathering data about mental health and addiction issues, a literature review of needs assessment methods was first conducted. The purpose of this task was to identify the best methods for accurately and comprehensively assessing needs and strengths in the community. The following brief literature review includes a discussion of how to define the concept of need and is followed by a review of methods for conducting community needs assessment studies.

Defining Need

Need is not a unitary concept. Bradshaw (1972) identified a four-fold classification of needs: 1) felt needs, which are things that people say they want or the problems they think need to be addressed, 2) expressed needs, which are felt needs that progress to demands on the part of clients, 3) normative needs, which are needs as identified by experts and, in this case, clinical professionals, and 4) comparative needs, in which a person's or group's needs are evaluated in relation to the resources of other people or groups. In some mental health systems, there has been a change in focus from normative needs to perceived or assessed need (Meadows, Burgess et al., 2002). This change in focus is the result of studies demonstrating that diagnostic categorization may not be the best indicator of functional needs (e.g., Cohen-Mansfield & Frank, 2008; English et al., 1986; Meaney, Croke, & Kirby, 2005). Nevertheless, other researchers have also cautioned that the self-identification of needs depends on self-insight

and insight abilities may be compromised in individuals in need of psychiatric care (Carter, 2003).

Not only is there a distinction between “objective” need and “perceived” need, need is also characterized at different levels of analysis. At the broadest level, there is population needs assessment in which the mental health care needs and trends are assessed at a national or state level. At the other extreme is an individual needs assessment in which a caregiver identifies the needs of an individual for a targeted treatment plan. Perhaps most germane to the current project are the community needs between these two extremes: the needs at the local or catchment level. Unfortunately, it is this area of mental health needs assessment that is underdeveloped relative to either population-level or individual-level needs assessment (Smith, 1998).

At the population-level, there are five primary means of determining mental health and addiction needs for service planning (Bebbington & Rees, 2001). The first is an epidemiological needs assessment, which involves the identification of morbidity, prevalence, and incidence of disorders at the population level. The second is a sociodemographic approach that utilizes computational models of need developed from studies of predictors and risk factors (Aoun, Pennebaker, & Wood, 2004). The third is an analysis of current service usage. This third approach has a number of disadvantages in that current usage either may underestimate need because of existing barriers to service or may overestimate need because of the overuse of services by individuals who do not have a need (e.g., Aoun et al., 2004; Hanson et al., 2006). The fourth approach is the recruitment of key informants such as service planners, clinicians, and users. The fifth approach, which is considered the most comprehensive, is to aggregate data from the direct assessment of the needs of individuals. Thus, individual assessment ultimately is the most comprehensive form of population-level needs. Albeit this fifth approach is impractical for assessing most population-level needs.

Recognizing previous methods for examining community mental health and addiction needs, the present study examined the specific goals of the assessment through several lenses. These methods involved a review of existing epidemiological data sources, inventories of current services, and surveys of direct service and ancillary services providers. Additionally, the methods involved purposeful focus groups and individual interviews with key informants including both views of consumers of mental health and addiction services, as well as direct and ancillary service providers. A review of the specific methodology follows.

II. Methodology

The primary methods used for examining the study goals included (a) a review of epidemiological data, (b) inventories and surveys of direct service and ancillary service providers, and (c) individual and focus group interviews with key direct service and ancillary providers and consumers of mental health and addiction services. These methods are described below.

A. Review of Epidemiological Data

One primary goal of the needs assessment study is to compare the findings from this project to epidemiological data associated with local, state, and national mental health and addiction needs. Epidemiological data refer to the incidence of health-related issues and the factors that contribute to the existence of those issues. To conduct the secondary analysis, Diehl Consulting performed a comprehensive internet search to identify organizations, studies, surveys, and reports that may contain mental health and addiction data. Examples of organizations cited include the Substance Abuse and Mental Health Services Administration, the Centers for Disease Control, the Indiana Prevention Resource Center, and the Indiana State Department of Health. Specific studies and surveys include the National Survey on Drug Use and Health, the Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey of youth, and the Welborn Baptist Foundation Adult Health Indicators Survey.

In addition to the secondary data analysis described above, members of the Planning Team and Advisory Committee recommended data sources to incorporate into the report. Members had an opportunity to review data tables that contained epidemiological data and make suggestions regarding additional sources that may have needed to be included.

B. Inventories and Surveys of Direct and Ancillary Service Providers

The review of needs assessment methods and the specific project goals identified in the initial stages of the study were utilized to guide development of data collection instruments. The specific target populations and the information that each would be able to contribute to the study also were taken into account when selecting study participants and constructing the instruments.

Participants

The Planning Team identified two unique target groups from which mental health and addiction data would be collected. Both providers of mental health and addiction services and organizations that provide ancillary support services such as housing, food, job skills training, and other important services were included in the initial target participant population. With assistance from the Planning Team, a comprehensive list of direct service and ancillary service

providers was identified for Gibson, Posey, Vanderburgh, and Warrick Counties. The following table defines the target participant populations and how those organizations were identified.

Table 1. Target Needs Assessment Participant Groups			
Direct Providers of Mental Health and Addiction Services	Ancillary Service Providers		
	Support Services	Prevention/Intervention/ Enrichment	Referral Sources
Criteria for Inclusion: • Organization must provide direct clinical care to individuals in the area of mental health and addiction **Identification of organizations:** • Utilized SAMHSA's National Mental Health Information Center Mental Health Locator • Utilized Southwestern Healthcare 2008 Annual Report to determine affiliates and service locations • Utilized Yellow Pages to locate direct care services; key words: 'Mental Health Services,' 'Psychologists,' 'Psychotherapists,' and 'Physicians & Surgeons-MD-Psychiatry' • Accessed health insurance provider directories	**Criteria for Inclusion:** • Organization provides non-clinical ancillary services that support and improve the lives of individuals being treated for mental health or addiction issues **Identification of organizations:** • Utilized United Way Community Resource Guide	**Criteria for Inclusion:** • Organization provides non-clinical services designed to prevent mental health issues, addiction, and substance use; provides non-clinical interventions that improve and enrich the lives of individuals dealing with mental health or addiction issues **Identification of organizations:** • Utilized United Way Community Resource Guide	**Criteria for Inclusion:** • Organization primarily serves as referral source for mental health services; organization types include schools, court system, primary health care facilities, government agencies **Identification of organizations:** • Utilized list of referral sources provided by Southwestern Healthcare • Utilized United Way Community Resource Guide • Utilized Indiana Department of Education listing of area school systems • Reviewed health insurance provider directories for primary health care providers

It should be noted that data from direct service and ancillary service providers are presented for sub-populations of each group. For direct service providers, organizations are separated into three groups based on the number of clients they serve on an annual basis. The specific groups include: 1) small organizations – serve less than 250 clients annually, 2) medium organizations – serve between 250 and 999 clients annually, and 3) large organizations – serve 1,000 or more clients annually. In addition to these groupings, data from each of the inventory items are also aggregated for all respondents. For the ancillary service providers, organizations are separated into schools and non-school organizations. As noted by the response rates, a large number of schools participated in the survey. Therefore, data are disaggregated into two separate groups to assess effects for each type of organization.

The following tables detail key characteristics of organizations that participated in the survey aspect of the study, including primary service areas and target populations. Specifically for direct service providers, a large number of participating organizations provide services in all four of the study's geographic focus areas. The reach of these organizations is also seen by the service areas that extend beyond the four-county region.

Direct Service Providers

Table 2. Direct Service Provider Primary Service Areas – All Respondents		
County	N	% of Respondents (N=24)
Vanderburgh	23	95.8%
Gibson	21	87.5%
Posey	21	87.5%
Warrick	21	87.5%
Illinois	7	29.2%
Kentucky	7	29.2%
Knox	5	20.8%
Spencer	5	20.8%
Dubois	4	16.7%
Perry	3	12.5%
Pike	3	12.5%
Daviess, IN	2	8.3%
Entire state of Indiana	2	8.3%
Martin	1	4.2%
Enrolled students only	1	4.2%

Note: 20 organizations provide services in all four counties targeted by the needs assessment

Table 3. Direct Service Provider Primary Service Areas – By Organization Grouping		
Small Providers (serve less than 250 clients annually)		
County	N	% of Respondents (N=10)
Vanderburgh	10	100%
Gibson	9	90.0%
Posey	9	90.0%
Warrick	9	90.0%
Illinois	2	20.0%
Kentucky	2	20.0%
Knox	1	10.0%
Spencer	1	10.0%
Dubois	1	10.0%
Perry	1	10.0%
Pike	1	10.0%
Daviess, IN	1	10.0%
Entire state of Indiana	1	10.0%
Martin	1	10.0%
Enrolled students only	0	0.0%

Medium Providers (serve 250 – 999 clients annually)		
County	**N**	**% of Respondents (N=7)**
Vanderburgh	6	85.7%
Gibson	6	85.7%
Posey	5	71.4%
Warrick	5	71.4%
Illinois	4	57.1%
Kentucky	4	57.1%
Knox	2	28.6%
Spencer	0	0.0%
Dubois	2	28.6%
Perry	1	14.3%
Pike	1	14.3%
Daviess, IN	0	0.0%
Entire state of Indiana	0	0.0%
Martin	0	0.0%
Enrolled students only	0	0.0%
Large Providers (serve 1,000 + clients annually)		
County	**N**	**% of Respondents (N=7)**
Vanderburgh	7	100%
Gibson	6	85.7%
Posey	7	100%
Warrick	7	100%
Illinois	2	28.6%
Kentucky	1	14.3%
Knox	2	28.6%
Spencer	0	0.0%
Dubois	2	28.6%
Perry	1	14.3%
Pike	1	14.3%
Daviess, IN	1	14.3%
Entire state of Indiana	0	0.0%
Martin	0	0.0%
Enrolled students only	1	14.3%

As noted in the table below, the vast majority (over 90%) of participating direct service providers serve the 18 to 64 population, and approximately three quarters serve individuals age 65 and over. Comparatively, a relatively small number of organizations directly serve children ages 0 to 5 (approximately 21%).

Table 4. Direct Service Provider Target Populations – All Respondents		
Age Group	**N**	**% of Respondents (N=24)**
Ages 0-5	5	20.8%
Ages 6-14	11	45.8%
Ages 15-17	12	50.0%
Ages 18-64	22	91.7%
Ages 65+	18	75.0%

Table 5. Direct Service Provider Target Populations – By Organization Grouping		
Small Providers (serve less than 250 clients annually)		
Age Group	N	% of Respondents (N=10)
Ages 0-5	0	0.0%
Ages 6-14	3	30.0%
Ages 15-17	3	30.0%
Ages 18-64	8	80.0%
Ages 65+	6	60.0%
Medium Providers (serve 250 – 999 clients annually)		
Age Group	N	% of Respondents (N=7)
Ages 0-5	2	28.6%
Ages 6-14	3	42.9%
Ages 15-17	4	57.1%
Ages 18-64	7	100%
Ages 65+	6	85.7%
Large Providers (serve 1,000 + clients annually)		
Age Group	N	% of Respondents (N=7)
Ages 0-5	3	42.9%
Ages 6-14	5	71.4%
Ages 15-17	5	71.4%
Ages 18-64	7	100%
Ages 65+	6	85.7%

Ancillary Service Providers

Of the 74 schools that responded to the ancillary survey, over half are located in Vanderburgh County. The other schools are fairly evenly spread across Gibson, Posey, and Warrick Counties. Almost 70% of the 113 non-school organizations that responded provide services in Vanderburgh County, with approximately 40-45% providing services in the other three focus areas of the study. A total of 28 of the non-school organizations provide services in all four of the study's primary geographic target areas.

Table 6. Ancillary Survey Primary Service Areas				
County	Schools		Non-Schools	
	N	% of Respondents (N=74)	N	% of Respondents (N=113)
Vanderburgh	42	56.8%	77	68.1%
Gibson	12	16.2%	45	39.8%
Posey	9	12.2%	46	40.7%
Warrick	11	14.9%	51	45.1%
Knox	0	0.0%	4	3.5%
Perry	0	0.0%	5	4.4%
Pike	0	0.0%	8	7.1%
Spencer	0	0.0%	6	5.3%
Daviess, IN	0	0.0%	4	3.5%

Dubois	0	0.0%	5	4.4%
Crawford	0	0.0%	1	0.9%
Orange	0	0.0%	1	0.9%
Martin	0	0.0%	3	2.7%
Harrison	0	0.0%	1	0.9%
Greene	0	0.0%	1	0.9%
Illinois	0	0.0%	1	0.9%
Kentucky	0	0.0%	2	1.8%
Other Counties Not Specified	0	0.0%	5	4.4%

Note: 28 non-school organizations provide services in all four counties targeted by the needs assessment

As expected, the largest target age population for schools that responded to the survey are the 6 to 14, 0 to 5, and 15 to 17 age groups. Of the school types, primary schools made up the greatest percentage of respondents. Among non-school respondents, approximately 72% provide services to individuals in the 18 to 64 age group, the largest target population for these organizations. The group least served by non-school respondents is the 0 to 5 age group, with approximately 49% providing services to children in this age bracket.

Table 7. Ancillary Survey Organization Types (N=187)		
Organization Type	**N**	**%**
Primary school	45	24.1%
Non-profit	42	22.5%
Secondary school	27	14.4%
Primary medical care	23	12.3%
Other*	20	10.7%
Court system	10	5.3%
Law enforcement agency	9	4.8%
Faith-based	5	2.7%
Correction facility/jail	3	1.6%
Preschool or other early childhood facility	2	1.1%
Nursing home	1	0.5%
Hospice	0	0.0%

*Of those organizations that specified their "Other" type, they are broken down as follows: assisted living (n=1); county service office (n=1); food pantry service (n=1); government agency (n=5); health department (n=2); hospital (n=1); pain management (n=1); provider of welfare benefits (n=1); public defender agency (n=1); rehabilitation services (n=1); residential (not specific to addiction or mental health) (n=1); social service agency (n=1); transportation company (n=1); and vocational rehabilitation (n=1).

Table 8. Ancillary Survey Target Populations				
Age Group	**Schools**		**Non-Schools**	
	N	**% of Respondents (N=74)**	**N**	**% of Respondents (N=87)**
Ages 0-5	19	25.7%	43	49.4%
Ages 6-14	57	77.0%	47	54.0%
Ages 15-17	18	24.3%	54	62.1%
Ages 18-64	3	4.1%	63	72.4%
Ages 65+	1	1.4%	54	62.1%

Instruments

Given that two unique provider groups were identified, two separate data collection instruments were developed – an inventory of addiction and mental health services and a survey of ancillary services. Each is described in detail below and provided in the Appendix.

Inventory of Addiction and Mental Health Services. This instrument is designed to collect data from organizations that provide direct mental health and addiction services such as counseling, treatment, and therapy. Data collected with the Inventory include general information about the organization; the levels of service provided by the organization and the number of people treated through each; mental health/addiction issues for which organizations treat clients and the number of people treated; ancillary services provided by the organization; the organization's capacity to offer services, including the type and number of professionals employed by the organization; community mental health needs and strengths identified by the organization; the level of collaboration that exists among service providers; the degree to which clients need and receive ancillary services; and the barriers that clients face in accessing mental health and addiction services.

Survey of Ancillary Services. This instrument is designed to collect data from organizations that provide ancillary services in the following areas: support, such as housing, food, and job skills training; prevention/intervention/enrichment; and referral to mental health/addiction services (includes schools, law enforcement agencies, primary care physicians, courts, and other referring agencies). Data collected with this survey include basic organization information; mental health and addiction issues for which the organization refers clients; the degree to which clients need and receive ancillary services; the barriers that clients face in accessing mental health and addiction services; community mental health needs and strengths identified by the organization; and the level of collaboration that exists among service providers.

Procedures for Data Collection

In March, 2009, providers were mailed the inventories and surveys. To gather additional input from provider organizations, a second administration of the instruments was conducted in April, 2009. The following tables show the response rates for both of the data collection instruments.

Table 9. Response Rates for Inventory of Addiction and Mental Health Services		
Returned	**Distributed**	**Response Rate**
24	72	33.3%

Table 10. Response Rates for Survey of Ancillary Services			
Group	**Returned**	**Distributed**	**Response Rate**
All Recipients	**185**	**416**	**44.5%**
Support	49	104	47.1%
Prevention/Int./Enrich.	10	25	40.0%
Referral	126	287	43.9%
Schools	*74*	*100*	*74.0%*
Non-schools	*52*	*187*	*27.8%*
All Recipients	**185**	**416**	**44.5%**
Schools	74	100	74.0%
Non-schools	111	316	35.1%
Schools			
Gibson	12	17	70.6%
Posey	9	14	64.3%
Vanderburgh	42	53	79.2%
Warrick	11	16	68.8%

To ensure the highest response rates possible, multiple contacts were made with the target organizations. Specifically with the direct service providers, an initial letter that introduced the project was mailed prior to the distribution of the inventory. In addition to the two distributions in March and April of 2009, direct service providers were sent a letter detailing the progress of the study. Further, attempts were made to contact organizations by telephone and email to encourage participation.

Although a number of the direct service providers did not respond to the Inventory of Addiction and Mental Health Services, a group of critical providers was identified due to their size and reach in the community. Additional efforts were made to encourage these specific organizations to participate. Of the critical group, over 60% of the organizations responded. Of the total 72 organizations that were invited to participate, many of those that did not respond included single providers, such as individual Licensed Clinical Social Workers with their own practice and other smaller organizations. Based on a review of the direct service providers who responded to the survey, there appeared to be a representative sample of mental health services being provided in the community.

C. Individual and Focus Group Interviews

In addition to the surveys that were distributed to direct service and ancillary service providers, a series of individual interviews and focus groups were conducted for the needs assessment study. The purpose was to collect more detailed information about a targeted set of topics associated with mental health and addiction needs. Incorporation of these methods also allowed for consumers' perspectives to be included in the study.

Focus groups were conducted for two separate populations – providers and consumers. Providers included those delivering direct mental health and addiction services and those that provide ancillary services or make referrals to services. Consumers included individuals who had been treated or were currently being treated for mental health/addiction issues and family members of those individuals. Within each of the provider and consumer populations, both general and targeted focus groups were scheduled.

General focus groups included anyone who either provided services to consumers or consumers and family members themselves. Targeted groups included specific individuals who were identified because they were part of a particular treatment group, such as a drug court program, or because they represented a specific group of providers, such as professionals who provide services primarily in Gibson, Posey, and Warrick Counties. Overall, 25 focus groups were scheduled among Gibson, Posey, Vanderburgh, and Warrick Counties. This coverage allowed providers and consumers to attend focus groups in the counties in which they live and/or work. In some cases, individuals were interviewed individually. The table below indicates the focus groups that were conducted in the four counties.

Table 11. Focus Group Descriptions

Focus Group Type	Location	Number of Focus Groups Offered
Provider-General	Vanderburgh County	4
Provider-General	Gibson County	2
Provider-General	Posey County	2
Provider-General	Warrick County	2
Provider-Southwestern Behavioral Healthcare, Inc. employees who provide services in Gibson, Posey, and Warrick Counties	Vanderburgh County	1
Provider-Youth First, Inc. School Social Workers	Vanderburgh County	1
Consumer-General	Vanderburgh County	2
Consumer-General	Gibson County	2
Consumer-General	Posey County	2
Consumer-General	Warrick County	2
Consumer-Warrick County Drug Court	Warrick County	1
Consumer-Stepping Stone Clients	Vanderburgh County	1
Consumer-National Alliance on Mental Illness group	Vanderburgh County	1
Consumer-Parents of children receiving mental health treatment	Vanderburgh County	1
Consumer-Older Adult Population	Vanderburgh County	1

Focus Group Protocol

A separate standard focus group protocol was developed for providers and consumers. The specific questions that were included in each protocol are listed in Tables 12a and 12b.

Table 12a. Focus Group Protocol – Providers
1. What do you believe are the greatest addiction and/or mental health needs in your county? Needs are the mental health and addiction issues experienced by residents of your community. (Prompt: Are these needs specific to a particular age group?)
2. What addiction and/or mental health needs in your county are not being adequately met by existing services? (Prompt: Are these needs specific to a particular age group?)
3. What do you believe are the greatest strengths within your county related to current addiction and/or mental health services being provided?
4. For the needs that you identified as not being adequately met by existing services, why do you think those needs are not being met? (Prompt: Are there specific barriers that keep the needs from being met? Do the necessary services actually exist? Do we have the services available but individuals are unable to access them?)
5. For individuals in your county who have mental health or addiction concerns, what additional services do they need that they are not receiving? (Prompt: Types of services may include housing, education, or job skills training.)
6. What can direct service providers in your county do to ensure that clients are receiving the additional services they need?
7. To what extent are services in your county being integrated within the community? How well do service providers in your county collaborate to ensure effective delivery of services? Provide an example of where this is occurring and an example of where it is not occurring.
8. To fully meet the mental health and addiction needs in your county, what do we really need or what needs to happen? What do you think are the solutions? Are there opportunities for better service in your county that service providers are not taking advantage of?
9. To what degree does the level of insurance coverage impact access to mental health and addiction services in your community? (Prompt: What is a more significant concern—the lack of insurance, having insurance that only covers a portion of services, or having insurance with a high deductible?)

Table 12b. Focus Group Protocol – Consumers
1. What do you believe are the greatest addiction and/or mental health needs in your county? Needs are the mental health and addiction issues experienced by residents of your community. (Prompt: Are these needs specific to a particular age group?)
2. What addiction and/or mental health needs in your county are not being adequately met by existing services? (Prompt: Are these needs specific to a particular age group?)
3. What do you believe are the greatest strengths within your county related to current addiction and/or mental health services being provided?
4. For the needs that you identified as not being adequately met by existing services, why do you think those needs are not being met? (Prompt: Are there specific barriers that keep the needs from being met? Do the necessary services actually exist? Do we have the services available but individuals are unable to access them?)

Table 12b. Focus Group Protocol – Consumers (cont.)
5. For individuals in your county who have mental health or addiction concerns, what additional services do they need that they are not receiving? (Prompt: Types of services may include housing, education, or job skills training.)
6. To fully meet the mental health and addiction needs in your county, what do we really need or what needs to happen? What do you think are the solutions? Are there opportunities for better service in your county that service providers are not taking advantage of?
7. To what degree does the level of insurance coverage impact access to mental health and addiction services in your community? (Prompt: What is a more significant concern—the lack of insurance, having insurance that only covers a portion of services, or having insurance with a high deductible?)

Participants

Overall, a total of 59 individuals participated in the focus groups (25 providers and 34 consumers). The tables below present demographic data for focus group participants.

Table 13. Demographic Data for Focus Groups		
Which of the following best describes you? (providers and consumers)		
Category	**N**	**%**
Provider of mental health or addiction services	16	27.1%
Ancillary service providers	9	15.3%
Consumers	34	57.6%
County in which services primarily performed (provider only)		
County	**N**	**%**
Vanderburgh	18	72.0%
Gibson	2	8.0%
Posey	3	12.0%
Warrick	2	8.0%
Average number of years providing service (provider only)		
Average years	17.9 years	
Gender (providers and consumers)		
Category	N	%
Male	21	35.6%
Female	38	64.4%
Race/Ethnicity (providers and consumers)		
Category	N	%
African American	2	3.4%
Caucasian	51	86.4%
Hispanic/Latino	1	1.7%
Unknown/Did Not Report	5	8.5%
Age (consumers only)		
Average Age	43.7 years	
Marital Status (consumers only)		
Category	N	%
Married	18	52.9%

Never married	5	14.7%
Divorced or separated	7	20.6%
Living with a partner	4	11.8%
Highest Level of Education (consumers only)		
Category	N	%
Some high school	3	8.8%
High school graduate	6	17.6%
Some college	15	44.1%
College graduate	9	26.5%
Graduate degree	1	2.9%
Employment Status (consumers only)		
Category	**N**	**%**
Employed full- or part-time	12	37.5%
Retired	4	12.5%
Unemployed	16	50.0%
Annual Household Income (consumers only)		
Category	N	%
Less than $20,000	16	47.1
$20,000-$49,999	11	32.4
$50,000-$74,999	3	8.8
$75,000 or more	4	11.8
Primary County of Residence (consumers only)		
County	N	%
Vanderburgh	19	55.9%
Gibson	2	5.9%
Posey	3	8.8%
Warrick	10	29.4%
County in which Services Primarily Received (consumers only)		
County	N	%
Vanderburgh	26	76.5%
Warrick	5	14.7%
Unknown/Did Not Report	3	8.8%
About which categories can you provide the most information? (check all that apply) (providers and consumers)		
Category	N	% of respondents (N=51)
Addiction needs and services	32	62.7%
Adult mental health needs and services	23	45.1%
Parenting and child/adolescent needs and services	15	29.4%
Geriatric needs and services	4	7.8%
Other*	6	11.8%

*Other categories included: Bipolar Disorder; Domestic violence and homeless population; retardation; suicide; and vocational rehabilitation needs

D. Organization of the Report

The Community Addiction and Mental Health Needs Assessment Report is organized by project goals. Within each section, the project goal is defined, and indicators for assessing the goal are presented. Next, findings from the Inventory of Addiction and Mental Health Services and Survey of Ancillary Services are provided and discussed. Following the presentation of survey findings, applicable secondary epidemiological data are presented to allow for triangulation of data sources and comparison to local, state, and national data. Finally, qualitative data collected during focus groups are discussed to provide depth to and elaboration on the survey data.

Goal One: To conduct an epidemiological study that compares prevalence of mental health and addiction conditions to available services in the region.

The purpose of this goal is to present epidemiological data related to the prevalence of mental health and addiction issues and to compare specific conditions to the services that are available in the four-county region of Vanderburgh, Gibson, Posey, and Warrick Counties. The following are specific types of prevalence data that have been identified.

Indicator 1.1 Population estimates for Gibson, Posey, Warrick and Vanderburgh Counties, the state of Indiana, and the United States

Indicator 1.2 Estimates of the percentage of individuals in the nation, state of Indiana, and local counties who have specific mental health disorders or addictions

Indicator 1.3 Estimates of the percentage of individuals in the nation and state of Indiana who experience serious psychological distress and other selected mental health characteristics

Indicator 1.4 Findings from the Welborn Baptist Foundation Adult Health Indicators Survey regarding mental health issues among individuals in Vanderburgh and Warrick Counties

Indicator 1.5 Data regarding the number of suicides in the four-county study area

Indicator 1.6 Rates of alcohol and drug use among high school students and other selected age groups in Southwestern Indiana, the state of Indiana, and the United States

Indicator 1.7 Treatment episode data regarding admissions to hospitals due to alcohol and drug use

Indicator 1.8 Highlights from the 2007 National Survey on Drug Use and Health

Overview of Findings

Findings presented below have been extracted from data tables presented in this section of the report. Data are described in relation to categories of mental health statistics, substance use-alcohol statistics, and substance use-other drugs statistics. When available, local figures related to mental health and substance use issues are presented.

Mental Health Statistics

- Based on data from the Surgeon General's 1999 report on mental health, approximately 18.9% of youth (9 to 17 years), 21.0% of adults (18 to 54 years), and 19.8% of older adults (55 years and older) in the United States have some form of mental disorder.

- The most recently reported findings from the National Survey on Drug Use and Health (2007) indicate that 7.5% of adults (18 years or older) experienced a major depressive episode in the past year. Data from the same survey indicate that 8.2% of youth (12 to 17 years old) experienced a major depressive episode in the past year.

- National survey data indicates that the best estimates of the percentage of adults in the U.S. who have anxiety disorders range from 16.4% to 18.1% (Regier, Narrow, and Rae, 1999; Kessler, Chiu, Demler, and Walters, 2005; National Institute on Mental Health, 2008). Estimates for other disorders include bipolar disorder (estimated range from 1.1% to 2.6%); schizophrenia (estimated range from 1.1% to 1.3%); post-traumatic stress disorder (estimated range from 3.5% to 3.6%); obsessive-compulsive disorder (estimated range from 1.0% to 2.4%); and eating disorders (anorexia estimated in 0.1% to 3.7% of the adult population and bulimia estimated in 1.1% to 4.2% of the adult population).

- The following national-level data indicate the prevalence of mental health issues in children and adolescents age 9 to 17. In the United States, it is estimated that 13.0% of children and adolescents have an anxiety disorder, 6.2% have a mood disorder, and 10.3% experience issues classified as disruptive disorders (Shaffer, et al., 1996; Mental Health: A Report of the Surgeon General, 1999).

- Data from the 2005 and 2006 National Survey on Drug Use and Health indicate that 8.67% of adults (18 years or older) and 8.01% of youth (12 to 17 years) in Indiana experienced at least one major depressive episode in the past year. These numbers were slightly higher for the 2006/2007 Indiana averages, with 8.80% of adults (18 years or older) and 8.42% of youth (12 to 17 years) having at least one major depressive episode in the past year.

- Among the 12 to 17 year old age group, 16 and 17 year olds in the United States are almost three times as likely to experience a past-year major depressive episode (SAMHSA, 2004-2006 National Survey on Drug Use and Health).

- Based on data from the 2005 and 2006 National Survey on Drug Use and Health, 10.21% of 18 to 25 year olds in Indiana experienced a major depressive episode in the past year. This rate is similar to the 2006/2007 average of 10.72%.

- Data from the Substance Abuse and Mental Health Services Administration (2004/2005 average) indicate that the following number of individuals in the four listed counties had major depression: Gibson – 2,264; Posey – 1,815; Vanderburgh – 11,725; and Warrick – 3,790.

- Based on data from the Centers for Disease Control (2005/2006 average), there are significant differences between individuals in poverty and those above the poverty line in terms of the degree to which they have depression. Overall, individuals are at least twice as likely to experience depression if they are below the poverty level. Among 40 to 59 year olds, the gap is even greater, with individuals in poverty almost four times as likely to experience depression.

- Data from the 2008 Welborn Baptist Foundation Adult Health Indicators Survey indicate that 23.7% of adults in Vanderburgh and Warrick Counties combined have been told by a health care provider that they had an anxiety disorder, and 28.6% of adults in the same geographic area had been told they suffered from depression. Overall, 31.3% of survey respondents indicated that they had sought help from a professional for mental health or help with an emotional situation.

Substance Use – Alcohol Statistics

- Slightly more than half of Americans aged 12 or older reported being current drinkers of alcohol in the 2007 survey (51.1%). This translates to an estimated 126.8 million people, which was similar to the 2006 estimate of 125.3 million people (50.9%).

- More than one fifth (23.3%) of persons aged 12 or older participated in binge drinking (having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey) in 2007. This translates to about 57.8 million people, similar to the estimate in 2006.

- In 2007, among young adults aged 18 to 25, the rate of binge drinking was 41.8%, and the rate of heavy drinking was 14.7%. These rates were similar to the rates in 2006.

- The rate of current alcohol use among youths aged 12 to 17 was 15.9% in 2007. Youth binge and heavy drinking rates were 9.7% and 2.3%, respectively. These rates were essentially the same as the 2006 rates.

- In Southwestern Indiana, it is estimated that approximately 50% of persons 12 years and older engaged in past-month alcohol use, and approximately 24% engaged in binge drinking in the past month (SAMHSA, National Survey on Drug Use and Health, 2004-2006).

- Results from the 2007 Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey indicate that 34.4% of 10th graders and 42.3% of 12th graders in Southwestern Indiana had engaged in alcohol use within the past month. These rates are higher than state averages (Youth First, Inc.).

- Results from the 2007 Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey indicate that 23.0% of 10th graders and 31.5% of 12th graders in Southwestern Indiana had engaged in binge drinking (5 or more drinks at a sitting) within the past two weeks. These rates are higher than state and national averages. (Youth First, Inc.).

Substance Use – Other Drugs

- In 2007, an estimated 19.9 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.0% of the population aged 12 years old or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

- The national rate of current illicit drug use among persons aged 12 or older in 2007 (8.0%) was similar to the rate in 2006 (8.3%).

- Marijuana was the most commonly used illicit drug (14.4 million past month users) in the U.S. Among persons aged 12 or older, the rate of past month marijuana use in 2007 (5.8%) was similar to the rate in 2006 (6.0%).

- There were 6.9 million (2.8%) persons aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month in the U.S. Of these, 5.2 million used pain relievers, the same as the number in 2006.

- In 2007, there were an estimated 529,000 current users of methamphetamine aged 12 or older (0.2% of the population) in the U.S. These estimates were not significantly different from the estimates for 2006 (731,000 or 0.3%).

- In Southwestern Indiana, it is estimated that 5.2% of persons 12 years and older engaged in past-month marijuana use, and 7.3% engaged in any illicit drug use in the past month (SAMHSA, National Survey on Drug Use and Health, 2004-2006).

- Results from the 2007 Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey indicate that 17.1% of 10th graders and 16.2% of 12th graders in Southwestern Indiana had engaged in marijuana use within the past month. These rates are higher than state averages. (Youth First, Inc.)

- Results from the 2007 Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey indicate that 5.1% of 10th graders and 5.3% of 12th graders in Southwestern Indiana engaged in daily marijuana use. For 10th graders, these rates are higher than state and national averages. For 12th graders, the rate is equivalent to the state average and higher than the national average. (Youth First, Inc.)

Indicator 1.1 Population estimates for Gibson, Posey, Warrick and Vanderburgh Counties, the state of Indiana and the United States

To provide a basis for comparison to other indicators, Table 14 provides population estimates for the four counties, the state of Indiana, and the United States by age. Table 15 further disaggregates these data by age and gender.

Table 14. 2007 Population Estimates, All Counties, Indiana, and U.S. by Age Group

Age Group	Gibson		Posey		Vanderburgh		Warrick		Indiana		U.S.	
	N	%	N	%	N	%	N	%	N	%	N	%
Total	32,754	100%	26,262	100%	174,425	100%	57,090	100%	6,345,289	100%	301,621,157	100%
Under 5 years	2,097	6.40%	1,267	4.82%	11,887	6.81%	3,486	6.11%	437,494	6.89%	20,724,125	6.87%
5 to 9 years	2,062	6.30%	1,556	5.92%	11,208	6.43%	3,732	6.54%	434,918	6.85%	19,849,628	6.58%
10 to 14 years	2,234	6.82%	1,900	7.23%	10,735	6.15%	4,005	7.02%	437,919	6.90%	20,314,309	6.74%
15 to 19 years	2,125	6.49%	2,009	7.65%	12,350	7.08%	3,990	6.99%	452,551	7.13%	21,473,690	7.12%
20 to 24 years	1,942	5.93%	1,738	6.62%	13,164	7.55%	3,523	6.17%	428,771	6.76%	21,032,396	6.97%
25 to 29 years	2,219	6.77%	1,351	5.14%	11,408	6.54%	3,668	6.42%	446,678	7.04%	21,057,706	6.98%
30 to 34 years	1,909	5.83%	1,283	4.89%	10,703	6.14%	3,284	5.75%	405,807	6.40%	19,533,220	6.48%
35 to 39 years	2,081	6.35%	1,632	6.21%	10,984	6.30%	3,655	6.40%	430,722	6.79%	21,176,460	7.02%
40 to 44 years	2,329	7.11%	2,007	7.64%	11,838	6.79%	4,196	7.35%	453,546	7.15%	21,984,829	7.29%
45 to 49 years	2,677	8.17%	2,448	9.32%	13,095	7.51%	4,895	8.57%	481,524	7.59%	22,861,373	7.58%
50 to 54 years	2,414	7.37%	2,338	8.90%	12,865	7.38%	4,530	7.93%	449,801	7.09%	21,013,387	6.97%
55 to 59 years	2,104	6.42%	1,852	7.05%	10,614	6.09%	4,121	7.22%	386,839	6.10%	18,236,259	6.05%
60 to 64 years	1,680	5.13%	1,499	5.71%	8,222	4.71%	3,164	5.54%	303,278	4.78%	14,475,817	4.80%
65 to 69 years	1,316	4.02%	1,067	4.06%	6,401	3.67%	2,251	3.94%	227,990	3.59%	10,752,441	3.56%
70 to 74 years	1,115	3.40%	774	2.95%	5,246	3.01%	1,573	2.76%	179,833	2.83%	8,599,708	2.85%
75 to 79 years	926	2.83%	643	2.45%	5,105	2.93%	1,288	2.26%	153,432	2.42%	7,324,882	2.43%
80 to 84 years	756	2.31%	460	1.75%	4,302	2.47%	894	1.57%	119,521	1.88%	5,698,629	1.89%
85 years and over	768	2.34%	438	1.67%	4,298	2.46%	835	1.46%	114,665	1.81%	5,512,298	1.83%
Persons under 18	7,763	23.70%	6,040	23.00%	40,467	23.20%	13,873	24.30%	1,586,322	25.00%	73,897,183	24.50%

Source: U.S. Census Bureau, Population Estimates Program

Table 15. 2007 Population Estimates, All Counties, Indiana, and U.S. by Gender and Age Group						
Age Group	Gibson	Posey	Vanderburgh	Warrick	Indiana	U.S.
Total	32,754	26,262	174,425	57,090	6,345,289	301,621,157
Male	16,150	13,128	83,219	28,179	3,126,580	148,658,898
Under 5 years	1,059	665	6,141	1,817	224,168	10,602,857
5 to 9 years	1,090	784	5,723	1,966	221,801	10,148,578
10 to 14 years	1,106	1,001	5,481	2,043	224,494	10,399,927
15 to 19 years	1,111	1,037	6,002	2,065	232,554	11,006,869
20 to 24 years	1,028	902	6,198	1,763	219,579	10,852,937
25 to 29 years	1,128	744	5,389	1,866	226,856	10,776,189
30 to 34 years	968	620	5,348	1,619	206,075	9,906,361
35 to 39 years	1,059	809	5,493	1,789	217,225	10,654,911
40 to 44 years	1,186	982	5,759	2,055	227,246	10,963,823
45 to 49 years	1,372	1,252	6,475	2,396	239,847	11,302,842
50 to 54 years	1,206	1,213	6,401	2,164	222,540	10,292,071
55 to 59 years	1,063	908	5,122	2,097	189,039	8,847,222
60 to 64 years	810	732	3,829	1,531	145,641	6,927,866
65 to 69 years	616	540	2,860	1,109	106,808	5,019,063
70 to 74 years	497	358	2,255	751	80,265	3,867,910
75 to 79 years	353	276	1,976	536	63,419	3,106,968
80 to 84 years	280	173	1,605	360	44,570	2,205,705
85 years and over	218	132	1,162	252	34,453	1,776,799
Female	16,604	13,134	91,206	28,911	3,218,709	152,962,259
Under 5 years	1,038	602	5,746	1,669	213,326	10,121,268
5 to 9 years	972	772	5,485	1,766	213,117	9,701,050
10 to 14 years	1,128	899	5,254	1,962	213,425	9,914,382
15 to 19 years	1,014	972	6,348	1,925	219,997	10,466,821
20 to 24 years	914	836	6,966	1,760	209,192	10,179,459
25 to 29 years	1,091	607	6,019	1,802	219,822	10,281,517
30 to 34 years	941	663	5,355	1,665	199,732	9,626,859
35 to 39 years	1,022	823	5,491	1,866	213,497	10,521,549
40 to 44 years	1,143	1,025	6,079	2,141	226,300	11,021,006
45 to 49 years	1,305	1,196	6,620	2,499	241,677	11,558,531
50 to 54 years	1,208	1,125	6,464	2,366	227,261	10,721,316
55 to 59 years	1,041	944	5,492	2,024	197,800	9,389,037
60 to 64 years	870	767	4,393	1,633	157,637	7,547,951
65 to 69 years	700	527	3,541	1,142	121,182	5,733,378
70 to 74 years	618	416	2,991	822	99,568	4,731,798
75 to 79 years	573	367	3,129	752	90,013	4,217,914
80 to 84 years	476	287	2,697	534	74,951	3,492,924
85 years and over	550	306	3,136	583	80,212	3,735,499

Source: U.S. Census Bureau, Population Estimates Program

Indicator 1.2 Estimates of the percentage of individuals in the nation, state of Indiana, and local counties that have specific mental health disorders or addictions

Table 16 provides estimates for the percentage of individuals in the United States who experience various mental health disorders on an annual basis. Data from the National Institute of Mental Health Epidemiologic Catchment Area (ECA) Study and the National Comorbidity Study (NCS), as well as a 'best estimate' using these data sources, are presented. Anxiety disorders appear to be the most common in terms of prevalence.

Table 16. Best estimate 1-year prevalence based on Epidemiologic Catchment Area (ECA) and National Comorbidity Study (NCS), ages 18-54, 1999

Disorder	ECA Prevalence (%)	NCS Prevalence (%)	Best Estimate (%)
Any Anxiety Disorder	13.1	18.7	16.4
Simple Phobia	8.3	8.6	8.3
Social Phobia	2.0	7.4	2.0
Agoraphobia	4.9	3.7	4.9
Generalized Anxiety Disorder	(1.5)*	3.4	3.4
Panic Disorder	1.6	2.2	1.6
Obsessive-Compulsive Disorder	2.4	(0.9)*	2.4
Post-Traumatic Stress Disorder	(1.9)*	3.6	3.6
Any Mood Disorder	7.1	11.1	7.1
Major Depressive Episode	6.5	10.1	6.5
Unipolar Major Depression	5.3	8.9	5.3
Dysthymia	1.6	2.5	1.6
Bipolar I	1.1	1.3	1.1
Bipolar II	0.6	0.2	0.6
Schizophrenia	1.3	--	1.3
Nonaffective Psychosis	--	0.2	0.2
Somatization	0.2	--	0.2
Antisocial Personality Disorder	2.1	--	2.1
Anorexia Nervosa	0.1	--	0.1
Severe Cognitive Impairment	1.2	--	1.2
Any Disorder	19.5	23.4	21.0

*Numbers in parentheses indicate the prevalence of the disorder without any comorbidity. These rates were calculated using the NCS data for GAD and PTSD, and the ECA data for OCD. The rates were not used in calculating the "any anxiety disorder" and "any disorder" totals for the ECA and NCS columns. The unduplicated GAD and PTSD rates were added to the best estimate total for "any anxiety disorder" (3.3%) and "any disorder" (1.5%).

Source: Primary – Regier, D., Narrow, W., & Rae, D., personal communication, 1999; Secondary – Mental Health: A Report of the Surgeon General, 1999

Table 17 presents mental health disorder one-year prevalence rates from the Epidemiologic Catchment Area Study specifically for ages 55 and older. Almost 20% of adults in this age group are estimated to have a mental disorder.

Table 17. Best estimate 1-year prevalence rates based on Epidemiologic Catchment Area, age 55+, 1999	
Disorder	**Prevalence (%)**
Any Anxiety Disorder	11.4
Simple Phobia	7.3
Social Phobia	1.0
Agoraphobia	4.1
Panic Disorder	0.5
Obsessive-Compulsive Disorder	1.5
Any Mood Disorder	4.4
Major Depressive Episode	3.8
Unipolar Major Depression	3.7
Dysthymia	1.6
Bipolar I	0.2
Bipolar II	0.1
Schizophrenia	0.6
Somatization	0.3
Antisocial Personality Disorder	0.0
Anorexia Nervosa	0.0
Severe Cognitive Impairment	6.6
Any Disorder	19.8

Source: Primary - Regier, D., Narrow, W., & Rae, D., personal communication, 1999; Secondary – Mental Health: A Report of the Surgeon General, 1999

Table 18 includes prevalence data for adults in the United States for all diagnosable mental disorders as well as specific disorders. As noted, approximately 26% of the adult population are estimated to have a diagnosable mental disorder.

Table 18. The Numbers Count: Mental Disorders in America, adults ages 18 or older (as published by the National Institute on Mental Health)	
Disorder	**Prevalence**
All diagnosable mental disorders[1]	26.2%* (n=57,700,000)
Serious mental illness[1]	6.0%
Mood disorders[1]	9.5% (n=20,900,000)
Major depressive disorder[1]	6.7% (n=14,800,000)
Dysthymic disorder[1]	1.5% (n=3,300,000)
Bipolar disorder[1]	2.6% (n=5,700,000)

Schizophrenia[2]	1.1% (n=2,400,000)
Anxiety disorders[1]	18.1% (n=40,000,000)
Panic disorder[1]	2.7% (n=6,000,000)
Obsessive-compulsive disorder[1]	1.0% (n=2,200,000)
Post-traumatic stress disorder[1]	3.5% (n=7,700,000)
Generalized anxiety disorder[1]	3.1% (n=6,800,000)
Social phobia[1]	6.8% (n=15,000,000)
Agoraphobia[1]	0.8% (n=1,800,000)
Specific phobia[1]	8.7% (n=19,200,000)
Anorexia[3]	0.5% - 3.7%
Bulimia[3]	1.1% - 4.2%
Binge-eating disorder[4,5]	2.0%-5.0% (in 6-month period)
Attention Deficit Hyperactivity Disorder[1]	4.1%
**Impulse control[1]	8.9%
**Substance use disorder[1]	3.8%

*22.3% of the 26.2% overall prevalence (or 5.7% of the total population) include cases that were identified as serious.
**Not reported by NIMH in the "Numbers Count" publication
Sources: [1]Kessler, R.C., Chiu, W.T., Demler, O., & Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, *62*, 617-27. [2]Regier, D.A., Narrow, W.E., Rae, D.S., Manderscheid, R.W., Locke, B.Z., & Goodwin, F.K. (1993). The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, *50*, 85-94. [3]American Psychiatric Association Work Group on Eating Disorders. (2000). Practice guideline for the treatment of patients with eating disorders (revision). *American Journal of Psychiatry*, *157*(1 Suppl), 1-39. [4]Spitzer, R.L., Yanovski, S., Wadden, T., Wing, R., Marcus, M.D., Stunkard, A., Devlin, M., Mitchell, J., Hasin, D., & Horne R.L. (1993). Binge eating disorder: its further validation in a multisite study. *International Journal of Eating Disorders*, *13*, 137-53. [5]Bruce, B. & Agras, W.S. Binge eating in females: a population-based investigation. (1992). *International Journal of Eating Disorders*, *12*, 365-73.

Table 19 presents the estimated percentage of individuals in the United States who have mental health disorders at some point in their lives. Addtionally, the average age of onset for the disorders is provided. Approximately 46% of individuals experience a mental health disorder in their lifetime. Anxiety disorders, which are the most commonly experienced conditions, have an average onset age of 11 years.

Table 19. Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication, 2005

Disorder	Lifetime Prevalence	Age of Onset
Anxiety disorders	28.8%	11 years
Mood disorders	20.8%	30 years
Impulse control disorders	24.8%	11 years
Substance use disorders	14.6%	20 years
Any disorder	46.4%	--

Source: Kessler, R.C., Chiu, W.T., Demler, O., & Walters, E.E. (2005). Prevalence, severity, and comorbidity of twelve-month DSM-IV disorders in the National Comorbidity Survey Replication (NCS-R). *Archives of General Psychiatry*, *62*, 617-27.

Table 20 shows the percentage of children and adolescents age 9 to 17 who experience mental or addictive disorders within a six-month period. Approximately 21% of individuals in this age range experience such conditions.

Table 20. Children and adolescents age 9-17 with mental or addictive disorders, combined MECA sample, 6-month (current) prevalence*, 1999

Disorder	%
Anxiety Disorders	13.0
Mood Disorders	6.2
Disruptive Disorders	10.3
Substance Use Disorders	2.0
Any Disorder	20.9

*Disorders include diagnosis-specific impairment and CGAS < or = 70 (mild global impairment)

Source: Primary – Shaffer, D., et al. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. Methods for Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry, 23*, 865-877.; Secondary - Mental Health: A Report of the Surgeon General, 1999

Table 21 presents the best estimates of one-year prevalence rates of mental disorders in the United States for three different age groups, including youth (9 to 17 years), adults (18 to 54 years), and adults (55 years and older). Although all three groups are fairly similar in prevalence, the 18 to 54 age group is the most likely to experience disorders.

Table 21. Surgeon General's best estimates of 1-year prevalence rates of mental disorder, United States, 1999

Age Group	Percent with Mental Disorder*
Youth (9-17 years)	18.9%
Adults (18-54 years)	21.0%
Adults (55 years +)	19.8%

*Represents approximately 44 million people

Source: U.S. Department of Health and Human Services (data consolidated from National Comorbidity Survey, Epidemiologic Catchment Area, and Methods for the Epidemiology of Child and Adolescent Mental Disorders)

Table 22 indicates the estimated number of people who have major depression in Gibson, Posey, Vanderburgh, and Warrick Counties.

Table 22. Number of People with Major Depression by County (2004/2005 Average)			
Gibson	Posey	Vanderburgh	Warrick
2,264	1,815	11,725	3,790

Source: Primary – Substance Abuse and Mental Health Services Administration; Secondary – Community Health Status Indicators, U.S. Department of Health & Human Services

Table 23 presents the percentage of individuals in the United States who are estimated to have current depression. Data are broken down by age, sex, and race/ethnicity. Among the different age groups, individuals in the 40 to 59 age group are most likely to experience depression. Females have higher estimates for current depression than males. This difference is statistically significant. Further, non-Hispanic black individuals are more likely to have depression than Mexican Americans or non-Hispanic white individuals.

Table 23. Percentage of persons 12 years of age and older with current depression by demographic characteristics: United States, 2005-2006	
Group	Percentage
Total	5.4
Age	
12-17	4.3
18-39	4.7
40-59	7.3[1]
60 and older	4.0
Sex	
Female	6.7[2]
Male	4.0
Race and Hispanic origin	
Mexican American	6.3
Non-Hispanic black	8.0[3]
Non-Hispanic white	4.8

[1]Significantly different from all other age groups
[2]Significantly different from men
[3]Significantly different from non-Hispanic white persons
Source: Centers for Disease Control/National Center for Health Statistics, National Health and Nutrition Examination Survey

Table 24 presents United States and Indiana 2005/2006 estimates for the percentage of individuals who had at least one major depressive episode in the past year. Per SAMSHA, a Major Depressive Episode (MDE) is defined as a period of at least 2 weeks when a person experienced a depressed mood or loss of interest or pleasure in daily activities and had a majority of the symptoms for depression as described in the 4th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV). Data are broken down by age group. As noted, the 18 to 25 age group is higher than the 12 to 17 or 26 and older age groups. Further, Indiana's adult (18 or older), 18 to 25, and 26 or older estimates are higher than comparable groups in the United States.

Table 24. Having at Least One Major Depressive Episode in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2005 and 2006 NSDUHs								
	18 or Older		AGE GROUP (Years)					
			12-17		18-25		26 or Older	
Location	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval
Total U.S.	7.25	--	8.36	--	9.36	--	6.88	--
Indiana	8.67	(7.24-10.35)	8.01	(6.58-9.71)	10.21	(8.45-12.29)	8.39	(6.79-10.33)

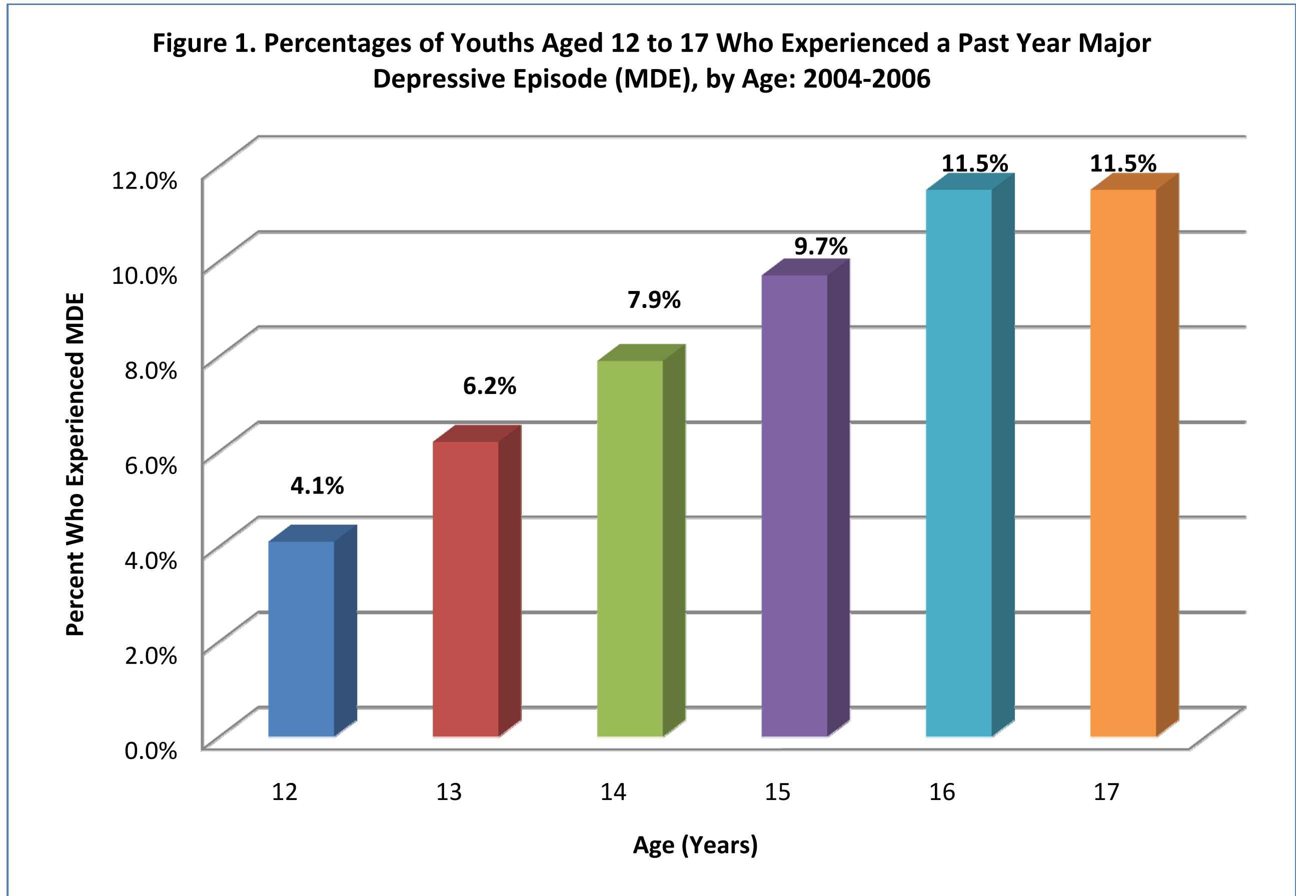
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2005 and 2006

Table 25 presents United States and Indiana 2006 and 2007 estimates for the percentage of adults and youth who experienced at least one major depressive episode in the past year. The Indiana rates are higher than the United States rates for all indicated age groups.

Table 25. Percent of adults and youth who experienced at least one major depressive episode in the past year, United States (2007 data) and Indiana (2006 and 2007 data averaged)		
Age Group	U.S.	Indiana
Adults (18 or older)	7.50	8.80
Youth (12 to 17)	8.20	8.42
Adults (18 to 25)	8.90	10.72

Source: SAMHSA, 2006 and 2007 National Survey on Drug Use and Health

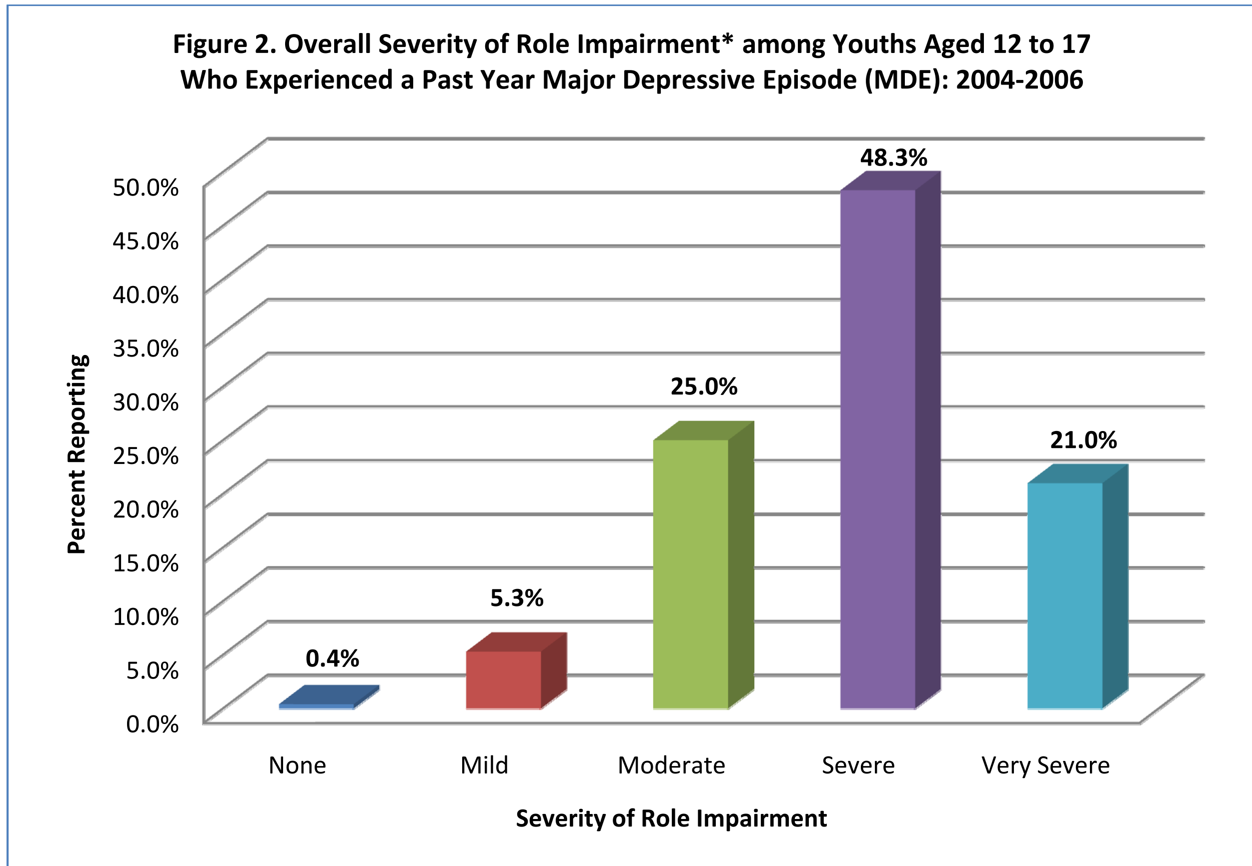
Figure 1 indicates the percentage of youth in the United States age 12 to 17 who experienced a past year major depressive episode (2004-2006 average). Data are broken down by each age. As noted, 16 and 17 year olds are the most likely among the group to experience a major depressive episode, with 11.5% of both ages expected to have this condition each year.



Source: SAMHSA, 2004-2006 National Drug Survey on Drug Use and Health

Percentages of Youths Aged 12 to 17 Who Experienced a Past Year Major Depressive Episode (MDE), by Age: 2004-2006	
Age	**Percent**
12	4.1%
13	6.2%
14	7.9%
15	9.75
16	11.5%
17	11.5%

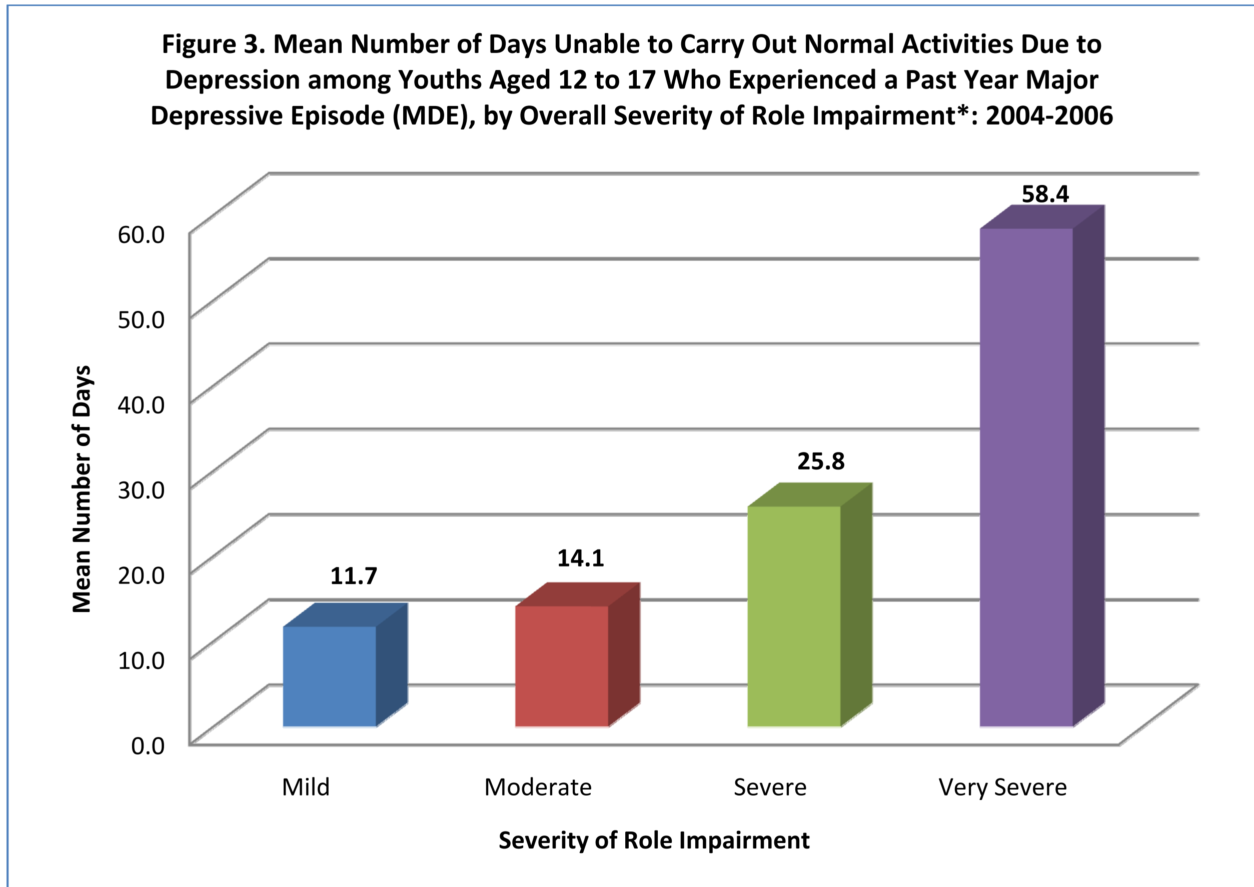
Figure 2 indicates the overall severity of role impairment among youth in the United States age 12 to 17 who experienced a major depressive episode in the past year. Almost half of those who experienced this condition were identified as having 'severe' role impairment. Role impairment is based on the Sheehan Disability Scale, which assesses functional impairment in work/school, social, and family domains.



Source: SAMHSA, 2004-2006 National Survey on Drug Use and Health

Overall Severity of Role Impairment* among Youths Aged 12 to 17 Who Experienced a Past Year Major Depressive Episode (MDE): 2004-2006	
Severity of Role Impairment	**Percent**
None	0.4%
Mild	5.3%
Moderate	25.0%
Severe	48.3%
Very Severe	21.0%

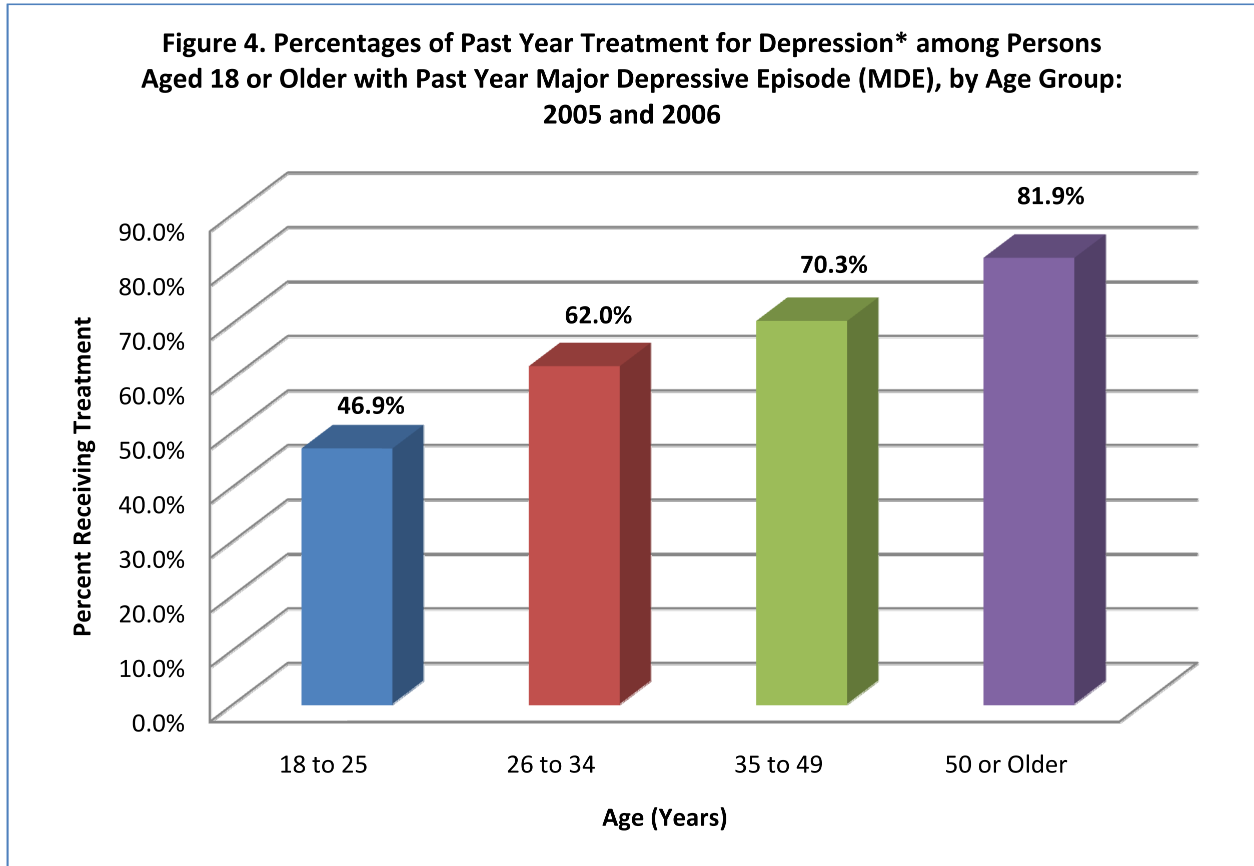
Figure 3 shows the mean number of days that individuals in the 12 to 17 age group who experienced a past-year major depressive episode were unable to carry out normal activities due to the condition. Data are presented by severity of role impairment. Within the past year, youth age 12 to 17 who were classified as 'very severe' were unable to carry out normal activities approximately 58 days within the course of one year.



Source: SAMHSA, 2004-2006 National Survey on Drug Use and Health

Mean Number of Days Unable to Carry Out Normal Activities Due to Depression among Youths Aged 12 to 17 Who Experienced a Past Year Major Depressive Episode (MDE), by Overall Severity of Role Impairment*: 2004-2006	
Severity of Role Impairment	Mean Number of Days
Mild	11.7
Moderate	14.1
Severe	25.8
Very Severe	58.4

Figure 4 indicates the percentage of individuals in the United States who received past-year treatment for depression. Data are for adults who had a past-year major depressive episode. As shown, individuals age 50 or older are most likely to receive treatment, with 82% falling into this category, and those in the 18 to 25 age group are the least likely to receive treatment, with less than half of those who had a major depressive episode who also received treatment.



Note: Average of all age groups: 67.4%; total males = 72.2%, total females = 58.2%
Source: SAMHSA, 2005 and 2006 National Survey on Drug Use and Health

Percentages of Past Year Treatment for Depression* among Persons Aged 18 or Older with Past Year Major Depressive Episode (MDE), by Age Group: 2005 and 2006	
Age	Percent Receiving Treatment
18 to 25	46.9%
26 to 34	62.0%
35 to 49	70.3%
50 or Older	81.9%

Table 26 presents data from the 2007 Mental Health America study on depression across the states regarding the percentage of individuals who experienced a past-year major depressive episode and past-year serious psychological distress in Indiana and the United States. The estimated number of poor mental health days experienced within the past thirty days is also presented. On average, individuals in Indiana experience 3.67 poor mental health days within a thirty-day period, compared to 3.31 in the United States. Note: the indication of 'poor mental health days' was based on the CDC Behavioral Risk Factor Surveillance System measure of 'mentally unhealthy days.' The item used to collect these data is, "Now thinking about your mental health, which includes stress, depression, and problems with emotions, for how many days during the past 30 days was your mental health not good?"

Table 26. Components of State Depression Status Indicator from Mental Health America Study on Depression, 2007

Indicator	Indiana	United States
% of adolescents with past-year major depressive episode (2004-2005)	8.80	8.95
% of adults with past-year major depressive episode (2004-2005)	8.90	8.05
% of adults with past-year serious psychological distress (2004-2005)	12.52	11.63
No. of poor mental health days in the past 30 days	3.67	3.31

Source: Mental Health America, *Ranking of America's Mental Health: An Analysis of Depression Across the States*, December 11, 2007

Table 27 provides an indication of the differences in depression prevalence between individuals in poverty and those at or able the poverty level. Data are broken down by age group. Overall, individuals in the United States are almost three times as likely to have depression if they are in poverty. This difference is especially pronounced for individuals in the 40 to 49 age group.

Table 27. Percentage of Persons with Depression by Age and Poverty Status: United States, 2005-2006

Age Group	Below Poverty Level	At or Above Poverty Level
Total	13.1[1]	4.4
12-17	6.4	4.0
18-39	11.5[1]	3.5
40-59	22.4[1,2]	5.9
60 and older	7.4*	3.8

[1]Significantly different from at or above poverty level
[2]Significantly different from other age groups
*Estimate is unreliable
Source: Centers for Disease Control/National Center for Health Statistics, National Health and Nutrition Examination Survey

Table 28a presents the percentage of individuals in the United States and Indiana who experienced serious psychological distress in the past year. Serious psychological distress is based on the K6 screening instrument for nonspecific psychological distress. Per SAMSHA, The K6 consists of six questions that ask respondents how frequently they experienced symptoms of psychological distress during the one month in the past year when they were at their worst emotionally. As noted by the 2005/2006 survey averages, 12.73% of adults in Indiana 18 or older experienced serious psychological distress in the past year. The rate of 12.77 for 2006/2007 was very similar to the 2005/2006 average. The 18 to 25 age group is particularly susceptible to serious psychological distress, with around 20% of Indiana residents in this age group experiencing this condition. Indiana's rate exceeds the national rate in all indicated age groups.

Table 28a. Serious Psychological Distress in Past Year, by Age Group and State: Percentages, Annual Averages Based on 2005 and 2006 NSDUHs

Location	18 or Older		AGE GROUP (Years)			
			18-25		26 or Older	
	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval	Estimate	95% Prediction Interval
Total U.S.	11.29	--	18.14	--	10.10	--
Indiana	12.73	(11.02-14.65)	19.42	(16.97-22.12)	11.52	(9.65-13.70)

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2005 and 2006

Table 28b. Percent of adults and youth who experienced serious psychological distress in the past year, United States (2007 data) and Indiana (2006 and 2007 data averaged)

Age Group	U.S.	Indiana
Adults (18 or older)	10.90	12.77
Adults (18 to 25)	17.90	20.33

Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2006 and 2007

Indicator 1.3 Estimates of the percentage of individuals in the nation and state of Indiana who experience serious psychological distress and other selected mental health characteristics

Table 29 presents the percentage of persons age 50 or older in the United States who experienced serious psychological distress in the past year. Data are broken down into the 50 to 64 and 65 or older age groups and by gender, education attainment, family income, employment status, and health insurance. Individuals between 50 and 64 are estimated to be more likely to have serious psychological distress than those 65 or older. Additionally, females,

individuals with less than high school completion, those in poverty, and those with no insurance are particularly affected with this condition.

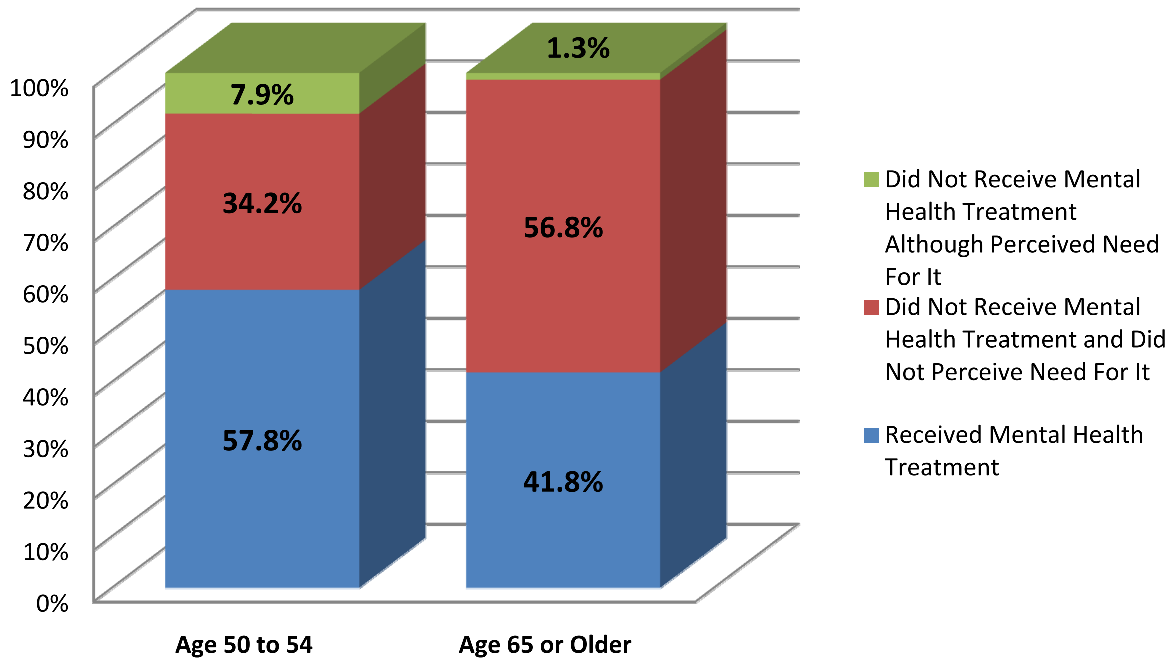
Table 29. Percentages of persons aged 50 or older with past year serious psychological distress (SPD), by age group and demographic characteristics: 2005 and 2006			
Demographic Characteristic	Total Aged 50 or Older	Aged 50 to 64	Aged 65 or Older
Total	7.0	8.8	4.5
Gender			
Male	5.2	6.4	3.1
Female	8.7	11.1	5.6
Education			
<High School	10.2	13.9	7.5
High School Graduate	6.4	8.1	4.4
Some College	7.6	10.0	3.3
College Graduate	5.2	6.6	1.9
Family Income			
<$20,000	11.7	18.3	7.0
$20,000-$49,999	6.9	10.2	3.7
$50,000-$74,999	6.1	7.4	3.5
≥ $75,000	4.4	4.9	2.8
Current Employment			
Employed (Full or Part Time)	5.9	6.6	2.3
Retired	4.9	6.6	4.5
Health Insurance			
Any Health Insurance	6.7	8.5	4.4
No Health Insurance	12.3	11.9	--

Source: SAMHSA, 2005 and 2006 National Survey on Drug Use and Health

Table 30 indicates the percentage of individuals age 50 or older with past-year serious psychological distress who received mental health treatment. Additionally, among those who did not receive treatment, the percentage who perceived a need for treatment is indicated. Breakdowns are provided for gender, education attainment, family income, and employment status. Overall, 53.7% of individuals received mental health treatment. Females, college graduates, those with higher family incomes, and those who are employed are more likely to receive treatment. Among those who did not receive treatment, a fairly small number of people perceived a need for treatment. Of the 46.3% of individuals with serious psychological distress who did not receive treatment, only 6.2% perceived a need for it. Figure 5 also presents findings regarding mental health treatment and perceived need for treatment.

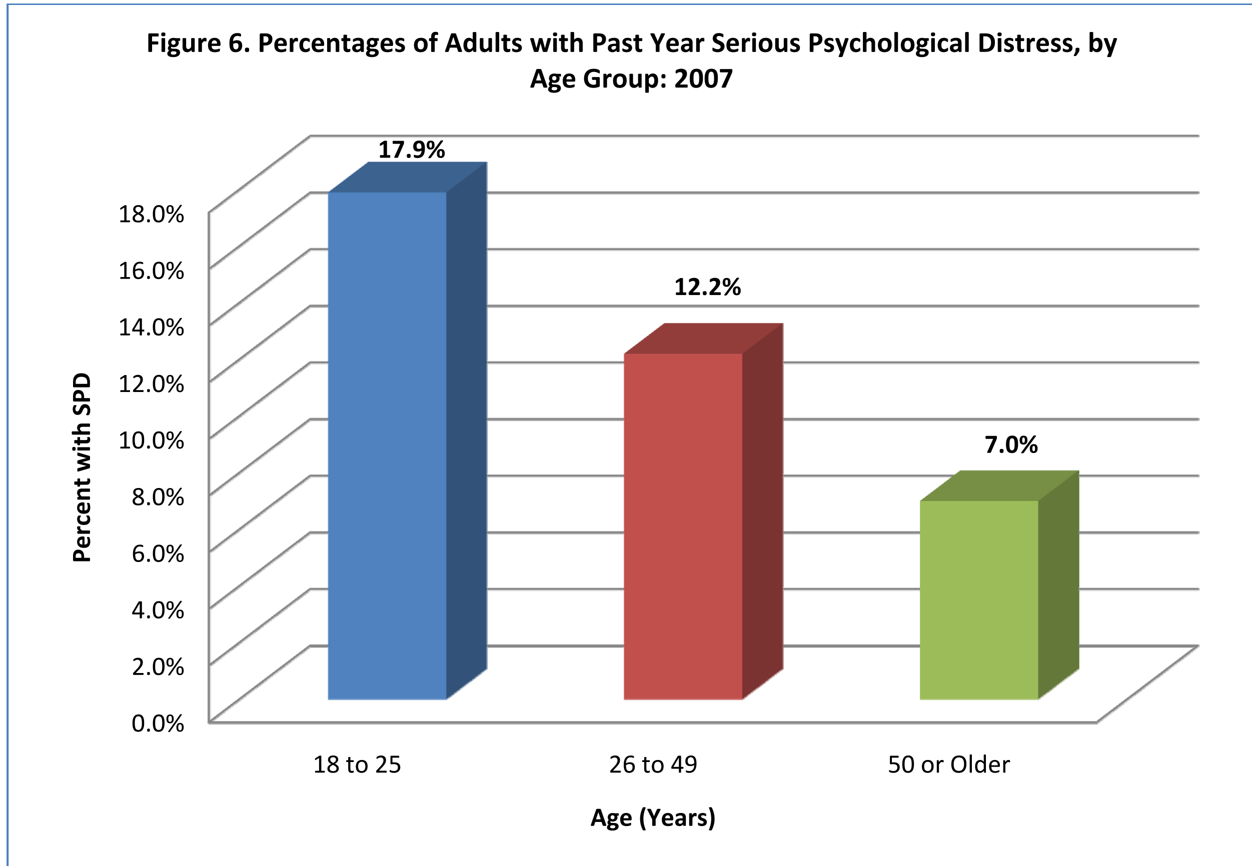
Table 30. Percentages of persons aged 50 or older with past year serious psychological distress (SPD) who reported past year mental health treatment and perceived need for treatment, by demographic characteristics: 2005 and 2006			
		Did Not Receive Mental Health Treatment	
Demographic Characteristic	Received Mental Health Treatment*	Perceived Need for Treatment	Did Not Perceive Need for Treatment
Total	53.7	6.2	40.1
Gender			
Male	48.7	6.7	44.6
Female	56.2	6.0	37.9
Education			
<High School	40.7	5.3	54.0
High School Graduate	51.4	4.7	43.9
Some College	58.8	9.1	32.1
College Graduate	67.8	6.2	25.9
Family Income			
<$20,000	51.0	4.6	44.4
$20,000-$49,999	53.4	5.7	41.0
$50,000-$74,999	52.7	9.7	37.6
≥ $75,000	60.1	7.2	32.6
Current Employment			
Employed (Full or Part Time)	49.5	8.8	41.7
Retired	45.4	2.8	51.8

*Individuals who had received mental health treatment in the past year but who felt they needed additional treatment are categorized as having received treatment.
Source: SAMHSA, 2005 and 2006 National Survey on Drug Use and Health



Source: SAMHSA, 2005 and 2006 National Survey on Drug Use and Health

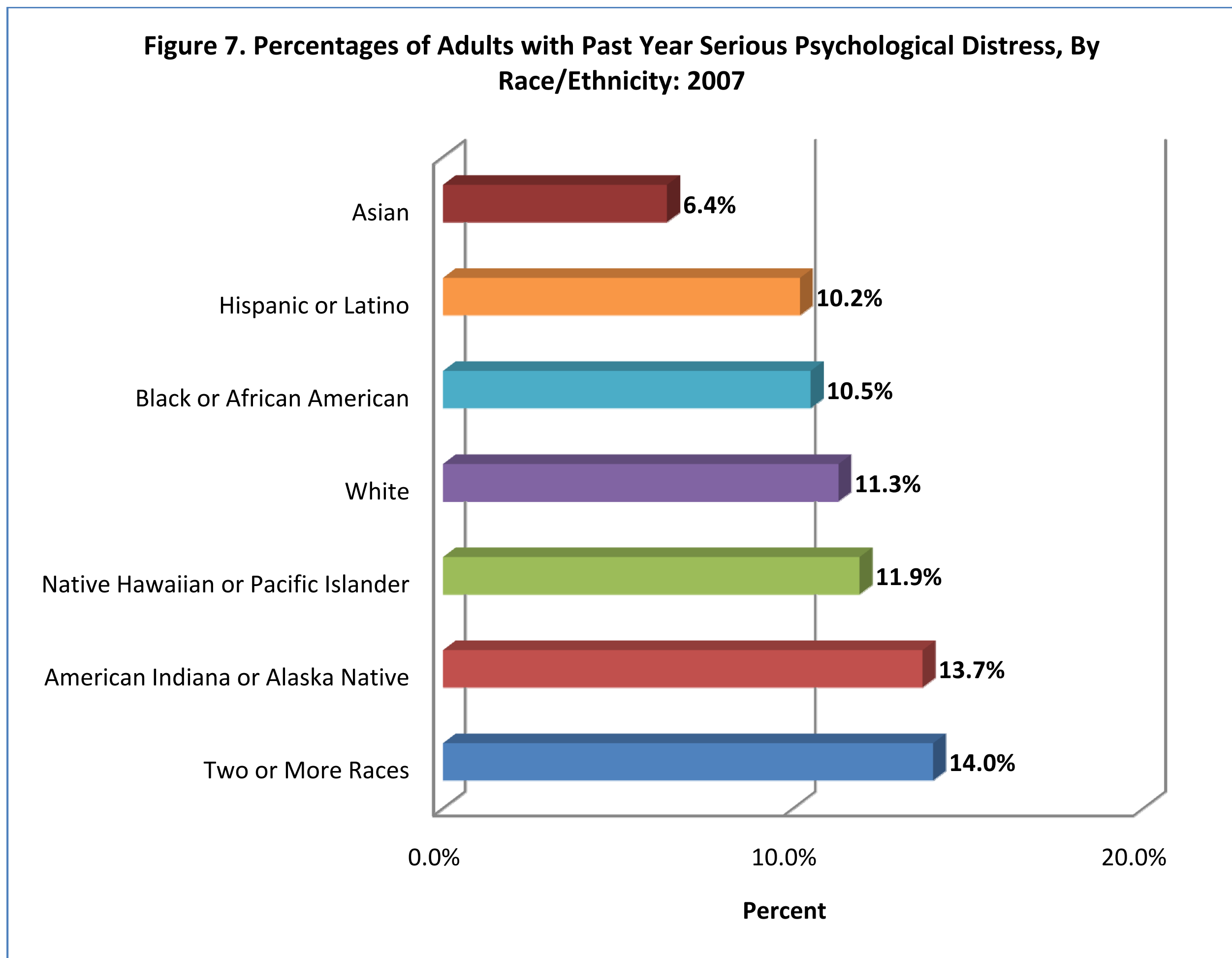
Figure 6 presents the percentage of adults in the United States with past-year serious psychological distress by age group. Specifically in 2007, 17.9% of adults 18 to 25 years old experienced serious psychological distress in the past year. This is the highest rate among the age groups shown.



Note: An estimated 24.3 million adults aged 18 or older experienced SPD in the past year (represents 10.9% of the adult population); females = 13.4% and males = 8.2%
Source: SAMHSA, 2007 National Survey on Drug Use and Health

Percentages of Adults with Past Year Serious Psychological Distress, by Age Group: 2007	
Age	Percent with SPD
18 to 25	17.9%
26 to 49	12.2%
50 or Older	7.0%

Figure 7 presents 2007 national estimates of past-year serious psychological distress by race/ethnicity. Overall, Asians were least likely to experience this condition and those with two or more races were most likely to have serious psychological distress.



Percentages of Adults with Past Serious Psychological Distress, By Race/Ethnicity: 2007	
Reason	**Percentage Selecting Reason**
Two or More Races	14.0%
American Indiana or Alaska Native	13.7%
Native Hawaiian or Pacific Islander	11.9%
White	11.3%
Black or African American	10.5%
Hispanic or Latino	10.2%
Asian	6.4%

Table 31 presents the percentage of adults in the United States age 18 or older who experienced serious psychological distress during the past thirty days from 1998 to 2007. As noted, rates have remained fairly stable over the ten-year time span. Table 32 presents these data broken down by age and sex. As shown, rates for females in the 45 to 64 age group are slightly higher than the other age groups. Males 65 or older have the lowest rates of 30-day serious psychological distress.

Table 31. Percentage of adults aged 18 years and over who experienced serious psychological distress during the past 30 days: United States, 1998-2007

Year	Crude Percent (95% confidence interval)	Age-adjusted[1] Percent (95% confidence interval)
1998	3.0 (2.7-3.2)	3.0 (2.8-3.2)
1999	2.4 (2.2-2.6)	2.4 (2.2-2.6)
2000	2.7 (2.5-2.9)	2.7 (2.5-2.9)
2001	3.2 (2.9-3.4)	3.2 (2.9-3.4)
2002	3.0 (2.8-3.2)	3.0 (2.8-3.2)
2003	3.1 (2.9-3.4)	3.1 (2.9-3.4)
2004	3.1 (2.9-3.4)	3.0 (2.8-3.3)
2005	3.0 (2.74-3.20)	2.9 (2.72-3.17)
2006	3.0 (2.73-3.23)	2.9 (2.68-3.17)
2007	2.7 (2.43-2.98)	2.7 (2.39-2.93)

[1]Estimates are age adjusted using the projected 2000 U.S. population as the standard population and using three age groups: 18-44 years, 45-64 years, and 65 years and over.
Source: Centers for Disease Control, National Health Interview Survey, 1998-2007. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

Table 32. Percentage of adults aged 18 and over who experienced serious psychological distress during the past 30 days, by age group and sex: United States, 2007

Age and sex	Percent	95% confidence interval
18-44 years		
Total	2.4	2.06-2.78
Male	1.8	1.37-2.26
Female	3.0	2.48-3.57
45-64 years		
Total	3.4	2.88-3.95
Male	2.4	1.84-2.88
Female	4.4	3.55-5.27
65 years and over		
Total	2.1	1.58-2.58
Male	1.3	0.76-1.91
Female	2.6	1.94-3.34
18 years and over: crude		
Total	2.7	2.43-2.98
Male	1.9	1.63-2.24
Female	3.4	3.01-3.85

18 years and over: age-adjusted[1]		
Total	2.7	2.39-2.93
Male	1.9	1.59-2.20
Female	3.4	2.96-3.79

[1]Estimates are age adjusted using the projected 2000 U.S. population as the standard population and using three age groups: 18-44 years, 45-64 years, and 65 years and over.
Source: Centers for Disease Control, National Health Interview Survey, 1998-2007. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

Table 33. Age-sex-adjusted percentage of adults aged 18 years and over who experienced serious psychological distress during the past 30 days, by race/ethnicity: United States, 2007		
Race/ethnicity	Percent[1]	95% confidence interval
Hispanic or Latino	3.7	3.04-4.41
Not Hispanic or Latino		
White, single race	2.6	2.25-2.90
Black, single race	2.6	2.04-3.22

[1]Estimates are age-sex adjusted using the projected 2000 U.S. population as the standard population and using five age groups: 18-24 years, 25-34 years, 35-44 years, 45-64 years, and 65 years and over.
Source: Centers for Disease Control, National Health Interview Survey, 1998-2007. Data are based on household interviews of a sample of the civilian noninstitutionalized population.

Table 34 presents the percentage of individuals in the United States age 18 or older who experienced feelings of sadness, hopelessness, worthlessness, or that everything is an effort within the past thirty days. Data are broken down by sex, age, race/ethnicity, marital status, and geographic region. Table 35 presents a similar breakdown for feelings of nervousness and restlessness.

Table 34. Percents of feelings of sadness, hopelessness, worthlessness, or that everything is an effort in the past 30 days among persons 18 years of age and over, by selected characteristics: United States, 2000								
Selected characteristic	Selected mental health characteristics							
	Sadness		Hopelessness		Worthlessness		Everything is an effort	
	All or most of the time	Some of the time	All or most of the time	Some of the time	All or most of the time	Some of the time	All or most of the time	Some of the time
Total	3.2	7.8	1.9	3.7	1.7	3.0	4.8	7.4
Sex								
Male	2.6	5.8	1.6	2.8	1.5	2.4	4.2	6.6
Female	3.8	9.7	2.2	4.4	1.9	3.4	5.3	8.3
Age								
18-44 years	2.8	7.6	1.6	3.7	1.3	2.7	4.9	7.8
45-64 years	3.9	7.6	2.5	3.9	2.3	3.3	4.6	7.2
65-74 years	3.4	8.9	2.1	2.9	2.0	2.6	4.7	5.9
75 years and over	3.2	9.4	1.7	3.4	1.7	3.6	4.7	7.8
Race								
1 race	3.2	7.8	1.9	3.6	1.7	2.9	4.7	7.4
White	3.0	7.4	1.8	3.5	1.7	2.9	4.4	7.3

Black or African American	4.0	9.5	1.9	3.8	1.7	2.9	7.1	7.6
American Indian or Alaska Native	3.9	13.9	1.7	10.2	4.3	4.2	6.7	9.3
Asian	3.0	6.4	1.7	3.3	1.3	3.0	4.1	6.7
Native Hawaiian or other Pacific Islander	7.3	11.5	3.1	4.2	3.1	--	9.4	5.8
Hispanic or Latino	4.4	9.7	3.1	4.8	2.5	3.0	4.8	6.0
Marital status								
Married	2.4	6.1	1.5	2.9	1.4	2.3	3.5	6.6
Widowed	5.5	13.2	2.6	4.7	2.6	4.6	5.9	8.9
Divorced or separated	6.1	11.8	3.8	6.2	3.5	4.9	7.6	9.7
Never married	3.1	8.6	1.7	3.9	1.4	2.9	5.8	7.8
Living with a partner	3.8	9.7	2.8	5.3	1.8	4.1	7.6	9.1
Region								
Northeast	2.7	8.9	1.6	3.3	1.2	2.5	3.6	6.7
Midwest	2.8	7.6	1.7	3.5	1.7	2.8	5.1	7.0
South	3.5	7.7	2.1	3.9	1.9	3.1	5.0	7.7
West	3.7	7.4	2.3	3.8	1.9	3.4	5.0	8.3

Source: Centers for Disease Control, National Center for Health Statistics, 2000 National Health Interview Survey

Table 35. Percents of feelings of nervousness or restlessness among persons 18 years of age and over in the past 30 days, by selected characteristic: United States, 2000

Selected characteristic	Selected mental health characteristics			
	Nervousness		Restlessness	
	All or most of the time	Some of the time	All or most of the time	Some of the time
Total	4.0	11.4	5.0	11.5
Sex				
Male	3.0	9.5	4.6	10.1
Female	4.9	13.2	5.4	12.7
Age				
18-44 years	3.6	12.2	5.2	12.3
45-64 years	4.6	10.7	5.1	10.6
65-74 years	4.7	10.6	4.7	10.5
75 years and over	3.8	10.0	3.5	9.8
Race				
1 race	4.0	11.4	5.0	11.4
White	4.1	11.8	5.0	11.7
Black or African American	2.9	9.5	5.0	10.4

American Indian or Alaska Native	6.2	12.9	6.7	12.0
Asian	2.2	8.0	2.6	7.5
Native Hawaiian or other Pacific Islander	*3.1	*6.9	*3.1	*15.9
Hispanic or Latino	4.6	10.5	5.0	9.5
Marital status				
Married	3.2	10.2	4.2	10.3
Widowed	6.2	11.9	5.1	11.6
Divorced or separated	6.1	13.8	7.5	14.0
Never married	4.0	13.0	5.2	13.2
Living with a partner	5.1	14.2	7.7	13.2
Region				
Northeast	3.4	11.6	3.8	10.9
Midwest	3.9	11.5	5.0	11.7
South	4.1	11.2	5.7	11.3
West	4.4	11.6	5.1	12.2

Source: Centers for Disease Control, National Center for Health Statistics, 2000 National Health Interview Survey

Table 36 indicates the percentage of children in the United States age 4 to 17 who have emotional and behavioral difficulties. Data are broken down by age and gender, poverty status, race/ethnicity, and family structure. Overall, males appear to experience more definite or severe emotional or behavioral difficulties than females at every age level. Further, children in poverty are shown to have more difficulties than those above poverty. Children who are white alone/non-Hispanic have more reported emotional and behavioral difficulties than the other race/ethnic groups. Finally, children with a mother only are shown to have more definite/severe difficulties than children with a father only or two parents.

Table 36. Emotional and behavioral difficulties: Percentage of children ages 4-17 reported by a parent to have definite/severe, minor, or no difficulties with emotions, concentration, behavior, or getting along with other people, by selected characteristics, 2006

Characteristic	Definite/severe difficulties	Minor difficulties	No difficulties
Age and gender			
Total ages 4-17	5.0	15.5	79.5
Ages 4-7	4.0	13.9	82.1
Ages 8-10	4.9	14.4	80.8
Ages 11-14	5.6	15.8	78.6
Ages 15-17	5.6	18.0	76.4
Males ages 4-17	6.6	16.9	76.5
Ages 4-7	5.3	15.5	79.2

Ages 8-10	6.7	15.9	77.4
Ages 11-14	7.4	17.8	74.8
Ages 15-17	7.1	18.4	74.4
Females ages 4-17	3.3	14.0	82.7
Ages 4-7	2.6	12.1	85.3
Ages 8-10	3.0	12.7	84.2
Ages 11-14	3.8	13.8	82.4
Ages 15-17	3.9	17.6	78.4
Poverty status			
Below 100% poverty	6.6	17.1	76.3
100-100% poverty	5.6	16.7	77.7
200% poverty and above	4.2	14.4	81.3
Race and Hispanic origin			
White alone, non-Hispanic	5.7	16.4	77.9
Black alone, non-Hispanic	5.0	14.6	80.4
Hispanic	3.6	13.6	82.8
Other, non-Hispanic and multiple races	2.7	13.8	83.5
Family structure			
Two parents	4.0	13.9	82.1
Mother only	7.8	18.4	73.8
Father only	4.8	19.0	76.2
No parents	7.0	22.1	70.9

Note: Children with emotional and behavioral difficulties are defined as those who parent responded "yes, definite" or "yes, severe" to the following question on the Strengths and Difficulties Questionnaire (SDQ): "Overall, do you think that (child) has any difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get along with other people?" Response choices were: (1) no; (2) yes, minor difficulties; (3) yes, definite difficulties; and (4) yes, severe difficulties.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, 2006 National Health Interview Survey

Table 37 provides of indication of treatment for children with emotional and behavioral difficulties. Overall, 84% of children with definite/severe difficulties had contact with a health care provider or school staff, 48.8% were prescribed medication, and 43.5% had treatment other than medication.

Table 37. Emotional and behavioral difficulties: Percentage of children ages 4-17 whose parent had contact with a health care provider or school staff, who were prescribed medication, or who received treatment other than medication by level of emotional and behavioral difficulty, 2006			
Level of difficulty	Contact with health care provider or school staff	Prescribed medication	Treatment other than medication
Definite/severe	84.0	48.8	43.5
Minor difficulties	48.5	14.2	16.8
No difficulties	3.8	0.9	0.9

Note: Children with emotional and behavioral difficulties are defined as those who parent responded "yes, definite" or "yes, severe" to the following question on the Strengths and Difficulties Questionnaire (SDQ): "Overall, do you think that (child) has any difficulties in one or more of the following areas: emotions, concentration, behavior, or being able to get along with other people?" Response choices were: (1) no; (2) yes, minor difficulties; (3) yes, definite difficulties; and (4) yes, severe difficulties.
Source: Centers for Disease Control and Prevention, National Center for Health Statistics, 2006 National Health Interview Survey

Table 38 shows the mean mentally unhealthy days that individuals in Indiana and the United States experienced in a thirty-day period. Data are presented for 1998 through 2007. While the 2007 mean rates for Indiana and the U.S. are the same, Indiana's rate has tended to be slightly higher than that for the nation. In 2007, it was estimated that Indiana residents experienced 3.4 mean mentally unhealthy days within the past thirty days.

Table 38. Mean mentally unhealthy days in past 30 days: overall, U.S. and Indiana trend, 1998-2007			
Year	Mean	Confidence Interval (95%)	N
1998 Indiana	3.2	(2.9-3.7)	2,351
1998 U.S.	3.0	(2.9-3.1)	141,744
1999 Indiana	3.0	(2.5-3.5)	2,348
1999 U.S.	3.0	(2.9-3.1)	150,957
2000 Indiana	3.4	(3.1-3.8)	2,815
2000 U.S.	3.2	(3.1-3.3)	172,960
2001 Indiana	3.6	(3.3-3.9)	3,826
2001 U.S.	3.4	(3.3-3.5)	194,471
2002 Indiana	No data	No data	No data
2002 U.S.	3.2	(3.1-3.4)	234,736
2003 Indiana	3.7	(3.4-4.0)	5,225
2003 U.S.	3.4	(3.3-3.5)	246,134
2004 Indiana	3.6	(3.3-3.8)	6,150
2004 U.S.	3.5	(3.4-3.6)	282,380
2005 Indiana	3.7	(3.4-4.0)	5,349
2005 U.S.	3.3	(3.2-3.4)	331,517
2006 Indiana	3.7	(3.4-4.0)	6,301
2006 U.S.	3.4	(3.3-3.5)	334,606
2007 Indiana	3.4	(3.1-3.7)	5,686
2007 U.S.	3.4	(3.3-3.5)	401,732

Source: Centers for Disease Control, Behavioral Risk Factor Surveillance System

Table 39 presents the percentage of individuals in Indiana and the United States who experienced at least 14 mentally unhealthy days in the past year. Data are provided for 1998 through 2007. Indiana's 2007 rate of 10.3 days per year is slightly higher than the national rate, which is somewhat typical of recent years.

Table 39. Percentage with 14 or more mentally unhealthy days (Frequent Mental Distress) annually: overall, U.S. and Indiana trend, 1998-2007

Year	Mean	Confidence Interval (95%)	N
1998 Indiana	9.0	(7.7-10.3)	2,351
1998 U.S.	9.1	(8.8-9.4)	141,744
1999 Indiana	8.2	(6.5-10.0)	2,348
1999 U.S.	8.9	(8.6-9.2)	150,957
2000 Indiana	10.4	(9.1-11.7)	2,815
2000 U.S.	9.6	(9.3-9.9)	172,960
2001 Indiana	10.9	(9.7-12.0)	3,826
2001 U.S.	10.0	(9.7-10.3)	194,471
2002 Indiana	No data	No data	No data
2002 U.S.	9.5	(9.0-9.9)	234,736
2003 Indiana	11.3	(10.3-12.3)	5,225
2003 U.S.	10.2	(10.0-10.5)	246,134
2004 Indiana	10.4	(9.4-11.3)	6,150
2004 U.S.	10.4	(10.1-10.7)	282,380
2005 Indiana	11.0	(9.9-12.1)	5,349
2005 U.S.	10.0	(9.8-10.3)	331,517
2006 Indiana	11.1	(10.1-12.2)	6,301
2006 U.S.	10.2	(9.9-10.5)	334,606
2007 Indiana	10.3	(9.1-11.4)	5,686
2007 U.S.	10.1	(9.9-10.4)	401,732

Source: Centers for Disease Control, Behavioral Risk Factor Surveillance System

Indicator 1.4 Findings from the Welborn Baptist Foundation Adult Health Indicators Survey regarding mental health issues among individuals in Vanderburgh and Warrick Counties

The following tables provide data from the 2008 Welborn Baptist Foundation Adult Health Indicators Survey. Of specific interest to this study are the items that relate to mental health, including frequency of depressed or anxious feelings and the extent to which adults have accessed mental health services. The survey included several counties in the Southwestern Indiana region. Given that Vanderburgh and Warrick Counties were the only two from the Welborn survey that also were in this study's target population, data from those two locations were pulled out and aggregated for the analysis below. The tables do not include data from Gibson or Posey Counties.

As shown in Table 44, 31.9% of respondents indicated feeling down, depressed, or hopeless at least one day in the past two weeks. Further, 23.7% of respondents indicated that a health care provider had told them they had an anxiety disorder (Table 45), and 28.6% of respondents indicated that they had been told they suffered from any type of depression (Table 46). To give a sense of the degree to which individuals access mental health services, 31.3% of respondents had sought help from a professional for mental health reasons or for help with an emotional situation (Table 47).

Table 40. Question: Would you say in general your health is…?					
1 Excellent	2 Very Good	3 Good	4 Fair	5 Poor	Total
19.6% n=220	31.4% n=353	31.2% n=350	12.7% n=143	5.1% n=57	100% n=1,123

Source: Welborn Baptist Foundation Adult Health Indicators Survey 2008

Table 41. Question: In general, how satisfied are you with your life?				
1 Very Satisfied	2 Satisfied	3 Dissatisfied	4 Very Dissatisfied	Total
39.0% n=434	51.3% n=571	7.6% n=84	2.1% n=23	100% n=1,112

Source: Welborn Baptist Foundation Adult Health Indicators Survey 2008

Table 42. Question: Over the past 2 weeks, how many days have you had little interest or pleasure in doing things?				
None	1 to 3	4 to 7	8 or more	Total
62.2% n=686	18.0% n=199	9.0% n=99	10.8% n=119	100% n=1,103

Source: Welborn Baptist Foundation Adult Health Indicators Survey 2008

Table 43. Question: Over the past 2 weeks, how many days have you had trouble concentrating on things?				
None	1 to 3	4 to 7	8 or more	Total
74.9% n=828	11.5% n=127	4.8% n=53	8.9% n=98	100% n=1,106

Source: Welborn Baptist Foundation Adult Health Indicators Survey 2008

Table 44. Question: Over the past 2 weeks, how many days have you felt down, depressed or hopeless?				
None	1 to 3	4 to 7	8 or more	Total
68.1% n=756	18.4% n=204	4.5% n=50	9.0% n=100	100% n=1,110

Source: Welborn Baptist Foundation Adult Health Indicators Survey 2008

Table 45. Question: Has a health care provider ever told you that you had an anxiety disorder?		
Yes	No	Total
23.7% n=265	76.3% n=854	100% n=1,119

Source: Welborn Baptist Foundation Adult Health Indicators Survey 2008

Table 46. Question: Has a health care provider ever told you that you suffered from any type of depression?		
Yes	No	Total
28.6% n=320	71.4% n=800	100% n=1,120

Source: Welborn Baptist Foundation Adult Health Indicators Survey 2008

Table 47. Question: Have you ever sought help from a professional for mental health or help with an emotional situation?		
Yes	No	Total
31.3% n=350	68.7% n=767	100% n=1,117

Source: Welborn Baptist Foundation Adult Health Indicators Survey 2008

Indicator 1.5 Data regarding the number of suicides in the four-county study area

Table 48 presents suicide counts for Indiana and the counties included in the needs assessment study. As noted, the number of suicides in Indiana experienced a noticeable increase between 2005 and 2006. Further, the number of suicides in Vanderburgh County spiked to a high of 40 in 2007.

Table 48. Suicide Data, Indiana and All Counties, 2002-2006[1]							
Location	**2002**	**2003**	**2004**	**2005**	**2006**	**2007**	**2008**
Indiana	727 (11.87)	725 (11.76)	702 (11.31)	735 (11.70)	815 (12.81)	--	--
Gibson	4 (13.55)	5 (13.84)	4 (13.72)	3 (8.01)	3 (7.01)	1[2] *(3.05)*	--
Posey	3 (10.10)	2 (6.81)	2 (6.87)	8 (30.43)	2 (5.50)	--	--
Vanderburgh	25 (14.86)	32 (18.65)	25 (14.56)	28 (15.96)	22 (12.95)	40 *(22.93)*	38
Warrick	3 (5.20)	5 (8.89)	2 (4.51)	6 (12.35)	7 (13.64)	--	--

[1]Data also include 2007 suicide counts for Gibson and Vanderburgh Counties
[2]Count does not include December 2007
Note: Data in parentheses are age-adjusted rates per 100,000 population (2007 rates for Gibson and Vanderburgh Counties, noted in italics, are not age-adjusted); other numbers indicate the actual counts of suicides; 2007 and 2008 data not available for all counties or for Indiana as a whole
Source: Indiana State Department of Health, Public Health System Development and Data Commission, Data Analysis Team; Vanderburgh County Coroner; Gibson County Sheriff's Department

Table 49 presents the number of suicides and suicide attempts for Indiana and the four-county study area for the time period of 2003 to 2005. Data are based on hospital emergency department/outpatient and inpatient figures.

Table 49. County-Level and Indiana Suicides and Suicide Attempts[1] 2003-2005		
Location	**Suicides**	**Suicide Attempts**
Gibson	12	114
Posey	12	73
Vanderburgh	85	806
Warrick	13	185
Indiana	2,162	15,921

[1]Numbers based on hospital emergency department/outpatient center and inpatient data. Due to only 55% of hospital discharge records having E-codes, the numbers are a gross underestimation of the actual number of suicide attempts.
Source: Indiana State Department of Health, Injury Prevention Program

Table 50 presents suicide-related data from the Youth Risk Behavior Survey for Indiana and the United States. Data are from the 2003, 2005, and 2007 surveys. Whereas Indiana rates for suicide consideration, development of plans, and attempts were lower in 2003 than U.S. rates, the 2005 and 2007 rates were actually higher than the national figures. In 2007, 7.2% of Indiana youth attempted suicide, 11.7% made a suicide plan, and 15.8% seriously considered attempting suicide.

Table 50. Suicide-related Data from the Youth Risk Behavior Survey, Indiana and U.S., 2003, 2005, 2007

Item	2003		2005		2007	
	Indiana	U.S.	Indiana	U.S.	Indiana	U.S.
Felt sad or hopeless[1]	25.3%	28.6%	27.3%	28.5%	27.5%	28.5%
Seriously considered attempting suicide[2]	16.0%	16.9%	18.0%	16.9%	15.8%	14.5%
Made a suicide plan[2]	12.6%	16.5%	14.9%	13.0%	11.7%	11.3%
Attempted suicide[2]	6.6%	8.5%	9.6%	8.4%	7.2%	6.9%
Suicide attempt requiring medical attention[2]	1.6%	2.9%	3.5%	2.3%	2.9%	2.0%

[1]Almost every day for 2 weeks or more
[2]One or more times during the past 12 months
Source: CDC, Youth Risk Behavior Survey

Indicator 1.6 Rates of alcohol and drug use among high school students and other selected age groups in Southwestern Indiana, the state of Indiana, and the United States

Tables 51 through 55 present data from the Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey of youth. Data are broken down by grade (8th, 10th, and 12th grades), location (Southwestern Indiana, Indiana, and the United States), and year (1999-2007). Specific prevalence data includes daily alcohol use, monthly alcohol use, binge drinking, daily marijuana use, and monthly marijuana use.

Students in Southwestern Indiana showed a decrease in all measures between 1999 and 2007 for the vast majority of grade levels. In 2007, rates among 8th graders in Southwestern Indiana were lower than the state on all measures. Rates of monthly alcohol use, binge drinking, and

monthly marijuana use are noticeably higher for this region than the state among 10th and 12th graders.

Table 51. Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey Results: Daily Alcohol Use % - Southwestern Indiana, Indiana, and United States (1999, 2003, 2005, 2007)			
Grade/Year	Southwestern Indiana	Indiana	United States
8th Grade			
1999	1.5	2.1	1.0
2003	1.7	2.1	0.8
2005	1.7	1.8	0.6
2007	0.9	1.8	0.5
10th Grade			
1999	4.4	4.5	1.9
2003	3.6	4.0	1.5
2005	4.0	3.6	1.3
2007	3.2	3.4	1.4
12th Grade			
1999	7.5	7.1	3.4
2003	7.3	6.0	3.2
2005	6.7	5.4	2.8
2007	4.2	4.2	3.0

Source: Local and State – Indiana Prevention Resource Center at Indiana University & Youth First, Inc.; National – Monitoring the Future Study, University of Michigan

Table 52. Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey Results: Monthly Alcohol Use % - Southwestern Indiana, Indiana, and United States (1999, 2003, 2005, 2007)			
Grade/Year	Southwestern Indiana	Indiana	United States
8th Grade			
1999	29.1	27.7	24.0
2003	23.2	24.3	19.7
2005	22.6	21.1	18.6
2007	17.1	19.9	17.2
10th Grade			
1999	44.0	41.6	40.0
2003	39.2	36.9	35.4
2005	37.2	33.0	35.2
2007	34.4	31.1	33.8
12th Grade			
1999	50.8	51.7	51.0
2003	50.8	46.1	47.5
2005	51.7	41.8	48.0
2007	42.3	39.7	45.3

Source: Local and State – Indiana Prevention Resource Center at Indiana University & Youth First, Inc.; National – Monitoring the Future Study, University of Michigan

Table 53. Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey Results: Binge Drinking[1] % - Southwestern Indiana, Indiana, and United States (1999, 2003, 2005, 2007)			
Grade/Year	**Southwestern Indiana**	**Indiana**	**United States**
8th Grade			
1999	18.4	19.5	15.2
2003	12.2	13.4	11.9
2005	12.2	11.6	11.4
2007	10.3	13.2	10.9
10th Grade			
1999	28.2	28.8	25.6
2003	22.4	21.8	22.2
2005	19.9	19.3	22.0
2007	23.0	21.7	21.9
12th Grade			
1999	36.8	36.3	30.8
2003	32.3	29.3	27.9
2005	32.7	25.9	29.2
2007	31.5	28.6	26.5

[1]Binge Drinking: Consuming five or more drinks in one sitting within two weeks of taking the survey
Source: Local and State – Indiana Prevention Resource Center at Indiana University & Youth First, Inc.; National – Monitoring the Future Study, University of Michigan

Table 54. Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey Results: Daily Marijuana Use % - Southwestern Indiana, Indiana, and United States (1999, 2003, 2005, 2007)			
Grade/Year	**Southwestern Indiana**	**Indiana**	**United States**
8th Grade			
1999	2.0	2.3	1.4
2003	2.3	2.6	1.0
2005	2.4	2.4	0.8
2007	1.3	2.0	1.0
10th Grade			
1999	5.1	6.5	3.8
2003	6.4	5.6	3.6
2005	5.4	5.0	3.2
2007	5.1	4.6	2.8
12th Grade			
1999	8.0	8.2	6.0
2003	7.8	7.4	6.0
2005	7.1	6.3	5.6
2007	5.3	5.3	5.0

Source: Local and State – Indiana Prevention Resource Center at Indiana University & Youth First, Inc.; National – Monitoring the Future Study, University of Michigan

Table 55. Indiana Prevention Resource Center Alcohol, Tobacco, and Other Drugs Survey Results: Monthly Marijuana Use % - Southwestern Indiana, Indiana, and United States (1999, 2003, 2005, 2007)			
Grade/Year	**Southwestern Indiana**	**Indiana**	**United States**
8th Grade			
1999	10.9	11.3	9.7
2003	8.8	10.6	7.5
2005	10.3	9.3	6.4
2007	7.3	8.3	6.5
10th Grade			
1999	20.4	21.1	19.4
2003	20.2	18.2	17.0
2005	20.1	16.0	15.9
2007	17.1	14.4	14.2
12th Grade			
1999	25.7	23.5	23.1
2003	19.6	19.8	21.2
2005	21.4	17.8	19.9
2007	16.2	15.8	18.3

Source: Local and State – Indiana Prevention Resource Center at Indiana University & Youth First, Inc.; National – Monitoring the Future Study, University of Michigan

Table 56 presents 2004/2005 estimates for the number of people who were recent drug users within the past month for Gibson, Posey, Vanderburgh, and Warrick Counties.

Table 56. Number of People who are Recent Drug Users (within past month) (2004/2005 Average)			
Gibson	**Posey**	**Vanderburgh**	**Warrick**
1,435	1,177	7,726	2,427

Source: Primary – Substance Abuse and Mental Health Services Administration; Secondary – Community Health Status Indicators, U.S. Department of Health & Human Services

Table 57 shows Southwestern Indiana and state of Indiana data from the National Survey on Drug Use and Health regarding past-month drug use among persons 12 or older. Averages for 2004-2006 indicate that 7.25% of individuals in Southwestern Indiana used illicit drugs in the past month. More recent averages from the 2006 and 2007 surveys indicate that 8.42% of people 12 or older across the entire state were illicit drug users in the past month.

Table 57. Drug Use in Past Month among Persons 12 or Older

Substance Type	Southwestern Indiana		Indiana		
	2002-2004 (%)	2004-2006 (%)	2002-2004 (%)	2004-2006 (%)	2006-2007 (%)
Any Illicit Drugs[1]	8.07	7.25	7.77	7.72	8.42
Illicit Drugs Excluding Marijuana	3.92	4.06	3.55	3.94	4.05
Marijuana	5.60	5.22	5.93	5.51	6.02
Alcohol (12+)	49.36	50.45	48.11	49.72	50.05
Binge Drinking (12+)[2]	23.23	23.91	22.65	21.84	22.34
Alcohol (12-20)	28.52	27.53	28.05	27.54	26.37
Binge Drinking (12-20)[2]	20.19	20.39	19.18	19.05	18.46
Cigarettes	29.77	31.05	28.35	28.03	27.96
Any Tobacco Product[3]	34.74	35.97	33.08	33.12	33.49

[1] Any Illicit Drug includes marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used non-medically.
[2] Binge Drinking is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least one day in the past 30 days.
[3] Tobacco product includes cigarettes, smokeless tobacco (i.e., chewing tobacco, or snuff), cigars, or pipe tobacco.
Source: SAMSHA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, 2005, 2006, and 2007

Table 58 indicates the level of marijuana, cocaine, and pain reliever use in the past year among persons 12 or older in Southwestern Indiana and the state of Indiana.

Table 58. Drug Use in Past Year among Persons 12 or Older

Substance Type	Southwestern Indiana		Indiana		
	2002-2004 (%)	2004-2006 (%)	2002-2004 (%)	2004-2006 (%)	2006-2007 (%)
Marijuana	9.88	8.56	10.54	9.60	9.87
Cocaine	2.13	2.14	2.41	2.24	2.19
Pain Relievers[1]	6.06	5.34	5.84	5.73	6.22

[1] Refers to non-medical use
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, 2005, 2006, and 2007

Table 59 shows the percentage of individuals 12 or older in Southwestern Indiana and the state of Indiana who experience drug dependence or abuse in the past year. As noted, the rates for illicit drug or alcohol dependence or abuse in Southwestern Indiana has tended to be slightly higher than the rates for Indiana as a whole.

Table 59. Drug Dependence or Abuse in Past Year among Persons 12 or Older

Drug Dependence or Abuse Type	Southwestern Indiana		Indiana		
	2002-2004 (%)	2004-2006 (%)	2002-2004 (%)	2004-2006 (%)	2006-2007 (%)
Alcohol Dependence	3.52	3.30	3.40	3.47	3.40
Illicit Drug Dependence[1]	1.77	2.20	1.90	2.01	1.98
Alcohol Dependence or Abuse	8.10	8.02	8.01	7.81	7.27
Illicit Drug Dependence or Abuse[1]	2.87	3.04	2.86	2.87	2.95
Illicit Drug or Alcohol Dependence or Abuse	9.72	9.82	9.36	9.14	8.73

[1] Illicit Drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or any prescription-type psychotherapeutic used non-medically.
Source: SAMHSA, Office of Applied Studies, National Survey on Drug Use and Health, 2002, 2003, 2004, 2005, 2006, and 2007

Indicator 1.7 Treatment episode data regarding admissions to hospitals due to alcohol and drug use

Figures 8 through 11 indicate the number of individuals in Vanderburgh County who were treated for alcohol-related issues between 2001 and 2006. The graphs indicate instances where alcohol was the primary or secondary drug for which individuals received treatment. If it was the secondary drug, it indicates that persons also were treated for another substance. As noted, males were more likely to be treated for alcohol issues than females. The treatment numbers remained fairly consistent over the six-year period, especially when alcohol was the primary drug of abuse.

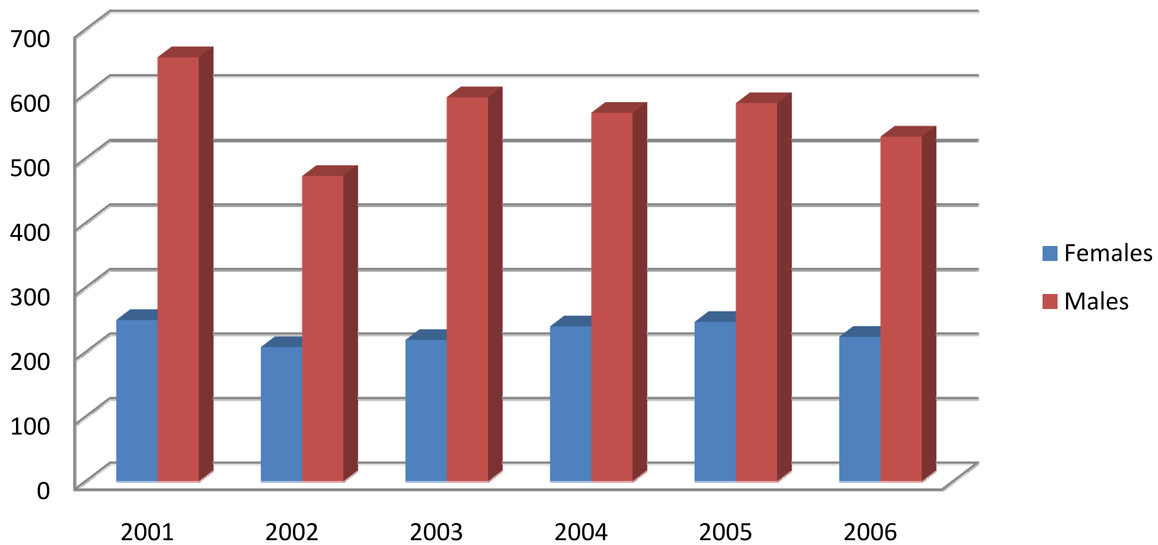
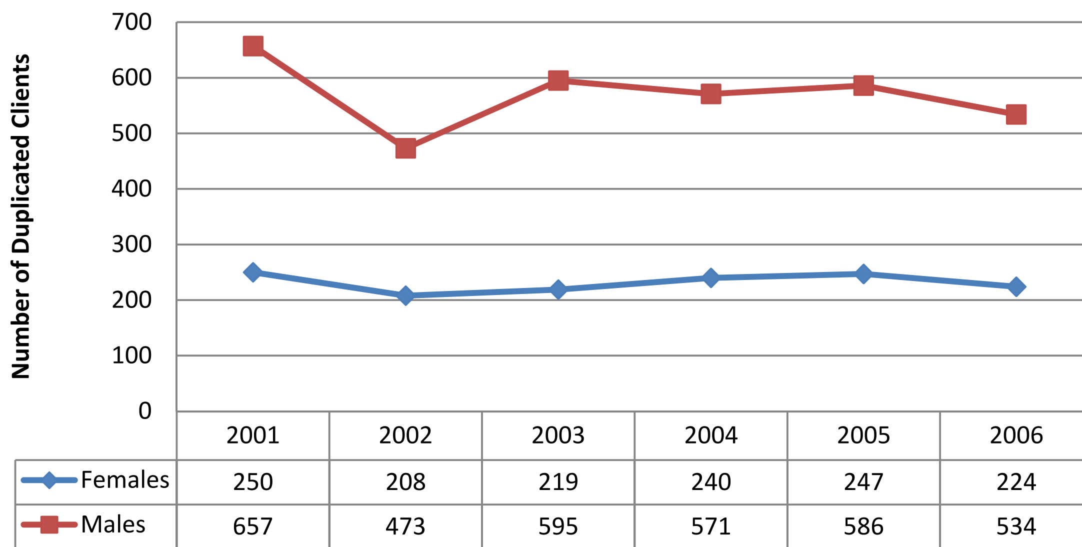


Figure 8. Treatment Episodes for Duplicated Clients Across Primary Drug of Abuse Vanderburgh County 2001- 2006: Alcohol

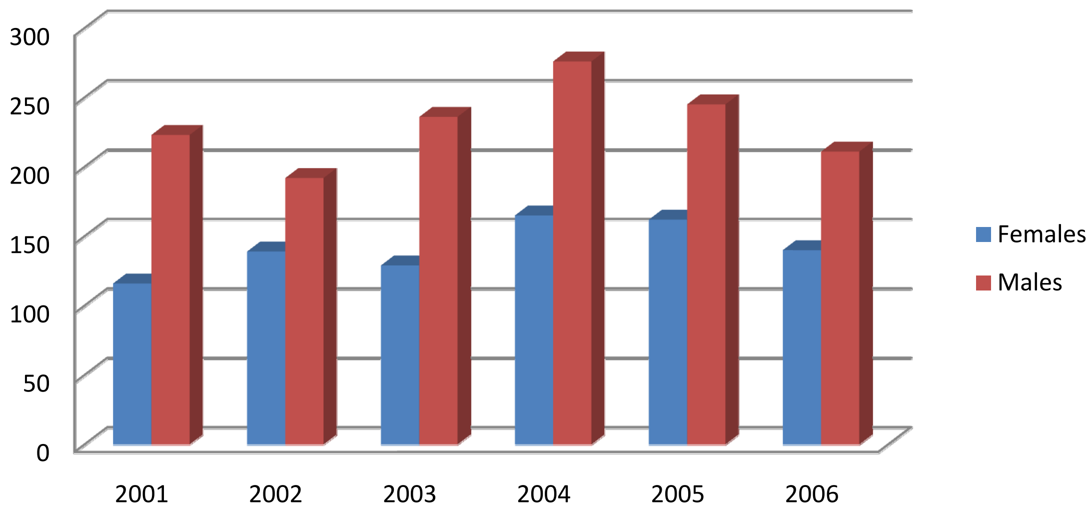
Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC



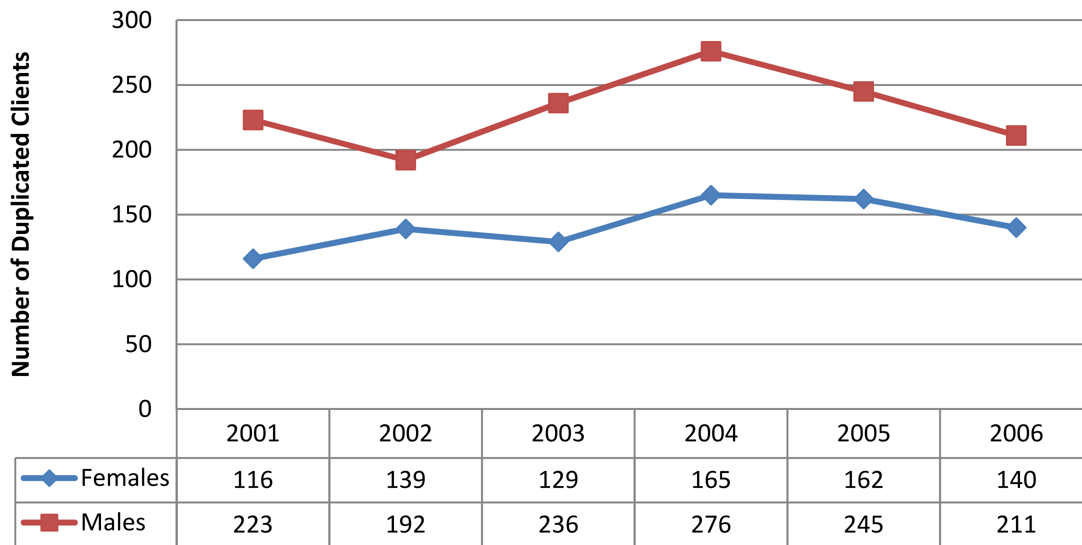
	2001	2002	2003	2004	2005	2006
Females	250	208	219	240	247	224
Males	657	473	595	571	586	534

Figure 9. Treatment Episodes for Duplicated Clients Across Primary Drug of Abuse Vanderburgh County 2001- 2006: Alcohol

Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC



Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC



	2001	2002	2003	2004	2005	2006
Females	116	139	129	165	162	140
Males	223	192	236	276	245	211

Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC

Table 60 and Figures 12 and 13 indicate the other drugs for which individuals in Vanderburgh County were primarily treated. Note that treatment for females is much more comparable to males for other drugs than it was for alcohol. For males, treatment for the different drugs were fairly consistent over the past few years, with some increases in more recent years. Treatment for methamphetamine showed the greatest increase. Overall, males are far more likely to be treated for alcohol as the primary drug than other drugs. For females, treatment for methamphetamine as the primary drug showed the greatest growth. Other drug treatment numbers remained fairly stable. Note that within the female population, they are more likely to be treated for other drugs in comparison to alcohol when compared to males. In other words, alcohol treatment as the primary drug is not as prominent for females as it is for males.

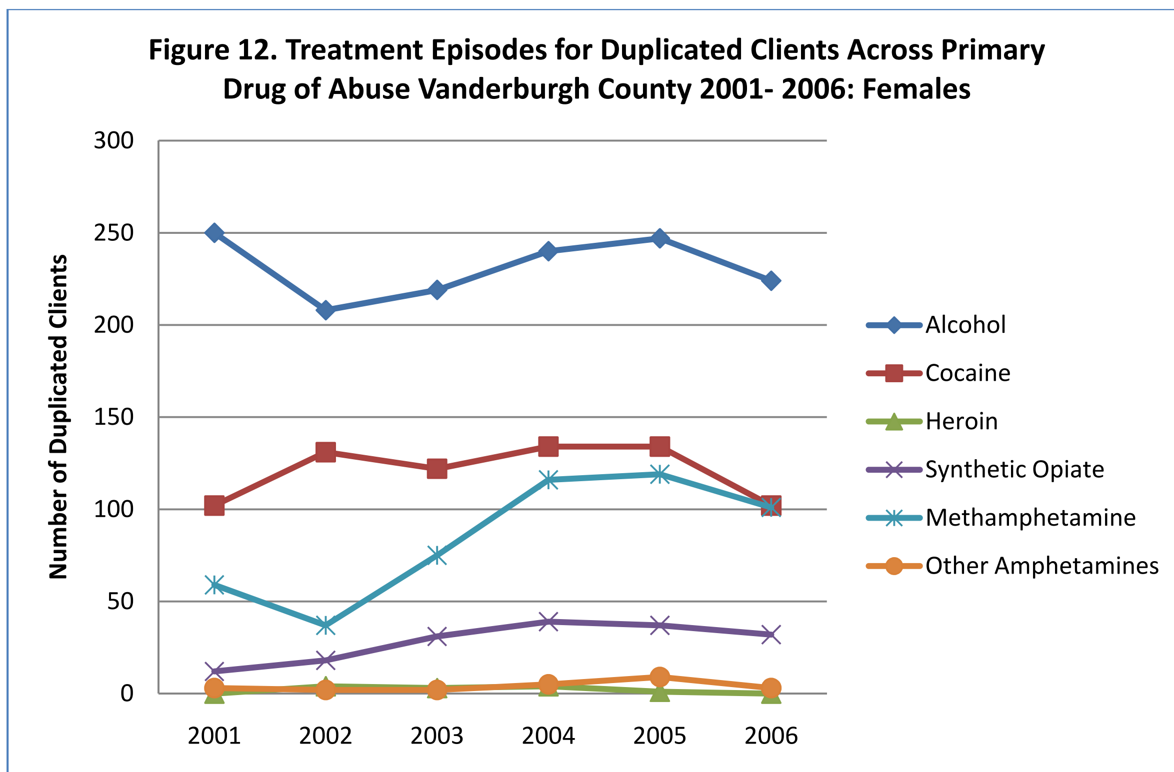
Table 60. Treatment Episodes for Duplicated Clients Across Primary Drug of Abuse Vanderburgh County 2001- 2006

Primary Drug	Females						Males					
	2001	2002	2003	2004	2005	2006	2001	2002	2003	2004	2005	2006
Alcohol	250	208	219	240	247	224	657	473	595	571	586	534
Cocaine	102	131	122	134	134	102	93	85	97	150	115	123
Heroin[1]	0	4	3	4	1	0	1	5	5	8	9	1
Synthetic Opiate[1]	12	18	31	39	37	32	12	15	16	23	31	34
Methamphetamine[2]	59	37	75	116	119	101	54	43	71	106	123	118
Other Amphetamines[2]	3	2	2	5	9	3	0	3	2	5	0	2

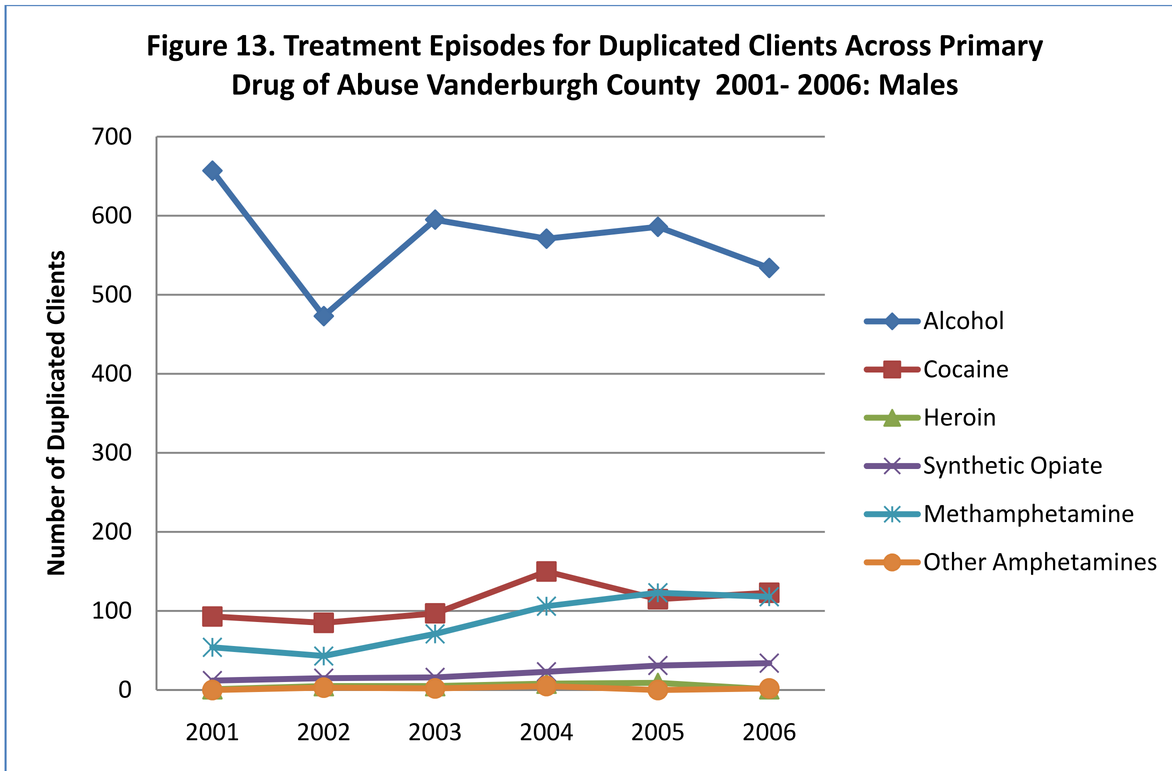
[1] For 2005-2006, opiates were divided into two categories: *Heroin* and *Synthetic Opiates*. For 2001-2004, all opiates were counted in one category.

[2] For 2001-2004, all amphetamines were grouped in one category.

Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC



Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC



Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC

Table 61 and Figures 14 and 15 show the secondary drugs for which males and females in Vanderburgh County received treatment. After alcohol, females were most likely to be treated for methamphetamine as a secondary drug, whereas males were most likely to be treated for cocaine.

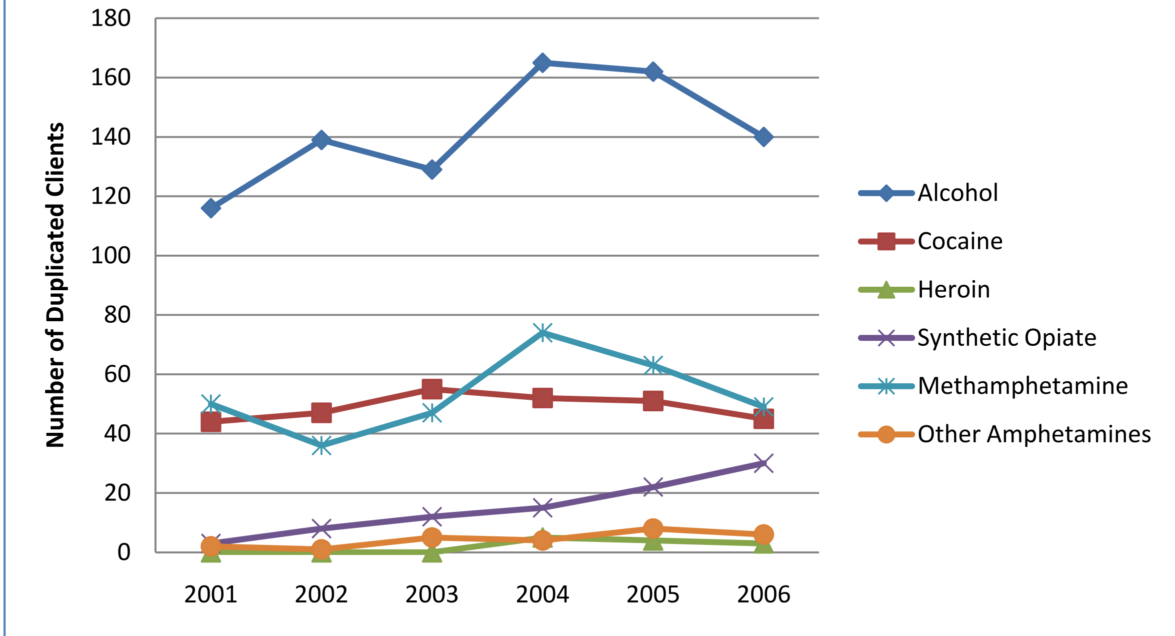
Table 61. Treatment Episodes for Duplicated Clients Across Secondary Drug of Abuse Vanderburgh County 2001-2006

Primary Drug	Females						Males					
	2001	2002	2003	2004	2005	2006	2001	2002	2003	2004	2005	2006
Alcohol	116	139	129	165	162	140	223	192	236	276	245	211
Cocaine	44	47	55	52	51	45	59	74	79	74	75	75
Heroin[1]	0	0	0	5	4	3	0	0	1	0	0	2
Synthetic Opiate[1]	3	8	12	15	22	30	8	17	13	37	25	17
Methamphetamine[2]	50	36	47	74	63	49	31	31	52	75	74	66
Other Amphetamines[2]	2	1	5	4	8	6	2	5	10	7	6	4

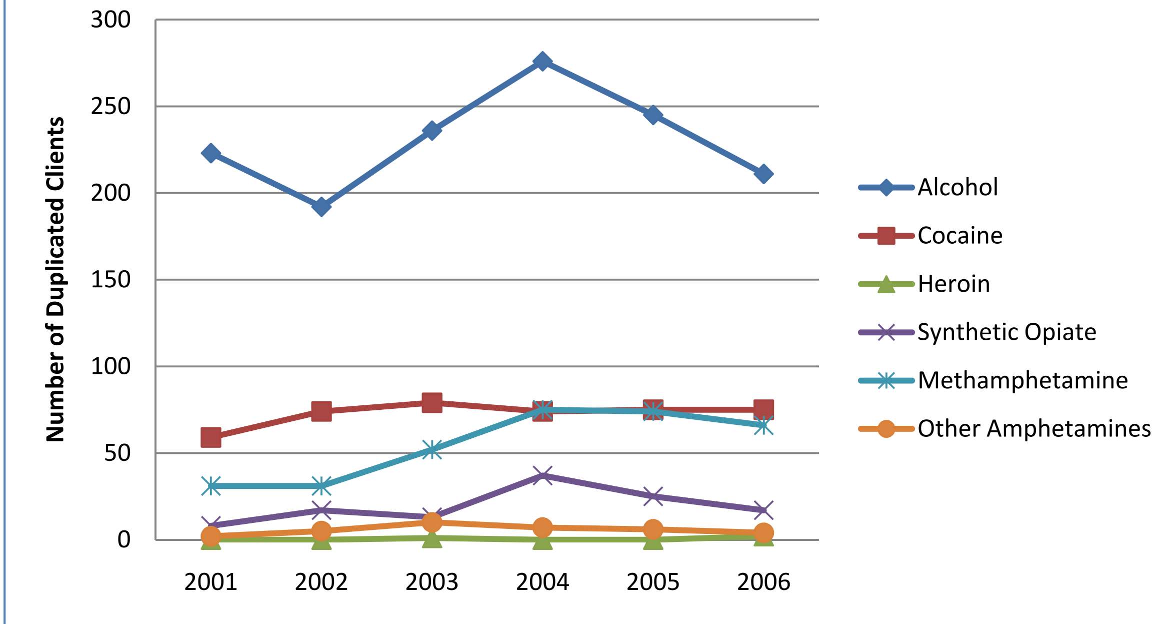
[1] For 2005-2006, opiates were divided into two categories: *Heroin* and *Synthetic Opiates*. For 2001-2004, all opiates were grouped in one category.

[2] For 2001-2004, all amphetamines were grouped in one category.

Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC



Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC



Source: Primary – SAMHSA, Treatment Episode Data Set 2001-2006; Secondary – IPRC

The following information presents highlights from the most recently published National Survey on Drug Use and Health. This survey is a leading assessment of addiction and mental health prevalence in the United States. Data presented below are national in scope. Per SAMHSA, all material appearing below is in the public domain and may be reproduced or copied without permission from the Substance Abuse and Mental Health Services Administration. However, this publication may *not* be reproduced or distributed for a fee without specific, written authorization of the Office of Communications, SAMHSA, U.S. Department of Health and Human Services. Citation of the source is appreciated. Suggested citation:

Substance Abuse and Mental Health Services Administration, Office of Applied Studies (2008). *Results from the 2007 National Survey on Drug Use and Health: National Findings* (NSDUH Series H-34, DHHS Publication No. SMA 08-4343). Rockville, MD.

This report presents the first information from the 2007 National Survey on Drug Use and Health (NSDUH), an annual survey sponsored by the Substance Abuse and Mental Health Services Administration (SAMHSA). The survey is the primary source of information on the use of illicit drugs, alcohol, and tobacco in the civilian, noninstitutionalized population of the United States aged 12 years old or older. The survey interviews approximately 67,500 persons each year. Unless otherwise noted, all comparisons in this report described using terms such as "increased," "decreased," or "more than" are statistically significant at the .05 level.

Indicator 1.8 Highlights from the 2007 National Survey on Drug Use and Health

Illicit Drug Use

- In 2007, an estimated 19.9 million Americans aged 12 or older were current (past month) illicit drug users, meaning they had used an illicit drug during the month prior to the survey interview. This estimate represents 8.0 percent of the population aged 12 years old or older. Illicit drugs include marijuana/hashish, cocaine (including crack), heroin, hallucinogens, inhalants, or prescription-type psychotherapeutics used nonmedically.

- The rate of current illicit drug use among persons aged 12 or older in 2007 (8.0 percent) was similar to the rate in 2006 (8.3 percent).

- Marijuana was the most commonly used illicit drug (14.4 million past month users). Among persons aged 12 or older, the rate of past month marijuana use in 2007 (5.8 percent) was similar to the rate in 2006 (6.0 percent).

- In 2007, there were 2.1 million current cocaine users aged 12 or older, comprising 0.8 percent of the population. These estimates were similar to the number and rate in 2006 (2.4 million or 1.0 percent).

- Hallucinogens were used in the past month by 1.0 million persons (0.4 percent) aged 12 or older in 2007, including 503,000 (0.2 percent) who had used Ecstasy. These estimates were similar to the corresponding estimates for 2006.

- There were 6.9 million (2.8 percent) persons aged 12 or older who used prescription-type psychotherapeutic drugs nonmedically in the past month. Of these, 5.2 million used pain relievers, the same as the number in 2006.

- In 2007, there were an estimated 529,000 current users of methamphetamine aged 12 or older (0.2 percent of the population). These estimates were not significantly different from the estimates for 2006 (731,000 or 0.3 percent).

- Among youths aged 12 to 17, the current illicit drug use rate remained stable from 2006 (9.8 percent) to 2007 (9.5 percent). Between 2002 and 2007, youth rates declined significantly for illicit drugs in general (from 11.6 to 9.5 percent) and for marijuana, cocaine, hallucinogens, LSD, Ecstasy, prescription-type drugs used nonmedically, pain relievers, stimulants, methamphetamine, and the use of illicit drugs other than marijuana.

- The rate of current marijuana use among youths aged 12 to 17 declined from 8.2 percent in 2002 to 6.7 percent in 2007. The rate decreased for both males (from 9.1 to 7.5 percent) and females (from 7.2 to 5.8 percent).

- Among young adults aged 18 to 25, there were decreases from 2006 to 2007 in the rate of current use of several drugs, including cocaine (from 2.2 to 1.7 percent), Ecstasy (from 1.0 to 0.7 percent), stimulants (from 1.4 to 1.1 percent), methamphetamine (from 0.6 to 0.4 percent), and illicit drugs other than marijuana (from 8.9 to 8.1 percent).

- From 2002 to 2007, there was an increase among young adults aged 18 to 25 in the rate of current use of prescription pain relievers, from 4.1 to 4.6 percent. There were decreases in the use of hallucinogens (from 1.9 to 1.5 percent), Ecstasy (from 1.1 to 0.7 percent), and methamphetamine (from 0.6 to 0.4 percent).

- Among those aged 50 to 54, the rate of past month illicit drug use increased from 3.4 percent in 2002 to 5.7 percent in 2007. Among those aged 55 to 59, current illicit drug use showed an increase from 1.9 percent in 2002 to 4.1 percent in 2007. These trends may partially reflect the aging into these age groups of the baby boom cohort, whose lifetime rates of illicit drug use are higher than those of older cohorts.

- Among persons aged 12 or older who used pain relievers nonmedically in the past 12 months, 56.5 percent reported that the source of the drug the most recent time they

used was from a friend or relative for free. Another 18.1 percent reported they got the drug from just one doctor. Only 4.1 percent got the pain relievers from a drug dealer or other stranger, and 0.5 percent reported buying the drug on the Internet. Among those who reported getting the pain reliever from a friend or relative for free, 81.0 percent reported in a follow-up question that the friend or relative had obtained the drugs from just one doctor.

- Among unemployed adults aged 18 or older in 2007, 18.3 percent were current illicit drug users, which was higher than the 8.4 percent of those employed full time and 10.1 percent of those employed part time. However, most illicit drug users were employed. Of the 17.4 million current illicit drug users aged 18 or older in 2007, 13.1 million (75.3 percent) were employed either full or part time.

- In 2007, there were 9.9 million persons aged 12 or older who reported driving under the influence of illicit drugs during the past year. This corresponds to 4.0 percent of the population aged 12 or older, similar to the rate in 2006 (4.2 percent), but lower than the rate in 2002 (4.7 percent). In 2007, the rate was highest among young adults aged 18 to 25 (12.5 percent).

Alcohol Use

- Slightly more than half of Americans aged 12 or older reported being current drinkers of alcohol in the 2007 survey (51.1 percent). This translates to an estimated 126.8 million people, which was similar to the 2006 estimate of 125.3 million people (50.9 percent).

- More than one fifth (23.3 percent) of persons aged 12 or older participated in binge drinking (having five or more drinks on the same occasion on at least 1 day in the 30 days prior to the survey) in 2007. This translates to about 57.8 million people, similar to the estimate in 2006.

- In 2007, heavy drinking was reported by 6.9 percent of the population aged 12 or older, or 17.0 million people. This rate was the same as the rate of heavy drinking in 2006. Heavy drinking is defined as binge drinking on at least 5 days in the past 30 days.

- In 2007, among young adults aged 18 to 25, the rate of binge drinking was 41.8 percent, and the rate of heavy drinking was 14.7 percent. These rates were similar to the rates in 2006.

- The rate of current alcohol use among youths aged 12 to 17 was 15.9 percent in 2007. Youth binge and heavy drinking rates were 9.7 and 2.3 percent, respectively. These rates were essentially the same as the 2006 rates.

- Past month and binge drinking rates among underage persons (aged 12 to 20) have remained essentially unchanged since 2002. In 2007, about 10.7 million persons aged 12 to 20 (27.9 percent of this age group) reported drinking alcohol in the past month.

Approximately 7.2 million (18.6 percent) were binge drinkers, and 2.3 million (6.0 percent) were heavy drinkers.

- Among persons aged 12 to 20, past month alcohol use rates in 2007 were 16.8 percent among Asians, 18.3 percent among blacks, 24.7 percent among Hispanics, 26.2 percent among those reporting two or more races, 28.3 percent among American Indians or Alaska Natives, and 32.0 percent among whites.

- In 2007, 56.3 percent of current drinkers aged 12 to 20 reported that their last use of alcohol in the past month occurred in someone else's home, and 29.4 percent reported that it had occurred in their own home. About one third (30.2 percent) paid for the alcohol the last time they drank, including 8.2 percent who purchased the alcohol themselves and 21.8 percent who gave money to someone else to purchase it. Among those who did not pay for the alcohol they last drank, 37.2 percent got it from an unrelated person aged 21 or older, 20.7 percent from another person under 21 years of age, and 19.5 percent got it from a parent, guardian, or other adult family member.

- In 2007, an estimated 12.7 percent of persons aged 12 or older drove under the influence of alcohol at least once in the past year. This percentage has decreased since 2002, when it was 14.2 percent. From 2006 to 2007, the rate of driving under the influence of alcohol among persons aged 18 to 25 decreased from 24.4 to 22.8 percent.

Tobacco Use

- In 2007, an estimated 70.9 million Americans aged 12 or older were current (past month) users of a tobacco product. This represents 28.6 percent of the population in that age range. In addition, 60.1 million persons (24.2 percent of the population) were current cigarette smokers; 13.3 million (5.4 percent) smoked cigars; 8.1 million (3.2 percent) used smokeless tobacco; and 2.0 million (0.8 percent) smoked tobacco in pipes.

- The rate of current use of any tobacco product among persons aged 12 or older decreased from 29.6 percent in 2006 to 28.6 percent in 2007, but the rates of current use of cigarettes, smokeless tobacco, cigars, and pipe tobacco did not change significantly over that period. Between 2002 and 2007, past month use of any tobacco product decreased from 30.4 to 28.6 percent, and past month cigarette use declined from 26.0 to 24.2 percent. Rates of past month use of cigars, smokeless tobacco, and pipe tobacco were similar in 2002 and 2007.

- The rate of past month cigarette use among 12 to 17 year olds declined from 13.0 percent in 2002 to 9.8 percent in 2007. However, past month smokeless tobacco use was higher in 2007 (2.4 percent) than in 2002 (2.0 percent).

- Among pregnant women aged 15 to 44, combined data for 2006 and 2007 indicated that the rate of past month cigarette use was 16.4 percent. The rate was higher among women in that age group who were not pregnant (28.4 percent).

Initiation of Substance Use (Incidence, or First-Time Use) within the Past 12 Months

- In 2007, an estimated 2.7 million persons aged 12 or older used an illicit drug for the first time within the past 12 months. A majority of these past year illicit drug initiates reported that their first drug was marijuana (56.2 percent). Nearly one third initiated with psychotherapeutics (30.6 percent, including 19.0 percent with pain relievers, 6.5 percent with tranquilizers, 4.1 percent with stimulants, and 1.1 percent with sedatives). A sizable proportion reported inhalants (10.7 percent) as their first illicit drug, and a small proportion used hallucinogens as their first drug (2.0 percent).

- The illicit drug categories with the largest number of past year initiates among persons aged 12 or older were nonmedical use of pain relievers (2.1 million) and marijuana use (2.1 million). These estimates were not significantly different from the numbers in 2006.

- In 2007, there were 775,000 persons aged 12 or older who had used inhalants for the first time within the past 12 months; 66.3 percent were under age 18 when they first used. There was no significant change in the number of inhalant initiates from 2006 to 2007.

- The number of past year initiates of methamphetamine among persons aged 12 or older was 157,000 in 2007. This estimate was significantly lower than the estimate in 2002 (299,000), 2003 (260,000), 2004 (318,000), and 2006 (259,000).

- Ecstasy initiation remained essentially unchanged from 2006 (860,000) to 2007 (781,000), but was lower in 2007 than in 2002 (1.2 million).

- Most (85.9 percent) of the 4.6 million past year alcohol initiates were younger than age 21 at the time of initiation.

- The number of persons aged 12 or older who smoked cigarettes for the first time within the past 12 months was 2.2 million in 2007, which was significantly lower than the estimate in 2006 (2.4 million) but significantly higher than the estimate for 2002 (1.9 million). Most new smokers in 2007 were under age 18 when they first smoked cigarettes (59.7 percent).

Youth Prevention-Related Measures

- Perceived risk is measured by NSDUH as the percentage reporting that there is great risk in the substance use behavior. Among youths aged 12 to 17, there were no changes in the perceived risk of marijuana, cocaine, or heroin use between 2006 and 2007. However, between 2002 and 2007, there were increases in the perceived risk of

smoking marijuana once a month (from 32.4 to 34.5 percent) and smoking marijuana once or twice a week (from 51.5 to 54.7 percent). On the other hand, the percentage of youths who perceived that trying heroin once or twice is a great risk declined from 58.5 percent in 2002 to 57.0 percent in 2007, and those who perceived that using LSD once or twice a week is a great risk declined from 76.2 to 74.2 percent.

- Almost half (49.1 percent) of youths aged 12 to 17 reported in 2007 that it would be "fairly easy" or "very easy" for them to obtain marijuana if they wanted some. Around one quarter reported it would be easy to get cocaine (24.5 percent). About one in seven (14.1 percent) indicated that heroin would be "fairly" or "very" easily available, and 14.4 percent reported easy availability for LSD.

- The percentage of youths aged 12 to 17 reporting that it would be easy to obtain cocaine declined from 25.9 percent in 2006 to 24.5 percent in 2007. In addition, the perceived availability decreased between 2002 and 2007 for marijuana (from 55.0 to 49.1 percent), heroin (from 15.8 to 14.1 percent), and LSD (from 19.4 to 14.4 percent).

- A majority of youths aged 12 to 17 (91.0 percent) in 2007 reported that their parents would strongly disapprove of their trying marijuana or hashish once or twice. Current marijuana use was much less prevalent among youths who perceived strong parental disapproval for trying marijuana or hashish once or twice than for those who did not (4.6 vs. 28.1 percent).

- In 2007, 11.3 percent of youths aged 12 to 17 reported that they had participated in substance use prevention programs outside of school within the past year. Almost four fifths (77.9 percent) reported having seen or heard drug or alcohol prevention messages from sources outside of school, lower than in 2002 when the percentage was 83.2 percent. Most (59.6 percent) youths reported in 2007 that they had talked with a parent in the past year about the dangers of drug, tobacco, or alcohol use.

Substance Dependence, Abuse, and Treatment

- In 2007, an estimated 22.3 million persons (9.0 percent of the population aged 12 or older) were classified with substance dependence or abuse in the past year based on criteria specified in the *Diagnostic and Statistical Manual of Mental Disorders*, 4th edition (DSM-IV). Of these, 3.2 million were classified with dependence on or abuse of both alcohol and illicit drugs, 3.7 million were dependent on or abused illicit drugs but not alcohol, and 15.5 million were dependent on or abused alcohol but not illicit drugs.

- Between 2002 and 2007, there was no change in the number of persons with substance dependence or abuse (22.0 million in 2002, 22.3 million in 2007).

- The specific illicit drugs that had the highest levels of past year dependence or abuse in 2007 were marijuana (3.9 million), followed by pain relievers (1.7 million) and cocaine (1.6 million).

- Adults aged 21 or older who had first used alcohol before age 21 were more likely than adults who had their first drink at age 21 or older to be classified with alcohol dependence or abuse (9.6 vs. 2.2 percent).

- The rate of substance dependence or abuse for males aged 12 or older in 2007 was about twice as high as the rate for females (12.5 vs. 5.7 percent). Among youths aged 12 to 17, however, the rate of substance dependence or abuse among males was the same as the rate among females (7.7 percent for both).

- Treatment need is defined as having a substance use disorder or receiving treatment at a specialty facility (hospital inpatient, drug or alcohol rehabilitation, or mental health centers) within the past 12 months. In 2007, 23.2 million persons aged 12 or older needed treatment for an illicit drug or alcohol use problem (9.4 percent of persons aged 12 or older). Of these, 2.4 million (1.0 percent of persons aged 12 or older and 10.4 percent of those who needed treatment) received treatment at a specialty facility. Thus, 20.8 million persons (8.4 percent of the population aged 12 or older) needed treatment for an illicit drug or alcohol use problem but did not receive treatment at a specialty substance abuse facility in the past year.

- Of the 20.8 million people in 2007 who were classified as needing substance use treatment but did not receive treatment at a specialty facility in the past year, 1.3 million persons (6.4 percent) reported that they felt they needed treatment for their illicit drug or alcohol use problem. Of these 1.3 million persons who felt they needed treatment, 380,000 (28.5 percent) reported that they made an effort to get treatment, and 955,000 (71.5 percent) reported making no effort to get treatment.

Mental Health

- Serious psychological distress (SPD) is an overall indicator of past year nonspecific psychological distress that is constructed from the K6 scale administered to adults aged 18 or older in NSDUH. In 2007, there were an estimated 24.3 million adults aged 18 or older in the United States with SPD in the past year. This represents 10.9 percent of all adults in this country, a rate similar to the SPD rate in 2006 (11.3 percent) but below the rate in 2004 (12.2 percent).

- Rates of SPD in 2007 were highest for adults aged 18 to 25 (17.9 percent) and lowest for adults aged 50 or older (7.0 percent).

- The prevalence of SPD among women aged 18 or older (13.4 percent) was higher than that among men in that age group (8.2 percent).

- SPD in the past year was associated with past year substance dependence or abuse in 2007. Among adults aged 18 or older with SPD in 2007, 22.1 percent (5.4 million) were dependent on or abused illicit drugs or alcohol. The rate among adults without SPD was 7.6 percent (15.0 million).

- Among the 24.3 million adults with SPD in 2007, 10.8 million (44.6 percent) used mental health services in the past year. Among all adults with SPD, 38.8 percent received a prescription medication, 27.3 percent received outpatient services, and 5.1 percent received inpatient services for a mental health problem in the past year.

- Among the 5.4 million adults with both SPD and substance dependence or abuse (i.e., a substance use disorder) in 2007, nearly half (46.5 percent) received mental health care or substance use treatment at a specialty facility; 10.4 percent received both mental health care and specialty substance use treatment, 33.3 percent received only mental health care, and 2.8 percent received only specialty substance use treatment.

- In 2007, 7.5 percent of persons aged 18 or older (16.5 million persons) had at least one major depressive episode (MDE) in the past year. Almost 1 in 20 adults (4.6 percent or 10.1 million persons) had a past year MDE with severe impairment.

- Having MDE in the past year was associated with past year substance dependence or abuse. In 2007, adults aged 18 or older with past year MDE had higher rates of past year illicit drug use than those without MDE (27.4 vs. 12.8 percent). Adults with past year MDE were more likely than those without MDE to be dependent on or abuse illicit drugs (8.8 vs. 2.1 percent) and alcohol (17.0 vs. 7.0 percent).

- Among adults aged 18 or older who had MDE in the past year, 64.5 percent received treatment (i.e., saw or talked to a medical doctor or other professional or used prescription medication) for depression in the same time period, which was lower than in 2006 (69.1 percent).

- Among adults aged 18 or older with MDE in the past year in 2007, women were more likely than men to receive treatment for depression in the past year (68.0 vs. 57.8 percent), though the treatment rate for women was significantly lower than in 2006 (73.7 percent).

- In 2007, there were 2.0 million youths (8.2 percent of the population aged 12 to 17) who had MDE during the past year. An estimated 1.4 million (5.5 percent) had MDE with severe impairment in one or more role domains (chores at home; school or work; close relationships with family; or social life).

- The rate of MDE in the past year was higher for adolescent females (11.9 percent) than for adolescent males (4.6 percent). The prevalence of MDE with severe impairment was 8.2 percent for females and 3.0 percent for males.

- Among 12 to 17 year olds who had past year MDE in 2007, 35.5 percent had used illicit drugs during the same period. This was higher than the rate of 17.2 percent among youths who did not have past year MDE. Similarly, the rates of past month daily cigarette use and heavy alcohol use were higher for youths with MDE (4.8 and

3.8 percent, respectively) than for youths who did not have MDE (2.3 and 2.2 percent, respectively).

- In 2007, 38.9 percent of youths aged 12 to 17 with past year MDE received treatment for depression (saw or talked to a medical doctor or other professional or used prescription medication). Among youths with past year MDE, 20.5 percent saw or talked to a medical doctor or other professional only, 2.5 percent used prescription medication only, and 15.6 percent received treatment from both sources for depression in the past year.

- In 2007, 3.1 million youths aged 12 to 17 (12.5 percent) received treatment or counseling for problems with behavior or emotions in the specialty mental health setting (inpatient or outpatient care). Additionally, 11.5 percent of youths received services in the education setting, and 2.8 percent received mental health services in the general medical setting in the past 12 months. Mental health services were received in both the specialty setting and either the education or general medical settings (i.e., care from multiple settings) by 5.1 percent of youths.

Goal Two: To conduct an inventory of existing mental healthcare and addiction providers and programs

The purpose of this goal is to document the levels of service offered by mental health and addiction treatment organizations in the community and to determine the mental health and addiction issues for which organizations provide service. The following are specific indicators associated with this goal.

Indicator 2.1 The service level (e.g., inpatient, outpatient, residential) offered by each organization and the number of clients who access those services on an annual basis

Indicator 2.2 The specific mental health and addiction issues for which a direct service provider delivers treatment and the number of clients seen annually for each issue; for ancillary service providers, the associated indicator is the type of issue(s) for which organizations make referrals and the highest areas of referrals

Indicator 2.3 Ancillary services (e.g., housing, food, clothing, job skills training) that direct service providers offer to clients and the age groups to whom services are provided

Summary of Findings

Inventory of Service Levels

- Respondents were asked to identify the type of service levels that their organization provides (e.g., inpatient, partial hospitalization/day treatment, intensive outpatient, outpatient, residential (short-term, < 30 days), residential (long-term >= 30 days), or in-home care), as well as the number of individual services within the last reporting period.
    - Outpatient services are, by far, the ones that are most provided by responding direct service providers, with approximately 78% of the organizations providing this form of care. Overall, direct service providers indicated that 15,792 clients were served in the last reporting year. This figure represents approximately 72% of the clients served.
    - The smallest areas of coverage by organizations included partial hospitalization/day treatment, with 13.0% of the organizations providing this level of service and 490 clients receiving services, and in-home care, with none of the organizations providing this level of service. Although six of the organizations indicated they have long-term residential services, the smallest number of individuals, 282, received services through this level of care. Additionally, seven (30.4%) of the organizations indicated providing inpatient (hospitalization) services. However, there are only four organizations in the four-county area that have inpatient beds. One explanation for the 'yes' responses by

three of the organizations is that they may treat patients who are or have been hospitalized, which may have led those organizations to specify inpatient (hospitalization) services as a level of care they provide.

Inventory of Issues for which Treatment is Delivered

- The types of issues most treated by participating direct service providers are substance-related disorders, with approximately 81% of organizations providing service in this area. Other issues for which a large number of organizations provide service include major depressive disorder (77.3% of organizations), post traumatic stress disorder (68.2% of organizations), anxiety disorders (65.2% of organizations), and bipolar disorder (manic depression) (63.6% of organizations).

- The issues for which the smallest percentage of responding organizations provide service include disorders related to the elderly (18.2% of organizations), delirium (22.7% of organizations), sexual orientation and gender identity issues (27.3% of organizations), and developmental disorders (autism, mental retardation, etc.) (27.3% of organizations).

- Based on data provided by direct service providers, the largest number of individuals treated by those organizations were seen for major depressive disorder, with over 5,000 individuals receiving services, followed by substance-related disorders (4,230 receiving services), and schizophrenia or other psychotic disorders (2,536 receiving services). While post traumatic stress disorder is one of the issues for which services are provided by a majority of organizations, far fewer individuals were treated for this issue in the last annual reporting period. Other areas for which a fairly large number of individuals received services included anxiety disorders and childhood disorders (ADHD, etc.).

Inventory of Ancillary Services (e.g., housing, food, clothing, job skills training)

- While completing treatment for mental health or addiction issues, many individuals have need for ancillary services such as housing, child care, transportation, and job skills training. The types of services provided by a large percentage of organizations include group therapy and/or counseling, medication management, court-ordered work, family therapy and/or counseling, information and referral services, and case management. The services provided least by participating organizations include in-home family services, neuropsychological services, payeeships, and therapeutic foster care, with none of the organizations providing services in these areas.

Indicator 2.1 The service level (e.g., inpatient, outpatient, residential) offered by each organization and the number of clients who access those services on an annual basis

The level of service provided by the largest percentage of participating direct service providers is outpatient therapy, with approximately 78% of the organizations providing this form of care. Outpatient services are, by far, the ones that are most provided by responding direct service providers. Overall, direct service providers indicated that 15,792 clients were served in the last reporting year. This figure represents approximately 72% of the clients served.

The smallest areas of coverage by organizations included partial hospitalization/day treatment, with 13.0% of the organizations providing this level of service and 490 clients receiving services, and in-home care, with none of the organizations providing this level of service. Although six of the organizations indicated they have long-term residential services, the smallest number of individuals, 282, received services through this level of care. Additionally, seven (30.4%) of the organizations indicated providing inpatient (hospitalization) services. However, there are only four organizations in the four-county area that have inpatient beds. One explanation for the 'yes' responses by three of the organizations is that they may treat patients who are or have been hospitalized, which may have led those organizations to specify inpatient (hospitalization) services as a level of care they provide.

Table 62. Levels of Service Provided by Direct Service Providers – All Respondents

Service Level	Does the organization offer the specified level of service?			Number of clients served annually			
	Yes	No	N	Min	Max	Median	Total
Inpatient (hospitalization)*	30.4% n=7	69.6% n=16	23	3	2,164	206	3,255
Partial hospitalization/day treatment	13.0% n=3	87.0% n=20	23	2	265	223	490
IOP (Intensive Outpatient Program)	21.7% n=5	78.3% n=18	23	2	264	190	671
Outpatient	78.3% n=18	21.7% n=5	23	14	7,007	310.5	15,792
Residential (short-term <30 days)	21.7% n=5	78.3% n=17	23	2	1,444	43	1,530
Residential (long-term >=30 days)	26.1% n=6	73.9% n=17	23	3	170	30	282
In-home care	0.0% n=0	100% n=23	23	na	na	na	na

*Note: Totals are based on participant responses regarding the level of service provided by each organization. In the four-county region of Vanderburgh, Posey, Gibson, and Warrick counties, only 4 organizations provide inpatient (hospitalization) services.

The following table indicates the level of service provided by the subgroups of direct service providers based on the number of clients they serve each year.

Table 63. Levels of Service Provided by Direct Service Providers – By Organization Grouping							
Small Providers (serve less than 250 clients annually)							
Service Level	**Does the organization offer the specified level of service?**			**Number of clients served annually**			
	Yes	**No**	**N**	**Min**	**Max**	**Median**	**Total**
Inpatient (hospitalization)*	40.0% n=4	60.0% n=6	10	3	206	25	259
Partial hospitalization/day treatment	10.0% n=1	90.0% n=9	10	2	2	2	2
IOP (Intensive Outpatient Program)	10.0% n=1	90.0% n=9	10	2	2	2	2
Outpatient	60.0% n=6	40.0% n=4	10	14	211	123.5	675
Residential (short-term <30 days)	30.0% n=3	70.0% n=7	10	84	84	84	84
Residential (long-term >=30 days)	40.0% n=4	60.0% n=6	10	30	79	54.5	109
In-home care	0.0% n=0	100% n=10	10	na	na	na	na
Medium Providers (serve 250 – 999 clients annually)							
Service Level	**Does the organization offer the specified level of service?**			**Number of clients served annually**			
	Yes	**No**	**N**	**Min**	**Max**	**Median**	**Total**
Inpatient (hospitalization)*	14.3% n=1	85.7% n=6	7	404	404	404	404
Partial hospitalization/day treatment	0.0% n=0	100% n=7	7	na	na	na	na
IOP (Intensive Outpatient Program)	14.3% n=1	85.7% n=6	7	190	190	190	190
Outpatient	85.7% n=6	14.3% n=1	7	150	474	321	1,695
Residential (short-term <30 days)	14.3% n=1	85.7% n=6	7	2	2	2	2
Residential (long-term >=30 days)	14.3% n=1	85.7% n=6	7	3	3	3	3
In-home care	0.0% n=0	100% n=7	7	na	na	na	na
Large Providers (serve 1,000 + clients annually)							
Service Level	**Does the organization offer the specified level of service?**			**Number of clients served annually**			
	Yes	**No**	**N**	**Min**	**Max**	**Median**	**Total**
Inpatient (hospitalization)*	33.3% n=2	66.7% n=4	6	428	2,164	1,296	2,592
Partial hospitalization/day treatment	33.3% n=2	66.7% n=4	6	223	265	244	488

IOP (Intensive Outpatient Program)	50.0% n=3	50.0% n=3	6	10	264	205	479
Outpatient	100% n=6	0.0% n=0	6	1,027	7,007	1,664	13,572
Residential (short-term <30 days)	16.7% n=1	83.3% n=5	6	1,444	1,444	1,444	1,444
Residential (long-term >=30 days)	16.7% n=1	83.3% n=5	6	170	170	170	170
In-home care	0.0% n=0	100% n=6	6	na	na	na	na

Secondary Data Related to Mental Health Service Levels

Tables 64 – 66 present the demographic characteristics of persons served in mental health facilities in Indiana and the United States.

Table 64. Demographic Characteristics of Persons Served by the State Mental Health Authority, FY 2006

Group	Total Served				Penetration Rates (rate per 1,000 population)		
	Indiana		U.S.				
	N	%	N	%	Indiana	Midwest	U.S.
Age							
0 to 12	18,324	21.1%	874,945	14.6%	16.1	16.1	16.8
13 to 17	11,474	13.2%	789,884	13.2%	24.8	32.1	37.1
18 to 20	3,019	3.5%	262,626	4.4%	11.5	19.4	20.9
21 to 64	50,216	58.0%	3,765,452	63.0%	13.8	20.2	21.7
65 to 74	2,061	2.4%	160,775	2.7%	5.3	6.9	8.6
75 and over	1,553	1.8%	109,681	1.8%	4.0	4.7	6.0
Not available	-	-	18,016	0.3%			
Gender							
Female	46,517	53.7%	3,072,778	51.4%	14.6	18.8	20.1
Male	40,130	46.3%	2,883,993	48.25	13.0	18.1	19.5
Not available	-	-	22608	0.4%	-		
Race/Ethnicity							
American Indian/Alaskan Native	723	0.8%	73,616	1.2%	42.7	34.2	25.7
Asian	187	0.2%	80,502	1.3%	2.5	4.5	6.3
Black/African American	12,266	14.2%	1,224,298	20.5%	22.1	30.8	32.3
Native Hawaiian/ Pacific Islander	98	0.15	9,962	0.2%	34.1	41.4	20.9

White	69,299	80.0%	3,777,738	63.2%	12.5	16.2	15.9
Hispanic	*	*	240,513	4.0%	*	5.7	14.5
Multi-Racial	2,144	2.5%	81,752	1.4%	31.4	12.0	19.8
Not Available	1,930	2.2%	490,998	8.2%			
Hispanic Origin							
Hispanic or Latino	3,345	3.9%	703,487	14.2%	11.7	10.8	24.4
Not Hispanic or Latino	83,302	96.1%	3,631,433	73.4%	13.9	18.2	17.8
Hispanic Status Unknown	-	-	612,102	12.4%			

Notes: This table uses data from URS/DIG Table 2a, Table 2B and from the US Census Bureau.
All denominators use US Census data from 2005.
US totals are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.
*Reported under Hispanic Origin
Source: The Center for Mental Health Services Uniform Reporting System

Table 65. Persons Served in Community Mental Health Programs by Age and Gender, FY 2006						
Group	Served in Community				Penetration Rates (rate per 1,000 population)	
	Indiana		U.S.			
	N	%	N	%	Indiana	U.S.
Age						
0 to 17	29,723	35%	1,447,375	27%	18.5	21.0
18 to 20	2,990	3%	230,601	4%	11.4	19.7
21 to 64	49,444	58%	3,326,262	63%	13.6	20.3
65 and over	3,560	4%	244,953	5%	4.6	7.1
Not available	--	--	15,483	0%	--	--
Gender						
Female	46,225	54%	2,718,767	52%	14.5	18.9
Male	39,492	46%	2,523,800	48%	12.8	18.1
Not available	--	--	22,107	0%	--	--

Notes: U.S. totals are based on states reporting; this table uses data from URS/DIG Table 3; U.S. totals are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.
Source: The Center for Mental Health Services Uniform Reporting System

Table 66. Persons Served in State Psychiatric Hospitals by Age and Gender, FY 2006						
Group	Served in Community				Penetration Rates (rate per 1,000 population)	
	Indiana		U.S.			
	N	%	N	%	Indiana	U.S.
Age						
0 to 17	141	10%	16,199	9%	0.09	0.25
18 to 20	48	3%	9,543	6%	0.18	0.80
21 to 64	1,211	82%	138,286	81%	0.33	0.83
65 and over	68	5%	6,847	4%	0.09	0.19
Not available	--	--	250	0%	--	--
Gender						
Female	508	35%	64,235	38%	0.16	0.44
Male	960	65%	105,116	61%	0.31	0.77
Not available	--	--	1,774	1%	--	--

Notes: U.S. totals are based on states reporting; this table uses data from URS/DIG Table 3 (hospital data includes civil and forensic clients); U.S. totals are calculated uniquely for each data element based on only those states who reported numerator (clients served) data.
Source: The Center for Mental Health Services Uniform Reporting System

The following tables present data from the most recently published National Survey of Substance Abuse Treatment Services. The information presented in the tables pertains specifically to organizations in Indiana. The data may be used as a reference regarding the substance abuse services that exist across the state of Indiana. Note that several of the categories are mirrored in the present Southwestern Indiana needs assessment study.

Table 67. N-SSATS Indiana Profile - Type of Care, 2007							
Type	Facilities		Clients in Treatment on March 30, 2007				
			All Clients			Clients Under Age 18	
	No.	%	No.	%	Median No. of Clients per Facility	No.	%
Outpatient	**301**	**93.8**	**26,023**	**95.7**	**43**	**1,432**	**94.7**
Regular outpatient	282	87.9	16,411	60.3	25		
Intensive outpatient	203	63.2	5,130	18.9	15		
Day treatment/partial hospitalization	63	19.6	449	1.7	0		
Detoxification	29	9.0	178	0.7	0		
Methadone	19	5.9	3,855	14.2	30		
Residential	**38**	**11.8**	**752**	**2.8**	**13**	**27**	**1.8**
Short term	23	7.2	190	0.7	0		
Long term	33	10.3	516	1.9	11		

Detoxification	7	2.2	46	0.2	4		
Hospital Inpatient	**34**	**10.6**	**428**	**1.6**	**2**	**53**	**3.5**
Rehabilitation	18	5.6	323	1.2	6		
Detoxification	32	10.0	105	0.4	1		
Total	**321**		**27,203**	**100**	**42**	**1,512**	**100**

Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

Table 68. N-SSATS Indiana Profile - Opioid Treatment Programs (OTPs), 2007		
Type	No.	%
Facilities with OTPs		
Maintenance only	3	25.0
Detoxification only	0	0.0
Both maintenance and detoxification	9	75.0
Total	12	100
Clients in Facilities with OTPs		
Methadone	5766	--
Buprenorphine	31	--
Total	5797	--

Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

Table 69. N-SSATS Indiana Profile - Facility Ownership/Operation, 2007						
Type	Facilities		Clients in Treatment on March 30, 2007			
			All Clients		Clients Under Age 18	
	No.	%	No.	%	No.	%
Private Non-profit	201	62.6	15,743	57.9	1,019	67.4
Private For profit	97	30.2	9,621	35.4	387	25.6
Local government	15	4.7	1,545	5.7	101	6.7
State government	4	1.2	199	0.7	5	0.3
Federal government	4	1.2	95	0.3	0	0.0
Dept. of Veterans Affairs	4	1.2	95	0.3	0	0.0
Dept. of Defense	0	0.0	0	0.0	0	0.0
Indian Health Service	0	0.0	0	0.0	0	0.0
Other	0	0.0	0	0.0	0	0.0
Tribal government	0	0.0	0	0.0	0	0.0
Total	321	100	27,203	100	1,512	100

Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

Table 70. N-SSATS Indiana Profile - Primary Focus of Facility, 2007						
Focus	Facilities		Clients in Treatment on March 30, 2007			
			All Clients		Clients Under Age 18	
	No.	%	No.	%	No.	%
Substance abuse treatment services	119	37.1	13,313	48.9	469	31.0
Mental health services	34	10.6	2,876	10.6	168	11.1
Mix of mental health and substance abuse treatment services	160	49.8	10,292	37.8	848	56.1
General health care	1	0.3	16	0.1	0	0.0
Other/unknown	7	2.2	706	2.6	27	1.8
Total	321	100	27,203	100	1,512	100

Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

Tables 71 – 73 provide data related to admissions to mental health organizations, the number of mental health organizations, and the number of beds devoted to mental health treatment in the United States.

Table 71. Admissions to mental health organizations, by type of service and organization, United States, 1990, 2002, 2004						
Service & Organization	Admissions in thousands			Admissions per 100,000 civilian population		
	1990	2002	2004	1990	2002	2004
24-hour hospital and residential treatment						
All organizations	2,110	2,158	2,713	833.0	738.9	910.5
State and county mental hospitals	283	234	266	111.6	80.1	89.1
Private psychiatric hospitals	411	477	599	162.4	163.3	200.9
Nonfederal general hospital psych services	962	1087	1533	379.9	372.2	514.6
Dept. of Vet Affairs medical centers	203	158	---	80.3	54.1	---

Residential treatment centers for emotionally disturbed children	50	63	61	19.8	21.6	20.3
All other organizations	200	139	255	79.0	47.6	85.5
Less than 24-hour care						
All organizations	3,377	4,099	4,667	1,333.3	1,403.2	1,566.6
State and county mental hospitals	50	62	130	19.7	21.2	43.6
Private psychiatric hospitals	163	598	447	64.5	204.7	150.1
Nonfederal general hospital psych services	661	681	900	260.8	233.0	302.2
Dept. of Vet Affairs medical centers	235	99	---	92.8	33.9	---
Residential treatment centers for emotionally disturbed children	100	222	194	39.3	75.8	65.2
All other organizations	2,168	2,438	2,995	856.2	834.3	1,005.4

Source: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

Table 72. Mental health organizations and beds for 24-hour hospital and residential treatment, by type of organization, United States, 1990, 2000, 2002, 2004

Type of organization	1990	2000	2002	2004
Number of mental health organizations				
All organizations	3,942	3,211	3,044	2,891
State and county mental hospitals	278	229	227	237
Private psychiatric hospitals	464	271	255	264
Nonfederal general hospital psych services	1,577	1,325	1,231	1,230

Dept. of Vet Affairs medical centers	131	134	132	---
Residential treatment centers for emotionally disturbed children	501	476	510	458
All other organizations	991	776	689	702
Number of beds				
All organizations	325,529	214,186	211,040	212,231
State and county mental hospitals	102,307	61,833	57,314	57,034
Private psychiatric hospitals	45,952	26,402	24,996	28,422
Nonfederal general hospital psych services	53,576	40,410	40,520	41,403
Dept. of Vet Affairs medical centers	24,779	8,989	9,581	---
Residential treatment centers for emotionally disturbed children	35,170	33,508	39,407	33,835
All other organizations	63,745	43,044	39,222	51,536
Beds per 100,000 civilian population				
All organizations	128.5	74.8	72.2	71.2
State and county mental hospitals	40.4	21.6	19.6	19.1
Private psychiatric hospitals	18.1	9.2	8.6	9.5
Nonfederal general hospital psych services	21.2	14.1	13.9	13.9
Dept. of Vet Affairs medical centers	9.9	3.1	3.3	---

Residential treatment centers for emotionally disturbed children	13.9	11.7	13.5	11.4
All other organizations	25.2	15.0	13.4	17.3

Source: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services

The following table indicates the facility capacity and utilization rate for substance abuse treatment facilities in Indiana.

Table 73. N-SSATS Indiana Profile - Facility Capacity and Utilization Rate (%), 2007		
Type	Residential	Hospital Inpatient
Number of facilities[1]	26	8
Number of clients	614	247
Designated beds	663	277
Utilization rate	93	89.2
Designated beds per facility (average)	26	35

[1]Excludes facilities not reporting both client counts and number of beds, facilities whose client counts were reported by another facility, facilities that included client counts from other facilities, and facilities that did not respond to this question.
Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

As an indication of the percentage of the population that utilizes different types of treatment services for mental/addictive disorders, the following tables are provided for adults and children/adolescents. Based on data presented in the tables, 15% of the adult population and 21% of the child/adolescent population uses any of the specified services for mental/addictive disorders each year. Table 76 appears to indicate somewhat higher use of mental health services, with over 40% noted as receiving some treatment for mental health issues.

Table 74. Proportion of adult population using mental/addictive disorder services in one year	
Services	**Percent Use***
Total Health Sector	11%**
Specialty Mental Health	6%
General Medical	6%
Human Services Professionals	5%
Voluntary Support Network	3%
Any of the Above Services	15%

*Percent Use determined from Epidemiologic Catchment Area study and National Comorbidity Survey
**Subtotals do not add to total due to overlap
Source: Primary – Regier, D.A., Narrow, W.E., Rae, D.S., Manderscheid, R.W., Locke, B.Z., & Goodwin, F.K. (1993). The de facto mental and addictive disorders service system. Epidemiologic Catchment Area prospective 1-year prevalence rates of disorders and services. *Archives of General Psychiatry*, *50*, 85-94.; Kessler, R.C., et al. (1996). The 12-month prevalence and correlates of serious mental illness (SMI). In R.W. Manderscheid & M.A. Sonnenschein (Eds.), Center for Mental Health Services, Mental health United States, 1996, (DHHS Pub. No. SMA 96-3098) (pp. 59-70). Washington, DC: Superintendent of Documents, U.S. Government Printing Office.; Secondary – Mental Health: A Report of the Surgeon General, 1999

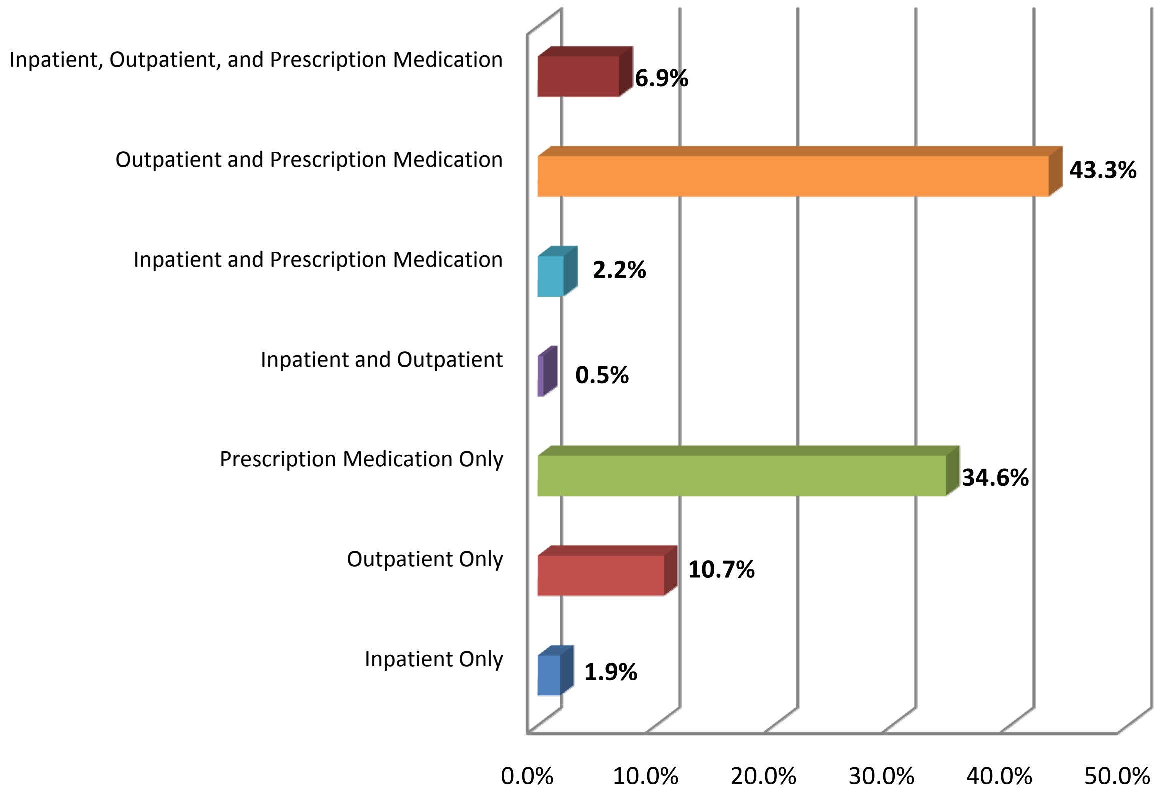
Table 75. Proportion of child/adolescent populations (ages 9-17) using mental/addictive disorder services in one year	
Services	**Percent Use***
Total Health Sector	9%**
Specialty Mental Health	8%
General Medical	3%
Human Services Professionals	17%
School Services	16%
Other Human Services	3%
Any of Above Services	21%

*Percent Use determined from National Institute of Mental Health multisite survey of children and adolescents ages 9 to 17 years
**Subtotals do not add to total due to overlap
Source: Primary – Shaffer, D., et al. (1996). The NIMH Diagnostic Interview Schedule for Children Version 2.3 (DISC-2.3): Description, acceptability, prevalence rates, and performance in the MECA Study. Methods for Epidemiology of Child and Adolescent Mental Disorders Study. *Journal of the American Academy of Child and Adolescent Psychiatry, 23*, 865-877.; Secondary - Mental Health: A Report of the Surgeon General, 1999

Table 76. Twelve-month use of mental health services in the United States, 2005	
Service	**Percent of Adults Using Services**
Receiving some treatment	41.1%
Treated by psychiatrist	12.3%
Treated by non-psychiatrist mental health specialist	16.0%
Treated by general medical provider	22.8%
Treated by a human services provider	8.1%
Treated by complementary and alternative medical provider	6.8%

Source: Wang, P.S., Lane, M., Olfson, M., Pincus, H.A., Wells, K.B., & Kessler, R.C. (2005). Twelve-month use of mental health services in the United States: results from the National Comorbidity Survey Replication. *Archives of General Psychiatry, 62*, 629-640.

Figure 16 and Table 77 indicate the percentages of types of mental health services received in the past year by adults in the United States who experienced serious psychological distress. As noted, the combination of outpatient services and prescription medication was the most utilized forms of treatment for individuals with such mental health issues.

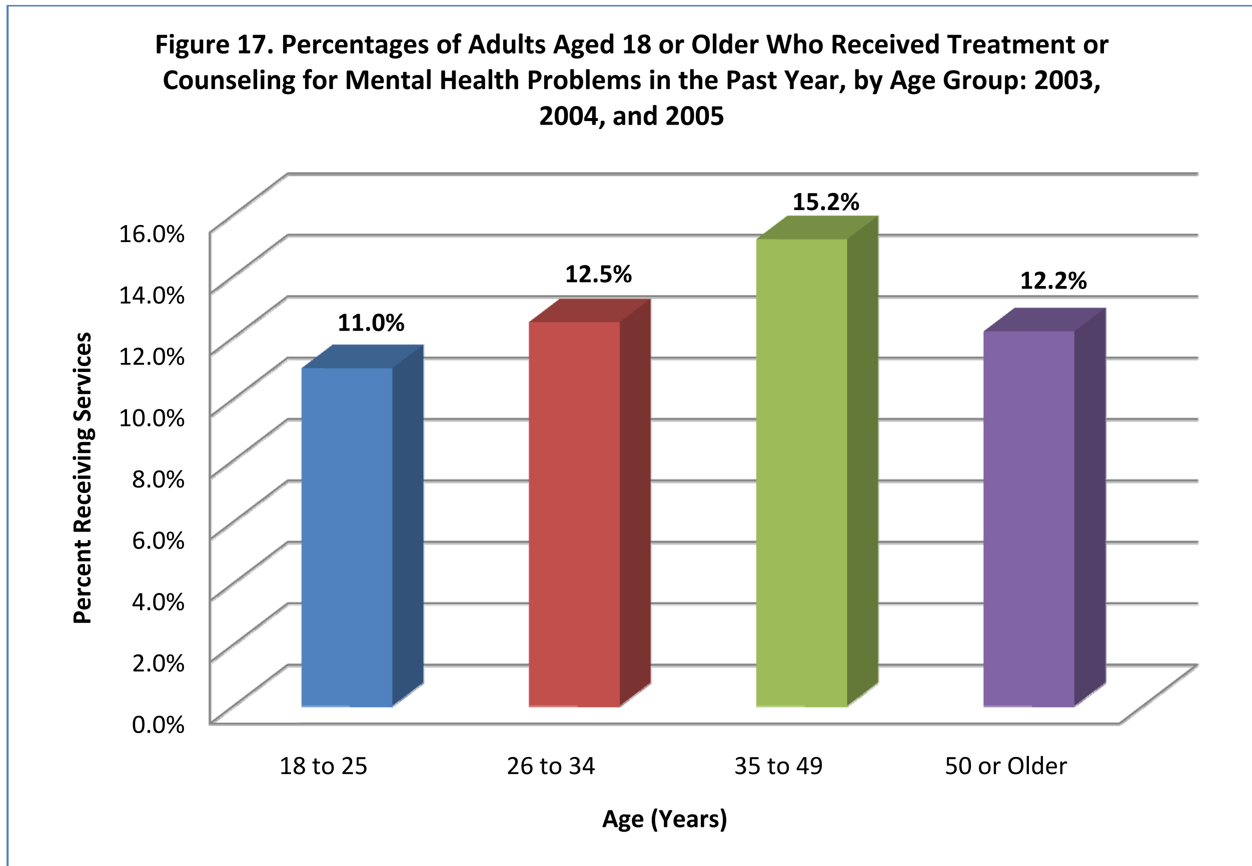


Percentages of Types of Mental Health Services Received in the Past Year among Adults with Past Year Serious Psychological Distress Who Received Mental Health Services in the Past Year: 2007	
Service	**Percentage Receiving Service**
Inpatient Only	1.9%
Outpatient Only	10.7%
Prescription Medication Only	34.6%
Inpatient and Outpatient	0.5%
Inpatient and Prescription Medication	2.2%
Outpatient and Prescription Medication	43.3%
Inpatient, Outpatient, and Prescription Medication	6.9%

Table 77. Specific types of mental health services received in the past year among persons aged 18 or older with past year serious psychological distress who received mental health services in the past year, by demographic characteristics: percentages, 2007			
Demographic Characteristic	Inpatient	Outpatient	Prescription Medication
Total	11.4	61.3	87.0
Age in Years			
18 to 25	13.2	59.5	79.2
26 to 49	10.8	65.0	87.7
50 or older	11.7	55.9	89.7
Gender			
Male	16.8	56.6	87.5
Female	9.1	63.4	86.8
Race/Ethnicity			
White	9.4	61.5	88.6
Black or African American	--	60.9	86.3
Hispanic or Latino	--	--	--

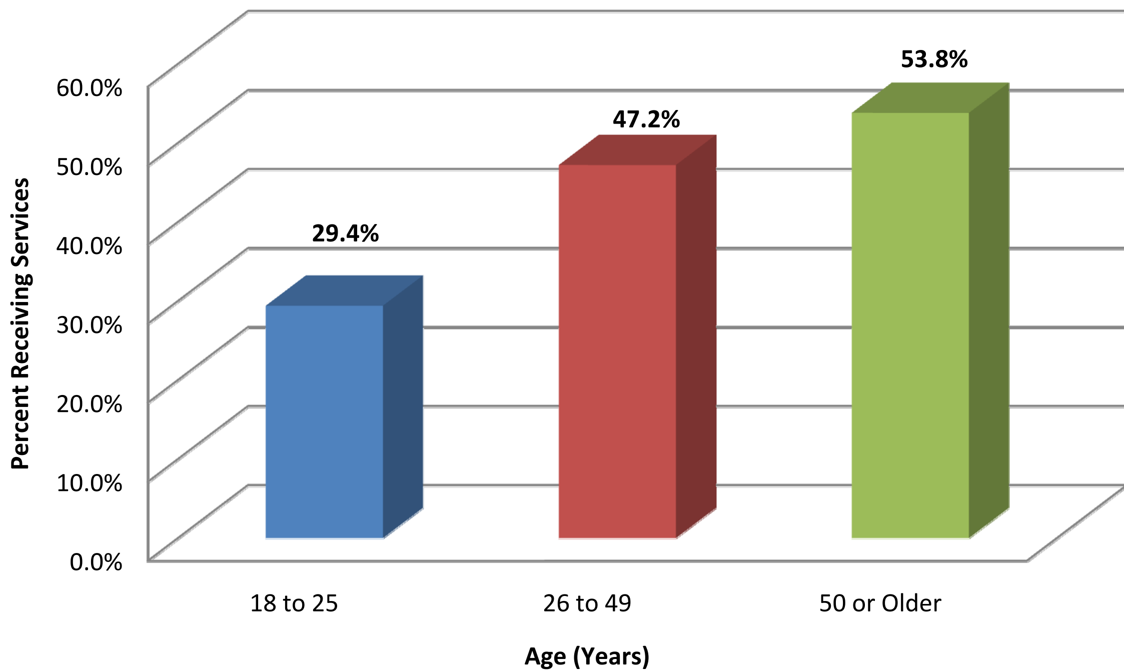
Source: SAMHSA, 2007 National Survey on Drug Use and Health

The following figures and tables provide national data related to the percentages of adults who received treatment for general mental health problems, serious psychological distress, and depression within the past year. Data are broken down by gender and race/ethnicity.

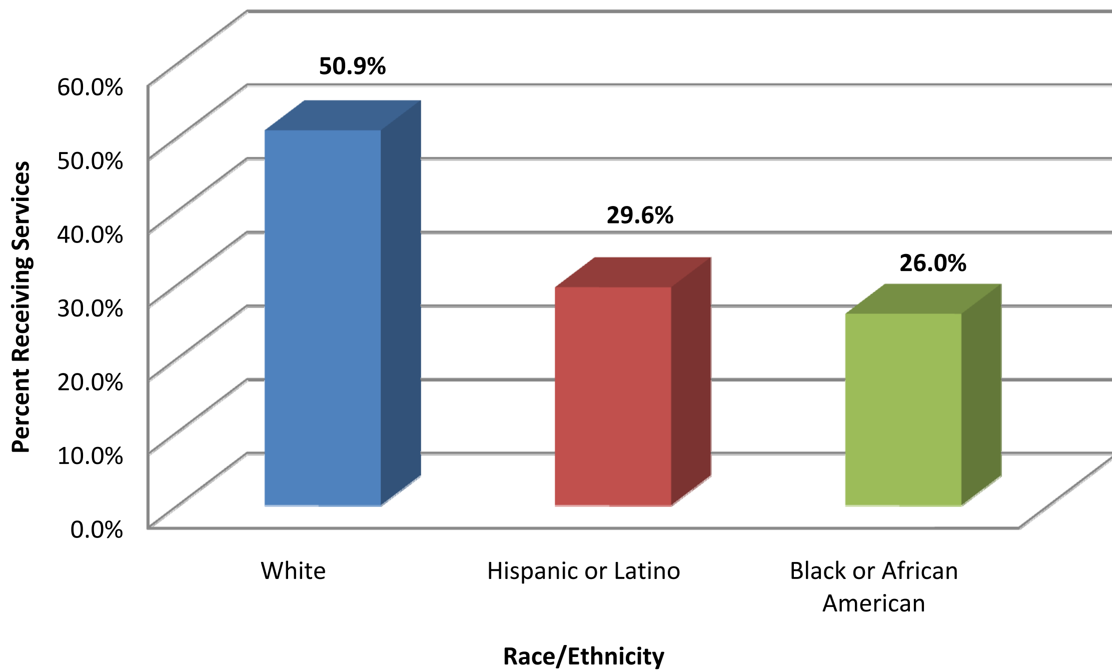


Note: Average of all adults (18 or older) who received treatment for mental health problems in past 12 months (2003-2005 combined) = 13.0%; Females = 16.9%, Males = 8.7%
Source: SAMHSA, 2003, 2004, and 2005 National Survey on Drug Use and Health

Percentages of Adults Aged 18 or Older Who Received Treatment or Counseling for Mental Health Problems in the Past Year, by Age Group: 2003, 2004, and 2005	
Age	Percent Receiving Services
18 to 25	11.0%
26 to 34	12.5%
35 to 49	15.2%
50 or Older	12.2%



Percentages of Adults Aged 18 or Older Who Received Treatment or Counseling for Mental Health Problems in the Past Year, by Age Group: 2003, 2004, and 2005	
Age	**Percent Receiving Services**
18 to 25	29.4%
26 to 49	47.2%
50 or Older	53.8%



Source: SAMHSA, 2007 National Survey on Drug Use and Health

Percentages of Adults Aged 18 or Older Who Received Treatment or Counseling for Mental Health Problems in the Past Year, by Age Group: 2003, 2004, and 2005	
Race/Ethnicity	**Percent Receiving Services**
White	50.9%
Hispanic or Latino	29.6%
Black or African American	26.0%

Table 78. Use of Mental Health Services by African Americans, 1994		
12-month disorder	Mental Health Specialist* % (se)	Any Provider** % (se)
Mood disorder	15.6 (3.5)	28.7 (4.5)
Anxiety disorder	12.6 (2.4)	25.6 (5.3)

The SE (Standard Error) is the average dispersion around the percentage.
*Psychologist, psychiatrist, or social worker
**Mental health specialist, general medical provider, other professional (nurse, occupational therapist, other health professional, minister, priest, rabbi, counselor), spiritualist, herbalist, natural therapist, or faith healer
Source: Primary – Kessler, R.C., et al. (1994). Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States. Results from the National Comorbidity Survey. *Archives of General Psychiatry, 51*, 8-19.; Secondary – SAMHSA, Mental Health: Culture, Race, Ethnicity-Chapter 3, Availability of Services

Table 79. Type of treatment received for major depressive episode, ages 18 or older, 2005 and 2006	
Treatment Type	%
Saw medical doctor or other professional and used prescription medication	69.4
Saw medical doctor or other professional but did not take prescription medication	23.8
Took prescription medication for depression but did not see medical doctor or other professional	6.7

Source: SAMHSA, 2005 and 2006 National Survey on Drug Use and Health

Indicator 2.2 The specific mental health and addiction issues for which a direct service provider delivers treatment and the number of clients seen annually for each issue. For ancillary service providers, the associated indicator is the type of issue(s) for which organizations make referrals and the highest areas of referrals.

As noted in the table below, the types of issues most treated by participating direct service providers are substance-related disorders, with approximately 81% of organizations providing service in this area. Other issues for which a large number of organizations provide service include major depressive disorder (77.3% of organizations), post traumatic stress disorder (68.2% of organizations), anxiety disorders (65.2% of organizations), and bipolar disorder (manic depression) (63.6% of organizations).

The issues for which the smallest percentage of responding organizations provide service include disorders related to the elderly (18.2% of organizations), delirium (22.7% of organizations), sexual orientation and gender identity issues (27.3% of organizations), and developmental disorders (autism, mental retardation, etc.) (27.3% of organizations).

Based on data provided by direct service providers, the largest number of individuals treated by those organizations were seen for major depressive disorder, with over 5,000 individuals receiving services, followed by substance-related disorders (4,230 receiving services), and schizophrenia or other psychotic disorders (2,536 receiving services). While post traumatic stress disorder is one of the issues for which services are provided by a majority of organizations, far fewer individuals were treated for this issue in the last annual reporting period. Other areas for which a fairly large number of individuals received services included anxiety disorders and childhood disorders (ADHD, etc.).

Caution should be exercised when reporting the numbers-served data for two key reasons. First, these data do not represent every organization that provides mental health/addiction services in the four-county area. Second, not all participating organizations reported their numbers-served data for specific issues, which means that a larger number of individuals were treated by the organizations that actually did respond to the Inventory of Addiction and Mental Health Services.

Table 80. Types of Issues for which Clients Served by Direct Service Providers – All Respondents							
Issue	**Does the organization treat the specified issue?**			**Number of clients served annually**			
	Yes	**No**	**N**	**Min**	**Max**	**Median**	**Total**
Anxiety disorders	65.2% n=15	34.8% n=8	23	1	1,325	64	2,198
Major depressive disorder	77.3% n=17	22.7% n=5	22	0	2,680	76.5	5,101
Bipolar disorder (manic depression)	63.6% n=14	36.4% n=8	22	0	226	18.5	482
Personality disorders	54.5% n=12	45.5% n=10	22	2	271	20	613
Delirium	22.7% n=5	77.3% n=17	22	0	28	0	31
Dementia	36.4% n=8	63.6% n=14	22	3	159	10	207
Schizophrenia or other psychotic disorders	50.0% n=11	50.0% n=11	22	1	1,240	16.5	2,536
Childhood disorders (ADHD, etc.)	54.5% n=12	45.5% n=10	22	1	1,626	109	2,164
Disorders related to the elderly	18.2% n=4	81.8% n=18	22	0	40	2	42
Eating disorders	36.4% n=8	63.6% n=14	22	0	27	5.5	55
Substance-related disorders	81.8% n=18	18.2% n=4	22	1	1,912	100	4,230
Adjustment disorders	59.1% n=19	40.9% n=9	22	10	481	47	1,108
Sleep disorders	45.5% n=10	54.5% n=12	22	0	142	2.5	181
Sexual orientation and gender identity issues	27.3% n=6	72.7% n=16	22	0	4	1	5
Child physical and/or sexual abuse	36.4% n=8	63.6% n=14	22	1	15	3.5	23
Developmental disorders (autism, mental retardation, etc.)	27.3% n=6	72.7% n=16	22	3	1,320	31	1,393
Traumatic/organic brain injury & complications	31.8% n=7	68.2% n=15	22	2	44	10	74
Post traumatic stress disorder	68.2% n=15	31.8% n=7	22	1	474	9.5	748

Note: Other issues listed by respondents include: adult ADHD (n=1); borderline intellectual functioning (n=1); disruptive behavior disorder (n=1); dysthymia (n=1); impulse control disorder (n=1); mental disorder due to medical condition (n=1); OCD (n=1); pain disorders (n=1); relative attachment disorder (n=1); tics (n=1); and Tourette's disorder (n=2). A total of 189 clients were treated by the responding organizations for these other issues.

The following table shows the issues for which services are provided by the subgroups of direct service providers. There do appear to be some differences in the focus of the organizations depending on the number of clients they serve. While depression and substance-related disorders are a focus for all subgroups, many of the medium-sized organizations offer services for eating disorders and sleep disorders, and many of the large-sized organizations offer services for personality disorders, schizophrenia or other psychotic disorders, adjustment disorders, and child physical and/or sexual abuse.

Table 81. Types of Issues for which Clients Served by Direct Service Providers – By Organization Grouping

Small Providers (serve less than 250 clients annually)							
Issue	Does the organization treat the specified issue?			Number of clients served annually			
	Yes	No	N	Min	Max	Median	Total
Anxiety disorders	44.4% n=4	55.6% n=5	9	1	45	14.5	75
Major depressive disorder	62.5% n=5	37.5% n=3	8	2	152	43	293
Bipolar disorder (manic depression)	50.0% n=4	50.0% n=4	8	1	40	21	83
Personality disorders	37.5% n=3	62.5% n=5	8	5	9	7	14
Delirium	12.5% n=1	87.5% n=7	8	0	0	0	0
Dementia	25.0% n=2	75.0% n=6	8	10	14	12	24
Schizophrenia or other psychotic disorders	37.5% n=3	62.5% n=5	8	1	103	2	106
Childhood disorders (ADHD, etc.)	37.5% n=3	62.5% n=5	8	1	10	4	15
Disorders related to the elderly	0.0% n=0	100.0% n=8	8	na	na	na	na
Eating disorders	0.0% n=0	100.0% n=8	8	na	na	na	na
Substance-related disorders	62.5% n=5	37.5% n=3	8	1	150	20	204
Adjustment disorders	37.5% n=3	62.5% n=5	8	10	10	10	20
Sleep disorders	25.0% n=2	75.0% n=6	8	1	15	8	16
Sexual orientation and gender identity issues	12.5% n=1	87.5% n=7	8	1	1	1	1
Child physical and/or sexual abuse	0.0% n=0	100% n=8	8	na	na	na	na
Developmental disorders (autism, mental retardation, etc.)	25.0% n=2	75.0% n=6	8	3	34	18.5	37
Traumatic/organic brain injury & complications	12.5% n=1	87.5% n=7	8	2	2	2	2

Post traumatic stress disorder	50.0% n=4	50.0% n=4	8	1	5	3	6
Medium Providers (serve 250 – 999 clients annually)							
Service Level	**Does the organization treat the specified issue?**			**Number of clients served annually**			
	Yes	**No**	**N**	**Min**	**Max**	**Median**	**Total**
Anxiety disorders	57.1% n=4	42.9% n=3	7	34	70	65	169
Major depressive disorder	85.7% n=6	14.3% n=1	7	0	242	55	405
Bipolar disorder (manic depression)	71.4% n=5	28.6% n=2	7	0	72	10	106
Personality disorders	57.1% n=4	42.9% n=3	7	10	61	20	91
Delirium	14.3% n=1	85.7% n=6	7	0	0	0	0
Dementia	28.6% n=2	71.4% n=5	7	3	15	9	18
Schizophrenia or other psychotic disorders	42.9% n=3	57.1% n=4	7	2	25	3	30
Childhood disorders (ADHD, etc.)	42.9% n=3	57.1% n=4	7	115	180	147.5	295
Disorders related to the elderly	28.6% n=2	71.4% n=5	7	0	2	1	2
Eating disorders	71.4% n=5	28.6% n=2	7	0	27	5.5	38
Substance-related disorders	100% n=7	0% n=0	7	3	350	160.5	1022
Adjustment disorders	57.1% n=4	42.9% n=3	7	25	198	40	263
Sleep disorders	85.7% n=6	14.3% n=1	7	0	142	3	165
Sexual orientation and gender identity issues	28.6% n=2	71.4% n=5	7	0	0	0	0
Child physical and/or sexual abuse	42.9% N=3	57.1% n=4	7	2	5	3.5	7
Developmental disorders (autism, mental retardation, etc.)	28.6% n=2	71.4% n=5	7	31	1320	675.5	1351
Traumatic/organic brain injury & complications	42.9% n=3	57.1% n=4	7	6	44	10	60
Post traumatic stress disorder	85.7% n=6	14.3% n=1	7	1	474	12	514

Large Providers (serve 1,000 + clients annually)							
Service Level	Does the organization treat the specified issue?			Number of clients served annually			
	Yes	No	N	Min	Max	Median	Total
Anxiety disorders	100% n=7	0.0% n=0	7	64	1325	282.5	1954
Major depressive disorder	85.7% n=6	14.3% n=1	7	73	2680	825	4403
Bipolar disorder (manic depression)	71.4% n=5	28.6% n=2	7	17	226	50	293
Personality disorders	71.4% n=5	28.6% n=2	7	2	271	117.5	508
Delirium	42.9% n=3	57.1% n=4	7	0	28	3	31
Dementia	57.1% n=4	42.9% n=3	7	6	159	10	175
Schizophrenia or other psychotic disorders	71.4% n=5	28.6% n=2	7	8	1,240	577	2,402
Childhood disorders (ADHD, etc.)	14.3% n=1	85.7% n=6	7	103	1,626	125	1,854
Disorders related to the elderly	28.6% n=2	71.4% n=5	7	40	40	40	40
Eating disorders	42.9% n=3	57.1% n=4	7	2	15	8.5	17
Substance-related disorders	85.7% n=6	14.3% n=1	7	275	1,912	817	3,004
Adjustment disorders	85.7% n=6	14.3% n=1	7	54	481	300	835
Sleep disorders	28.6% n=2	71.4% n=5	7	1	1	1	1
Sexual orientation and gender identity issues	42.9% n=3	57.1% n=4	7	4	4	4	4
Child physical and/or sexual abuse	71.4% n=5	28.6% n=2	7	1	15	8	16
Developmental disorders (autism, mental retardation, etc.)	28.6% n=2	71.4% n=5	7	5	5	5	5
Traumatic/organic brain injury & complications	42.9% n=3	57.1% n=4	7	10	12	11	22
Post traumatic stress disorder	71.4% n=5	28.6% n=2	7	45	184	114.5	229

While direct service providers indicated the issues for which they provide services to clients, ancillary service providers indicated the issues for which they refer clients to mental health or addiction service organizations. The following table shows a ranking of issues for which schools and non-school ancillary organizations refer clients. For schools, the highest percentage of organizations refer students for behavioral issues (fighting, aggression toward family and

classmates, etc.) (89.2% of schools refer students), childhood disorders (ADHD, etc.) (79.7% of schools refer students), and anger management (78.4% of schools refer students). None of the schools indicate they refer students for cognitive issues (dementia, delirium, etc.), gambling addiction, or other addictions.

For non-school organizations, the highest percentage of organizations refer clients for abuse and/or addiction to alcohol (66.0% of organizations refer clients), abuse and/or addiction to other drugs (65.0% of organizations refer clients), mood issues (depression, mood swings, etc.) (63.0% of organizations refer clients), anxiety/stress (61.0% of organizations refer clients), and behavioral issues (fighting, aggression toward family and classmates, etc.) (61.0% of organizations refer clients). The areas for which the smallest percentage of organizations refer clients include other addictions (3.0%), sexual and/or gender identity issues (10.0%), sex and/or pornography addiction (11.0%), and gambling addiction (11.0%).

Table 82. Ranking of Issues for which Ancillary Organizations Refer Clients

Schools				Non-Schools			
Issue	Rank	N	% of Respondents (N=74)*	Issue	Rank	N	% of Respondents (N=100)*
Behavioral issues (fighting, aggression toward family/classmates, etc.)	1	66	89.20%	Abuse and/or addiction to alcohol	1	66	66.00%
Childhood disorders (ADHD, etc.)	2	59	79.70%	Abuse and/or addiction to other drugs	2	65	65.00%
Anger management	3	58	78.40%	Mood issues (depression, mood swings, etc.)	3	63	63.00%
Mood issues (depression, mood swings, etc.)	4	51	68.90%	Anxiety/stress	4	61	61.00%
Anxiety/stress	5	49	66.20%	Behavioral issues (fighting, aggression toward family/classmates, etc.)	4	61	61.00%
Learning disabilities	6	43	58.10%	Anger management	6	53	53.00%
Suicidal behaviors	7	38	51.40%	Family and/or marital problems	7	49	49.00%
Symptoms of personality disorder (antisocial, obsessive/compulsive, etc.)	8	33	44.60%	Domestic violence	8	44	44.00%
Abuse and/or addiction to other drugs	9	28	37.80%	Childhood disorders (ADHD, etc.)	9	43	43.00%
Child physical abuse	10	27	36.50%	Suicidal behaviors	10	42	42.00%
Child sexual abuse	10	27	36.50%	Symptoms of personality disorder (antisocial, obsessive/compulsive, etc.)	11	40	40.00%
Developmental issues (autism, mental retardation, etc.)	12	25	33.80%	Parenting problems	12	39	39.00%
Self-mutilation	12	25	33.80%	Signs of schizophrenia or psychosis	13	35	36.00%

Abuse and/or addiction to alcohol	14	24	32.40%	Child sexual abuse	14	33	33.00%
Family and/or marital problems	14	24	32.40%	Developmental issues (autism, mental retardation, etc.)	14	33	33.00%
Parenting problems	16	23	31.10%	Cognitive issues (dementia, delirium, etc.)	16	31	31.00%
Eating issues (anorexia, bulimia, etc.)	17	17	23.00%	Learning disabilities	16	31	31.00%
Domestic violence	18	13	17.60%	Child physical abuse	18	28	28.00%
Signs of schizophrenia or psychosis	19	9	12.20%	Self-mutilation	19	23	23.00%
Sexual and/or gender identity issues	20	7	9.50%	Eating issues (anorexia, bulimia, etc.)	20	22	22.00%
Sleep-related problems	21	6	8.10%	Sleep-related problems	21	18	18.00%
Adult sexual abuse	22	3	4.10%	Adult sexual abuse	22	15	15.00%
Sex and/or pornography addiction	23	2	2.70%	Gambling addiction	23	11	11.00%
Cognitive issues (dementia, delirium, etc.)	24	0	0.00%	Sex and/or pornography addiction	23	11	11.00%
Gambling addiction	24	0	0.00%	Sexual and/or gender identity issues	25	10	10.00%
Other addictions	24	0	0.00%	Other addictions	26	3	3.00%

*A total of 74 schools and 100 non-school organizations indicated they refer clients to mental health/addiction services

Ancillary service providers were asked to indicate their three highest areas of referral to mental health or addiction service organizations. These areas are very similar to the rankings of issues for which ancillary service providers refer students/clients. It should be noted that the number/types of issues for which non-schools make referrals is broader than schools, which is understandable given the limited age populations schools primarily serve and the concentration of issues that youth typically experience.

Table 83. Ranking of Highest Areas of Referral from Community Organizations							
Schools				Non-Schools			
Area of Referral	Rank	N	% of Respondents (N=61)*	Area of Referral	Rank	N	% of Respondents (N=81)*
Childhood disorders (ADHD, etc.)	1	39	63.90%	Abuse and/or addiction to other drugs	1	32	39.50%
Behavioral issues (fighting, aggression toward family/classmates, etc.)	2	36	59.00%	Mood issues (depression, mood swings, etc.)	1	32	39.50%
Mood issues (depression, mood swings, etc.)	3	21	34.40%	Abuse and/or addiction to alcohol	3	31	38.30%
Anger management	4	20	32.80%	Behavioral issues (fighting, aggression toward family/classmates, etc.)	4	21	25.90%
Learning disabilities	5	17	27.90%	Anxiety/stress	5	16	19.80%
Suicidal behaviors	6	10	16.40%	Childhood disorders (ADHD, etc.)	6	15	18.50%

Anxiety/stress	7	8	13.10%	Family and/or marital problems	7	14	17.30%
Abuse and/or addiction to other drugs	8	6	9.80%	Domestic violence	8	12	14.80%
Family and/or marital problems	9	5	8.20%	Anger management	9	8	9.90%
Child physical abuse	10	4	6.60%	Cognitive issues (dementia, delirium, etc.)	9	8	9.90%
Symptoms of personality disorder (antisocial, obsessive/compulsive, etc.)	10	4	6.60%	Suicidal behaviors	9	8	9.90%
Child sexual abuse	12	3	4.90%	Symptoms of personality disorder (antisocial, obsessive/compulsive, etc.)	9	8	9.90%
Developmental issues (autism, mental retardation, etc.)	12	3	4.90%	Developmental issues (autism, mental retardation, etc.)	13	6	7.40%
Self-mutilation	12	3	4.90%	Signs of schizophrenia or psychosis	13	6	7.40%
Abuse and/or addiction to alcohol	15	1	1.60%	Child physical abuse	15	5	6.20%
Adult sexual abuse	16	0	0.00%	Parenting problems	15	5	6.20%
Cognitive issues (dementia, delirium, etc.)	16	0	0.00%	Child sexual abuse	17	3	3.70%
Domestic violence	16	0	0.00%	Sleep-related problems	17	3	3.70%
Eating issues (anorexia, bulimia, etc.)	16	0	0.00%	Eating issues (anorexia, bulimia, etc.)	19	2	2.50%
Gambling addiction	16	0	0.00%	Sex and/or pornography addiction	20	1	1.20%
Other addictions	16	0	0.00%	Adult sexual abuse	21	0	0.00%
Parenting problems	16	0	0.00%	Gambling addiction	21	0	0.00%
Sex and/or pornography addiction	16	0	0.00%	Learning disabilities	21	0	0.00%
Sexual and/or gender identity issues	16	0	0.00%	Other addictions	21	0	0.00%
Signs of schizophrenia or psychosis	16	0	0.00%	Self-mutilation	21	0	0.00%
Sleep-related problems	16	0	0.00%	Sexual and/or gender identity issues	21	0	0.00%

*A total of 61 schools and 81 non-schools provided at least one highest area of referral

Secondary Data Related to Treatment of Specific Mental Health Issues

The following table indicates the types of substance abuse problems treated by facilities across Indiana as reported in the National Survey of Substance Abuse Treatment Services. As noted, 94.4% of facilities treat clients with both alcohol and drug abuse, representing over 12,000 clients on a given day.

Table 84. N-SSATS Indiana Profile - Substance Abuse Problem Treated, 2007					
Focus	Facilities[1,2]		Clients in Treatment on March 30, 2007		
			Clients		Clients per 100,000 Pop.
	No.	%	No.	%	Aged 18 and Over
Clients with both alcohol and drug abuse	235	94.4	12,404	45.6	244
Clients with drug abuse only	196	78.7	9,909	36.5	202
Clients with alcohol abuse only	207	83.1	4,870	17.9	96
Total[2]	249		27,183	100	542

[1]Facilities may be included in more than one category.
[2]Facilities excluded because they were not asked or did not respond to this question: 72 facilities
Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

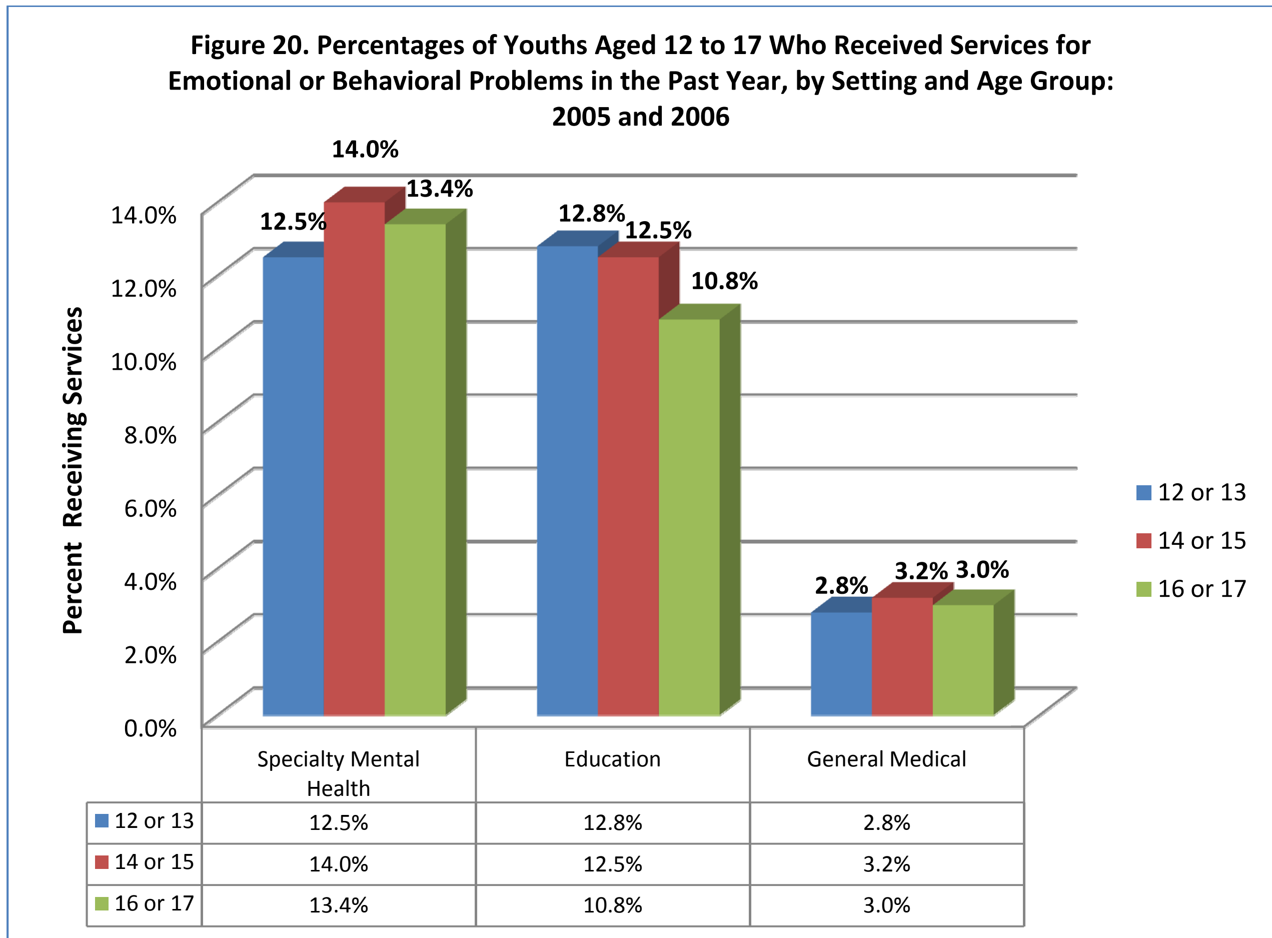
Table 85 indicates the estimated number and percentage of youths age 12 to 17 in the United States who received mental health services for emotional or behavioral problems in the past year. As noted, 13.3% of youth received treatment from a specialty mental health provider for emotional and behavioral problems.

Table 85. Estimated numbers (in thousands) and percentages of youths aged 12 to 17 receiving mental health services for emotional or behavioral problems in the past year, by setting: 2005 and 2006		
Setting	Estimated Number (in 1000s)	%
Specialty Mental Health (Combined Inpatient and Outpatient)	3,344	13.3
Outpatient	2,991	11.9
Private Therapist, Psychologist, Psychiatrist, Social Worker, or Counselor	2,495	9.9
Mental Health Clinic or Center	623	2.5
Partial Day Hospital or Day Treatment Program	461	1.8
In-Home Therapist, Counselor, or Family Preservation Worker	724	2.9
Inpatient or Residential	683	2.7
Overnight or Longer Stay in any Type of Hospital	523	2.1
Overnight or Longer Stay in a Residential Treatment Center	227	0.9
Overnight or Longer Stay in Foster Care or in a Therapeutic Foster Care Home	136	0.5
Education	3,012	12.0

School Counselor, School Psychologist, or Having Regular Meetings with a Teacher	2,485	9.9
Special Education Services While in a Regular Classroom or in a Special Classroom or Placement in a Special Program or Special School	977	3.9
General Medical	752	3.0
Pediatrician or Other Family Doctor	752	3.0

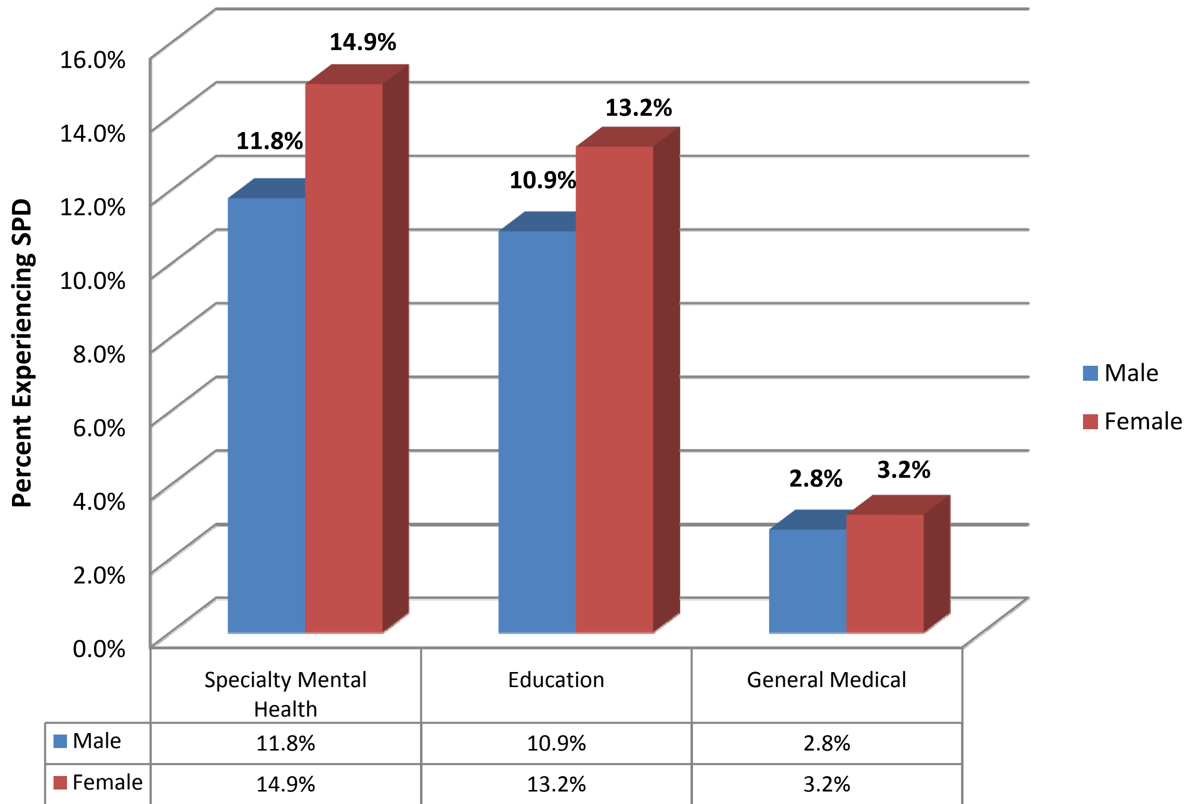
Source: SAMHSA, 2005 and 2006 National Survey on Drug Use and Health

The following figures indicate the percentages of youth in the U.S. who received services for emotional or behavioral issues broken down by age group and gender.



	Specialty Mental Health	Education	General Medical
12 or 13	12.5%	12.8%	2.8%
14 or 15	14.0%	12.5%	3.2%
16 or 17	13.4%	10.8%	3.0%

Source: SAMHSA, 2005 and 2006 National Survey on Drug Use and Health



	Specialty Mental Health	Education	General Medical
Male	11.8%	10.9%	2.8%
Female	14.9%	13.2%	3.2%

Source: SAMHSA, 2005 and 2006 National Survey on Drug Use and Health

Indicator 2.3 Ancillary services (e.g., housing, food, clothing, job skills training) that the direct service provider offers to clients and the age groups to whom services are provided.

While completing treatment for mental health or addiction issues, many individuals have need for ancillary services such as housing, child care, transportation, and job skills training. The following table displays the types of ancillary services that are provided by direct service providers. As noted, the type of service that is most provided by responding organizations is individual therapy and/or counseling, with over 90% providing this service. Other types of services provided by a large percentage of organizations include group therapy and/or counseling, medication management, court-ordered work, family therapy and/or counseling, information and referral services, and case management. Note that it would be expected that a large number of organizations would list therapy and/or counseling as services they provide since they are likely viewed as forms of direct mental health or addiction treatment as opposed to ancillary services. The services provided least by participating organizations include in-home family services, neuropsychological services, payeeships, and therapeutic foster care, with none of the organizations providing services in these areas.

Table 86. Ranking of Services Provided by Direct Service Providers – All Respondents

Service	No. of orgs who provide the service	% of Respondents (N=24)
Individual therapy and/or counseling	22	91.7%
Group therapy and/or counseling	17	70.8%
Medication management	13	54.2%
Court-ordered work	12	50.0%
Family therapy and/or counseling	12	50.0%
Information and referral services	12	50.0%
Case management	11	45.8%
Emergency and crisis services	8	33.3%
Psychological testing	7	29.2%
Assistance to hearing-impaired	6	25.0%
Assistance to non-English	5	20.8%
Drug screening services	5	20.8%
Home-based services	5	20.8%
Parenting education	5	20.8%
Meal services	4	16.7%
Mental retardation/developmental disabilities services	4	16.7%
Money management	4	16.7%
Nutrition services	4	16.7%
Specialized services for the elderly	4	16.7%
Family support services	3	12.5%
General daily living activities	3	12.5%
Homeless services	3	12.5%
Housing services	3	12.5%
Primary health care	3	12.5%

School-based services	3	12.5%
Supported employment	3	12.5%
Transportation services	3	12.5%
Independent living services	1	4.2%
Legal advocacy	1	4.2%
Supported education/training	1	4.2%
Wrap-around services	1	4.2%
Youth education	1	4.2%
In-home family services	0	0.0%
Neuropsychological services	0	0.0%
Payeeships	0	0.0%
Therapeutic foster care	0	0.0%

Note: One organization listed other services that it provides, which include recreation/art therapy and occupational therapy.

The following table presents the services provided by direct service providers broken down by the size of the organization. As noted, individual and group therapy and/or counseling are provided by most of the organizations no matter their size. The percentage of organizations that offer family therapy does appear to partially depend on the organization's size, with fewer of the smaller organizations providing these services. Aside from the forms of therapy or counseling, the following are the largest areas of service for the different sizes of organizations.

- Small organizations: case management; medication management; court-ordered work; information and referral services
- Medium organizations: information and referral services; medication management; case management; court-ordered work; and psychological testing
- Large organizations: court-ordered work; emergency and crisis services; information and referral services; medication management

Table 87. Services Provided by Direct Service Providers – By Organization Grouping

Service	Small Organizations		Medium Organizations		Large Organizations	
	No. of orgs who provide the service	% of Respondents (N=10)	No. of orgs who provide the service	% of Respondents (N=7)	No. of orgs who provide the service	% of Respondents (N=7)
Assistance to hearing-impaired	1	10.0%	2	28.6%	3	42.9%
Assistance to non-English	1	10.0%	2	28.6%	2	28.6%
Case management	6	60.0%	3	42.9%	2	28.6%
Court-ordered work	4	40.0%	3	42.9%	5	71.4%
Drug screening services	2	20.0%	1	14.3%	2	28.6%
Emergency and crisis services	1	10.0%	2	28.6%	5	71.4%
Family support services	1	10.0%	0	0.0%	2	28.6%
Family therapy and/or counseling	3	30.0%	4	57.1%	5	71.4%
General daily living activities	3	30.0%	0	0.0%	0	0.0%
Group therapy and/or counseling	7	70.0%	5	71.4%	5	71.4%
Home-based services	2	20.0%	1	14.3%	2	28.6%
Homeless services	1	10.0%	1	14.3%	1	14.3%

Housing services	2	20.0%	1	14.3%	0	0.0%
Independent living services	1	10.0%	0	0.0%	0	0.0%
Individual therapy and/or counseling	9	90.0%	7	100%	6	85.7%
Information and referral services	4	40.0%	5	71.4%	4	57.1%
In-home family services	0	0.0%	0	0.0%	0	0.0%
Legal advocacy	1	10.0%	0	0.0%	0	0.0%
Meal services	2	20.0%	1	14.3%	1	14.3%
Medication management	5	50.0%	4	57.1%	4	57.1%
Mental retardation/developmental disabilities services	1	10.0%	2	28.6%	1	14.3%
Money management	2	20.0%	1	14.3%	1	14.3%
Neuropsychological services	0	0.0%	0	0.0%	0	0.0%
Nutrition services	1	10.0%	1	14.3%	2	28.6%
Parenting education	3	30.0%	0	0.0%	2	28.6%
Payeeships	0	0.0%	0	0.0%	0	0.0%
Primary health care	2	20.0%	0	0.0%	1	14.3%
Psychological testing	3	30.0%	3	42.9%	1	14.3%
School-based services	0	0.0%	0	0.0%	3	42.9%
Specialized services for the elderly	2	20.0%	0	0.0%	2	28.6%
Supported education/training	1	10.0%	0	0.0%	0	0.0%
Supported employment	1	10.0%	0	0.0%	2	28.6%
Therapeutic foster care	0	0.0%	0	0.0%	0	0.0%
Transportation services	3	30.0%	0	0.0%	0	0.0%
Wrap-around services	0	0.0%	0	0.0%	1	14.3%
Youth education	1	10.0%	0	0.0%	0	0.0%

Direct service providers that completed the Inventory of Addiction and Mental Health Services indicated the age groups for which they provided ancillary services. Overall, it appears that individuals in the 18 to 64 age group are most likely to be the recipients of ancillary services provided by direct service providers, followed by the 65 and older age group. This is consistent with the finding that these two age groups are the highest target populations for respondents. Youth, particularly those age 5 and under, are the least likely to receive the ancillary services.

Table 88. Age Groups to which Services Provided by Direct Service Providers are Offered – All Respondents

Service	No. of orgs that provide the service	Age Groups**				
		0-5	6-14	15-17	18-64	65+
Individual therapy and/or counseling	22	4 18.2%	11 50.0%	11 50.0%	19 86.4%	13 59.1%
Group therapy and/or counseling	17	1 5.9%	7 41.2%	7 41.2%	14 82.4%	10 58.8%
Information and referral services	13	2 16.7%	4 33.3%	7 58.3%	13 100%	10 83.3%

Medication management	13	2 15.4%	5 38.5%	6 46.2%	10 76.9%	8 61.5%
Court-ordered work	12	1 8.3%	2 16.7%	3 25.0%	12 100%	7 58.3%
Family therapy and/or counseling	12	*	*	*	*	*
Case management	11	0 0.0%	6 54.5%	6 54.5%	9 81.8%	6 54.5%
Emergency and crisis services	8	1 12.5%	4 50.0%	4 50.0%	6 75.0%	5 62.5%
Psychological testing	7	2 28.6%	4 57.1%	3 42.9%	6 85.7%	4 57.1%
Assistance to hearing-impaired	6	1 16.7%	2 33.3%	2 33.3%	6 100%	4 66.7%
Assistance to non-English	5	2 40.0%	2 40.0%	2 40.0%	4 80.0%	4 80.0%
Drug screening services	5	1 20.0%	1 20.0%	3 60.0%	5 100%	4 80.0%
Home-based services	5	0 0.0%	1 20.0%	1 20.0%	3 60.0%	2 40.0%
Parenting education	5	0 0.0%	2 40.0%	1 20.0%	2 40.0%	0 0.0%
Meal services	4	1 25.0%	2 50.0%	2 50.0%	3 75.0%	3 75.0%
Mental retardation/developmental disabilities services	4	1 25.0%	1 25.0%	2 50.0%	4 100%	3 75.0%
Money management	4	0 0.0%	0 0.0%	1 25.0%	4 100%	2 50.0%
Nutrition services	4	1 25.0%	1 25.0%	1 25.0%	4 100%	4 100%
Specialized services for the elderly	4	0 0.0%	0 0.0%	0 0.0%	3 75.0%	4 100%
Family support services	3	0 0.0%	1 33.3%	1 33.3%	1 33.3%	1 33.3%
General daily living activities	3	0 0.0%	1 33.3%	1 33.3%	2 66.7%	2 66.7%
Homeless services	3	0 0.0%	1 33.3%	1 33.3%	3 100%	3 100%
Housing services	3	0 0.0%	0 0.0%	0 0.0%	3 100%	2 66.7%
Primary health care	3	0 0.0%	1 33.3%	1 33.3%	3 100%	3 100%
School-based services	3	0 0.0%	3 100%	3 100%	0 0.0%	0 0.0%
Supported employment	3	0 0.0%	0 0.0%	0 0.0%	3 100%	1 33.3%
Transportation services	3	0 0.0%	1 33.3%	1 33.3%	2 66.7%	2 66.7%

Independent living services	1	0 0.0%	0 0.0%	1 100%	0 0.0%	0 0.0%
Legal advocacy	1	0 0.0%	0 0.0%	0 0.0%	1 100%	1 100%
Supported education/training	1	0 0.0%	0 0.0%	0 0.0%	1 100%	1 100%
Wrap-around services	1	0 0.0%	1 100%	1 100%	0 0.0%	0 0.0%
Youth education	1	0 0.0%	1 100%	0 0.0%	0 0.0%	0 0.0%
In-home family services	0	na	na	na	na	na
Neuropsychological services	0	na	na	na	na	na
Payeeships	0	na	na	na	na	na
Therapeutic foster care	0	na	na	na	na	na

*Note: Family therapy, by definition, applies to all age groups.
**Note that not all organizations that indicated they provide a particular service also specified the age groups to which the service is provided.

Table 89. Age Groups to which Services Provided by Direct Service Providers are Offered – By Organization Groupings

Small Providers (serve less than 250 clients annually)

Service	No. of orgs that provide the service	Age Groups**				
		0-5	6-14	15-17	18-64	65+
Assistance to hearing-impaired	1	0	0	0	1	1
Assistance to non-English	1	0	0	0	1	1
Case management	6	0	3	3	4	3
Court-ordered work	4	0	0	0	4	2
Drug screening services	2	0	0	1	2	1
Emergency and crisis services	1	0	1	1	0	0
Family support services	1	0	1	1	0	0
Family therapy and/or counseling	3	*	*	*	*	*
General daily living activities	3	0	1	1	2	2
Group therapy and/or counseling	7	0	3	2	5	3
Home-based services	2	0	1	1	1	1
Homeless services	1	0	0	0	1	1
Housing services	2	0	0	0	2	1
Independent living services	1	0	0	1	0	0
Individual therapy and/or counseling	9	0	3	2	6	3
Information and referral services	4	0	0	3	4	3
In-home family services	0	na	na	na	na	na
Legal advocacy	1	0	0	0	1	1
Meal services	2	0	1	1	1	1
Medication management	5	0	2	2	3	2
Mental retardation/developmental	1	0	0	0	1	1

disabilities services						
Money management	2	0	0	0	2	2
Neuropsychological services	0	na	na	na	na	na
Nutrition services	1	0	0	0	1	1
Parenting education	3	0	2	1	1	0
Payeeships	0	na	na	na	na	na
Primary health care	2	0	1	1	2	2
Psychological testing	3	0	1	0	2	1
School-based services	0	na	na	na	na	na
Specialized services for the elderly	2	0	0	0	2	2
Supported education/training	1	0	0	0	1	1
Supported employment	1	0	0	0	1	0
Therapeutic foster care	0	na	na	na	na	na
Transportation services	3	0	1	1	2	2
Wrap-around services	0	na	na	na	na	na
Youth education	1	0	1	0	0	0

Medium Providers (serve 250 – 999 clients annually)						
Service	**No. of orgs that provide the service**	**Age Groups****				
		0-5	**6-14**	**15-17**	**18-64**	**65+**
Assistance to hearing-impaired	2	0	0	0	2	1
Assistance to non-English	2	1	0	0	1	1
Case management	3	0	1	1	3	2
Court-ordered work	3	0	0	0	3	2
Drug screening services	1	0	0	0	1	1
Emergency and crisis services	2	0	0	0	2	2
Family support services	0	na	na	na	na	na
Family therapy and/or counseling	4	*	*	*	*	*
General daily living activities	0	na	na	na	na	na
Group therapy and/or counseling	5	0	0	1	5	4
Home-based services	1	0	0	0	1	0
Homeless services	1	0	0	0	1	1
Housing services	1	0	0	0	1	1
Independent living services	0	na	na	na	na	na
Individual therapy and/or counseling	7	2	3	4	7	5
Information and referral services	5	1	2	2	5	1
In-home family services	0	na	na	na	na	na
Legal advocacy	0	na	na	na	na	na
Meal services	1	0	0	0	1	1
Medication management	4	1	1	2	4	3
Mental retardation/developmental disabilities services	2	1	1	2	2	2
Money management	1	0	0	1	1	0
Neuropsychological services	0	na	na	na	na	na
Nutrition services	1	0	0	0	1	1

Parenting education	0	na	na	na	na	na
Payeeships	0	na	na	na	na	na
Primary health care	0	na	na	na	na	na
Psychological testing	3	2	2	2	3	3
School-based services	0	na	na	na	na	na
Specialized services for the elderly	0	na	na	na	na	na
Supported education/training	0	na	na	na	na	na
Supported employment	0	na	na	na	na	na
Therapeutic foster care	0	na	na	na	na	na
Transportation services	0	na	na	na	na	na
Wrap-around services	0	na	na	na	na	na
Youth education	0	na	na	na	na	na
Large Providers (serve 1,000 + clients annually)						
Service	**No. of orgs that provide the service**	**Age Groups****				
		0-5	**6-14**	**15-17**	**18-64**	**65+**
Assistance to hearing-impaired	3	1	2	2	3	2
Assistance to non-English	2	1	2	2	2	2
Case management	2	0	2	2	2	1
Court-ordered work	5	1	2	3	5	3
Drug screening services	2	1	1	2	2	2
Emergency and crisis services	5	1	3	3	4	3
Family support services	2	0	0	0	1	1
Family therapy and/or counseling	5	*	*	*	*	*
General daily living activities	0	na	na	na	na	na
Group therapy and/or counseling	5	1	4	4	4	3
Home-based services	2	0	0	0	1	1
Homeless services	1	0	1	1	1	1
Housing services	0	na	na	na	na	na
Independent living services	0	na	na	na	na	na
Individual therapy and/or counseling	6	2	5	5	6	5
Information and referral services	4	1	2	2	4	3
In-home family services	0	na	na	na	na	na
Legal advocacy	0	na	na	na	na	na
Meal services	1	1	1	1	1	1
Medication management	4	1	2	2	3	3
Mental retardation/developmental disabilities services	1	0	0	0	1	0
Money management	1	0	0	0	1	0
Neuropsychological services	0	na	na	na	na	na
Nutrition services	2	1	1	1	2	2
Parenting education	2	0	0	0	1	0
Payeeships	0	na	na	na	na	na
Primary health care	1	0	0	0	1	1
Psychological testing	1	0	1	1	1	0

School-based services	3	0	3	3	0	0
Specialized services for the elderly	2	0	0	0	1	2
Supported education/training	0	na	na	na	na	na
Supported employment	2	0	0	0	2	1
Therapeutic foster care	0	na	na	na	na	na
Transportation services	0	na	na	na	na	na
Wrap-around services	1	0	1	1	0	0
Youth education	0	na	na	na	na	na

*Note: Family therapy, by definition, applies to all age groups.
**Note that not all organizations that indicated they provide a particular service also specified the age groups to which the service is provided.

Secondary Data Related to Ancillary Services

The following tables indicate the types of services offered by substance abuse treatment facilities across Indiana. As noted, the vast majority of facilities indicate they offer ancillary services and transitional services. Other frequently offered services include assessment and pre-treatment services, counseling, and substance abuse education.

Table 90. N-SSATS Indiana Profile - Types of Services Offered, 2007		
Type	Facilities[1]	
	No.	%
Assessment and pre-treatment services	317	98.8
Screening for substance abuse	304	94.7
Comprehensive substance abuse assessment or diagnosis	300	93.5
Screening for mental health disorders	227	70.7
Comprehensive mental health assessment or diagnosis	189	58.9
Outreach to persons in community who may need treatment	158	49.2
Interim services for clients when immediate admission is not possible	139	43.3
Counseling	317	98.8
Individual counseling	282	87.9
Group counseling	289	90.0
Family counseling	259	80.7
Marital/couples counseling	178	55.5
Pharmacotherapies	187	58.3
Medications for psychiatric disorders	163	50.8
Campral	87	27.1
Antabuse	83	25.9
Nicotine replacement	62	19.3
Naltrexone	68	21.2
Buprenorphine	54	16.8
Subutex	34	10.6

Suboxone	53	16.5
Methadone	14	4.4
Testing	295	91.9
Drug or alcohol urine screening	260	81.0
Breathalyzer or other blood alcohol testing	210	65.4
TB screening	112	34.9
HIV testing	67	20.9
Screening for Hepatitis C	69	21.5
Screening for Hepatitis B	74	23.1
STD testing	49	15.3
Transitional services	305	95.0
Discharge planning	288	89.7
Aftercare/continuing care	272	84.7
Ancillary services	314	97.8
Substance abuse education	296	92.2
Case management services	240	74.8
Social skills development	213	66.4
HIV or AIDS education, counseling, or support	140	43.6
Mental health services	219	68.2
Assistance with obtaining social services	173	53.9
Health education other than HIV/AIDS	109	34.0
Self-help groups	135	42.1
Mentoring/peer support	104	32.4
Assistance in locating housing for clients	135	42.1
Transportation assistance to treatment	97	30.2
Domestic violence services	161	50.2
Employment counseling or training for clients	124	38.6
Early intervention for HIV	48	15.0
Child care for clients' children	23	7.2
Acupuncture	9	2.8
Residential beds for clients' children	6	1.9

Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

Table 91. N-SSATS Indiana Profile - Programs for Special Groups, 2007		
Program	Facilities	
	No.	%
Any program or group	254	79.1
Co-occurring disorders	113	35.2
Adult women	68	21.2
Adolescents	126	39.3
DUI/DWI offenders	116	36.1
Criminal justice clients	93	29.0
Adult men	48	15.0
Pregnant or postpartum women	19	5.9
Persons with HIV or AIDS	16	5.0
Seniors or Older Adults	16	5.0
Gays or lesbians	15	4.7
Other groups	26	8.1

Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

Table 92. N-SSATS Indiana Profile - Services for the Hearing Impaired and in Languages Other than English, 2007		
Services	Facilities	
	No.	%
Hearing impaired/sign language	119	37.1
Any language other than English	148	46.1
Spanish	62	96.9
American Indian/Alaska Native languages	2	3.1
Other	9	14.1
Services Provided by:		
On-call interpreter	84	56.8
Staff counselor	47	31.8
Both staff counselor and on-call interpreter	17	11.5

Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

Goal Three: To assess the capacity of providers to deliver mental health and addiction services and how individual organizations function and work together to accomplish service delivery.

The purpose of this goal is to determine the degree to which organizations are able to deliver mental health and addiction services given the number of professionals they employ to treat clients and other administrative frameworks that exist in their organization. Additionally, this goal relates to the level of collaboration and integration of services that exist among providers. The following are specific indicators associated with this goal. Except for items related to collaboration, indicators for Goal 3 were included in the direct service provider Inventory of Addiction and Mental Health Services only.

Indicator 3.1 The total number of individuals served in the last annual reporting period (unduplicated count)

Indicator 3.2 The number of individuals placed on waiting lists during the last annual reporting period

Indicator 3.3 The average amount of time individuals must wait to receive services

Indicator 3.4 Fees for service, the specific methods of payment for services, and the percentage of individuals who utilize each payment method

Indicator 3.5 The percentage of clients who are unable to pay for services

Indicator 3.6 The degree to which organizations offer assistance to clients for the cost of services

Indicator 3.7 The total number of full-time and part-time employees within each organization

Indicator 3.8 The number of specific mental health and addiction professionals (e.g., psychiatrists, licensed clinical social workers, psychiatric nurses) employed by each organization and the number of vacant positions

Indicator 3.9 The number of short-term and long-term residential beds allotted by each organization

Indicator 3.10 How often responding organizations collaborate with other service providers and how often service providers in general collaborate with one another

Summary of Findings

Number of individuals served: Over 27,000 unduplicated individuals were served in the last reporting year by the 22 organizations that provided data related to total clients served. Two organizations did not provide numbers-served data. As would be expected, large organizations, which serve at least 1,000 clients annually, served the vast majority of the total population served.

Number of individuals on waiting lists: The vast majority (83.3%) of responding organizations indicated that there were no individuals placed on a waiting list during their last reporting period.

Average amount of time individuals must wait to receive services: Most organizations (68.2%) indicated that clients are able to receive services in less than seven days or with no waiting time at all.

Fees and methods of payment: Eighty-three percent of responding organizations have fees for their services, and this rate is fairly consistent across all organization size groupings. The most common method of payment is self-payment, with 85% of direct service providers indicating they accept this method of payment. The next highest methods of payment include private insurance (65%), Medicaid (65%), and Medicare (50%). The least common method of payment is other public insurance. Further, 40% of responding organizations indicated they do have situations when they offer services as charity cases, or no fees charged.

Clients who are unable to pay for services: A total of 14 responding organizations indicated whether they have clients who are not able to pay for services. Sixty-five percent (9/14) of organizations indicated that they had clients who were unable to pay for services, whereas the remaining approximate one-third (5/14) indicated that none of their clients fall into this category. Of the 9 organizations indicating that some clients could not pay for services, 5 (56%) of these organizations indicated this was the case for 1-10% of clients, 1 (11%) indicated 11-25% of clients, 2 (22%) indicated 26-50% of clients, and 1 (11%) indicated that over 75% of its clients are unable to pay for services.

Types of financial assistance provided to clients: Overall, approximately 76% of responding organizations indicated they offer assistance to clients to pay for services. It appears that medium and large organizations are more equipped to provide such assistance than small organizations. Half of those who offer assistance use a sliding scale, and half indicated other forms of payment.

Number of full-time and part-time employees: Of the 23 organizations that provided employee counts, a total of 983 employees were identified, including 776 full-time employees, 164 part-time employees, and 43 PRN (pro re nata, or as needed) employees.

Number of specific mental health and addiction professionals: Responding organizations indicated that 477 individuals were employed in mental health and/or addiction service roles. The largest categories include psychiatric-mental health nurses (140 employed), licensed clinical social workers (86 employed), case managers (43 employed), master of social work employees (36 employed), and licensed practical nurses (36 employed). While many of the job titles do not have vacancies reported by the organizations, the largest shortages based on the number of total positions reported included LPNs (25% of total positions unfilled), clinical psychologists (20% of total positions unfilled), and psychiatrists (12.5% of total positions unfilled).

Number of short-term and long-term residential beds: Of the three responding organizations that have short-term residential beds, a total of 90 beds are available. Of the three responding organizations that have long-term residential beds, a total of 119 beds are available.

Level of collaboration: Both direct and ancillary service providers were asked to indicate the level of collaboration they have with other service providers and the level of collaboration that service providers in general demonstrate. The majority of respondents indicated they collaborate 'often' with others. In terms of ancillary providers, non-schools reported collaborating with other service providers more so than schools. Further, direct service providers reported an even higher level of collaboration with others than ancillary service providers.

Indicator 3.1 The total number of individuals served in the last annual reporting period (unduplicated count)

As shown in the table below, over 27,000 unduplicated individuals were served in the last reporting year by the 22 organizations that provided data related to total clients served. Two organizations did not provide numbers-served data. Subgroup categories for these two organizations were assigned based on publically available data regarding numbers served and/or the number of staff employed by the organizations. Large organizations, which serve at least 1,000 clients annually, served the vast majority of the total population served.

Table 93. Number of individuals served in the last annual reporting period by respondent organizations (unduplicated count)				
Value	All Respondents (N=22)*	Small Orgs. (N=9)	Medium Orgs. (N=6)	Large Orgs. (N=7)
Minimum	20	20	300	1,027
Maximum	9,536	211	562	9,536
Median	330.5	142	372	2,300
Total	27,253	1,209	2,377	23,667

*Note: A total of 22 organizations provided unduplicated counts of individuals served in the last reporting period.

Indicator 3.2 The number of individuals placed on waiting lists during the last annual reporting period

As shown in the table below, the vast majority (83.3%) of organizations that responded to the item indicated that there were no individuals placed on a waiting list during their last reporting period.

Table 94. Number of individuals placed on waiting lists during annual reporting period – All Respondents (N = 18)*	
Number on waiting list	Number of organizations
0	15
24	1
81	1
Very Few	1

*Note: A total of 18 organizations indicated the number of individuals who are placed on a waiting list. As noted, one organization specified “Very Few.”

Indicator 3.3 The average amount of time individuals must wait to receive services

As shown in the table below, most organizations (68.2%) indicated that clients are able to receive services in less than seven days or with no waiting time at all.

Table 95. Average amount of time individuals must wait to receive services				
Amount of wait time	All Respondents (N=22)*	Small Orgs. (N=8)	Medium Orgs. (N=7)	Large Orgs. (N=7)
No wait time	5	2	2	1
Less than 24 hours	1	0	0	1
1 to 7 days	10	3	4	3
14 days (2 weeks)	3	2	0	1
4 to 6 weeks	1	1	0	0
Counseling – 1 to 2 weeks; evaluations – 3 to 6 months	1	0	1	0
If for a physician, wait can be 3 to 4 weeks	1	0	0	1

*Note: A total of 22 organizations specified the wait time to receive services.

Indicator 3.4 Fees for service, the specific methods of payment for services, and the percentage of individuals who utilize each payment method

As shown below, approximately 83% of the organizations have fees for their services, and this rate is fairly consistent across all organization size groupings.

Table 96. Are there fees for services provided by responding organizations?								
Response	All Respondents (N=24)*		Small Orgs. (N=10)		Medium Orgs. (N=7)		Large Orgs. (N=7)	
	N	Percent	N	Percent	N	Percent	N	Percent
Yes	20	83.3%	8	80.0%	6	85.7%	6	85.7%
No	4	16.7%	2	20.0%	1	14.3%	1	14.3%

*Note: A total of 24 organizations indicated whether there are fees for their services.

In terms of methods of payment for services, the most common method is self-payment, with 85% of direct service providers indicating they accept this method of payment. The next highest methods of payment include private insurance (65%), Medicaid (65%), and Medicare (50%). The least common method of payment is other public insurance. Further, 40% of responding organizations indicated they do have situations when they offer services as charity cases, or no fees charged. Findings are presented in the following table.

Table 97. Methods of payment for services								
Method of Payment	Do clients use the specified method of payment?							
	All Respondents (N=20)*		Small Orgs. (N=8)		Medium Orgs. (N=6)		Large Orgs. (N=6)	
	Yes	No	Yes	No	Yes	No	Yes	No
Private insurance	13 65.0%	7 35.0%	5 62.5%	3 37.5%	4 66.7%	2 33.3%	4 66.7%	2 33.3%
Medicaid	13 65.0%	7 35.0%	5 62.5%	3 37.5%	3 50.0%	3 50.0%	5 83.3%	1 16.7%
Medicare	10 50.0%	10 50.0%	3 37.5%	5 62.5%	3 50.0%	3 50.0%	4 66.7%	2 33.3%
Other public insurance	1 5.0%	19 95.0%	0 0.0%	8 100%	1 16.7%	5 83.3%	0 0.0%	6 100%
Military insurance	7 35.0%	13 65.0%	1 12.5%	7 87.5%	2 33.3%	4 66.7%	4 66.7%	2 33.3%
Self payment	17 85.0%	3 15.0%	5 62.5%	3 37.5%	6 100%	0 0.0%	6 100%	0 0.0%
Charity (no fees charged)	8 40.0%	12 60.0%	1 12.5%	7 87.5%	3 50.0%	3 50.0%	4 66.7%	2 33.3%
Employee assistance program	4 20.0%	16 80.0%	1 12.5%	7 87.5%	1 16.7%	5 83.3%	2 33.3%	4 66.7%
Other forms of payment**	7 35.0%	13 65.0%	3 37.5%	5 62.5%	3 50.0%	3 50.0%	1 16.7%	5 83.3%

*Note: A total of 20 organizations indicated that there are fees for their services and specified a method of payment.

**Other forms of payment include: Access to Recovery; grants; indigent; and Vocational Rehabilitation psychological evaluations

Secondary Data Related to Payment for Services

The following table indicates the types of payment that are accepted by substance abuse treatment facilities across Indiana. As noted, the most common form of payment accepted is cash or self-payment followed by private health insurance. Note that approximately 37% of the organizations indicate that they provide treatment at no charge for clients who are unable to pay for services.

Table 98. N-SSATS Indiana Profile - Type of Payment Accepted, 2007		
Type	Facilities[1]	
	No.	%
Cash or self-payment	317	98.8
Private health insurance	256	79.8
Medicare	184	57.3
Medicaid	192	59.8
Other state-financed health insurance	157	48.9
Federal military insurance	157	48.9
Access to Recovery (ATR) vouchers	0	0.0
No payment accepted	0	0.0
Accepts other payments	22	6.9
Sliding fee scale	242	75.4
Treatment at no charge for clients who cannot pay	120	37.4

Source: Substance Abuse and Mental Health Services Administration, National Survey of Substance Abuse Treatment Services

Methods of Payment from Mental Health and Addiction Study

Among organizations that participated in the needs assessment study, the highest percentage of clients pay for services with private insurance, followed closely by Medicaid and Medicare. The smallest percentage of consumers pay for services through an employee assistance program and military insurance.

Table 99. Percent of consumers who pay for services using each method of payment – All Respondents				
Method of payment	N	Minimum	Maximum	Median
Private insurance	13	0.03%	75.00%	30.00%
Medicaid	13	1.00%	99.97%	28.00%
Medicare	10	2.00%	79.00%	24.00%
Other public insurance	1	Not specified	Not specified	Not specified
Military insurance	7	0.90%	5.00%	1.50%
Self payment	17	1.00%	100%	5.19%
Charity (no fees charged)	8	1.00%	23.00%	6.23%
Employee assistance program	16	0.90%	24.00%	1.00%
Other forms of payment**	7	1.00%	100%	24.5%

Table 100. Percent of consumers who pay for services using each method of payment – By Organization Grouping				
Small Providers (serve less than 250 clients annually)				
Method of payment	**N**	**Minimum**	**Maximum**	**Median**
Private insurance	5	0.03%	65.00%	30.00%
Medicaid	5	1.00%	99.97%	28.00%
Medicare	3	29.00%	50.00%	35.00%
Other public insurance	0	na	na	Na
Military insurance	1	2.00%	2.00%	2.00%
Self payment	5	1.00%	1005	33.00%
Charity (no fees charged)	1	1.00%	1.00%	1.00%
Employee assistance program	1	No data	No data	No data
Other forms of payment**	3	1.00%	100%	39.00%
Medium Providers (serve 250 – 999 clients annually)				
Method of payment	**N**	**Minimum**	**Maximum**	**Median**
Private insurance	4	2.50%	75.00%	38.75%
Medicaid	3	2.00%	50.00%	26.00%
Medicare	3	10.00%	10.00%	10.00%
Other public insurance	1	No data	No data	No data
Military insurance	2	1.00%	2.00%	1.50%
Self payment	6	1.00%	90.00%	50.00%
Charity (no fees charged)	3	10.00%	10.00%	10.00%
Employee assistance program	1	1.00%	1.00%	1.00%
Other forms of payment**	3	1.00%	50.00%	10.00%
Large Providers (serve 1,000 + clients annually)				
Method of payment	**N**	**Minimum**	**Maximum**	**Median**
Private insurance	4	10.00%	66.00%	29.03%
Medicaid	5	2.00%	38.33%	22.50%
Medicare	4	2.00%	79.00%	20.38%
Other public insurance	0	na	na	na
Military insurance	4	0.90%	5.00%	1.00%
Self payment	6	1.00%	5.19%	2.00%
Charity (no fees charged)	4	1.00%	23.00%	2.46%
Employee assistance program	2	0.90%	24.00%	12.45%
Other forms of payment**	1	No data	No data	No data

Indicator 3.5 The percentage of clients who are unable to pay for services

A total of 14 organizations indicated whether they have clients who are not able to pay for services. Approximately one-third indicated that none of their clients fall into this category, and approximately one-third indicated 1-10% of their clients fit this description. One organization indicated that over 75% of its clients are unable to pay for services.

Table 101. Percent of clients who are not able to pay for services								
Percent of Clients	All Respondents (N=14)*		Small Orgs. (N=7)		Medium Orgs. (N=2)		Large Orgs. (N=5)	
	N	Percent of Respondents	N	Percent of Respondents	N	Percent of Respondents	N	Percent of Respondents
0%	5	35.7%	4	57.1%	1	50.0%	0	0.0%
1 – 10%	5	35.7%	2	28.6%	1	50.0%	2	40.0%
11 – 25%	1	7.1%	0	0.0%	0	0.0%	1	20.0%
26 – 50%	2	14.2%	1	14.3%	0	0.0%	1	20.0%
51 – 75%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
76 – 100%	1	7.1%	0	0.0%	0	0.0%	1	20.0%

*Note: A total of 14 organizations indicated whether their clients are able to pay for services.

Indicator 3.6 The degree to which organizations offer assistance to clients for the cost of services

Overall, approximately 76% of responding organizations indicated they offer assistance to clients to pay for services. It appears that medium and large organizations are more equipped to provide such assistance than small organizations. Half of those who offer assistance use a sliding scale, and half indicated other forms of payment.

Table 102. Do you offer assistance to consumers to pay for services?								
Response	All Respondents (N=21)*		Small Orgs. (N=8)		Medium Orgs. (N=6)		Large Orgs. (N=7)	
	N	Percent	N	Percent	N	Percent	N	Percent
Yes**	16	76.2%	4	50.0%	6	100%	6	85.7%
No	5	23.8%	4	50.0%	0	0.0%	1	14.3%

*Note: A total of 21 organizations indicated whether they offer assistance to consumers.
**Of those who offer assistance, 8 indicated that they have a sliding scale based on income. A total of 8 organizations indicated other forms of payment including: adjusted rate; United Way; assistance determined by monthly income (range 10-100%); payment plan; installment; other financial plan; some arrangements made on case-by-case basis; and sometimes work out a payment plan.

Secondary Data Related to Health Insurance Coverage

The following tables provide supporting documentation related to the health insurance status of individuals in the United States, Indiana, and local communities. These data may be used as a reference to determine the degree to which individuals in the community are able to pay for health services.

Table 103. 2005 Health Insurance Coverage Status for Age (under 65 years), Income (all income levels), and sex (both sexes)							
County	No. Insured	MOE for No. Insured	No. Uninsured	MOE for No. Uninsured	No. in Demographic Group	% Uninsured	MOE for % Uninsured
Gibson	24,761	677	3,656	672	28,417	12.9%	2.4%
Posey	20,544	492	2,905	485	23,449	12.4%	2.1%
Vanderburgh	126,349	3,084	18,403	2,971	144,751	12.7%	2.1%
Warrick	44,637	1,042	5,946	1,009	50,583	11.8%	2.0%
Indiana	4,672,110	40,939	786,664	38,879	5,458,773	14.4%	0.7%

Source: U.S. Census Bureau, Small Area Health Insurance Estimates

Table 104. Health Insurance Coverage of the Total Population, Indiana (2006/2007) and United States (2007)				
Type	IN Number	IN Percent	US Number	US Percent
Employer	3,832,574	61%	159,311,384	53%
Individual	241,215	4%	14,541,782	5%
Medicaid	685,776	11%	39,155,452	13%
Medicare	774,590	12%	36,155,452	12%
Other Public	27,811	0%	3,253,122	1%
Uninsured	732,256	12%	45,657,193	15%
Total	6,294,222	100%	298,215,356	100%

Source: Primary-Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements); Secondary-The Henry J. Kaiser Family Foundation, statehealthfacts.org

Table 105. Health Insurance Coverage of Nonelderly 0-64, Indiana (2006/2007) and United States (2007)				
Type	IN Number	IN Percent	US Number	US Percent
Employer	3,843,849	69%	159,106,557	61%
Individual	237,996	4%	14,347,160	5%
Medicaid	656,077	12%	36,359,407	14%
Other Public	96,472	2%	6,642,562	3%
Uninsured	722,376	13%	44,970,781	17%
Total	5,556,769	100%	261,426,467	100%

Source: Primary-Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements); Secondary-The Henry J. Kaiser Family Foundation, statehealthfacts.org

Table 106. Health Insurance Coverage of Adults 19-64, Indiana (2006/2007) and United States (2007)				
Type	IN Number	IN Percent	US Number	US Percent
Employer	2,765,253	71%	115,601,757	63%
Individual	179,110	5%	10,889,568	6%
Medicaid	226,023	6%	14,648,289	8%
Other Public	91,684	2%	5,542,938	3%
Uninsured	608,795	16%	36,098,694	20%
Total	3,870,866	100%	182,781,246	100%

Source: Primary-Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements); Secondary-The Henry J. Kaiser Family Foundation, statehealthfacts.org

Table 107. Health Insurance Coverage of Children 0-18, Indiana (2006/2007) and United States (2007)				
Type	IN Number	IN Percent	US Number	US Percent
Employer	1,078,595	64%	43,504,800	55%
Individual	58,886	4%	3,457,592	4%
Medicaid	430,053	26%	21,711,118	28%
Other Public	NSD	NSD	1,099,624	1%
Uninsured	113,581	7%	8,872,087	11%
Total	1,685,904	100%	78,645,221	100%

Source: Primary-Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2007 and 2008 Current Population Survey (CPS: Annual Social and Economic Supplements); Secondary-The Henry J. Kaiser Family Foundation, statehealthfacts.org

Table 108. Distribution of 1996 U.S. population and mental disorder direct costs by insurance status		
Insurance Status	Population	Direct Costs
Private	63%*	47%
Public	***	53%
Medicare	13%*	14%
Medicaid	12%**	19%
Uninsured	***	--
State/Local	16%	18%
Other Federal	***	2%
Total	100%	100%

*About 70 percent of the population has some private insurance—reflecting the fact that 7 percent of the population has both Medicare and Medigap or other dual private insurance coverage. Although 61 percent of the population has employment-base private insurance, this percentage also includes some military insurance coverage.
**Since 2 percent of the population has both Medicare and Medicaid insurance coverage, adding this duplicated count to each insurance category results in the first column adding to a duplicated total of 104 percent.
***Although some state/local/and other Federal government support goes to those who are underinsured in the private and public insured groups, these funds are primarily allocated to the uninsured population.
Source: Primary – Mark, T., McKusick, D., King, E., Harwood, H., & Genuardi, J. (1998). *National expenditures for mental health, alcohol, and other drug abuse treatment, 1996*. Rockville, MD: Substance Abuse and Mental Health Services Administration; Secondary - Mental Health: A Report of the Surgeon General, 1999
Source: Substance Abuse and Mental Health Services Administration, Center for Mental Health Services (CMHS), Survey of Mental Health Organizations

Table 109. Medicare Beneficiaries by County, 2005		
County	Elderly (65+)	Disabled
Gibson	4,957	732
Posey	3,163	503
Vanderburgh	25,305	4,933
Warrick	5,846	981

Source: Primary – HRSA, Area Resource File, 2005; Secondary – Community Health Status Indicators, U.S. Department of Health & Human Services

Table 110. Medicaid Statistics Highlights by County, December 2007				
Category	Gibson	Posey	Vanderburgh	Warrick
Enrollment by Service Delivery and Total Expenditure				
Total Medicaid Enrollment	3,927	2,558	25,748	4,689
Risk-Based Managed Care Enrollment	2,347	1,603	15,558	2,770
Traditional Medicaid Enrollment	1,406	835	8,851	1,679
Medicaid Select Enrollment	174	120	1,329	240
Total Medicaid Expenditure	$1,755,435	$1,084,240	$11,629,746	$2,580,403
Enrollment by Aid Category Grouping				
Aged (Including Partials)	496	246	2229	657
Blind and Disabled (Including Dual/Non-Dual and Partials)	612	413	4150	788
Adult	358	332	3153	331
Child	2,014	1,318	13,778	2,225
CHIP	342	194	1740	552
Pregnant Women	105	55	698	136
Nursing Facility Information				
Number of Nursing Facilities	5	3	13	7
Number of Nursing Facility Recipients	189	102	821	371
Nursing Facility Payments	$604,919	$317,513	$2,838,516	$1,139,354
Average Payment Per Recipient	$3,201	$3,113	$3,457	$3,071
HoosierRx Information				
HoosierRx Participants for December 2007	22	12	122	16

Source: Indiana Family and Social Services Administration

Indicator 3.7 The total number of full-time and part-time employees within each organization

Overall, the 23 organizations that provided employee counts indicated they employ a total of 983 individuals, including 776 full-time employees, 164 part-time employees, and 43 PRN (pro re nata, or as needed) employees.

Table 111. Number of individuals employed by responding organizations – All Respondents (N = 23)*				
Employees	Minimum	Maximum	Median	Total
All employees	1	225	14	983**
Full-time employees	0	199	8	776
Part-time employees	0	44	3	164

*Note: A total of 23 organizations provided employee counts.
**A total of 43 PRN employees are included in this total.

Table 112. Number of individuals employed by responding organizations – By Organization Grouping				
Small Providers (serve less than 250 clients annually)				
Employees	Minimum	Maximum	Median	Total
All employees	1	114	20.5	289
Full-time employees	0	114	14	253
Part-time employees	0	13	1.5	34
Medium Providers (serve 250 – 999 clients annually)				
Employees	Minimum	Maximum	Median	Total
All employees	4	11	6	39
Full-time employees	3	6	4	25
Part-time employees	0	7	1.5	14
Large Providers (serve 1,000 + clients annually)				
Employees	Minimum	Maximum	Median	Total
All employees	6	225	22	655
Full-time employees	5	199	17	496
Part-time employees	0	44	9	116

Indicator 3.8 The number of specific mental health and addiction professionals (e.g., psychiatrists, licensed clinical social workers, psychiatric nurses) employed by each organization and the number of vacant positions

As shown in the table below, responding organizations indicated they employ a total of 477 individuals in mental health and/or addiction service roles. The largest categories include psychiatric-mental health nurses (140 employed), licensed clinical social workers (86 employed), case managers (43 employed), master of social work employees (36 employed), and licensed practical nurses (36 employed). While many of the job titles do not have vacancies reported by the organizations, the largest shortages based on the number of total positions reported included LPNs (25% of total positions unfilled), clinical psychologists (20% of total positions unfilled), and psychiatrists (12.5% of total positions unfilled).

Table 113. Employee counts for mental health and addiction positions (N = 24)*

Job Role/Title	Number of organizations with job role/title	Total Current Employees	Total Vacancies
Psychiatrist	8	21	3
Other physicians[1]	6	7	0
Clinical psychologist	6	8	2
Licensed Clinical Social Worker (LCSW)	19	86	1
Master of Social Work (MSW)	10	36	0
Bachelor of Social Work (BSW)	6	11	1
Psychiatric-Mental Health Nurse (RN)	11	140	6
Licensed Practical Nurse (LPN)	4	36	12
Clinical Nurse Specialist	3	5	0
Nurse Practitioner	6	10	1
Licensed Professional Counselor	9	21	0
Case Manager	5	43	0
Certified Alcohol & Drug Counselor (CADC)	6	8	0
Volunteers who provide service (individuals are not employees-served on voluntary basis only)	1	10	0
Other licensed professionals[2]	4	15	0
Other certified professionals[3]	4	9	0
Other job roles/titles[4]	6	11	0
Totals	--	477	26

*Note: A total of 24 organizations provided employee counts for mental health and addiction positions.
[1]Other physicians listed include: Addictionologist and MD.
[2]Other licensed professionals include: Marriage and Family Therapist; Occupational Therapist; RN (non-psychiatric)
[3]Other certified professionals include: Certified Recreation Therapy Specialist; CMA
[4]Other job roles/titles include: clerical; certified nursing assistant (CNA); Master's degree level counselor; Master's mental health counseling; office manager; support staff

Secondary Data Related to Health Professionals

The following tables provide local and state data related to the number of persons employed in various health professions. Specific tables related to mental health positions are included.

Table 114. Indiana health professionals, Gibson County and Indiana, 2005				
Job Title*	Gibson No.	Gibson % of all professionals	Indiana No.	Indiana % of all professionals
Audiologist	1	0.1%	313	0.2%
Chiropractor	3	0.4%	950	0.6%
Clinical Social Worker	8	1.0%	3,126	2.1%
Certified Nurse/Midwife	0	0.0%	75	0.1%
Clinical Nurse Specialist	1	0.1%	133	0.1%
Dental Hygienist	19	2.4%	3,472	2.3%
Dentist	13	1.6%	3,133	2.1%
Dietician	2	0.2%	899	0.6%
LPN	127	15.8%	23,232	15.5%
Marriage & Family Therapist	4	0.5%	911	0.6%
Mental Health Counselor	2	0.2%	1,295	0.9%
Nurse/Midwife	0	0.0%	57	0.0%
Nurse Practitioner	2	0.2%	1,590	1.1%
Occupational Therapist	9	1.1%	1,939	1.3%
Occupational Therapy Asst.	5	0.6%	572	0.4%
Optometrist	6	0.7%	1,078	0.7%
Pharmacist	25	3.1%	6,114	4.1%
Physical Therapist	20	2.5%	3,210	2.1%
Physical Therapy Asst.	29	3.6%	1,499	1.0%
Physician	22	2.7%	13,275	8.9%
Physician Asst.	1	0.1%	430	0.3%
Psychologist	2	0.2%	1,101	0.7%
RN	435	54.2%	67,950	45.4%
Respiratory Care Practitioner	22	2.7%	3,473	2.3%
Social Worker	7	0.9%	2,083	1.4%
Speech Pathologist	6	0.7%	1,610	1.1%
Total Health Professionals*	803	--	149,810	--

*While not all health professionals are shown in this table, the "Total Health Professionals" row does contain the total number of professionals in the county and state
Source: Indiana Professional Licensing Agency

Table 115. Indiana health professionals, Posey County and Indiana, 2005				
Job Title*	Posey No.	Posey % of all professionals	Indiana No.	Indiana % of all professionals
Audiologist	0	0.0%	313	0.2%
Chiropractor	3	0.6%	950	0.6%
Clinical Social Worker	8	1.6%	3,126	2.1%
Certified Nurse/Midwife	0	0.0%	75	0.1%
Clinical Nurse Specialist	0	0.0%	133	0.1%
Dental Hygienist	13	2.7%	3,472	2.3%
Dentist	7	1.4%	3,133	2.1%
Dietician	4	0.8%	899	0.6%
LPN	84	17.2%	23,232	15.5%
Marriage & Family Therapist	2	0.4%	911	0.6%
Mental Health Counselor	2	0.4%	1,295	0.9%
Nurse/Midwife	0	0.0%	57	0.0%
Nurse Practitioner	2	0.4%	1,590	1.1%
Occupational Therapist	14	2.9%	1,939	1.3%
Occupational Therapy Asst.	0	0.0%	572	0.4%
Optometrist	3	0.6%	1,078	0.7%
Pharmacist	25	5.15	6,114	4.1%
Physical Therapist	9	1.8%	3,210	2.1%
Physical Therapy Asst.	13	2.7%	1,499	1.0%
Physician	7	1.4%	13,275	8.9%
Physician Asst.	1	0.2%	430	0.3%
Psychologist	0	0.0%	1,101	0.7%
RN	244	49.9%	67,950	45.4%
Respiratory Care Practitioner	14	2.9%	3,473	2.3%
Social Worker	9	1.8%	2,083	1.4%
Speech Pathologist	6	1.2%	1,610	1.1%
Total Health Professionals*	489	--	149,810	--

*While not all health professionals are shown in this table, the “Total Health Professionals” row does contain the total number of professionals in the county and state

Source: Indiana Professional Licensing Agency

Table 116. Indiana health professionals, Vanderburgh County and Indiana, 2005				
Job Title*	Vanderburgh No.	Vanderburgh % of all professionals	Indiana No.	Indiana % of all professionals
Audiologist	11	0.2%	313	0.2%
Chiropractor	34	0.7%	950	0.6%
Clinical Social Worker	155	3.2%	3,126	2.1%
Certified Nurse/Midwife	1	0.0%	75	0.1%
Clinical Nurse Specialist	4	0.1%	133	0.1%
Dental Hygienist	113	2.3%	3,472	2.3%
Dentist	101	2.1%	3,133	2.1%
Dietician	30	0.6%	899	0.6%
LPN	567	11.7%	23,232	15.5%
Marriage & Family Therapist	45	0.9%	911	0.6%
Mental Health Counselor	25	0.5%	1,295	0.9%
Nurse/Midwife	0	0.0%	57	0.0%
Nurse Practitioner	59	1.2%	1,590	1.1%
Occupational Therapist	110	2.3%	1,939	1.3%
Occupational Therapy Asst.	28	0.6%	572	0.4%
Optometrist	43	0.9%	1,078	0.7%
Pharmacist	173	3.6%	6,114	4.1%
Physical Therapist	127	2.6%	3,210	2.1%
Physical Therapy Asst.	72	1.5%	1,499	1.0%
Physician	591	12.2%	13,275	8.9%
Physician Asst.	17	0.4%	430	0.3%
Psychologist	34	0.7%	1,101	0.7%
RN	2,091	43.1%	67,950	45.4%
Respiratory Care Practitioner	92	1.9%	3,473	2.3%
Social Worker	107	2.25	2,083	1.4%
Speech Pathologist	47	1.0%	1,610	1.1%
Total Health Professionals*	4,849	--	149,810	--

*While not all health professionals are shown in this table, the “Total Health Professionals” row does contain the total number of professionals in the county and state

Source: Indiana Professional Licensing Agency

Table 117. Indiana health professionals, Warrick County and Indiana, 2005				
Job Title*	Warrick No.	Warrick % of all professionals	Indiana No.	Indiana % of all professionals
Audiologist	2	0.1%	313	0.2%
Chiropractor	14	0.8%	950	0.6%
Clinical Social Worker	38	2.1%	3,126	2.1%
Certified Nurse/Midwife	0	0.0%	75	0.1%
Clinical Nurse Specialist	4	0.2%	133	0.1%
Dental Hygienist	48	2.6%	3,472	2.3%
Dentist	23	1.3%	3,133	2.1%
Dietician	12	0.7%	899	0.6%
LPN	232	12.8%	23,232	15.5%
Marriage & Family Therapist	15	0.8%	911	0.6%
Mental Health Counselor	11	0.6%	1,295	0.9%
Nurse/Midwife	1	0.1%	57	0.0%
Nurse Practitioner	19	1.0%	1,590	1.1%
Occupational Therapist	33	1.8%	1,939	1.3%
Occupational Therapy Asst.	3	0.2%	572	0.4%
Optometrist	9	0.5%	1,078	0.7%
Pharmacist	81	4.5%	6,114	4.1%
Physical Therapist	48	2.6%	3,210	2.1%
Physical Therapy Asst.	31	1.7%	1,499	1.0%
Physician	155	8.5%	13,275	8.9%
Physician Asst.	4	0.2%	430	0.3%
Psychologist	9	0.5%	1,101	0.7%
RN	880	48.4%	67,950	45.4%
Respiratory Care Practitioner	33	1.8%	3,473	2.3%
Social Worker	34	1.9%	2,083	1.4%
Speech Pathologist	21	1.2%	1,610	1.1%
Total Health Professionals*	1,819	--	149,810	--

*While not all health professionals are shown in this table, the “Total Health Professionals” row does contain the total number of professionals in the county and state
Source: Indiana Professional Licensing Agency

Table 118. Mental Health Professionals-Active Licenses, March 2009 (All Counties Disaggregated and Indiana)										
License Type	Gibson Pop: 32,666[1]		Posey Pop: 26,079		Vanderburgh Pop: 174,729		Warrick Pop: 57,656		Indiana Pop: 6,376,792	
	No.	Rate[2]	No.	Rate	No.	Rate	No.	Rate	No.	Rate
Clinical Social Worker	0	0.00	8	30.68	160	91.57	44	76.31	3,349	52.52
Marriage & Family Therapist	0	0.00	1	3.83	43	24.61	10	17.34	853	13.38
Mental Health Counselor	1	3.06	1	3.83	25	14.31	11	19.08	1,428	22.39
Psychiatrist	1	3.06	1	3.83	30	17.17	2	3.47	--	--
Psychologist	2	6.12	0	0.00	34	19.46	10	17.34	1,166	18.29
Social Worker	10	30.61	5	19.17	92	52.65	30	52.03	1,905	29.87

[1] Population data are 2008 U.S. Census Bureau estimates.

[2]Rate per 100,000 individuals

Source: Indiana Professional Licensing Agency; U.S. Census Bureau

Table 119. Mental Health Professionals-Active Licenses, March 2009 (All Counties Aggregated and Indiana)				
License Type	All Counties Combined[1] Population: 291,130[2]		Indiana Population: 6,376,792	
	No.	Rate[3]	No.	Rate
Clinical Social Worker	212	72.82	3,349	52.52
Marriage & Family Therapist	54	18.55	853	13.38
Mental Health Counselor	38	13.05	1,428	22.39
Psychiatrist	36	12.37	--	--
Psychologist	46	15.80	1,166	18.29
Social Worker	137	47.06	1,905	29.87

[1]Counties include: Gibson, Posey, Vanderburgh, and Warrick

[2]Population data are 2008 U.S. Census Bureau estimates.

[3]Rate per 100,000 individuals

Note: In 2006, the American Medical Association indicated there were 41,400 psychiatrists in the U.S. (rate of 13.83 per 100,000); per Dr. Christopher McDougle, Indiana University School of Medicine, Indiana ranks 43rd in the nation in the number of psychiatrists per capita (data presented at the August 19, 2008 meeting of the Indiana Commission on Mental Health)

Source: Indiana Professional Licensing Agency; U.S. Census Bureau

The following table provides a comparison of Indiana to other states on different mental health resources indicators, including the number of psychiatrists, psychologists, and social workers. As noted, Indiana has a lower per capita rate of these professionals compared to all surrounding states.

Table 120. Comparison of Indiana to Surrounding States on Mental Health Resources Indicators, 2007

Indicator	Indiana	Michigan	Ohio	Kentucky	Missouri	Illinois
State mental health authority expenditures per capita	$80.58	$90.96	$64.06	$49.69	$69.33	$68.51
No. of specialty mental health organizations providing 24 hour treatment (per 100,000 population)	1.33	0.90	1.23	1.29	1.29	1.27
No. of specialty mental health organizations providing less than 24 hour treatment (per 100,000 population)	1.07	1.08	1.58	0.88	1.09	1.48
Psychiatrists (no. per 100,000 population)	7.41	10.22	9.99	9.24	9.33	11.71
Psychologists (no. per 100,000 population)	18.34	55.82	39.58	20.64	32.35	51.00
Social workers (no. per 100,000 population)	95.22	229.66	191.18	114.80	173.72	208.27

Source: Mental Health America, *Ranking of America's Mental Health: An Analysis of Depression Across the States*, December 11, 2007

Table 121. Key Results from the Mental Health America Study "Ranking America's Mental Health: An Analysis of Depression Across the States", 2007

- On average, the higher the number of psychiatrists, psychologists, and social workers per capita in a state, the lower the suicide rate.
- The lower the percentage of the population reporting that they could not obtain healthcare because of costs, the lower the suicide rate and the better the state's depression status. In addition, the lower the percentage of the population that reported unmet mental healthcare needs, the better the state's depression status.
- Holding the baseline level of depression in the state constant, the higher the number of antidepressant prescriptions per capita in the state, the lower the suicide rate.
- The more educated the population and the greater the percentage with health insurance, the lower the suicide rate. The more educated the population, the better the state's depression status.
- The more generous a state's mental health parity coverage, the greater the number of people in the population that receive mental health services.

Source: Mental Health America, *Ranking of America's Mental Health: An Analysis of Depression Across the States*, December 11, 2007

Indicator 3.9 The number of short-term and long-term residential beds allotted by each organization

Of the three responding organizations that have short-term residential beds, a total of 90 beds are available. Of the three responding organizations that have long-term residential beds, a total of 119 beds are available.

Table 122. Residential beds operated by responding organizations		
Length of Treatment	Number of Organizations	Total Beds
Short-term	3	90
Long-term	3	119

Indicator 3.10 How often responding organizations collaborate with other service providers and how often service providers in general collaborate with one another

Both direct and ancillary service providers were asked to indicate the level of collaboration they have with other service providers and the level of collaboration that service providers in general demonstrate. On a scale of 1 to 5, where 1 is 'almost never' and 5 is 'almost always,' direct service providers had a mean of 3.57 for the level of collaboration they have with other service providers. The majority of respondents indicated they collaborate 'often' with others. In terms of ancillary providers, schools had a mean of 2.92 on the collaboration-with-others scale, compared to non-schools who had a mean of 3.29. This indicates that non-schools reported collaborating with other service providers more so than schools and that direct service providers reported an even higher level of collaboration with others than ancillary service providers.

Table 123. How often do you collaborate with other addiction and/or mental health service providers? (Direct Service Providers)							
All Respondents							
Response Options					N	Mean*	SD
Almost Never	Rarely	Sometimes	Often	Almost Always			
4.2% n=1	12.5% n=3	25.0% n=6	45.8% n=11	12.5% n=3	24	3.57	0.99
Small Providers (serve less than 250 clients annually)							
Response Options					N	Mean	SD
Almost Never	Rarely	Sometimes	Often	Almost Always			
10.0% n=1	10.0% n=1	20.0% n=2	40.0% n=4	20.0% n=2	10	3.50	1.27
Medium Providers (serve 250 – 999 clients annually)							
Response Options					N	Mean	SD
Almost Never	Rarely	Sometimes	Often	Almost Always			
0.0% n=0	0.0% n=0	42.9% n=3	57.1% n=4	0.0% n=0	7	3.57	0.54
Large Providers (serve 1,000 + clients annually)							
Response Options					N	Mean	SD
Almost Never	Rarely	Sometimes	Often	Almost Always			
0.0% n=0	28.6% n=2	14.3% n=1	42.9% n=3	14.3% n=1	7	3.43	1.13

*The higher the mean, the more often organizations indicated they collaborate with other providers.

Table 124. How often do you collaborate with other addiction and/or mental health service providers?								
Respondent Group	Response Options					N	Mean*	SD
	Almost Never	Rarely	Sometimes	Often	Almost Always			
Schools	14.1% n=10	25.4% n=18	25.4% n=18	25.4% n=18	9.9% n=7	71	2.92	1.22
Non-Schools	10.2% n=11	7.1% n=7	39.8% n=38	28.6% n=28	14.3% n=15	99	3.29	1.15

*The higher the mean, the more often organizations indicated they collaborate with other providers.

When asked to rate the level of collaboration that exists among providers in general, direct service providers had a mean of 3.14 on the same scale as before. Therefore, direct service providers rate their own level of collaboration higher than the level of collaboration in which they believe others engage. This pattern is also true with ancillary service providers. Further, when comparing schools to non-school, non-schools have a more favorable view of collaboration in general than schools.

Table 125. How often do addiction and/or mental health service providers in the area collaborate with one another?

Response Options					N	Mean*	SD
All Respondents							
Almost Never	Rarely	Sometimes	Often	Almost Always	N	Mean*	SD
0.0% n=0	21.7% n=5	52.2% n=12	21.7% n=5	4.3% n=1	23	3.14	0.77
Small Providers (serve less than 250 clients annually)							
Almost Never	Rarely	Sometimes	Often	Almost Always	N	Mean	SD
0.0% n=0	22.2% n=2	44.4% n=4	22.2% n=2	11.1% n=1	9	3.22	0.97
Medium Providers (serve 250 – 999 clients annually)							
Almost Never	Rarely	Sometimes	Often	Almost Always	N	Mean	SD
0.0% n=0	14.3% n=1	71.4% n=5	14.3% n=1	0.0% n=0	7	3.00	0.58
Large Providers (serve 1,000 + clients annually)							
Almost Never	Rarely	Sometimes	Often	Almost Always	N	Mean	SD
0.0% n=0	28.6% n=2	42.9% n=3	28.6% n=2	0.0% n=0	7	3.00	0.82

*The higher the mean, the more often organizations indicated service providers collaborate with one another.

Table 126. How often do addiction and/or mental health service providers in the area collaborate with one another?

Respondent Group	Response Options					N	Mean*	SD
	Almost Never	Rarely	Sometimes	Often	Almost Always			
Schools	12.1% n=7	27.6% n=16	43.1% n=25	15.5% n=9	1.7% n=1	58	2.67	0.94
Non-Schools	11.1% n=10	18.5% n=15	45.7% n=37	18.5% n=15	6.1% n=5	82	2.87	1.04

*The higher the mean, the more often organizations indicated service providers collaborate with one another.

Provider Focus Group Responses

To further explore levels of collaboration, providers attending focus groups were asked to describe the level of service integration. Themes are provided in the table below. Of note, while a high degree of collaboration was identified, the need to improve collaboration between certain providers was recognized.

Table 127. Provider Perceptions of Integration of Services	
8. To what extent are services in your county being integrated within the community? How well do service providers in in your county collaborate to ensure effective delivery of services?	
Providers Only	
Themes	Number of Comments
• High Levels of Collaboration among Certain Providers (e.g., legal system, schools, Drug Court, and mental health service providers)	6
• Need Improved Collaboration among Certain Providers	4
• Specific Barriers to Collaboration/Integration (e.g., not enough time to communicate, not enough staff to collaborate, some providers more interested in obtaining vouchers/payment than collaborating about services)	3
• General, Positive Comments about Collaboration (e.g., good relationships among providers)	3
• Lack of Communication (e.g., little knowledge of what services other providers are providing or have provided to an individual)	3
• Monthly Meetings (e.g., all social service providers meet once each month)	3
• School Community Council (e.g., may not include everyone that should be included, but certainly involves collaboration among a number of organizations)	3
• County-Specific Issues (e.g., a general feeling that collaboration is better within Vanderburgh County than in or with the surrounding counties)	3
• Lack of Integration (e.g., providers do not actively or deliberately work together to provide complimentary services to a single individual)	2
• Technological Collaboration (e.g., agencies like Aurora reach out to other providers through email)	1
• Hosting Speakers (e.g., organizations collaborate to jointly host guest speakers on topics relevant to mental health or addiction)	1
• Lack of Services (e.g., small number of providers in smaller communities forces communication between those that do exist)	1
• Shared Knowledge (e.g., everyone knows the "circle of things" in the community; providers are aware of what services other providers are providing)	1
• Improving Collaboration (e.g., new Safe Schools Healthy Students grant will improve collaboration in Posey County)	1
• Dedication of Provider (e.g., collaboration is dependent on how dedicated and motivated the providers are)	1

Goal Four: To assess mental health and addiction needs perceived by referral sources, providers, patients, and members of the community

The purpose of this goal is to better understand the mental health and addiction needs in the four-county study area as perceived by direct service providers, ancillary service providers, and consumers of mental health and addiction services. The following are specific indicators associated with this goal.

Indicator 4.1 The greatest addiction and/or mental health needs as perceived by direct service providers, ancillary service providers, and consumers

Indicator 4.2 The addiction and/or mental health needs that are not being adequately met by existing services as perceived by direct service providers, ancillary service providers, and consumers

Indicator 4.3 Specifically for ancillary service providers, the issues for which referrals are often made to organizations outside the four-county study area

Indicator 4.4 The greatest addiction and/or mental health strengths in the community as perceived by direct service providers, ancillary service providers, and consumers

Indicator 4.5 An indication of the specific ancillary services for which clients have need, the degree to which they have the need, and the extent to which clients receive the needed services

Indicator 4.6 The barriers to accessing mental health and addiction services that consumers experience and the degree to which certain issues pose barriers for clients

Indicator 4.7 The solutions to addressing barriers in accessing mental health and addiction services that consumers experience

Indicator 4.1 The greatest addiction and/or mental health needs as perceived by direct services providers, ancillary service providers, and consumers

Both direct service providers and ancillary service providers responded to the following open-ended question: What do you believe are the greatest addiction and/or mental health needs (e.g., issues that clients present with) in the four-county area? In terms of the greatest needs, direct service providers listed a wide range of concerns. Approximately 43% of the organizations that provided a response mentioned an issue pertaining to substance use/addiction. Specifically, providers indicated the need for additional inpatient substance abuse treatment, problems with methamphetamine addiction, and treatment for pain medication abuse. Among the mental health issues or disorders listed by direct service providers, depression and anxiety were cited most often. The actual responses provided by direct service providers may be viewed in the tables below.

Given the number of responses provided by ancillary service providers, data were aggregated for analysis. In terms of addiction, the largest number of schools mentioned methamphetamine, alcohol, and other drug addictions as the greatest concerns. Depression, ADHD, and anxiety/stress were noted as the greatest mental health needs. Other issues such as family conflict/dysfunction, parenting skills, and the lack of psychiatrists and other mental health professionals were also top rated needs.

Non-schools also listed alcohol, other drug use, and methamphetamine addiction by far as the top rated addiction needs. Depression and anxiety/stress were particularly a concern to the non-schools in terms of general mental health needs. Other top rated needs included domestic violence, early intervention, funding for programs, and funding for necessary psychiatric medications.

Table 128. Item 30: What do you believe are the greatest addiction and/or mental health needs (e.g., issues that clients present with) in the four-county area? (Direct Service Providers)
• Access to medications (high cost, lack of insurance)
• Anxiety D.O.; depression
• Developmental disabilities; depression; anxiety; ADHD; autism
• Drug addiction; acute mental illness; community supports for those with serious, persistent mental illness; child behavioral issues
• General stress; meth addiction; frequent relapse
• Geriatric depression
• High rates of depression, suicide, and addiction without adequate community resources and programs to address needs, especially for the uninsured and underinsured
• Insurance coverage for outpatient and medications
• Lack of services
• Legal issues; substance abuse; personality disorders
• More detox and inpatient services
• Narcotic addiction (i.e., Lortab); Xanax addiction; better coordination with primary medical doctor

• Need for timely services
• Pain medications treatment
• Psychiatric time
• Scope of the problems of addiction vs. those seeking/accepting help for their illness (i.e., many of those who have addiction problems are not seeking and receiving treatment for their issues)
• Suicide prevention; inpatient substance abuse treatment
• There are various trends over the years. Currently, methamphetamine is prominent as crack was years ago.
• Transportation; child care
• Treatment/management of patients with mental retardation
• Wrap around/case management services for children; services to children in the autism spectrum disorders

Table 129. What do you believe are the greatest addiction and/or mental health needs (e.g., issues that clients present with) in the four-county area? (Ancillary Service Providers - Schools (n = 53))

Issues	No. of organizations reporting need
Addiction Issues	
Meth use and addiction	8
Alcohol use and addiction	7
Drug use and addiction	7
Marijuana use	4
Prescription drug addiction	3
Substance use	3
Drugs in home/parents' drug addiction	2
Over-the-counter pill use	1
Addiction	1
Alcohol/drug education	1
Incarceration due to drug crimes	1
Fetal alcohol/drug problems	1
Specific Mental Health Disorders	
Depression	12
ADHD	6
Anxiety/stress	4
ODD	3
Bipolar	3
Childhood Disorders	2
Autism	1
Other Mental Health Concerns	
Behavior issues/fighting	5
Suicidal behaviors	3
Anger management	3
Mood management	2
Child sex abuse therapy	1

Self-esteem problems	1
Cutting	1
Coping skills	1
Aggression	1
Lack of self-control	1
Learning disabilities	1
Child mental health issues	1
Getting medications for ADHD	1
Family Issues	
Family conflict/dysfunction	8
Parenting skills	6
Mental Health System Issues	
Lack of psychiatrists and other professionals	6
Wait time for appointments	1
Few inpatient options for severe problems	1
Other	
Problems associated with Medicaid	2
Bullying	1
School services for children needing counseling/testing	1
Socialization	1
Children overmedicated	1
Education about mental health needs and how to treat	1

Table 130. What do you believe are the greatest addiction and/or mental health needs (e.g., issues that clients present with) in the four-county area? (Ancillary Service Providers - Non-Schools (n = 83))

Issues	No. of organizations reporting need
Addiction Issues	
Alcohol Abuse and Addiction	17
Drug Abuse and Addiction	16
Meth Abuse and Addiction	15
Prescription medicine abuse	4
Alcohol and drug use by youth	2
People self-medicating	2
Addiction	1
Poly drug use	1
Cocaine	1
Gambling	1
Sex/pornography addiction	1
Specific Mental Health Disorders	
Depression	11
Anxiety/stress	8
ADHD	3
Dementia	3

Bipolar	3
Psychosis/schizophrenia	2
Personality disorders	2
Behavioral issues	2
Mood disorders	1
ADHD with comorbidity	1
Cognitive disorders	1
Eating disorders	1
Anger management	1
Other Mental Health Concerns	
Suicide intervention	2
Learning disabilities	1
Family Issues	
Domestic violence	4
Family violence	1
Parenting skills	1
Child care	1
Parents don't follow through with treatment/appointments	1
Mental Health System Issues	
Early intervention	4
Funding to implement services	4
Long wait time to receive services	3
Substance abuse intensive inpatient treatment facilities	3
Not enough psychiatrists	2
Availability of counseling	2
More inpatient treatment centers	2
Need more low-cost services	2
Affordable drug addiction treatment	1
Need more treatment options	1
Longer inpatient treatment for substance abuse	1
No emergency mental health counseling	1
MR/DD services	1
Services for dually diagnosed clients	1
Short-term counseling for depression	1
Collaboration among youth serving organizations	1
Emergency facility for minors	1
Support groups	1
Clients don't know where to access services	1
Need for aftercare	1
Need longer-term services	1
Lack of IOP	1
Psychiatrists for Medicaid patients	1
Education of physicians regarding elderly issues	1
Elderly interventions	1

Other	
Clients need funding to obtain psych medications	4
Medicaid problems	2
Transportation	2
Homeless services	2
Housing	2
School dropouts	1
Legal issues	1
Lack of prenatal care until Medicaid approved	1
Primary healthcare	1
Overcoming felony drug convictions (barriers to employment)	1
Issues specific to illegal immigrants	1
Need for life skills training	1
Can't get government assistance	1

Provider and Consumer Focus Group Responses

As shown in the table below, when participant focus group responses were compared, a number of common themes emerged between providers and consumers. Themes included accessing and coordination of services, primary healthcare (e.g., family doctors are not comfortable prescribing medications), need for psychiatrists (e.g., not enough child or adult), co-occurring disorders (e.g., addiction and mental health issues; need more integrated treatment--addiction and mental health issues), transitional housing (e.g., women who are addicts to recover; good environments for men to recover), youth alcohol and other drug addiction, need for long-term treatment facilities (residential and inpatient children/adults; long wait list, few facilities), need for medical detoxification services (e.g., longer time to recover –"it takes so long to detox"), and treatment of methamphetamine addiction.

Table 131. Provider and Consumer Perceptions of the Greatest Addiction and Mental Health Needs in the Community

1. What do you believe are the greatest addiction and/or mental health needs in your county? Needs are the mental health and addiction issues experienced by residents of your community. (Prompt: Are these needs specific to a particular age group?)

Providers		Shared Respondent Group Themes	Consumers	
Themes	Number of Comments		Themes	Number of Comments
• Accessing Services	12	• Accessing and coordination of services • Primary healthcare (e.g., family doctors are not comfortable prescribing medications) • Need for psychiatrists (e.g., not enough child or adult)	• Increased consistency (e.g., too much fragmentation between the individual with mental health need, his/her family, family doctor, and	4

		• Co-occurring disorders (e.g., addiction and mental health issues; need more integrated treatment-- addiction and mental health issues) • Transitional housing (e.g., women who are addicts to recover; good environments for men to recover) • Youth alcohol and other drug addiction • Need for long-term treatment facilities (residential and inpatient children/adults; long wait list, few facilities) • Need for medical detoxification services (e.g., longer time to recover –"it takes so long to detox") • Methamphetamine addiction	mental health service)	
• Psychiatric services	8		• Insufficient services for those with criminal histories	3
• Need for mental health services for individuals with mental retardation and other developmental disorders	5		• Co-occurring disorders (e.g., addiction and mental health issues; need more integrated treatment-- addiction and mental health issues)	3
• Youth alcohol and other drug addiction	5		• Programs for youth (e.g., afterschool programs that can handle kids with mental health issues while parents are working)	3
• Need for services for the senior citizens and caregivers (e.g., accessing services)	5		• Transitional housing (e.g., women who are addicts to recover; good environments for men to recover)	3
• Alcohol addiction	4		• Educational issues (e.g., ISTEP pressures; not enough self-contained classes; teacher training)	3
• Need for medical detoxification services	4		• Better crisis management (e.g., more communication between legal, medical, and mental health personnel)	2
• Difficult to treat specific diagnosis and disorders (e.g., personality disorders, sexual addictions)	4		• Need for psychiatrists (e.g., not enough child or adult)	2

• Need for long-term treatment facilities (residential and inpatient; long wait list, few facilities)	4		• Insufficient services for children (e.g., not enough residential beds for children)	1
• Youth mental health disorders/symptoms (aggressive behavior, ADHD, Oppositional Defiant Disorder)	4		• Addiction in younger ages	1
• Need to address specific mental health disorders (e.g., social phobia, PTSD, anxiety)	3		• Need for medical detoxification services (e.g., longer time to recover-it takes so long to detox)	1
• Methampheta-mine addiction	3		• Family member treatment for addiction (e.g., services needed for family not just the addict)	1
• Other (e.g., DUI, parenting)	3		• Inpatient (e.g., not enough facilities)	1
• Cost/Funding/Insurance	2		• Mental health issues (e.g., depression and anxiety)	1
• Medication issues (e.g., do not have, refuse to take)	2		• Methampheta-mine addiction	1
• Prescription drug addiction	2		• Primary health care (e.g., family doctors are not comfortable prescribing)	1
• Primary healthcare (e.g., family doctors not comfortable prescribing medications)	2		• Need for respite care (e.g., can't just go to a babysitter)	1
• Need for youth school based social workers	2			
• Co-occurring disorders (e.g., addiction and	1			

mental health issues)				
• Need for a drug court (Gibson Cty)	1			
• Need to increase knowledge and understanding of issues (e.g., court system to be more understanding)	1			
• Need for more psychologists	1			
• Need to address risk factors (e.g., poverty)	1			
• Transitional housing(e.g., lack of homes for women leaving treatment)	1			

Indicator 4.2 The addiction and/or mental health needs that are not being adequately met by existing services as perceived by direct service providers, ancillary service providers, and consumers

Both direct service providers and ancillary service providers responded to the following open-ended question: What addiction and/or mental health needs in the four-county area are not being adequately met by existing services (e.g., gaps in services)? In response to this question, direct service providers mentioned the need for additional residential and inpatient services. This need relates to the need for extended treatment of addiction and mental health issues. Further, direct service providers expressed the need for affordable services and a need to have shorter waiting periods to receive services.

From the perspective of schools, the most often mentioned issue was the wait time for an appointment. Other unmet needs included child psychiatric services, parenting skills, youth addiction services, the loss of school social workers, and care for the uninsured and underinsured.

Non-schools also listed the wait time for an appointment as the top unmet need. This was followed by the number of psychiatrists, the lack of providers, and methamphetamine abuse and addiction.

Table 132. Item 31: What addiction and/or mental health needs in the four-county area are not being adequately met by existing services (e.g., gaps in services)?
• Ability to serve number of those addicted in need of residential services
• Access to affordable medication; residential care
• Bipolar; borderline personality disorders
• Free services (many clients report homophobic attitudes present among many service providers); substance abuse; ongoing out-pt; harm reduction
• Initial appointment with psychiatrist is not timely to meet clients' needs.
• Inpatient addiction (detox and treatment)
• Inpatient care for MR/DD/MI population; substance/addiction; respite care; case management services; transportation; medication management for MR/DD population
• Lack of extended in-house residential treatment
• Lack of long-term, intensive therapy services, especially for individuals who are uninsured or underinsured; lack of specialized services and programs for individuals with eating disorders and personality disorders; lack of access to psychiatric services
• Long waiting periods for individuals who need help
• Mental health needs that result in legal problems – more diversion needed
• Need for sex addiction treatment and healthy support groups
• Psychiatric medication assessments and management
• Psychological testing; all medical offices should offer mental health services (less of a stigma)
• Wrap around/case management services for children; services to children in the autism spectrum disorders; too few psychiatrists to cover patients needs; not enough providers who take Medicaid as payment
• Suicide prevention; inpatient substance abuse treatment
• Need for longer, more intensive addiction treatment services for some people – long-term residential, extended aftercare; need for more in-home treatment services for some children and families – in-home therapy; need for more intensive treatment services for children with serious emotional problems – IOP, after-school, wraparound, respite care; need for more intensive treatment services for adults with acute mental illness – day treatment, IOP; more readily accessible services by psychiatrists; more mental health services for persons in nursing homes, assisted living, adults day programs, older adults in home; better integration of physical health care for adults with serious and persistent mental illnesses; more counseling and psychiatric services for persons with MR/DD issues; more intensive services for persons while incarcerated or at release-in jail and community corrections, outdates from DOC
• There is a need for holistic, faith-based treatment. The spiritual dimensions of life are an important part of overcoming addictions.
• Treatment for sexual abuse victims; adolescent drug and alcohol; youth; sexual abuse perpetrators; anger management; psychiatric and medical; psychological evaluations
• Treatment of dual diagnosis (mental illness and substance abuse) patients, child and adolescent patients
• Unsure – I see transportation problems

Table 133. What addiction and/or mental health needs in the four-county area are not being adequately met by existing services (e.g., gaps in services)? (Ancillary Service Providers - Schools (n = 44))	
Issues	**No. of organizations reporting need**
Addiction Issues	
Youth addiction services	3
Inpatient substance abuse treatment	2
Adolescent substance abuse treatment	2
Outpatient substance abuse treatment	1
Children exposed to meth in utero	1
Services for children of addicted parents	1
Drug addiction	1
Education for parents concerning drug issues	1
Community drug problems	1
Mental Health Issues	
ADHD	2
Behavioral issues	2
Child abuse	1
Child therapy	1
Inpatient programs for teens and adults	1
Programs for pre-k through 5	1
Services for children with low cognitive abilities	1
Services for children with learning disabilities	1
Family Issues	
Parenting skills	4
Family therapy	1
Emotionally abused children living with abuser	1
Support to families who have incarcerated members (specifically drug related)	1
Mental Health System Issues	
Wait time to receive appointment	7
Child psychiatric services	5
Loss of school social workers	3
Care for the uninsured and underinsured	3
Medicaid problems	2
Length of services too short	1
More outreach into community; better client/provider relationships	1
Lack of school nurse services	1
Referral services	1
Services for poor teens	1
Long-term residential	1
Lack of schooling while in treatment	1
Free/sliding scale services	1
Other	
Lack of follow up	2

Early intervention with youth	1
Transportation	1

Table 134. What addiction and/or mental health needs in the four-county area are not being adequately met by existing services (e.g., gaps in services)? (Ancillary Service Providers - Non-Schools (n = 73))	
Issues	**No. of organizations reporting need**
Addiction Issues	
Meth abuse and addiction	4
Drug abuse and addiction	3
Alcohol abuse and addiction	1
Adolescent addiction	1
Mental Health Issues	
Mental health issues pertaining to the elderly	3
Depression	1
Eating disorders	1
Dementia	1
Youth grief/mental health	1
Suicide prevention	1
Support groups	1
Times services available	1
Pediatric services	1
Family Issues	
Domestic violence	1
Mental Health System Issues	
Wait time for services/appointments	9
Number of psychiatrists	4
Not enough providers	4
Inpatient services for substance abuse	3
MR/DD services	3
Dually diagnosed psych services	2
Medicine management falling to family because of delays in accessing services	2
Number of psychiatrists for youth	2
Youth substance abuse services	2
Addiction services in outlying counties	1
Residential treatment for drug/alcohol issues	1
Spanish speaking professionals	1
Comprehensive/coordinated assessment	1
More psych testing at Medicaid rate	1
Too many early discharges	1
Inpatient drug and alcohol treatment for juveniles	1
Treatment for the incarcerated	1
Youth services	1
Group homes for mild patients	1

Not enough services for people in nursing homes	1
Long-term residential treatment	1
Monitoring clients' progress	1
CIT overwhelmed by 24-hour detentions	1
Mental health beds in hospital emergency rooms	1
Number of pediatric inpatient beds	1
Number of services for low/no income people	1
Emergency inpatient	1
Other	
Transportation	3
Medicaid problems	2
Cost of medications	2
Support for individuals after jail	2
Homelessness	2
Assistance for low income clients	1
HIV prevention	1
Education	1
Jobs	1
Permanent supported housing	1
How to handle mental health issues through the court system	1
Legal services	1

Provider and Consumer Focus Group Responses

As shown in the table below, when participant focus group responses were compared, a number of common themes emerged between providers and consumers. Themes included parent/education support (e.g., more therapy and education for the families of children with mental issues), need for psychiatric services (e.g., long waiting list), treatment for low income, uninsured or underinsured (e.g., client inability to afford treatment), need for medical detoxification services (e.g., before medically stable, detox for teens), and lack of local/accessible inpatient and residential treatment for youth and adults (e.g., go outside county for residential and inpatient treatment: Posey, Vanderburgh and Gibson).

Table 135. Provider and Consumer Perceptions of the Needs Not Being Addressed by Existing Services				
2. What addiction and/or mental health needs in your county are not being adequately met by existing services? (Prompt: Are these needs specific to a particular age group?)				
Providers		**Shared Respondent Group Themes**	**Consumers**	
Themes	**Number of Comments**		**Themes**	**Number of Comments**
• Lack of addiction services for youth (e.g., residential, inpatient, AA)	8	• Parent/education support (e.g., more therapy and education for the families of children with mental issues) • Need for psychiatric services (e.g., long waiting list) • Treatment for low income, uninsured or underinsured (e.g., client inability to afford treatment) • Need for medical detoxification services (e.g., before medically stable, detox for teens) • Lack of local/accessible inpatient and residential treatment for youth and adults (e.g., go outside county for residential and inpatient treatment: Posey, Vanderburgh and Gibson)	• Family concerns (e.g., more therapy and education for the families of children with mental issues)	3
• Lack of local/accessible treatment for adults (e.g., go outside county for residential and inpatient treatment: Posey, Vanderburgh and Gibson)	5		• Transportation (e.g., can be up to 4 hours a day both ways—too long for a child with mental health issues)	3
• Difficult to treat mental health diagnosis/disorder (e.g., eating disorders)	3		• Other (e.g., real world staff qualifications; intervention teams)	3
• Need for mental health services for individuals with mental retardation and other developmental disorders (e.g., no psychiatric treatment options)	3		• Concerns related to changing services (e.g., biggest worry is existing services changing or not being offered at older ages)	2
• Transitional/stable housing (e.g., no recovery houses, group homes, for people coming out of	3		• Coverage (e.g., gap among people who have too much income to qualify for “free” (state funded) services	2

treatment)			but not enough income to actually afford services)	
• Treatment for low income or uninsured (e.g., client inability to afford treatment)	3		• Inpatient (e.g., longer term, inpatient addiction services—2 weeks is not enough, it needs to be 6 months minimum to actually spark change)	2
• Other (e.g., change policies, staff cuts in area)	2		• Additional staff (e.g., need more staff working with school aged children that are already diagnosed or that are being diagnosed on an ongoing basis)	2
• Need for medical detoxification services (e.g., before medically stable, detox for teens)	2		• Child psychiatrists (e.g., long wait list)	1
• Need for Intensive Outpatient Programs (e.g., long waiting list	2		• Co-occurring conditions (e.g., need for dual diagnosis services)	1
• Need for long-term addiction treatment programs	2		• Need for detoxification services	1
• Need for treatment of methamphetamine addiction	2		• Lack of local/accessible treatment options (e.g., there are not many treatment options in Posey County)	1
• Parent education/support	2			
• Primary health care (e.g., lack of communication and doctors will not prescribe)	2			
• Need for treatment of sexual abuse	2			
• Need for more training/education in the area of mental health and addiction	2			
• Need for early	1			

intervention in daycares				
• Need for services for the elderly	1			
• Need more group treatment	1			
• Lack of Medicaid providers	1			
• Length of treatment (e.g., programs are too short)	1			
• Medication issues	1			
• Need more neuropsychologists	1			
• Need for payeeships	1			
• Need for psychiatric services	1			
• Need for psychologist to do psychological testing	1			

Indicator 4.3 Specifically for ancillary service providers, the issues for which referrals are often made to organizations outside the four-county study area

When completing the Survey of Ancillary Services, organizations were asked to indicate issues for which they must make referrals outside of the four-county study area. The table below indicates the specific responses provided by organizations and the type of organization that responded.

As noted, several of the organizations indicated sending clients or students for inpatient services, including treatment for substance abuse, dementia, and eating disorders. Others referred clients to residential services in other areas, particularly residential treatment for children and specifically for the issue of eating disorders. Further, approximately 60% of organizations that indicated they had referred individuals outside of the four-county area either specifically mentioned services for children or are schools that work with children and adolescents. This may indicate a particular need for services specifically related to this age group.

Table 136. Issues for Which Referrals are Made Outside of Four-County Region	
Issue	**Organization Type**
• ADHD evaluation 11 times for Medicaid – referred to IU	Primary medical care
• ADHD/ADD-Medicaid; no one takes Medicaid in Evansville for kids (inpatient)	Primary medical care
• Adolescent residential	Court system
• Adults (and children) with a diagnosis of MR/DD but also with mental health issues are not served by SW Indiana Mental Health Center. We can only find services for med administration and counseling in Vincennes or Indy – no services in Evansville!	Non-profit
• Behavioral issues, personality disorders, and developmental issues for persons who are dually-diagnosed or have borderline intellectual functioning or who have Asperger's form of autism	Other (government agency)
• Drugs and alcohol inpatient for adolescents. Acute in pt. psych. Care for lower IQ students <70	Primary school
• If a parent is looking for long term and/or intensive treatment	Secondary school
• Inpatient care for individuals with dementia	Primary medical care
• Inpatient substance abuse treatment, Trichotillomania, treatment facilities for eating disorders	Secondary school
• Inpatient treatment of eating disorders	Primary medical care
• Juvenile drug addiction services inpatient	Court system
• Long term inpatient eating disorders	Primary school
• Long-term inpatient substance abuse treatment	Non-profit
• Long-term residential care, eating disorders	Non-profit
• Long-term residential mental health facility	Primary school
• Most of our referrals involve assessment of development from lead intoxication.	Other (health department)
• None – patients do not have transport	Primary medical care
• Only refer outside when patient lives outside of area	Primary medical care
• Psychiatrists and counselors unwilling to serve DD and dual diagnosis	Non-profit
• Psychiatry for adults and peds	Other (hospital)
• Residential rehabilitation	Non-profit
• Residential services for issues related to eating disorders	Secondary school
• Substance abuse treatment facilities (due to bed availability or client selection); residential treatment facilities for children	Other
• We may recommend a long-term residential placement for children	Non-profit
• Working with county DCS case managers, there is frequently a need to place child in residential setting. Need is for therapeutic residential rather than penal-like institution.	Non-profit

Indicator 4.4 The greatest addiction and/or mental health strengths in the community as perceived by direct service providers, ancillary service providers, and consumers

Both direct service providers and ancillary service providers responded to the following open-ended question: What do you believe are the greatest strengths within the four-county region related to current addiction and/or mental health services being provided? Direct service providers referenced the existence of 12-step and support programs, the quality of the existing group of providers, and the number of organizations who provide some form of mental health or addiction treatment.

Schools listed providers working cooperatively and collaboratively and the presence of social workers as particular strengths in their communities. Non-schools also mentioned agencies cooperating, coordinating, and collaborating as a key strength, as well as the number of mental health options, the level of care and compassion demonstrated by providers, and the excellent psychiatrists and other well-trained professionals.

Table 137. Item 32: What do you believe are the greatest strengths within the four-county region related to current addiction and/or mental health services being provided?
• 2 large hospitals
• A.D.A.P.T. (Ron Wilson); Dr. Macke of Mulberry Center
• Access to current mental health services
• Community resources available in 12-step program community, especially in regard to recovery from alcohol dependence
• Competent and compassionate providers
• Consumer choices and services are expanding
• Good 12-step affiliation
• Good providers-just not enough of them
• In general, there are competent, caring professionals who do their best in often challenging environments.
• Inpatient services; for-fee services
• Large number of treatment groups and AA/NA locations
• Number of agencies available to render services
• Outreach
• Stable provider group; good support from local courts (i.e., drug courts)
• Suicide training offered by Deaconess Cross Pointe, community education offered; Crisis Intervention Team with Police Department and Council
• The sliding fee scales, grant opportunities, and shorter waiting periods offered by United Way-affiliated agencies
• There are a number of agencies providing individual outpatient services; residential drug and alcohol for adults; state facilities and private for inpatient services
• Well-trained psychiatrists and therapists (just not enough of them)

Table 138. What do you believe are the greatest strengths within the four-county region related to current addiction and/or mental health services being provided? (Ancillary Service Providers - Schools (n = 33))	
Strengths	**No. of organizations reporting strength**
Providers working cooperatively and collaboratively	4
School social workers (specifically through Youth First)	4
Drug/alcohol addiction support	2
Always expanding services	2
Efforts to raise awareness	2
Dedicated people willing to help	2
Good prevention and early intervention programs	2
Number of services	2
Offices in each county (specifically mentioned Southwestern)	2
211 in Gibson County	1
Addiction and mental health services for clinical issues	1
Existence of case managers	1
Community roundtable	1
Deaconess Cross Pointe	1
Variety of places to get counseling	1
Having major hospitals nearby	1
Learning disability services	1
Speech therapy services	1
School-based services	1
Southwestern	1

Table 139. What do you believe are the greatest strengths within the four-county region related to current addiction and/or mental health services being provided? (Non-Schools – n = 60)	
Strengths	**No. of organizations reporting strength**
Agency cooperation/coordination/collaboration	7
Many mental health options	7
Care and compassion demonstrated by providers	4
Excellent psychiatrists and other well-trained professionals	4
Alcohol treatment	2
Collaboration with Deaconess Cross Pointe and Southwestern	2
Outpatient services	2
Southwestern	2
211	1
Agencies willing to offer services	1
Availability of Southwestern services	1
Caring community	1

Centralized service providers	1
Community Corrections	1
Cooperation among EPD, Deaconess, St. Mary's, Southwestern, and Mulberry Center	1
Courts are identifying substance abuse and mental health issues	1
Deaconess Cross Pointe	1
Education regarding drug addiction issues	1
Emergency room access	1
EPCC	1
Good emergency care	1
Good therapists for children at Lampion and Southwestern	1
Good youth development programs	1
Homeless network	1
In-home services	1
Inpatient acute psychiatric care	1
Many adult services	1
Many substance abuse facilities	1
Mental health nurses via home care nurses	1
Outreach for early intervention	1
Partnerships with Spanish language organizations	1
Presence of school social workers	1
Primary care physicians doing good job making up for shortage of depression care	1
Services for chronically mentally ill	1
Visibility of services	1

Provider and Consumer Focus Group Responses

As shown in the table below, when participant focus group responses were compared, a number of common themes emerged between providers and consumers. Themes included local organizations and support groups (e.g., National Alliance on Mental Illness, Southwestern Healthcare, Youth Day Treatment, Youth Outreach Program, Hillcrest , various not-for profits, Lampion Center, Churches Embracing Offenders and other faith based organizations, USI, Aurora, Mental Health of America, Evansville Psychiatric Children's Center, Deaconess CrossPointe, Warrick County Drug Court, Narcotics Anonymous (NA), and Alcoholics Anonymous (AA)), existing services (e.g., intensive outpatient, outpatient services, drug courts, self-help groups (AA, NA), various mental health and addiction services/resources that are available), qualified mental health and addiction professionals (e.g., techs, case workers in schools), and collaboration among various social service and government organizations (e.g., collaboration/coordination that takes place between Southwestern, Deaconess, St. Mary's, etc.).

Table 140. Provider and Consumer Perceptions of the Greatest Strengths in the Community				
3. What do you believe are the greatest strengths within your county related to current addiction and/or mental health services being provided?				
Providers		**Shared Respondent Group Themes**	**Consumers**	
Themes	**Number of Comments**		**Themes**	**Number of Comments**
• Existing services (e.g., drug courts, self-help groups (AA, NA), various mental health and addiction services/resources that are available)	15	• Local organizations and support groups (e.g., National Alliance on Mental Illness, Southwestern Healthcare, Youth Day Treatment, Youth Outreach Program, Hillcrest , various not-for profits, Lampion center, Churches Embracing Offenders and other faith based organizations, USI, Aurora, Mental Health of America, Evansville Psychiatric Children's Center, Deaconess Crosspointe, Warrick County Drug Court, NA, and AA)	• Local organizations and support groups (e.g., National Alliance on Mental Illness, Southwestern Healthcare, Youth Day Treatment, Aurora, Mental Health of America, Evansville Psychiatric Children's Center, Deaconess Crosspointe, Warrick County Drug Court, NA, and AA)	12
• Local organizations (e.g., Stepping Stone, Youth First, Evansville Psychiatric Children's Center, Youth Outreach Program, Hillcrest, Southwestern Healthcare, USI, various not-for profits, Lampion Center, Churches Embracing Offenders and other faith based organizations)	10	• Existing services (e.g., intensive outpatient, outpatient services, drug courts, self-help groups (AA, NA), various mental health and addiction services/resources that are available)	• Existing services (e.g., intensive outpatient, outpatient services)	8
• Collaboration among various social service and government organizations	8	• Qualified mental health and addiction professionals (e.g., techs, case workers in schools)	• Qualified mental health and addiction professionals (e.g., techs, case workers in schools)	3
• Community members (e.g., people in the county generally care about children's needs)	3	• Collaboration among various social service and government organizations (e.g., There is some collaboration/coalition that takes place between Southwestern, Deaconess, St. Mary's, etc.)	• Collaboration (e.g., collaboration/ coordination that takes place between Southwestern, Deaconess, St. Mary's, etc.)	1
• Mental health care and addiction professionals (e.g., dedicated, passionate	3			

individual therapists)				
• Timeliness of treatment (e.g., can get people in within 2 weeks (7-10 days)	2			
• Innovation (e.g., providers are dedicated to trying new treatments and strategies (Cognitive Behavioral Therapy for Depression and Dynamic Deconstructive Therapy for Personality Disorders)	1			

Indicator 4.5 An indication of the specific ancillary services for which clients have need, the degree to which they have the need, and the extent to which clients receive the needed services

Methodology Used to Examine Goal

To address this indicator, both the Inventory of Addiction and Mental Health Services and the Survey of Ancillary Services contained an item related to the need for 36 different services, the frequency with which clients have the need for the services, and the degree to which clients receive the services. To complete the item, respondents followed the steps below.

1. Indicate whether your clients have need for this particular service. Response options were Yes or No. Examples of services included transportation services, medication management, and psychological testing.
2. If you selected yes (your clients have a need for this service), how often do your clients have a need for this service? Select from the following response options:
   - 1=Almost never
   - 2=Rarely
   - 3=Sometimes
   - 4=Often
   - 5=Almost Always
3. If you selected yes (your clients have a need for this service), how often do your clients receive this service from you or other organizations? Select from the following response options:
   - 1=Almost never
   - 2=Rarely
   - 3=Sometimes
   - 4=Often
   - 5=Almost Always

Findings

Tables and figures that contain data associated with this item are provided for direct service providers, schools, and non-school ancillary service providers. Using Table 141 as an example, the table first contains a ranking of services that are needed by clients of responding organizations based on the number of respondents that indicated their clients need each service. For each service, frequency distributions are provided for the questions pertaining to the degree to which clients need the service and the degree to which they receive the service. Further, a mean scale rating (based on the 1-5 scale shown above) is provided for each item.

To better describe the information contained in the tables, note the first service listed on Table 141, individual therapy and/or counseling. Of the direct service providers that responded, 23 of the 24 who responded, or 95.8%, indicated that their clients have a need for this service. In response to the question, "How often do your clients have a need for this service?" 65.2% indicated 'Almost Always,' 30.4% indicated 'Often,' and 4.3% indicated 'Sometimes.' None of

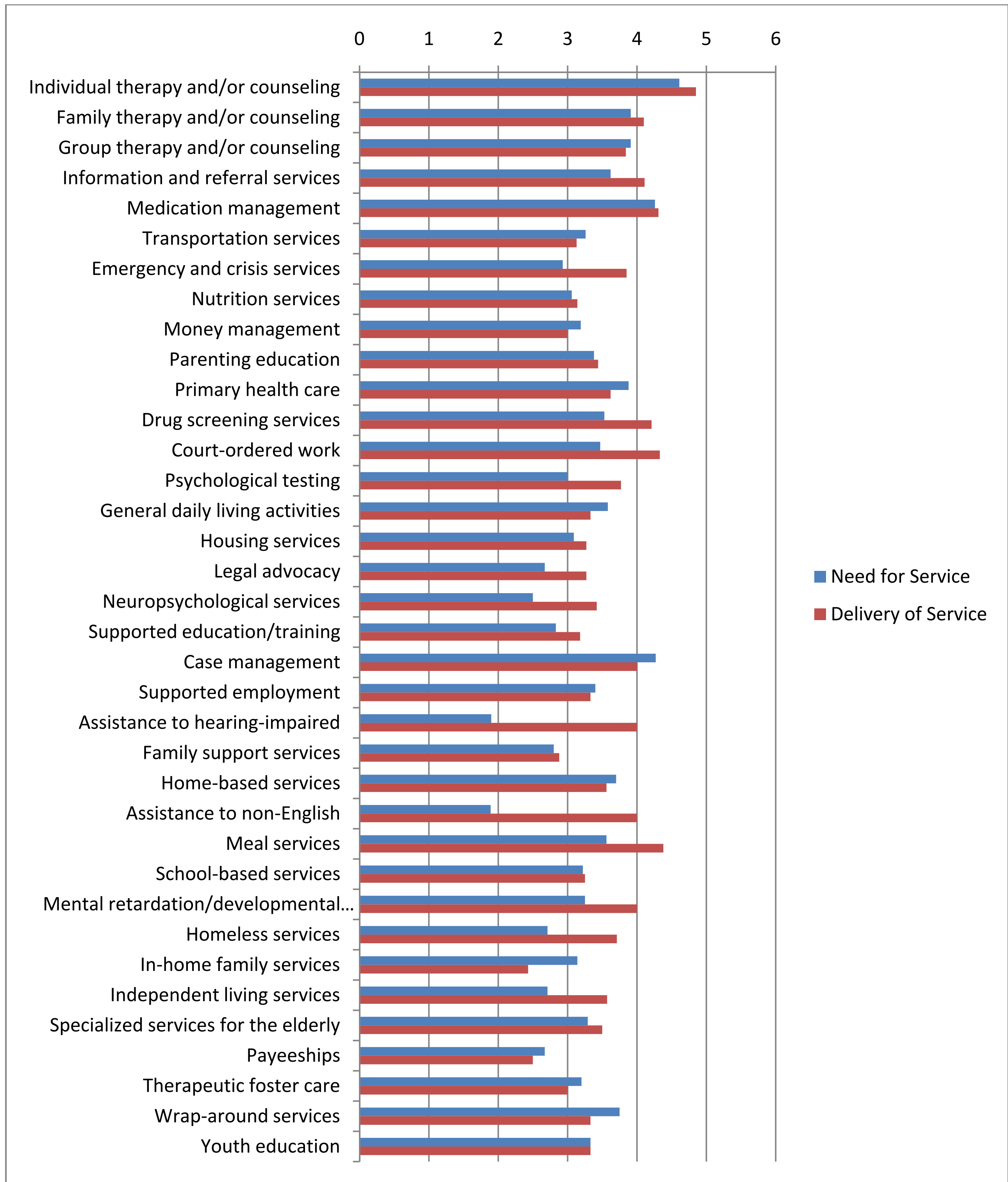
the respondents answered ‘Rarely’ or ‘Almost Never.’ The mean rating for this item was 4.61 on a 1 to 5 scale. In response to the question, “How often do your clients receive this service?” 85.0% indicated ‘Almost Always’ and 15.0% indicated ‘Often.’ None of the respondents answered ‘Sometimes,’ ‘Rarely’ or ‘Almost Never.’ The mean rating for this item was 4.85 on a 1 to 5 scale.

To further describe the findings, a graph is presented after each frequency distribution table, such as Figure 22. The graph presents the services in the same order as the table, with the service for which respondents indicated the most need for their clients at the top and the service with the least need at the bottom. Beside each service is presented a pair of columns that represent the mean rating for the items, “How often do your clients have a need for this service?” and “How often do your clients receive this service?” As shown in Figure 22, the ‘need for service’ mean rating is slightly less than the ‘delivery of service’ mean rating for individual therapy and/or counseling. This direct comparison allows for an assessment of the gap in service that clients may experience in attempting to receive the service. Generally speaking, when the mean for ‘need for service’ is higher than the mean for ‘delivery of service,’ it is likely that clients are not receiving the service as often as they need it. In the example of individual therapy and/or counseling, delivery of service exceeds need for service, which means that respondents believe this need is being met.

Table 141. Ranking of Services for Which Clients Have Need – Direct Service Providers (All Respondents)														
Service	Number of organizations whose clients have need for service		How often do clients need this service?						How often do clients receive this service from you or other organizations?					
	Number of Respondents	Percent of Respondents	1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always	Mean	1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always	Mean
Individual therapy and/or counseling	23/24	95.8%	0% (n=0)	0% (n=0)	4.3% (n=1)	30.4% (n=7)	65.2% (n=15)	4.61	0% (n=0)	0% (n=0)	0% (n=0)	15.0% (n=3)	85.0% (n=17)	4.85
Family therapy and/or counseling	22/24	91.7%	4.5% (n=1)	4.5% (n=1)	22.7% (n=5)	31.8% (n=7)	36.4% (n=8)	3.91	0% (n=0)	0% (n=0)	28.6% (n=6)	33.3% (n=7)	38.1% (n=8)	4.10
Group therapy and/or counseling	22/24	91.7%	0% (n=0)	4.5% (n=1)	36.4% (n=8)	22.7% (n=5)	36.4% (n=8)	3.91	5.3% (n=1)	10.5% (n=2)	26.3% (n=5)	10.5% (n=2)	47.4% (n=9)	3.84
Information and referral services	21/24	87.5%	9.5% (n=2)	0% (n=0)	42.9% (n=9)	23.8% (n=5)	23.8% (n=5)	3.62	0% (n=0)	0% (n=0)	22.2% (n=4)	44.4% (n=8)	33.3% (n=6)	4.11
Medication management	19/24	79.2%	0% (n=0)	5.3% (n=1)	10.5% (n=2)	36.8% (n=7)	47.4% (n=9)	4.26	0% (n=0)	6.3% (n=1)	12.5% (n=2)	25.0% (n=4)	56.3% (n=9)	4.31
Transportation services	19/24	79.2%	5.3% (n=1)	10.5% (n=2)	42.1% (n=8)	36.8% (n=7)	5.3% (n=1)	3.26	12.5% (n=2)	18.8% (n=3)	31.3% (n=5)	18.8% (n=3)	18.8% (n=3)	3.13
Emergency and crisis services	17/24	70.8%	6.7% (n=1)	40.0% (n=6)	13.3% (n=2)	33.3% (n=5)	6.7% (n=1)	2.93	0% (n=0)	23.1% (n=3)	23.1% (n=3)	0% (n=0)	53.8% (n=7)	3.85
Nutrition services	17/24	70.8%	11.8% (n=2)	17.6% (n=3)	35.3% (n=6)	23.5% (n=4)	11.8% (n=2)	3.06	14.3% (n=2)	28.6% (n=4)	21.4% (n=3)	0% (n=0)	35.7% (n=5)	3.14
Money management	16/24	66.7%	0% (n=0)	31.3% (n=5)	25.0% (n=4)	37.5% (n=6)	6.3% (n=1)	3.19	6.7% (n=1)	26.7% (n=4)	40.0% (n=6)	13.3% (n=2)	13.3% (n=2)	3.00
Parenting education	16/24	66.7%	0% (n=0)	12.5% (n=2)	43.8% (n=7)	37.5% (n=6)	6.3% (n=1)	3.38	6.3% (n=1)	6.3% (n=1)	43.8% (n=7)	25.0% (n=4)	18.8% (n=3)	3.44
Drug screening services	15/24	65.2%	0% (n=0)	13.3% (n=2)	40.0% (n=6)	26.7% (n=4)	20.0% (n=3)	3.53	0% (n=0)	7.1% (n=1)	21.4% (n=3)	14.3% (n=2)	57.1% (n=8)	4.21
Court-ordered work	15/24	62.5%	0% (n=0)	20.0% (n=3)	33.3% (n=5)	26.7% (n=4)	20.0% (n=3)	3.47	0% (n=0)	0% (n=0)	20.0% (n=3)	26.7% (n=4)	53.3% (n=8)	4.33
Primary health care	16/24	66.7%	0% (n=0)	6.3% (n=1)	25.0% (n=4)	43.8% (n=7)	25.0% (n=4)	3.88	0% (n=0)	15.4% (n=2)	38.5% (n=5)	15.4% (n=2)	30.8% (n=4)	3.62
Psychological testing	14/24	58.3%	7.1% (n=1)	14.3% (n=2)	50.0% (n=7)	28.6% (n=4)	0% (n=0)	3.00	7.7% (n=1)	7.7% (n=1)	15.4% (n=2)	38.5% (n=5)	30.8% (n=4)	3.77
General daily living activities	12/24	50.0%	0% (n=0)	16.7% (n=2)	25.0% (n=3)	41.7% (n=5)	16.7% (n=2)	3.58	0% (n=0)	25.0% (n=3)	41.7% (n=5)	8.3% (n=1)	25.0% (n=3)	3.33
Housing services	12/24	50.0%	9.1% (n=1)	0% (n=0)	63.6% (n=7)	27.3% (n=3)	0% (n=0)	3.09	0% (n=0)	18.2% (n=2)	54.5% (n=6)	9.1% (n=1)	18.2% (n=2)	3.27

Legal advocacy	12/24	50.0%	8.3% (n=1)	33.3% (n=4)	41.7% (n=5)	16.7% (n=2)	0% (n=0)	2.67	9.1% (n=1)	0% (n=0)	63.6% (n=7)	9.1% (n=1)	18.2% (n=2)	3.27
Neuropsychological services	12/24	50.0%	16.7% (n=2)	33.3% (n=4)	33.3% (n=4)	16.7% (n=2)	0% (n=0)	2.50	16.7% (n=2)	8.3% (n=1)	8.3% (n=1)	50.0% (n=6)	0% (n=0)	3.42
Supported education/training	12/24	50.0%	8.3% (n=1)	25.0% (n=3)	50.0% (n=6)	8.3% (n=1)	8.3% (n=1)	2.83	0% (n=0)	36.4% (n=4)	27.3% (n=3)	18.2% (n=2)	18.2% (n=2)	3.18
Case management	11/24	45.8%	0% (n=0)	0% (n=0)	18.2% (n=2)	36.4% (n=4)	45.5% (n=5)	4.27	0% (n=0)	0% (n=0)	40.0% (n=4)	20.0% (n=2)	40.0% (n=4)	4.00
Supported employment	11/24	45.8%	0% (n=0)	10.0% (n=1)	50.0% (n=5)	30.0% (n=3)	10.0% (n=1)	3.40	0% (n=0)	11.1% (n=1)	55.6% (n=5)	22.2% (n=2)	11.1% (n=1)	3.33
Assistance to hearing-impaired	10/24	41.7%	30.0% (n=3)	50.0% (n=5)	20.0% (n=2)	0% (n=0)	0% (n=0)	1.90	11.1% (n=1)	0% (n=0)	22.2% (n=2)	11.1% (n=1)	55.6% (n=5)	4.00
Assistance to non-English	9/24	37.5%	44.4% (n=4)	33.3% (n=3)	11.1% (n=1)	11.1% (n=1)	0% (n=0)	1.89	0% (n=0)	25.0% (n=2)	12.5% (n=1)	0% (n=0)	62.5% (n=5)	4.00
Family support services	10/24	41.7%	20.0% (n=2)	40.0% (n=4)	0% (n=0)	20.0% (n=2)	20.0% (n=2)	2.80	12.5% (n=1)	12.5% (n=1)	50.0% (n=4)	25.0% (n=2)	0% (n=0)	2.88
Home-based services	10/24	41.7%	0% (n=0)	10.0% (n=1)	40.0% (n=4)	20.0% (n=2)	30.0% (n=3)	3.70	0% (n=0)	0% (n=0)	66.7% (n=6)	11.1% (n=1)	22.2% (n=2)	3.56
Meal services	9/24	37.5%	11.1% (n=1)	22.2% (n=2)	11.1% (n=1)	11.1% (n=1)	44.4% (n=4)	3.56	0% (n=0)	12.5% (n=1)	0% (n=0)	25.0% (n=2)	62.5% (n=5)	4.38
School-based services	9/24	37.5%	0% (n=0)	22.2% (n=2)	44.4% (n=4)	22.2% (n=2)	11.1% (n=1)	3.22	12.5% (n=1)	0% (n=0)	37.5% (n=3)	50.0% (n=4)	0% (n=0)	3.25
Mental retardation/developmental disabilities services	8/24	33.3%	12.5% (n=1)	37.5% (n=3)	0% (n=0)	4.2% (n=1)	37.5% (n=3)	3.25	0% (n=0)	25.0% (n=2)	12.5% (n=1)	0% (n=0)	62.5% (n=5)	4.00
Homeless services	7/24	29.2%	14.3% (n=1)	28.6% (n=2)	42.9% (n=3)	0% (n=0)	14.3% (n=1)	2.71	14.3% (n=1)	0% (n=0)	42.9% (n=3)	0% (n=0)	42.9% (n=3)	3.71
Specialized services for the elderly	7/24	29.2%	0% (n=0)	14.3% (n=1)	57.1% (n=4)	14.3% (n=1)	14.3% (n=1)	3.29	0% (n=0)	0% (n=0)	66.7% (n=4)	16.7% (n=1)	16.7% (n=1)	3.50
In-home family services	7/24	29.2%	14.3% (n=1)	57.1% (n=4)	14.3% (n=1)	0% (n=0)	14.3% (n=1)	3.14	28.6% (n=2)	0% (n=0)	71.4% (n=5)	0% (n=0)	0% (n=0)	2.43
Independent living services	7/24	29.2%	14.3% (n=1)	28.6% (n=2)	28.6% (n=2)	28.6% (n=2)	0% (n=0)	2.71	0% (n=0)	0% (n=0)	57.1% (n=4)	28.6% (n=2)	14.3% (n=1)	3.57
Payeeships	6/24	25.0%	16.7% (n=1)	33.3% (n=2)	16.7% (n=1)	33.3% (n=2)	0% (n=0)	2.67	16.7% (n=1)	16.7% (n=1)	66.7% (n=4)	0% (n=0)	0% (n=0)	2.50
Therapeutic foster care	5/24	20.8%	0% (n=0)	20.0% (n=1)	40.0% (n=2)	40.0% (n=2)	0% (n=0)	3.20	0% (n=0)	0% (n=0)	100% (n=5)	0% (n=0)	0% (n=0)	3.00
Wrap-around services	4/24	16.7%	0% (n=0)	0% (n=0)	50.0% (n=2)	25.0% (n=1)	25.0% (n=1)	3.75	0% (n=0)	0% (n=0)	66.7% (n=2)	33.3% (n=1)	0% (n=0)	3.33
Youth education	3/24	12.5%	0% (n=0)	0% (n=0)	66.7% (n=2)	33.3% (n=1)	0% (n=0)	3.33	0% (n=0)	33.3% (n=1)	0% (n=0)	66.7% (n=2)	0% (n=0)	3.33

Figure 22. Need for Service and Delivery of Service for Ranked Services Needed by Clients (Direct Service Providers)



Note: Services listed above are ranked based on the need indicated by clients of direct service providers.

Table 142. Ranking of Services for Which Clients Have Need – Direct Service Providers (By Organization Grouping)								
Service	All Respondents (N=24)		Small Orgs. (N=10)		Medium Orgs. (N=7)		Large Orgs. (N=7)	
	% of Respondents	Rank	% of Respondents	Rank	% of Respondents	Rank	% of Respondents	Rank
Individual therapy and/or counseling	95.8%	1	100	1	100	1	85.7	1
Family therapy and/or counseling	91.7%	2	100	1	85.7	3	85.7	1
Group therapy and/or counseling	91.7%	2	90.0	4	100	1	85.7	1
Information and referral services	87.5%	4	100	1	71.4	5	85.7	1
Medication management	79.2%	5	90.0	4	71.4	5	71.4	6
Transportation services	79.2%	5	90.0	4	71.4	5	71.4	6
Emergency and crisis services	70.8%	7	70.0	10	85.7	3	57.1	11
Nutrition services	70.8%	7	70.0	10	71.4	5	71.4	6
Money management	66.7%	9	80.0	7	57.1	13	57.1	11
Parenting education	66.7%	9	60.0	13	71.4	5	71.4	6
Primary health care	66.7%	9	80.0	7	57.1	13	57.1	11
Drug screening services	65.2%	12	80.0	7	50.0	18	57.1	11
Court-ordered work	62.5%	13	50.0	19	71.4	5	71.4	6
Psychological testing	58.3%	14	60.0	13	71.4	5	42.9	16
General daily living activities	50.0%	15	70.0	10	42.9	19	28.6	21
Housing services	50.0%	15	50.0	19	57.1	13	42.9	16
Legal advocacy	50.0%	15	60.0	13	57.1	13	28.6	21
Neuropsychological services	50.0%	15	60.0	13	42.9	19	42.9	16
Supported education/training	50.0%	15	50.0	19	71.4	5	28.6	21
Case management	45.8%	20	60.0	13	42.9	19	28.6	21
Supported employment	45.8%	20	60.0	13	42.9	19	28.6	21
Assistance to hearing-impaired	41.7%	22	20.0	32	28.6	29	85.7	1
Family support services	41.7%	22	40.0	24	42.9	19	42.9	16
Home-based services	41.7%	22	50.0	19	42.9	19	28.6	21
Assistance to non-English	37.5%	25	30.0	26	28.6	29	57.1	11
Meal services	37.5%	25	50.0	19	42.9	19	14.3	32
School-based services	37.5%	25	30.0	26	42.9	19	42.9	16
Mental retardation/developmental disabilities services	33.3%	28	30.0	26	42.9	19	28.6	21
Homeless services	29.2%	29	10.0	36	57.1	13	28.6	21
In-home family services	29.2%	29	40.0	24	42.9	19	0.0	36

Independent living services	29.2%	29	30.0	26	28.6	29	28.6	21
Specialized services for the elderly	29.2%	29	30.0	26	28.6	29	28.6	21
Payeeships	25.0%	33	20.0	32	28.6	29	28.6	21
Therapeutic foster care	20.8%	34	30.0	26	14.3	34	14.3	32
Wrap-around services	16.7%	35	20.0	32	14.3	34	14.3	32
Youth education	12.5%	36	20.0	32	0.0	36	14.3	32

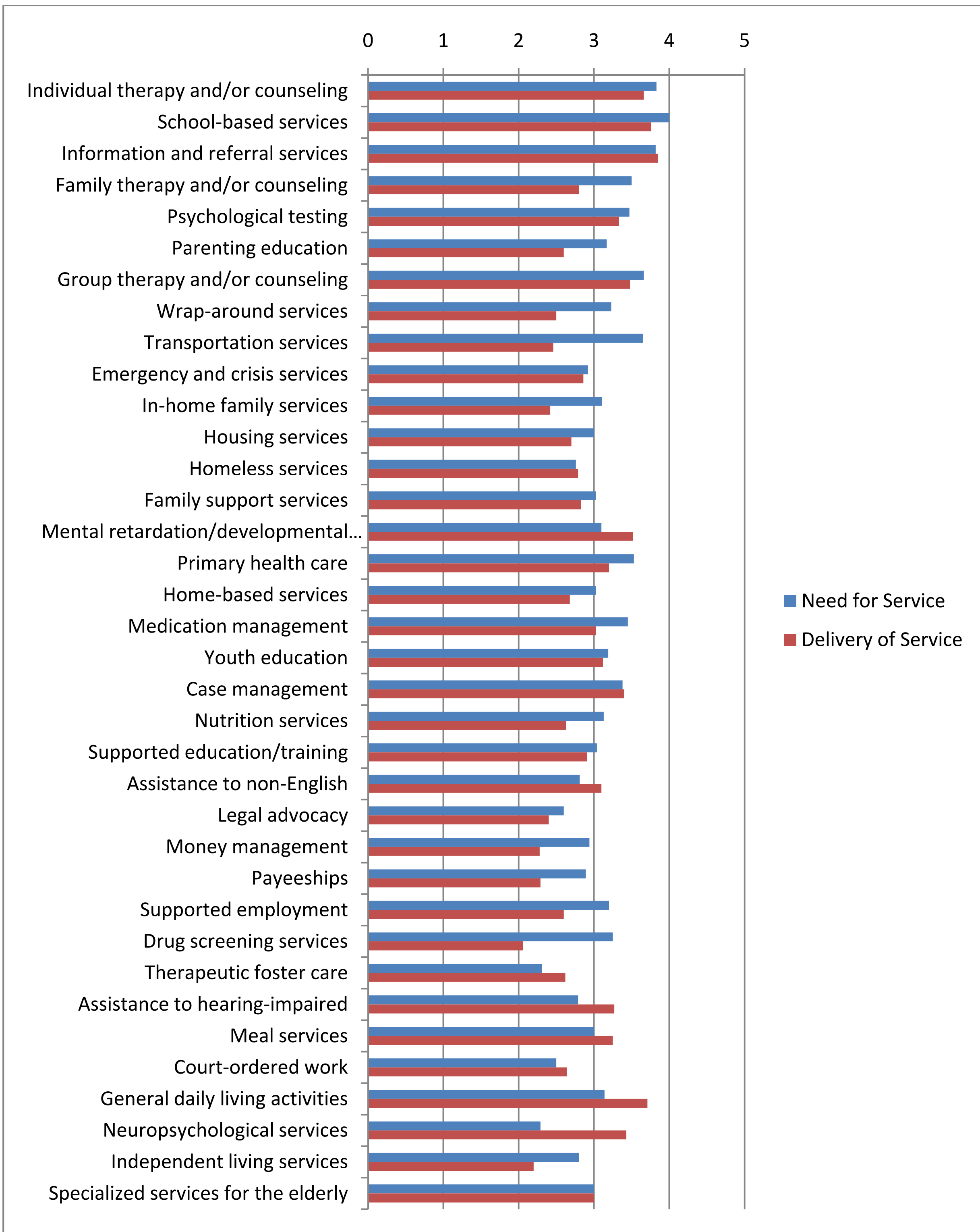
Note: Not every organization indicated whether or not their clients have need for a particular service.

Table 143. Ranking of Services for Which Clients Have Need – Ancillary Service Providers (Schools)														
Service	Number of organizations whose clients have need for service		How often do clients need this service?						How often do clients receive this service from you or other organizations?					
	Number of Respondents	Percent of Respondents	1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always	Mean	1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always	Mean
Individual therapy and/or counseling	67/71	94.4%	0% (n=0)	3.1% (n=2)	29.7% (n=19)	48.4% (n=31)	18.8% (n=12)	3.83	1.6% (n=1)	6.6% (n=4)	32.8% (n=20)	42.6% (n=26)	16.4% (n=10)	3.66
School-based services	64/70	91.4%	0% (n=0)	4.5% (n=3)	22.7% (n=15)	40.9% (n=27)	31.8% (n=21)	4.00	3.2% (n=2)	9.5% (n=6)	25.4% (n=16)	31.7% (n=20)	30.2% (n=19)	3.76
Information and referral services	62/71	87.3%	0% (n=0)	6.6% (n=4)	24.6% (n=15)	49.2% (n=30)	19.7% (n=12)	3.82	0% (n=0)	11.9% (n=7)	18.6% (n=11)	42.4% (n=25)	27.1% (n=16)	3.85
Family therapy and/or counseling	60/71	84.5%	3.4% (n=2)	5.2% (n=3)	43.1% (n=25)	34.5% (n=20)	13.8% (n=8)	3.50	12.7% (n=7)	27.3% (n=15)	32.7% (n=18)	21.8% (n=12)	5.5% (n=3)	2.80
Psychological testing	59/71	83.1%	0% (n=0)	13.8% (n=8)	37.9% (n=22)	36.2% (n=21)	12.1% (n=7)	3.47	5.5% (n=3)	18.2% (n=10)	34.5% (n=19)	21.8% (n=12)	20.0% (n=11)	3.33
Parenting education	53/72	73.6%	5.7% (n=3)	18.9% (n=10)	37.7% (n=20)	28.3% (n=15)	9.4% (n=5)	3.17	14.0% (n=7)	34.0% (n=17)	34.0% (n=17)	14.0% (n=7)	4.0% (n=2)	2.60
Group therapy and/or counseling	47/71	66.2%	0% (n=0)	8.5% (n=4)	34.0% (n=16)	40.4% (n=19)	17.0% (n=8)	3.66	4.5% (n=2)	11.4% (n=5)	31.8% (n=14)	36.4% (n=16)	15.9% (n=7)	3.48
Wrap-around services	43/70	61.4%	2.3% (n=1)	18.6% (n=8)	44.2% (n=19)	23.3% (n=10)	11.6% (n=5)	3.23	20.0% (n=8)	37.5% (n=15)	25.0% (n=10)	7.5% (n=3)	10.0% (n=4)	2.50
Transportation services	41/72	56.9%	0% (n=0)	5.0% (n=2)	40.0% (n=16)	40.0% (n=16)	15.0% (n=6)	3.65	28.2% (n=11)	23.1% (n=9)	30.8% (n=12)	10.3% (n=4)	7.7% (n=3)	2.46
Emergency and crisis services	38/70	54.3%	5.3% (n=2)	31.6% (n=12)	36.8% (n=14)	18.4% (n=7)	7.9% (n=3)	2.92	13.9% (n=5)	33.3% (n=12)	19.4% (n=7)	19.4% (n=7)	13.9% (n=5)	2.86
In-home family services	35/71	49.3%	5.7% (n=2)	17.1% (n=6)	42.9% (n=15)	28.6% (n=10)	5.7% (n=2)	3.11	30.3% (n=10)	21.2% (n=7)	24.2% (n=8)	24.2% (n=8)	0% (n=0)	2.42
Housing services	33/70	47.1%	0% (n=0)	25.0% (n=8)	56.3% (n=18)	12.5% (n=4)	6.3% (n=2)	3.00	20.0% (n=6)	20.0% (n=6)	36.7% (n=11)	16.7% (n=5)	6.7% (n=2)	2.70
Homeless services	33/71	46.5%	6.1% (n=2)	30.3% (n=10)	51.5% (n=17)	6.1% (n=2)	6.1% (n=2)	2.76	24.1% (n=7)	17.2% (n=5)	31.0% (n=9)	10.3% (n=3)	17.2% (n=5)	2.79
Family support services	32/70	45.7%	6.3% (n=2)	21.9% (n=7)	43.8% (n=14)	18.85 (n=6)	9.4% (n=3)	3.03	17.2% (n=5)	27.6% (n=8)	27.6% (n=8)	10.3% (n=3)	17.2% (n=5)	2.83
Mental retardation/development al disabilities services	32/70	45.7%	9.7% (n=3)	19.4% (n=6)	35.5% (n=11)	22.6% (n=7)	12.9% (n=4)	3.10	10.3% (n=3)	17.2% (n=5)	17.2% (n=5)	20.7% (n=6)	34.5% (n=10)	3.52

Primary health care	32/70	45.7%	0% (n=0)	6.7% (n=2)	46.7% (n=14)	33.3% (n=10)	13.3% (n=4)	3.53	6.7% (n=2)	13.3% (n=4)	46.7% (n=14)	20.0% (n=6)	13.3% (n=4)	3.20
Home-based services	32/71	45.1%	9.4% (n=3)	21.9% (n=7)	40.6% (n=13)	12.5% (n=4)	15.6% (n=5)	3.03	19.4% (n=6)	19.4% (n=6)	41.9% (n=13)	12.9% (n=4)	6.5% (n=2)	2.68
Medication management	30/70	42.9%	6.9% (n=2)	6.9% (n=2)	41.4% (n=12)	24.1% (n=7)	20.7% (n=6)	3.45	6.9% (n=2)	24.1% (n=7)	37.9% (n=11)	20.7% (n=6)	10.3% (n=3)	3.03
Youth education	28/68	41.2%	7.4% (n=2)	25.9% (n=7)	25.9% (n=7)	22.2% (n=6)	18.5% (n=5)	3.19	16.0% (n=4)	20.0% (n=5)	28.0% (n=7)	8.0% (n=2)	28.0% (n=7)	3.12
Case management	27/67	40.3%	0% (n=0)	11.5% (n=3)	46.2% (n=12)	34.6% (n=9)	7.7% (n=2)	3.38	4.0% (n=1)	20.0% (n=5)	24.0% (n=6)	36.0% (n=9)	16.0% (n=4)	3.40
Nutrition services	25/69	36.2%	0% (n=0)	2.92% (n=7)	41.7% (n=10)	16.7% (n=4)	12.5% (n=3)	3.13	8.7% (n=2)	34.8% (n=2)	34.8% (n=8)	17.4% (n=4)	4.3% (n=1)	2.63
Supported education/training	23/68	33.8%	0% (n=0)	26.1% (n=6)	47.8% (n=11)	21.7% (n=5)	4.3% (n=1)	3.04	4.5% (n=1)	27.3% (n=6)	45.5% (n=10)	18.2% (n=4)	4.5% (n=1)	2.91
Assistance to non-English	21/71	29.6%	9.5% (n=2)	38.1% (n=8)	23.8% (n=5)	19.0% (n=4)	9.5% (n=2)	2.81	15.0% (n=3)	15.0% (n=3)	30.0% (n=6)	25.0% (n=5)	15.0% (n=3)	3.10
Legal advocacy	20/71	28.2%	10.0% (n=2)	30.0% (n=6)	50.0% (n=10)	10.0% (n=2)	0% (n=0)	2.60	30.0% (n=6)	25.0% (n=5)	25.0% (n=5)	15.0% (n=3)	5.0% (n=1)	2.40
Money management	18/68	26.5%	5.6% (n=1)	33.3% (n=6)	33.3% (n=6)	16.7% (n=3)	11.1% (n=2)	2.94	27.8% (n=5)	33.3% (n=6)	22.2% (n=4)	16.7% (n=3)	0% (n=0)	2.28
Payeeships	18/68	26.5%	5.6% (n=1)	38.9% (n=7)	22.2% (n=4)	27.8% (n=8)	5.6% (n=1)	2.89	28.6% (n=4)	35.7% (n=5)	21.4% (n=3)	7.1% (n=1)	7.1% (n=1)	2.29
Supported employment	16/68	23.5%	0% (n=0)	20.0% (n=3)	53.3% (n=8)	13.3% (n=2)	13.3% (n=2)	3.20	26.7% (n=4)	6.7% (n=1)	46.7% (n=7)	20.0% (n=3)	0% (n=0)	2.60
Drug screening services	16/69	23.2%	0% (n=0)	18.8% (n=3)	37.5% (n=6)	43.8% (n=7)	0% (n=0)	3.25	31.3% (n=5)	43.8% (n=7)	12.5% (n=2)	12.5% (n=2)	0% (n=0)	2.06
Therapeutic foster care	13/68	19.1%	30.8% (n=4)	23.1% (n=3)	30.8% (n=4)	15.4% (n=2)	0% (n=0)	2.31	38.5% (n=5)	7.7% (n=1)	23.1% (n=3)	15.4% (n=2)	15.4% (n=2)	2.62
Assistance to hearing-impaired	13/70	18.6%	7.1% (n=1)	28.6% (n=4)	42.9% (n=6)	21.4% (n=3)	0% (n=0)	2.79	13.3% (n=2)	13.3% (n=2)	33.3% (n=5)	13.3% (n=2)	26.7% (n=4)	3.27
Meal services	12/69	17.4%	8.3% (n=1)	16.7% (n=2)	50.0% (n=6)	16.7% (n=2)	8.3% (n=1)	3.00	8.3% (n=1)	16.7% (n=2)	41.7% (n=5)	8.3% (n=1)	25.0% (n=3)	3.25
Court-ordered work	10/68	14.7%	10.0% (n=1)	50.0% (n=5)	20.0% (n=2)	20.0% (n=2)	0% (n=0)	2.50	10.0% (n=1)	40.0% (n=4)	10.0% (n=1)	30.0% (n=3)	10.0% (n=1)	2.64
General daily living activities	7/69	10.1%	0% (n=0)	28.6% (n=2)	42.9% (n=3)	14.3% (n=1)	14.3% (n=1)	3.14	0% (n=0)	14.3% (n=1)	28.6% (n=2)	28.6% (n=2)	28.6% (n=2)	3.71
Neuropsychological services	7/69	10.1%	28.6% (n=2)	28.6% (n=2)	28.6% (n=2)	14.3% (n=1)	0% (n=0)	2.29	14.3% (n=1)	14.3% (n=1)	14.3% (n=1)	28.6% (n=2)	28.6% (n=2)	3.43

Independent living services	5/67	7.5%	0% (n=0)	40.0% (n=2)	40.0% (n=2)	20.0% (n=1)	0% (n=0)	2.80	40.0% (n=2)	20.0% (n=1)	20.0% (n=1)	20.0% (n=1)	0% (n=0)	2.20
Specialized services for the elderly	1/68	1.5%	0% (n=0)	0% (n=0)	100% (n=1)	0% (n=0)	0% (n=0)	3.00	0% (n=0)	0% (n=0)	1.4% (n=1)	0% (n=0)	0% (n=0)	3.00

Figure 23. Need for Service and Delivery of Service for Ranked Services Needed by Clients (Schools)



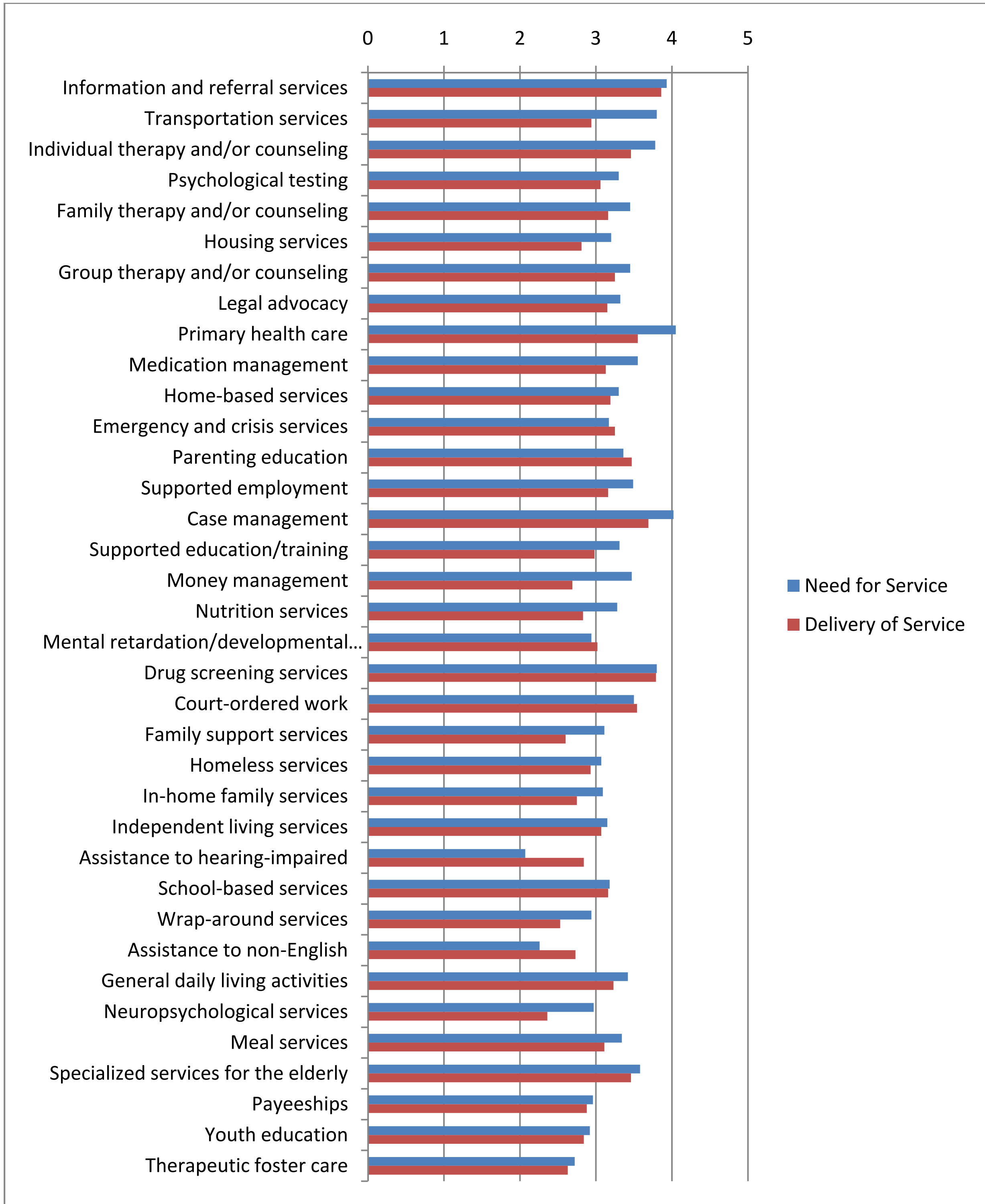
Note: Services listed above are ranked based on the need indicated by clients of direct service providers.

Table 144. Ranking of Services for Which Clients Have Need – Ancillary Service Providers (Non Schools)														
Service	Number of organizations whose clients have need for service		How often do clients need this service?						How often do clients receive this service from you or other organizations?					
	Number of Respondents	Percent of Respondents	1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always	Mean	1 Almost Never	2 Rarely	3 Sometimes	4 Often	5 Almost Always	Mean
Information and referral services	92/103	89.3%	0% (n=0)	9.1% (n=8)	25.0% (n=22)	29.5% (n=26)	36.4% (n=32)	3.93	2.4% (n=2)	8.2% (n=7)	27.1% (n=23)	25.9% (n=22)	36.5% (n=31)	3.86
Transportation services	84/101	83.2%	0% (n=0)	7.2% (n=6)	32.5% (n=27)	33.7% (n=28)	26.5% (n=22)	3.80	13.6% (n=11)	25.9% (n=21)	29.6% (n=24)	14.8% (n=12)	16.0% (n=13)	2.94
Individual therapy and/or counseling	82/99	82.8%	2.6% (n=2)	5.2% (n=4)	27.3% (n=21)	41.6% (n=32)	23.4% (n=32)	3.78	8.3% (n=6)	9.7% (n=7)	27.8% (n=20)	36.1% (n=26)	18.1% (n=13)	3.46
Psychological testing	72/95	75.8%	0% (n=0)	17.4% (n=12)	44.9% (n=31)	27.5% (n=19)	10.1% (n=7)	3.30	10.6% (n=7)	16.7% (n=11)	40.9% (n=27)	19.7% (n=13)	12.1% (n=8)	3.06
Family therapy and/or counseling	67/94	71.3%	0% (n=0)	13.8% (n=9)	4.1% (n=28)	27.7% (n=18)	15.4% (n=10)	3.45	9.7% (n=6)	16.1% (n=10)	37.1% (n=23)	22.6% (n=14)	14.5% (n=9)	3.16
Housing services	69/97	71.1%	7.7% (n=5)	16.9% (n=11)	38.5% (n=25)	21.5% (n=14)	15.4% (n=10)	3.20	15.6% (n=10)	23.4% (n=15)	34.4% (n=22)	17.2% (n=11)	9.4% (n=6)	2.81
Group therapy and/or counseling	67/96	69.8%	1.5% (n=1)	13.6% (n=9)	37.9% (n=25)	31.8% (n=21)	15.2% (n=10)	3.45	7.9% (n=5)	17.5% (n=11)	31.7% (n=20)	27.0% (n=17)	15.9% (n=10)	3.25
Legal advocacy	67/99	67.7%	4.6% (n=3)	16.9% (n=11)	41.5% (n=27)	15.4% (n=10)	21.5% (n=14)	3.32	11.5% (n=7)	16.4% (n=10)	39.3% (n=24)	11.5% (n=7)	21.3% (n=13)	3.15
Primary health care	64/95	67.4%	1.6% (n=1)	6.6% (n=4)	21.3% (n=13)	26.2% (n=16)	44.3% (n=27)	4.05	5.0% (n=3)	16.7% (n=10)	30.0% (n=18)	15.0% (n=9)	33.3% (n=20)	3.55
Medication management	63/95	66.3%	1.6% (n=1)	12.9% (n=8)	30.6% (n=19)	38.7% (n=24)	16.1% (n=10)	3.55	10.0% (n=6)	20.0% (n=12)	33.3% (n=20)	20.0% (n=12)	16.7% (n=10)	3.13
Home-based services	61/97	62.9%	1.8% (n=1)	17.5% (n=10)	43.9% (n=25)	22.8% (n=13)	14.0% (n=8)	3.30	5.6% (n=3)	27.8% (n=15)	29.6% (n=16)	16.7% (n=9)	20.4% (n=11)	3.19
Emergency and crisis services	59/95	62.1%	5.2% (n=3)	15.5% (n=9)	48.3% (n=28)	19.0% (n=11)	12.1% (n=7)	3.17	7.3% (n=4)	21.8% (n=12)	32.7% (n=18)	14.5% (n=8)	23.6% (n=13)	3.25
Parenting education	58/94	61.7%	5.5% (n=3)	14.5% (n=8)	38.2% (n=21)	21.8% (n=12)	20.0% (n=11)	3.36	3.6% (n=2)	23.6% (n=13)	20.0% (n=11)	27.3% (n=15)	25.5% (n=14)	3.47
Supported employment	58/96	60.4%	2.0% (n=1)	7.8% (n=4)	41.2% (n=21)	37.3% (n=19)	11.8% (n=6)	3.49	8.0% (n=4)	20.0% (n=10)	38.0% (n=19)	16.0% (n=8)	18.0% (n=9)	3.16
Case management	59/98	60.2%	3.6% (n=2)	3.6% (n=2)	25.0% (n=14)	23.2% (n=13)	44.6% (n=25)	4.02	13.0% (n=7)	3.7% (n=2)	27.8% (n=15)	13.0% (n=7)	42.6% (n=23)	3.69

Supported education/training	56/93	60.2%	1.9% (n=1)	11.1% (n=6)	50.0% (n=27)	27.8% (n=15)	9.3% (n=5)	3.31	11.3% (n=6)	18.9% (n=10)	43.4% (n=23)	13.2% (n=7)	13.2% (n=7)	2.98
Money management	57/96	59.4%	1.9% (n=1)	15.1% (n=8)	39.6% (n=21)	20.8% (n=11)	22.6% (n=12)	3.47	17.3% (n=9)	21.2% (n=11)	42.3% (n=22)	13.5% (n=7)	5.8% (n=3)	2.69
Nutrition services	52/95	54.7%	6.0% (n=3)	8.0% (n=4)	46.0% (n=23)	32.0% (n=16)	8.0% (n=4)	3.28	14.9% (n=7)	17.0% (n=8)	46.8% (n=22)	12.8% (n=6)	8.5% (n=4)	2.83
Mental retardation/developmental disabilities services	51/96	53.1%	6.4% (n=3)	21.3% (n=10)	53.2% (n=25)	10.6% (n=5)	8.5% (n=4)	2.94	8.7% (n=4)	23.9% (n=11)	34.8% (n=16)	21.7% (n=10)	10.9% (n=5)	3.02
Drug screening services	49/93	52.7%	6.1% (n=3)	2.0% (n=1)	32.7% (n=16)	24.5% (n=12)	34.7% (n=17)	3.80	8.3% (n=4)	12.5% (n=6)	16.7% (n=8)	16.7% (n=8)	45.8% (n=22)	3.79
Court-ordered work	49/96	51.0%	6.0% (n=3)	16.0% (n=8)	22.0% (n=11)	34.0% (n=17)	22.0% (n=11)	3.50	6.5% (n=3)	10.9% (n=5)	30.4% (n=14)	26.1% (n=12)	26.1% (n=12)	3.54
Family support services	49/96	51.0%	4.4% (n=2)	15.6% (n=7)	53.3% (n=24)	17.8% (n=8)	8.9% (n=4)	3.11	16.3% (n=7)	30.2% (n=13)	37.2% (n=16)	9.3% (n=4)	7.0% (n=3)	2.60
Homeless services	48/95	50.5%	8.7% (n=4)	23.9% (n=11)	34.8% (n=16)	17.4% (n=8)	15.2% (n=7)	3.07	9.3% (n=4)	32.6% (n=14)	32.6% (n=14)	7.0% (n=3)	18.6% (n=8)	2.93
In-home family services	46/96	47.9%	6.5% (n=3)	19.6% (n=9)	45.7% (n=21)	15.2% (n=7)	13.0% (n=6)	3.09	20.5% (n=9)	25.0% (n=11)	29.5% (n=13)	9.1% (n=4)	15.9% (n=7)	2.75
Independent living services	45/96	46.9%	0% (n=0)	24.4% (n=10)	48.8% (n=20)	14.6% (n=6)	12.2% (n=5)	3.15	16.7% (n=7)	16.7% (n=7)	26.2% (n=11)	23.8% (n=10)	16.7% (n=7)	3.07
Assistance to hearing-impaired	43/96	44.8%	26.2% (n=11)	50.0% (n=21)	16.7% (n=7)	4.8% (n=2)	2.4% (n=1)	2.07	23.7% (n=9)	26.3% (n=10)	18.4% (n=7)	5.3% (n=2)	26.3% (n=10)	2.84
School-based services	41/95	43.2%	2.6% (n=1)	10.3% (n=4)	66.7% (n=26)	7.7% (n=3)	12.8% (n=5)	3.18	10.8% (n=4)	10.8% (n=4)	45.9% (n=17)	16.2% (n=6)	16.2% (n=6)	3.16
Wrap-around services	39/94	41.5%	2.8% (n=1)	27.8% (n=10)	47.2% (n=17)	16.7% (n=6)	5.6% (n=2)	2.94	11.1% (n=4)	47.2% (n=17)	25.0% (n=9)	11.1% (n=4)	5.6% (n=2)	2.53
Assistance to non-English	40/98	40.8%	16.3% (n=7)	48.8% (n=21)	30.2% (n=13)	2.3% (n=1)	2.3% (n=1)	2.26	19.5% (n=8)	29.3% (n=12)	22.0% (n=9)	17.1% (n=7)	12.2% (n=5)	2.73
General daily living activities	33/90	36.7%	3.0% (n=1)	15.2% (n=5)	36.4% (n=12)	27.3% (n=9)	18.2% (n=6)	3.42	3.2% (n=1)	25.8% (n=8)	32.3% (n=10)	22.6% (n=7)	16.1% (n=5)	3.23
Neuropsychological services	32/91	35.2%	6.9% (n=2)	31.0% (n=9)	31.0% (n=9)	20.7% (n=6)	10.3% (n=3)	2.97	28.6% (n=8)	28.6% (n=8)	25.0% (n=7)	14.3% (n=4)	3.6% (n=1)	2.36
Meal services	29/90	32.2%	13.8% (n=4)	13.8% (n=4)	27.6% (n=8)	13.8% (n=4)	31.0% (n=9)	3.34	14.3% (n=4)	28.6% (n=8)	17.9% (n=5)	10.7% (n=3)	28.6% (n=8)	3.11
Specialized services for the elderly	29/92	31.5%	3.8% (n=1)	15.4% (n=4)	30.8% (n=8)	19.2% (n=5)	30.8% (n=8)	3.58	3.8% (n=1)	11.5% (n=3)	42.3% (n=11)	19.2% (n=5)	23.1% (n=6)	3.46

Payeeships	29/97	29.9%	3.6% (n=1)	25.0% (n=7)	53.6% (n=15)	7.1% (n=2)	10.7% (n=3)	2.96	0% (n=0)	30.8% (n=8)	57.7% (n=15)	3.8% (n=1)	7.7% (n=2)	2.88
Youth education	26/90	28.9%	4.0% (n=1)	32.0% (n=8)	40.0% (n=10)	16.0% (n=4)	8.0% (n=2)	2.92	8.0% (n=2)	36.0% (n=9)	32.0% (n=8)	12.0% (n=3)	12.0% (n=3)	2.84
Therapeutic foster care	17/95	17.9%	11.1% (n=2)	33.3% (n=6)	38.9% (n=7)	5.6% (n=1)	11.1% (n=2)	2.72	25.0% (n=4)	25.0% (n=4)	25.0% (n=4)	12.5% (n=2)	12.5% (n=2)	2.63

Figure 24. Need for Service and Delivery of Service for Ranked Services Needed by Clients (Non-School Ancillary Service Providers)



Note: Services listed above are ranked based on the need indicated by clients of direct service providers.

Table 145. Ranking of Services for Which Clients Have Need – Ancillary Service Providers (All Respondents)					
Schools			Non-Schools		
Service	Rank	% of respondents that indicate clients have need for service	Service	Rank	% of respondents that indicate clients have need for service
Individual therapy and/or counseling	1	94.4%	Information and referral services	1	89.3%
School-based services	2	91.4%	Transportation services	2	83.2%
Information and referral services	3	87.3%	Individual therapy and/or counseling	3	82.8%
Family therapy and/or counseling	4	84.5%	Psychological testing	4	75.8%
Psychological testing	5	83.1%	Family therapy and/or counseling	5	71.3%
Parenting education	6	73.6%	Housing services	6	71.1%
Group therapy and/or counseling	7	66.2%	Group therapy and/or counseling	7	69.8%
Wrap-around services	8	61.4%	Legal advocacy	8	67.7%
Transportation services	9	56.9%	Primary health care	9	67.4%
Emergency and crisis services	10	54.3%	Medication management	10	66.3%
In-home family services	11	49.3%	Home-based services	11	62.9%
Housing services	12	47.1%	Emergency and crisis services	12	62.1%
Homeless services	13	46.5%	Parenting education	13	61.7%
Family support services	14	45.7%	Supported employment	14	60.4%
Mental retardation/developmental disabilities services	14	45.7%	Case management	15	60.2%
Primary health care	14	45.7%	Supported education/training	15	60.2%
Home-based services	17	45.1%	Money management	17	59.4%
Medication management	18	42.9%	Nutrition services	18	54.7%
Youth education	19	41.2%	Mental retardation/developmental disabilities services	19	53.1%
Case management	20	40.3%	Drug screening services	20	52.7%
Nutrition services	21	36.2%	Court-ordered work	21	51.0%
Supported education/training	22	33.8%	Family support services	21	51.0%
Assistance to non-English	23	29.6%	Homeless services	23	50.5%
Legal advocacy	24	28.2%	In-home family services	24	47.9%
Money management	25	26.5%	Independent living services	25	46.9%
Payeeships	25	26.5%	Assistance to hearing-impaired	26	44.8%
Supported employment	27	23.5%	School-based services	27	43.2%
Drug screening services	28	23.2%	Wrap-around services	28	41.5%
Therapeutic foster care	29	19.1%	Assistance to non-English	29	40.8%
Assistance to hearing-impaired	30	18.6%	General daily living activities	30	36.7%
Meal services	31	17.4%	Neuropsychological services	31	35.2%
Court-ordered work	32	14.7%	Meal services	32	32.2%
General daily living activities	33	10.1%	Specialized services for the elderly	33	31.5%
Neuropsychological services	33	10.1%	Payeeships	34	29.9%
Independent living services	35	7.5%	Youth education	35	28.9%
Specialized services for the elderly	36	1.5%	Therapeutic foster care	36	17.9%

Indicator 4.6 The barriers to accessing mental health and addiction services that consumers experience and the degree to which certain issues pose barriers for clients

One of the key issues addressed through the needs assessment process was the extent to which various barriers prevent individuals from receiving mental health and addiction services. Both direct service and ancillary service providers responded to a list of potential barriers by rating how much of a barrier the issues were to their clients. The scale ranged from 'Not a Barrier' to 'Extreme Barrier.' The top five barriers rated by direct service providers included:

- Underinsured patients
- Clients unable to pay for services
- Lack of early intervention
- Clients have co-existing conditions
- Stigma related to seeking/receiving mental healthcare

The ranking of barriers was fairly similar for the different subgroups of direct service providers. Medium organizations did rate the lack of treatment providers for minorities or individuals from other cultures as the greatest barrier, which was not mirrored by the other groups or the overall numbers.

Table 146. Potential Barriers to Clients Receiving Addiction and/or Mental Health Services – Direct Service Providers (All Respondents)								
Potential Barrier	Response Options					N	Mean*	SD
	Not a Barrier	Somewhat of a Barrier	Moderate Barrier	Large Barrier	Extreme Barrier			
Lack of early intervention	21.7% n=5	17.4% n=4	30.4% n=7	17.4% n=4	13.0% n=3	23	2.83	1.34
Lack of access to medication	30.4% n=7	17.4% n=4	13.0% n=3	30.4% n=7	8.7% n=2	23	2.70	1.43
Clients who require services are incarcerated	56.5% n=13	17.4% n=4	13.0% n=3	8.7% n=2	4.3% n=1	23	1.87	1.22
Clients have co-existing conditions	12.5% n=3	29.2% n=7	37.5% n=9	12.5% n=3	8.3% n=2	24	2.75	1.11
Transportation issues	25.0% n=6	45.8% n=11	12.5% n=3	8.3% n=2	8.3% n=2	24	2.29	1.20
Transient populations	45.5% n=10	36.4% n=8	18.2% n=4	0.0% n=0	0.0% n=0	22	1.73	0.77
Language barriers	56.5% n=13	34.8% n=8	4.3% n=1	4.3% n=1	0.0% n=0	23	1.57	0.79
Clients unable to pay for services	13.0% n=3	30.4% n=7	21.7% n=5	17.4% n=4	17.4% n=4	23	2.96	1.33
Clients unaware of existing services	13.0% n=3	30.4% n=7	39.1% n=9	13.0% n=3	4.3% n=1	23	2.65	1.03
Stigma related to seeking/ receiving mental healthcare	17.4% n=4	26.1% n=6	39.1% n=9	0.0% n=0	17.4% n=4	23	2.74	1.29

Child care while client in treatment	21.7% n=5	47.8% n=11	13.0% n=3	8.7% n=2	8.7% n=2	23	2.35	1.19
Lack of weekend or evening appointment times	43.5% n=10	34.8% n=8	17.4% n=4	4.3% n=1	0.0% n=0	23	1.83	0.89
Underinsured patients	27.3% n=6	13.6% n=3	13.6% n=3	22.7% n=5	22.7% n=5	22	3.00	1.57
Lack of treatment providers for minorities or individuals from other cultures	31.8% n=7	31.8% n=7	13.6% n=3	13.6% n=3	9.1% n=2	22	2.36	1.33
Lack of specialized services for the elderly	47.6% n=10	28.6% n=6	9.5% n=2	9.5% n=2	4.8% n=1	21	1.95	1.20
Lack of specialized services for youth	50.0% n=10	15.0% n=3	10.0% n=2	5.0% n=1	20.0% n=4	20	2.30	1.63
No service available for client's issue	52.4% n=11	14.3% n=3	14.3% n=3	9.5% n=2	9.5% n=2	21	2.10	1.41
Lack of trained staff to provide treatment to clients	60.0% n=12	15.0% n=3	15.0% n=3	10.0% n=2	0.0% n=0	20	1.75	1.07
Lack of 24-hour emergency services	65.0% n=13	5.0% n=1	15.0% n=3	15.0% n=3	0.0% n=0	20	1.80	1.20

*The higher the mean, the more significant the barrier as rated by direct service providers (possible mean range is 1 to 5)

Note: Other barriers include (1) Lack of long-term intensive services for individuals without insurance or unemployed, (2) Lack of psych services-hospitalization for MRDD population, (3) Lack of specialized services for MR patients, (4) Medicaid enrollment procedure, (5) Excessively long wait times for initial appointment 8-12 weeks sometimes, (6) Lack of specialized services for eating disorders patients, and (7) Lack of access to psychiatrist for med assessment

Table 147. Potential Barriers to Clients Receiving Addiction and/or Mental Health Services – Direct Service Providers (By Organization Grouping)

Small Providers (serve less than 250 clients annually)

Potential Barrier	Response Options					N	Mean*	SD
	Not a Barrier	Somewhat of a Barrier	Moderate Barrier	Large Barrier	Extreme Barrier			
Lack of early intervention	20.0% n=2	10.0% n=1	30.0% n=3	30.0% n=3	10.0% n=1	10	3.00	1.33
Lack of access to medication	40.0% n=4	30.0% n=3	10.0% n=1	20.0% n=2	0.0% n=0	10	2.10	1.20
Clients who require services are incarcerated	70.0% n=7	10.0% n=1	0.0% n=0	20.0% n=2	0.0% n=0	10	1.70	1.25
Clients have co-existing conditions	10.0% n=1	40.0% n=4	40.0% n=4	0.0% n=0	10.0% n=1	10	2.60	1.08
Transportation issues	20.0% n=2	60.0% n=6	10.0% n=1	0.0% n=0	10.0% n=1	10	2.20	1.14
Transient populations	60.0% n=6	30.0% n=3	10.0% n=1	0.0% n=0	0.0% n=0	10	1.50	0.71

Language barriers	70.0% n=7	30.0% n=3	0.0% n=0	0.0% n=0	0.0% n=0	10	1.30	0.48
Clients unable to pay for services	30.0% n=3	20.0% n=2	20.0% n=2	20.0% n=2	10.0% n=1	10	2.60	1.43
Clients unaware of existing services	20.0% n=2	30.0% n=3	40.0% n=4	0.0% n=0	10.0% n=1	10	2.50	1.18
Stigma related to seeking/ receiving mental healthcare	20.0% n=2	20.0% n=2	40.0% n=4	0.0% n=0	20.0% n=2	10	2.80	1.40
Child care while client in treatment	20.0% n=2	60.0% n=6	20.0% n=2	0.0% n=0	0.0% n=0	10	2.00	0.67
Lack of weekend or evening appointment times	30.0% n=3	40.0% n=4	20.0% n=2	10.0% n=1	0.0% n=0	10	2.10	0.99
Underinsured patients	30.0% n=3	20.0% n=2	20.0% n=2	20.0% n=2	10.0% n=1	10	2.60	1.43
Lack of treatment providers for minorities or individuals from other cultures	30.0% n=3	50.0% n=5	10.0% n=1	0.0% n=0	10.0% n=1	10	2.10	1.20
Lack of specialized services for the elderly	60.0% n=6	30.0% n=3	0.0% n=0	0.0% n=0	10.0% n=1	10	1.70	1.25
Lack of specialized services for youth	50.0% n=5	10.0% n=1	10.0% n=1	10.0% n=1	20.0% n=2	10	2.40	1.71
No service available for client's issue	60.0% n=6	10.0% n=1	10.0% n=1	0.0% n=0	20.0% n=2	10	2.10	1.66
Lack of trained staff to provide treatment to clients	60.0% N=6	30.0% n=3	0.0% n=0	10.0% n=1	0.0% n=0	10	1.60	0.97
Lack of 24-hour emergency services	80.0% n=8	0.0% n=0	20.0% n=2	0.0% n=0	0.0% n=0	10	1.40	0.84
Medium Providers (serve 250 – 999 clients annually)								
Potential Barrier	**Response Options**					**N**	**Mean***	**SD**
	Not a Barrier	Somewhat of a Barrier	Moderate Barrier	Large Barrier	Extreme Barrier			
Lack of early intervention	28.6% n=2	28.6% n=2	14.3% n=1	0.0% n=0	14.3% n=1	6	2.33	1.51
Lack of access to medication	33.3% n=2	16.7% n=1	0.0% n=0	16.7% n=1	33.3% n=2	6	3.00	1.90
Clients who require services are incarcerated	57.1% n=4	14.3% n=1	14.3% n=1	0.0% n=0	14.3% n=1	7	2.00	1.53
Clients have co-existing conditions	14.3% n=1	28.6% n=2	14.3% n=1	28.6% n=2	14.3% n=1	7	3.00	1.41
Transportation issues	42.9% n=3	14.3% n=1	14.3% n=1	14.3% n=1	14.3% n=1	7	2.43	1.62
Transient populations	33.3% n=2	33.3% n=2	33.3% n=2	0.0% n=0	0.0% n=0	6	2.00	0.89
Language barriers	50.0% n=3	16.7% n=1	16.7% n=1	16.7% n=1	0.0% n=0	6	2.00	1.27

Clients unable to pay for services	0.0% n=0	33.3% n=2	16.7% n=1	16.7% n=1	33.3% n=2	6	3.50	1.38
Clients unaware of existing services	16.7% n=1	16.7% n=1	50.0% n=3	16.7% n=1	0.0% n=0	6	2.67	1.03
Stigma related to seeking/ receiving mental healthcare	16.7% n=1	33.3% n=2	16.7% n=1	0.0% n=0	33.3% n=2	6	3.00	1.67
Child care while client in treatment	16.7% n=1	16.7% n=1	16.7% n=1	16.7% n=1	33.3% n=2	6	3.33	1.63
Lack of weekend or evening appointment times	33.3% n=2	50.0% n=3	16.7% n=1	0.0% n=0	0.0% n=0	6	1.83	0.75
Underinsured patients	20.0% n=1	20.0% n=1	0.0% n=0	20.0% n=1	40.0% n=2	5	3.40	1.82
Lack of treatment providers for minorities or individuals from other cultures	0.0% n=0	20.0% n=1	0.0% n=0	60.0% n=3	20.0% n=1	5	3.80	1.10
Lack of specialized services for the elderly	40.0% n=2	20.0% n=1	0.0% n=0	40.0% n=2	0.0% n=0	5	2.40	1.52
Lack of specialized services for youth	50.0% n=2	25.0% n=1	0.0% n=0	0.0% n=0	25.0% n=1	4	2.25	1.89
No service available for client's issue	60.0% n=3	0.0% n=0	20.0% n=1	20.0% n=1	0.0% n=0	5	2.00	1.41
Lack of trained staff to provide treatment to clients	60.0% n=3	0.0% n=0	20.0% n=1	20.0% n=1	0.0% n=0	5	2.00	1.41
Lack of 24-hour emergency services	40.0% n=2	0.0% n=0	20.0% n=1	40.0% n=2	0.0% n=0	5	2.60	1.52
Large Providers (serve 1,000 + clients annually)								
Potential Barrier	**Response Options**					**N**	**Mean***	**SD**
	Not a Barrier	Somewhat of a Barrier	Moderate Barrier	Large Barrier	Extreme Barrier			
Lack of early intervention	14.3% n=1	14.3% n=1	42.9% n=3	14.3% n=1	14.3% n=1	7	3.00	1.29
Lack of access to medication	14.3% n=1	0.0% n=0	28.6% n=2	57.1% n=4	0.0% n=0	7	3.29	1.11
Clients who require services are incarcerated	33.3% n=2	33.3% n=2	33.3% n=2	8.7% n=0	4.3% n=0	6	2.00	0.89
Clients have co-existing conditions	14.3% n=1	14.3% n=1	57.1% n=4	14.3% n=1	0.0% n=0	7	2.71	0.95
Transportation issues	14.3% n=1	57.1% n=4	14.3% n=1	14.3% n=1	0.0% n=0	7	2.29	0.95
Transient populations	33.3% n=2	50.0% n=3	16.7% n=1	0.0% n=0	0.0% n=0	6	1.83	0.75
Language barriers	42.9% n=3	57.1% n=4	0.0% n=0	0.0% n=0	0.0% n=0	7	1.57	0.54
Clients unable to pay for services	0.0% n=0	42.9% n=3	28.6% n=2	14.3% n=1	14.3% n=1	7	3.00	1.16

Clients unaware of existing services	0.0% n=0	42.9% n=3	28.6% n=2	28.6% n=2	0.0% n=0	7	2.86	0.90
Stigma related to seeking/ receiving mental healthcare	14.3% n=1	28.6% n=2	57.1% n=4	0.0% n=0	0.0% n=0	7	2.43	0.79
Child care while client in treatment	28.6% n=2	57.1% n=4	0.0% n=0	14.3% n=1	0.0% n=0	7	2.00	1.00
Lack of weekend or evening appointment times	71.4% n=5	14.3% n=1	14.3% n=1	0.0% n=0	0.0% n=0	7	1.43	0.79
Underinsured patients	28.6% n=2	0.0% n=0	14.3% n=1	28.6% n=2	28.6% n=2	7	3.29	1.70
Lack of treatment providers for minorities or individuals from other cultures	57.1% n=4	14.3% n=1	28.6% n=2	0.0% n=0	0.0% n=0	7	1.71	0.95
Lack of specialized services for the elderly	33.3% n=2	33.3% n=2	33.3% n=2	0.0% n=0	0.0% n=0	6	2.00	0.89
Lack of specialized services for youth	50.0% n=3	16.7% n=1	16.7% n=1	0.0% n=0	16.7% n=1	6	2.17	1.60
No service available for client's issue	33.3% n=2	33.3% n=2	16.7% n=1	16.7% n=1	0.0% n=0	6	2.17	1.17
Lack of trained staff to provide treatment to clients	60.0% n=3	0.0% n=0	40.0% n=2	0.0% n=0	0.0% n=0	6	1.80	1.10
Lack of 24-hour emergency services	60.0% n=3	20.0% n=1	0.0% n=0	20.0% n=1	0.0% n=0	5	1.80	1.30

*The higher the mean, the more significant the barrier as rated by direct service providers (possible mean range is 1 to 5)

Table 148. Ranking of Potential Barriers from Most to Least Significant Barrier – Direct Service Providers (All Respondents)				
Ranking	Barrier	N	Mean	SD
1	Underinsured patients	22	3.00	1.57
2	Clients unable to pay for services	23	2.96	1.33
3	Lack of early intervention	23	2.83	1.34
4	Clients have co-existing conditions	24	2.75	1.11
5	Stigma related to seeking/receiving mental healthcare	23	2.74	1.29
6	Lack of access to medication	23	2.70	1.43
7	Clients unaware of existing services	23	2.65	1.03
8	Lack of treatment providers for minorities or individuals from other cultures	22	2.36	1.33
9	Child care while client in treatment	23	2.35	1.19
10	Transportation issues	24	2.29	1.20
11	No service available for client's issue	21	2.10	1.41
12	Lack of specialized services for the elderly	21	1.95	1.20
12	Lack of specialized services for youth	21	1.95	1.20
14	Clients who require services are incarcerated	23	1.87	1.22
15	Lack of weekend or evening appointment times	23	1.83	0.89
16	Lack of 24-hour emergency services	20	1.80	1.20
17	Lack of trained staff to provide treatment to clients	20	1.75	1.07
18	Transient populations	22	1.73	0.77
19	Language barriers	23	1.57	0.79

Table 149. Ranking of Potential Barriers from Most to Least Significant Barrier – Direct Service Providers (By Organization Grouping)								
Barrier	All Respondents		Small Orgs.		Medium Orgs.		Large Orgs.	
	Mean	Rank	Mean	Rank	Mean	Rank	Mean	Rank
Underinsured patients	3.00	1	2.60	3	3.40	3	3.29	1
Clients unable to pay for services	2.96	2	2.60	3	3.50	2	3.00	3
Lack of early intervention	2.83	3	3.00	1	2.33	12	3.00	3
Clients have co-existing conditions	2.75	4	2.60	3	3.00	5	2.71	6
Stigma related to seeking/receiving mental healthcare	2.74	5	2.80	2	3.00	5	2.43	7
Lack of access to medication	2.70	6	2.10	9	3.00	5	3.29	1
Clients unaware of existing services	2.65	7	2.50	6	2.67	8	2.86	5
Lack of treatment providers for minorities or individuals from other cultures	2.36	8	2.10	9	3.80	1	1.71	17
Child care while client in treatment	2.35	9	2.00	13	3.33	4	2.00	11
Transportation issues	2.29	10	2.20	8	2.43	10	2.29	8
No service available for client's issue	2.10	11	2.10	9	2.00	14	2.17	9
Lack of specialized services for the elderly	1.95	12	1.70	14	2.40	11	2.00	11
Lack of specialized services for youth	1.95	12	2.40	7	2.25	13	2.17	9
Clients who require services are incarcerated	1.87	14	1.70	14	2.00	14	2.00	11
Lack of weekend or evening appointment times	1.83	15	2.10	9	1.83	19	1.43	19
Lack of 24-hour emergency services	1.80	16	1.40	18	2.60	9	1.80	15
Lack of trained staff to provide treatment to clients	1.75	17	1.60	16	2.00	14	1.80	15
Transient populations	1.73	18	1.50	17	2.00	14	1.83	14
Language barriers	1.57	19	1.30	19	2.00	14	1.57	18

When comparing barriers rated by direct service providers to ancillary service providers, it is noted that the top three barriers for direct service providers were the same for non-school ancillary organizations – 1) underinsured patients, 2) clients unable to pay for services, and 3) lack of early intervention. Transportation issues and the lack of access to medication rounded out the top five for non-school organizations. Note the mean ratings for direct service providers compared to non-schools, where the higher mean indicates a greater barrier. Overall, the non-school ancillary providers were more likely to rate the barriers as more substantial than the direct service providers.

In terms of schools, the barriers listed as the most challenging to consumers were somewhat different from non-schools and direct service providers. Specifically, the top-rated barrier for schools was clients being unaware of existing services. This was followed by clients being unable to pay for services, underinsured patients, lack of early intervention, and lack of specialized services for youth.

Table 150. Potential Barriers to Clients Receiving Addiction and/or Mental Health Services – Schools

Potential Barrier	Response Options					N	Mean*	SD
	Not a Barrier	Somewhat of a Barrier	Moderate Barrier	Large Barrier	Extreme Barrier			
Lack of early intervention	13.0% n=9	23.2% n=16	27.5% n=19	23.2% n=16	13.0% n=9	69	3.00	1.24
Lack of access to medication	17.1% n=12	22.9% n=16	27.1% n=19	21.4% n=15	11.4% n=8	70	2.87	1.26
Clients who require services are incarcerated	82.8% n=53	10.9% n=7	3.1% n=2	1.6% n=1	1.6% n=1	64	1.28	0.75
Clients have co-existing conditions	40.9% n=27	22.7% n=15	22.7% n=15	10.6% n=7	3.0% n=2	66	2.12	1.16
Transportation issues	35.8% n=24	17.9% n=12	23.9% n=16	7.5% n=5	14.9% n=10	67	2.48	1.43
Transient populations	46.3% n=31	16.4% n=11	13.4% n=9	9.0% n=6	14.9% n=10	67	2.30	1.50
Language barriers	70.3% n=45	17.2% n=11	3.1% n=2	9.4% n=6	0.0% n=0	64	1.52	0.94
Clients unable to pay for services	11.6% n=8	24.6% n=17	21.7% n=15	18.8% n=13	23.2% n=16	69	3.17	1.35
Clients unaware of existing services	6.0% n=4	17.9% n=12	28.4% n=19	31.3% n=21	16.4% n=11	67	3.34	1.14
Stigma related to seeking/ receiving mental healthcare	21.7% n=15	20.3% n=14	27.5% n=19	21.7% n=15	8.7% n=6	69	2.75	1.27
Child care while client in treatment	47.7% n=31	26.2% n=17	12.3% n=8	10.8% n=7	3.1% n=2	65	1.95	1.15
Lack of weekend or evening appointment times	35.4% n=23	16.9% n=11	20.0% n=13	18.5% n=12	9.2% n=6	65	2.49	1.38
Underinsured patients	15.2% n=10	24.2% n=16	19.7% n=13	18.2% n=12	22.7% n=15	66	3.09	1.40

Lack of treatment providers for minorities or individuals from other cultures	71.9% n=46	12.5% n=8	6.3% n=4	3.1% n=2	6.3% n=4	64	1.59	1.15
Lack of specialized services for the elderly	87.3% n=55	3.2% n=2	3.2% n=2	4.8% n=3	1.6% n=1	63	1.30	0.87
Lack of specialized services for youth	20.3% n=14	21.7% n=15	20.3% n=14	23.2% n=16	14.5% n=10	69	2.90	1.36
No service available for client's issue	52.3% n=34	21.5% n=14	16.9% n=11	4.6% n=3	4.6% n=3	65	1.88	1.14
Lack of trained staff to provide treatment to clients	46.2% n=30	12.3% n=8	29.2% n=19	4.6% n=3	7.7% n=5	65	2.15	1.28
Lack of 24-hour emergency services	54.8% n=34	21.0% n=13	14.5% n=9	1.6% n=1	8.1% n=5	62	1.87	1.22

*The higher the mean, the more significant the barrier as rated by direct service providers (possible mean range is 1 to 5)
Note: Other barriers listed by respondents include: lack of adequate addiction services; lack of long term residential mental health facility; large gap of time for available appointments for mental health counseling; limited number of beds at [local addiction/mental health facility]; limited number of psychiatrists and available appointments; not enough child and adolescent psychiatrists; and turnover of therapists at mental health facility.

Table 151. Ranking of Potential Barriers from Most to Least Significant Barrier – Schools				
Ranking	Barrier	N	Mean	SD
1	Clients unaware of existing services	67	3.34	1.14
2	Clients unable to pay for services	69	3.17	1.35
3	Underinsured patients	66	3.09	1.40
4	Lack of early intervention	69	3.00	1.24
5	Lack of specialized services for youth	69	2.90	1.36
6	Lack of access to medication	70	2.87	1.26
7	Stigma related to seeking/ receiving mental healthcare	69	2.75	1.27
8	Lack of weekend or evening appointment times	65	2.49	1.38
9	Transportation issues	67	2.48	1.43
10	Transient populations	67	2.30	1.50
11	Lack of trained staff to provide treatment to clients	65	2.15	1.28
12	Clients have co-existing conditions	66	2.12	1.16
13	Child care while client in treatment	65	1.95	1.15
14	No service available for client's issue	65	1.88	1.14
15	Lack of 24-hour emergency services	62	1.87	1.22
16	Lack of treatment providers for minorities or individuals from other cultures	64	1.59	1.15
17	Language barriers	64	1.52	0.94
18	Lack of specialized services for the elderly	63	1.30	0.87
19	Clients who require services are incarcerated	64	1.28	0.75

Table 152. Potential Barriers to Clients Receiving Addiction and/or Mental Health Services – Non-Schools								
Potential Barrier	Response Options					N	Mean*	SD
	Not a Barrier	Somewhat of a Barrier	Moderate Barrier	Large Barrier	Extreme Barrier			
Lack of early intervention	6.5% n=6	14.1% n=13	27.2% n=25	38.0% n=35	14.1% n=13	92	3.39	1.10
Lack of access to medication	7.7% n=7	14.3% n=13	30.8% n=28	33.0% n=30	14.3% n=13	91	3.32	1.12
Clients who require services are incarcerated	39.5% n=34	16.3% n=14	26.7% n=23	11.6% n=10	5.8% n=5	86	2.28	1.26
Clients have co-existing conditions	9.3% n=8	19.8% n=17	26.7% n=23	27.9% n=24	16.3% n=14	86	3.22	1.21
Transportation issues	12.5% n=11	11.4% n=10	21.6% n=19	35.2% n=31	19.3% n=17	88	3.38	1.27
Transient populations	32.9% n=28	20.0% n=17	22.4% n=19	15.3% n=13	9.4% n=8	85	2.48	1.34
Language barriers	44.8% n=39	39.1% n=34	10.3% n=9	2.3% n=2	3.4% n=3	87	1.80	0.96
Clients unable to pay for services	10.5% n=10	12.6% n=12	20.0% n=19	31.6% n=30	25.3% n=24	95	3.48	1.29
Clients unaware of existing services	7.5% n=7	14.0% n=13	36.6% n=34	24.7% n=23	17.2% n=16	93	3.30	1.14
Stigma related to seeking/ receiving mental healthcare	14.1% n=13	27.2% n=25	25.0% n=23	18.5% n=17	15.2% n=14	92	2.93	1.28
Child care while client in treatment	25.0% n=22	26.1% n=23	15.9% n=14	17.0% n=15	15.9% n=14	88	2.73	1.42
Lack of weekend or evening appointment times	16.1% n=14	19.5% n=17	27.6% n=24	19.5% n=17	17.2% n=15	87	3.02	1.32
Underinsured patients	6.7% n=6	13.5% n=12	21.3% n=19	27.0% n=24	31.5% n=28	89	3.63	1.25
Lack of treatment providers for minorities or individuals from other cultures	36.1% n=30	31.3% n=26	13.3% n=11	8.4% n=7	10.8% n=9	83	2.27	1.33
Lack of specialized services for the elderly	41.0% n=34	25.3% n=21	14.5% n=12	12.0% n=10	7.2% n=6	83	2.19	1.29
Lack of specialized services for youth	27.2% n=22	23.5% n=19	22.2% n=18	11.1% n=9	16.0% n=13	81	2.65	1.41
No service available for client's issue	27.7% n=23	27.7% n=23	25.3% n=21	9.6% n=8	9.6% n=8	83	2.46	1.26
Lack of trained staff to provide treatment to clients	26.8% n=22	19.5% n=16	23.2% n=19	18.3% n=15	12.2% n=10	82	2.70	1.37
Lack of 24-hour emergency services	31.3% n=25	21.3% n=17	18.8% n=15	12.5% n=10	16.3% n=13	80	2.61	1.45

*The higher the mean, the more significant the barrier as rated by direct service providers (possible mean range is 1 to 5)

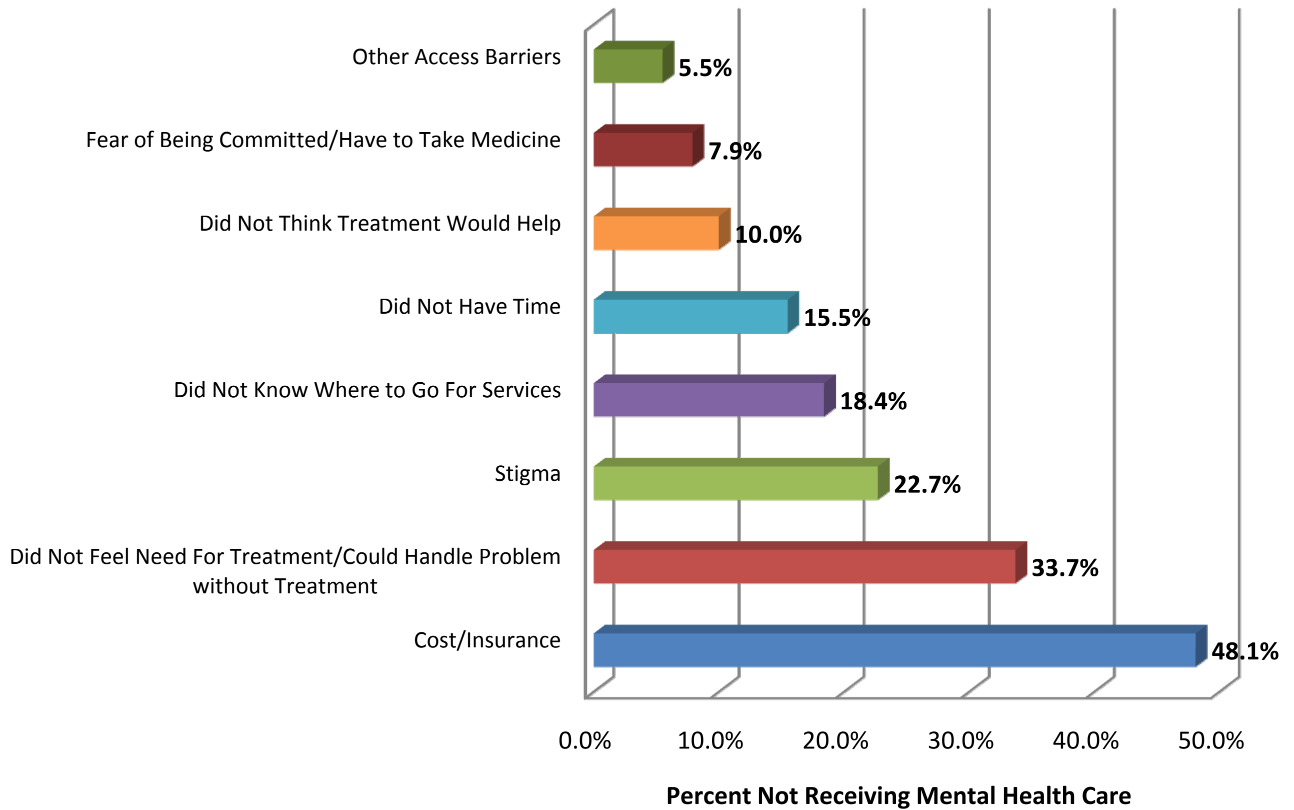
Note: Other barriers listed by respondents include: Behavioral issues, anger management, and dealing with anxiety/stress; clients not motivated; difficulty scheduling appointments; lack of accessible providers; language/cultural issues; Medicaid enrollees; no services to MR/DD clients who are also mentally ill (dually diagnosed); psychological testing; young adult substance abuse treatment; and youth substance abuse treatment.

Table 153. Ranking of Potential Barriers from Most to Least Significant Barrier – Non-Schools				
Ranking	Barrier	N	Mean	SD
1	Underinsured patients	89	3.63	1.25
2	Clients unable to pay for services	95	3.48	1.29
3	Lack of early intervention	92	3.39	1.10
4	Transportation issues	88	3.38	1.27
5	Lack of access to medication	91	3.32	1.12
6	Clients unaware of existing services	93	3.30	1.14
7	Clients have co-existing conditions	86	3.22	1.21
8	Lack of weekend or evening appointment times	87	3.02	1.32
9	Stigma related to seeking/receiving mental healthcare	92	2.93	1.28
10	Child care while client in treatment	88	2.73	1.42
11	Lack of trained staff to provide treatment to clients	82	2.70	1.37
12	Lack of specialized services for youth	81	2.65	1.41
13	Lack of 24-hour emergency services	80	2.61	1.45
14	Transient populations	85	2.48	1.34
15	No service available for client's issue	83	2.46	1.26
16	Clients who require services are incarcerated	86	2.28	1.26
17	Lack of treatment providers for minorities or individuals from other cultures	83	2.27	1.33
18	Lack of specialized services for the elderly	83	2.19	1.29
19	Language barriers	87	1.80	0.96

Table 154. Ranking of Potential Barriers from Most to Least Significant Barrier – All Respondents			
Schools		Non-Schools	
Ranking	Barrier	Ranking	Barrier
1	Clients unaware of existing services	1	Underinsured patients
2	Clients unable to pay for services	2	Clients unable to pay for services
3	Underinsured patients	3	Lack of early intervention
4	Lack of early intervention	4	Transportation issues
5	Lack of specialized services for youth	5	Lack of access to medication
6	Lack of access to medication	6	Clients unaware of existing services
7	Stigma related to seeking/ receiving mental healthcare	7	Clients have co-existing conditions
8	Lack of weekend or evening appointment times	8	Lack of weekend or evening appointment times
9	Transportation issues	9	Stigma related to seeking/receiving mental healthcare
10	Transient populations	10	Child care while client in treatment
11	Lack of trained staff to provide treatment to clients	11	Lack of trained staff to provide treatment to clients
12	Clients have co-existing conditions	12	Lack of specialized services for youth
13	Child care while client in treatment	13	Lack of 24-hour emergency services
14	No service available for client's issue	14	Transient populations
15	Lack of 24-hour emergency services	15	No service available for client's issue
16	Lack of treatment providers for minorities or individuals from other cultures	16	Clients who require services are incarcerated
17	Language barriers	17	Lack of treatment providers for minorities or individuals from other cultures
18	Lack of specialized services for the elderly	18	Lack of specialized services for the elderly
19	Clients who require services are incarcerated	19	Language barriers

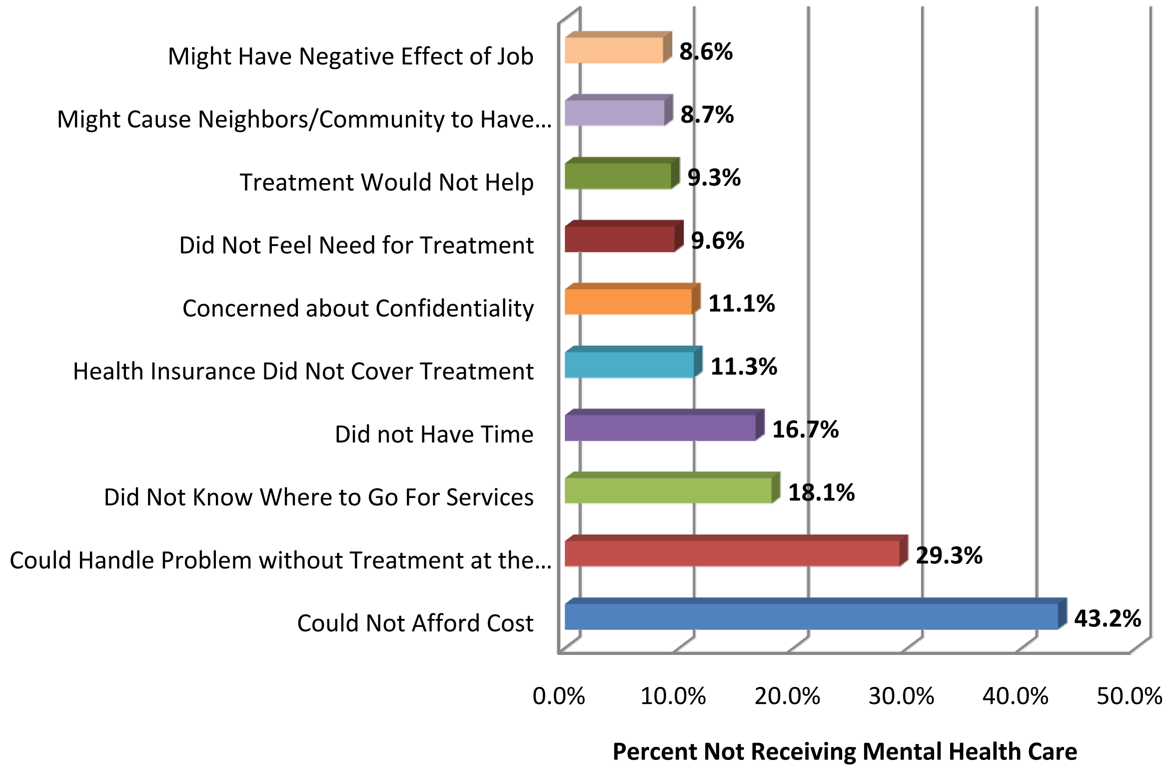
Secondary Data Related to Barriers to Service

The following figures and tables provide national data from the National Survey of Drug Use and Health regarding the reasons individuals do not receive mental health services. Specifically in 2007, the reason most cited for not receiving treatment was not being able to afford the cost. Believing they could handle the problem on their own and not knowing where to go for services also were prominent reasons. Overall, approximately 11% of individuals indicated the reason they did not get treatment was because their health insurance did not cover treatment.



Note: For reason "Did not feel need for treatment/could handle problem without treatment," females = 35.1% and males = 30.7%; for reason "Did not have time," females = 18.2% and males = 10.0%; for reason "Other access barriers," females = 6.2% and males 4.2%; for reason "Fear of being committed/have to take medicine," males = 9.8% and females = 7.0%.
Source: SAMHSA, 2003, 2004, and 2005 National Survey on Drug Use and Health

Reasons for Not Getting Treatment or Counseling for Mental Health Problems in the Past Year among Adults Aged 18 or Older Who Perceived an Unmet Need for Treatment for Mental Health Problems: 2003, 2004, and 2005	
Reason	**Percentage Selecting Reason**
Cost/Insurance	48.1%
Did Not Feel Need For Treatment/Could Handle Problem without Treatment	33.7%
Stigma	22.7%
Did Not Know Where to Go For Services	18.4%
Did Not Have Time	15.5%
Did Not Think Treatment Would Help	10.0%
Fear of Being Committed/Have to Take Medicine	7.9%

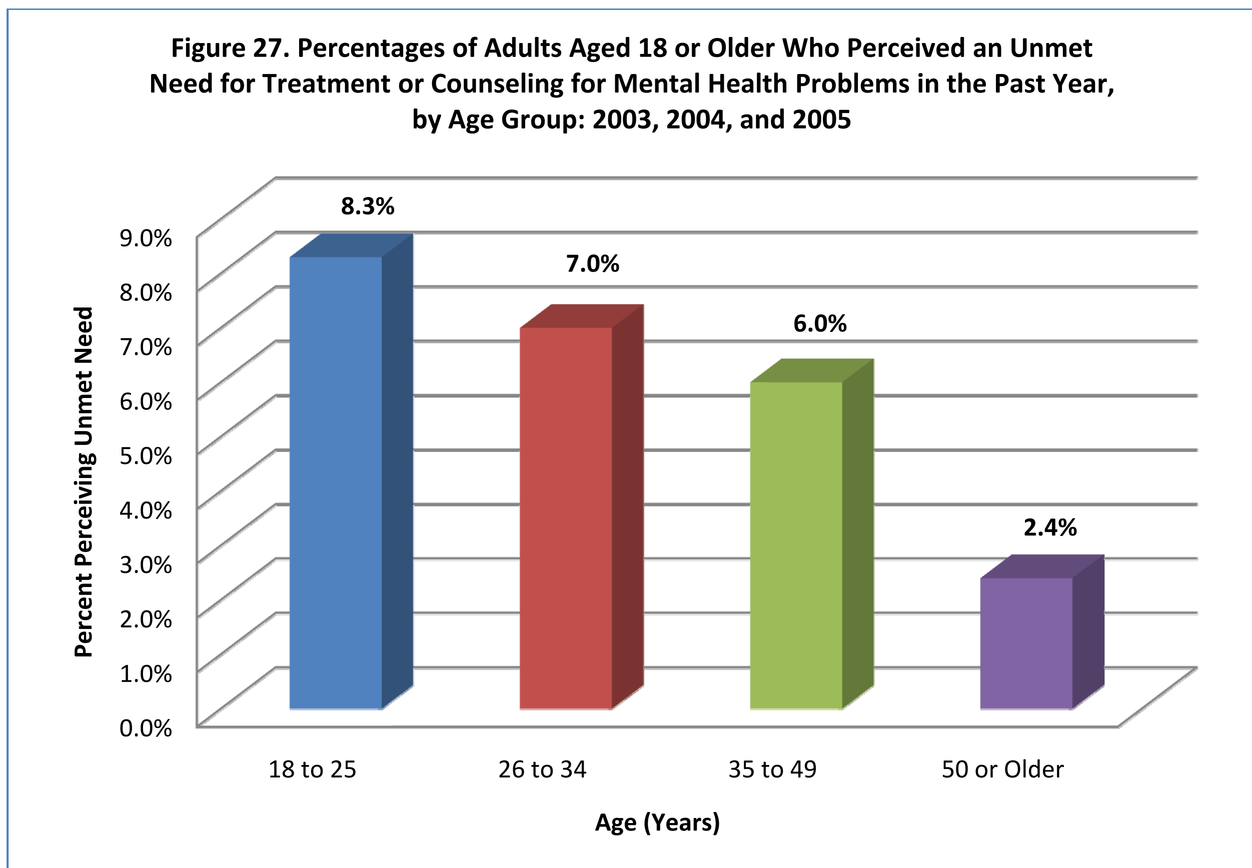


Reasons for Not Receiving Mental Health Treatment in the Past Year among Adults Aged 18 or Older with an Unmet Need for Treatment Who Did Not Receive Treatment: 2007	
Reason	**Percentage Selecting Reason**
Could Not Afford Cost	43.2%
Could Handle Problem without Treatment at the Time	29.3%
Did Not Know Where to Go For Services	18.1%
Did not Have Time	16.7%
Health Insurance Did Not Cover Treatment	11.3%
Concerned about Confidentiality	11.1%
Did Not Feel Need for Treatment	9.6%
Treatment Would Not Help	9.3%
Might Cause Neighbors/Community to Have Negative Opinion	8.7%
Might Have Negative Effect of Job	8.6%

Table 155. Comparison of Indiana to Surrounding States on Barriers to Access Indicators, 2007						
Indicator	Indiana	Michigan	Ohio	Kentucky	Missouri	Illinois
Percent of population reporting could not get health care because of cost	14.1	12.3	13.1	17.7	13.2	12.4
Percent of population reporting unmet need for mental health care treatment/counseling in the past year	5.7	5.1	5.3	6.3	7.4	4.6

Source: Mental Health America, *Ranking of America's Mental Health: An Analysis of Depression Across the States*, December 11, 2007

The following secondary data pertain to unmet needs for mental health services and the rates of people who receive minimally adequate treatment in the United States.



Note: Average of all adults (18 or older) who perceived an unmet need for treatment or counseling for mental health problems in past 12 months (2003-2005 combined) = 5.1%; Females = 6.5%, Males = 3.6%
Source: SAMHSA, 2003, 2004, and 2005 National Survey on Drug Use and Health

Percentages of Adults Aged 18 or Older Who Perceived an Unmet Need for Treatment or Counseling for Mental Health Problems in the Past Year, by Age Group: 2003, 2004, and 2005	
Age	**Percent Perceiving Unmet Need**
18 to 25	8.3%
26 to 34	7.0%
35 to 49	6.0%
50 or Older	2.4%

Table 156. Percent of adults who received treatment for mental health problems and perceived unmet need for treatment in past year, average of 2003-2005	
Group	**% Perceived Unmet Need**
Total Adults*	19.2
Females	20.0
Males	17.2
Age 18 to 25	30.7
Age 26 to 34	24.6
Age 35 to 49	21.0
Age 50 or older	11.1

*A total of 27.9 million adults received treatment in the past year (average of 2003-2005 rates)
Source: SAMHSA, 2003, 2004, and 2005 National Survey on Drug Use and Health

Table 157. Percent of people with serious mental illness who receive minimally adequate treatment, United States, 2002	
Treatment	**Percent**
Received minimally adequate treatment	15.3%
Treatment not minimally adequate	24.7%
Did not receive treatment	60.0%

Source: Primary - Wang, P.S., Demler, O., Kessler, R.C. (2002). Adequacy of treatment for serious mental illness in the United States**.** *American Journal of Public Health, 92*, 92-98.; Secondary - 2004 Chartbook on Mental Health and Disability

Provider and Consumer Focus Group Responses

As shown in the table below, when participant focus group responses were compared, a number of common themes emerged between providers and consumers. Themes included lack of accessible services at the necessary capacity (e.g., not enough programs, and not enough space in the existing programs), cost (e.g., patients are unable to pay for treatment, and necessary treatment programs are under-funded), transportation (e.g., many clients do not have driver's license), lack of individualized treatment (e.g., group programs can be the only options), lack of knowledge about available services (e.g., treatment options and support groups are not advertised), school-related issues (e.g., teachers do not have the authority and/or understanding to refer students for mental health treatment), collaboration among providers (e.g., not working as a team to provide integrated services), court system issues (e.g., mentally ill individuals end up in jail instead of being referred to the treatment they need), and lack of treatment for dual diagnoses (mental illness and addiction, mental illness and MR/DD).

Table 158. Provider and Consumer Perceptions of Barriers to Service				
4. For the needs that you identified as not being adequately met by existing services, why do you think those needs are not being met? (Prompt: Are there specific barriers that keep the needs from being met? Do the necessary services actually exist? Do we have the services available but individuals are unable to access them?)				
Providers		Shared Respondent Group Themes	Consumers	
Themes	Number of Comments		Themes	Number of Comments
• Lack of local/accessible services (e.g., shortage of residential substance abuse treatment programs)	10	• Lack of accessible services at the necessary capacity (e.g., not enough programs, and not enough space in the existing programs)	• Lack of staff/capacity (e.g., Limit on the number of patients ACT team can serve; psychiatrists have to come in from Terre Haute)	7
• Cost/funding (e.g., patients' inability to pay or lack of funding for adolescent addiction services)	9	• Cost (e.g., patients are unable to pay for treatment, and necessary treatment programs are under-funded)	• Cost/funding (e.g., Extensive outpatient (EOP) treatment is based on income ($12/day if no income), but can be as much as $180 per week)	5
• Stigma (e.g., A hug social issue for addicts—no "face of addiction" like there is for mental illness)	7	• Transportation (e.g., many clients do not have driver's license) • Lack of individualized treatment (e.g., group programs can be the only options)	• Employment concerns (e.g., If people cannot find a legitimate job and have trouble paying for treatment, they remember how easy it was to make a lot of money selling drugs and are tempted to do so)	4
• Transportation/ mobility (e.g., Many addicts have lost	6	• Lack of knowledge	• Lack of Individualized attention (e.g., even when individuals can get	3

their driver's license)		about available services (e.g., treatment options and support groups are not advertised)	into a class, there is not enough individual attention focus on a specific person's issues)	
• Lack of psychiatrists (e.g., hardly any child psychiatrists in the area)	4	• School-related issues (e.g., teachers do not have the authority and/or understanding to refer students for mental health treatment)	• Unknown services (e.g., need more communication about available services—NAMI is not advertised to patients)	3
• Lack of understanding about mental Illness (e.g., among family doctors, teachers, and those needing services)	3	• Collaboration among providers (e.g., not working as a team to provide integrated services)	• School concerns (e.g., children are just treated like delinquents and the underlying mental issues are not addressed—this is especially true in the school system)	2
• Lack of coordination between providers (e.g., not working as a team to fully address needs)	2	• Court system issues (e.g., mentally ill individuals end up in jail instead of being referred to the treatment they need)	• Communication issues (e.g., Lack of communication with hospitals)	2
• Client resistance to services (e.g., may underutilize services because they do not want to go through treatment)	2	• Lack of dual diagnoses (mental illness and addiction, mental illness and MR/DD)	• Transportation issues (e.g., no public transportation in Warrick County)	2
• Poor communication with courts (e.g., courts do not refer to existing services enough)	2		• Lack of discharge planning (e.g., need to verbally communicate options and next steps because patients do not always read pamphlets/literature they are provided)	1
• School limitations (e.g., schools technically cannot refer to services; only recommendations)	2		• Lack of integrated care (e.g., people may have to contact multiple organizations to get care)	1
• Transience among providers (e.g., Case Managers are not around long enough to develop trust)	2		• Court system (e.g., mentally ill individuals are sent to jail to get them off the street)	1
• Unknown services (e.g., lack of communication and/or advertisement about available services)	2		• Lack of dual diagnoses (e.g. mental illness and addiction)	1

• Lack of Education/training for some providers (e.g., some just have basic understanding)	1			
• Lack of Insurance coverage (e.g., restricts what providers can treat)	1			
• Lack of Individualized treatment options	1			
• Medication issues (e.g., hard to prevent people from obtaining pain medications)	1			
• Lack of dual diagnoses (e.g., system keeps mental health and MR/DD under two different umbrellas)	1			
• Scheduling issues (e.g., services are provided during a time of day when clients cannot access them)	1			
• Technology barriers (e.g., many prospective client cannot receive email communication or access the internet)	1			
• Lack of evaluation of providers (e.g., no research into whether or not programs are actually working)	1			
• Policy issues (e.g., policies of providers sometimes get in the way of serving people)	1			

To further examine issues related to funding services, focus group participants were asked to further discuss the impact of insurance coverage. As shown in the table below, when participant focus group responses were compared, a number of common themes emerged between providers and consumers including No Insurance a significant concern (e.g., individuals without any coverage at all), Partial Coverage (e.g., insurance may not cover all the visits or all the providers), Medicaid Issues (e.g., responses were mixed about acceptance of Medicaid; difficult to get on Medicaid), High Copayment or Deductible (e.g., insurance covers services but remaining expenses are still too high), and Alternative Coverage Options or Payment Plans (e.g., HIP coverage or other activities clients can do that count as credits toward the bill).

<table>
<tr><th colspan="5">Table 159. Provider and Consumer Perceptions of Insurance Issues</th></tr>
<tr><th colspan="5">7. To what degree does the level of insurance coverage impact access to mental health and addiction services in your community? (Prompt: What is a more significant concern—the lack of insurance, having insurance that only covers a portion of services, or having insurance with a high deductible?)</th></tr>
<tr><th colspan="2">Providers</th><th rowspan="2">Shared Respondent Group Themes</th><th colspan="2">Consumers</th></tr>
<tr><th>Themes</th><th>Number of Comments</th><th>Themes</th><th>Number of Comments</th></tr>
<tr><td>• Decreasing problem (e.g., providers (Southwestern, ECHO, etc.) strive to serve people with or without insurance)</td><td>5</td><td rowspan="6">• No insurance a significant concern (e.g., individuals without any coverage at all)
• Partial coverage (e.g., insurance may not cover all the visits or all the providers)
• Medicaid issues (e.g., responses were mixed about acceptance of Medicaid; difficult to get on Medicaid)
• High copayment or deductible (e.g., insurance covers services but remaining expenses are still too high)
• Alternative coverage options or payment plans (e.g., HIP coverage or other activities clients can do that count as credits toward the bill)</td><td>• No insurance (e.g., many clients do not have steady jobs, so they are often not covered at all)</td><td>5</td></tr>
<tr><td>• No Insurance (e.g., people often get the bill and stop receiving services)</td><td>5</td><td>• Partial coverage (e.g., may not cover all of the doctors an individual needs to see)</td><td>4</td></tr>
<tr><td>• Partial coverage (e.g., insurance may only cover a certain number of visits)</td><td>5</td><td>• Medicaid issues (e.g., those on Medicaid are typically covered, but it is difficult to get on Medicaid)</td><td>3</td></tr>
<tr><td>• Medicaid limitations (e.g., very few providers accept Medicaid)</td><td>5</td><td>• Services not covered by insurance (e.g., summer Youth Day Treatment, Southwestern if an individual has a private physician)</td><td>2</td></tr>
<tr><td>• High copayment (e.g., can be a problem since Medicare only covers 80%)</td><td>3</td><td>• Pharmaceutical patient assistance (e.g., need plans in place to help with medications)</td><td>2</td></tr>
<tr><td>• Difficulty enrolling in Medicaid (e.g., long waiting period)</td><td>2</td><td>• High deductibles</td><td>1</td></tr>
</table>

• Alternative coverage (e.g., Hoosier Heathwise, Hoosier Insurance Program (HIP))	2	•	• Difficulty getting on Social Security or disability	1
• Lesser treatment (e.g., uninsured or underinsured may be sent to the lesser of two treatment facilities)	1		• Alternative payment plans (e.g., completing classes should count as payment toward the bill)	1
• Relatively small issue (e.g., insurance issue is small compared to lack of psychiatrists)	1			

Indicator 4.7 The solutions to addressing barriers in accessing mental health and addiction services that consumers experience

Through focus groups, providers and consumers were asked to identify additional services that are needed to address mental health and addiction needs. As shown in the table below, when participant focus group responses were compared, a number of common themes emerged between providers and consumers. Themes included housing (e.g., more options for individuals with mental illness, addiction, and related criminal records), support groups (e.g., separate from treatment, more groups for families and children), life skills training (e.g., financial education and money management training), general education (e.g., continuing education for adults and students with mental health issues), affordable treatment (e.g., activities individuals can do to reduce treatment costs), attention from physicians (e.g., medical treatment during mental health or addiction treatment), and youth treatment (e.g., particularly related to substance abuse).

<table>
<tr><th colspan="5">Table 160. Provider and Consumer Perceptions of Need for Additional Services</th></tr>
<tr><th colspan="5">5. For individuals in your county who have mental health or addiction concerns, what additional services do they need that they are not receiving? (Prompt: Types of services may include housing, education, or job skills training.)</th></tr>
<tr><th colspan="2">Providers</th><th rowspan="2">Shared Respondent Group Themes</th><th colspan="2">Consumers</th></tr>
<tr><th>Themes</th><th>Number of Comments</th><th>Themes</th><th>Number of Comments</th></tr>
<tr><td>• Housing (e.g., not many housing options for low-income and/or drug or sexual offenders)</td><td>9</td><td rowspan="5">• Housing (e.g., more options for individuals with mental illness, addiction, and related criminal records)
• Support groups (e.g., separate from treatment, more groups for families and children)
• Life skills training (e.g., financial education and money management training)
• General education (e.g., continuing education for adults and students with mental health issues)
• Affordable treatment (e.g., activities individuals can do to reduce treatment costs)</td><td>• Assistance finding a job (e.g., some employment agencies are not responsive to individuals with mental health or addiction issues)</td><td>6</td></tr>
<tr><td>• Transportation (e.g., cannot get to treatment because cannot afford bus fare or live outside of the bus range)</td><td>6</td><td>• Job training (e.g., more focus on actual skills and less on interviewing)</td><td>3</td></tr>
<tr><td>• Support groups (e.g., more groups for children, adolescents, and families)</td><td>5</td><td>• Life skills training (e.g., people previously supported themselves by selling drugs and may not know what else is available)</td><td>3</td></tr>
<tr><td>• Medication assistance (e.g., pharmacy assistance programs)</td><td>4</td><td>• Community awareness and support (e.g., more social incentive for staying clean)</td><td>2</td></tr>
<tr><td>• Life skills training (e.g., money management, budgeting)</td><td>3</td><td>• General education (e.g., maintain educational requirements and opportunities in home schools while dealing with students with mental health</td><td>2</td></tr>
</table>

		• Attention from physicians (e.g., medical treatment during mental health or addiction treatment) • Youth treatment (e.g., particularly related to substance abuse)	issues)	
• Childcare (e.g., affordable daycare during parents' treatment)	2		• Affordable treatment (e.g., services or programs to help with treatment bills, such as organized fundraisers)	2
• Insurance coverage	2		• Housing (e.g., many places are not even accepting applications)	2
• Parenting classes	2		• Support groups (e.g., keeping a parent support group—not just therapy)	2
• General education (e.g., help earning G.E.D.)	1		• Youth treatment (e.g., this is especially a need in smaller communities)	2
• Affordable services	1		• Afterschool programming (e.g., available options that can handle students with mental illnesses)	1
• Follow-up from Case Managers (e.g., checking to make sure clients are complying with treatment)	1		• Alternative schools (e.g., longer time allowed in Youth Day Treatment)	1
• Legal assistance	1		• Employment concerns (e.g., government disability often pays more than actually getting a job)	1
• Long-term treatment options (e.g., especially a need for long-term day treatment (beyond 2 weeks))	1		• Family shelters (e.g., if an individual has children, need to house the entire family)	1
• Treatment of mental Illnesses by physician	1		• Food stamps	1
• Drug prevention education for Youths	1		• Medical attention during treatment	1
• Psychiatric evaluations	1		• Information about available services (e.g., people do not know their options after treatment)	1
• Youth treatment (e.g., more substance abuse treatment programs for adolescents)	1		• Social opportunities (e.g., opportunities to interact with other individuals with mental health or addiction issues)	1
• School safety	1		• Treatment options in public schools (e.g., someone for the students to talk to instead of just kicking them	1

			out)	
			• Volunteer opportunities (e.g., something productive for individuals to do while in treatment and not working)	1

To further examine these additional services, focus group participants were asked to identify potential solutions and opportunities. As shown in the table below, when participant focus group responses were compared, a number of common themes emerged between providers and consumers. Themes included increased or continued services (e.g., capacity should increase to match the increasing need for services), increased staff (e.g., attracting new case managers, psychiatrists, etc., and retaining existing providers), collaboration (e.g., team treatment among various mental health providers and primary health care), increased community awareness (e.g., public education targeting stigmas associated with mental illness and addiction), promote mental health services (e.g., ensure that individuals are aware of services they need), and transportation (e.g., more options for those for whom public transportation is not available or affordable).

Table 161. Provider and Consumer Perceptions of Solutions

6. To fully meet the mental health and addiction needs in your county, what do we really need or what needs to happen? What do you think are the solutions? Are there opportunities for better service in your county that service providers are not taking advantage of?

Providers		Shared Respondent Group Themes	Consumers	
Themes	**Number of Comments**		**Themes**	**Number of Comments**
• Increased services provided (e.g., inpatient services in Gibson County, long-term care (6-12 months), ancillary services)	11	• Increased or continued services (e.g., capacity should increase to match the increasing need for services) • Increased staff (e.g., attracting new case managers, psychiatrists, etc., and retaining existing providers) • Collaboration (e.g., team treatment among various mental health providers and primary health care) • Increased community awareness (e.g., public education targeting stigmas associated with mental illness and	• Increased or continued services (e.g., ensure that programs already in place continue to grow)	5
• Collaboration/Integration of service providers (e.g., centralized locations to receive all necessary services)	8		• Retain/Increase staff (e.g., find a way to prevent case managers, physicians, and psychiatrists from leaving the area)	4
• Increased staff (e.g., more psychiatrists, more use of current Advanced Nurse Practitioners)	7		• Integration of primary health care (e.g., family doctors should be able to handle certain mental health issues to alleviate the workload of psychiatrists)	3
• Insurance coverage (e.g., Medicaid covers only a portion of	2		• Transitional programs (e.g., halfway houses that transition clients	3

services)		addiction)	from treatment into the real world)	
• Reduced duplication of services	2	• Promote mental health services (e.g., ensure that individuals are aware of services they need)	• Increased community awareness (e.g., a public educational campaign about mental illness)	2
• Client accountability (e.g., ensure that clients are complying with program requirements)	1	• Transportation (e.g., more options for those for whom public transportation is not available or affordable)	• Manage costs (e.g., case managers should monitor bill and adjust services before it becomes too high)	2
• Increased community awareness (e.g., more business/industry support of addiction/mental health problems)	1		• Increased funding for mental illness (e.g., more federal funding and advocacy of services)	2
• Established community for mentally ill (e.g., a community specifically for housing mentally ill individuals)	1		• Treatment in schools (e.g., train teachers and principals about early signs of mental illness)	2
• Dual diagnoses (e.g., further integration of mental health and addiction services)	1		• Family treatment (e.g., especially treatment for children of a recovering individual)	1
• Emergency onsite services (e.g., particularly in Posey County, better response to mental health crises)	1		• Promote services (e.g., ensure people know what is available)	1
• Evaluation of treatment programs (e.g., more efforts to determine which treatment programs are actually working)	1		• Support groups (e.g., more local support groups, especially for parents and families)	1
• Housing for students (e.g., address students living with various family members and friends)	1		• Transportation (e.g., especially for those without driver's license and public transportation options)	1
• Employment for clients (e.g., have jobs reserved specifically for mentally ill	1			

individuals)				
• Parent education about mental illness	1			
• Promote underutilized services	1			
• Reduce stigma (e.g., single men have less access to services than women with children)	1			
• Transportation (e.g., particularly an issue in surrounding counties where there is no public transportation)	1			

To provide further clarification, providers were asked about solutions to ensure clients receive the additional services. As shown in the table below, the three primary themes included Advertising/Promotion of Services (e.g., each organization should raise community awareness about what they offer; physicians should promote mental health services that mainly benefit patients), Collaboration/Integration of Services (e.g., work together to develop individualized treatment plans; know what other organizations can provide and make referrals as needed), and Follow-up After Treatment (e.g., ensure that clients are taking medications and taking advantage of supplemental services to which they have been referred).

Table 162. Provider and Consumer Perceptions of Service Providers' Role in Ensuring Services are Received	
8. What can direct service providers in your county do to ensure that clients are receiving the additional services they need?	
Providers Only	
Themes	Number of Comments
• Advertising/promotion of services (e.g., each organization should raise community awareness about what they offer; physicians should promote mental health services that mainly benefit patients)	6
• Collaboration/integration of services (e.g., work together to develop individualized treatment plans; know what other organizations can provide and make referrals as needed)	5
• Follow-up after treatment (e.g., ensure that clients are taking medications and taking advantage of supplemental services to which they have been referred)	4
• Increase funding (e.g., existing organizations/programs should seek additional funding from grants and other sources)	2
• Housing (e.g., individuals need a place to which they can transition from treatment in order for treatment to be effective)	2
• Outreach programs (e.g., establish a mobile assessment clinic)	2
• Attract psychiatrists (e.g., hire and retain more psychiatrists in the area)	1
• Improve discharge planning (e.g., ensure clients know what additional resources are available so that they do not end up right back in treatment)	1
• Employment help (e.g., aid clients in finding appropriate employment opportunities)	1
• Research (e.g., evaluate current treatment programs to determine what is actually working)	1
• Training (e.g., provide training to develop existing treatment programs)	1

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Appendix

Inventory of Addiction and Mental Health Services and Survey of Ancillary Service Providers

Inventory of Addiction and Mental Health Services
Community Addiction and Mental Health Needs Assessment

I. Organization Information

1. Organization name:

2. Name of Chief Executive Officer:

3a. Our organization gives permission to Diehl Evaluation & Consulting Services, Inc. to publish information from the Inventory for the Community Needs Assessment: ☐ Yes ☐ No

3b. ☐ Check here if you would like a copy of the needs assessment report.

4. Name of person completing this form:	5. Title:

6. Mailing Address:

7. Phone:	8. Fax:	9. Email:	10. Website:

11. Business hours:

12. Names of counties in primary service area: ☐ Vanderburgh ☐ Gibson ☐ Posey ☐ Warrick ☐ Other Counties (specify):

13. Target population(s) served (check all that apply): ☐ 0-5 ☐ 6-14 ☐ 15-17 ☐ 18-64 ☐ 65+

II. Inventory of Services

14. Please specify the levels of care provided by your organization and the number of individuals served in each level during the <u>latest 12-month reporting period*</u>. (check all that apply)

***Since reporting years may vary by organization, please specify the latest 12-month period for which you are reporting data (e.g., January 1, 2008 to December 31, 2008). Specify: ☐ Calendar year ☐ Fiscal year**
Define Reporting Period: Start Date____________________ End Date: ____________________

Note: The number served may be a duplicated count if the same person was in more than one service level within the reporting period.

Level of care	
☐ Inpatient (hospitalization)	Number served in latest reporting period:
☐ Partial hospitalization/day treatment	Number served in latest reporting period:
☐ IOP (Intensive Outpatient Program)	Number served in latest reporting period:
☐ Outpatient	Number served in latest reporting period:
☐ Residential (short-term < 30 days)	Number served in latest reporting period:
☐ Residential (long-term >= 30 days)	Number served in latest reporting period:
☐ In-home care	Number served in latest reporting period:

15. Please indicate the issues for which you serve clients and the number of people served for each issue in the latest 12-month reporting period. Count only the primary diagnosis for each client.

Issue	
☐ Anxiety disorders	Number served in latest reporting period:
☐ Major depressive disorder	Number served in latest reporting period:
☐ Bipolar disorder (manic depression)	Number served in latest reporting period:
☐ Personality disorders	Number served in latest reporting period:
☐ Delirium	Number served in latest reporting period:
☐ Dementia	Number served in latest reporting period:
☐ Schizophrenia or other psychotic disorders	Number served in latest reporting period:
☐ Childhood disorders (ADHD, etc.)	Number served in latest reporting period:
☐ Disorders related to the elderly	Number served in latest reporting period:
☐ Eating disorders	Number served in latest reporting period:
☐ Substance-related disorders	Number served in latest reporting period:
☐ Adjustment disorders	Number served in latest reporting period:
☐ Sleep disorders	Number served in latest reporting period:
☐ Sexual orientation and gender identity issues	Number served in latest reporting period:
☐ Child physical and/or sexual abuse	Number served in latest reporting period:
☐ Developmental disorders (autism, mental retardation, etc.)	Number served in latest reporting period:
☐ Traumatic/organic brain injury & complications	Number served in latest reporting period:
☐ Post traumatic stress disorder	Number served in latest reporting period:
☐ Other:	Number served in latest reporting period:

16. Please indicate the services that are provided by your organization. For each service provided by your organization, indicate the age group(s) directly served. If you don't provide any of these services, leave all boxes blank.	
☐ Transportation services (i.e., getting to and from appointments)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Assistance to non-English speaking individuals	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Assistance to hearing-impaired individuals	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Housing services (i.e., assistance in locating housing)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Payeeships (i.e., financial guardianship)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Information and referral services (information regarding where to obtain services or referral to organizations that can provide needed services, etc.)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Legal advocacy	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Case management	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Individual therapy and/or counseling	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Group therapy and/or counseling	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Family therapy and/or counseling	N/A
☐ Psychological testing	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Emergency and crisis services (i.e., after hours or emergencies)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Family support services (i.e., services provided to family members of clients such as respite care)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Home-based services (i.e., services provided at the home of clients)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Independent living services	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ In-home family services (family counseling provided in the home, etc.)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Mental retardation/developmental disability services	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ School-based services (social work or case management services contracted with schools, etc.)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Supported employment (i.e., assistance in obtaining employment)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Wrap-around services (i.e., individually designed set of services and supports for children and their families)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+

☐ Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Money management (guidance regarding tax credits, budgeting, etc.)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Supported education/training (i.e., assistance in obtaining educational or vocational training)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Meal services (i.e., meals provided to those receiving treatment)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Parenting education (i.e., training in appropriate parenting techniques)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Specialized services for the elderly	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Neuropsychological services	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Drug screening services	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ General daily living activities	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+
☐ Other:	☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+

III. Capacity

17. Number of individuals served in the latest reporting period by your organization (unduplicated):

18. Typically, how many (number) individuals who seek services at your organization are placed on a waiting list (during your reporting period):

19. Average amount of time individuals must wait to receive services (in days):

20. Are there fees for your services? ☐ Yes ☐ No
If there are fees for your services, please indicate how they are paid and the percentage of consumers who pay using each method annually.

☐ Private insurance	% of consumers:
☐ Medicaid	% of consumers:
☐ Medicare	% of consumers:
☐ Other public insurance (please specify):	% of consumers:
☐ Military insurance	% of consumers:
☐ Self payment	% of consumers:
☐ Charity (no fees charged)	% of consumers:
☐ Employee Assistance Program	% of consumers:
☐ Other:	% of consumers:

21. What percent of your clients are not able to pay for services? ____%

22. Do you offer assistance to consumers to pay for services? ☐ Yes ☐ No
23. If yes, what form of assistance do you offer? ☐ Sliding fee scale based on income ☐ Other:

24. Current staffing levels

Total no. employees:	Full time:	Part time:

25. If you provide <u>residential services</u>, please specify the number of beds that are available for short-term (less than 30 days) and long-term (30 or more days) treatment.

Number of beds for short-term:	Number of beds for long-term:

26. Please indicate the number of mental health professionals employed by your organization and the number of current vacancies for each job title. <u>Choose the most appropriate category for each employee and place each employee in one category only. If an employee holds multiple licenses or has multiple degrees, choose the category that represents their highest license or degree. Only include mental health professionals who provide direct service to clients.</u>		
Psychiatrist A medical doctor who specializes in preventing, diagnosing, and treating mental disorders.	**No. Employed:**	**Vacant:**
Other Physicians (does not include Psychiatrists)(specify title(s)):	**No. Employed:**	**Vacant:**
Clinical Psychologist Work directly with individuals at all developmental levels, as well as groups, using a wide range of assessment and intervention methods to promote mental health and to alleviate discomfort and maladjustment. An earned doctorate from a Clinical Psychology program represents the basic entry for the provision of clinical psychology services.	**No. Employed:**	**Vacant:**
Licensed Clinical Social Worker (LCSW) Engages in the professional application of social work theory and methods to the treatment and prevention of psychosocial dysfunction disability, or impairment, including emotional and mental disorders. Requires doctoral or Master's degree and clinical experience. Requires state licensure.	**No. Employed:**	**Vacant:**
Licensed Social Worker (LSW) See definition for LCSW. Must complete a Bachelor or Master level degree program in social work from a CSWE approved university. Bachelor level applicants must complete two years of supervised work to receive license.	**No. Employed:**	**Vacant:**
Master of Social Work (MSW) See definition for LCSW. MSW maintains a Master's degree but has not acquired state licensure.	**No. Employed:**	**Vacant:**
Bachelor of Social Work (BSW) This employee has NOT completed requirements to become a Licensed Social Worker.	**No. Employed:**	**Vacant:**
Psychiatric-Mental Health Nurse (RN) An RN who specializes in the field of psychiatry/mental health. Does not require an advanced degree.	**No. Employed:**	**Vacant:**
Licensed Practical Nurse (LPN)	**No. Employed:**	**Vacant:**
Clinical Nurse Specialist An advanced practice nurse who is a clinical expert in the field of diagnosis and treatment of illness, and the delivery of evidence-based nursing interventions. Requires a minimum of a Master's degree.	**No. Employed:**	**Vacant:**
Nurse Practitioner An advanced practice nurse who provides high-quality healthcare services similar to those of a doctor; diagnose and treat a wide range of health problems. Maintain graduate, advanced education and clinical training beyond registered nurse preparation.	**No. Employed:**	**Vacant:**

Licensed Professional Counselor **Also known as Licensed Mental Health Counselor; Master's level mental health service providers trained to work with individuals, families, and groups in treating mental, behavioral, and emotional problems and disorders.**	**No. Employed:**	**Vacant:**
Case Manager **Also may be known as Care Coordinator; coordinates services for individuals being treated for mental health issues to assure continuity of care and accountability for service provision; services involve vocational, financial, housing, and other daily living needs**	**No. Employed:**	**Vacant:**
Certified Alcohol & Drug Counselor (CADC) **Mid-level certification for alcohol and drug counselors; help treat clients for addiction to drugs and alcohol through a variety of counseling techniques; if licensed, known as Licensed Clinical Alcohol & Drug Counselor (LCACD)**	**No. Employed:**	**Vacant:**
Volunteers who provide direct service	**No. Employed:**	**Vacant:**
Other Licensed Professionals:	**No. Employed:**	**Vacant:**
Other Certified Professionals:	**No. Employed:**	**Vacant:**
Other:	**No. Employed:**	**Vacant:**

	Almost Never	Rarely	Some-times	Often	Almost Always
27. How often do you collaborate with other addiction and/or mental health service providers in the area? (circle one option)	1	2	3	4	5
28. How often do addiction and/or mental health service providers in the area collaborate with one another? (circle one option)	1	2	3	4	5

29. List 3 addiction and/or mental health service providers that you collaborate with the most.

1. ____

2. ____

3. ____

IV. Perceptions of Need and Access to Services

30. What do you believe are the greatest addiction and/or mental health needs (e.g., issues that clients present with) in the four-county area?

31. What addiction and/or mental health needs in the four-county area are not being adequately met by existing services (e.g., gaps in services)?

32. What do you believe are the greatest strengths within the four-county region related to current addiction and/or mental health services being provided?

33. The following items refer to those individuals to whom you are providing addiction and/or mental health services or referring to addiction and/or mental health services. Using a 5-point scale where *1=Almost Never* and 5=*Almost Always*, indicate how often your clients have a need for the services listed below and how often your clients actually receive each service when needed.

Service	Do your clients have need for this service?	If you selected yes (your clients have a need for this service), how often do your clients have a need for this service? *1=Almost Never 2=Rarely 3=Sometimes 4=Often 5=Almost Always*	If you selected yes (your clients have a need for this service), how often do your clients receive this service from you or other organizations? *1=Almost Never 2=Rarely 3=Sometimes 4=Often 5=Almost Always*
a. **Transportation services** (i.e., getting to and from appointments)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
b. **Assistance to non-English speaking individuals**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
c. **Assistance to hearing-impaired individuals**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
d. **Housing services** (i.e., assistance in locating housing)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
e. **Payeeships** (i.e., financial guardianship)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
f. **Homeless services** (outreach services to ensure homeless individuals have access to care, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
g. **Information and referral services** (information regarding where to obtain services or referral to organizations that can provide needed services, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
h. **Legal advocacy**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
i. **Court-ordered work** (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
j. **Case management**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
k. **Individual therapy and/or counseling**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
l. **Group therapy and/or counseling**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
m. **Family therapy and/or counseling**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
n. **Psychological testing**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
o. **Emergency and crisis services** (i.e., after hours or emergencies)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
p. **Family support services** (i.e., services provided to family members of clients such as respite care)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
q. **Home-based services** (i.e., services provided at the home of clients)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
r. **Independent living services**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
s. **In-home family services** (family counseling provided in the home, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5

Service	Do your clients have need for this service?	If you selected yes (your clients have a need for this service), how often do your clients have a need for this service? *1=Almost Never 2=Rarely 3=Sometimes 4=Often 5=Almost Always*	If you selected yes (your clients have a need for this service), how often do your clients receive this service from you or other organizations? *1=Almost Never 2=Rarely 3=Sometimes 4=Often 5=Almost Always*
t. **Mental retardation/developmental disability services**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
u. **School-based services** (social work or case management services contracted with schools, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
v. **Supported employment** (i.e., assistance in obtaining employment)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
w. **Therapeutic foster care** (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
x. **Wrap-around services** (i.e., individually designed set of services and supports for children and their families)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
y. **Primary health care** (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
z. **Nutrition services** (guidance provided by a nutritionist or dietician in healthy diet, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
aa. **Medication management** (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
bb. **Money management** (guidance regarding tax credits, budgeting, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
cc. **Supported education/training** (i.e., assistance in obtaining educational or vocational training)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
dd. **Meal services (i.e., meals provided to those receiving treatment)**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
ee. **Parenting education (i.e., training in appropriate parenting techniques)**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
ff. **Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
gg. **Specialized services for the elderly**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
hh. **Neuropsychological services**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
ii. **Drug screening services**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
jj. **General daily living activities**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
kk. **Other:**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5

34. Using the 5-point scale below, where 1=*Not a barrier* and 5=*Extreme barrier*, please indicate how much of a barrier each item below is to your clients receiving addiction and/or mental health services.

	Potential Barrier	1 Not a barrier	2 Somewhat of a barrier	3 Moderate barrier	4 Large barrier	5 Extreme barrier
a.	**Lack of early intervention** (i.e., clients who have been dealing with an issue for an extended period of time may find it difficult to obtain the intensive treatment that is now required to treat their concern)	☐	☐	☐	☐	☐
b.	**Lack of access to medication** (i.e., lack of medication treatment due to poverty or other circumstances may make other treatment difficult or may keep people from continuing treatment)	☐	☐	☐	☐	☐
c.	**Clients who require services are incarcerated**	☐	☐	☐	☐	☐
d.	**Clients have co-existing conditions**	☐	☐	☐	☐	☐
e.	**Transportation issues**	☐	☐	☐	☐	☐
f.	**Transient populations**	☐	☐	☐	☐	☐
g.	**Language barriers**	☐	☐	☐	☐	☐
h.	**Clients unable to pay for services**	☐	☐	☐	☐	☐
i.	**Clients unaware of existing services**	☐	☐	☐	☐	☐
j.	**Stigma related to seeking/receiving mental healthcare**	☐	☐	☐	☐	☐
k.	**Child care while client in treatment**	☐	☐	☐	☐	☐
l.	**Lack of weekend or evening appointment times**	☐	☐	☐	☐	☐
m.	**Underinsured patients** (i.e., have insurance but does not provide enough coverage to pay for services)	☐	☐	☐	☐	☐
n.	**Lack of treatment providers for minorities or individuals from other cultures**	☐	☐	☐	☐	☐
o.	**Lack of specialized services for the elderly**	☐	☐	☐	☐	☐
p.	**Lack of specialized services for youth**	☐	☐	☐	☐	☐
q.	**No service available for client's issue**	☐	☐	☐	☐	☐
r.	**Lack of trained staff to provide treatment to clients**	☐	☐	☐	☐	☐
s.	**Lack of 24-hour emergency services**	☐	☐	☐	☐	☐
t.	**Other:**	☐	☐	☐	☐	☐
u.	**Other:**	☐	☐	☐	☐	☐
v.	**Other:**	☐	☐	☐	☐	☐

Survey of Ancillary Services
Community Addiction and Mental Health Needs Assessment

I. Organization Information

1. Names of counties in primary service area: ☐ Vanderburgh ☐ Gibson ☐ Posey ☐ Warrick
☐ Other Counties:

2. Please check the box that best describes your organization. Check only one box.

- ☐ Primary school
- ☐ Secondary school
- ☐ Preschool or other early child care facility
- ☐ Faith-based (specify):
- ☐ Law enforcement agency
- ☐ Court system
- ☐ Non-profit (specify type):
- ☐ Correction facility/jail
- ☐ Primary medical care (i.e., family practice, internal medicine, pediatric practice)
- ☐ Nursing home
- ☐ Hospice
- ☐ Other:

3. Primary target population(s) served (check all that apply): ☐0-5 ☐6-14 ☐15-17 ☐18-64 ☐65+

II. Referral to Addiction and/or Mental Health Services

4a. If you refer clients to addiction and/or mental health service organizations, please indicate the issues for which you refer clients. Check all that apply.	4b. Select the three highest areas of referral
☐ Abuse and/or addiction to alcohol	☐
☐ Abuse and/or addiction to other drugs	☐
☐ Gambling addiction	☐
☐ Other addictions (specify):	☐
☐ Behavioral issues (fighting, aggression toward family/classmates, etc.)	☐
☐ Anxiety/stress	☐
☐ Eating issues (anorexia, bulimia, etc.)	☐
☐ Mood issues (depression, mood swings, etc.)	☐
☐ Cognitive issues (dementia, delirium, etc.)	☐
☐ Signs of schizophrenia or psychosis	☐
☐ Symptoms of personality disorder (antisocial, obsessive/compulsive, etc.)	☐
☐ Childhood disorders (ADHD, etc.)	☐
☐ Sleep-related problems	☐
☐ Developmental issues (autism, mental retardation, etc.)	☐
☐ Sexual and/or gender identity issues	☐
☐ Family and/or marital problems	☐
☐ Parenting problems	☐
☐ Anger management	☐
☐ Learning disabilities	☐
☐ Suicidal behaviors	☐
☐ Self-mutilation	☐
☐ Domestic violence	☐
☐ Child sexual abuse	☐
☐ Child physical abuse	☐
☐ Adult sexual abuse	☐
☐ Sex and/or pornography addiction	☐
☐ Other:	☐

4c. Please list any addiction and/or mental health issues for which you make referrals outside of the four-county region because no local services are provided.

III. Client Services

5. **The following items refer to those individuals to whom you are providing addiction and/or mental health services or referring to addiction and/or mental health services. Using a 5-point scale where *1=Almost Never* and *5=Almost Always*, indicate how often your clients have a need for the services listed below and how often your clients actually receive each service when needed.**

Service	Do your clients have need for this service?	If you selected yes (your clients have a need for this service), how often do your clients have a need for this service? *1=Almost Never 2=Rarely 3=Sometimes 4=Often 5=Almost Always*	If you selected yes (your clients have a need for this service), how often do your clients receive this service from you or other organizations? *1=Almost Never 2=Rarely 3=Sometimes 4=Often 5=Almost Always*
a. **Transportation services** (i.e., getting to and from appointments)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
b. **Assistance to non-English speaking individuals**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
c. **Assistance to hearing-impaired individuals**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
d. **Housing services** (i.e., assistance in locating housing)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
e. **Payeeships** (i.e., financial guardianship)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
f. **Homeless services** (outreach services to ensure homeless individuals have access to care, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
g. **Information and referral services** (information regarding where to obtain services or referral to organizations that can provide needed services, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
h. **Legal advocacy**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
i. **Court-ordered work** (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
j. **Case management**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
k. **Individual therapy and/or counseling**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
l. **Group therapy and/or counseling**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
m. **Family therapy and/or counseling**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
n. **Psychological testing**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
o. **Emergency and crisis services** (i.e., after hours or emergencies)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
p. **Family support services** (i.e., services provided to family members of clients such as respite care)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
q. **Home-based services** (i.e., services provided at the home of clients)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
r. **Independent living services**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
s. **In-home family services** (family counseling provided in the home, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5

Service	Do your clients have need for this service?	If you selected yes (your clients have a need for this service), how often do your clients have a need for this service? *1=Almost Never* *2=Rarely* *3=Sometimes* *4=Often* *5=Almost Always*	If you selected yes (your clients have a need for this service), how often do your clients receive this service from you or other organizations? *1=Almost Never* *2=Rarely* *3=Sometimes* *4=Often* *5=Almost Always*
t. **Mental retardation/developmental disability services**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
u. **School-based services** (social work or case management services contracted with schools, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
v. **Supported employment** (i.e., assistance in obtaining employment)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
w. **Therapeutic foster care** (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
x. **Wrap-around services** (i.e., individually designed set of services and supports for children and their families)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
y. **Primary health care** (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
z. **Nutrition services** (guidance provided by a nutritionist or dietician in healthy diet, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
aa. **Medication management** (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
bb. **Money management** (guidance regarding tax credits, budgeting, etc.)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
cc. **Supported education/training** (i.e., assistance in obtaining educational or vocational training)	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
dd. **Meal services (i.e., meals provided to those receiving treatment)**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
ee. **Parenting education (i.e., training in appropriate parenting techniques)**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
ff. **Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
gg. **Specialized services for the elderly**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
hh. **Neuropsychological services**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
ii. **Drug screening services**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
jj. **General daily living activities**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5
kk. **Other:**	☐ Yes ☐ No	1 2 3 4 5	1 2 3 4 5

6. Using the 5-point scale below, where 1=*Not a barrier* and 5=*Extreme barrier*, please indicate how much of a barrier each item below is to your clients receiving addiction and/or mental health services.

Potential Barrier	1 Not a barrier	2 Somewhat of a barrier	3 Moderate barrier	4 Large barrier	5 Extreme barrier
a. **Lack of early intervention** (i.e., clients who have been dealing with an issue for an extended period of time may find it difficult to obtain the intensive treatment that is now required to treat their concern)	◻	◻	◻	◻	◻
b. **Lack of access to medication** (i.e., lack of medication treatment due to poverty or other circumstances may make other treatment difficult or may keep people from continuing treatment)	◻	◻	◻	◻	◻
c. **Clients who require services are incarcerated**	◻	◻	◻	◻	◻
d. **Clients have co-existing conditions**	◻	◻	◻	◻	◻
e. **Transportation issues**	◻	◻	◻	◻	◻
f. **Transient populations**	◻	◻	◻	◻	◻
g. **Language barriers**	◻	◻	◻	◻	◻
h. **Clients unable to pay for services**	◻	◻	◻	◻	◻
i. **Clients unaware of existing services**	◻	◻	◻	◻	◻
j. **Stigma related to seeking/receiving mental healthcare**	◻	◻	◻	◻	◻
k. **Child care while client in treatment**	◻	◻	◻	◻	◻
l. **Lack of weekend or evening appointment times**	◻	◻	◻	◻	◻
m. **Underinsured patients** (i.e., have insurance but does not provide enough coverage to pay for services)	◻	◻	◻	◻	◻
n. **Lack of treatment providers for minorities or individuals from other cultures**	◻	◻	◻	◻	◻
o. **Lack of specialized services for the elderly**	◻	◻	◻	◻	◻
p. **Lack of specialized services for youth**	◻	◻	◻	◻	◻
q. **No service available for client's issue**	◻	◻	◻	◻	◻
r. **Lack of trained staff to provide treatment to clients**	◻	◻	◻	◻	◻
s. **Lack of 24-hour emergency services**	◻	◻	◻	◻	◻
t. **Other:**	◻	◻	◻	◻	◻
u. **Other:**	◻	◻	◻	◻	◻
v. **Other:**	◻	◻	◻	◻	◻

7. What do you believe are the greatest addiction and/or mental health needs (e.g., issues that clients present with) in the four-county area?

8. What addiction and/or mental health needs in the four-county area are not being adequately met by existing services (e.g., gaps in services)?

9. What do you believe are the greatest strengths within the four-county region related to current addiction and/or mental health services being provided?

	Almost Never	Rarely	Sometimes	Often	Almost Always
10. How often do <u>you</u> collaborate with other addiction and/or mental health service providers in the area? (circle one option)	1	2	3	4	5
11. How often do addiction and/or mental health service providers in the area collaborate with one another? (circle one option)	1	2	3	4	5