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MENTAL HEALTH AND ADDICTION SERVICES NEEDS ASSESSMENT REPORT

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Introduction

In 1999, the first Surgeon General's report issued on mental health and mental illness was published. The science-based report conveyed two major messages: (1) mental health is fundamental to health and (2) mental disorders are real, physiological health conditions. Mental illnesses continue to impact many lives. According to epidemiologic surveys, 20% of Americans have a mental disorder in any one year. Furthermore, the direct costs to treat mental illness are immense, $69 billion in the United States in 1996. The Surgeon General's report indicated that mental health services are continually in short supply and that the expansion of effective, evidence-based services throughout the Nation is imperative (U.S. Department of Health and Human Services, 1999). To assess the efficiency of the public adult mental healthcare system, the National Alliance on Mental Illness (NAMI) published a state-by-state 'report card' (National Alliance on Mental Illness, 2006). Grading was based on 39 specific criteria, organized into four categories (infrastructure, information access, services, and recovery supports). According to the report, Indiana received a grade of D-. Especially, the state's infrastructure for delivering mental health services as well as recovery supports received failing grades (see Appendix A) (National Alliance on Mental Illness, 2006).

To evaluate the current situation, the Center for Health Policy (CHP) conducted a mental health and addiction services needs assessment for North Central Health Services (NCHS) in Benton, Carroll, Clinton, Fountain, Montgomery, Tippecanoe, Warren, and White counties. For this purpose, an epidemiologic profile on mental illness and substance abuse was completed, existing resources (facilities, providers, programs, and services) were reviewed, capacity was assessed, and service gaps were identified. Based on the assessment, the CHP proposes data-driven funding recommendations to meet the treatment needs of the communities.

Demographic Profile

The eight-county region had a total population of 306,380 in 2005. Showing continued growth, the counties had a 10.3% increase in population from 1990 to 2000. There were a few counties who varied slightly from the region overall. Tippecanoe County saw an individual increase of 14.1% while Benton and Fountain counties saw less than 1%. The largest population for the region were adults aged 25 to 44 with a total of 82,095 individuals; making that age range 26.8% of the total population. The smallest age ranges were adults older than 65 and young children below the age of 4. The region was dominantly one race with 94.5% of the population considering themselves to be white alone. The counties combined, had 85% of their residents acquiring a high school diploma which was above the state average of 82.1%. Seven of the eight counties had a range of 10 to 14% of their residents holding a bachelor degree or higher with Tippecanoe County skewing the scale with 33.2% of their residents graduating college. Though the region had higher than average high school graduates, the per capita personal income of $26,417 was well below the state average of $30,204 in 2004. Conversely, the poverty rate for the region in 2004 was lower than that of the state with rates of 9.71% and 11.1% respectively. The lower poverty rates may be attributable to less unemployment. In 2005, there were 7,745 unemployed residents in the region yielding an unemployment rate of 4.9%. The end of 2006 brought positive results, with an unemployment rate of only 4.0% for these counties, while the state was a half percentage point higher at 4.5% (Indiana Business Research Center, n.d.).

Epidemiologic Profile

Mental Illness

Mental illnesses are biologically-based brain disorders that can influence a person's thinking, feeling, mood, ability to relate to others, and daily functioning. Psychological disorders are widespread in the population and fall along a continuum of severity. Serious mental illness (SMI) refers to severe, disabling, and long-lasting psychological disorders such as schizophrenia (any type), major depression, and bipolar disorder. According to the World Health Organization (WHO), four of the ten leading causes of disability in the United States and other developed countries are mental disorders. It is estimated that by 2020, major depression will be the leading cause of disability in the world for women and children (National Alliance on Mental Illness, n.d.). Furthermore, people with SMI die, on average, 25 years earlier than the general population. Causes for premature deaths include suicide and injury, but excess mortality is largely due to preventable health conditions (National Association of State Mental Health Program Directors, 2006).

In Indiana, the estimated prevalence rate of adults with serious mental illness (SMI) is 5.4%, which translates into 12,628 individuals being affected in the eight-county region (see Table 1). Prevalence estimates for children (ages 9 to 17) with serious emotional disturbance (SED) and a Global Assessment of Functioning (GAF[1]) Scale of (1) less than 50 is 6.0%, which amounts to 2,307 children in the target region and (2) less than 60 is 10.0%, which represents 3,846 children in NCHS' service area (see Table 2) (Indiana Family and Social Services Administration, n.d.).

Alcohol and Drug Addiction/Dependence[2]

Substance use can have a variety of physiological and psychological effects. Prolonged and heavy use of alcohol and/or other drugs may result in physical and psychological harm and substance dependency. Although initial drug use might be voluntary, consumption of such substances has been shown to alter brain chemistry. Once addiction develops, these brain changes interfere with a person's ability to make voluntary decisions, which can lead to compulsive drug cravings, seeking, and use. The physiological impact of addiction can be far reaching and includes cardiovascular disease, stroke, cancer, HIV/AIDS, hepatitis, and lung disease (National Institute on Drug Abuse, 2005). Furthermore, intoxication by alcohol or drugs may increase an individual's risk of committing suicide by decreasing inhibitions, increasing aggressiveness, and impairing judgment. Additionally, substance use increases the lethality of some medications, making it more likely that a suicide attempt via overdose will be lethal (National Strategy for Suicide Prevention, n.d.).

Substance use: Alcohol is the most frequently used substance in Indiana; 49.94% of Hoosiers 12 years and older report current (past month) use. Particularly, binge and heavy drinking are consumption patterns that have been proven problematic. In Indiana, the prevalence rate for binge drinking[3] is 21.99%; the age group mostly affected is 18- to 25-year olds (42.03%; see

[1] The Global Assessment of Functioning (GAF) Scale is a 100-point instrument used to rate overall psychological, social, and occupational functioning of people. It is included in the Diagnostic and Statistical Manual of Mental Disorders, Text Revision (DSM-IV TR) in the section on multi-axial assessments. A score between 51 and 60 refers to "Moderate symptoms OR any moderate difficulty in social, occupational, or school functioning". A score between 41 and 50 refers to "Serious symptoms OR any serious impairment in social, occupational, or school functioning".

[2] In this report, the terms 'addiction' and 'dependence' are used interchangeably.

[3] Binge drinking is defined as consuming five or more servings of alcohol on the same occasion in the past month.

Figure 1) (Substance Abuse and Mental Health Services Administration, 2007). The prevalence for heavy drinking[4] is 4.1%; 18- to 25-year olds report the highest rate of heavy use (8.5%) (Centers for Disease Control and Prevention, 2006). Underage drinking is another concern; 41.4% of Indiana high school students currently drink alcohol and 24.6% engage in binge drinking (Centers for Disease Control and Prevention, 2007). The prevalence rate for current illicit drug use in Indiana is 7.37%, with 18- to 25-year olds displaying the highest rate of use (18.52%). Marijuana is the most frequently consumed illicit substance, with a past month use rate of 5.12% (14.37% for 18- to 25-year olds; see Figure 2) (Substance Abuse and Mental Health Services Administration, 2007). Among Indiana high school students, 18.9% report currently using marijuana and 3.0% state current use of cocaine (see Figure 3). Lifetime methamphetamine use rate in 9th through 12th graders is 7.0% (Centers for Disease Control and Prevention, 2007).

Addiction: Estimated prevalence rates of chronic addiction vary by age group, with 18- to 25-year olds displaying the highest rate (22.55% or 5,480 individuals); prevalence for 12- to 17-year olds is 10.69% (2,663 children) and for individuals 26 years and older it is 7.49% (15,697 adults; see Table 3) (Indiana Family and Social Services Administration, n.d.). Hoosiers in the eight-county region receiving treatment for substance use disorders predominantly report alcohol as their primary drug at the time of admission (47.1% or 552 clients), followed by marijuana/hashish (31.1% or 364 clients), and cocaine/crack (6.8% or 80 clients; see Table 4). Over half of the individuals in treatment use more than one substance (polysubstance use: 53.4% or 625 clients; see Table 5) (Indiana Division of Mental Health and Addiction, 2005). Furthermore, data show that treatment needs of individuals are not met: 2.59% of Hoosiers 12 years and older are in need of but don't receive treatment for illicit drug use and 7.52% for alcohol use (see Figure 4) (Substance Abuse and Mental Health Services Administration, 2007).

Co-occurring Disorder[5]

Individuals who suffer from both mental illness and a substance use disorder are said to have a co-occurring disorder. According to reports in the *Journal of the American Medical Association (JAMA)*, co-occurring disorders are very common: roughly 50% of individuals with SMI are affected by substance abuse; 37% of alcohol abusers and 53% of drug abusers also have at least one serious mental illness; and of all people diagnosed as mentally ill, 29% abuse either alcohol or drugs (National Alliance on Mental Illness, 2003). Individuals with co-occurring disorder tend to have multiple health and social problems; many are at increased risk for homelessness and incarceration (National Association of State Mental Health Program Directors, 1998). Research strongly suggests that to recover from the disorder, treatment for both mental illness and addiction is necessary (National Alliance on Mental Illness, 2003).

The prevalence among adults with SMI to have a co-occurring disorder, i.e., SMI **and** chronic addiction, is estimated to be 23.2% in Indiana, which means that 2,930 individuals 18 years and older are affected in the NCHS service area (see Table 6) (Indiana Family and Social Services Administration, n.d.).

[4] Heavy drinking is defined as consuming an average of more than two drinks/day for men and more than one drink/day for women.

[5] Co-occurring disorders are also known as dual diagnosis.

Review of Existing Services and Capacity Assessment

To gain a better understanding and establish a baseline of the current mental health and addiction treatment system, existing services, programs, and facilities were examined. The Substance Abuse and Mental Health Services Administration (SAMHSA) provides public access to mental health and substance abuse treatment locators. These online databases supply comprehensive information on treatment providers and types of services offered within the United States (Substance Abuse and Mental Health Services Administration, 2005, n.d.). To review the addiction treatment system in the eight-county region, the zip codes within all counties (Benton, Carroll, Clinton, Fountain, Montgomery, Tippecanoe, Warren, and White) were identified and individually entered into the substance abuse treatment locator (Substance Abuse and Mental Health Services Administration, n.d.); information on providers within a 25-mile radius was collected. The mental health facility database, even though administrated by the same agency, is organized differently: treatment providers are listed by city and entering a search radius is not an option (Substance Abuse and Mental Health Services Administration, 2005). Facilities in cities within the eight counties were ascertained. Additionally, treatment providers in cities from neighboring counties distanced 25 miles or less from the eight-county region were identified, including facilities from Iroquois and Vermilion counties in Illinois. Furthermore, information on mental health and addiction treatment providers was compiled using public databases (such as *Yellow Pages*). To determine the service area, individual zip codes were entered into a zip code-radius finder and a search radius of 25 miles was keyed in (Zip-Codes.Com, n.d.).

A number of database entries were outside the eight-county region, some even out-of-state. Selection of providers and facilities was not simply based on their location but also their service area. We defined the service area by length of travel/distance. According to the U.S. Department of Health and Human Services, a 40-minute commute to a mental health/addiction treatment facility can be imposed. The 40-minute travel time corresponds to 20 miles in mountainous terrain or in areas with only secondary roads available; 25 miles under normal conditions with primary roads available; and 30 miles in flat terrain or in areas connected by interstate highways (U.S. Department of Health and Human Services, 1992). For this project, we used the median value of 25 miles to define the 40-minute commute and our service area.

Currently, 115 mental health and/or addiction treatment facilities can be found within a 25-mile radius of the region: 61 settings within the eight counties, 38 providers in neighboring counties within Indiana, and 16 facilities are out-of-state (see Table 7 and Map 1). Of these facilities, 85 provide mental health services and 57 offer substance abuse treatments [missing data on 15 providers]. These numbers are not exclusive since some providers make both types of services available to their clients (see Table 8). Most facilities provide outpatient care (79), followed by residential services (22), and inpatient treatment (7); some settings offer multiple modes of care but most provide only inpatient, outpatient, **or** residential [missing data on 17 providers] (see Table 9). In regard to types of payment accepted, 42 providers take public insurance such as Medicaid, while 22 only accept private insurance or self-payment [missing data on 51 providers] (see Table 10). A catalog compiling treatment providers, types of services and care, accepted source of payment, and service region has been attached (see Attachment A “Treatment Facilities Serving the Eight-County Region”).

Focus Groups

To gain insight in the current mental health and addiction treatment system, especially gaps in services, focus groups with local stakeholders were conducted. Focus groups are a data collection technique that capitalizes on group interactions to provide qualitative information on a range of topics and in various research fields (Asbury, 1995). Our objective was to receive input from individuals providing services (e.g., mental health professionals and addiction counselors; facility administrators; professionals in legal, educational, and prevention fields) as well as from consumers (e.g., clients with mental illness and family members of clients with mental illness). Altogether nine focus groups were conducted.

Perspective: Treatment System

Seven focus groups were scheduled during May 2007 in various areas of the eight-county region (Crawfordsville, Delphi, Frankfort, Lafayette, West Lafayette, and West Lebanon). Local stakeholders who play a part in the treatment of mental health and addiction issues were invited. We sent out advance letters informing them about the study and, a week later, invitations to participate to 76 subjects by mail. Phone calls and/or email messages were used as a reminder prior to the meetings. A total of 27 individuals took part in the focus groups; this represents a response rate of almost 36%. Participants included mental health/addiction professionals and administrators of treatment facilities; Department of Child Services (DCS) directors; prosecutors; superintendents and other school personnel; and directors from local Boys and Girls Clubs. Focus group sessions were audio-taped and notes were taken. The following is a brief summary of needs as voiced by participants:

Fountain and Warren counties indicated that an inpatient facility for children as well as psychiatrists is needed. Since no psychiatrists are available to treat patients with severe mental illness, they often must be "shipped" out of the area, often as far as Indianapolis, for treatment. Furthermore, transportation is a big issue. A "free-meds" program has been established to provide free medication to clients (sponsored by the drug companies) but no reimbursement to distribute these medications (reimbursement to cover the cost of the pharmacist or the facility to disburse the drugs) is available.

Tippecanoe County participants stated a need to expand inpatient services and increase the number of inpatient beds. A lack of availability of psychiatric care was also mentioned. Housing seems to be another concern: they have nowhere to place clients with mental illness or individuals on probation for a drug conviction, primarily due to addiction. The prison system sends them to the homeless shelter. Also, no program money is provided to cover services offered to the un- or underinsured. The participants all agreed that a program to educate each agency on the types of services and programs available would be beneficial. Additionally, Hispanic services are needed.

A major concern for White and Carroll counties is the MMR[6] population; many mental health/addiction treatment providers don't want to take clients who are also mentally retarded. The counties' addiction services are growing faster than they can maintain. Their resident psychiatrist is retiring this month and has not been replaced. Transportation is an obstacle as well.

Clinton County has a need for a new medical health facility (to replace the current facility that is old and too small to meet the needs or the growing demands). They do not have an IOP[7] and

[6] MMR = Mild Mental Retardation
[7] IOP = Intensive Outpatient Treatment

can not maintain one based on the current requirements. Hispanic services are also needed. It was suggested to place a mental health professional into the school system to conduct counseling sessions and substance abuse prevention programs. Additionally, transportation is a major hindrance to providing services and staff recruitment is an issue.

Montgomery County indicated a need for a local treatment facility to provide substance abuse services. An inpatient unit for clients with severe mental illness as well as an intensive outpatient program is also needed. Furthermore, more AA[8] and similar programs, a forensic diversion program, a loan debt relief for mental health/addiction professionals, and a medication monitoring program were mentioned. The suggestion of a "mega complex" was made, where all the agencies could be housed in one location. This would also address their other need of cross-agency education and communication. Again, transportation seemed to be a problem. [See Appendices B and C and Attachment B]

A number of needs and challenges listed by focus group participants were county-specific. However, some trends and common motives emerged as well:

- Funding
  The funding of programs and payment for services is a major concern in all counties. Often, medical coverage does not include mental health services or insurance companies limit their preferred providers list making it difficult for clients finding local treatment options. Un- and underinsured clients cause not-for-profit facilities to have high expenditures on charity care. Additionally, low Medicaid reimbursement rates, managed care plans, and other system-related limitations lead to providers being "spread too thin".
- Expansion/establishment of specific treatment services
  All counties listed specific treatment services that need to be established or expanded within their community. Needed services include inpatient, outpatient, and intensive outpatient care; day treatments; assessments and evaluations; wrap-around services[9]; and respite care[10].
- Psychiatrists
  Carroll, Fountain, Tippecanoe, Warren, and White counties reported a lack of local psychiatrists. Reasons for the deficiency include difficulties recruiting and keeping psychiatrists on staff due to funding issues. Managed care and low reimbursement rates from Medicaid don't fully cover the expenses. Some focus group participants also expressed a need for psychiatric nurses, psychiatric nurse practitioners, and a psychiatric ER.
- Transportation
  Carroll, Clinton, Fountain, Montgomery, Warren, and White counties identified transportation as a major barrier to providing adequate services to clients. Not being able to keep an appointment due to a lack of transportation is not in the best interest of the client or the treatment provider.
- Collaboration among organizations
  Carroll, Fountain, Montgomery, Tippecanoe, Warren, and White counties articulated that better communication and collaboration among all players within the treatment community is necessary. This would be beneficial in trying to solve problems on the county level and lead to a greater awareness of resources within the community.

[8] AA = Alcoholics Anonymous
[9] Wrap-around services refer to a system of care that provides multi-disciplinary team-based comprehensive services to clients.
[10] Respite care provides temporary intermittent time off for family members who care for someone who is ill, injured, or frail. It can take place in the home or in a variety of out-of-home settings.

- Hispanic services
  Clinton and Tippecanoe counties mentioned a need for Hispanic services. It was stated that approximately 10% of the population is Hispanic; however, not enough bilingual case workers and therapists are available because of a tendency to work in more urban settings with better compensation. A number of individuals in need of mental health/addiction services don't have any type of medical coverage because they are illegal immigrants and don't try to access services out of fear of deportation.
- Other needs and challenges
  Many focus group participants mentioned capacity issues, such as a lack of psychiatrists; long waiting lists for clients/clients can't get in during times of crisis; increased demand for services; and a high turnover rate for mental health professionals. The implementation of a loan debt relief program for mental health professionals was proposed to recruit and keep staff. Other recommendations included increasing awareness of mental health and addiction issues within the general population and school-based programs to educate teachers and screen children.

[See Table 11]

Most of the reported needs and challenges target individuals with mental health and/or addiction issues in general. However, some comments aim at special populations, such as individuals in the court-system/incarcerated, children and adolescents, clients with MMR[11] and/or SMI[12], racial/ethnic minorities, and women.

Perspective: Consumers

Two focus groups, one with mentally ill but clinically stable clients and one with family members of individuals with mental illness, were conducted in June of 2007. Subjects were recruited by the National Alliance on Mental Illness West Central Indiana (NAMI-WCI) in Lafayette (Tippecanoe County). Focus group sessions were audio-taped and notes were taken. Many of the concerns mentioned by the participants echoed the comments made by representatives of the treatment system. Overall, focus participants referred to the limited capacity of the mental health system in the community. The following is a summary of the results:

- Payment for services and medications
  Many comments were made about the reimbursement system: Medicaid and private insurances don't cover all the services and medications that are needed, which leaves clients with large, sometimes unaffordable, co-payments. Often individuals have to make a choice between paying the rent (or other necessities) and receiving mental health treatment. Additionally, many service providers don't accept Medicaid recipients due to low reimbursement rates. To implement better insurance practices for mental health issues, similar to medical coverage, was suggested.
- Expansion/establishment of specific treatment services
  The need and demand for mental health services is greater than its availability; long waiting lists to see a mental health professional are common. To expand inpatient services (increase number of beds), especially for children and adolescents, is a crucial aspect of quality care. Placing mentally ill patients into a regular hospital unit seems ineffective because these individuals require specialized care ("it's like putting a cancer patient in the middle of the psych ward and saying now take care of him"). Furthermore, a need for outpatient care was listed.
- Psychiatrists and other mental health professionals

[11] MMR = Mild Mental Retardation
[12] SMI = Serious Mental Illness

The need for more psychiatrists was frequently mentioned by focus group participants. In addition, other mental health professionals, such as case managers and entitlement specialists[13], are in demand. The high turn-over rate of mental health staff was noted and attributed to these professionals being overworked and underpaid.

- Education
  Education about mental health issues among the general public and legislators is essential to increase awareness and decrease stigma.

Surveys

To get a more in-depth description of the types of mental health/addiction services currently provided and local treatment capacity, the Center for Health Policy developed three web-based surveys, the *Mental Health and Addiction Facilities Survey* and the *Emergency Facilities Surveys* (*LAW* and *ER*). The *Mental Health and Addiction Facilities Survey* was designed for administrators or other staff knowledgeable about a facility's services, staffing, and funding issues. The purpose of the questionnaire was to get a detailed account of available services and target populations, size of the facility, budget and funding, core mental health professionals/addiction counselors on staff, hours of operation, number of clients served (actual count) and number of potential clients (capacity), challenges in providing services, and gaps in services. The *Emergency Facilities Survey – LAW* targeted law enforcement officers, such as police or sheriffs' departments and crisis intervention teams, and the *Emergency Facilities Survey – ER* was intended for emergency room staff. Both professional groups often come into contact with mentally ill and/or intoxicated individuals. We believe that information, such as number of incidences involving mental illness or substance abuse and the course of action taken in these instances is of interest. All potential subjects were contacted by mail with a formal invitation to participate in the survey and, additionally, via email and/or phone to remind them of the questionnaires.

Mental Health and Addiction Facilities Survey

We contacted 41 administrators of mental health and/or addiction facilities in the eight-county region and invited them to participate in the study. However, only four subjects completed the questionnaire, which left us with the low response rate of 10%. The respondents were from Tippecanoe (2), Hendricks (1), and Montgomery (1) counties. Two subjects represented the private for-profit sector and two belonged to the private nonprofit system. Only one of the treatment providers offered transportation services for clients. Available services from these providers included adolescent-specific programs (3), alcohol detoxification (1), education programs for substance abuse (2), education programs for mental illness (2), geriatric-specific services (1), inpatient care for mental illness (1), intensive outpatient treatment for substance abuse (1), nursing home/in-home visits (1), outpatient care for mental illness (3), outpatient care for substance abuse (2), supported employment programs (1), support groups (1), treatment for co-occurring disorders (2), gambling interventions (2), and "other" programs (3), such as services for children, school-based programs, and partial hospitalization. Between the four providers that completed the survey, 2,934 clients were treated for mental illness, 338 for substance abuse, 116 for co-occurring disorders, and 4 for gambling. The total costs for mental health and/or addiction services for all four treatment providers for the 2006 fiscal year was $4,406,097 (mean = 1,468,699.0; sd = 1,271,498.9); gross revenues combined to $5,476,439 (mean = 1,825,479.7; sd = 1,497,193.9) and net revenues added up to $2,176,683 (mean =

[13] Entitlement specialists assist clients in receiving their social entitlements such as Medicaid, Medicare, social security, supplemental security income (SSI), social security disability, and unemployment insurance.

725,561.0; sd = 1,106,349.6). The average percentage of revenue paid by diverse sources was as follows: private insurance 51.0% (sd = 32.2); Hoosier Assurance Plan (HAP) 25.0% (sd = n/a); Medicaid Select 20.0% (sd = n/a); self-pay 14.5% (sd = 11.4); Medicare 12.7% (sd = 19.3); and "other" 22.5% (sd = 31.8); 10.0% (sd = n/a) were deemed charity care. In regard to reimbursement trends, one respondent reported a decline, while the other three stated that compensation flat-lined. When asked about the adequacy of services, two participants asserted that individuals suffering from serious mental illness (SMI) do not, for the most part, receive adequate treatment in the community, while the other two subjects reported they were not sure. The following challenges to providing mental health and/or addiction treatment and gaps in services have been identified by the survey respondents:

Challenges

- Costs of services
- The barriers for the near-poor are almost insurmountable; they don't qualify for aid but are largely uninsured
- Public policy changes at state and federal levels
- The new Medicaid managed care program in Indiana is limiting access to care and reducing care
- Public funds in care have been essentially flat-lined for over a decade
- Lack of psychiatrists (especially for children and adolescents)
- Emergency care options
- Too many "silos" in terms of care; the various agencies don't integrate efforts effectively

Gaps

- Housing
- Providing medications for the mentally ill
- Employment services
- Jail diversion programs
- Prevention and early intervention services
- Lack of psychiatrists

Emergency Facilities Survey – LAW

Twenty-six (26) professionals in law enforcement were invited to fill out the instrument. Only two individuals completed the survey; this represents a response rate of roughly 8%. According to the data, the law enforcement agencies had, on average, contact with 1,5010.00 individuals (sd = 1,400.07) in 2006. Of these, 262.50 were due to substance abuse issues (sd = 265.17), 35.00 because of mental illness (sd = 21.21), and 22.50 were related to suicide attempts (sd = 24.75). In other words, 17.38%, 2.32%, and 1.49% of all contacts with law enforcement personnel was attributable to substance abuse, mental health, and suicide issues respectively. Subjects reported an average of 6.00 immediate detentions (sd = 5.66) and 11.00 emergency detentions (sd = 1.41) for the year. Furthermore, both respondents stated that their county does not have a CIT[14] (Crisis Intervention Team) unit available and that their agency's services could be improved to better serve individuals with mental illness, substance use disorders, and those who are suicidal. The law enforcement officers also indicated that limited capacity ("getting placements" and "having bed space available for those who need detained") are the greatest challenges in serving individuals with mental health issues. Furthermore, increasing treatment

[14] The CIT (Crisis Intervention Team) program, also known as the Memphis Model, is an innovative program that provides law enforcement-based crisis intervention training for helping those individuals with mental illness. Involvement in CIT is voluntary and based in the patrol division of the police department. In addition, CIT works in partnership with those in mental health care to provide a system of services that is friendly to the individuals with mental illness, family members, and the police officers.

capacity, greater cooperation between law enforcement and mental health agencies, and streamlining the paper work officers have to complete when dealing with mentally ill persons were suggested to improve services. However, these results are not necessarily representative due to the low response rate.

Emergency Facilities Survey – ER

Five potential subjects were contacted to complete the survey and provide information on clients who were seen by emergency room staff due to a primary or secondary complaint of mental illness, substance abuse, or suicide attempt. None of the individuals contacted completed the questionnaire; the response rate was 0%.

Conclusion

The Center for Health Policy (CHP) conducted an assessment to help North Central Health Services (NCHS) identify the mental health and addiction services needs in the region. The goal was to evaluate if the current system is capable of meeting the needs within the eight target counties. The assessment revealed gaps in the existing treatment system: providers and consumers of mental health services alike expressed a need for effective, comprehensive, and timely services. Facilities currently lack the capacity to fully meet the needs of the community. Funding to increase capacity will improve a community's ability to respond to the mental health and addiction issues of its members. Inadequately treated individuals are more likely to experience social, legal, and medical problems. The benefits of an improved mental health system are numerous and impact not only persons diagnosed with a psychological disorder and their families but all within the county.

TABLES

Table 1: Indiana Estimated Prevalence of Adults (Age 18 Years and Over) with Serious Mental Illness (SMI), by County, SFY 2006

State/region/ county	*Est. total population*	*Est. adult population*	*Est. prev. of adults with SMI (5.4%)*
Indiana	**6,293,476**	**4,579,475**	**247,285**
8-county region	**309,365**	**233,876**	**12,628**
Benton	9,360	6,729	363
Carroll	20,547	15,114	816
Clinton	34,566	24,764	1,337
Fountain	17,987	13,218	714
Montgomery	38,571	28,286	1,527
Tippecanoe	154,056	120,506	6,507
Warren	8,892	6,517	352
White	25,386	18,742	1,012

Source: (Indiana Family and Social Services Administration, n.d.)

Table 2: Indiana Estimated Prevalence of Children (Ages 9 to 17) with Serious Emotional Disturbance (SED), by County, SFY 2006

State/region/ county	*Est. total population*	*Est. population of children*	*Est. prev. SED with GAF<50 (6.0%)*	*Est. prev. SED with GAF<60 (10.0%)*
Indiana	**6,293,476**	**857,854**	**51,470**	**85,791**
8-county region	**309,365**	**38,456**	**2,307**	**3,846**
Benton	9,360	1,341	80	134
Carroll	20,547	2,772	166	277
Clinton	34,566	4,996	300	500
Fountain	17,987	2,430	146	243
Montgomery	38,571	5,239	314	524
Tippecanoe	154,056	17,077	1,025	1,708
Warren	8,892	1,212	73	121
White	25,386	3,389	203	339

Source: (Indiana Family and Social Services Administration, n.d.)

Table 3: Indiana Estimated Prevalence of Adults and Children with Chronic Addiction, by Age, by County, SFY 2006

State/county level	*Est. total population*	*Est. prev. 12-17 (10.69%)*	*Est. prev. 18-25 (22.55%)*	*Est. prev. 26 and over (7.49%)*	*Est. population with chronic addiction*
Indiana	**6,293,476**	**59,395**	**79,870**	**316,599**	**455,864**
8-county region	**309,365**	**2,663**	**5,480**	**15,697**	**23,840**
Benton	9,360	93	90	474	657
Carroll	20,547	192	215	1,061	1,468
Clinton	34,566	346	370	1,733	2,449
Fountain	17,987	168	178	931	1,277
Montgomery	38,571	363	374	1,996	2,733
Tippecanoe	154,056	1,182	3,897	7,727	12,806
Warren	8,892	84	85	460	629
White	25,386	235	271	1,315	1,821

Source: (Indiana Family and Social Services Administration, n.d.)

Table 4: Primary Substance Reported at Time of Admission by Individuals in Substance Abuse Treatment in Indiana, by County, 2005

State/county level	*Alcohol*	*Cocaine/ Crack*	*Marijuana*	*Meth*	*Other*	*Total*
Indiana	**13,791 (47.2%)**	**3,674 (12.6%)**	**7,018 (24.0%)**	**1,616 (5.5%)**	**3,116 (10.7%)**	**29,215 (100.0%)**
8-county region	**552 (47.1%)**	**80 (6.8%)**	**364 (31.1%)**	**104 (8.9%)**	**71 (6.1%)**	**1,171 (100.0%)**
Benton	20 (62.5%)	3 (9.4%)	9 (28.1%)	0 (0.0%)	0 (0.0%)	32 (100.0%)
Carroll	43 (47.3%)	3 (3.3%)	30 (33.0%)	12 (13.2%)	3 (3.3%)	91 (100.0%)
Clinton	10 (41.7%)	3 (12.5%)	8 (33.3%)	1 (4.2%)	2 (8.3%)	24 (100.0%)
Fountain	48 (49.5%)	3 (3.1%)	30 (30.9%)	12 (12.4)	4 (4.1%)	97 (100.0%)
Montgomery	128 (47.2%)	8 (3.0%)	92 (33.9%)	21 (7.7%)	22 (8.2%)	271 (100.0%)
Tippecanoe	254 (46.4%)	55 (10.1%)	157 (28.7%)	46 (8.4%)	35 (6.4%)	547 (100.0%)
Warren	8 (42.1%)	1 (5.3%)	7 (36.8%)	2 (10.5%)	1 (5.3%)	19 (100.0%)
White	41 (45.6%)	4 (4.4%)	31 (34.4%)	10 (11.1%)	4 (4.4%)	90 (100.0%)

Source: (Indiana Division of Mental Health and Addiction, 2005)

Table 5: Number (Percent) of Individuals in Substance Abuse Treatment in Indiana Reporting to Have Engaged in Polysubstance Use, by County, 2005

State/county level	*Using > 1 Substance*
Indiana	**16,098 (55.1%)**
8-county region	**625 (53.4%)**
Benton	17 (53.1%)
Carroll	39 (42.9%)
Clinton	13 (54.2%)
Fountain	58 (59.8%)
Montgomery	129 (47.6%)
Tippecanoe	302 (55.2%)
Warren	11 (57.9%)
White	56 (62.2%)

Source: (Indiana Division of Mental Health and Addiction, 2005)

Table 6: Indiana Estimated Prevalence among Adults with SMI to Have a Co-occurring Disorder (SMI and Chronic Addiction), by County, SFY 2006

State/county level	*Est. total population*	*Est. adult population*	*Est. prev. of adults with co-occurring disorder (23.2%)*
Indiana	**6,293,476**	**4,579,475**	**57,374**
8-county region	**309,365**	**233,876**	**2,930**
Benton	9,360	6,729	84
Carroll	20,547	15,114	189
Clinton	34,566	24,764	310
Fountain	17,987	13,218	166
Montgomery	38,571	28,286	354
Tippecanoe	154,056	120,506	1,510
Warren	8,892	6,517	82
White	25,386	18,742	235

Source: (Indiana Family and Social Services Administration, n.d.)

Table 7: Number of Mental Health and/or Addiction Treatment Providers Serving the Eight-County Region

County/Area	*Number of Facilities*	*Percent*
Boone	5	4.3
Carroll	1	.9
Cass	8	7.0
Clinton	2	1.7
Fountain	3	2.6
Hamilton	8	7.0
Hendricks	5	4.3
Howard	6	5.2
Jasper	1	.9
Montgomery	15	13.0
Parke	1	.9
Pulaski	1	.9
Putnam	2	1.7
Tippecanoe	36	31.3
Vermillion	1	.9
Warren	1	.9
White	3	2.6
Out-of State	16	13.9
Total	***115***	***100.0***

Table 8: Number of Treatment Providers by Service Type and County

County/Area	*Substance abuse providers*	*Mental health providers*	*Providers whose type of service is unknown*
Boone	2	5	0
Carroll	1	1	0
Cass	1	8	0
Clinton	2	2	0
Fountain	3	3	0
Hamilton	8	4	0
Hendricks	3	4	0
Howard	1	6	0
Jasper	1	1	0
Montgomery	9	8	3
Parke	1	1	0
Pulaski	1	1	0
Putnam	2	2	0
Tippecanoe	14	26	9
Vermillion	1	1	0
Warren	0	0	1
White	1	1	2
Out-of State	6	11	0
Total	***57***	***85***	***16***

Categories 'Substance abuse providers' and 'Mental health providers' are not mutually exclusive because some facilities offer both types of services

Table 9: Number of Treatment Providers by Types of Care and County

County/Area	*Inpatient services*	*Outpatient services*	*Residential services*
Boone	0	3	3
Carroll	0	1	0
Cass	1	5	2
Clinton	0	2	0
Fountain	0	3	0
Hamilton	0	7	1
Hendricks	0	3	3
Howard	2	6	1
Jasper	0	1	0
Montgomery	1	9	0
Parke	0	1	0
Pulaski	0	1	0
Putnam	1	2	1
Tippecanoe	1	24	3
Vermillion	0	1	0
White	0	1	0
Out-of State	1	9	8
Total	***7***	***79***	***22***

Categories are not mutually exclusive because some facilities offer a combination of or all types of care

Table 10: Number and Percentage of Treatment Providers by Accepted Source of Payment and County

County/Area	Payment		Total
	Public insurance NOT accepted	Public insurance accepted	
Boone	0 (0.0%)	2 (100.0%)	2 (100.0%)
Carroll	0 (0.0%)	1 (100.0%)	1 (100.0%)
Cass	0 (0.0%)	1 (100.0%)	1 (100.0%)
Clinton	0 (0.0%)	2 (100.0%)	2 (100.0%)
Fountain	2 (66.7%)	1 (33.3%)	3 (100.0%)
Hamilton	3 (37.5%)	5 (62.5%)	8 (100.0%)
Hendricks	2 (66.7%)	1 (33.3%)	3 (100.0%)
Howard	0 (0.0%)	1 (100.0%)	1 (100.0%)
Jasper	0 (0.0%)	1 (100.0%)	1 (100.0%)
Montgomery	2 (28.6%)	5 (71.4%)	7 (100.0%)
Parke	0 (0.0%)	1 (100.0%)	1 (100.0%)
Pulaski	0 (0.0%)	1 (100.0%)	1 (100.0%)
Putnam	0 (0.0%)	2 (100.0%)	2 (100.0%)
Tippecanoe	11 (47.8%)	12 (52.2%)	23 (100.0%)
Vermillion	0 (0.0%)	1 (100.0%)	1 (100.0%)
White	0 (0.0%)	1 (100.0%)	1 (100.0%)
Out-of State	2 (33.3%)	4 (66.7%)	6 (100.0%)
Total	***22 (34.4%)***	***42 (65.6%)***	***64 (100.0%)***

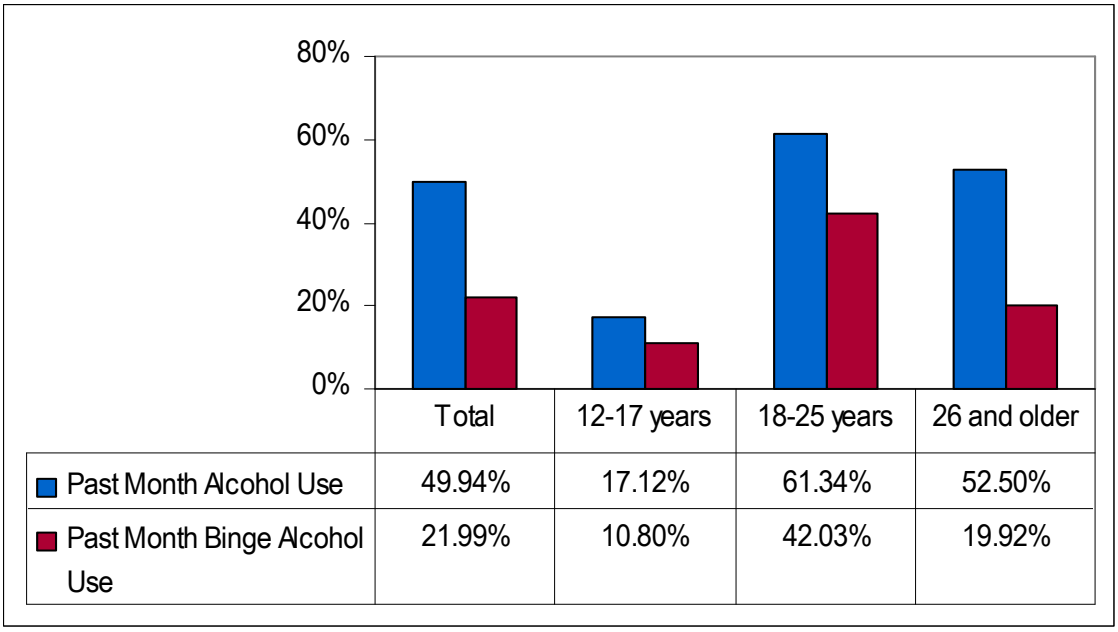
Table 11: Counties Reporting Needs and Challenges (Based on Focus Group Comments)

	Fountain and Warren	Tippecanoe	Carroll and White	Clinton	Montgomery
Funding Needs	Yes	Yes	Yes	Yes	Yes
Treatment Needs	Yes	Yes	Yes	Yes	Yes
Psychiatrists Needed	Yes	Yes	Yes	No	No
Transportation Problems	Yes	No	Yes	Yes	Yes
Collaboration Needed	Yes	Yes	Yes	No	Yes
Hispanic Services Needs	No	Yes	No	Yes	No
Other Needs	Yes	Yes	Yes	Yes	Yes

Yes = Focus group participants reported this to be a need or challenge in the county
No = Focus group participants did not report this to be a need or challenge in the county; this does not necessarily imply that it is not a need or challenge

FIGURES

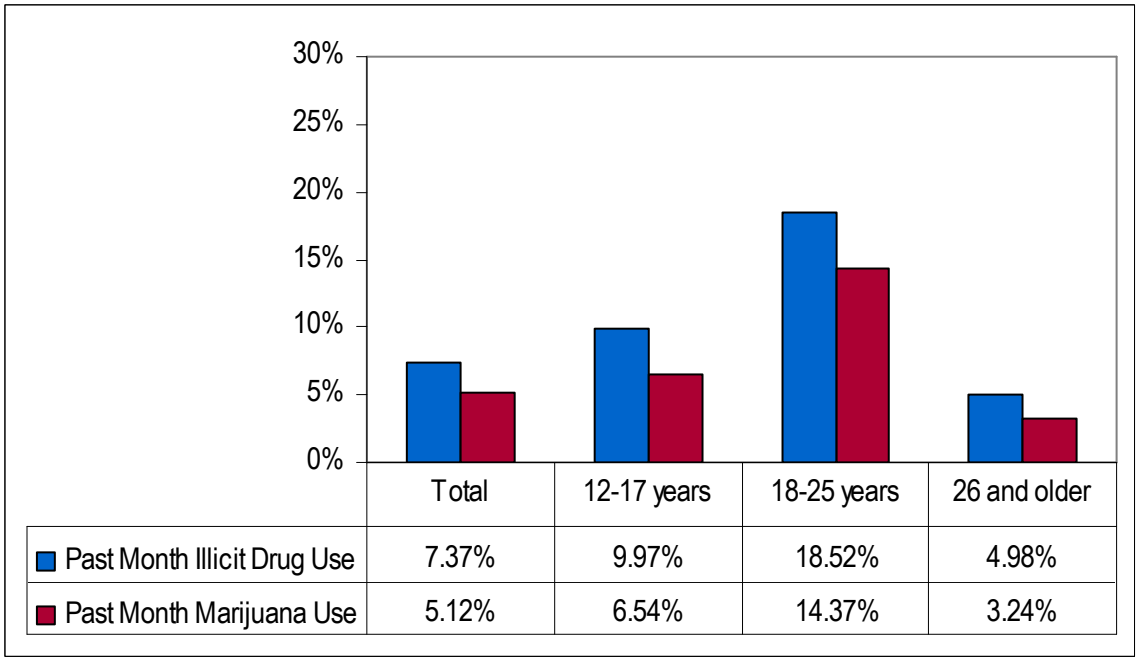
Figure 1: Percentage of Individuals 12 Years and Older in Indiana Reporting Past Month Alcohol Use and Past Month Binge Alcohol Use, by Age Group (National Survey on Drug Use and Health, NSDUH, 2004-2005)



	Total	12-17 years	18-25 years	26 and older
Past Month Alcohol Use	49.94%	17.12%	61.34%	52.50%
Past Month Binge Alcohol Use	21.99%	10.80%	42.03%	19.92%

Source: (Substance Abuse and Mental Health Services Administration, 2007)

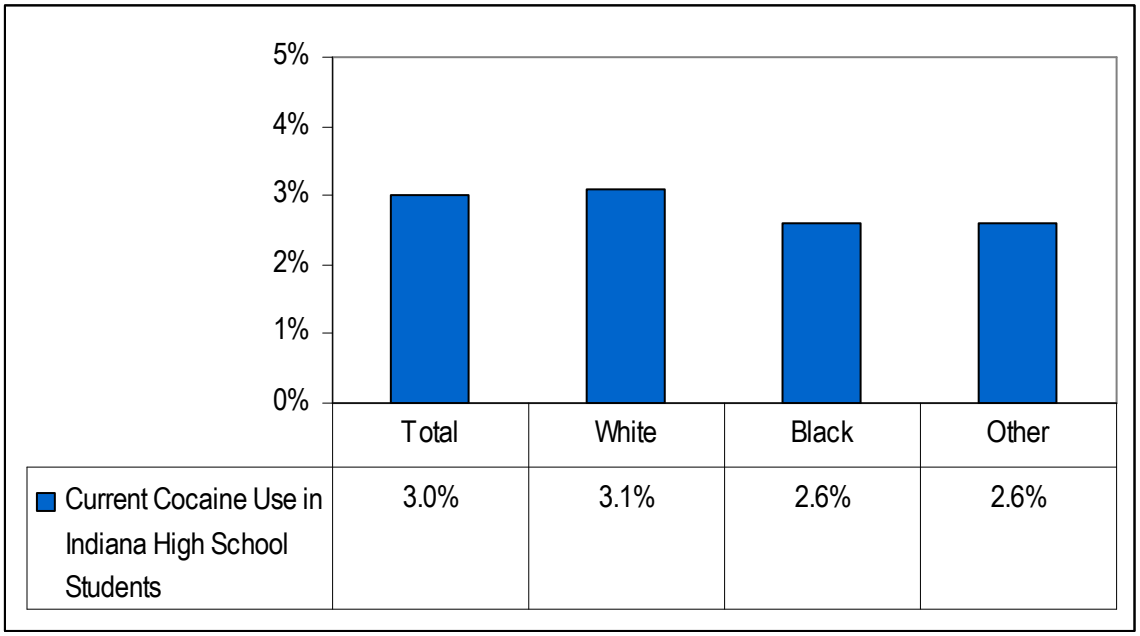
Figure 2: Percentage of Individuals 12 Years and Older in Indiana Reporting Past Month Illicit Drug Use and Past Month Marijuana Use (National Survey on Drug Use and Health, NSDUH, 2004-2005)



	Total	12-17 years	18-25 years	26 and older
Past Month Illicit Drug Use	7.37%	9.97%	18.52%	4.98%
Past Month Marijuana Use	5.12%	6.54%	14.37%	3.24%

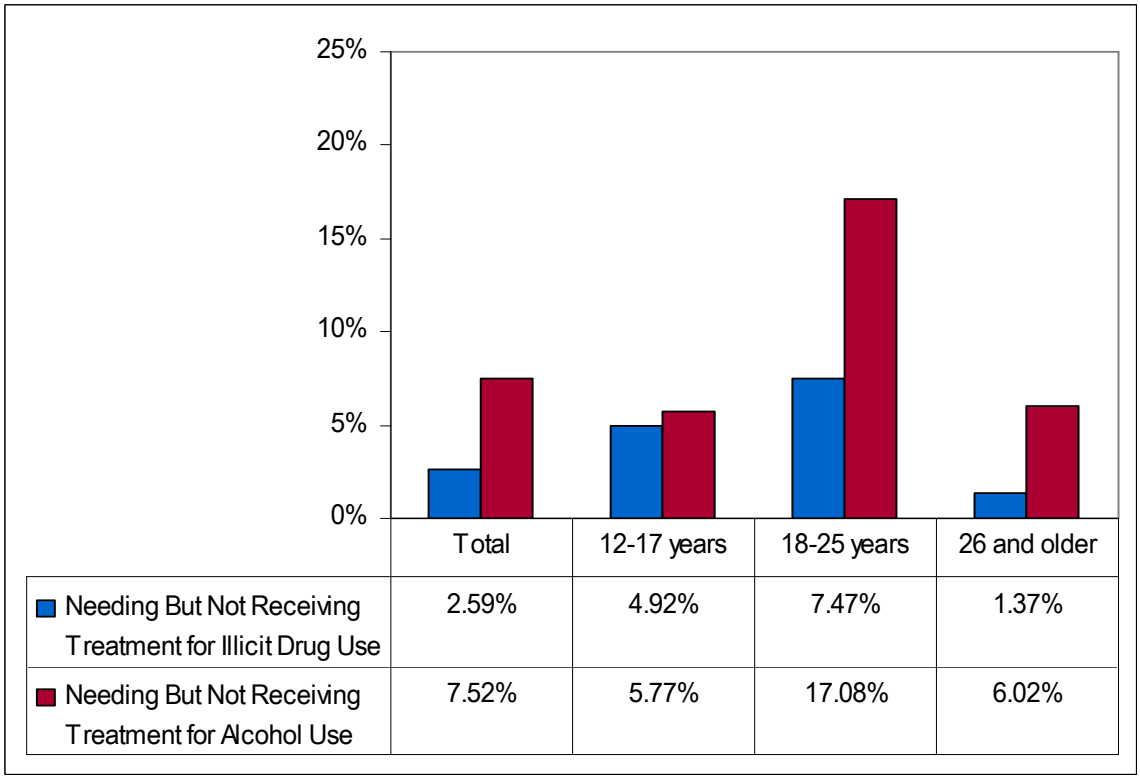
Source: (Substance Abuse and Mental Health Services Administration, 2007)

Figure 3: **Percentage of Indiana High School Students Currently Using Cocaine (Youth Risk Behavior Surveillance System, YRBSS, 2005)**



Source: (Centers for Disease Control and Prevention, 2007)

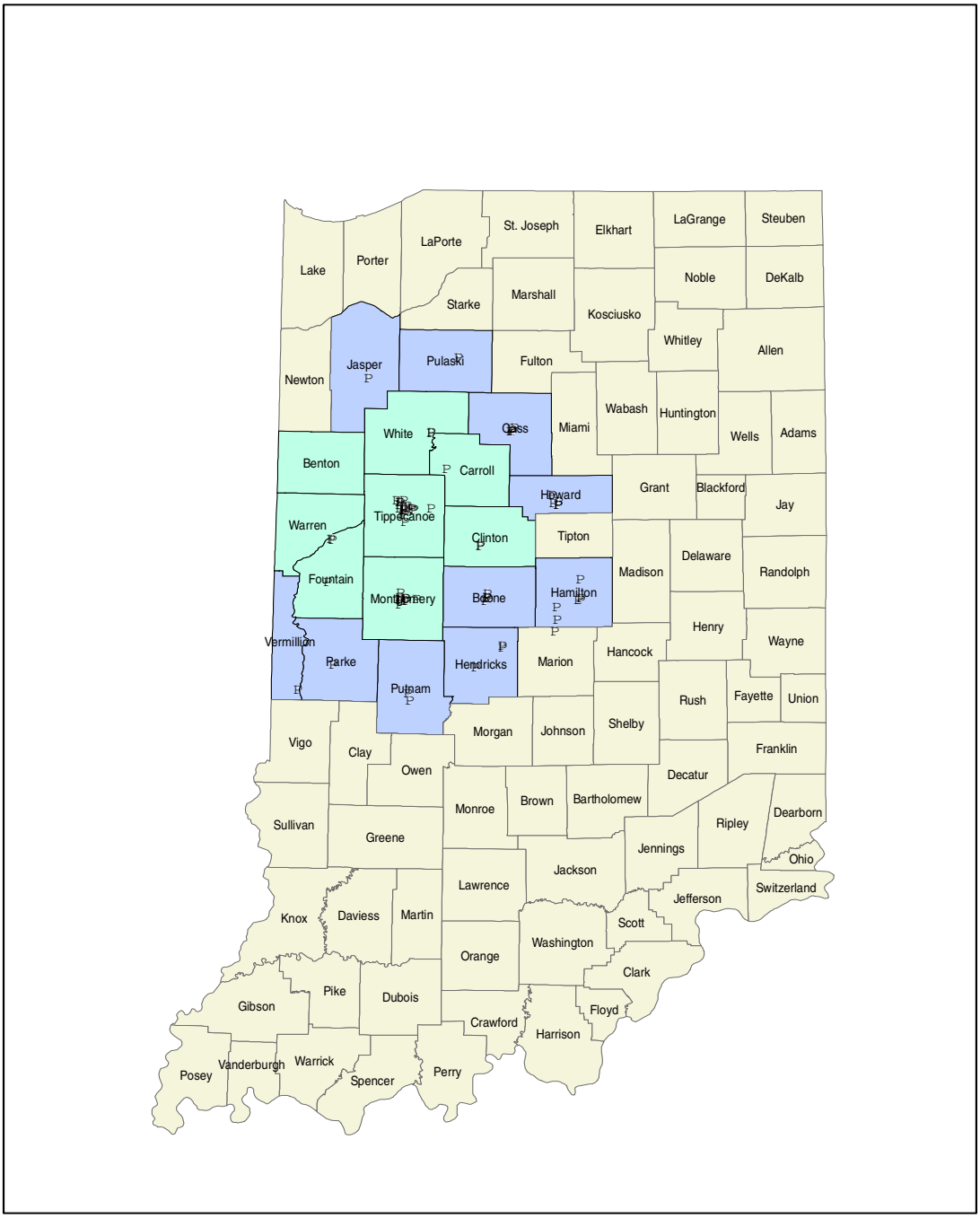
Figure 4: **Percentage of Individuals 12 Years and Older in Indiana Needing but Not Receiving Treatment for Illicit Drug and Alcohol Use, by Age Group (National Survey on Drug Use and Health, NSDUH, 2004-2005)**



Source: (Substance Abuse and Mental Health Services Administration, 2007)

MAPS

Map 1: Existing Mental Health and/or Addiction Treatment Facilities in Indiana Serving the Eight-County Region



APPENDIX A

Report Card: Indiana's Public Adult Mental Healthcare System

Indiana

Grade: D-

Category Grades	
Infrastructure	F
Information Access	C+
Services	D
Recovery Supports	F

Spending, Income, & Rankings		
PC Spending/Rank	$72.37	28
PC Income	$27,328	36
Total MH Spending/Rank	$448 *(in millions)*	19
Suicide Rank		24

Recent Innovations

- Commitment to transformation
- Implementation of ACT in partnership with universities
- Prison education program

Urgent Needs

- Caution on scope and speed of changes
- Greater transparency
- Consumer and family participation in decisions
- Waiting list reduction for community services

Source: (National Alliance on Mental Illness, 2006)

APPENDIX B

FOCUS GROUPS SUMMARY

Fountain and Warren Counties

NEEDS

- Local inpatient facility for children
- Psychiatrists
- Reimbursement to disburse free medication ("free meds" program sponsored by pharmacological companies)
- Building community partners to cover costs that are not covered by Medicaid
- Medical coverage for people from 18 to 65 years
- Funding to provide more of existing programs and services

CHALLENGES/BARRIERS

- Transportation
    - For clients
    - For mental health professionals to visit clients (reimburse travel and related costs)
- Frequently, insurance/medical coverage does not include mental health services
- Too few providers accept Medicaid recipients
- Managed care issues such as limited prescription coverage, which may lead to deterioration in clients mental health status
- Level/amount of charity care has increased
- DMHA uses recovery model and Medicaid follows a managed care model

Tippecanoe County

NEEDS

- Hispanic services
- More inpatient beds/expanded inpatient services (for children/adolescents and adults)
- Juvenile Justice Center (is being built)
    - Wrap-around services
    - Assessment of mental health needs and risk level of juveniles and development of appropriate services
- Psychiatric care
    - Psychiatrists, psychiatric nurses (with prescription authority), psychiatric ER
    - Psychiatric services for children
    - Establish a certified psychiatric nurse practitioner program at Purdue
- Access center
    - Evaluation of mental health status
    - A single point-of-entry to get people started
    - Also used by CIT officers for assessment of individuals
- Women's residential/addiction services
- Respite care
- Housing (e.g., group homes; housing opportunities for individuals released from jail or prison, especially if suffering from mental illness)

- Educational programs for school teachers to learn to identify psychiatric problems
- At least 10-12 more case managers for school system
- Communication among treatment providers
- Funding to provide more of existing programs and services
- Suspension, not termination, of federal benefits for individuals who are incarcerated

CHALLENGES/BARRIERS

- DMHA and Medicaid at opposite ends of the spectrum (DMHA is incorporating a recovery model and Medicaid uses a managed care model)
- Volume of services has doubled within the last two years (in 2004: 10+ million; in 2006: 20+ million) and still can't keep up with the need
- Clients that are un- or underinsured (the numbers are growing and demand cannot be met)
- Insurance companies limit preferred providers list, which makes it difficult for providers to get on the list
- Parents whose insurance doesn't pay for substance abuse treatment for their children (or are limited in their choices of services) and/or who don't qualify for public assistance but still can't cover the services themselves
- Clients with mental illness or addiction **and** mental retardation are difficult to treat and many facilities don't want to take them
- Waiting lists for clients (often no prompt services)
- Large amount of charity care
- Lafayette is the "hub" in providing services for surrounding rural counties
- Psych ER has been closed (loss of 20 beds), so regular ER must accept psychiatric emergencies
- Psychiatrists; hands are being tied by managed care, i.e., frequently the medications they want to prescribe are not approved and not covered by the organization
- Due to low Medicaid reimbursement rates, it is not affordable to hire and keep a psychiatrist on staff
- Children/adolescents usually have to get involved with the law before services are provided
    - Not many services specifically for low- to moderate-risk adolescents
- Individuals with SMI who don't receive adequate treatment are more likely to self-medicate (use drugs), which exacerbates the problem

<u>Carroll and White Counties</u>

NEEDS

- Cohesive wrap-around services (for general and MMR populations)
- Emergency placement after business hours
- Respite care
- Education of general public on issues of mental health and addictions and available services
- Communication among service providers – to work together
- Psychiatrists

CHALLENGES/BARRIERS

- Increase in addictions (general population and adolescents)
- Many clients with MMR needs

    - Many providers don't want to take clients who are also mentally retarded
- Transportation
- Shortage of physicians and no psychiatrists
- Difficult to keep up with demand of services
- Less and less insurance options for private practices

Clinton County

NEEDS

- Resident mental health counselor in each school (can be shared among the four schools)
    - Substance abuse programs
    - Therapy
- New mental health facility
    - Local outpatient facility; IOP (substance abuse and mental health)
- Hispanic services

CHALLENGES/BARRIERS

- Alcohol and drug abuse among school-aged children (identification of problem is the biggest issue)
- Local community frequently doesn't seek treatment until medical problems or involvement in legal system
- Limited awareness of mental health/addiction issues in the community
- It becomes more difficult to obtain authorization from insurance companies for inpatient detoxification
- No local outpatient programs; for IOP clients need to go to Kokomo
- Hispanic population (language is a barrier; no translators; often fear of deportation)
- Long waiting times to see mental health professional (often can't get in during time of crisis)
- Medicaid reimbursement issues
- Staff recruitment
- Transportation

Montgomery County

NEEDS

- Local treatment facilities
    - Provide space for court-ordered residential services
    - Provide court-ordered substance abuse services
    - Adult IOP (Matrix)
    - Residential for meth (or other recreational drugs) addicts
    - Reliable day treatment
- Free county-wide transportation
- More education and communication among various agencies and organizations within county for comprehensive provision of services
- More AA and similar programs
- Mega complex ("one-stop shopping")
    - Services easily accessible for clients

    - Providers could track that mandated services are being sought and completed
    - Better understanding of what services/programs are available
- Loan debt relief for mental health/addiction professionals (incentive to help with recruitment and continuity of professional staff)
- Forensic Diversion Program [to ensure that adults with mental illness or an addictive disorder who have been convicted of a crime receive adequate community-based treatment or other services instead of incarceration]
- Prescription monitoring for patients that use their medication for street currency
- More programs, more providers, more choices, and more competition

CHALLENGES/BARRIERS

- Transportation
- High turnover rate for mental health professionals
- There is no place to put patients with severe mental illness

APPENDIX C

COUNTY WISH LIST

- Establishment and/or Expansion of Specific Services -

	Fountain/ Warren	Tippecanoe	Carroll/ White	Clinton	Montgomery
Inpatient	√	√			
Outpatient/IOP				√	√
Residential		√			√
Day treatments/partial hospitalization					√
Housing		√			
Respite care		√	√		
Wrap-around services		√	√		
Services for MMR		√	√		
Emergency placement (after-hours)			√		
Evaluation/assessment of mental health needs		√			
School counselors (therapists, case managers, etc.)		√		√	
Educational programs/increase awareness		√	√	√	√
Psychiatrists	√	√	√		
Transportation	√		√	√	√
Hispanic services		√		√	

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