Phelps County Regional Medical Center

2018

Community Mental Health and Addiction Needs and Resource Assessment

Crawford County

Dent County

Maries County

Phelps County

Pulaski County

Texas County

DIEHL CONSULTING GROUP
evaluation | analytics | solutions

Acknowledgements

The 2018 Community Mental Health and Addiction Needs Assessment was commissioned by Phelps County Regional Medical Center. Diehl Consulting Group was contracted to conduct the needs assessment study. A Planning Team comprised of local addiction and mental health professionals, as well as other key community stakeholders, 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.

Planning Team

Leah Isakson, Administrative Director of Organizational Development and Innovation, PRCMC

Starlyn Reynolds, MA, RN-CEN, EMT-P, Assistant Director of Clinical Education, PCRMC

Jade Chapman, RN, MSN, Training and Development Specialist, PCRMC

Kim Woodson, Care Manager, PCRMC

David Duncan, Community Mental Health Liaison, Pathways

Lucas Chapman, Assistant Director of Rolla Technical Institute

Felisha Richards, Director, Southeast Missouri Behavioral Health

The Planning Team acknowledges the following individual who compiled hospital admissions data for the project:

Cindy Mitchell BSN, RN, Director Applications & Analytics, PCRMC

Diehl Consulting Group

Doug Berry, MA, Senior Consultant

Jason Chadwell, MA, Senior Consultant

Heather Davis, MS, Assistant Consultant

Dan Diehl, MA, MSW, Ph.D., LCSW, President/Senior Consultant

Andrea Swain, BS, CHES, Associate Consultant

Amanda Vote, MS, Associate Consultant

EXECUTIVE SUMMARY
October 2018

PHELPS COUNTY REGIONAL MEDICAL CENTER

Community Mental Health and Addiction Needs and Resource Assessment

Crawford, Dent, Phelps, Pulaski, Maries and Texas Counties

Overview

This assessment was conducted by Diehl Consulting Group, an independent third party evaluation firm with extensive experience in providing evaluation services and community needs and resource assessments. An initial advisory group comprised of key community stakeholders informed study methodology and a planning team guided implementation.

Methodology

Mixed quantitative and qualitative methods were used to identify mental health and addiction needs and strengths within the six-county study area, as well as potential strategies to address them. This study included a review of various secondary data sources, and utilized surveys, interviews and focus groups with **356** providers and clients and/or family members across all counties.

- **10** Provider Focus Groups (n=**26**)
- **15** Client/Family Focus Groups (n=**28**)
- Direct Service Provider Surveys (n=**36**)
- Ancillary Service Provider Surveys (n=**117**)
- Stakeholder Interviews (n=**23**)
- Client Surveys (n=**126**)

INTRODUCTION

Phelps County Regional Medical Center (PCMRC) commissioned a study to conduct a community mental health and addiction needs assessment for the following counties in its service region: **Crawford, Dent, Maries, Phelps, Pulaski, and Texas**. 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. The current study was an outgrowth of a Community Health Needs Assessment the health system had conducted, which indicated that mental health was a primary need in the community. This study represents a more in-depth assessment of issues related to mental health and addiction by examining perceptions of mental health and addiction issues provided by direct and ancillary service providers and consumers of services (clients and family members), along with a review of various secondary data sources.

GUIDING QUESTIONS

What are the primary mental health and addiction needs of residents (and service gaps) **in the health system's six**-county service area?

What resources (strengths) exist to address needs?

What are the most useful strategies to address the needs?

What are the primary mental health and addiction needs of residents (and service gaps) in the health **system's six**-county service area?

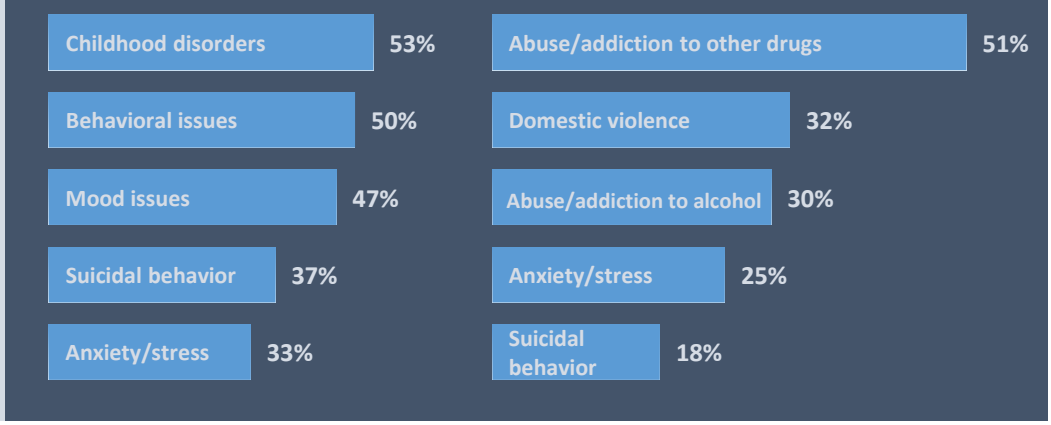
Various groups of professionals and community members informed needs through surveys, interviews and focus groups. These included: (1) providers of mental health and addiction services (Direct Service Providers), (2) organizations that provide ancillary support services such as housing, food, job skills training, education, and other important services (Ancillary Service Providers [schools and nonschools]), and (3) clients or family members who have accessed mental health and/or addiction services (Clients). Collectively, a total of 356 individuals participated in some manner. Categories of need were derived by triangulating all data sources. Highlights from selected individual data sources are first presented, followed by the synthesis of identified needs and suggested strategies to address them.

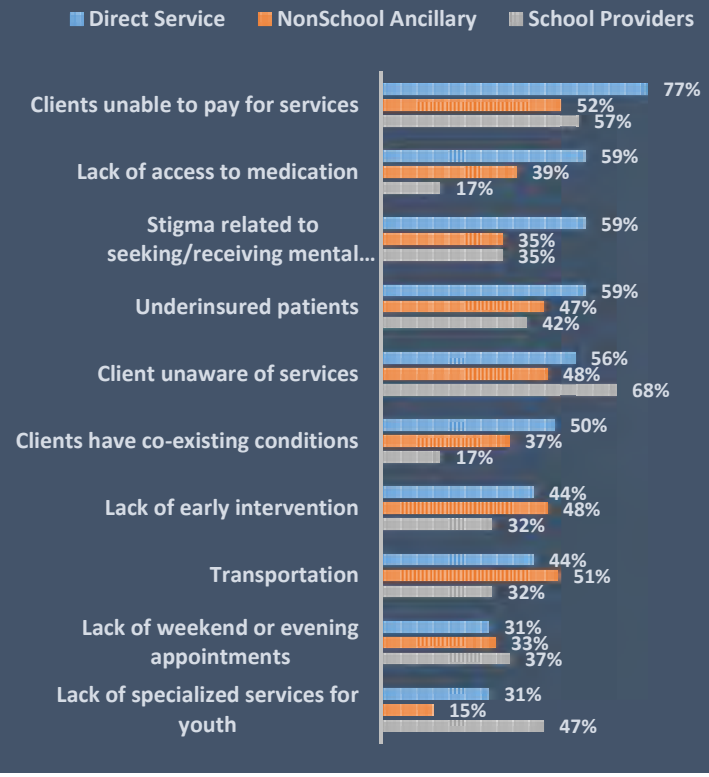
Top Referral Reasons

Most referrals by nonschool providers were for **abuse/ addiction to other drugs**.

School providers referred mostly for **childhood disorders** & **behavior issues.**

Suicide behaviors were shared referrals reasons.





Large to Extreme Barriers Identified by Service Providers

Most (>50%) provider groups identified clients' **inability to pay** as a large to extreme barrier.

Greatest Barriers for Each Group

Direct service providers:

- → Costs/insurance issues
- → Stigma
- → Unaware of services
- → Co-existing conditions
- → Access to medication

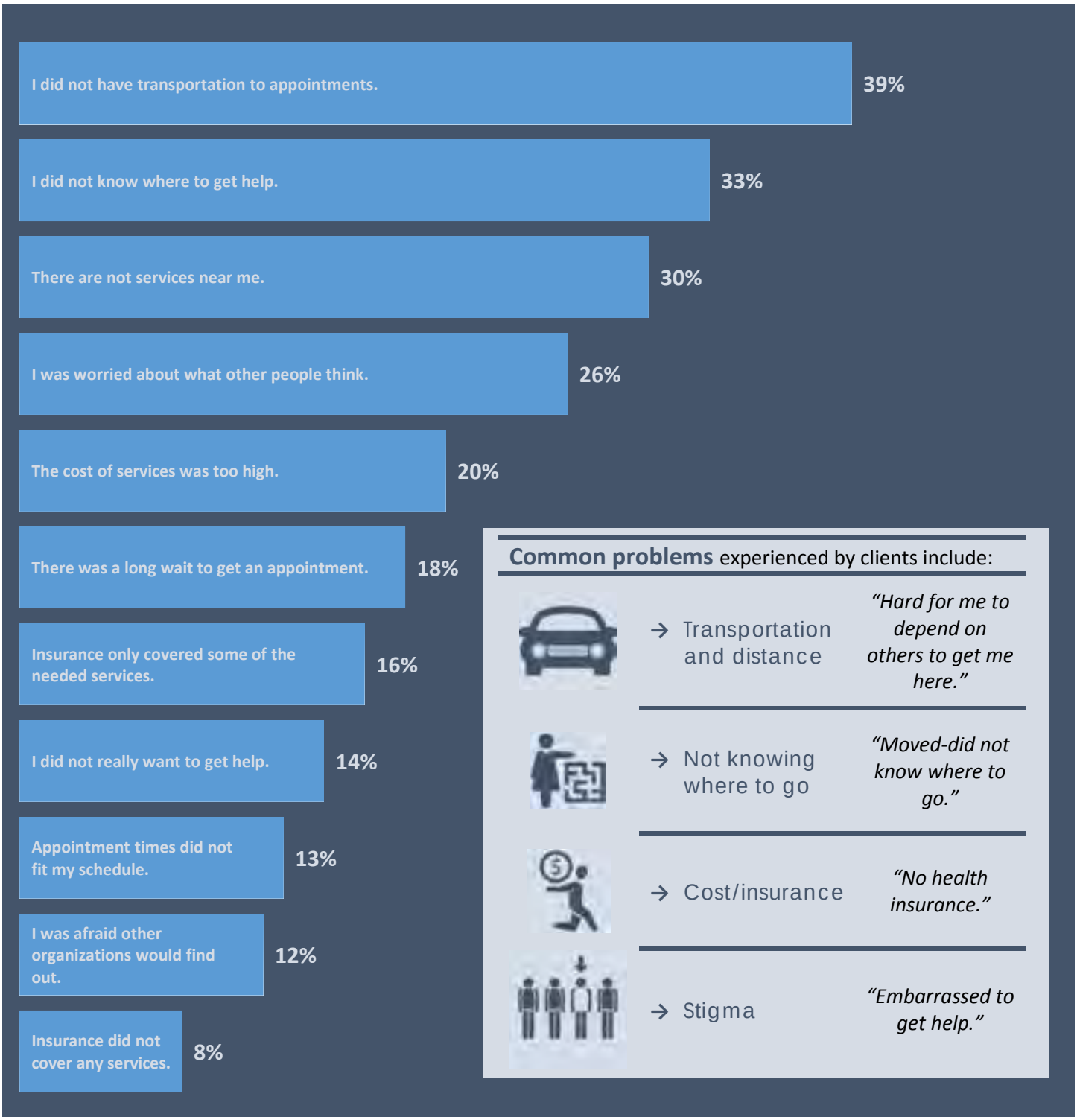
Ancillary (nonschool) providers:

- → Costs/insurance issues
- → Transportation

Ancillary (school) providers:

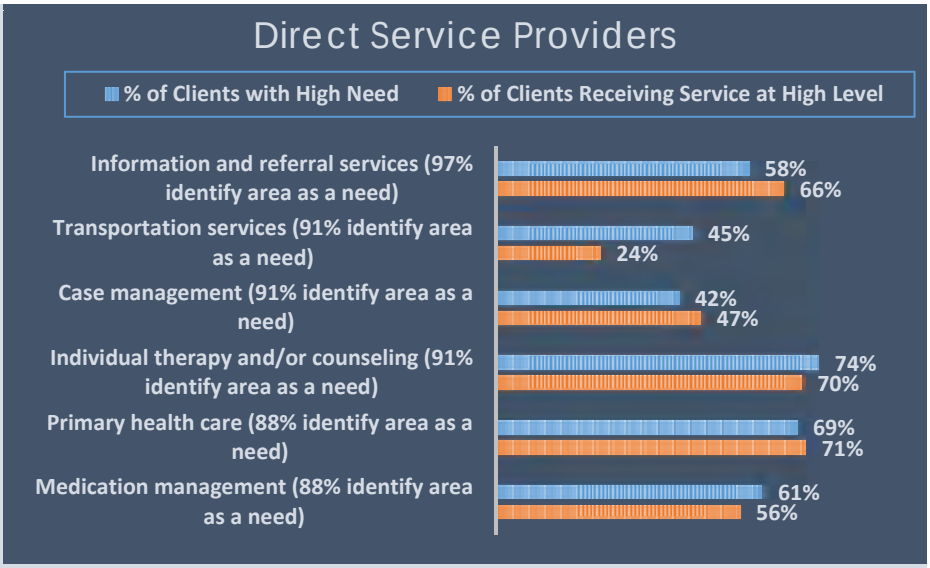
- → Costs/insurance issues
- → Unaware of services

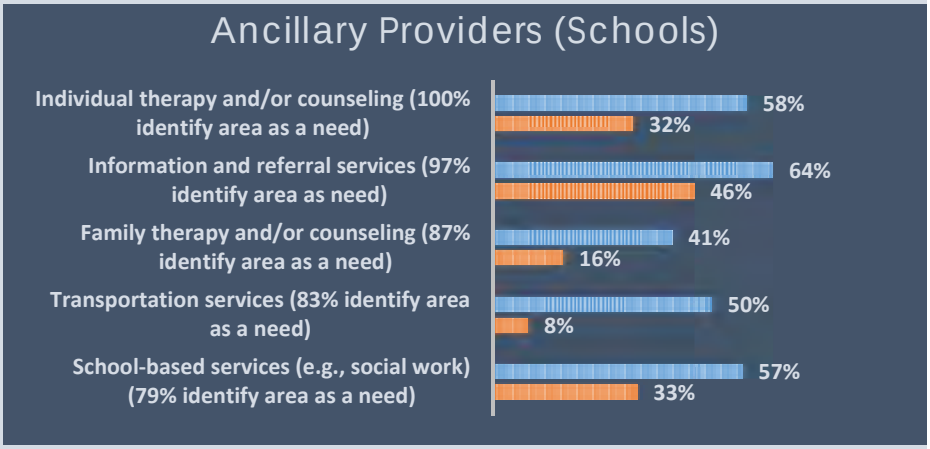
Problems Experienced by Clients

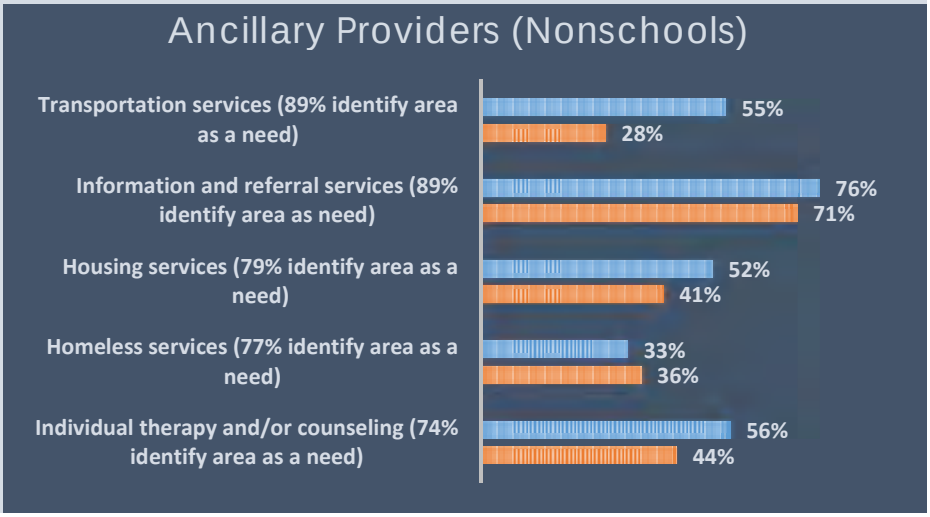


Frequency of Identified Needs, Magnitude, and Extent to which Needs are being Addressed

- Top needs identified across direct and ancillary service providers included **transportation**, **individual therapy and/or counseling services**, and **information and referral services**.
- **Transportation** was consistently endorsed by all provider groups as not being addressed at a high level, with **8% to 28%** of providers reporting that clients received the service "often" or "almost always."
- **70%** of direct service providers reported clients received individual therapy/counseling at a high level, while **32%** of school-based **44%** of non-school ancillary service providers reported that clients actually received the service. This suggests that direct service providers believe they are addressing those presenting with the need; however, ancillary providers believe client needs are not being addressed at a high level.







SYNTHESIS OF NEEDS & STRATEGIES

All quantitative and qualitative data sources were triangulated to provide a comprehensive assessment of need. **Five primary categories** and **fifteen subcategories** were identified. Through interviews and focus groups, participants were also asked to identify potential strategies. While the feasibility of strategies needs further consideration, they are included below to guide subsequent planning efforts.

High Prevalence of Mental Health and Addiction Issues

Prevalence represents the degree to which mental health and addiction issues are present within the region. Data from primary and secondary data sources served to underscore the high prevalence of issues. Issues pertaining to behavioral and mental health include specific conditions, which may or may not include multiple conditions or co-occurrence with addiction; mental health issues may be diagnosed or undiagnosed. The use of and addiction to prescription, legal, and illegal substances (including alcohol), which may or may not include multiple addictions or co-occurrence with other mental health issues; addiction issues may be diagnosed or undiagnosed.

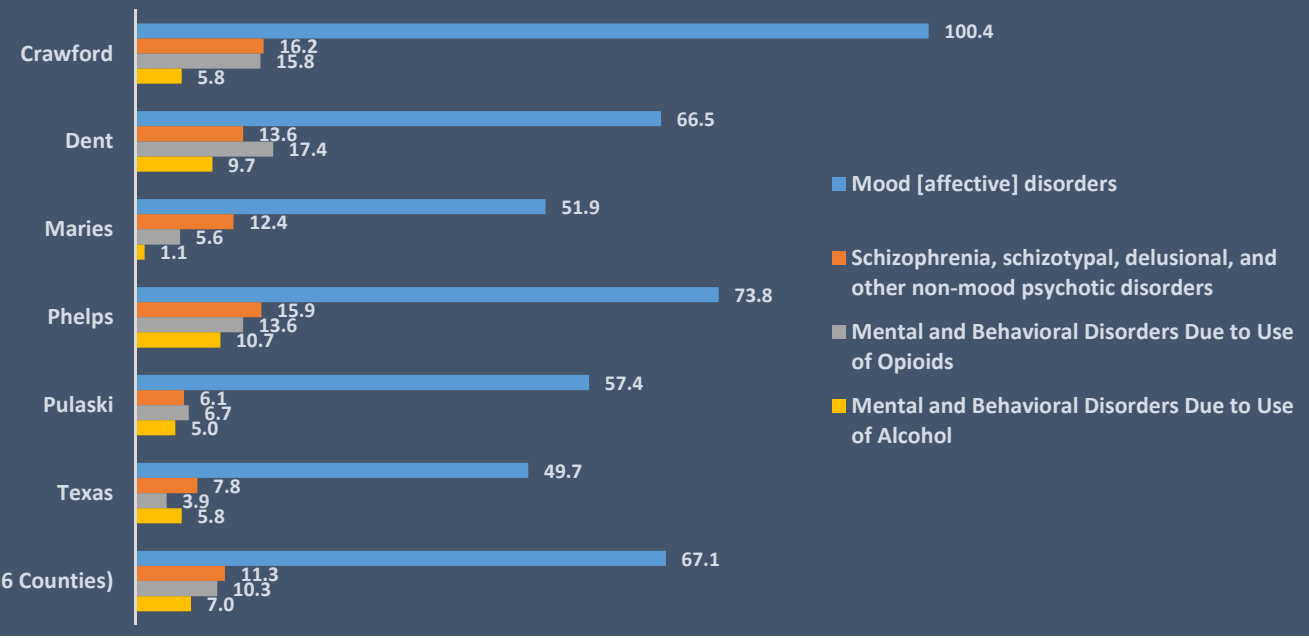
Prevalence of Mental Health Issues

- → The **most common mental health issues** include mood issues (depression, mood swings), anxiety, behavioral issues, suicidal ideation, PTSD, anger management, and childhood disorders.
- → For all counties, the count and rate of mental health-related hospital admissions was approximately **three times higher** than addiction-related admissions.
- → Overall, across all counties, mood (affective) disorders accounted for **more than half** of all admissions in both 2016 and 2017.

Prevalence of Addiction Issues

- → The addiction issues identified as the **most problematic** in the region include meth, opioids, heroin, alcohol, and prescription drugs.
- → Abuse and/or addiction to drugs and alcohol were among the **top reasons for referral** to treatment services by ancillary organizations.
- → Hospital admissions data show that **opioid misuse is the top addiction-related reason** for admission. This was followed by alcohol misuse.

Rates of Diagnoses Type (based on highest DX areas) by County: 2017



Structures/Operations of Systems Impacting Access to Mental Health and Addiction

Systems represent the ways in which communities and organizations are structured and operate including efficiencies and impacts on service delivery, along with the existence of policies, rules, and regulations that have been created and implemented at multiple levels, including organizational and governmental. Systems also represent the availability of transportation services, including public and private, the degree to which systems support modes of transportation, and the impacts on access to mental health and addiction services. Several systems issues were identified as impacting access to mental health and addiction services within the community.

Lack of Transportation/Distance

Not having access to transportation to travel to existing mental health and addiction services represents a need within the region. This need is directly related to not being able to afford a vehicle or gas for travel, the absence of reliable public transportation within the service region, and the distance that individuals (especially within outlying counties) must travel to obtain services.

- → Transportation was the **highest barrier** to accessing services identified by clients.
- → The need for transportation services was among the **highest needs** identified by providers and the **second highest need** among direct service providers. It was also the **top need** identified by ancillary (non-school) providers.
- → Between **one-third and one-half** of direct and ancillary service providers rated transportation issues as a large to extreme barrier to receiving services. Transportation was the **second highest barrier** identified by ancillary (non-school) service providers.

"First of all, transportation is a problem—it's a big problem."
-Client Focus Group Respondent

Potential Strategies

- **Create/identify affordable and accessible transportation systems/options**
- **Provide satellite facilities/clinics within counties**
- **Telehealth more available and accessible to individuals throughout the region**

Costs/Affordability of Services

Cost and affordability are barriers to accessing mental health and addiction services. This includes not being able to afford available services due to a lack of insurance or not having enough insurance to cover necessary expenses. In some cases, individuals who have insurance may lack specific coverage for the needed treatment.

- → When asked to identify problems experienced when accessing services, **20%** of clients reported that the costs of services were too high, and **24%** reported that insurance only covered some or did not cover any of the needed services.
- → Inability to pay for services was either the **highest** or **second highest barrier** identified by direct and ancillary service providers.
- → Being underinsured was within the **top five barriers** identified by direct and ancillary service providers.

"A lot of people need medical services can't get medical services, period. They can't afford them. They don't have Medicaid or insurance."
-Client Focus Group Respondent

Potential Strategies

- **Insurance options (availability and understanding of options)**
- **Services for low-income individuals (e.g., sliding scale fee structures)**

Policy, Rules, Regulations, Operations including Wait Times/Appointment Scheduling

The way organizations deliver services and the policies/rules/regulations pertaining to services has the potential to significantly impact the affordability and timeliness of services for clients. This includes wait times and scheduling of services, which are concerns expressed by providers and clients.

- → Provider and client focus groups uncovered themes associated with long wait times, difficulty in scheduling appointments, and lack of convenient appointment times, as well as regulations to qualify for services and the number of stipulations to access services.
- → When asked to identify problems experienced when accessing services, **18%** of clients reported that there was a long wait to get an appointment, and **13%** reported that appointment times did not fit their schedule.
- → Lack of weekend or evening appointment times were the **fifth highest barrier** identified by ancillary (school) service providers.

"There are a lot of gate keepers, and there are a lot of stipulations to access care."
-Provider Focus Group Respondent

Potential Strategies

- **Review provider policies for accessing services to ensure individuals are connected to treatment**

Continuity of Care/Coordination of Services/Transition

Streamlined processes that avoid duplication of services support more efficient access to mental health and addiction services, thus reducing wait times, ensuring earlier intervention, and avoiding the compounding of issues. This area includes how services are coordinated for clients, as well as the transition of individuals from different types of services (e.g., inpatient to outpatient, care during incarceration to community living). A need to strengthen collaboration and communication among current providers is also included in this area.

- → The need for case management services was **among the highest needs** identified by direct service providers. While this need was less for ancillary providers, the magnitude of the need and extent to which the need was addressed is an important consideration.
- → The need for school-based and wrap around services was a **high need** specifically identified by ancillary (school) service providers.
- → Collaboration among organizations is essential to ensuring continuity of care for clients. Slightly over **one-third** of organizations report collaborating highly with other mental health and/or addiction providers in the area, and approximately the same amount report rarely or almost never collaborating.

"When we get them discharged, we set them up with follow-up appointments with the psychiatrist and sometimes with their primary care provider. But after they get discharged, there's no follow-up."
-Provider Focus Group Respondent

Potential Strategies

- **Case Management/Care Navigators**
- **Continue and strengthen collaborative services and initiatives**
- **Improve transitions for individuals who are incarcerated**

Availability of Treatment Options to Address Mental Health and Addiction Issues

The resources and services available to treat mental health and addiction issues is a primary need identified in this study. Treatment options pertain to both age-specific and general populations and relate to both mental health and addiction concerns, as well as the co-occurrence of such issues. More intensive services such as inpatient and psychiatric services are also addressed in this need area.

Need for More Counselors & Providers (General) and Psychiatric Services

Resources and Services pertaining to the availability of counselors and providers in general and psychiatric services specifically are identified as needs for the six-county area.

- → The need for individual therapy and/or counseling was among the **top five highest needs** identified by all providers. Importantly, direct service providers were more likely to indicate that this service was addressed often, while ancillary service providers reported that the service was provided **less than half the time**.
- → **Barriers** specific to this need area included lack of trained staff to provide treatment to clients and no service available for a client's issue.
- → Additionally, group therapy and/or counseling, family therapy and/or counseling, and psychological testing were also identified as **high needs** within this area.

"We actually need a psychiatrist, and of course counselors."
-Client Focus Group Respondent

Potential Strategies

- **More counselors/providers and psychiatric services**

Need for Mental Health Services for Specific Populations and Treatment of Child/Adolescent Issues

Specific focus was placed on resources and services pertaining to certain age populations, particularly options available for youth mental health and substance issues. Options available for elderly individuals is also included in this need area.

- → A **large percentage** of schools indicated that their students have a need for school-based services, while only **one-third** indicated youth actually receive the service at a high level.
- → The **majority** of direct service providers indicated that their clients have a need for specialized services for the elderly. Of those indicating their clients need the service at a high level, **less than half** actually receive it at this level.
- → Lack of specialized services for youth and the elderly were identified as **barriers** by a portion of direct and ancillary service providers.

"There's no child psychiatrist within this area."
-Provider Focus Group Respondent

Potential Strategies

- **Address suicidal ideation among students**
- **Better addiction and mental health services for students and youth**
- **Better and alternative treatment options for people with developmental disorders**
- **Help students stay in school while receiving services**
- **More child psychiatrists and treatment options for geriatric population**

Need for Inpatient, Intensive and Long-term Services

The availability of hospitalization services and services that require in-depth and/or long-term treatment are a need in the community. This is due to the complex nature of the mental health and addiction issues that are prevalent in the six-county area.

- → While several services are present within the community, lack of inpatient, intensive and long-term services were identified as **common themes** across open-ended survey responses, focus groups, and interviews.
- → Specific inpatient issues identified included lack of hospital beds for treatment (both for drug/alcohol and psychiatric issues), lack of partial hospitalization services, lack of long-term facility that does medication review and adjustment, and further needs for stabilization services.

"A facility that will take a mentally ill person and keep them admitted until a full medication review has been conducted."
-Client Focus Group Respondent

Potential Strategies

- **Provide more drug/alcohol detox facilities**
- **Provide additional investment and more intensive outpatient programs**
- **Provide more inpatient care, and long-term care/hospitalization options**
- **Options for transitional programs/halfway homes (especially for incarcerated)**

Need for Services to Treat Addiction

Given the scope of addiction issues in the community, the lack of services to address such concerns is identified as a key need in the current study. Due to the intensive nature of drug and alcohol treatment, there is some overlap with the need for intensive, long-term and transition services described elsewhere in this report. However, additional services and resources specific to addiction were highlighted in several areas.

- → Lack of services to treat addiction was identified as a **common theme** across open-ended survey responses, focus groups, and interviews. This theme included lack of detox facilities, lack of long-term addiction treatment, the need for medication-assisted treatment, the lack of local CSTAR programs, and a lack of Suboxone and Vivitrol providers.

"Need three to five doctors who specialize in addiction medicine, particularly who accept Medicaid. Also need a place for medical detox and medication-assisted treatment."
-Stakeholder Interview Respondent

Potential Strategies

- **Addiction addressed through court system (e.g., drug court)**
- **Embrace harm reduction model and priority of addressing addiction**
- **Additional MAT (Medication Assisted Treatment) and more professionals**
- **Provide specific addiction medications (e.g., Suboxone, Narcan)**

Medication Management & Treatment for Co-Occurring Issues

The appropriate use and access to medications for mental health and addiction concerns was identified as a concern within the region. Due to the prevalence of medication use in the treatment of mental health and addiction issues, proper management of such substances is important to successful treatment. This need also recognizes the complexity of co-occurring conditions that may be exacerbated without treatment.

- → The need for medication management was the **sixth highest need** identified by direct service providers. While less than half of ancillary providers noted medication management as a need, only approximately **20%** reported the need is often addressed.
- → **One-half** of direct service providers rated clients having co-existing conditions as a **large to extreme barrier** to receiving services.

"Overall need for proper medication management, adjustment and review."
-Stakeholder Interview Respondent

Potential Strategies

- **Better understanding of co-occurring disorders and treatment**
- **Provide and strengthen medication management practices**
- **Provide assistance with medication costs**
- **Engage in responsible prescription practices**

Availability of Ancillary Resources, Services, & Supports to Address Mental Health

The availability of ancillary resources and services to support those individuals who are experiencing mental health and addiction issues is a primary need identified in this study. Ancillary supportive services such as housing, food, and clothing were identified as important protective factors for individuals experiencing mental health or addiction concerns.

Need for Ancillary Resources, Services, and Supports

The availability of ancillary resources and services for those individuals who are experiencing mental health and addiction issues is a primary need.

- → Ancillary supportive services such as homeless housing, food, and clothing were identified as **important protective factors** for individuals experiencing mental health or addiction concerns.
- → **More than half** of direct and ancillary service providers indicated their clients have a need for services related to housing, homeless services, parenting education, and supportive employment.

"There is no homeless shelter close. There are people that truly have basic housing needs."
-Provider Focus Group Respondent

Potential Strategies

- **Address basic needs (food, clothing, employment)**
- **Affordable housing/homeless support**
- **Case Management/Care Navigators**
- **Family support programs and services, and childcare (for specific needs)**
- **Law enforcement initiatives and justice system programs (e.g., drug task force)**
- **Provide/access support groups for recovery (e.g., AA, NA, faith-based)**

Need for Prevention and Early Intervention

Preventive measures such as school-based drug/alcohol education and social work services are important to limit the onset and further development of addiction and/or mental health issues. Community prevention education is also important as a broader environmental strategy. Additionally, early intervention through proper screenings and timely implementation of services help to avoid the compounding of issues that may become more difficult to address if left untreated.

- → Between **one-third and one-half** of direct and ancillary service providers identified lack of early intervention as a **large or extreme barrier** to clients receiving mental health and/or addiction services.
- → Almost **80%** of schools and **over half** of direct service providers identified school-based services such as social work or case management as a need for clients. While the majority of schools identified this as a high need, only **one-third** believe clients (youth) are receiving those services as frequently as needed.

"I think it needs to start younger. Start young because the addiction problem starts at 12-13; it doesn't start at 25."
-Provider Focus Group Respondent

Potential Strategies

- **Family support programming**
- **Individual screening and assessment of needs**
- **More counseling earlier in the judicial process**
- **Programs focusing on intergenerational poverty**
- **Specific prevention programs currently in place (e.g., Prevention Consultants, Bright Futures program)**
- **Targeted evidence based early intervention and education**
- **Youth programming and services**

Lack of Awareness of Mental Health and Addiction Issues

Awareness of mental health and addiction issues may be divided into two separate categories, including the knowledge of existing resources in the community and a better understanding of mental health and addiction issues in general. Comprehensive, up-to-date listings of resources for particular conditions supports access to services and more timely treatment. Greater awareness about mental health and addiction issues in general helps to prevent stigma associated with accessing services, promotes support throughout the community for addressing issues, and helps individuals know when they should seek help for their concerns.

Knowledge and Understanding of Available Resources Used to Address Mental Health and Addiction Concerns

The degree to which individuals know about and understand the existing resources and services that are available to support mental health and addiction needs is lacking within the region. This area reflects an overall lack of awareness of existing services, how to navigate current service systems, and available resources to help with accessing these services.

- → The need for information regarding where to obtain services or referrals to organizations that provide services was **among the highest needs** identified by providers.
- → When asked to identify problems experienced when seeking services, **one-third** of clients reported that they did not know where to get help.
- → At least **one-half** of direct and ancillary service providers rated clients being unaware of existing services as a **large to extreme barrier** to receiving services.
- → Lack of awareness of services was the **fifth highest barrier** identified by direct service providers, the **highest barrier** among ancillary (school) service providers, and the **third highest barrier** among ancillary (non-school) service providers.

> ***"Insufficient awareness of treatment options."***
> *-Stakeholder Interview Respondent*

Potential Strategies

- **Better advertising of/marketing & communication of available services**
- **Case Management/Care Navigators**
- **Create a central/up to date community resource/provider list**
- **Create a hotline to receive help (crisis, identifying resources)**
- **Ensure all organizations in the community understand available services**
- **Bring awareness and provide education in the community**

Better Understanding of Mental Health and Addiction Issues

Lack of understanding related to the causes and consequences of mental health and addiction issues impacts access to resources and a community's response to overall service delivery. This need for education and awareness contributes to perceived stigma associated with those experiencing issues, which may impact an individual's pursuit of service.

- → Stigma related to seeking/receiving mental healthcare was noted by **over half** of direct service providers, which represented the **third highest barrier** to receiving services.
- → **One-third** of all ancillary service providers identified stigma as a **barrier**.
- → When asked to identify problems experienced when accessing services, **many clients** reported that they were worried about others findings out.

> ***"That can also cause a stigma to where they keep using because they don't want people to see that they are sick. They are embarrassed to get help."***
> *-Client Focus Group Respondent*

Potential Strategies

- **Engage the community through proactive outreach**
- **Ensure people who understand issues are involved and leading initiatives**
- **Provide training for non-mental health professionals (e.g., law enforcement)**
- **Promote greater willingness to address the issues in the community**

What resources (strengths) exist to address needs?

The six-county study area demonstrates several strengths associated with mental health and addiction issues. Strength areas represent progress the community has already made in addressing the most significant concerns and establish a foundation on which further efforts may capitalize. Strengths pertain to current treatment resources, collaboration among providers and other organizations, community engagement, and existence of ancillary services.

Existing Mental Health and Addiction Providers

The quality of and satisfaction with current providers was identified across client and provider open-ended survey responses, focus groups, and interviews. When clients were asked what has helped them the most, nearly half credited current providers or services being received (e.g., case workers, therapists, counselors, assistance with getting resources), while approximately one-third specifically mentioned receiving psychiatric support and/or medication management as the most helpful.

EXAMPLES

- Specific providers identified (e.g., A Place for Grace, Pathways, Phelps County Regional Medical Center (PCMRC), Ozarks Medical Center, Mercy Clinic, Your Community Health Center, SEMO)
- Current counseling/therapy groups
- Specific professionals/individuals listed by name

Collaboration and Communication Among Providers and Organizations

The degree to which providers and service organizations demonstrate collaborative practices and effective communication emerged as a theme across client and provider open-ended survey responses, focus groups, and interviews. This theme represented current partnerships that are underway within the community and overall cooperation among providers. While survey data indicated collaboration levels could be higher, the feedback provided through the qualitative data collection process indicated that some organizations are already working together to address mental health and addiction needs.

EXAMPLES

- Crisis Intervention Team (CIT)
- Systems of Care
- Intra-agency connections
- Cooperation and shared resources
- Community roundtable discussions (involving law enforcement)

Available Ancillary Services and Supports

The availability of supportive services that are needed for clients to access treatment resources and experience a greater likelihood of recovery was identified as a strength. The existence of support groups, school supports, and services through the justice system are examples of currently available ancillary services and supports. Several client respondents reported in the Client Survey that services they had received in the community and interaction with others receiving treatment had been very helpful in addressing their mental health and addiction issues.

EXAMPLES

- Specific programs (Celebrate Recovery, Drug Task Force, Backpack Program)
- Support groups (e.g., AA, NA, Alanon, Alateen, Church groups)
- Schools supports (e.g., counselors)
- Law enforcement and court system

Community Engagement and Response

The degree to which members of the community are engaged to address mental health and addiction issues was identified as a strength. Based on feedback from community stakeholders, there are some grassroots efforts to understand and address mental health and addiction issues in the community. This involves various segments of the community, including schools and family members who have been directly impacted by the issues under investigation.

EXAMPLES

- Caring people within the community
- Needs assessment process
- Desire to do better and help

Current Community Awareness Initiatives and Growing Awareness and Recognition of Mental Health and Addiction Issues

The degree to which members of the community have an understanding of mental health and addiction issues, including their causes and impacts was identified as a strength. As identified by providers, stakeholders, and clients, there are already initiatives in the community that have increased awareness and understanding of mental health and addiction concerns.

EXAMPLES

- Increased awareness of the need
- Openness to more services in the community
- Individuals willing to get treatment
- Bystander intervention and S&T
- Drug education efforts and mental health first aid trainings in the community

Existing Services, Programs or Resources to Treat Addiction or Support Treatment

Community members identified resources that exist to address not only the treatment of addiction but also the community support services that help organizations address addiction from their specific perspectives. Programs such as drug court, resources for law enforcement, and specific programs offered by providers were cited as strengths.

EXAMPLES

- Drug Court
- Law enforcement use and availability of Narcan
- Specific programs offered by providers (e.g., rehab facilities, free clinic for drug addiction, detox)

Existing Inpatient Resources

While there appears to be a need for additional inpatient resources to address mental health and addiction, providers, stakeholders, and clients cited the quality of existing inpatient services as a strength in the community. Specific facilities mentioned include PCRMC and New Vision.

EXAMPLES

- Specific facility mentioned (e.g., PCMRC Stress Center, New Vision Drug treatment facility)

Considerations

This needs assessment study followed a comprehensive data collection process that involved multiple quantitative and qualitative methods. The study expanded prior needs assessments by involving more key stakeholders and consumers of mental health and addiction services. Collectively, 356 individuals across six counties contributed to surveys, focus groups, and stakeholder interviews, and approximately 450 organizations and individuals were invited to complete surveys and interviews. While the needs assessment process was robust, there are considerations that should be taken into account when understanding needs, strengths and strategies.

First, the four main providers of mental health and addiction services in the six-county area participated at varying levels within the study (e.g., attending focus groups and interviews, administering client surveys). However, not all main mental health and addiction providers completed the Inventory of Mental Health and Addiction Services, which collected detailed information about service counts, employment levels, and other specific data. With only one of the four main providers completing this profile, this information was not available for the final analysis. Therefore, data related to actual numbers of mental health professionals in the area were drawn from secondary data sources. While these data sources validated a need for more professionals within the community, further examination of the specific professionals needed may be warranted.

Next, some of the counties did not have as much representation in the stakeholder interview process as others. While efforts were made to reach out to various stakeholders (e.g., phones calls, email, letters), participation did differ somewhat across counties in the interview process. However, efforts were made to include key stakeholders in all counties through surveys and focus groups (e.g., phones calls, multiple focus groups held in all counties), and each county was represented in some manner through the process.

Additionally, the rural nature and large geographical area included within the study posed challenges in collecting data and communicating the intention of the study. Substantial efforts on the part of the planning team were given to outreach and recruitment. As discovered through the assessment process, these challenges also underscored the overall need for education, awareness, and understanding of mental health and addiction issues throughout the region. As strategies to address the identified needs are considered and implemented, it is likely that any further assessment of the needs and strengths will be strengthened by increasing the overall engagement of providers and community members in addressing these issues.

Finally, while mentioned in different ways throughout this report, the overall engagement of individuals who participated in this study should be emphasized. Participants were willing to share their story and impress upon researchers the needs and strengths within their community. This level of engagement signifies a degree of readiness for more substantial outreach.

TABLE OF CONTENTS

Section 1 Introduction

Phelps County Regional Medical Center commissioned a study to conduct a community mental health and addiction needs assessment for the following counties in its service region: **Crawford, Dent, Maries, Phelps, Pulaski, and Texas**. 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. The current study was an outgrowth of a Community Health Needs Assessment the health system had conducted, which indicated that mental health was a primary need in the community. This study represents a more in-depth assessment of issues related to mental health and addiction.

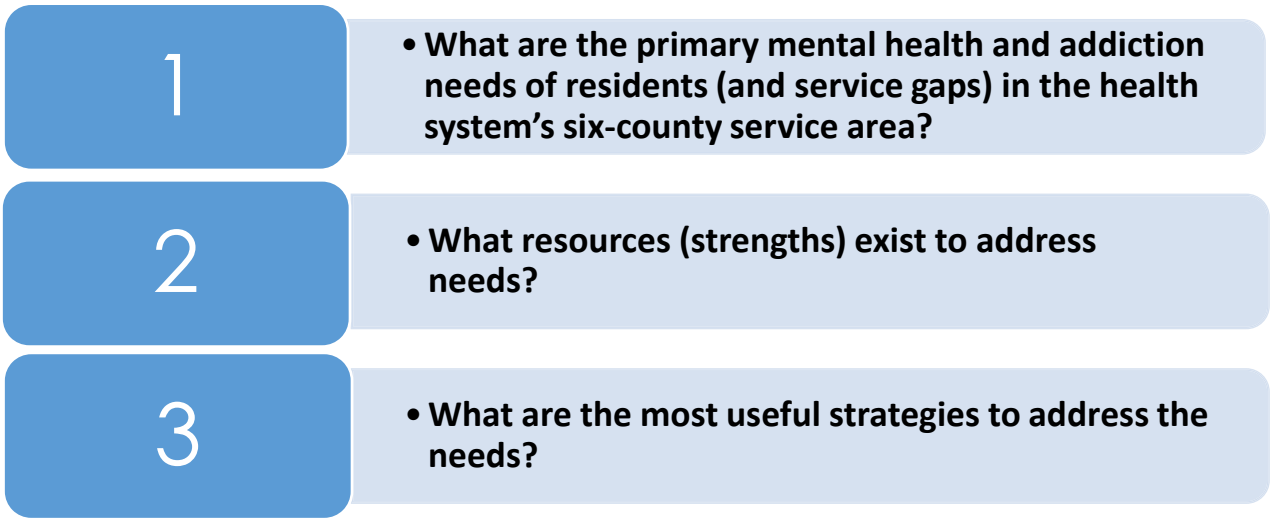
Additionally, information gathered through the process will also serve as an education tool regarding the types of services provided in the region. Ultimately, the data from the needs assessment will serve to improve the quality of mental health and addiction services provided to members of the community, 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 Consulting Group was contracted to conduct the needs assessment study. In addition to the Diehl 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, and review of needs assessment findings. Members of this team included mental health and addiction professionals who work directly with consumers throughout the six-county area, as well as other key community stakeholders. An introduction meeting occurred at the beginning of the project, which included a broader group of individuals representing key providers, as well as criminal justice and education organizations. Many of these individuals served as participants in the stakeholder interview process described in this report. The study timeline ranged from November 2017 to September 2018. During this time, the Planning Team met to inform, review, and discuss the progress of the study. Additional ongoing communication occurred between key Phelps contacts and the evaluation team. Names of Planning Team members are 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

Three primary research questions were identified by the planning team:



Defining Need

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.

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 secondary data sources, inventories of current services, and surveys of direct/ancillary service providers and clients. Additionally, the methods involved purposeful focus groups and individual interviews with key stakeholders 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.

Methodology

The primary methods used for examining the study goals included:

- **A.** A review of secondary data related to mental health and addiction,
- **B.** Inventories and surveys of providers and clients,
- **C.** Focus/discussion groups with providers and clients of mental health and addiction services, and
- **D.** Individual interviews with key community stakeholders.

A. Review of Secondary Data

The initial source document for this study was the most recent Community Health Needs Assessment, which highlighted key health needs in the community. This document served as guidance for data sources that may be included in the current study. To provide additional supporting evidence regarding mental health and addiction needs, a review of pertinent secondary data sources was conducted. Data were related to issues such as social determinants of mental health, prevalence of substance use, and utilization of treatment services. The largest portion of data were obtained from the online data system provided by the Missouri Department of Mental Health. Most data were available at the county and state level. Additional data sources included County Health Rankings, CDC-Behavioral Risk Factor Surveillance System, and the U.S. Census Bureau.

In addition to the secondary data analysis described above, members of the Planning Team and Advisory Committee provided and recommended data sources to incorporate into the report. These data related to service utilization and the current resources available in the community.

B. Inventories and Surveys of Providers and Clients

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

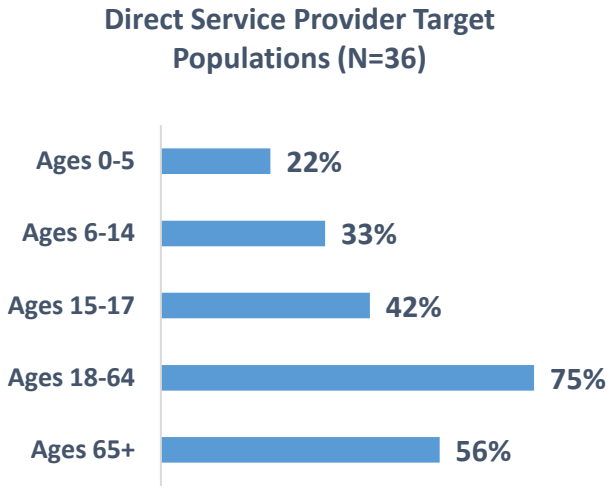
The Planning Team identified three unique target groups from which mental health and addiction data would be collected. The groups included: (1) providers of mental health and addiction services, (2) organizations that provide ancillary support services such as housing, food, job skills training, education, and other important services, and (3) clients who have accessed mental health and/or addiction services. Clients included both those specifically receiving the service, as well as family members. With assistance from the Planning Team, a comprehensive list of direct service and ancillary service providers was identified for Crawford, Dent, Maries, Phelps, Pulaski, and Texas Counties. The Planning Team also determined the specific client population from which to collect data. The table below defines the target participant populations and how those groups were identified, followed by key characteristics of organizations and individuals who participated in the survey aspect of the study.

<table>
<tr><th colspan="5">Target Needs Assessment Participant Groups</th></tr>
<tr><th rowspan="2">Direct Providers of Mental Health and Addiction Services</th><th colspan="3">Ancillary Service Providers</th><th rowspan="2">Clients of Mental Health and Addiction Services</th></tr>
<tr><th>Support Services</th><th>Prevention/Intervention/ Enrichment</th><th>Referral Sources</th></tr>
<tr>
<td>Criteria for Inclusion:
Organization must provide direct clinical care to individuals in the area of mental health and addiction; includes primary health care providers
Identification:
Utilized current resource listings provided by members of the Planning Team
Conducted internet searches to locate direct care services; key words: ‘Mental Health Services,’ ‘Psychologists,’ ‘Psychotherapists,’ and ‘Physicians & Surgeons-MD-Psychiatry’
Reviewed health insurance provider directories for mental health and primary health care providers</td>
<td>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:
Utilized current resource listings provided by members of the Planning Team
Conducted internet searches to identify organizations</td>
<td>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:
Utilized current resource listings provided by members of the Planning Team
Conducted internet searches to identify organizations</td>
<td>Criteria for Inclusion:
Organization primarily serves as referral source for mental health services; organization types include schools, court system, government agencies
Identification:
Utilized current resource listings provided by members of the Planning Team
Conducted internet searches to identify organizations
Utilized Missouri Department of Elementary and Secondary Education listing of area school systems</td>
<td>Criteria for Inclusion:
Individual has accessed mental health and/or addiction services for self or dependent
Identification:
The primary direct service providers in the community (PCRMC, Pathways, SEMO, and Your Community Health Center) were asked to distribute surveys to individuals who access their services</td>
</tr>
</table>

Direct Service Providers

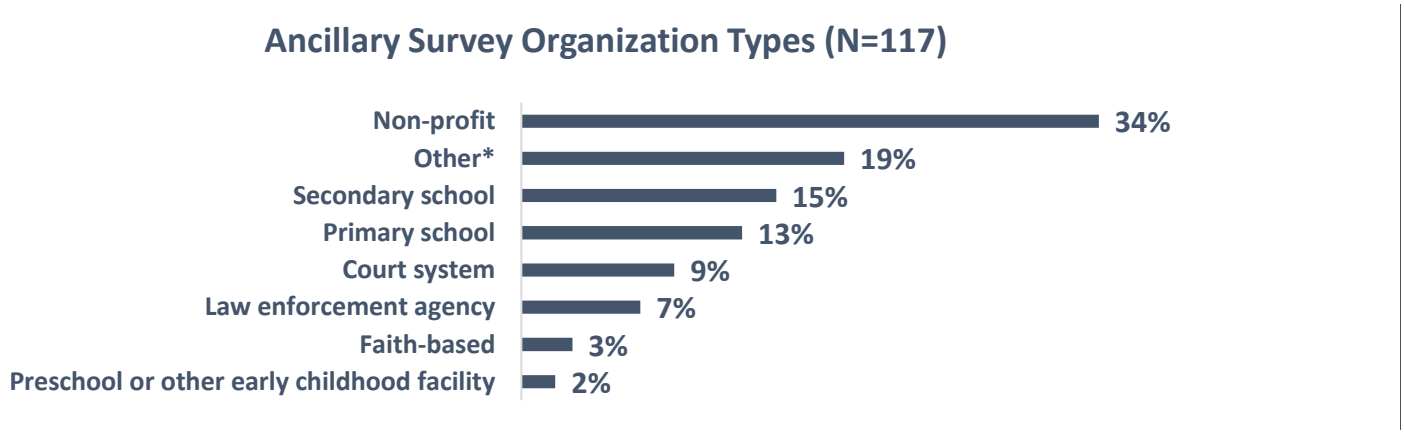
For direct service providers, a large number of participating organizations provide services in all six of the study's geographic focus areas. The reach of these organizations is also seen by the service areas that extend beyond the six-county region. Specifically, a total of 36 direct service providers participated in the survey process. As noted in the table below, providers that participated in the survey process have extensive coverage throughout the six-county region and beyond. Phelps and Pulaski Counties are the most widely served but also represent the two largest county populations. In terms of ages served, the majority of participating direct service providers serve the 18 to 64 and 65+ populations. The population least served by providers is the 0 to 5 age group.

Direct Service Provider Primary Service Areas – All Respondents		
County	N	% of Respondents (N=36)
Phelps	28	78%
Pulaski	21	58%
Dent	17	47%
Crawford	14	39%
Texas	14	39%
Maries	12	33%
Camden	3	8%
Gasconade	2	6%
LaClede	2	6%
Franklin	1	3%
Iron	1	3%
Miller	1	3%
Reynolds	1	3%
Shannon	1	3%
Webster	1	3%



Ancillary Service Providers

A total of 117 ancillary service organizations participated in the survey process. Across all ancillary service providers, the largest group represented was non-profits, which accounted for approximately one-third of organizations. The next highest percentages were the other category, secondary schools, and primary schools.



**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).*

Of the 34 schools that responded to the ancillary survey, almost half were in Pulaski County. The percentage from Dent, Phelps, and Texas Counties was fairly consistent, followed by Crawford and Maries. Note that all counties had schools represented in the survey process. Exactly 58% of the 83 non-school organizations that responded provide services in Phelps County, with approximately 40% providing services in Crawford, Dent, Maries, and Pulaski Counties. A somewhat smaller number provide services in Texas County. However, the distribution below indicates that each county in the study had representation in the survey process.

Ancillary Survey Primary Service Areas				
County	Schools		Non-Schools	
	N	% of Respondents (N=34)	N	% of Respondents (N=83)
Crawford	6	18%	32	39%
Dent	3	9%	33	40%
Maries	2	6%	31	37%
Phelps	6	18%	48	58%
Pulaski	12	35%	32	39%
Texas	5	15%	18	22%
Other	--	--	47	57%

Note: *Other counties include: Franklin and Gasconade (both 6%); Camden and LaClede (both 5%); Miller, Osage, and Washington (all 4%); Iron and St. Francois (both 2%); Boone, Callaway, Christian, Cole, Dallas, Douglas, Montineau, Morgan, Reynolds, Shannon, St. Charles, St. Louis, Taney, Wayne, Webster, and Wright (all 1%).*

Across schools, the largest percentage serve children ages 6 to 14, followed by ages 15 to 17. Across non-schools, the largest percentage serve individuals ages 18 to 64, followed by 65+ and 15 to 17. The smallest group served is children ages 0 to 5.

Ancillary Survey Target Populations				
Age Group	Schools		Non-Schools	
	N	% of Respondents (N=34)	N	% of Respondents (N=83)
Ages 0-5	9	26%	27	33%
Ages 6-14	23	68%	29	35%
Ages 15-17	14	41%	39	47%
Ages 18-64	4	12%	62	75%
Ages 65+	--	--	47	57%

Clients

A total of 126 clients participated in the survey process. The largest portion of respondents reside in Crawford, Phelps, and Pulaski Counties, with additional participants from Dent, Maries, and Texas Counties. The table below provides demographic information for client survey participants.

Client Survey Demographics		
County of Residence		
County	**N**	**%**
Crawford	32	26%
Dent	4	3%
Maries	4	3%
Phelps	25	21%
Pulaski	37	30%
Texas	15	12%
Other (Howell, Wright, Washington)	5	4%
Military Veteran		
Status	**N**	**%**
Yes	11	9%
No	113	91%
Marital Status		
Status	**N**	**%**
Married	29	24%
Never Married	37	30%
Divorced	35	29%
Separated	9	7%
Widowed	3	2%
Living with Long-Time Partner	10	8%
Have Children Under 18		
Status	**N**	**%**
Yes	40	33%
No	82	67%

Instruments

Given that two unique provider groups were identified, three separate data collection instruments were developed – an inventory of addiction and mental health services, a shorter provider survey, 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. The Planning Team determined that only the main mental health providers in the community would be invited to complete this measure.

- ***Provider Survey.*** This instrument is a shortened provider survey that focuses on needed services and barriers. The Planning Team determined that all other providers outside of the largest organizations would be invited to complete this measure.
- ***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, 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.
- ***Client Survey.*** This instrument focuses on how individuals had accessed services, barriers in obtaining services, and the most helpful things in treating their issue. The Planning Team determined that the main mental health and addiction providers in the community would be asked to distribute surveys to their clients.

Procedures for Data Collection

In March 2018, providers were mailed the provider (short version) and ancillary surveys. The primary study contacts with Phelps County Regional Medical Center (PCRMC) made direct contact with the organizations that were asked to complete the full inventories and the primary health clinics in the community. This was done to better explain the needs assessment process and to be available to answer any questions. To gather additional input from provider organizations, a second administration of the instruments was conducted in May 2018. The following tables show the response rates for the three data collection instruments.

Response Rates for Inventory and Surveys of Addiction and Mental Health Services

Measure	Returned	Distributed	Response Rate
Inventory*	1	4	25%
Provider Survey	36	79	46%
Ancillary Survey	117	311	38%

**As noted above, the inventory of services was administered to four core mental health and addiction services. Only one complete inventory and one partial inventory were returned, which limited analysis.*

Response Rates for Survey of Ancillary Services

Group	Returned	Distributed	Response Rate
All Recipients	**117**	**311**	**38%**
Support	37	124	30%
Prevention/Int./Enrich.			
Referral	***80***	***187***	***43%***
Schools	*34*	*84*	*40%*
Non-schools	*46*	*103*	*45%*
All Recipients	**117**	**311**	**38%**
Schools	34	84	40%
Non-schools	83	227	37%
Schools			
Crawford	6	12	50%
Dent	3	9	33%
Maries	2	7	29%
Phelps	6	18	33%
Pulaski	12	21	57%
Texas	5	17	29%

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 May of 2018, multiple attempts were made to contact organizations by telephone and email to encourage participation. As indicated previously, Phelps staff members made personal contacts with key providers to encourage participation. The main service providers in the community also had been invited to participate on the Planning Team.

C. Focus Groups

In addition to the surveys and inventory that were distributed to direct service and ancillary service providers, a series of 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 was an additional effort to include consumers' perspectives in the study.

Focus groups were conducted for two separate populations – providers and consumers. Providers included those delivering direct mental health and addiction services, though it is likely that some of those organizations also provide ancillary 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 the provider population, both general and targeted focus groups were scheduled. The targeted group included members of the CIT group, which meets at the Rolla Police Department and includes multiple law enforcement agencies and mental health/addiction providers. All client focus groups were open to anyone in the community who had experienced mental health and/or addiction issues and believed could provide valuable insight into the needs and services in the region. Prior to beginning each group, clients were asked to read and sign an informed consent form and to fill out a demographic sheet. Interviews were recorded for transcription purposes and quality assurance. The focus group facilitators also took notes.

Overall, 25 focus groups were scheduled across Crawford, Dent, Maries, Phelps, Pulaski, and Texas Counties—15 client groups and 10 provider groups. 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.

Focus Group Descriptions		
Location	Number of Focus Groups Offered	
	Provider-General	Client-General
Crawford County	1	4
Dent County	1	1
Maries County	2	2
Phelps County	2	3
Pulaski County	1	3
Texas County	2	2
CIT Group-Rolla Police Dept.	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 the tables below.

Focus Group Protocol – Providers
1. What do you believe are the biggest mental health and addiction needs in your county or service area? Needs are the mental health and addiction issues experienced by residents of your community. Needs are also problems that should be addressed. (Follow-up: Are these needs specific to a particular age group?)
2. What are the strengths related to mental health and addiction in your county or service area? What is being done well?
3. What mental health and/or addiction needs in your county or service area are not being adequately met? (Follow-up: Are these needs specific to a particular age group?)
4. For the needs that you identified as not being adequately met, 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 do you think are the best strategies for addressing mental health and addiction needs in your county or service area?
7. What are the priorities for addressing mental health and addiction issues? In other words, what should be addressed first?

Focus Group Protocol – Clients
1. What do you believe are the biggest mental health and addiction needs in your county? Needs are the mental health and addiction issues experienced by residents of your community. Needs are also problems that should be addressed. (Follow-up: Are these needs specific to a particular age group?)
2. What are the strengths related to mental health and addiction in your county? What is being done well?
3. What has been the most helpful to you in addressing mental health or addiction issues?
4. What mental health and/or addiction needs in your county or service area are not being adequately met? (Follow-up: Are these needs specific to a particular age group?)
5. For the needs that you identified as not being adequately met, 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?)
6. 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.)
7. 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?

Participants

Overall, a total of 54 individuals participated in the focus groups (26 providers and 28 clients). The tables below present demographic data for focus group participants.

Demographic Data for Focus Groups		
Which of the following best describes you? (providers and consumers)		
Category	**N**	**%**
Provider of mental health and/or addiction services	19	35%
Consumer/client of mental health and/or addiction services	28	52%
Law enforcement	5	9%
Other	1	2%
County in which services primarily performed (provider only)		
County	**N**	**%**
Crawford	4	15%
Dent	5	19%
Maries	4	15%
Phelps	22	85%
Pulaski	8	31%
Texas	1	4%
Average number of years providing service (provider only)		
Average years	13 years	
Gender (providers and consumers)		
Category	**N**	**%**
Male	20	38%
Female	33	62%
Race/Ethnicity (providers and consumers)		
Category	**N**	**%**
African American	3	6%
American Indian or Alaska Native	2	4%
Caucasian	47	89%
Asian	1	2%
Hawaiian or Pacific Islander	1	2%
Age (consumers only)		
Average Age	46 years (range: 23-83)	
Marital Status (consumers only)		
Category	**N**	**%**
Married	10	38%
Never married	5	19%
Divorced or separated	6	23%
Widowed	2	8%
Living with a partner	3	12%
Highest Level of Education (consumers only)		
Category	**N**	**%**
Some high school	6	23%
High school graduate	6	23%
Some college	5	19%
College graduate	5	19%
Graduate degree	4	15%

Employment Status (consumers only)		
Category	N	%
Employed full- or part-time	15	56%
Retired	5	19%
Unemployed	7	26%
Annual Household Income (consumers only)		
Category	N	%
Less than $20,000	11	44%
$20,000-$49,999	10	40%
$50,000-$74,999	3	12%
$75,000 or more	1	4%
Primary County of Residence (consumers only)		
County	N	%
Crawford	3	11%
Dent	6	21%
Maries	9	32%
Phelps	6	21%
Pulaski	1	4%
Texas	3	11%
County in which Services Primarily Received (consumers only)		
County	N	%
Crawford	2	8%
Dent	3	13%
Maries	2	8%
Phelps	8	33%
Pulaski	1	4%
Texas	2	8%
Other (Columbia, St. Louis, Osage County)	7	29%

D. Stakeholder Interviews

In addition to the surveys that were distributed and focus groups that were conducted, a series of individual stakeholder interviews were conducted for the needs assessment study. Similar to the focus groups, the purpose was to collect more detailed information about a targeted set of topics associated with mental health and addiction needs. Approximately 70 individuals across the six counties were identified by the Planning Team as key stakeholders who likely would have in-depth knowledge about mental health/addiction issues and needs of residents in their communities. This group included government officials, direct service providers, ancillary service providers, and school counselors. Of those approximately 70 individuals who were invited to participate in an interview, 23 chose to participate. Stakeholders' organizations provide service across all counties except Maries. Multiple people from this county were invited to participate but did not respond to the invitation.

Prior to being formally invited to participate in an interview, each individual was contacted by a Phelps County Regional Medical Center staff member to introduce the purpose of the needs assessment process. A member of Diehl Consulting Group followed with an email invitation that contained a link to sign up for specific appointment times. Appointments were divided into 30-minute slots, though each interview ended up taking approximately 10-15 minutes. At the scheduled time, a Diehl member telephoned the stakeholder and proceeded to ask a series of questions shown in the table below. Prior to beginning each interview, the interviewer indicated that the individual would not be identified in any reporting documents and that all responses were confidential. Interviews were recorded for quality assurance. The interviewer also took notes during the conversation.

Stakeholder Interview Protocol
1. What are the biggest mental health and addiction needs for residents in your county or service area? Needs are the mental health and addiction issues experienced by residents of your community. Needs also are the problems in your community that should be addressed.
2. What mental health and/or addiction needs in your county or service area are not being adequately met, and why do you think this is the case?
3. What are the strengths related to mental health and addiction in your county or service area? What is being done well?
4. What do you think are the best strategies for addressing mental health and addiction needs in your county or service area?
5. What are the priorities for addressing mental health and addiction issues? In other words, what should be addressed first?

Section 2 Synthesis of Needs, Strengths, and Strategies

As illustrated below, data from direct and ancillary service provider surveys, stakeholder interviews, client surveys, and provider and client focus groups were triangulated to determine the greatest mental health and addiction needs and strengths in the six-county area, along with potential strategies to address these needs. This section synthesizes these data by needs, strengths, and strategies.

Synthesis of Identified Needs within the Region

Five primary domains and 15 subcategories of need were identified. These domains and subcategories are depicted below. A synthesis of data supporting the need follows for each subcategory.

(1) High Prevalence of Mental Health and Addiction Issues Including Specific Diagnoses

a. Prevalence of Mental Health Needs
b. Prevalence of Addiction Needs

(2) Structures/Operations of Systems Impacting Access to Mental Health and Addiction Services

a. Lack of Transportation/Distance
b. Costs/Affordability of Services
c. Policy, Rules, Regulations, Operations including Wait Times/Appointment Scheduling
d. Continuity of Care/Coordination of Services/Transition

(3) Availability of Treatment Options to Address Mental Health and Addiction Issues

a. Need for Counselors/Providers (General) and Psychiatric Services
b. Need for Mental Health Services for Specific Populations and Treatment of Child/Adolescent Issues
c. Need for Inpatient, Intensive and Long-term Services
d. More Services Needed to Treat Addiction
e. Medication Management and Treatment for Co-Occurring Issues

(4) Availability of Ancillary Resources, Services, & Supports to Address Mental Health and Addiction Issues

a. Need for Ancillary Resources, Services and Supports
b. Need for Prevention and Early Intervention

(5) Lack of Awareness of Mental Health and Addiction Issues

a. Knowledge and Understanding of Available Resources Used to Address Mental Health and Addiction Concerns
b. Better Understanding of Mental Health and Addiction Concerns

(1) High Prevalence of Mental Health and Addiction Issues including Specific Diagnoses

Prevalence represents the degree to which mental health and addiction issues are present within the region. Data from primary and secondary data sources served to underscore the high prevalence of issues within the region. Issues pertaining to behavioral and mental health include specific conditions, which may or may not include multiple conditions or co-occurrence with addiction; mental health issues may be diagnosed or undiagnosed. The use of and addiction to prescription, legal, and illegal substances (including alcohol), which may or may not include multiple addictions or co-occurrence with other mental health issues; addiction issues may be diagnosed or undiagnosed. Prevalence data are described separately for mental health and addiction issues. However, it is understood that these issues are often co-occurring and represent a significant need in the community.

(1A) Prevalence of Mental Health Issues

(1B) Prevalence of Addiction Issues

(1A) Prevalence of Mental Health Needs

Description: Prevalence relates to the degree to which mental health needs exist within the area and the extent of specific concerns. Data collected through the needs assessment process uncovered a range of mental health issues and concerns in the six-county area.

Evidence:

- The **prevalence of mental health needs** was identified as a **common theme** across open-ended survey responses, focus groups, and interviews. Specifically, when participants were asked to identify the greatest needs within the area, a large number of comments focused on specific diagnoses and the degree to which mental health issues were present within the region. In fact, the prevalence of mental health issues represented the second highest subcategory among all subcategory themes identified. Issues most identified through this process include depression, anxiety, suicidal ideation, PTSD, behavioral issues, and childhood disorders. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- The mental health conditions for which **all ancillary providers** most often refer clients include:
  - Behavioral issues (**69% of providers refer for issue**)
  - Anxiety/stress (**68%**)
  - Mood issues (depression, mood swings) (**60%**)
  - Suicidal behaviors (**54%**)
  - Anger management (**49%**)
- The **top five** mental health conditions for which **early childhood/schools** most often refer clients include: behavioral issues, anxiety/stress, mood issues (depression, mood swing), suicidal behaviors, and childhood disorders.
- The **top five** mental health conditions (or related issues) for which **other (non-school) ancillary service providers** most often refer clients include: anxiety/stress, domestic violence, behavioral issues, mood issues, and suicidal behaviors.

"Some of the people I know have mental health issues that are ongoing. They don't seem to have the support they need."
-Client Focus Group Respondent

"I have PTSD because my mother and father were meth abusers and alcoholics. It's hard for me to find good mental health counseling and crisis counseling."
-Client Focus Group Respondent

"In this immediate space, there are a lot of mental health patients that need help."
-Provider Focus Group Respondent

"There are a lot of autistic and behaviorally challenged youth in the area."
-Stakeholder Interview Respondent

"Abundance of anxiety and depression—leads to overprescribed meds."
-Stakeholder Interview Respondent

County Snapshot and Related Needs:

- For all counties, the count and rate of mental health-related hospital admissions was approximately three times higher than addiction-related admissions. Between 2016 and 2017, admissions for both reasons fell slightly for most counties. The rates for mental health-related admissions were highest for Crawford County, followed by Phelps and Dent Counties. The rates for addiction-related admissions were also highest for these three counties, with rates of approximately 33 to 39 per 10,000 population (Hospital Industry Data Institute (HIDI) data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center (PCRMC) Applications & Analytics).
- Overall, across all counties, mood (affective) disorders accounted for more than half of all admissions (55%) in both 2016 (56%) and 2017 (55%). Within the mood (affective) disorder category for both 2016 and 2017, major depressive disorder and bipolar disorder accounted for 85% of diagnoses. In 2017, Crawford County had the highest rate of admissions for mood disorders. The Phelps County rate was also above the average for the six-county area. A similar trend occurred in 2016, with the Dent County rate also being above the region

average (Hospital Industry Data Institute (HIDI) data extracted on April 5, 2018 and compiled by PCRMC Applications & Analytics).

- Overall, the 19 to 29 year old age group has the highest percentage of hospital admissions for both 2016 and 2017. When specific diagnoses are coded as either primarily alcohol related or primarily mental health related, most admissions for this age group (along with other age groups) is a result of a mental health diagnosis. Further, a notable finding concerns the high percent of 13-18 admissions. In 2017, this age group accounted for 22% of mental health on April 5, 2018 and compiled by PCRMC Applications & Analytics).admissions, which was tied with the 19-29 age group (Hospital Industry Data Institute (HIDI) data extracted
- The mental health issues for which ancillary providers make referrals are fairly consistent across the six counties. Anxiety/stress was the most referred issue for Crawford, Dent, and Maries Counties. Behavioral issues were the most referred for Phelps and Pulaski Counties. Overall, behavioral issues, anxiety/stress, and mood issues represented the highest areas for referral.
- Comprehensive psychiatric services treatment data provided by the State of Missouri indicates that the following disorder types are the most addressed through such services: mood disorders; anxiety disorders; psychotic disorder; and impulse control disorder. In terms of county-level data, mood disorders were the top treated in each county in FY2017 except Dent, which had the highest count for anxiety.
- Suicide and injuries intentionally self-inflicted data indicate that the 2016 suicide count was highest for Pulaski County (16), followed by Phelps (9) and Crawford (8). Phelps had the highest count of self-inflicted injuries (43), followed by Dent and Pulaski, which both had 30.
- County Health Rankings presents the average number of poor mental health days experienced by individuals in the past 30 days. On average, residents in the six-county region experience between 4.1 and 4.9 poor mental health days. Crawford has the highest rate, and Crawford, Dent, and Texas Counties are higher than the state average.
- When asked in 2016 whether they had seriously considered suicide in the past year (MO Student Survey), almost 18% of students in Phelps County said yes. This rate is noticeably higher than the state rate and most other counties.
- When students were asked how often they were very sad in the last month (MO Student Survey), upwards of one quarter of students indicated often or always. The rate was highest in Dent County, with that location and Phelps and Texas having higher rates than the state of Missouri.
- For Dent, Phelps, and Texas Counties, one out of every five students had reported some form of self-injury in 2016 (MO Student Survey). These rates are higher than the state of Missouri. Crawford and Pulaski Counties had slightly lower rates.
- When asked whether they had been the victim of bullying at school (Yes or No), approximately one-third of students indicated that they had (MO Student Survey). Rates have increased slightly since 2010, and the 2016 rates for all counties was higher than the state of Missouri rate.

(1B) Prevalence of Addiction Needs

Description: Prevalence relates to the degree to which addiction needs exist within the area and the extent of specific concerns. Data collected through the needs assessment process uncovered a range of addiction issues and concerns in the six-county area.

Evidence:

- The **prevalence of addiction needs** was identified as a **common theme** across open-ended survey responses, focus groups, and interviews. Specifically, when participants were asked to identify the greatest needs within the area, a large number of comments focused on addiction-specific issues present within the region. In fact, the prevalence of addiction issues represented the **highest subcategory** among all subcategory themes identified. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- Based on feedback collected through focus groups, stakeholder interviews, and open-ended survey items, the substances that are **most problematic** in the six-county area include:
  - Meth (29 mentions of this substance)
  - Opioids (24 mentions)
  - Heroin (23 mentions)
  - Alcohol (20 mentions)
  - Prescription drugs (8 mentions)
- Across all counties, **abuse and/or addiction to other drugs** was the **fourth highest** referral reason by ancillary providers (55% refer for this reason), and abuse and/or addiction to alcohol was the **fifth highest** (54% refer for this reason).
- When examining non-school ancillary organizations, **70%** refer for alcohol abuse/addiction (**number 1 referral reason**) and **68%** refer for other drugs abuse/addiction (**number 2 referral reason**). These were also the top two reasons for referral when examining the age 18+ population only.

"Meth—it's just out of control."
-Client Focus Group Respondent

"The addiction here is absolutely unbelievable. It's an epidemic all over the country."
-Client Focus Group Respondent

"There are a lot of heroin addicts in this county."
-Client Focus Group Respondent

"The opioids crisis in this area is huge. The overdose with heroin is huge."
-Provider Focus Group Respondent

"A lot of times they are self-medicating with illegal narcotics."
-Provider Focus Group Respondent

"The holy trinity—opiates, amphetamines, and alcohol."
-Stakeholder Interview Respondent

County Snapshot and Related Needs:

- Overall, the 19 to 29 year old age group has the highest percentage of hospital admissions for both 2016 and 2017. When specific diagnoses are coded as either primarily alcohol related or primarily mental health related, most admissions for this age group (along with other age groups) is a result of a mental health diagnosis. However, when addiction-related diagnoses are examined alone, the 19 to 29 year old age group accounted for 37% of all admissions in 2017. This did not seem to change much from 2016.
- When diagnoses related to addiction are examined, mental and behavioral disorders due to opioids was the highest diagnosis area, representing 8% of all diagnoses in 2017 and 11% in 2016. In 2017, Dent County had the highest rate of admission for opioids. The rates for Crawford and Phelps were also above the average for the six-county area. In 2016, Crawford had the highest rate, followed closely by Dent County (Hospital Industry Data Institute (HIDI) data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center Applications & Analytics).

- Mental and behavioral disorders due to alcohol was the second highest (6%) diagnoses type related to addiction. In 2017, Phelps County had the highest rate of admission for alcohol use, followed closely by Dent County. In 2016, Texas County had the highest rate of admission for alcohol, followed by Phelps County.
- In terms of referral by ancillary providers for abuse and/or addiction to drugs, Dent County had the highest percentage of organizations making referrals for this issue at 65%. That rate was followed by Phelps at 60% and Texas at 59%.
- In terms of referral by ancillary providers for abuse and/or addiction to alcohol, Phelps County had the highest percentage of organizations making referrals for this issue at 60%. This was followed by Maries and Texas at 59% and Dent at 58%.
- Based on data presented by County Health Rankings, almost one out of every five residents in the community engages in excessive drinking (binge or heavy drinking). The rate for Pulaski County is the highest of the six-county region.
- Substance use treatment admissions provide some insight into the issues faced within each county. In terms of alcohol-related admissions, the 2016 rates for Crawford, Dent, and Phelps were higher than the state of Missouri rate. Crawford County had a particularly high rate of admissions for methamphetamine use, with rates almost twice that of the state. The Dent County rate was also quite high. Marijuana-related admissions were highest in Phelps County and have been consistently higher than the state. The rates in Crawford and Dent Counties also have been high but have decreased somewhat in the most recent data. In 2017, the heroin-related admission rates for Crawford, Dent, Phelps, and Pulaski were higher than the state, with the highest rate in Pulaski County.
- Opioid mortality data shed light on the severity of this substance in the six-county area.

  All Opioid Deaths: Between 2013 and 2017, Crawford County had the highest rate of deaths due to opioid overdoses among the six counties, ranking it 6th out of all Missouri counties. Pulaski had the highest total count at 43 deaths. All counties in the six-county region were ranked in the top half of Missouri counties.

  Heroin Overdose Deaths: Between 2013 and 2017, Maries County had the highest rate of deaths due to heroin overdoses among the six counties, ranking it 5th out of all Missouri counties. Note that heroin overdoses is a subset of the opioid overdoses shown above. The count for Pulaski was quite high, which was almost as high as the other five counties combined. All counties except Texas were ranked in the top 20 of all Missouri counties.

  Non-Heroin Opioid Overdose Deaths: Between 2013 and 2017, Crawford County had the highest rate and Pulaski County had the highest count of non-heroin overdose deaths.
- Youth substance use data provide additional insight into the prevalence of use in the counties. Data indicate that students report overall decreases in **past-month alcohol use**. The rate for Pulaski County has remained fairly consistent, and Texas County showed a spike in 2016. The overall decreases mirror the trend across the state. The 2016 rates for Pulaski and Texas were especially higher than the state. While **marijuana use** among students has shown fluctuations across time periods, the highest rate appears to be in Pulaski County, with a rate that is noticeably higher than the other counties and state. **Prescription drug misuse** has shown some fluctuations, with an uptick in the 2016 data. Pulaski County has the highest levels of student prescription drug misuse, with levels higher than the state.
- The prevalence of drug and alcohol addiction issues is related to the prevalence of mental health issues, social determinants such as poverty, education, and social/cultural norms, and the treatment options that are available to address the issues.

(2) Structures/Operations of Systems Impacting Access to Mental Health and Addiction

Systems represent the ways in which communities and organizations are structured and operate including efficiencies and impacts on service delivery, along with the existence of policies, rules, and regulations that have been created and implemented at multiple levels, including organizational and governmental. Systems also represent the availability of transportation services, including public and private, the degree to which systems support modes of transportation, and the impacts on access to mental health and addiction services. Several systems issues were identified as impacting access to mental health and addiction services within the community.

(2A) Lack of Transportation/Distance

(2B) Costs/Affordability of Services

(2C) Policy, Rules, Regulations, Operations including Wait Times/Appointment Scheduling

(2D) Continuity of Care/Coordination of Services/Transition

(2A) Lack of Transportation/Distance

Description: Not having access to transportation to travel to existing mental health and addiction services represents a need within the region. This need is directly related to not being able to afford a vehicle or gas for travel, the absence of reliable public transportation within the service region, and the distance that individuals (especially within outlying counties) must travel to obtain services.

Evidence:

- **Lack of transportation and distance to services** were identified as a **common theme** across client and provider open-ended survey responses, focus groups, and interviews. Transportation issues were within the **top three of all subcategories** of need for both client and provider focus group participants. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- When asked to identify problems experienced when accessing services, **39%** of clients reported not having transportation to appointments, which was the number one barrier reported, and 30% reported that there were not services near them. *(Client Survey)*
- **44%** of direct, **32%** of ancillary (school), and **51%** of ancillary (non-school) service providers rated transportation issues as a large to extreme barrier to receiving services. Transportation was the second highest barrier identified by ancillary (non-school) service providers. *(Provider Surveys)*
- The need for transportation services was among the **highest needs** identified by providers. This service was the second highest need among direct service providers and the top need identified by ancillary (non-school) providers. *(Provider Surveys)*

91%	*of **Direct** Service Providers…*	*report clients have a need for transport-ation services.*	**45%**	*indicate clients "often" or "almost always" had a need for the service, while…*	**24%**	*report clients actually received the service ("often or "almost always").*
83%	*of **Ancillary (school)** Service Providers…*		**50%**		**8%**	
89%	*of **Ancillary (non-school)** Service Providers…*		**55%**		**28%**	

"I don't have any money so I can't travel very far."
-Client Survey Respondent

"First of all, transportation is a problem—it's a big problem."
-Client Focus Group Respondent

"There is a Pathways in Owensville, but that is a totally different county and it's a little drive. I don't have a driver's license. I don't have a car."
-Client Focus Group Respondent

"Transportation would be one of them [additional needs for clients]."
-Provider Focus Group Respondent

"In this county, transportation is the biggest. We do have the OATS bus, but that isn't accessible for everyone that needs transportation."
-Provider Focus Group Respondent

"No transportation; mental health patients not able to get to the doctor and get meds."
-Stakeholder Interview Respondent

County Snapshot and Related Needs:

- The need for transportation to access services was identified as a top need across direct and ancillary service providers within **all counties**. The distance between available service providers appears to be greatest for all of Maries County and the southern half of Crawford County counties. Additionally, while the services in Dent and Texas Counties are centrally located, the size of those counties result in people living closer to their county boundaries having to travel greater distances to reach services. This is particularly challenging for those without reliable transportation. A key contributing factor to lack of transportation is poverty, which is a concern for all counties in the study. Rates of poverty are higher than the state for most counties and are particularly high for Crawford, Maries, and Texas Counties. Crawford County has the highest family poverty rate (17.9%), Texas County has the highest overall individual poverty rate (26.2%), and Texas (37.5%) and Maries (33.2%) have the highest youth poverty rates.

(2B) Costs/Affordability of Services

Description: Cost and affordability are barriers to accessing mental health and addiction services. This includes not being able to afford available services due to a lack of insurance or not having enough insurance to cover necessary expenses. In some cases, individuals who have insurance may lack specific coverage for the needed treatment.

Evidence:

- **The cost/affordability of services** was identified as a **common theme** across client and provider open-ended survey responses, focus groups, and interviews. This theme included not being able to pay for services because costs were too high, not having insurance, or being underinsured, or their condition not being covered. Costs/affordability issues were within the **top three of all subcategories** of need for provider survey and focus group participants. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- When asked to identify problems experienced when accessing services, **20%** of clients reported that the cost of services were too high, and **24%** reported that insurance only covered some or did not cover any of the needed services. *(Client Survey)*
- **77%** of direct, **57%** of ancillary (school), and **52%** of ancillary (non-school) service providers rated clients being unable to pay for services as a large to extreme barrier to receiving services. Inability to pay for services was either the highest or second highest barrier identified by direct and ancillary service providers. *(Provider Surveys)*
- **59%** of direct, **42%** of ancillary (school), and **47%** of ancillary (non-school) service providers rated clients being underinsured (i.e., having insurance but not having enough coverage to pay for services) as a large to extreme barrier to receiving services. Being underinsured was within the top five barriers identified by direct and ancillary service providers. *(Provider Surveys)*

"A lot of people need medical services can't get medical services, period. They can't afford them. They don't have Medicaid or insurance."
-Client Focus Group Respondent

"There is no facility around that does not take no-insurance people. They all need Medicaid and most of the people around here that need services do not have Medicaid."
-Client Focus Group Respondent

"It's kind of hard to get them into [providers], especially if you don't have insurance. Cost would be a big factor."
-Provider Focus Group Respondent

"Ability to pay."
-Stakeholder Interview Respondent

"High poverty, specifically rural poverty, which can be even more challenging."
-Client Focus Group Respondent

County Snapshot and Related Needs:

- Across all counties, the inability of clients to pay for services was a top barrier to receiving mental health and/or addiction treatment. Inadequate insurance coverage was also among the top five barriers identified by providers and ancillary organizations. Poverty rates are quite high across the six counties. In terms of family poverty rates, Crawford has the highest rate (17.9%), followed by Texas (17.0%) (compared to 10.8% for Missouri). Individual poverty rates are highest for Texas (26.2%) and Dent (22.4%) (compared to 15.3% for Missouri). Finally, child poverty is particularly high in Texas (37.5%) and Maries (33.2%) (compared to 21.1% for Missouri). Based on 2018 County Health Rankings data, the percentage of individuals who are uninsured is higher than the state in every county except Pulaski. Dent and Texas have the highest uninsured rates.
- The cost and affordability of services is particularly related to access to services (i.e., individuals who cannot afford services lack access to the services), lack of proper medication and medication management, lack of early intervention, and actually receiving services that may address mental health and/or addiction issues.

(2C) Policy, Rules, Regulations, and Operations Including Wait Times/Scheduling

Description: The way organizations deliver services and the policies/rules/regulations pertaining to services has the potential to significantly impact the affordability and timeliness of services for clients. This includes wait times and scheduling of services, which are concerns expressed by providers and clients.

Evidence:

- **The policies, rules, regulations and operations of organizations and wait times and scheduling** were identified as a **common theme** across client and provider open-ended survey responses, focus groups, and interviews. This theme included long wait times, difficulty in scheduling appointments, lack of convenient appointment times, as well as regulations to qualify for services and the number of stipulations to access services. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- When asked to identify problems experienced when accessing services, **18%** of clients reported that there was a long wait to get an appointment, and **13%** reported that appointment times did not fit their schedule. *(Client Survey)*
- **31%** of direct, **37%** of ancillary (school), and **33%** of ancillary (non-school) service providers rated lack of weekend or evening appointment times as a large to extreme barrier to receiving services. Lack of weekend or evening appointment times were the fifth highest barrier identified by ancillary (school) service providers. *(Provider Surveys)*

"There are a lot of gate keepers, and there are a lot of stipulations to access care."
-Provider Focus Group Respondent

"Wait times can be an issue."
-Stakeholder Interview Respondent

"Too many state regulations that close doors to people."
-Stakeholder Interview Focus Group Respondent

"We tried to organization a walk. The city pretty much told us it was a bad reflection on the community. I guess to admit that there was a drug problem."
-Client Focus Group Respondent

County Snapshot and Related Needs:

- Across all counties, over one-third of providers indicated that lack of more convenient appointment times was a significant barrier to clients receiving services. The policies and operations implemented by organizations have the potential to directly impact clients' access to services, particularly if processes for getting connected to services are not streamlined and convenient for individuals. The degree to which organizations collaborate and create person-centered processes also may significantly impact the timeliness and quality of services received by clients.
- This need area is directly related to clients' access to services in that systems policies and regulations may serve as a barrier to treatment access. Additionally, collaboration among organizations is a central issue when determining how systems can best work together to address their requirements for service access and delivery. Finally, as noted from open-ended survey responses, interviews and focus groups, the degree to which systems issues such as wait times may be effectively addressed depends partially on the personal responsibility of the client to follow through with appointments and their prescribed course of treatment.

(2D) Continuity of Care/Coordination of Services/Transition

Description: Streamlined processes that avoid duplication of services support more efficient access to mental health and addiction services, thus reducing wait times, ensuring earlier intervention, and avoiding the compounding of issues. This area includes how services are coordinated for clients, as well as the transition of individuals from different types of services (e.g., inpatient to outpatient, care during incarceration to community living). A need to strengthen collaboration and communication among current providers is also included in this area.

Evidence:

- **Continuity of care/coordination of services/transition** was identified as a **common theme** across open-ended survey responses, focus groups, and interviews. This theme included a lack of processes to get people into treatment, the need for better coordination of care, the need for better coordination between the legal system and supportive programs, and a lack of transition from incarceration back into the community. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- The need for case management services was among the **highest needs** identified by direct service providers. While this need was less for ancillary providers, the magnitude of the need and extent to which the need was addressed is an important consideration. *(Provider Surveys)*

91%	*of **Direct** Service Providers…*	*report clients have need for* case manage-ment services.	**42%**	*indicate clients "often" or "almost always" had a need for the service, while…*	**47%**	*report clients actually received the service ("often or "almost always").*
37%	*of **Ancillary (school)** Service Providers…*		**36%**		**45%**	
61%	*of **Ancillary (non-school)** Service Providers…*		**64%**		**60%**	

- The need for school-based and wrap around services was a **high need** specifically identified by ancillary (school) service providers. *(Provider Surveys)*

79%	*of **Ancillary (school)** Service Providers…*	*report clients have need for school-based services (*social work or case management contracted with schools).	**57%**	*indicate clients "often" or "almost always" had a need for the service, while…*	**33%**	*report clients actually received the service ("often or "almost always").*
60%	*of **Ancillary (school)** Service Providers…*	*report clients have a need for wrap-around services.*	**32%**		**17%**	

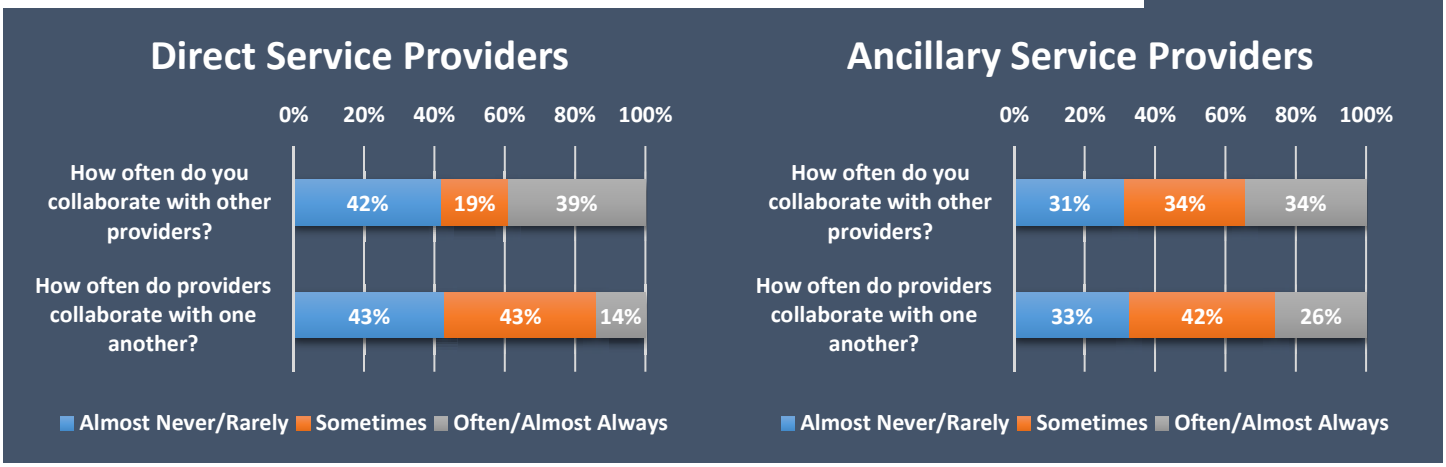
"Continuing services, follow-up services."
-Client Focus Group Respondent

"When we get them discharged, we set them up with follow-up appointments with the psychiatrist and sometimes with their primary care provider. But after they get discharged, there's no follow-up. We don't call them like two days and say, "Hey, do you need a ride to your facility?"
-Provider Focus Group Respondent

"Community mental health liaison and ER enhancement has helped identify those who need services but aren't getting them."
-Stakeholder Interview Respondent

"Need to work on how to address mental health and addiction issues through the court system."
-Stakeholder Interview Respondent

- → **39%** of direct service providers and **34%** of ancillary service providers indicated that they collaborate with other addiction and/or mental health service providers in their area "Often" or "Almost Always." Note that **42%** of direct service providers and **31%** of ancillary service providers reported that they "almost never" or "rarely" collaborated with other providers.
- → **14%** of direct service providers and **26%** of ancillary service providers reported that all providers in general collaborate with one another "Often" or "Almost Always." Note that **43%** of direct service providers and **33%** of ancillary service providers reported that all providers in general "almost never" or "rarely" collaborated with one another.



County Snapshot and Related Needs:

- → The need for case management services was among the top five provider-identified needs in all counties. While ancillary providers did not indicate case management as high of a need as direct providers, ancillary providers in Dent, Maries, and Texas Counties did rank this issue as one of their top ten identified needs.
- → Highly related to continuity of care and transition is communication and collaboration among service providers in the community, both direct and ancillary. This need area also has a significant impact on access to services.

(3) Availability of Treatment Options to Address Mental Health and Addiction Issues

The resources and services available to treat mental health and addiction issues is a primary need identified in this study. Treatment options pertain to both age-specific and general populations and relate to both mental health and addiction concerns, as well as the co-occurrence of such issues. More intensive services such as inpatient and psychiatric services are also addressed in this section.

- (3A) Need for More Counselors & Providers (General) and Psychiatric Services
- (3B) Need for Mental Health Services for Specific Populations and Treatment of Child/Adolescent Issues
- (3C) Need for Inpatient, Intensive and Long-term Services
- (3D) Need for Services to Treat Addiction
- (3E) Medication Management Issues and Treament for Co-Occurring Issues

(3A) Need for Counselors & Providers (General) and Psychiatric Services

Description: Resources and Services pertaining to the availability of counselors and providers in general and psychiatric services specifically are identified as needs for the six-county area.

Evidence:

- **Lack of counselor/providers and lack of psychiatric services** were identified as **common themes** across open-ended survey responses, focus groups, and interviews. This theme included an overall lack of psychiatrists across the region, lack of consistency with providers due to providers leaving practice and/or the community or an overall shortage of staff, and difficulty in recruiting/retaining providers. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- Barriers specific to this need area included **lack of trained staff to provide treatment to clients** (**22%** direct providers, **33%** schools, and **27%** non-schools identify this as large to extreme barrier) and **no service available for a client's issue** (**16%** direct providers, **23%** schools, and **18%** non-schools large to extreme barrier).
- The need for individual therapy and/or counseling was among the **top five highest needs** identified by all providers. Importantly, direct service providers were more likely to indicate that this service was addressed often, while ancillary service providers reported that the service was provided less than half the time. *(Provider Surveys)*

91%	*of **Direct** Service Providers…*	*report clients have need for individual therapy and/or counseling.*	**74%**	*indicate clients "often" or "almost always" had a need for the service, while…*	**70%**	*report clients actually received the service ("often or "almost always").*
100%	*of **Ancillary (school)** Service Providers…*		**58%**		**32%**	
74%	*of **Ancillary (non-school)** Service Providers…*		**56%**		**44%**	

- Additionally, group therapy and/or counseling, family therapy and/or counseling, and psychological testing were also identified as **high needs** within this area (ranging from **52%** to **83%** of providers reporting the areas as a need). *(Provider Surveys)*

"For Phelps County, I think there is a need to have choices of providers, more than what there tends to be right now."
-Provider Focus Group Respondent

"Treatment/ER…not many options"
-Provider Focus Group Respondent

"It's hard for me to find good mental health counseling and crisis counseling."
-Client Focus Group Respondent

"We actually need a psychiatrist, and of course counselors."
-Client Focus Group Respondent

"Just need more providers in the area to treat psychiatric issues."
-Stakeholder Interview Respondent

County Snapshot and Related Needs:

- The need for individual therapy and/or counseling was among the top seven provider- and ancillary-identified needs in all counties. While all counties rated this area as a high need, Phelps County showed the highest need among direct providers (89% indicating this is a need for clients), and Texas County had the highest need among ancillary service providers (89% indicating this area as a need).
- In terms of psychological testing, the highest need among direct providers was demonstrated in Pulaski County, with 80% indicating this as a need. The highest need among ancillary service providers was in Texas County, with 72% indicating need.
- Based on County Health Rankings data, Crawford, Maries, and Texas Counties have the highest provider-to-population ratios, which demonstrates the lack of mental health providers in those communities. In addition to those counties, the ratio for Dent is also lower than the state.
- The need for providers to address mental health issues is directly related to the prevalence of mental health issues in the community. Also related is the degree to which early intervention occurs, the degree of access individuals have to services, and the burden of transportation and costs associated with seeking services outside the community.

(3B) Need for Mental Health Services for Specific Populations and Treatment Child/Adolescent Issues

Description: Specific focus was placed on resources and services pertaining to certain age populations, particularly options available for youth mental health and substance issues. Options available for elderly individuals is also included in this need area.

Evidence:

- **Lack of mental health services for specific populations and to treat child/adolescent issues** were identified as **common themes** across open-ended survey responses, focus groups, and interviews. A key concern was the lack of child psychiatric services in the region. Additional issues include lack of geriatric psychiatric services, lack of substance use services for youth, and lack of school social workers and therapists. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- In terms of reasons for referral by ancillary organizations**,** **73%** of schools and **23%** of non-schools refer due to childhood disorders (**39%** across all ancillary providers). Further, 38% to 43% of all ancillary providers also report referrals for child sexual or physical abuse. The top five areas of referral for school-ancillary providers include childhood disorders, behavioral and mood issues, suicidal behaviors and anxiety/stress. *(Provider Surveys)*
- Barriers specific to this need area include **lack of specialized services for youth** (**31%** direct providers, **47%** schools, and **15%** non-schools identify as large to extreme barrier) and **lack of specialized services for the elderly** (**28%** direct providers note this as a large to extreme barrier).
- **79%** of schools indicated that their students have a need for school-based services. Of those providers, **57%** indicated clients "often" or "almost always" had a need for the service, while **33%** reported clients actually received the service ("often or "almost always"). Across direct providers, **52%** indicated their clients have a need for school-based services. *(Provider Surveys)*
- **61%** of direct service providers indicated that their clients have a need for specialized services for the elderly. Of those providers, **25%** indicated clients "often" or "almost always" had a need for the service, while **37%** reported clients actually received the service ("often or "almost always"). Of non-school ancillary providers, **42%** indicated this area as a need. *(Provider Surveys)*

"There's no child psychiatrist within this area."
-Provider Focus Group Respondent

"We spend a lot of time with students who refer to suicide, anxiety and depression as well as anger management."
-Stakeholder Interview Respondent

"No psych services for youth—must refer to St. Louis."
-Stakeholder Interview Respondent

"Youth are at a tremendous disadvantage in terms of services."
-Stakeholder Interview Respondent

County Snapshot and Related Needs:

- Overall, there were a high percent of hospital admissions for ages 13-18. In 2017, this age group accounted for 22% of mental health admissions, which was tied with the 19-29 age group (Hospital Industry Data Institute (HIDI) data extracted on April 5, 2018 and compiled by Phelps Cty Reg. Med. Center Applications & Analytics).
- The need for school-based services was the highest in Crawford and Phelps when examining direct service providers (46% indicated clients have this need) and highest in Pulaski among ancillary service providers (55% indicated clients have this need).
- In terms of specialized services for the elderly, the highest need among direct providers was demonstrated in Texas County, with 79% indicating this as a need. The highest need among ancillary service providers was in Phelps County, with 41% indicating need.
- Across ancillary service providers, Maries County had the highest rate of referral for childhood disorders at 41%.
- The lack of age-specific treatment options is particularly related to early intervention and the ancillary resources and services that pertain to school supports.

(3C) Need for Inpatient, Intensive and Long-term Services

Description: The availability of hospitalization services and services that require in-depth and/or long-term treatment are a need in the community. This is due to the complex nature of the mental health and addiction issues that are prevalent in the six-county area.

Evidence:

- → **Inpatient and more intensive services** in the community **are available** in the following areas:
  - **Crawford County:** Missouri Baptist Sullivan, New Hope Geriatric Psych and New Vision Drug & Alcohol Rehab
  - **Dent County:** Southeast Missouri Behavioral Health Crisis Stabilization Services
  - **Phelps County:** Phelps County Regional Medical Center Inpatient Psych Services, Pathways Psychiatric Residential Treatment Services
  - **Pulaski County:** Fort Leonard Wood Psychiatric Services (military members), Piney Ridge Center (residential treatment center for youth)
- → While several services are present within the community as noted above, **lack of inpatient, intensive and long-term services** were identified as **common themes** across open-ended survey responses, focus groups, and interviews. Specific inpatient issues identified included:
  - lack of hospital beds for treatment (both for drug/alcohol and psychiatric issues),
  - lack of partial hospitalization services,
  - lack of long-term facility that does medication review and adjustment, and
  - further needs for stabilization services.

  In terms of intensive/long-term services, participants noted the need for better follow-up after discharge, the lack of long-term aftercare (including supportive housing), and the need for more extensive drug addiction support. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*

"A facility that will take a mentally ill person and keep them admitted until a full medication review has been conducted."
-Stakeholder Interview Respondent

"Have students who need hospitalization for psych reasons—often get referred to St. Louis."
-Provider Focus Group Respondent

"Continuing services, follow-up services."
-Client Focus Group Respondent

"Lack of funds for beds for inpatient treatment (addiction)."
-Stakeholder Interview Respondent

"Hospitalization, stabilization, and medication review."
-Stakeholder Interview Respondent

County Snapshot and Related Needs:

- → Substance Use Treatment Data help to shine a light on the need for drug and alcohol treatment options in the community. The rate of **substance use treatment admissions primarily for alcohol** declined for all counties. The 2016 rates for Crawford, Dent, and Phelps were higher than the state of Missouri rate.
  - **Admissions primarily for methamphetamine** increased for Dent, Pulaski, and Texas counties between 2013 and 2016 but decreased for Crawford, Maries, and Phelps. The 2016 rates were higher than the state of Missouri for all counties except Pulaski. The Crawford rate was approximately twice that of the state.
  - **Admissions primarily for heroin** increased for Crawford, Dent, Phelps, and Pulaski counties. Data were unavailable for Maries and Texas. The 2016 rates for Dent, Phelps, and Pulaski were higher than the state of Missouri.

- Hospital Admissions Data is another source documented at the state level for each county in Missouri. Data specific to drug and alcohol treatment follows.
  - **Alcohol-related Hospitalization After ER Visit:** In line with the alcohol-related emergency room increases, the number that were followed by hospitalization also increased for all counties.
  - **Alcohol-related Hospitalization Without ER Visit:** The increase in alcohol-related hospitalizations without emergency room services was most noticeable for Crawford, Dent, and Phelps Counties. Pulaski County experienced a peak in 2010.
  - **Drug-related Hospitalization After ER Visit:** In line with the increase in drug-related emergency room episodes, the number that were followed by hospitalization increased for all counties except Texas.
  - **Drug-related Hospitalization Without ER Visit:** Similar to the emergency room data, the number of episodes that have bypassed ER services and ended up in the hospital has increased for all locations.
- The lack of inpatient and intensive, long-term strategies is largely related to funding opportunities, as well as the systems-level collaboration that may take place among providers in the community.

(3D) More Services Needed to Treat Addiction

Description: Given the scope of addiction issues in the community, the lack of services to address such concerns is identified as a key need in the current study. Given the intensive nature of drug and alcohol treatment, there is some overlap with the need for intensive, long-term and transition services described elsewhere in this report. However, additional services and resources specific to addiction were highlighted in several areas and warranted specific mention.

Evidence:

- **Lack of services to treat addiction** was identified as a **common theme** across open-ended survey responses, focus groups, and interviews. This theme included lack of detox facilities, lack of long-term addiction treatment, the need for medication-assisted treatment, the lack of local CSTAR programs, and a lack of Suboxone and Vivitrol providers. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- Addiction treatment services in the community are available in the following areas:
  - **Crawford County:** Missouri Baptist Sullivan, New Vision Drug & Alcohol Rehab; Southeast Missouri Behavioral Health (Cuba); Pathways (Sullivan)
  - **Dent County:** Southeast Missouri Behavioral Health (Salem); Ozark Healthcare (Salem); Pathways (Salem)
  - **Phelps County:** Phelps County Regional Medical Center (Rolla); Pathways (Rolla); Southeast Missouri Behavioral Health (Rolla); Missouri S&T Counseling Services (for university community)
  - **Pulaski County:** Southeast Missouri Behavioral Health (St. Robert); Piney Ridge Center (residential treatment center for youth in Waynesville)
  - **Texas County:** Southeast Missouri Behavioral Health (Houston)
- The prevalence of addiction issues indicates the need for treatment options to address a range of substances and complexity of problems. Issues identified under need area 1B speak to the severity of concerns. Primary substances identified include: methamphetamine, opioids, heroin, alcohol, and prescriptions drugs.

"There are no Suboxone clinics. I think the physicians here and in Rolla have their hands tied as far as prescribing those medications for detox."
-Provider Focus Group Respondent

"Meth is not being addressed well."
-Stakeholder Interview Respondent

"Need three to five doctors who specialize in addiction medicine, particularly who accept Medicaid. Also need a place for medical detox and medication-assisted treatment."
-Stakeholder Interview Respondent

"There are a lot of heroin addicts in this county…..we don't have a treatment center anywhere around here for these people."
-Client Focus Group Respondent

County Snapshot and Related Needs:

- Treatment admissions data provided under need area 1b and 3C indicate the severity of issues in the region. The rates for Crawford, Dent, and Phelps were particularly higher than the state in most substance abuse categories.
- Emergency room data also provide insight into the need for drug and alcohol addiction treatment services. **Alcohol Use Disorder:** Emergency room episodes with alcohol use disorder as the principal or secondary diagnosis increased slightly for Crawford, Maries, Pulaski, and Texas Counties but decreased for Dent and Phelps. The 2015 rate for all counties was lower than the state of Missouri rate.
- **Drug Use Disorder:** Emergency room episodes with drug use disorder as the principal or secondary diagnosis increased for all counties except Phelps. The 2015 rate for Crawford County was higher than the state of Missouri rate while all other counties were lower.

- → **ER Visits Due to Opioid Misuse:** In terms of ER visits due to opioid misuse, Crawford and Phelps had the highest rates, ranking those counties in the top ten of all Missouri counties.
- → The need for additional addiction services is directly related to the prevalence of addiction issues in the community, which have largely focused on alcohol, opioids, meth, and heroin. Systems-level factors such as how organizations collaboration to treat client, transportation limitations due to travel burdens, and poverty are also key related need areas.

(3E) Medication Management/Co-Occurring Issues

Description: The appropriate use and access to medications for mental health and addiction concerns was identified as a concern within the region. Due to the prevalence of medication use in the treatment of mental health and addiction issues, proper management of such substances is important to successful treatment. This need also recognizes the complexity of co-occurring conditions that may be exacerbated without proper treatment.

Evidence:

- **Medication management** and **co-occurring issues** were identified as **common themes** across open-ended survey responses, focus groups, and interviews. Medication management included ensuring that individuals have appropriate medications and that they take their medications as prescribed. Co-occurring issues related to challenges faced by individuals who have both mental health and addiction issues. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- **59%** of direct, **17%** of ancillary (school), and **39%** of ancillary (non-school) service providers rated lack of access to medication as a large to extreme barrier to receiving services. Note that this was the second highest barrier identified by direct providers. *(Provider Surveys)*
- **50%** of direct, **17%** of ancillary (school), and **37%** of ancillary (non-school) service providers rated clients having co-existing conditions as a large to extreme barrier to receiving services. Note that this was the second highest barrier identified by direct providers. *(Provider Surveys)*
- The need for medication management was the **sixth highest** need identified by direct service providers. While less than half of ancillary providers noted medication management as a need, only approximately **20%** reported that the need is often addressed. *(Provider Surveys)*

88%	*of **Direct** Service Providers…*	*report clients have a need for medication management.*	**61%**	*indicate clients "often" or "almost always" had a need for the service, while…*	**56%**	*report clients actually received the service ("often or "almost always").*
45%	*of **Ancillary (school)** Service Providers…*		**40%**		**20%**	
45%	*of **Ancillary (non-school)** Service Providers…*		**43%**		**21%**	

"Overall need for proper medication management, adjustment and review."
-Stakeholder Interview Respondent

"Some of my students disclosed that they used to go Pathways. They said they quit going and a lot of them quit their medications, which is not a good thing to quit your medications cold turkey."
-Provider Focus Group Respondent

"If people are on medication, they need medication. If people got their medications, they wouldn't be on drugs."
-Client Focus Group Respondent

County Snapshot and Related Needs:

- The need for medication management was one of the top areas identified by providers in every county (range of 79%-95% expressing a need for this issue). While all counties rated this area as a high need, Pulaski County showed the highest need among direct providers (95% indicating this is a need for clients). In terms of ancillary service providers, Dent County had the highest need related to medication management (63% indicating this area as a need).
- Medication management issues are related to access to care, the costs and affordability of services, and connection to appropriate, consistent treatment for mental health and addiction issues.

(4) Availability of Ancillary Resources, Services, & Supports to Address Mental Health & Addiction Issues

The availability of ancillary resources and services to support those individuals who are experiencing mental health and addiction issues is a primary need identified in this study. Ancillary supportive services such as housing, food, and clothing were identified as important protective factors for individuals experiencing mental health or addiction concerns.

(4A) Need for Ancillary Resources, Services, and Supports

(4B) Need for Prevention and Early Intervention

(4a) Need for Ancillary Resources, Services, and Supports

Description: The availability of ancillary resources and services to support those individuals who are experiencing mental health and addiction issues is a primary need identified in this study. Ancillary supportive services such as housing, food, and clothing were identified as important protective factors for individuals experiencing mental health or addiction concerns.

Evidence:

- **Lack of ancillary resources, services, and supports** was identified as **common theme** across open-ended survey responses, focus groups, and interviews. This theme included a need for a variety of supportive services to support individuals, such as housing, food, and clothing, as well as job skills training, childcare, and employment. Ancillary resources, services, and supports was the **highest subcategory** need identified within provider and client focus groups, and the **third highest** subcategory need identified by stakeholders. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- **More than half of…**
  - **Direct service providers** reported that their clients have a need for primary healthcare, nutrition services, money management, supportive employment, housing services, assistance in obtaining educational or vocational training, and homeless services.
  - **Ancillary (school) service providers** reported that their clients have a need for homeless services, housing services, parenting education, and primary health care.
  - **Ancillary (non school) service providers** reported that their clients have a need for housing services, homeless services, supported employment, money management, primary health care, legal advocacy, and parenting education.

"Having a place to stay, a place to call home; that means a lot to a guy."
-Client Focus Group Respondent

"We need to have job training skills here."
-Client Focus Group Respondent

"It sounds like there needs to be a halfway house here."
-Provider Focus Group Respondent

"There is no homeless shelter close. There are people that truly have basic housing needs."
-Provider Focus Group Respondent

"No homeless shelter in the area."
-Stakeholder Interview Respondent

County Snapshot and Related Needs:

- Across all counties, housing services (i.e., assistance in locating housing) and homeless services (i.e., outreach services to ensure homeless individuals have access to care) appeared to be common ancillary supports identified as needed by both direct and ancillary service providers. While the need appears to be present within all counties, Crawford and Phelps Counties had a higher percentage of direct service providers (greater than 68%) identifying housing assistance as a need, while Crawford also had the highest percent of direct service providers noting that homeless services were a top need. Among ancillary service providers, Maries County had the highest percent of ancillary providers noting housing and homeless services as a need. However, nearly three-fourths or greater of all ancillary providers noted a need for housing and homeless services.
- This need area is directly related to social determinants such as poverty, family dynamics, education, and unemployment. Low socioeconomic status places individuals in vulnerable financial positions, and supportive services such as food and housing are important to ensure access to needed mental health and/or addiction services. Also related is the need for transportation, which allows individuals to access both ancillary and treatment services.

(4b) Need for Prevention and Early Intervention

Description: Preventive measures such as school-based drug/alcohol education and social work services are important to limit the onset and further development of addiction and/or mental health issues. Community prevention education is also important as a broader environmental strategy. Additionally, early intervention through proper screenings and timely implementation of services help to avoid the compounding of issues that may become more difficult to address if left untreated.

Evidence:

- **Need for prevention and early intervention** was identified as **common theme** across open-ended survey responses, focus groups, and interviews. This theme included addressing issues early in the onset of a condition, as well as lack of early intervention resulting in more severe issues/compounding of issues. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- **44%** of direct, **32%** of ancillary (school), and **48%** of ancillary (non-school) service providers identified lack of early intervention as a large or extreme barrier to clients receiving mental health and/or addiction services. *(Provider Surveys)*
- Barriers identified through the Client Survey provide insight into the reasons why individuals may not experience early intervention. Key barriers identified by clients include lack of transportation, lack of knowledge about where to get help, concern about what others think, the cost of services, and long wait times.
- Provider and Ancillary Survey results also highlight barriers that may prevent early intervention for clients. Key barriers identified across all provider types include clients unable to pay for services, lack of access to medication, stigma related to seeking/receiving mental healthcare, underinsured patients, transportation issues, and clients unaware of existing services.
- **79%** of schools and **52%** of direct service providers identified school-based services such as social work or case management as a need for clients. While **57%** of schools identified this as a high need, only **33%** believe clients (youth) are receiving those services as frequently as needed.

"I think it needs to start younger. Start young because the addiction problem starts at 12-13; it doesn't start at 25."
-Provider Focus Group Respondent

"Work with Prevention Consultants for additional programming."
-Stakeholder Interview Respondent

"Must start at a young age."
-Stakeholder Interview Respondent

County Snapshot and Related Needs:

- The need for school-based services such as social work or case management was highest among ancillary service providers in Pulaski (55% indicated need), Texas (53%), and Dent (52%) Counties.
- Youth data related to both substance use and mental health status provide an insight into the concerns experienced by youth in each county. As indicated under the prevalence sections, Pulaski and Texas Counties have the highest rates of youth substance use in the six-county area. In terms of mental health, students in Dent, Phelps, and Texas Counties expressed the greatest concerns in terms of social-emotional well-being.
- The need of prevention and early intervention is related to awareness of mental health and addiction issues and access to services. An understanding of the complexity and potential severity of health outcomes is important to prompt individuals to address concerns at an early stage. Additionally, it is important to provide access to services to ensure that issues are addressed before they become more severe. Finally, personal responsibility and the willingness to seek treatment is key in ensuring that addiction and mental health concerns are addressed in a timely manner.

(5) Lack of Awareness of Mental Health and Addiction Issues

Awareness of mental health and addiction issues may be divided into two separate categories, including the knowledge of existing resources in the community and a better understanding of mental health and addiction issues in general. Comprehensive, up-to-date listings of resources for particular conditions supports access to services and more timely treatment. Greater awareness about mental health and addiction issues in general helps to prevent stigma associated with accessing services, promotes support throughout the community for addressing issues, and helps individuals know when they should seek help for their concerns.

(5A) Knowledge and Understanding of Available Resources Used to Address Mental Health and Addiction Concerns

(5B) Better Understanding of Mental Health and Addiction Issues

(5a) Knowledge and Understanding of Available Resources Used to Address Mental Health and Addiction Concerns

Description: The degree to which individuals know about and understand the existing resources and services that are available to support mental health and addiction needs is lacking within the region. This area reflects an overall lack of awareness of existing services, how to navigate current service systems, and available resources to help with accessing these services.

Evidence:

- → **Knowledge and understanding of available resources/services and treatment options was** identified as a **common theme** across open-ended survey responses, focus groups, and interviews. This theme included not being aware of services to address specific conditions, not understanding how to access existing services, and generally not being aware of treatment options. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- → When asked to identify problems experienced when seeking services, **33%** of clients reported that they did not know where to get help. *(Client Survey)*
- → **56%** of direct, **68%** of ancillary (school), and **48%** of ancillary (non-school) service providers rated clients being unaware of existing services as a large to extreme barrier to receiving services. Lack of awareness of services was the **fifth highest** barrier identified by direct service providers, the **highest** barrier among ancillary (school) service providers, and the **third highest** barrier among ancillary (non-school) service providers. *(Provider Surveys)*
- → The need for information regarding where to obtain services or referrals to organizations that provide services was among the **highest needs** identified by providers. *(Provider Surveys)*

97%	*of **Direct** Service Providers…*	*report clients have need for information regarding where to obtain services or a referral to organizations that provide services.*	**58%**	*indicate clients "often" or "almost always" had a need for the service, while…*	**66%**	*report clients actually received the service ("often or "almost always").*
83%	*of **Ancillary (school)** Service Providers…*		**50%**		**8%**	
89%	*of **Ancillary (non-school)** Service Providers…*		**55%**		**28%**	

"They just don't know what direction to go."
-Provider Focus Group Respondent

"People unaware of available services."
-Stakeholder Interview Respondent

"Insufficient awareness of treatment options."
-Stakeholder Interview Respondent

"Having some type of up to date real time accessible resource that everybody can access. We have probably 100 lists floating out in the community."
-Provider Focus Group Respondent

"There are a lot of people who don't know about SEMO or Pathways."
-Client Focus Group Respondent

County Snapshot and Related Needs:

- → The need for information regarding where to obtain services or referrals to organizations that provide services was a top need identified across all counties. No differences were evident across counties.
- → This need area is related to a general awareness of mental health and addiction issues, the specific resources that are available to treat particular concerns, and systems-level communication. The last area highlights the importance of organizations better communicating their resources and working to share those with members of the community.

(5b) Better Understanding of Mental Health and Addiction Issues

Description: Lack of understanding related to the causes and consequences of mental health and addiction issues impacts access to available resources, as well as a community's response to overall service delivery. This need for education and awareness contributes to perceived stigma associated with those experiencing issues, which may impact an individual's pursuit of service.

Evidence:

- **Understanding of mental health/addiction issues** was a **common theme** across client and provider open-ended survey responses, focus groups, and interviews. This theme included a need for more education and awareness within non mental health professionals and community members related to the treatment of mental health and addiction issues. This theme also includes stigma associated with individuals who may be experiencing mental health or addiction concerns. This subcategory was the third highest area from the client focus groups. *(Provider Surveys, Focus Groups, Stakeholder Interviews)*
- When asked to identify problems experienced when accessing services, **26%** of clients reported that they were worried about others findings out. *(Client Survey)*
- Stigma related to seeking/receiving mental healthcare was noted by **59%** of direct service providers, which represented the third highest barrier to receiving services. In addition, **35%** of ancillary (school and non-school) service providers identified stigma as a barrier.

"My children have had a stigma put on them because of my services."
-Client Survey Respondent

"That can also cause a stigma to where they keep using because they don't want people to see that they are sick. They are embarrassed to get help."
-Client Focus Group Respondent

"The stigma about mental health illness and substance abuse."
-Provider Focus Group Respondent

"A lot of it is a lack of knowledge. I don't think people know. We know about addiction and what it can do to people, but I don't think people take it that seriously, to the point where they are willing to be there for people like that."
-Provider Focus Group Respondent

County Snapshot and Related Needs:

- Stigma associated with receiving services appeared to be consistent across counties.
- In addition to knowledge of resources and treatment options, this need area is related to social determinants such as education and societal/community norms, the degree to which the community is engaged in initiatives related to mental health and addiction, prevention efforts, and systems-level communication among organizations.

Synthesis of Identified Strengths within the Area

The six-county study area demonstrates several strengths associated with mental health and addiction issues. Strength areas represent progress the community has already made in addressing the most significant concerns and establish a foundation on which further efforts may capitalize. Strengths pertain to current treatment resources, collaboration among providers and other organizations, community engagement, and existence of ancillary services.

1

Existing Mental Health and Addiction Providers

The quality of and satisfaction with current providers was identified across client and provider open-ended survey responses, focus groups, and interviews. When clients were asked what has helped them the most, nearly half (44%) credited current providers or services being received (e.g., case workers, therapists, counselors, assistance with getting resources), while 30% specifically mentioned receiving psychiatric support and/or medication management as the most helpful. A list of primary service providers is included at the end of this section.

EXAMPLES

- Specific providers identified (e.g., A Place for Grace, Pathways, Phelps County Regional Medical Center (PCMRC), Ozarks Medical Center, Mercy Clinic, Your Community Health Center, SEMO)
- Current counseling/therapy groups
- Specific professionals/individuals listed by name

2

Collaboration and Communication Among Service Providers and Organizations

The degree to which providers and service organizations demonstrate collaborative practices and effective communication emerged as a theme across client and provider open-ended survey responses, focus groups, and interviews. This theme represented current partnerships that are underway within the community and overall cooperation among providers. While qualitative findings pointed to areas of strength within collaboration, findings from provider surveys were mixed in relation to the frequency of the collaboration. Specifically, 66% of direct and ancillary service providers reported that they specifically collaborated with other addiction and mental health service providers in the area at least sometimes, and 65% reported that providers in the area collaborate with one another at least sometimes. However, about a third (35%) reported that they specifically collaborated with providers in the area “often” or “almost always,” and 23% reported providers in the area collaborate with one another “often” or “almost always.” Importantly, there do appear to be very effective collaborations within the area, such as the Crisis Intervention Team and several Systems of Care initiatives.

EXAMPLES

- Crisis Intervention Team (CIT)
- Systems of Care
- Intra-agency connections
- Cooperation and shared resources
- Community roundtable discussions (involving law enforcement)

3

Available Ancillary Services and Supports

The availability of supportive services that are needed for clients to access treatment resources and experience a greater likelihood of recovery was identified as a strength. The existence of support groups, school supports, and services through the justice system are examples of currently available ancillary services and supports. Several client respondents reported in the Client Survey that services they had received in the community and interaction with others receiving treatment had been very helpful in addressing their mental health and addiction issues.

EXAMPLES

- Specific programs (Celebrate Recovery, Drug Task Force, Backpack Program)
- Support groups (e.g., AA, NA, Alanon, Alateen, Church groups)
- Schools supports (e.g., counselors)
- Law enforcement and court system

4

Community Engagement and Response

The degree to which members of the community are engaged to address mental health and addiction issues was identified as a strength. Based on feedback from community stakeholders, there are some grassroots efforts to understand and address mental health and addiction issues in the community. This involves various segments of the community, including schools and family members who have been directly impacted by the issues under investigation.

EXAMPLES

- Caring people within the community
- Needs assessment process
- Desire to do better and help

5

Current Community Awareness Initiatives and Growing Awareness and Recognition of Mental Health and Addiction Issues

The degree to which members of the community have an understanding of mental health and addiction issues, including their causes and impacts was identified as a strength. As identified by providers, stakeholders, and clients, there are already initiatives in the community that have increased awareness and understanding of mental health and addiction concerns. Programs such as bystander intervention and Step Up at Missouri S&T have promoted awareness among the university community. Greater involvement of law enforcement through the CIT group and mental health crisis education has increased the knowledge base of first responders in the community. Mental health first aid training has been important in enhancing awareness and knowledge about how to address mental health issues among all members of the community. Through these education efforts, there appears to be a greater willingness to understand how to address issues and possibly devote additional resources to the areas of mental health and addiction.

EXAMPLES

- Increased awareness of the need
- Openness to more services in the community
- Individuals willing to get treatment
- Bystander intervention and S&T
- Drug education efforts
- Mental health first aid trainings in the community

6

Existing Services, Programs or Resources to Treat Addiction or Support Treatment

Given the prevalence of addiction issues in the community, it is important that resources exist to address not only the treatment of addiction but also the community support services that help organizations address addiction from their specific perspectives. Based on feedback from providers and clients, drug court initiatives have largely been successful in helping individuals arrested for drug crimes receive treatment and become contributing members of their communities. Respondents believe that additional resources in this area would be beneficial. Other initiatives such as Narcan availability for first responders were identified as a strength for the community. While included within ancillary services, the presence and use of support groups (e.g., AA, AA, NA, Alanon, Alateen, Church groups) to address addiction issues was noted as a strength and a key strategy to maintain sobriety.

EXAMPLES

- Drug Court
- Law enforcement use and availability of Narcan
- Specific programs offered by providers (e.g., rehab facilities, free clinic for drug addiction, detox)

7

Existing Inpatient Resources

While there appears to be a need for additional inpatient resources to address mental health and addiction, providers, stakeholders, and clients cited the quality of existing inpatient services as a strength in the community.

EXAMPLES

- Specific facility mentioned (e.g., PCMRC Stress Center, New Vision Drug treatment facility)

Primary Service Providers within the Six-County Area

County	City	Organization	Services
Crawford	Sullivan	Missouri Baptist Sullivan Hospital New Vision New Hope	• Drug Addiction • Geriatric psych
		Pathways	• Drug Addiction • Mental Health • Supportive Services
	Cuba	Southeast Missouri Behavioral Health	• Drug Addiction • Mental Health • Supportive Services • Community-based Services
	Steelville	Great Circle – Meramec Adventure Learning Ranch	• Therapeutic adventure and wilderness program for youth and families
Dent	Salem	Ozark Healthcare	• Drug Addiction
		Southeast Missouri Behavioral Health – Salem Center	• Detox • Crisis Stabilization • Community-based Services • Substance Use • Mental Health • Medication Assisted Treatment
		Pathways	• Drug Addiction • Mental Health • Supportive Services
Texas	Houston	Southeast Missouri Behavioral Health	• Drug Addiction • Mental Health • Supportive Services • Community-based Services
Phelps	Rolla	Southeast Missouri Behavioral Health	• Drug Addiction • Mental Health • Supportive Services • Community-based Services
		Pathways	• Drug Addiction • Mental Health • Supportive Services
		Your Community Health Center	• Mental/Behavioral Health • Supportive Services • Primary Medical Care • Medication Assisted Treatment
		Phelps County Regional Medical Center – Center for Psychiatric Services	• Inpatient and Outpatient Mental Health • Supportive Services
		Missouri S&T Counseling Services	• Mental Health • Substance Use Education • Supportive Services
	St. James	Great Circle – St. James School	• Childhood Developmental Issues
Pulaski	St. Robert	Southeast Missouri Behavioral Health	• Drug court
	Waynesville	Great Circle	• Individual, Family and Group Counseling
		Piney Ridge Center	• Residential treatment center for youth
	Fort Leonard Wood	General Leonard Wood Army Community Hosp.	• Psychological and psychiatric services
	Richland	Central Ozarks Medical Center	• Behavioral health services

Synthesis of Identified Strategies within the Area

Based on feedback from providers, stakeholders, and clients, several strategies for addressing mental health and addiction needs were identified. The tables below provide examples of key strategies related to the different need areas. While strategies were suggested by study participants, it is important for key stakeholders to review the feasibility of strategies and establish priorities for implementing them.

(1) High Prevalence of Mental Health and Addiction Issues Including Specific Diagnoses

a. Prevalence of Mental Health Needs and Addiction	• Strategies associated with prevalence are represented throughout need domains 2 through 5.
b. Prevalence of Addiction Needs	

(2) Structures/Operations of Systems Impacting Access to Mental Health and Addiction Services

Need Subcategory	Strategy	Strategy Examples
a. Lack of Transportation/ Distance	**Create/identify affordable and accessible transportation systems/options**	• Determine the feasibility of providing public transportation options, particularly for areas with the greatest travel distances to services • More transportation options for those without such means • Address rural transportation issues and further study the challenges that rural environments pose to transportation
	Provide satellite facilities/clinics within counties	• Provide more centrally-located and more accessible services that provide a full range of services • Additional local clinics to address mental health and addiction issues
	Telehealth	• Telehealth more available and accessible to individuals throughout the region
b. Costs/Affordability of Services	**Insurance options**	• Explore insurance options for different economic and family situations; ensure there is a complete understanding of what is available and who qualifies
	Services for low-income individuals (e.g., sliding scale fee structures)	• Examine opportunities to provide assistance with medication costs • More sliding scale fee structures offered by providers • Provide health navigators or liaisons to help individuals enroll in health plans specifically for the economically challenged and find additional financial resources

(2) Structures/Operations of Systems Impacting Access to Mental Health and Addiction Services *(Continued)*		
Need Subcategory	**Strategy**	**Strategy Examples**
c. Policy, Rules, Regulations, Operations including Wait Times/Appointment Scheduling	**Review provider policies for accessing services to ensure individuals are connected to treatment**	• Organizations devoting more resources to assistance with appointment scheduling • Continuation and implementation of positions such as community health liaisons or navigators • Organizational collaboration to determine how to reduce wait times for clients • Examination of current policies/rules/regulations to qualify for services in an effort to eliminate unnecessary and duplicated requirements • Explore treatment options for people with records, convictions, etc. (remove barriers) • Work to ensure that regulatory standards regarding opioid prescriptions do not negatively impact people who need pain treatment • More understanding of local issues by state (the impact of their decisions)
d. Continuity of Care/Coordination of Services/Transition	**Case Management/Care Navigators**	• Implement a Systems of Care model • Implement and fund community support workers for follow-up care • Continuation of community mental health liaison and ER enhancement
	Continue and strengthen collaborative services and initiatives	• Collaborative court program that involves court system and treatment providers working together to address client needs • Development of crisis team to address critical mental health and addiction situations • More collaboration among all providers (direct and ancillary) to address needs • More inter-agency meetings to discuss mental health and addiction strategies and more effective communication among those entities • Determine overlap in services to ensure maximized community resources • Create information sharing agreements among organizations regarding clients (would support continuity of care)
	Improve transitions for individuals who are incarcerated	• Improved transition processes for individuals leaving incarceration

(3) Availability of Treatment Options to Address Mental Health and Addiction Issues		
Need Subcategory	**Strategy**	**Strategy Examples**
a. Need for Counselors/Providers (General) and Psychiatric Services	**More counselors/providers and psychiatric services**	• Examine opportunities to further expand mental health services into additional communities • Focus on strategies to recruit and retain skilled providers to the region • Examine feasibility of expanding telemedicine while maintaining quality care and ensuring that such healthcare meets clients' needs • Continue to support funding for in-person services as opposed to Telemed • Focus on early intervention strategies to help minimize need for services • Better access to psych care and other treatment • More counseling groups to address mental health and addiction issues • Recruit additional healthcare professionals in addiction
b. Need for Mental Health Services for Specific Populations and Treatment of Child/Adolescent Issues	**Address suicidal ideation among students**	• Address suicide ideation among students through prevention education and social work services
	Better addiction and mental health services for students and youth	• Provide better addiction and mental health services for students and youth (due to lack of treatment options in the region)
	Better and alternative treatment options for people with developmental disorders	• Explore additional and better treatment options for clients with developmental disabilities
	Help students stay in school while receiving services	• Determine how to help students stay enrolled while getting services
	More child psychiatrists and treatment options for geriatric population	• Recruit and retain child psychiatrists • Use Reliant Care model (comprehensive services for geriatric and mental health patients)
c. Need for Inpatient, Intensive and Long-term Services	**Detox**	• Provide more drug and alcohol detox programs/facilities
	Funding	• Provide additional investment in intensive outpatient
	More inpatient care	• Support investment in inpatient drug treatment • Provide more inpatient beds in the community
	More intensive outpatient programs	• Implement intensive supervision program (like HOPE in Hawaii; provides long-term accountability) • Provide more intensive follow-up to clients so conditions do not recur • Provide stable aftercare to support improvement • Provide intensive addiction outpatient services (as complement to inpatient options)
	More long-term care/hospitalization options	• Explore intensive supervised programs to encourage/promote long-term accountability • Explore options for more long-term hospitalization for mental health and addiction • Focus on long-term treatment designed to change lifestyles (includes influence of family and environmental)
	Transitional programs/halfway homes	• Explore options for transitional programs/ halfway house (specifically for the incarcerated)

(3) Availability of Treatment Options to Address Mental Health and Addiction Issues (Continued)		
Need Subcategory	**Strategy**	**Strategy Examples**
d. More Services to Treat Addiction	**Addiction addressed through court system**	• Additional drug court services to continue progress made in this area; services provided through court system may provide a model for intensive, long-term addiction treatment
	Embrace harm reduction model and priority of addressing addiction	• Ensure that treatment is designed to reduce negative outcomes of drug use
	MAT (Medication Assisted Treatment) and other addiction medicine	• Additional Medication Assisted Treatment (MAT) services in the community • More healthcare professionals in the area of addiction medicine
	Provide specific addiction medications	• Ensure availability of Suboxone and similar treatments • Ensure availability of Narcan to first responders
e. Medication Management and Treatment for Co-Occurring Issues	**Better understanding of co-occurring disorders and treatment**	• Develop understanding of the association between drug/alcohol addiction and mental health issues; addiction often impacts brain chemistry in a way that contributes to development of mental health issues
	Provide and strengthen medication management practices	• Implement outreach and community-based strategies to promote proper management of medications, possibly combined with all health-related medications • Ensure strategies involve medication in combination with effective therapeutic or counseling methods to reduce reliance on medication as an easy fix • Focus on providing full medication evaluations
	Provide assistance with medication costs	• Explore options to better help with medication costs
	Responsible prescription practices	• Work with doctors and hospitals to explore options for less prescribing of certain drugs • Ensure responsibility by doctors in writing prescriptions for most addictive medications • Closer monitoring of Suboxone and other drugs (e.g., better tracking systems)

(4) Availability of Ancillary Resources, Services, & Supports to Address Mental Health and Addiction Issues

Need Subcategory	Strategy	Strategy Examples
a. Need for Ancillary Resources, Services and Supports	**Address basic needs (food, clothing, employment)**	• Focus on meeting clients' basic needs first • Explore better job opportunities and understand association with health outcomes • Help people avoid falling through the social safety nets by connecting them with services in a timely manner
	Advocacy (1 comment)	• More advocacy for campus issues
	Affordable housing/homeless support	• Address housing needs to ensure options exist for a range of income levels • Provide better support for the homeless, including development of housing and connection to needed services
	Case Management/Care Navigators	• Provide more wrap-around services in the schools • Implement effective and targeted case management to develop better continuity of care
	Childcare (including students with special needs) (1 comment)	• Explore developmental preschool options to determine this model as a supportive and preventive option for youth
	Family support programs and services	• Determine options for group homes to keep families together during times when family members receive care • Focus services on support systems for clients (include family and community) • Provide more support for families and caretakers of those receiving treatment or in need of treatment
	Law enforcement initiatives and justice system programs/services (e.g., drug task force)	• Provide supports for getting individuals into the justice system, specifically when they have addiction issues • Determine how to better address mental health issues through court system • Continued support and funding for drug courts in all counties • Explore opportunities for a diversionary program that is more like "drug court lite"
	Provide/access support groups for recovery (e.g., AA, NA, faith-based, community centers)	• Provide more addiction-related services through churches • Offer more grief recovery support for families • More AA/NA options throughout the counties • Ensure ancillary supports exist for those in addiction recovery • Develop sober community organizations/centers where individuals may have positive environments in which to recover
	Family/parent support programs	• More focused programming on parents' needs (including what to look for with their children)

(4) Availability of Ancillary Resources, Services, & Supports to Address Mental Health and Addiction Issues (Continued)		
Need Subcategory	**Strategy**	**Strategy Examples**
b. Need for Prevention and Early Intervention	**Family/parent support programs**	• More focused programming on parents' needs (including what to look for with their children)
	Individual screening and assessment of needs	• Develop better understanding of specific individuals in the system (to better meet their needs) • Ensure use of high quality mental health and addiction assessments by trained people • Develop accurate methods of determining individual's needs (both treatment and ancillary/support needs)
	More counseling earlier in the judicial process (1 comment)	• Provide more mental health and addiction counseling earlier in the judicial process
	Programs focusing on intergenerational poverty	• Focus on breaking the family cycle of addiction • Address the impact and role of poverty on mental health and addiction issues and outcomes
	Specific prevention programs currently in place (e.g., Prevention Consultants, Bright Futures program)	• Explore options like the Bright Futures Program in Texas County to determine how to implement models in other communities • Provide more programming such as that currently offered through Prevention Consultants
	Targeted evidence based early intervention and education	• Implement evidence-based prevention programming in schools and communities • Focus on early intervention through effective screenings • Start prevention education and screenings at a young age
	Youth programming and services	• Provide positive recreational activities for teens (free or inexpensive) • Provide education in schools about mental health and addiction
	Youth programming and services	• Provide positive recreational activities for teens (free or inexpensive) • Provide education in schools about mental health and addiction

(5) Lack of Awareness of Mental Health and Addiction Issues

Need Subcategory	Strategy	Strategy Examples
a. Knowledge and Understanding of Available Resources Used to Address mental Health and Addiction Concerns	**Better advertising of/marketing & communication of available services**	• Better advertising of available services throughout the community • Explore opportunities to increase community's awareness of available services
	Case Management/Care Navigators	• Focus on better client connections to services, along with guidance on accessing • Implement and fund navigators or case workers to help with Medicaid enrollment and connect to services • Focus on connecting students to mental health and addiction resources
	Create a central/up to date community resource/provider list	• Create a central, up-to-date resource list • Ensure that resource listings are updated on a frequent basis
	Create a hotline to receive help (crisis, identifying resources)	• Anonymous reporting process for students-creating processes for students to address mental health issues • Ensure availability of a Crisis Line (hotline and warmline for less severe concerns) • Create better channels for reporting immediate needs (so emergency situations are addressed faster)
	Ensure all organizations in the community understand available services	• Awareness for all organizations about available services • More information to ancillary service providers about who they can contact when someone has a mental health or addiction concern
	Bring awareness and provide education related to mental health and addiction issues within the community	• Promote a sense of purpose in the community around the issue • Educate the community regarding mental health and addiction issues • Address stigma and taboo of mental health and addiction
b. Better Understanding of Mental Health and Addiction Concerns	**Engage the community through proactive outreach**	• Give mental health clients a voice and better understand their needs • Provide more proactive outreach to clients (meeting them where they are instead of expecting them to always go to the service) • Understand how many individuals are not getting services and falling through the cracks
	Ensure people who understand issues are involved and leading initiatives	• Identify champions and torch bearers in the community around the issues of mental health and addiction
	Provide training for non-mental health professionals (e.g., law enforcement)	• Provide additional training opportunities for law enforcement in the areas of mental health and addiction • Continue CIT trainings for law enforcement • Understand connection between addiction and crime • Help organizations such as law enforcement know how to connect people to services
	Willingness to address the issues within the community	• Determine how to help communities acknowledge the issues of mental health and addiction • Focus on promoting greater willingness to accept education and awareness (specifically by schools)

Section 3 INTERVIEWS, FOCUS GROUPS, & SURVEY RESULTS

This section details results from primary data collection methods, including interviews, focus groups, and surveys. Data were collected from direct and ancillary service providers, as well as individuals and family members with mental health and addiction concerns. Participant information and data collection procedures are outlined in Section 1. While data collection methods are presented separately, all methods were integrated to inform the primary needs, strengths, and strategies outlined in prior sections.

A. Identifying Needs and Strengths from Interviews, Focus Groups and Open-ended Survey Responses

To determine **needs and strengths** based on qualitative data, information gathered from all stakeholders, providers, and clients (individuals and family members) through qualitative data collection methods (interviews, focus groups, provider open-ended survey responses) were combined. Through these processes, specific items pertained to either the needs of the community or the strengths of the community.

Responses for each of the three areas (needs, strengths, strategies) were grouped accordingly. Once data were separated into the two main groups, each comment or statement was reviewed and individual ideas or issues were documented. Issues that were mentioned multiple times were recorded as such. After each review, some issues were noted several times across the qualitative data collection processes, whereas others may have been mentioned only once. After completion of the recording of ideas/issues, main categories were identified as encompassing the full range of ideas/issues. Given that some categories included an extensive array of issues, subcategories were also created. For instance, when examining needs, Social Determinants included categories such as Poverty and Family Dynamics.

Following development of categories and subcategories, each individual idea/issue was coded with the most related category/subcategory. All coded issues were entered into a database, which allowed for quantifying of needs, strengths, and strategies. The total number of mentioned issues and ideas that fell into each category and subcategory were calculated to determine the areas that represented the greatest needs and strengths based on the qualitative feedback from stakeholders, providers, and clients. The counts provide an indication of the magnitude of a need or strength. While several areas may be viewed as needs or strengths, some areas were mentioned more than others.

Steps to Analyzing Qualitative Findings	
Step 1	→ Reviewed and combined information gathered from all stakeholders, providers, and clients (individuals and family members) through qualitative data collection methods (interviews, focus groups, provider open-ended survey responses)
Step 2	→ Data separated into two main groups: Need and Strength
Step 3	→ Each comment or statement was reviewed and individual ideas/issues documented
Step 4	→ Recorded issues mentioned multiple times
Step 5	→ Developed main categories encompassing the full range of ideas/issues
Step 6	→ Created subcategories
Step 7	→ Based on categories and subcategories, each individual idea/issue was coded
Step 8	→ Coded issues were entered into a database, which allowed for quantifying of needs and strengths
Step 9	→ The total number of mentioned issues and ideas for each category and subcategory were calculated to determine the areas that represented the greatest needs and strengths

Categories and Subcategories of Need

Six main categories of need and 27 subcategories of need were identified. Categories and subcategories are displayed below, along with descriptions and examples of ideas/comments used to derive them.

Description of Categories and Subcategories Associated Identified Needs	
(1) Overall Prevalence of Mental Health and Addiction Issues Including Specific Diagnoses: The use of and addiction to prescription, legal, and illegal substances (including alcohol), which may or may not include multiple addictions or co-occurrence with other mental health issues; addiction issues may be diagnosed or undiagnosed. Issues pertaining to **behavioral and mental health**, including specific conditions, which may or may not include multiple conditions or co-occurrence with addiction; mental health issues may be diagnosed or undiagnosed (Note: issues were placed in this category if respondents mentioned drug addiction in general or a specific type of drug, or mental health in general or a specific condition, not if they were referring to treatment or resources for mental health)	
Drug/Alcohol Addiction: General and Specific Concerns	• Drug addiction—general (38 comments overall) • Meth (29 comments overall) • Opioids (24 comments overall) • Heroin (23 comments overall) • Alcohol addiction (20 comments overall) • Prescription drugs (8 comments overall)
Mental Health: General and Specific Concerns	• Depression (25 comments overall) • Anxiety (25 comments overall) • Suicide ideation (7 comments overall) • PTSD (6 comments) • Behavioral issues (6 comments overall) • Childhood disorders (5 comments overall)
(2) Availability of Treatment Options to Address Mental Health and Addiction Issues: The resources and services available to treat mental health and addiction issues is a primary need identified in this study. Treatment options pertain to both age-specific and general populations and relate to both mental health and addiction concerns, as well as the co-occurrence of such issues. More intensive services such as inpatient and psychiatric services are also addressed in this section.	
Lack of Counselors/Providers-General	• Lack of certified counselors • Lack of consistency with providers (client sees many different therapists) • Need for more counseling groups • Providers do not stay in community very long
Lack of Mental Health Services: Specific Populations	• Lack of specialty providers (focusing on more complex issues)
Lack of Psychiatric Services (Not specific to children)	• Lack of psychiatrists in general
Lack of Inpatient, Intensive and Long-term Services	• Need inpatient rehabilitation programs • Lack of long-term facility that does medication review and adjustment • Lack of psychiatric beds • Lack of follow-up after discharge from inpatient facility • Lack of long-term aftercare for mental health and addiction issues • Need for more intensive services to identify root causes
Lack of Services to Treat Addiction	• Lack of detoxification facilities/services • Lack of drug rehabilitation facilities/services • Lack of Suboxone and Vivitrol providers • Need for medication-assisted treatment (MAT)
Lack of Services to Treat Child/Adolescent Issues	• Lack of child psychiatrists

Medication Management Issues	• Ensuring that individuals have the appropriate medications • Ensuring that individuals take medications as prescribed • Proper medication management helps individuals manage their overall health condition, thus avoiding compounding of issues and need for more intensive services
Co-occurring Issues	• Existence of co-occurring mental health and addiction issues
(3) Structure/Operations of Systems Impacting Access to Mental Health and Addiction Services: Systems represent the ways in which communities and organizations are structured and operate including efficiencies and impacts on service delivery, along with the existence of policies, rules, and regulations that have been created and implemented at multiple levels, including organizational and governmental. Systems also represent the availability of transportation services, including public and private, the degree to which systems support modes of transportation, and the impacts on access to mental health and addiction services. Several systems issues were identified as impacting access to mental health and addiction services within the community.	
Continuity/Coordination of Care/Collaboration/Transition	• Continuity of care and lack of a discharge plan • Lack of coordination of care and how to best achieve it
Wait Times/Appointment Scheduling	• Wait times for appointments • Need for more timely appointments
Lack of Transportation/Distance	• Individuals do not have transportation to access services • Expense of transportation is high • No public transportation system • Treatment facilities are far away and difficult to reach
Costs/Affordability of Services	• Cost of services and medications
Lack of Access to Services: General	• While services exist, it is sometimes difficult to get people connected to them • Access to affordable providers is sometimes limited
Policy, Rules, Regulations, Operations	• Too many stipulations for access to services (too many gatekeepers) • Lack of admission into facility unless condition is severe • Overcoming the political nature of issues
(4) Availability of Ancillary Resources, Services, & Supports to Address Mental Health and Addiction Issues: The availability of ancillary resources and services available to support those individuals who are experiencing mental health and addiction issues is a primary need identified in this study. Ancillary supportive services, such as housing, food, and clothing, were identified as important protective factors for individuals experiencing mental health or addiction concerns.	
Lack of Ancillary Resources, Services and Supports	• Housing (16 comments) • Job skills training (7 comments) • School-based supports (5 comments) • Employment opportunities (4 comments) • Childcare (4 comments)
Need for Prevention and Early Intervention	• Lack of mental health assessments to identify issues/conditions • Lack of early intervention in general

(5) Lack of Awareness of Mental Health and Addiction Issues: Awareness of mental health and addiction issues may be divided into two separate categories, including the knowledge of existing resources in the community and a better understanding of mental health and addiction issues in general. Comprehensive, up-to-date listings of resources for particular conditions supports access to services and more timely treatment. Greater awareness about mental health and addiction issues in general helps to prevent stigma associated with accessing services, promotes support throughout the community for addressing issues, and helps individuals know when they should seek help for their concerns.

Education/Understanding of Mental Health/Addiction	• Lack of community education about the impact of drugs • Lack of community understanding of addiction • Improved awareness of recognizing when an individual needs help
Lack of Awareness in General	• General lack of awareness about mental health and addiction
Knowledge of Resources/Services and Options	• Need for improved communication and awareness about existing services (for community, clients and providers) • Need for improved community resource directory • Lack of understanding about how to navigate the mental health treatment system
Community Norms/Culture	• Stigma specific to mental health • Fear of reporting drug-related issues; mistrust of the system (law enforcement and treatment providers)

(6) Social Determinants (conditions in which people are born, grow, live, work and age): The role of social determinants such as poverty and family dynamics is significant in whether needed services are accessed and the effectiveness of treatment. These issues demonstrate the complexity of addressing mental health and addiction issues in the context of many different social variables.

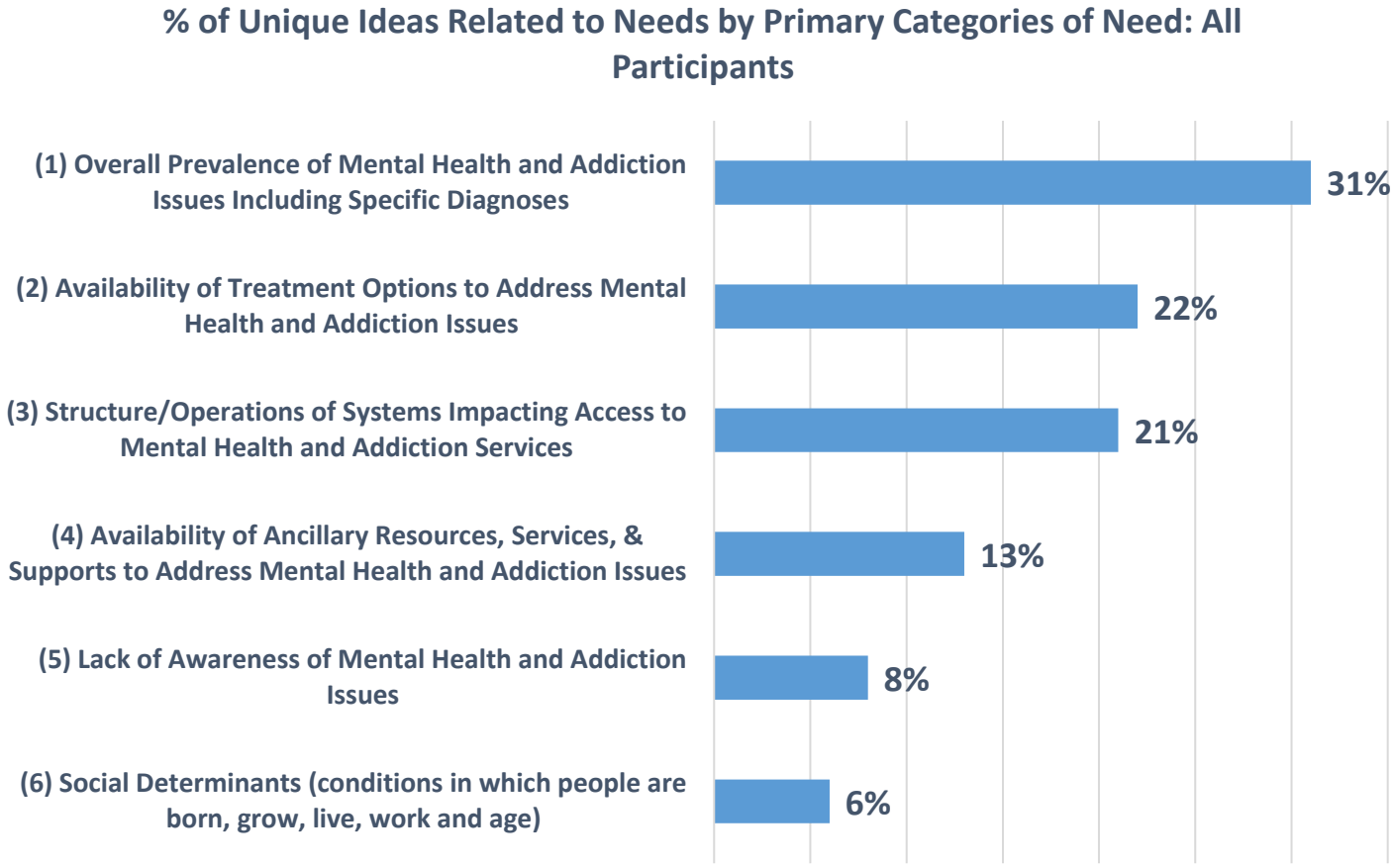
Crime	• Drug-related crime • Property crime
Environment	• Environment does not facilitate client change (presence of risk factors in personal environment) • Environmental stressors
Family	• Children dealing with consequences of family mental health or addiction issues Family cycle/culture of addiction • Need for parent education programs • Client remaining in a family environment that does not facilitate change
Personal Decision Making	• Individuals choose to self-medicate to treat their condition • Individuals are not willing to get help for their issue • People burning bridges with their support systems
Physical Health	• Need to address physical health issues • Chronic physical illness
Poverty	• Inability to pay for services (general) and medications • Treatment for complex psychiatric issues is not affordable for many • Lack of insurance and underinsurance (due to low-income status)

Identified Needs

As noted above, six primary categories of need were identified. The following figure displays the total percentage of unique ideas related to the primary need areas based on qualitative data collection methods (interviews, focus groups, and provider open-ended survey items from all surveys employed in the study).

To understand the frequency with which specific areas were mentioned, the number of times an issue pertaining to the area was mentioned is noted, and disaggregated by provider survey, stakeholder interview, and provider and client (including family) focus group participants. For example, drug addiction issues (under prevalence) were mentioned 177 times, 116 times by providers (based on survey responses), 34 times by key stakeholders (based on interviews), 13 times by providers (based on focus groups), and 14 times by clients (based on focus groups). Importantly, due to differences in sample sizes, the number of times an issue was mentioned should not be compared between providers and clients. Instead, when making comparisons, counts and percentages within participant responses are the most appropriate comparison. Also, further client qualitative data are presented later in this report and should be considered within the overall context of identified needs.

As shown below, with 31% of unique ideas falling in the category, participants mostly highlighted the overall prevalence of mental health and addiction issues within the area compared to other need areas. The overall need categories are displayed below, followed by detailed results for each subcategory and participant group.



How to read the following tables:

→ **Example: Lack of Counselors/Providers-General**: Of the 958 unique ideas/individual comments provided across the 229 interview and focus group participants, 215 comments were categorized under the main category of *Availability of Treatment Options to Address Mental Health and Addiction*, which represented 22% of all main categories of need. Within this main category, 37 comments were categorized under *Lack of Counselors/Providers-General,* which represented 4% of all subcategories of need. Examples of this subcategory may be found in the preceding table.

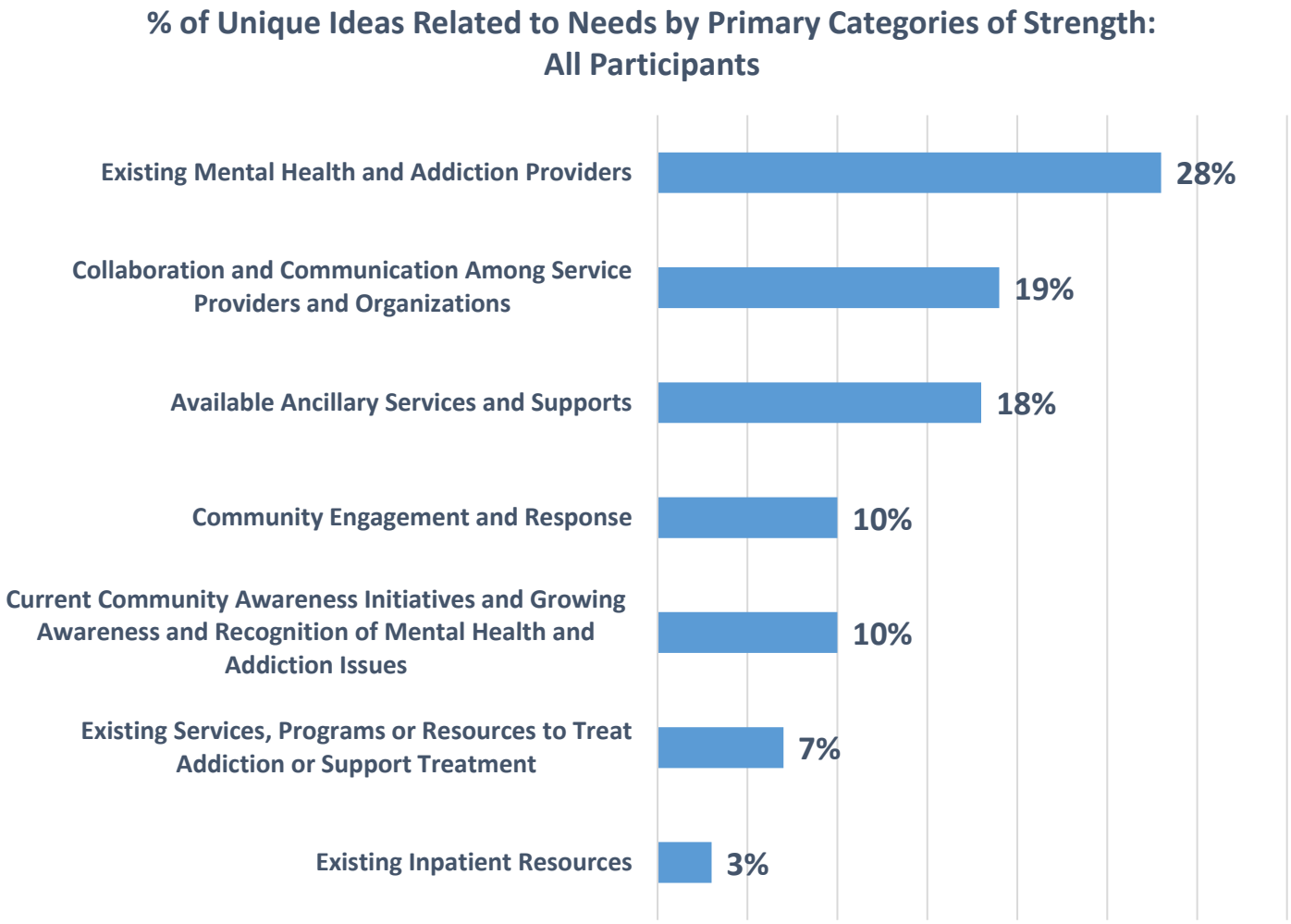
Primary Mental Health and Addiction Categories of Need: Direct/Ancillary Service Provider Surveys (Provider Surveys), Stakeholder Interviews, Provider Focus Groups, and Client Focus Groups

Note: A total of 230 participants provided 958 unique ideas. Counts and percentages are based on unique ideas.

Main Category/Subcategory	Provider Surveys N=153		Stakeholder Interviews N=23		Provider Focus Grps N=26		Client Focus Grps N=28		Total N=229	
	n	%	n	%	n	%	n	%	n	%
(1) Overall Prevalence of Mental Health and Addiction Issues Including Specific Diagnoses	**204**	**51%**	**61**	**27%**	**15**	**10%**	**15**	**8%**	**295**	**31%**
Drug/Alcohol Addiction: General and Specific Concerns	116	**29%**	34	**15%**	13	**9%**	14	**8%**	177	**18%**
Mental Health: General and Specific Concerns	88	**22%**	27	**12%**	2	**1%**	1	**1%**	118	**12%**
(2) Availability of Treatment Options to Address Mental Health and Addiction Issues	**88**	**22%**	**58**	**25%**	**35**	**23%**	**34**	**19%**	**215**	**22%**
Lack of Counselors/Providers-General	21	**5%**	2	**1%**	5	**3%**	9	**5%**	37	**4%**
Lack of Mental Health Services: Specific Populations	4	**1%**	4	**2%**	---	**---**	1	**1%**	9	**1%**
Lack of Psychiatric Services (Not specific to children)	2	**1%**	5	**2%**	4	**3%**	1	**1%**	12	**1%**
Lack of Inpatient, Intensive and Long-term Services	18	**5%**	24	**10%**	6	**4%**	3	**2%**	51	**5%**
Lack of Services to Treat Addiction	22	**6%**	11	**5%**	9	**6%**	11	**6%**	53	**6%**
Lack of Services to Treat Child/Adolescent Issues	19	**5%**	7	**3%**	7	**5%**	1	**1%**	34	**4%**
Medication Management Issues	---	**---**	3	**1%**	3	**2%**	6	**3%**	12	**1%**
Co-occurring Issues	2	**1%**	2	**1%**	1	**1%**	2	**1%**	7	**1%**
(3) Structure/Operations of Systems Impacting Access to Mental Health and Addiction Services	**50**	**13%**	**52**	**23%**	**46**	**31%**	**51**	**28%**	**199**	**21%**
Continuity/Coordination of Care/Collaboration/Transition	3	**1%**	4	**2%**	10	**7%**	5	**3%**	22	**2%**
Wait Times/Appointment Scheduling	5	**1%**	5	**2%**	3	**2%**	4	**2%**	17	**2%**
Lack of Transportation/Distance	13	**3%**	16	**7%**	12	**8%**	27	**15%**	68	**7%**
Costs/Affordability of Services	26	**7%**	11	**5%**	12	**8%**	8	**4%**	57	**6%**
Lack of Access to Services: General	1	**0%**	9	**4%**	5	**3%**	3	**2%**	18	**2%**
Policy, Rules, Regulations, Operations	2	**1%**	7	**3%**	4	**3%**	4	**2%**	17	**2%**
(4) Availability of Ancillary Resources, Services, & Supports to Address Mental Health and Addiction Issues	**21**	**5%**	**33**	**14%**	**23**	**15%**	**46**	**26%**	**123**	**13%**
Lack of Ancillary Resources, Services and Supports	12	**3%**	24	**10%**	19	**13%**	43	**24%**	98	**10%**
Need for Prevention and Early Intervention	9	**2%**	9	**4%**	4	**3%**	3	**2%**	25	**3%**
(5) Lack of Awareness of Mental Health/Addiction Issues	**14**	**4%**	**16**	**7%**	**18**	**12%**	**25**	**14%**	**73**	**8%**
Education/Understanding of Mental Health/Addiction	6	**2%**	4	**2%**	7	**5%**	17	**9%**	34	**4%**
Knowledge of Resources/Services and Options	7	**2%**	4	**2%**	5	**3%**	3	**2%**	19	**2%**
Community Norms/Culture	1	**0%**	8	**3%**	6	**4%**	5	**3%**	20	**2%**
(6) Social Determinants (conditions in which people are born, grow, live, work and age)	**23**	**6%**	**9**	**4%**	**13**	**9%**	**8**	**4%**	**53**	**6%**
Crime	---	**---**	2	**1%**	---	**---**	---	**---**	2	**0%**
Environment	2	**1%**	---	**---**	---	**---**	---	**---**	2	**0%**
Family	13	**3%**	2	**1%**	4	**3%**	3	**2%**	22	**2%**
Personal Decision Making	5	**1%**	5	**2%**	7	**5%**	3	**2%**	20	**2%**
Physical Health	3	**1%**	---	**---**	---	**---**	---	**---**	3	**0%**
Poverty	---	**---**	---	**---**	2	**1%**	2	**1%**	4	**0%**
TOTAL	400	100%	229	100%	150	100%	179	100%	958	100%

Categories and Subcategories of Strength

Seven main categories of strength were identified. As shown below, nearly a third of participants identified existing mental health and addiction providers as a strength in the area. Overall categories of strength are first displayed and detailed in the table below, including examples of ideas/comments used to derive them.



Primary Mental Health and Addiction Categories of Strength: Direct/Ancillary Service Provider Surveys (Provider Surveys), Stakeholder Interviews, Provider Focus Groups, and Client Focus Groups *Note: A total of 230 participants provided 239 unique ideas. Counts and percentages are based on unique ideas.*											
Categories	**Examples**	**Provider Surveys N=153**		**Stake-holder Interviews N=23**		**Provider Focus Grps N=26**		**Client Focus Grps N=28**		**Total N=229**	
		n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	**n**	**%**
Existing Mental Health and Addiction Providers	• Specific providers identified (e.g., A Place for Grace, Pathways, Phelps County Regional Medical Center (PCMRC), Ozarks Medical Center, Mercy Clinic, Your Community Health Center, SEMO) • Counseling/therapy groups • Specific individuals listed	32	**32%**	16	**19%**	16	**48%**	4	**19%**	68	**28%**
Collaboration and Communication Among Service Providers and Organizations	• Crisis Intervention Team (CIT) • Systems of Care • Intra-agency connections • Cooperation and shared resources • Community roundtable discussions (involving law enforcement)	22	**22%**	19	**22%**	4	**12%**	1	**5%**	46	**19%**
Available Ancillary Services and Supports	• Specific programs (Celebrate Recovery, Drug Task Force, Backpack Program) • Support groups (e.g., AA, NA, Alanon, Alateen, Church groups) • Schools supports (e.g., counselors) • Law enforcement and court system	19	**19%**	14	**17%**	5	**15%**	6	**29%**	44	**18%**
Community Engagement and Response	• Caring people within the community • Needs assessment process • Desire to do better and help	9	**9%**	9	**11%**	4	**12%**	2	**10%**	24	**10%**
Current Community Awareness Initiatives and Growing Awareness and Recognition of Mental Health and Addiction Issues	• Increased awareness of the need • Openness to more services in the community • Individuals willing to get treatment • Bystander intervention and S&T • Drug education efforts • Mental health first aid trainings in the community	8	**8%**	13	**15%**	2	**6%**	0	**0%**	23	**10%**
Existing Services, Programs or Resources to Treat Addiction or Support Treatment	• Drug Court • Law enforcement use and availability of Narcan • Specific programs offered by providers (e.g., rehab facilities, free clinic for drug addiction, detox)	5	**5%**	7	**8%**	1	**3%**	4	**19%**	17	**7%**
No Strengths Identified	• No strengths (“none”)	3	**3%**	2	**2%**	1	**3%**	4	**19%**	10	**4%**
Existing Inpatient Resources	• Specific facility mentioned (e.g., PCMRC Stress Center, New Vision Drug treatment facility)	2	**2%**	5	**6%**	0	**0%**	0	**0%**	7	**3%**
	Total	**100**	**100%**	**85**	**100%**	**33**	**100%**	**21**	**100%**	**239**	**100%**

Identifying Strategies

Client and provider focus group and stakeholder interview participants were asked to identify potential strategies and priorities to address the needs they had identified. The potential strategies were first grouped into common strategy themes. Next, these themes were linked with the main subcategories of need outlined within Section 2 (Synthesis of Needs, Strengths, and Strategies). Unlike the analysis of needs and strengths, the frequency with which a unique strategy idea was presented did not preclude the strategy from being considered a theme. This approach was intended to maximize the availability of strategies to consider in subsequent planning. Importantly, this method does not account for the feasibility or appropriateness of the suggested strategy.

Strategy themes are displayed below, along with the frequency with which the strategy was identified by participant groups. This display is useful in understanding various approaches to addressing the need. Importantly, to aid in interpretation, examples of strategy themes are provided in Section 2 (Synthesis of Strategies).

Potential Strategies by Primary Mental Health and Addiction Need Areas (based on needs identified within Section 2)
Note: A total of 77 participants provided 274 unique ideas. Counts and percentages are based on unique ideas.

Identified Need Areas and Potential Strategy Themes	Client Focus Grps N=28		Stakeholder Interviews N=23		Provider Focus Grps N=26		Total N=76	
	n	%	n	%	n	%	n	%
Better Understanding of Mental Health and Addiction Concerns	**7**	**11%**	**32**	**22%**	**12**	**19%**	**51**	**19%**
Bring awareness/education related to mental health and addiction issues within the community, as well as the importance of receiving services	3	**5%**	15	**10%**	5	**8%**	23	**8%**
Engage/involve the community through proactive outreach	2	**3%**	12	**8%**	1	**2%**	15	**5%**
Ensure people who understand issues are involved and leading initiatives	0	**0%**	2	**1%**	1	**2%**	3	**1%**
Mentorship programs	0	**0%**	0	**0%**	1	**2%**	1	**0%**
Training for non-mental health professionals (e.g., law enforcement)	1	**2%**	1	**1%**	3	**5%**	4	**1%**
Willingness to address issues	1	**2%**	2	**1%**	1	**2%**	4	**1%**
Continuity of Care/Coordination of Services/Transition	**0**	**0%**	**25**	**17%**	**12**	**19%**	**37**	**14%**
Case Management/Care Navigators	0	**0%**	2	**1%**	0	**0%**	2	**1%**
Continue and strengthen collaborative services and initiatives	0	**0%**	22	**15%**	10	**16%**	32	**12%**
Improve transitions for individuals who are incarcerated	0	**0%**	1	**1%**	1	**2%**	2	**1%**
Transitional programs/halfway homes	0	**0%**	0	**0%**	1	**2%**	1	**0%**
Costs/Affordability of Services	**1**	**2%**	**0**	**0%**	**2**	**3%**	**3**	**1%**
Insurance options	0	**0%**	0	**0%**	1	**2%**	1	**0%**
Services for low-income individuals (e.g., sliding scale fee structures)	1	**2%**	0	**0%**	1	**2%**	2	**1%**
Need for Inpatient, Intensive and Long-term Services	**0**	**0%**	**14**	**10%**	**3**	**5%**	**17**	**6%**
Detox	0	**0%**	1	**1%**	0	**0%**	1	**0%**
Funding	0	**0%**	2	**1%**	0	**0%**	2	**1%**
More inpatient care	0	**0%**	4	**3%**	1	**2%**	5	**2%**
More intensive outpatient programs	0	**0%**	4	**3%**	1	**2%**	5	**2%**
More long-term care/hospitalization options	0	**0%**	3	**2%**	1	**2%**	4	**1%**
Knowledge and Understanding of Available Resources	**4**	**6%**	**5**	**3%**	**9**	**14%**	**18**	**7%**
Better advertising of/marketing/communication of available services	2	**3%**	0	**0%**	2	**3%**	4	**1%**
Case Management/Care Navigators	0	**0%**	1	**1%**	4	**6%**	5	**2%**
Create a central/up to date community resource/provider list	0	**0%**	1	**1%**	1	**2%**	2	**1%**
Create a hotline to receive help (crisis, identifying resources)	2	**3%**	2	**1%**	0	**0%**	4	**1%**
Ensure all organizations in the community understand available services	0	**0%**	1	**1%**	2	**3%**	3	**1%**
Lack of Transportation/Distance	**3**	**5%**	**5**	**3%**	**3**	**5%**	**11**	**4%**
Create/identify affordable and accessible transportation systems/options	2	**3%**	2	**1%**	3	**5%**	7	**3%**
Provide satellite facilities/clinics within counties	1	**2%**	2	**1%**	1	**2%**	4	**1%**
Telehealth	0	**0%**	1	**1%**	0	**0%**	1	**0%**

Identified Need Areas and Potential Strategy Themes	Client Focus Grps N=28		Stakeholder Interviews N=23		Provider Focus Grps N=26		Total N=76	
	n	%	n	%	n	%	n	%
Medication Management and Treatment for Co-Occurring Issues	**5**	**8%**	**5**	**3%**	**6**	**9%**	**16**	**6%**
Better understanding of co-occurring disorders and treatment	1	**2%**	2	**1%**	3	**5%**	6	**2%**
Provide and strengthen medication management practices	3	**5%**	1	**1%**	2	**3%**	6	**2%**
Provide assistance with medication costs	0	**0%**	0	**0%**	1	**2%**	1	**0%**
Responsible prescription practices	1	**2%**	2	**1%**	0	**0%**	3	**1%**
More Services Needed to Treat Addiction	**1**	**2%**	**6**	**4%**	**0**	**0%**	**7**	**3%**
Embrace harm reduction model	0	**0%**	1	**1%**	0	**0%**	1	**0%**
MAT (Medication Assisted Treatment)	0	**0%**	3	**2%**	0	**0%**	3	**1%**
Provide specific addiction medications	0	**0%**	2	**1%**	0	**0%**	2	**1%**
Reduce addiction in general	1	**2%**	0	**0%**	0	**0%**	1	**0%**
Need for Ancillary Resources, Services and Supports	**18**	**29%**	**17**	**12%**	**8**	**13%**	**43**	**16%**
Address basic needs (food, clothing, employment)	1	**2%**	1	**1%**	2	**3%**	4	**1%**
Advocacy	0	**0%**	1	**1%**	0	**0%**	1	**0%**
Affordable housing/homeless support	1	**2%**	2	**1%**	4	**6%**	7	**3%**
Case Management/Care Navigators	1	**2%**	1	**1%**	0	**0%**	2	**1%**
Childcare (including students with special needs)	1	**2%**	0	**0%**	0	**0%**	1	**0%**
Family support programs and services	5	**8%**	0	**0%**	1	**2%**	6	**2%**
Law enforcement initiatives and justice system programs/services (e.g., drug task force)	4	**6%**	3	**2%**	0	**0%**	7	**3%**
More services/resources in general	1	**2%**	5	**3%**	0	**0%**	6	**2%**
Primary healthcare	1	**2%**	0	**0%**	0	**0%**	1	**0%**
Provide/access support groups for recovery (e.g., AA, NA, faith-based)	3	**5%**	4	**3%**	1	**2%**	8	**3%**
Need for Counselors/Providers (General) and Psychiatric Services	**14**	**22%**	**6**	**4%**	**2**	**3%**	**22**	**8%**
More counselors/providers and psychiatric services	14	**22%**	6	**4%**	2	**3%**	22	**8%**
Need for Mental Health Services for Special Populations and Treatment of Child/Adolescent Issues	**1**	**2%**	**6**	**4%**	**1**	**2%**	**8**	**3%**
Address suicidal ideation among students	0	**0%**	1	**1%**	0	**0%**	1	**0%**
Better addiction and mental health services for students and youth	0	**0%**	2	**1%**	0	**0%**	2	**1%**
Better/alternative options for people w/developmental disorders	1	**2%**	1	**1%**	0	**0%**	2	**1%**
Help students stay in school while receiving services	0	**0%**	1	**1%**	0	**0%**	1	**0%**
More child psychiatrists	0	**0%**	0	**0%**	1	**2%**	1	**0%**
Treatment options for geriatric population	0	**0%**	1	**1%**	0	**0%**	1	**0%**
Need for Prevention and Early Intervention	**7**	**11%**	**14**	**10%**	**5**	**8%**	**26**	**9%**
Family/parent support programs	2	**3%**	0	**0%**	0	**0%**	2	**1%**
Individual screening and assessment of needs	0	**0%**	4	**3%**	1	**2%**	5	**2%**
More counseling earlier in the judicial process	0	**0%**	0	**0%**	1	**2%**	1	**0%**
Programs focusing on intergenerational poverty	2	**3%**	0	**0%**	1	**2%**	3	**1%**
Specific prevention programs currently in place	0	**0%**	3	**2%**	0	**0%**	3	**1%**
Targeted evidence based early intervention and education	0	**0%**	7	**5%**	1	**2%**	8	**3%**
Youth programming and services	3	**5%**	0	**0%**	1	**2%**	4	**1%**
Policy, Rules, Regulations, Operations (Wait Times/Appoint. Scheduling)	**0**	**0%**	**8**	**5%**	**1**	**2%**	**9**	**3%**
Review policies for accessing services to ensure access to treatment	0	**0%**	8	**5%**	1	**2%**	9	**3%**
All Need Areas: General Access to Services/Treatment	2	**3%**	4	**3%**	0	**0%**	6	**2%**
Pursue/use grants and other funding	1	**2%**	3	**2%**	0	**0%**	4	**1%**
Meaningful, effective access to services	0	**0%**	1	**1%**	0	**0%**	1	**0%**
Spiritual foundation	1	**2%**	0	**0%**	0	**0%**	1	**0%**
Total	**63**	**100%**	**147**	**100%**	**64**	**100%**	**274**	**100%**

B. Frequency of Need and Service Received Subscale: Direct/Ancillary Providers

Direct and ancillary service providers completed the **Frequency of Need and Service Received Subscale** as part of the overall survey administered to providers. This scale included a list of specific areas needed by provider organizations' clients, including both treatment and ancillary services.

- To complete the scale, providers first indicated whether their clients have a need for a particular service or resource (response options: "Yes" or "No"). If a provider answered "Yes," they next indicated how often their clients have a need for the resource, using the following scale options: 1=Almost Never, 2=Rarely, 3=Sometimes, 4=Often, 5=Almost Always. Additionally, the provider indicated how often their clients receive the resources using the same frequency scale (1=Almost Never to 5=Almost Always).

The following tables present need areas based on the degree of need identified by provider survey respondents. First, the percentage of providers that indicated the service/resource was needed by clients is shown. (Note that the need areas are sorted by this percentage in descending order.) For the frequency of service needed and received items, response options were divided into "High" and "Low" need categories. Areas were categorized as "High" need if providers selected "Often" or "Almost Always" in reference to the frequency of service needed and received. Areas were deemed "Low" need if they selected response options of "Sometimes," "Rarely," or "Almost Never."

The following tables are broken down into direct service providers and ancillary service providers. Due to differences in primary populations served, ancillary providers were further divided into schools/early childhood centers and other organizations. In some cases, the direct and ancillary provider survey responses are further divided into specific counties served by the organizations. When interpreting county-level breakdowns, it is important to note that some organizations serve multiple counties and surveys did not differentiate responses between counties being served. Therefore, provider responses may be duplicated across counties. For example, Phelps Regional Medical Center serves all counties in the study area and their responses would be treated the same for all counties. The same data analysis described above was used for each grouping.

How to read the following tables:

→ **Information and referral services**: 97% of providers indicated that their clients have a need for information and referral services. Of those providers, 58% indicated that the frequency of this need was high, and 42% indicated the frequency of the need was low. Additionally, 66% of providers indicated their clients receive the service at a high (or frequent) level, whereas 34% indicated clients receive the service at a low, or infrequent, level.

Frequency of Clients Needing and Receiving Services: Providers (All Counties)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	34	97%	58%	42%	66%	34%
A	Transportation services (i.e., getting to and from appointments)	34	91%	45%	55%	24%	76%
J	Case management	34	91%	42%	58%	47%	53%
K	Individual therapy and/or counseling	34	91%	74%	26%	70%	30%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	33	88%	69%	31%	71%	29%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	33	88%	61%	39%	56%	44%
O	Emergency and crisis services (i.e., after hours or emergencies)	34	82%	25%	75%	59%	41%
Q	Home-based services (i.e., services provided at the home of clients)	33	82%	30%	70%	54%	46%
L	Group therapy and/or counseling	34	79%	48%	52%	50%	50%
M	Family therapy and/or counseling	34	79%	44%	56%	56%	44%
N	Psychological testing	33	79%	35%	65%	32%	68%
P	Family support services (i.e., services provided to family members of clients such as respite care)	34	74%	38%	63%	30%	70%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	33	73%	52%	48%	59%	41%
II	Drug screening services	33	73%	42%	58%	61%	39%
R	Independent living services	33	67%	18%	82%	38%	62%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	33	67%	32%	68%	19%	81%
JJ	General daily living activities	33	67%	36%	64%	48%	52%
S	In-home family services (family counseling provided in the home, etc.)	33	64%	24%	76%	37%	63%
T	Mental retardation/developmental disability services	33	64%	14%	86%	40%	60%
HH	Neuropsychological services	33	64%	14%	86%	30%	70%
V	Supported employment (i.e., assistance in obtaining employment)	33	61%	40%	60%	32%	68%
EE	Parenting education (i.e., training in appropriate parenting techniques)	33	61%	45%	55%	32%	68%
GG	Specialized services for the elderly	33	61%	25%	75%	37%	63%
D	Housing services (i.e., assistance in locating housing)	34	59%	30%	70%	26%	74%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	33	58%	26%	74%	17%	83%
B	Assistance to non-English speaking individuals	34	56%	10%	90%	21%	79%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	34	53%	22%	78%	29%	71%
H	Legal advocacy	34	53%	26%	74%	11%	89%
U	School-based services (social work or case management services contracted with schools, etc.)	33	52%	25%	75%	40%	60%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	33	45%	27%	73%	36%	64%
E	Payeeships (i.e., financial guardianship)	34	44%	6%	94%	14%	86%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	34	44%	27%	73%	29%	71%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	33	42%	36%	64%	15%	85%
DD	Meal services (i.e., meals provided to those receiving treatment)	33	42%	7%	93%	31%	69%
C	Assistance to hearing-impaired individuals	34	38%	0%	100%	33%	67%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	32	31%	30%	70%	33%	67%

Frequency of Clients Needing and Receiving Services: Schools/Early Childhood Centers (All Counties)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
K	Individual therapy and/or counseling	31	100%	58%	42%	32%	68%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	29	97%	64%	36%	46%	54%
M	Family therapy and/or counseling	30	87%	41%	59%	16%	84%
A	Transportation services (i.e., getting to and from appointments)	30	83%	50%	50%	8%	92%
U	School-based services (social work or case management services contracted with schools, etc.)	29	79%	57%	43%	33%	67%
L	Group therapy and/or counseling	29	76%	45%	55%	24%	76%
N	Psychological testing	29	76%	17%	83%	27%	73%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	30	70%	10%	90%	16%	84%
D	Housing services (i.e., assistance in locating housing)	29	66%	21%	79%	18%	82%
O	Emergency and crisis services (i.e., after hours or emergencies)	29	66%	26%	74%	28%	72%
EE	Parenting education (i.e., training in appropriate parenting techniques)	29	66%	40%	60%	11%	89%
S	In-home family services (family counseling provided in the home, etc.)	29	62%	16%	84%	13%	88%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	30	60%	32%	68%	17%	83%
Q	Home-based services (i.e., services provided at the home of clients)	29	59%	33%	67%	24%	76%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	29	59%	22%	78%	12%	88%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	29	52%	69%	31%	21%	79%
P	Family support services (i.e., services provided to family members of clients such as respite care)	29	48%	25%	75%	7%	93%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	29	48%	20%	80%	0%	100%
T	Mental retardation/developmental disability services	28	46%	7%	93%	38%	62%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	28	46%	36%	64%	31%	69%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	29	45%	43%	57%	21%	79%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	29	38%	45%	55%	25%	75%
J	Case management	27	37%	36%	64%	45%	55%
H	Legal advocacy	28	36%	18%	82%	20%	80%
V	Supported employment (i.e., assistance in obtaining employment)	28	36%	27%	73%	20%	80%
HH	Neuropsychological services	28	32%	11%	89%	10%	90%
B	Assistance to non-English speaking individuals	29	31%	0%	100%	20%	80%
II	Drug screening services	29	31%	20%	80%	38%	63%
C	Assistance to hearing-impaired individuals	28	29%	0%	100%	22%	78%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	28	29%	33%	67%	22%	78%
DD	Meal services (i.e., meals provided to those receiving treatment)	29	28%	25%	75%	25%	75%
E	Payeeships (i.e., financial guardianship)	29	21%	14%	86%	14%	86%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	28	14%	0%	100%	60%	40%
R	Independent living services	28	14%	0%	100%	0%	100%
JJ	General daily living activities	28	14%	25%	75%	25%	75%
GG	Specialized services for the elderly	28	7%	0%	100%	0%	100%

Frequency of Clients Needing and Receiving Services: Non School Ancillary Providers (All Counties)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	66	89%	55%	45%	28%	72%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	62	89%	76%	24%	71%	29%
D	Housing services (i.e., assistance in locating housing)	63	79%	52%	48%	41%	59%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	64	77%	33%	67%	36%	64%
K	Individual therapy and/or counseling	62	74%	56%	44%	44%	56%
O	Emergency and crisis services (i.e., after hours or emergencies)	62	73%	35%	65%	44%	56%
L	Group therapy and/or counseling	59	69%	55%	45%	39%	61%
M	Family therapy and/or counseling	62	68%	45%	55%	33%	68%
V	Supported employment (i.e., assistance in obtaining employment)	62	65%	56%	44%	33%	67%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	60	63%	54%	46%	26%	74%
J	Case management	59	61%	64%	36%	60%	40%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	59	61%	73%	27%	44%	56%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	58	59%	44%	56%	24%	76%
H	Legal advocacy	62	58%	39%	61%	47%	53%
EE	Parenting education (i.e., training in appropriate parenting techniques)	60	58%	50%	50%	35%	65%
N	Psychological testing	61	52%	28%	72%	23%	77%
P	Family support services (i.e., services provided to family members of clients such as respite care)	58	47%	52%	48%	48%	52%
Q	Home-based services (i.e., services provided at the home of clients)	59	46%	54%	46%	65%	35%
S	In-home family services (family counseling provided in the home, etc.)	58	45%	29%	71%	17%	83%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	58	45%	50%	50%	42%	58%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	58	45%	40%	60%	20%	80%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	62	42%	50%	50%	64%	36%
C	Assistance to hearing-impaired individuals	61	41%	17%	83%	39%	61%
GG	Specialized services for the elderly	56	41%	52%	48%	48%	52%
II	Drug screening services	61	41%	36%	64%	29%	71%
B	Assistance to non-English speaking individuals	60	40%	8%	92%	33%	67%
R	Independent living services	56	39%	33%	67%	36%	64%
DD	Meal services (i.e., meals provided to those receiving treatment)	57	39%	47%	53%	45%	55%
T	Mental retardation/developmental disability services	58	38%	48%	52%	39%	61%
E	Payeeships (i.e., financial guardianship)	57	35%	17%	83%	18%	82%
JJ	General daily living activities	55	35%	58%	42%	56%	44%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	58	33%	61%	39%	26%	74%
U	School-based services (social work or case management services contracted with schools, etc.)	57	30%	27%	73%	19%	81%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	57	23%	64%	36%	38%	62%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	58	22%	25%	75%	15%	85%
HH	Neuropsychological services	55	15%	57%	43%	29%	71%

Frequency of Clients Needing and Receiving Services: Providers (Crawford)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	13	100%	38%	62%	18%	82%
J	Case management	13	100%	31%	69%	50%	50%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	13	92%	50%	50%	55%	45%
K	Individual therapy and/or counseling	13	85%	64%	36%	60%	40%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	13	85%	64%	36%	70%	30%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	13	85%	50%	50%	56%	44%
L	Group therapy and/or counseling	13	77%	40%	60%	56%	44%
M	Family therapy and/or counseling	13	77%	40%	60%	56%	44%
O	Emergency and crisis services (i.e., after hours or emergencies)	13	77%	30%	70%	56%	44%
Q	Home-based services (i.e., services provided at the home of clients)	13	77%	20%	80%	67%	33%
N	Psychological testing	12	75%	33%	67%	38%	63%
D	Housing services (i.e., assistance in locating housing)	13	69%	33%	67%	25%	75%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	13	69%	22%	78%	38%	63%
P	Family support services (i.e., services provided to family members of clients such as respite care)	13	69%	22%	78%	25%	75%
T	Mental retardation/developmental disability services	13	69%	11%	89%	25%	75%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	13	69%	38%	63%	57%	43%
JJ	General daily living activities	13	69%	33%	67%	50%	50%
B	Assistance to non-English speaking individuals	13	62%	11%	89%	25%	75%
E	Payeeships (i.e., financial guardianship)	13	62%	13%	88%	14%	86%
R	Independent living services	13	62%	13%	88%	43%	57%
S	In-home family services (family counseling provided in the home, etc.)	13	62%	13%	88%	14%	86%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	13	62%	25%	75%	29%	71%
GG	Specialized services for the elderly	13	62%	13%	88%	29%	71%
HH	Neuropsychological services	13	62%	25%	75%	43%	57%
II	Drug screening services	13	62%	25%	75%	57%	43%
C	Assistance to hearing-impaired individuals	13	54%	0%	100%	17%	83%
H	Legal advocacy	13	54%	14%	86%	17%	83%
V	Supported employment (i.e., assistance in obtaining employment)	13	54%	29%	71%	33%	67%
U	School-based services (social work or case management services contracted with schools, etc.)	13	46%	0%	100%	25%	75%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	13	46%	17%	83%	40%	60%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	13	46%	17%	83%	20%	80%
DD	Meal services (i.e., meals provided to those receiving treatment)	13	46%	0%	100%	20%	80%
EE	Parenting education (i.e., training in appropriate parenting techniques)	13	46%	67%	33%	60%	40%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	13	38%	20%	80%	25%	75%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	13	31%	75%	25%	67%	33%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	13	23%	0%	100%	0%	100%

Frequency of Clients Needing and Receiving Services: Ancillary Service Providers-Combined (Crawford)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	28	96%	68%	32%	38%	63%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	28	93%	74%	26%	75%	25%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	28	86%	22%	78%	27%	73%
K	Individual therapy and/or counseling	26	85%	50%	50%	43%	57%
O	Emergency and crisis services (i.e., after hours or emergencies)	27	81%	36%	64%	57%	43%
D	Housing services (i.e., assistance in locating housing)	27	78%	45%	55%	37%	63%
M	Family therapy and/or counseling	26	77%	56%	44%	42%	58%
L	Group therapy and/or counseling	25	76%	59%	41%	42%	58%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	25	76%	74%	26%	50%	50%
EE	Parenting education (i.e., training in appropriate parenting techniques)	25	72%	58%	42%	28%	72%
V	Supported employment (i.e., assistance in obtaining employment)	24	71%	56%	44%	38%	63%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	24	67%	44%	56%	13%	87%
N	Psychological testing	26	65%	19%	81%	25%	75%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	25	64%	56%	44%	43%	57%
J	Case management	24	63%	64%	36%	60%	40%
H	Legal advocacy	26	62%	27%	73%	43%	57%
Q	Home-based services (i.e., services provided at the home of clients)	25	56%	62%	38%	71%	29%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	25	56%	50%	50%	38%	62%
II	Drug screening services	25	56%	36%	64%	36%	64%
T	Mental retardation/developmental disability services	24	54%	54%	46%	62%	38%
S	In-home family services (family counseling provided in the home, etc.)	25	52%	33%	67%	17%	83%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	25	52%	57%	43%	46%	54%
JJ	General daily living activities	21	52%	73%	27%	80%	20%
B	Assistance to non-English speaking individuals	27	48%	14%	86%	43%	57%
C	Assistance to hearing-impaired individuals	27	48%	15%	85%	50%	50%
R	Independent living services	23	48%	36%	64%	45%	55%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	25	48%	67%	33%	25%	75%
P	Family support services (i.e., services provided to family members of clients such as respite care)	25	44%	50%	50%	45%	55%
U	School-based services (social work or case management services contracted with schools, etc.)	23	43%	40%	60%	33%	67%
E	Payeeships (i.e., financial guardianship)	24	42%	27%	73%	22%	78%
DD	Meal services (i.e., meals provided to those receiving treatment)	24	42%	40%	60%	44%	56%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	24	38%	56%	44%	33%	67%
GG	Specialized services for the elderly	22	36%	25%	75%	38%	63%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	26	35%	50%	50%	75%	25%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	24	33%	13%	88%	25%	75%
HH	Neuropsychological services	22	14%	67%	33%	33%	67%

Frequency of Clients Needing and Receiving Services: Providers (Dent)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	16	100%	31%	69%	36%	64%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	16	94%	60%	40%	57%	43%
J	Case management	16	94%	40%	60%	36%	64%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	16	88%	54%	46%	50%	50%
K	Individual therapy and/or counseling	16	81%	62%	38%	50%	50%
O	Emergency and crisis services (i.e., after hours or emergencies)	16	81%	15%	85%	58%	42%
Q	Home-based services (i.e., services provided at the home of clients)	16	81%	38%	62%	67%	33%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	16	81%	69%	31%	75%	25%
M	Family therapy and/or counseling	16	75%	42%	58%	55%	45%
P	Family support services (i.e., services provided to family members of clients such as respite care)	16	75%	50%	50%	27%	73%
N	Psychological testing	15	73%	36%	64%	20%	80%
L	Group therapy and/or counseling	16	69%	45%	55%	40%	60%
R	Independent living services	16	69%	18%	82%	40%	60%
S	In-home family services (family counseling provided in the home, etc.)	16	69%	36%	64%	40%	60%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	16	69%	45%	55%	50%	50%
HH	Neuropsychological services	16	69%	18%	82%	30%	70%
GG	Specialized services for the elderly	16	63%	20%	80%	33%	67%
JJ	General daily living activities	16	63%	40%	60%	56%	44%
T	Mental retardation/developmental disability services	16	56%	22%	78%	38%	63%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	16	56%	33%	67%	13%	88%
II	Drug screening services	16	56%	33%	67%	63%	38%
B	Assistance to non-English speaking individuals	16	50%	11%	89%	25%	75%
D	Housing services (i.e., assistance in locating housing)	16	50%	38%	63%	14%	86%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	16	50%	25%	75%	43%	57%
H	Legal advocacy	16	50%	50%	50%	14%	86%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	16	50%	50%	50%	57%	43%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	16	50%	25%	75%	14%	86%
EE	Parenting education (i.e., training in appropriate parenting techniques)	16	50%	88%	13%	43%	57%
C	Assistance to hearing-impaired individuals	16	44%	0%	100%	33%	67%
E	Payeeships (i.e., financial guardianship)	16	44%	14%	86%	33%	67%
U	School-based services (social work or case management services contracted with schools, etc.)	16	44%	33%	67%	20%	80%
V	Supported employment (i.e., assistance in obtaining employment)	16	44%	57%	43%	33%	67%
DD	Meal services (i.e., meals provided to those receiving treatment)	16	44%	0%	100%	33%	67%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	16	38%	33%	67%	20%	80%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	16	31%	80%	20%	25%	75%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	16	31%	40%	60%	50%	50%

Frequency of Clients Needing and Receiving Services: Ancillary Service Providers-Combined (Dent)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	28	93%	70%	30%	71%	29%
A	Transportation services (i.e., getting to and from appointments)	30	87%	57%	43%	32%	68%
K	Individual therapy and/or counseling	27	85%	50%	50%	36%	64%
M	Family therapy and/or counseling	27	85%	38%	62%	33%	67%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	29	83%	23%	77%	33%	67%
D	Housing services (i.e., assistance in locating housing)	28	79%	52%	48%	44%	56%
EE	Parenting education (i.e., training in appropriate parenting techniques)	26	77%	53%	47%	33%	67%
J	Case management	24	75%	59%	41%	56%	44%
O	Emergency and crisis services (i.e., after hours or emergencies)	27	74%	26%	74%	44%	56%
L	Group therapy and/or counseling	25	72%	47%	53%	39%	61%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	25	72%	65%	35%	38%	63%
N	Psychological testing	26	69%	25%	75%	19%	81%
V	Supported employment (i.e., assistance in obtaining employment)	28	68%	60%	40%	33%	67%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	25	68%	53%	47%	25%	75%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	25	64%	50%	50%	29%	71%
C	Assistance to hearing-impaired individuals	27	63%	20%	80%	47%	53%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	24	63%	40%	60%	43%	57%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	24	63%	47%	53%	29%	71%
Q	Home-based services (i.e., services provided at the home of clients)	25	56%	75%	25%	69%	31%
H	Legal advocacy	28	54%	31%	69%	58%	42%
S	In-home family services (family counseling provided in the home, etc.)	25	52%	17%	83%	9%	91%
U	School-based services (social work or case management services contracted with schools, etc.)	23	52%	36%	64%	18%	82%
B	Assistance to non-English speaking individuals	26	50%	15%	85%	54%	46%
R	Independent living services	23	48%	45%	55%	45%	55%
T	Mental retardation/developmental disability services	24	46%	45%	55%	55%	45%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	24	46%	30%	70%	18%	82%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	24	46%	50%	50%	9%	91%
II	Drug screening services	26	46%	27%	73%	25%	75%
P	Family support services (i.e., services provided to family members of clients such as respite care)	24	42%	55%	45%	30%	70%
E	Payeeships (i.e., financial guardianship)	23	39%	10%	90%	25%	75%
JJ	General daily living activities	21	38%	50%	50%	57%	43%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	28	36%	38%	63%	50%	50%
DD	Meal services (i.e., meals provided to those receiving treatment)	23	35%	25%	75%	43%	57%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	23	35%	50%	50%	38%	63%
GG	Specialized services for the elderly	22	27%	50%	50%	50%	50%
HH	Neuropsychological services	22	23%	75%	25%	25%	75%

Frequency of Clients Needing and Receiving Services: Providers (Maries)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	12	100%	33%	67%	30%	70%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	12	92%	55%	45%	60%	40%
J	Case management	12	92%	27%	73%	50%	50%
K	Individual therapy and/or counseling	12	83%	50%	50%	56%	44%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	12	83%	70%	30%	67%	33%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	12	83%	33%	67%	50%	50%
O	Emergency and crisis services (i.e., after hours or emergencies)	12	75%	22%	78%	50%	50%
Q	Home-based services (i.e., services provided at the home of clients)	12	75%	22%	78%	50%	50%
N	Psychological testing	11	73%	13%	88%	29%	71%
L	Group therapy and/or counseling	12	67%	38%	63%	43%	57%
M	Family therapy and/or counseling	12	67%	25%	75%	43%	57%
P	Family support services (i.e., services provided to family members of clients such as respite care)	12	67%	38%	63%	29%	71%
T	Mental retardation/developmental disability services	12	67%	13%	88%	43%	57%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	12	67%	50%	50%	71%	29%
B	Assistance to non-English speaking individuals	12	58%	13%	88%	14%	86%
D	Housing services (i.e., assistance in locating housing)	12	58%	43%	57%	17%	83%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	12	58%	29%	71%	50%	50%
R	Independent living services	12	58%	14%	86%	33%	67%
S	In-home family services (family counseling provided in the home, etc.)	12	58%	14%	86%	17%	83%
HH	Neuropsychological services	12	58%	29%	71%	50%	50%
II	Drug screening services	12	58%	43%	57%	67%	33%
JJ	General daily living activities	12	58%	29%	71%	50%	50%
E	Payeeships (i.e., financial guardianship)	12	50%	17%	83%	20%	80%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	12	50%	17%	83%	20%	80%
GG	Specialized services for the elderly	12	50%	0%	100%	20%	80%
C	Assistance to hearing-impaired individuals	12	42%	0%	100%	0%	100%
H	Legal advocacy	12	42%	20%	80%	25%	75%
V	Supported employment (i.e., assistance in obtaining employment)	12	42%	20%	80%	50%	50%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	12	42%	20%	80%	25%	75%
EE	Parenting education (i.e., training in appropriate parenting techniques)	12	42%	60%	40%	50%	50%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	12	33%	25%	75%	33%	67%
U	School-based services (social work or case management services contracted with schools, etc.)	12	33%	0%	100%	50%	50%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	12	33%	25%	75%	67%	33%
DD	Meal services (i.e., meals provided to those receiving treatment)	12	33%	0%	100%	33%	67%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	12	17%	50%	50%	100%	0%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	12	8%	0%	100%	#DIV/0!	#DIV/0!

Frequency of Clients Needing and Receiving Services: Ancillary Service Providers-Combined (Maries)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	26	96%	54%	46%	23%	77%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	25	92%	14%	86%	18%	82%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	25	92%	77%	23%	67%	33%
D	Housing services (i.e., assistance in locating housing)	24	88%	43%	57%	32%	68%
K	Individual therapy and/or counseling	24	83%	45%	55%	32%	68%
M	Family therapy and/or counseling	24	79%	42%	58%	22%	78%
J	Case management	22	77%	59%	41%	59%	41%
L	Group therapy and/or counseling	22	77%	65%	35%	41%	59%
O	Emergency and crisis services (i.e., after hours or emergencies)	24	71%	24%	76%	41%	59%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	24	71%	47%	53%	25%	75%
EE	Parenting education (i.e., training in appropriate parenting techniques)	23	70%	63%	38%	31%	69%
B	Assistance to non-English speaking individuals	24	67%	13%	88%	40%	60%
H	Legal advocacy	24	67%	53%	47%	40%	60%
V	Supported employment (i.e., assistance in obtaining employment)	24	67%	56%	44%	29%	71%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	23	65%	53%	47%	20%	80%
C	Assistance to hearing-impaired individuals	25	64%	13%	87%	46%	54%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	22	64%	79%	21%	43%	57%
N	Psychological testing	23	61%	14%	86%	8%	92%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	22	59%	31%	69%	23%	77%
T	Mental retardation/developmental disability services	22	55%	42%	58%	50%	50%
S	In-home family services (family counseling provided in the home, etc.)	23	52%	9%	91%	9%	91%
Q	Home-based services (i.e., services provided at the home of clients)	22	50%	45%	55%	55%	45%
R	Independent living services	21	48%	27%	73%	30%	70%
II	Drug screening services	23	48%	27%	73%	11%	89%
P	Family support services (i.e., services provided to family members of clients such as respite care)	22	45%	55%	45%	45%	55%
E	Payeeships (i.e., financial guardianship)	21	43%	10%	90%	22%	78%
JJ	General daily living activities	19	42%	57%	43%	71%	29%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	22	41%	67%	33%	11%	89%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	22	41%	67%	33%	56%	44%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	24	38%	44%	56%	44%	56%
U	School-based services (social work or case management services contracted with schools, etc.)	21	38%	38%	63%	13%	88%
DD	Meal services (i.e., meals provided to those receiving treatment)	21	38%	38%	63%	38%	63%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	21	38%	50%	50%	38%	63%
GG	Specialized services for the elderly	20	30%	67%	33%	67%	33%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	22	27%	17%	83%	17%	83%
HH	Neuropsychological services	20	20%	75%	25%	25%	75%

Frequency of Clients Needing and Receiving Services: Providers (Phelps)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	28	96%	63%	37%	69%	31%
A	Transportation services (i.e., getting to and from appointments)	28	93%	42%	58%	21%	79%
J	Case management	28	93%	42%	58%	48%	52%
K	Individual therapy and/or counseling	28	89%	76%	24%	75%	25%
O	Emergency and crisis services (i.e., after hours or emergencies)	28	86%	25%	75%	61%	39%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	28	86%	67%	33%	74%	26%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	28	86%	61%	39%	59%	41%
L	Group therapy and/or counseling	28	79%	50%	50%	57%	43%
Q	Home-based services (i.e., services provided at the home of clients)	28	79%	32%	68%	52%	48%
M	Family therapy and/or counseling	28	75%	48%	52%	55%	45%
N	Psychological testing	27	74%	35%	65%	32%	68%
P	Family support services (i.e., services provided to family members of clients such as respite care)	28	71%	35%	65%	26%	74%
R	Independent living services	28	71%	15%	85%	32%	68%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	28	71%	47%	53%	56%	44%
II	Drug screening services	28	71%	35%	65%	63%	37%
D	Housing services (i.e., assistance in locating housing)	28	68%	26%	74%	28%	72%
S	In-home family services (family counseling provided in the home, etc.)	28	68%	21%	79%	35%	65%
T	Mental retardation/developmental disability services	28	64%	11%	89%	35%	65%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	28	64%	33%	67%	18%	82%
HH	Neuropsychological services	28	64%	17%	83%	29%	71%
B	Assistance to non-English speaking individuals	28	61%	11%	89%	18%	82%
GG	Specialized services for the elderly	28	61%	24%	76%	31%	69%
JJ	General daily living activities	28	61%	35%	65%	44%	56%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	28	57%	19%	81%	33%	67%
V	Supported employment (i.e., assistance in obtaining employment)	28	57%	31%	69%	33%	67%
H	Legal advocacy	28	54%	19%	81%	13%	87%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	28	54%	27%	73%	14%	86%
EE	Parenting education (i.e., training in appropriate parenting techniques)	28	54%	47%	53%	29%	71%
E	Payeeships (i.e., financial guardianship)	28	46%	7%	93%	17%	83%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	28	46%	31%	69%	33%	67%
U	School-based services (social work or case management services contracted with schools, etc.)	28	46%	25%	75%	36%	64%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	28	46%	23%	77%	25%	75%
C	Assistance to hearing-impaired individuals	28	39%	0%	100%	20%	80%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	28	39%	36%	64%	20%	80%
DD	Meal services (i.e., meals provided to those receiving treatment)	28	39%	9%	91%	30%	70%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	27	30%	13%	88%	14%	86%

Frequency of Clients Needing and Receiving Services: Ancillary Service Providers-Combined (Phelps)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	44	91%	70%	30%	70%	30%
A	Transportation services (i.e., getting to and from appointments)	48	85%	61%	39%	27%	73%
K	Individual therapy and/or counseling	45	82%	54%	46%	36%	64%
D	Housing services (i.e., assistance in locating housing)	44	80%	50%	50%	42%	58%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	45	78%	27%	73%	39%	61%
M	Family therapy and/or counseling	45	76%	47%	53%	27%	73%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	41	73%	68%	32%	37%	63%
L	Group therapy and/or counseling	41	71%	59%	41%	34%	66%
O	Emergency and crisis services (i.e., after hours or emergencies)	44	70%	37%	63%	52%	48%
EE	Parenting education (i.e., training in appropriate parenting techniques)	42	64%	50%	50%	41%	59%
N	Psychological testing	43	63%	19%	81%	23%	77%
V	Supported employment (i.e., assistance in obtaining employment)	43	63%	50%	50%	30%	70%
J	Case management	42	62%	52%	48%	54%	46%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	41	61%	39%	61%	28%	72%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	43	60%	52%	48%	29%	71%
H	Legal advocacy	43	58%	30%	70%	39%	61%
B	Assistance to non-English speaking individuals	43	51%	9%	91%	36%	64%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	41	49%	53%	47%	50%	50%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	41	49%	37%	63%	25%	75%
S	In-home family services (family counseling provided in the home, etc.)	42	48%	11%	89%	5%	95%
Q	Home-based services (i.e., services provided at the home of clients)	41	46%	56%	44%	58%	42%
C	Assistance to hearing-impaired individuals	44	45%	16%	84%	50%	50%
U	School-based services (social work or case management services contracted with schools, etc.)	41	44%	47%	53%	22%	78%
II	Drug screening services	43	44%	24%	76%	24%	76%
P	Family support services (i.e., services provided to family members of clients such as respite care)	41	41%	47%	53%	39%	61%
T	Mental retardation/developmental disability services	41	41%	44%	56%	50%	50%
GG	Specialized services for the elderly	39	41%	36%	64%	50%	50%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	43	37%	47%	53%	60%	40%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	42	36%	47%	53%	13%	87%
DD	Meal services (i.e., meals provided to those receiving treatment)	40	35%	33%	67%	36%	64%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	40	35%	50%	50%	36%	64%
E	Payeeships (i.e., financial guardianship)	40	33%	25%	75%	17%	83%
R	Independent living services	40	33%	23%	77%	38%	62%
JJ	General daily living activities	38	29%	45%	55%	64%	36%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	42	21%	33%	67%	11%	89%
HH	Neuropsychological services	38	18%	43%	57%	29%	71%

Frequency of Clients Needing and Receiving Services: Providers (Pulaski)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	21	95%	50%	50%	28%	72%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	21	95%	50%	50%	63%	37%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	20	95%	56%	44%	53%	47%
J	Case management	21	90%	37%	63%	44%	56%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	20	90%	67%	33%	65%	35%
K	Individual therapy and/or counseling	21	86%	61%	39%	53%	47%
Q	Home-based services (i.e., services provided at the home of clients)	20	85%	18%	82%	50%	50%
M	Family therapy and/or counseling	21	81%	29%	71%	53%	47%
O	Emergency and crisis services (i.e., after hours or emergencies)	21	81%	12%	88%	56%	44%
P	Family support services (i.e., services provided to family members of clients such as respite care)	21	81%	44%	56%	33%	67%
N	Psychological testing	20	80%	31%	69%	27%	73%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	20	75%	47%	53%	64%	36%
JJ	General daily living activities	20	75%	27%	73%	43%	57%
L	Group therapy and/or counseling	21	71%	33%	67%	29%	71%
R	Independent living services	20	65%	8%	92%	33%	67%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	20	65%	38%	62%	17%	83%
HH	Neuropsychological services	20	65%	15%	85%	33%	67%
S	In-home family services (family counseling provided in the home, etc.)	20	60%	17%	83%	36%	64%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	20	60%	33%	67%	18%	82%
EE	Parenting education (i.e., training in appropriate parenting techniques)	20	60%	58%	42%	36%	64%
GG	Specialized services for the elderly	20	60%	8%	92%	27%	73%
II	Drug screening services	20	60%	33%	67%	45%	55%
B	Assistance to non-English speaking individuals	21	57%	15%	85%	25%	75%
T	Mental retardation/developmental disability services	20	55%	9%	91%	60%	40%
V	Supported employment (i.e., assistance in obtaining employment)	20	55%	45%	55%	30%	70%
E	Payeeships (i.e., financial guardianship)	21	52%	9%	91%	20%	80%
D	Housing services (i.e., assistance in locating housing)	21	48%	40%	60%	11%	89%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	21	48%	30%	70%	33%	67%
H	Legal advocacy	21	48%	40%	60%	11%	89%
U	School-based services (social work or case management services contracted with schools, etc.)	20	45%	11%	89%	50%	50%
DD	Meal services (i.e., meals provided to those receiving treatment)	20	45%	0%	100%	38%	63%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	21	43%	33%	67%	25%	75%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	20	40%	25%	75%	43%	57%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	20	35%	43%	57%	17%	83%
C	Assistance to hearing-impaired individuals	21	33%	0%	100%	33%	67%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	20	30%	33%	67%	40%	60%

Frequency of Clients Needing and Receiving Services: Ancillary Service Providers-Combined (Pulaski)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	34	94%	60%	40%	54%	46%
A	Transportation services (i.e., getting to and from appointments)	34	88%	48%	52%	22%	78%
K	Individual therapy and/or counseling	33	88%	41%	59%	27%	73%
D	Housing services (i.e., assistance in locating housing)	33	79%	36%	64%	19%	81%
L	Group therapy and/or counseling	31	77%	54%	46%	13%	88%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	35	71%	13%	88%	22%	78%
O	Emergency and crisis services (i.e., after hours or emergencies)	33	70%	26%	74%	39%	61%
M	Family therapy and/or counseling	32	69%	57%	43%	19%	81%
N	Psychological testing	32	59%	25%	75%	16%	84%
V	Supported employment (i.e., assistance in obtaining employment)	33	58%	47%	53%	24%	76%
EE	Parenting education (i.e., training in appropriate parenting techniques)	31	58%	53%	47%	11%	89%
Q	Home-based services (i.e., services provided at the home of clients)	31	55%	39%	61%	44%	56%
U	School-based services (social work or case management services contracted with schools, etc.)	31	55%	47%	53%	19%	81%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	31	52%	71%	29%	31%	69%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	31	52%	41%	59%	25%	75%
S	In-home family services (family counseling provided in the home, etc.)	30	47%	7%	93%	0%	100%
B	Assistance to non-English speaking individuals	33	45%	6%	94%	25%	75%
J	Case management	31	45%	29%	71%	43%	57%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	31	45%	64%	36%	40%	60%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	32	44%	47%	53%	14%	86%
T	Mental retardation/developmental disability services	31	42%	40%	60%	47%	53%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	31	42%	21%	79%	8%	92%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	31	42%	36%	64%	29%	71%
II	Drug screening services	34	41%	27%	73%	18%	82%
R	Independent living services	30	40%	38%	62%	23%	77%
E	Payeeships (i.e., financial guardianship)	31	39%	8%	92%	33%	67%
H	Legal advocacy	33	39%	23%	77%	25%	75%
P	Family support services (i.e., services provided to family members of clients such as respite care)	31	39%	43%	57%	21%	79%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	31	39%	38%	62%	8%	92%
DD	Meal services (i.e., meals provided to those receiving treatment)	31	39%	27%	73%	36%	64%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	31	39%	31%	69%	31%	69%
C	Assistance to hearing-impaired individuals	34	38%	8%	92%	42%	58%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	33	30%	45%	55%	45%	55%
GG	Specialized services for the elderly	31	29%	60%	40%	50%	50%
HH	Neuropsychological services	31	29%	33%	67%	20%	80%
JJ	General daily living activities	31	29%	30%	70%	40%	60%

Frequency of Clients Needing and Receiving Services: Providers (Texas)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	14	100%	43%	57%	33%	67%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	14	93%	46%	54%	50%	50%
J	Case management	14	93%	23%	77%	42%	58%
O	Emergency and crisis services (i.e., after hours or emergencies)	14	86%	17%	83%	45%	55%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	14	86%	58%	42%	73%	27%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	14	86%	45%	55%	40%	60%
K	Individual therapy and/or counseling	14	79%	55%	45%	40%	60%
P	Family support services (i.e., services provided to family members of clients such as respite care)	14	79%	27%	73%	30%	70%
Q	Home-based services (i.e., services provided at the home of clients)	14	79%	9%	91%	40%	60%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	14	79%	45%	55%	60%	40%
GG	Specialized services for the elderly	14	79%	18%	82%	30%	70%
M	Family therapy and/or counseling	14	71%	40%	60%	56%	44%
R	Independent living services	14	71%	10%	90%	44%	56%
L	Group therapy and/or counseling	14	64%	56%	44%	50%	50%
T	Mental retardation/developmental disability services	14	64%	11%	89%	38%	63%
HH	Neuropsychological services	14	64%	11%	89%	25%	75%
JJ	General daily living activities	14	64%	33%	67%	50%	50%
N	Psychological testing	13	62%	38%	63%	14%	86%
B	Assistance to non-English speaking individuals	14	57%	22%	78%	38%	63%
D	Housing services (i.e., assistance in locating housing)	14	57%	13%	88%	14%	86%
E	Payeeships (i.e., financial guardianship)	14	57%	13%	88%	29%	71%
S	In-home family services (family counseling provided in the home, etc.)	14	57%	0%	100%	17%	83%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	14	57%	38%	63%	14%	86%
V	Supported employment (i.e., assistance in obtaining employment)	14	50%	14%	86%	17%	83%
DD	Meal services (i.e., meals provided to those receiving treatment)	14	50%	0%	100%	33%	67%
II	Drug screening services	14	50%	14%	86%	50%	50%
C	Assistance to hearing-impaired individuals	14	43%	0%	100%	40%	60%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	14	43%	17%	83%	40%	60%
H	Legal advocacy	14	43%	17%	83%	20%	80%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	14	43%	33%	67%	20%	80%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	14	36%	20%	80%	0%	100%
U	School-based services (social work or case management services contracted with schools, etc.)	14	36%	0%	100%	50%	50%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	14	36%	0%	100%	25%	75%
EE	Parenting education (i.e., training in appropriate parenting techniques)	14	36%	60%	40%	0%	100%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	14	29%	25%	75%	0%	100%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	13	23%	0%	100%	0%	100%

Frequency of Clients Needing and Receiving Services: Ancillary Service Providers-Combined (Texas)							
	Need Area	N	% Identifying Area as a Need	Frequency of Service Needed		Frequency of Service Received	
				High	Low	High	Low
A	Transportation services (i.e., getting to and from appointments)	19	95%	39%	61%	36%	64%
G	Information and referral services (information regarding where to obtain services or referral to organizations that provide services, etc.)	19	95%	61%	39%	73%	27%
K	Individual therapy and/or counseling	18	89%	56%	44%	36%	64%
M	Family therapy and/or counseling	18	89%	44%	56%	36%	64%
L	Group therapy and/or counseling	17	82%	50%	50%	31%	69%
F	Homeless services (outreach services to ensure homeless individuals have access to care, etc.)	19	79%	13%	87%	23%	77%
J	Case management	16	75%	50%	50%	58%	42%
N	Psychological testing	18	72%	15%	85%	27%	73%
Y	Primary health care (i.e., physical health care such as provided by a physician, nurse practitioner, or nurse)	17	71%	75%	25%	55%	45%
EE	Parenting education (i.e., training in appropriate parenting techniques)	17	71%	33%	67%	27%	73%
D	Housing services (i.e., assistance in locating housing)	19	68%	38%	62%	22%	78%
V	Supported employment (i.e., assistance in obtaining employment)	18	67%	42%	58%	36%	64%
O	Emergency and crisis services (i.e., after hours or emergencies)	19	63%	25%	75%	73%	27%
H	Legal advocacy	18	56%	10%	90%	22%	78%
B	Assistance to non-English speaking individuals	19	53%	10%	90%	50%	50%
Q	Home-based services (i.e., services provided at the home of clients)	17	53%	78%	22%	63%	38%
U	School-based services (social work or case management services contracted with schools, etc.)	17	53%	44%	56%	25%	75%
AA	Medication management (i.e., facilitating the appropriate use of medications for mental health and/or addiction treatment)	17	53%	56%	44%	56%	44%
CC	Supported education/training (i.e., assistance in obtaining educational or vocational training)	17	53%	67%	33%	33%	67%
C	Assistance to hearing-impaired individuals	19	47%	11%	89%	43%	57%
S	In-home family services (family counseling provided in the home, etc.)	17	47%	14%	86%	14%	86%
Z	Nutrition services (guidance provided by a nutritionist or dietician in healthy diet, etc.)	17	47%	63%	38%	50%	50%
BB	Money management (guidance regarding tax credits, budgeting, etc.)	17	47%	63%	38%	43%	57%
FF	Youth education (i.e., grade-level classes provided to youth who are receiving treatment while out of regular school)	17	47%	38%	63%	57%	43%
II	Drug screening services	19	47%	11%	89%	29%	71%
T	Mental retardation/developmental disability services	17	41%	38%	63%	57%	43%
I	Court-ordered work (i.e., provision of treatment services that are ordered by court system such as addiction treatment)	19	37%	43%	57%	43%	57%
E	Payeeships (i.e., financial guardianship)	17	35%	0%	100%	33%	67%
R	Independent living services	17	35%	33%	67%	33%	67%
X	Wrap-around services (i.e., individually designed set of services and supports for children and their families)	17	35%	33%	67%	17%	83%
W	Therapeutic foster care (i.e., care for children with severe emotional and behavioral problems delivered in private homes by specially trained foster parents)	17	29%	20%	80%	20%	80%
DD	Meal services (i.e., meals provided to those receiving treatment)	17	29%	20%	80%	40%	60%
GG	Specialized services for the elderly	17	29%	60%	40%	80%	20%
P	Family support services (i.e., services provided to family members of clients such as respite care)	17	24%	80%	20%	25%	75%
HH	Neuropsychological services	17	24%	50%	50%	25%	75%
JJ	General daily living activities	17	24%	50%	50%	75%	25%

C. Reasons for Referral Subscale: Ancillary Providers

Ancillary service providers completed the **Reasons for Referral Subscale** as part of the overall survey administered to ancillary service providers. This scale included a list of specific reasons for which providers may refer clients to mental health or addiction service organizations. Participants are asked to first select each reason for referral. Next, participants are asked to record the three top referral reasons.

The following tables depict results for all ancillary service providers. In some cases, data are disaggregated by county. As noted previously, when interpreting county-level breakdowns it is important to note that some organizations serve multiple counties and surveys did not differentiate responses between counties being served. Therefore, provider responses may be duplicated across counties. For example, Phelps Regional Medical Center serves all counties in the study area and their reasons for referral would be treated the same for all counties. Additionally, data were also disaggregated by two types of ancillary providers including schools/early childhood centers and other organizations (e.g., non-schools, community based social service organizations). This was primarily due to differences in populations served.

Reasons for Referral By All Ancillary Service Organizations Across Counties

	Reasons for Referral to Mental Health or Addiction Services Organizations	Crawford	Dent	Maries	Phelps	Pulaski	Texas	All Counties	All Counties
		N=30	N=31	N=27	N=47	N=41	N=22	N=99	Rank
		%	%	%	%	%	%	%	
E	Behavioral issues (fighting, aggression toward family/classmates, etc.)	57%	55%	59%	64%	66%	64%	69%	1
F	Anxiety/stress	60%	58%	67%	62%	61%	64%	68%	2
H	Mood issues (depression, mood swings, etc.)	43%	52%	59%	51%	54%	64%	60%	3
B	Abuse and/or addiction to other drugs	50%	65%	56%	60%	46%	59%	55%	4
A	Abuse and/or addiction to alcohol	53%	58%	59%	60%	46%	59%	54%	5
T	Suicidal behaviors	40%	42%	52%	45%	51%	45%	54%	5
R	Anger management	47%	48%	52%	47%	49%	41%	49%	6
V	Domestic violence	53%	58%	63%	49%	44%	50%	45%	7
W	Child sexual abuse	30%	32%	41%	38%	37%	41%	43%	8
L	Childhood disorders (ADHD), etc.)	33%	32%	41%	34%	39%	36%	39%	9
X	Child physical abuse	30%	23%	41%	34%	32%	32%	38%	10
P	Family and/or marital problems	47%	45%	56%	47%	34%	41%	37%	11
K	Symptoms of personality disorder (antisocial, obsessive/compulsive, etc.)	37%	39%	37%	34%	27%	27%	36%	12
Q	Parenting problems	37%	39%	44%	43%	34%	36%	33%	13
S	Learning disabilities	27%	32%	41%	28%	39%	32%	33%	13
U	Self-mutilation	20%	23%	19%	19%	29%	27%	30%	14
N	Developmental issues (autism, mental retardation, etc.)	30%	29%	37%	30%	29%	32%	29%	15
Y	Adult sexual abuse	33%	39%	33%	26%	20%	23%	27%	16
J	Signs of schizophrenia or psychosis	30%	26%	26%	30%	12%	18%	23%	17
G	Eating issues (anorexia, bulimia, etc.)	20%	16%	19%	21%	17%	32%	21%	18
I	Cognitive issues (dementia, delirium, etc.)	17%	16%	26%	26%	10%	14%	17%	19
M	Sleep-related problems	13%	16%	22%	15%	12%	23%	11%	20
O	Sexual and/or gender identity issues	7%	10%	11%	9%	15%	14%	11%	20
D	Other addictions	10%	13%	7%	11%	7%	5%	10%	21
Z	Sex and/or pornography addiction	7%	10%	7%	9%	7%	14%	8%	22
aa	Other	7%	3%	7%	4%	2%	0%	7%	23
C	Gambling addiction	3%	3%	4%	2%	0%	0%	1%	24

Reasons for Referral By Ancillary Service Organization Type (Early Childhood/Schools and Other Organizations)							
Reasons for Referral to Mental Health or Addiction Services Organizations		Early Childhood/ Schools (N=33)		Other Organizations (N=66)		Combined (N=99)	
		%	Rank	%	Rank	%	Rank
E	Behavioral issues (fighting, aggression toward family/classmates, etc.)	97%	1	55%	4	69%	1
F	Anxiety/stress	82%	2	61%	3	68%	2
H	Mood issues (depression, mood swings, etc.)	79%	3	50%	5	60%	3
B	Abuse and/or addiction to other drugs	27%	11	68%	2	55%	4
A	Abuse and/or addiction to alcohol	21%	12	70%	1	54%	5
T	Suicidal behaviors	73%	4	44%	6	54%	5
R	Anger management	64%	5	42%	7	49%	6
V	Domestic violence	27%	11	55%	4	45%	7
W	Child sexual abuse	58%	6	36%	10	43%	8
L	Childhood disorders (ADHD), etc.)	73%	4	23%	14	39%	9
X	Child physical abuse	52%	7	32%	11	38%	10
P	Family and/or marital problems	27%	11	42%	7	37%	11
K	Symptoms of personality disorder (antisocial, obsessive/compulsive, etc.)	45%	8	32%	11	36%	12
Q	Parenting problems	18%	13	41%	8	33%	13
S	Learning disabilities	45%	8	27%	12	33%	13
U	Self-mutilation	58%	6	17%	15	30%	14
N	Developmental issues (autism, mental retardation, etc.)	33%	10	27%	12	29%	15
Y	Adult sexual abuse	6%	17	38%	9	27%	16
J	Signs of schizophrenia or psychosis	15%	14	27%	12	23%	17
G	Eating issues (anorexia, bulimia, etc.)	36%	9	14%	16	21%	18
I	Cognitive issues (dementia, delirium, etc.)	0%	19	26%	13	17%	19
M	Sleep-related problems	12%	15	11%	18	11%	20
O	Sexual and/or gender identity issues	21%	12	6%	20	11%	20
D	Other addictions	6%	17	12%	17	10%	21
Z	Sex and/or pornography addiction	9%	16	8%	19	8%	22
aa	Other	3%	18	---	---	7%	23
C	Gambling addiction	0%	19	2%	21	1%	24

Reasons for Referral By Primary Ages Served in Ancillary Service Organizations									
Reasons for Referral to Mental Health or Addiction Services Organizations		0-17 (N=67)		18-64 (N=54)		65+ (N=35)		Combined N=99	
		%	Rank	%	Rank	%	Rank	%	Rank
E	Behavioral issues (fighting, aggression toward family/classmates, etc.)	76%	1	56%	4	51%	4	69%	1
F	Anxiety/stress	75%	2	63%	3	66%	3	68%	2
H	Mood issues (depression, mood swings, etc.)	67%	3	50%	5	51%	4	60%	3
B	Abuse and/or addiction to other drugs	49%	7	69%	2	69%	2	55%	4
A	Abuse and/or addiction to alcohol	48%	8	72%	1	71%	1	54%	5
T	Suicidal behaviors	63%	4	46%	6	43%	6	54%	5
R	Anger management	57%	5	46%	6	51%	4	49%	6
V	Domestic violence	40%	9	56%	4	49%	5	45%	7
W	Child sexual abuse	49%	7	33%	9	23%	11	43%	8
L	Childhood disorders (ADHD), etc.)	51%	6	19%	14	17%	13	39%	9
X	Child physical abuse	48%	8	31%	10	29%	9	38%	10
P	Family and/or marital problems	36%	12	50%	5	37%	7	37%	11
K	Symptoms of personality disorder (antisocial, obsessive/compulsive, etc.)	39%	10	31%	10	37%	7	36%	12
Q	Parenting problems	31%	14	43%	7	37%	7	33%	13
S	Learning disabilities	37%	11	26%	11	26%	10	33%	13
U	Self-mutilation	39%	10	19%	14	11%	15	30%	14
N	Developmental issues (autism, mental retardation, etc.)	34%	13	20%	13	29%	9	29%	15
Y	Adult sexual abuse	21%	17	39%	8	31%	8	27%	16
J	Signs of schizophrenia or psychosis	21%	16	31%	10	29%	9	23%	17
G	Eating issues (anorexia, bulimia, etc.)	28%	15	17%	15	14%	14	21%	18
I	Cognitive issues (dementia, delirium, etc.)	13%	19	24%	12	31%	8	17%	19
M	Sleep-related problems	13%	19	15%	16	20%	12	11%	20
O	Sexual and/or gender identity issues	16%	18	7%	19	6%	16	11%	20
D	Other addictions	12%	20	9%	18	14%	14	10%	21
Z	Sex and/or pornography addiction	12%	20	11%	17	11%	15	8%	22
aa	Other	4%	21	11%	17	14%	14	7%	23
C	Gambling addiction	1%	22	2%	20	3%	17	1%	24

Top Reasons for Referral By All Ancillary Service Organizations Combined and by Type (Early Childhood/Schools and Other Organizations)

Combined (N=87)

Area of Referral	n	%	Rank
Abuse and/or addiction to other drugs	30	34%	1
Anxiety/stress	24	28%	2
Behavioral issues	24	28%	2
Mood issues	23	26%	3
Suicidal behaviors	21	24%	4
Childhood disorders (ADHD, etc.)	20	23%	5
Domestic violence	18	21%	6
Abuse and/or addiction to alcohol	17	20%	7
Other	9	10%	8
Anger management	8	9%	9
Learning disabilities	7	8%	10
Child physical abuse	6	7%	11
Child sexual abuse	6	7%	11
Self-mutilation	6	7%	11
Family and/or marital problems	5	6%	12
Parenting problems	5	6%	12
Cognitive issues	4	5%	13
Developmental issues	4	5%	13
Signs of schizophrenia or psychosis	4	5%	13
Symptoms of personality disorder	4	5%	13
Adult sexual abuse	3	3%	14
Other addictions	3	3%	14
Eating issues	2	2%	15
Sleep-related problems	2	2%	15

Other Organizations (N=57)

Area of Referral	n	%	Rank
Abuse and/or addiction to other drugs	29	51%	1
Domestic violence	18	32%	2
Abuse and/or addiction to alcohol	17	30%	3
Anxiety/stress	14	25%	4
Suicidal behaviors	10	18%	5
Behavioral issues	9	16%	6
Mood issues	9	16%	6
Other	6	11%	7
Family and/or marital problems	5	9%	8
Anger management	4	7%	9
Child physical abuse	4	7%	9
Child sexual abuse	4	7%	9
Childhood disorders (ADHD, etc.)	4	7%	9
Cognitive issues	4	7%	9
Parenting problems	4	7%	9
Signs of schizophrenia or psychosis	4	7%	9
Adult sexual abuse	3	5%	10
Developmental issues	3	5%	10
Learning disabilities	3	5%	10
Other addictions	3	5%	10
Symptoms of personality disorder	3	5%	10
Sleep-related problems	2	4%	11
Eating issues	1	2%	12
Self-mutilation	1	2%	12

Early Childhood/Schools (N=30)

Area of Referral	n	%	Rank
Childhood disorders (ADHD, etc.)	16	53%	1
Behavioral issues	15	50%	2
Mood issues	14	47%	3
Suicidal behaviors	11	37%	4
Anxiety/stress	10	33%	5
Self-mutilation	5	17%	6
Anger management	4	13%	7
Learning disabilities	4	13%	7
Other	3	10%	8
Child physical abuse	2	7%	9
Child sexual abuse	2	7%	9
Abuse and/or addiction to other drugs	1	3%	10
Developmental issues	1	3%	10
Eating issues	1	3%	10
Parenting problems	1	3%	10
Symptoms of personality disorder	1	3%	10

Top Reasons for Referral By All Ancillary Service Organizations Combined and by County							
Crawford (N=25)				**Dent (N=28)**			
Area of Referral	**n**	**%**	**Rank**	**Area of Referral**	**n**	**%**	**Rank**
Abuse and/or addiction to other drugs	9	36%	1	Abuse and/or addiction to other drugs	13	46%	1
Abuse and/or addiction to alcohol	7	28%	2	Abuse and/or addiction to alcohol	10	36%	2
Behavioral issues	7	28%	3	Domestic violence	8	29%	3
Domestic violence	6	24%	4	Anxiety/stress	6	21%	4
Anxiety/stress	5	20%	5	Mood issues	6	21%	5
Anger management	4	16%	6	Behavioral issues	5	18%	6
Parenting problems	4	16%	6	Childhood disorders (ADHD, etc.)	5	18%	6
Childhood disorders (ADHD, etc.)	3	12%	7	Parenting problems	4	14%	7
Family and/or marital problems	3	12%	7	Anger management	3	11%	8
Mood issues	3	12%	7	Family and/or marital problems	3	11%	8
Other	3	12%	7	Signs of schizophrenia or psychosis	3	11%	8
Signs of schizophrenia or psychosis	3	12%	7	Cognitive issues	2	7%	9
Suicidal behaviors	3	12%	7	Learning disabilities	2	7%	9
Child physical abuse	2	8%	8	Other	2	7%	9
Learning disabilities	2	8%	8	Other addictions	2	7%	9
Symptoms of personality disorder	2	8%	8	Symptoms of personality disorder	2	7%	9
Child sexual abuse	1	4%	9	Child physical abuse	1	4%	10
Cognitive issues	1	4%	9	Child sexual abuse	1	4%	10
Developmental issues	1	4%	9	Developmental issues	1	4%	10
Other addictions	1	4%	9	Self-mutilation	1	4%	10
Sleep-related problems	1	4%	9	Sleep-related problems	1	4%	10
				Suicidal behaviors	1	4%	10
Maries (N=22)				**Phelps (N=43)**			
Area of Referral	**n**	**%**	**Rank**	**Area of Referral**	**n**	**%**	**Rank**
Abuse and/or addiction to other drugs	8	36%	1	Abuse and/or addiction to other drugs	15	35%	1
Abuse and/or addiction to alcohol	6	27%	2	Anxiety/stress	13	30%	2
Anxiety/stress	6	27%	3	Domestic violence	12	28%	3
Childhood disorders (ADHD, etc.)	5	23%	4	Behavioral issues	11	26%	4
Domestic violence	5	23%	5	Abuse and/or addiction to alcohol	10	23%	5
Behavioral issues	4	18%	6	Childhood disorders (ADHD, etc.)	10	23%	6
Family and/or marital problems	4	18%	6	Mood issues	8	19%	7
Mood issues	4	18%	6	Suicidal behaviors	5	12%	8
Anger management	3	14%	7	Anger management	4	9%	9
Parenting problems	3	14%	7	Child physical abuse	4	9%	9
Child physical abuse	2	9%	8	Developmental issues	4	9%	9
Other	2	9%	8	Family and/or marital problems	4	9%	9
Signs of schizophrenia or psychosis	2	9%	8	Learning disabilities	4	9%	9
Adult sexual abuse	1	5%	9	Child sexual abuse	3	7%	10
Child sexual abuse	1	5%	9	Cognitive issues	3	7%	10
Cognitive issues	1	5%	9	Other	3	7%	10
Developmental issues	1	5%	9	Parenting problems	3	7%	10
Learning disabilities	1	5%	9	Signs of schizophrenia or psychosis	3	7%	10
Other addictions	1	5%	9	Adult sexual abuse	2	5%	11
Self-mutilation	1	5%	9	Eating issues	2	5%	11
Sleep-related problems	1	5%	9	Other addictions	2	5%	11
Suicidal behaviors	1	5%	9	Sleep-related problems	2	5%	11
Symptoms of personality disorder	1	5%	9	Self-mutilation	1	2%	12
				Symptoms of personality disorder	1	2%	12

Top Reasons for Referral By All Ancillary Service Organizations Combined and County (Continued)							
Pulaski (N=37)				Texas (N=18)			
Area of Referral	n	%	Rank	Area of Referral	n	%	Rank
Abuse and/or addiction to other drugs	15	41%	1	Abuse and/or addiction to other drugs	6	33%	1
Anxiety/stress	13	35%	2	Anxiety/stress	5	28%	2
Domestic violence	12	32%	3	Behavioral issues	5	28%	3
Behavioral issues	11	30%	4	Childhood disorders (ADHD, etc.)	5	28%	4
Abuse and/or addiction to alcohol	10	27%	5	Mood issues	5	28%	5
Childhood disorders (ADHD, etc.)	10	27%	5	Abuse and/or addiction to alcohol	4	22%	6
Mood issues	8	22%	6	Anger management	3	17%	7
Suicidal behaviors	5	14%	7	Domestic violence	3	17%	7
Anger management	4	11%	8	Suicidal behaviors	3	17%	7
Child physical abuse	4	11%	8	Family and/or marital problems	2	11%	8
Developmental issues	4	11%	8	Learning disabilities	2	11%	8
Family and/or marital problems	4	11%	8	Other	2	11%	8
Learning disabilities	4	11%	8	Parenting problems	2	11%	8
Child sexual abuse	3	8%	9	Adult sexual abuse	1	6%	9
Cognitive issues	3	8%	9	Child physical abuse	1	6%	9
Other	3	8%	9	Cognitive issues	1	6%	9
Parenting problems	3	8%	9	Developmental issues	1	6%	9
Signs of schizophrenia or psychosis	3	8%	9	Self-mutilation	1	6%	9
Adult sexual abuse	2	5%	10	Sleep-related problems	1	6%	9
Eating issues	2	5%	10				
Other addictions	2	5%	10				
Sleep-related problems	2	5%	10				
Self-mutilation	1	3%	10				
Symptoms of personality disorder	1	3%	10				

D. Barriers to Receiving Services Subscale: Direct Service and Ancillary Providers

Direct and ancillary service providers completed the **Barriers to Receiving Services Subscale** as part of the overall survey administered to service providers. This subscale included a list of potential barriers clients may have in receiving services. Using a 5-point scale (1-Not a Barrier to 5-Extreme Barrier), participants were asked to rate the extent to which clients experience the respective barrier. Results are presented separately for direct service providers, ancillary service providers--schools and early childhood centers, and ancillary service providers--other organizations.

Extent of Barriers for Clients Receiving Addiction and/or Mental Health Services (Providers)

	Need Area	N	1 Not a barrier	2 Somewhat of a barrier	3 Moderate barrier	4 Large barrier	5 Extreme barrier	Large to Extreme Barrier
I	**Clients unable to pay for services**	30	7%	10%	7%	30%	47%	77%
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)	32	13%	16%	13%	38%	22%	59%
K	**Stigma related to seeking/receiving mental healthcare**	32	9%	16%	16%	38%	22%	59%
N	**Underinsured patients** (i.e., have insurance but does not provide enough coverage to pay for services)	32	6%	9%	25%	19%	41%	59%
J	**Clients unaware of existing services**	32	9%	16%	19%	41%	16%	56%
E	**Clients have co-existing conditions**	32	6%	19%	25%	25%	25%	50%
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)	32	3%	22%	31%	28%	16%	44%
F	**Transportation issues**	32	13%	13%	31%	34%	9%	44%
M	**Lack of weekend or evening appointment times**	32	31%	25%	13%	16%	16%	31%
Q	**Lack of specialized services for youth**	32	31%	16%	22%	22%	9%	31%
L	**Child care while client in treatment**	32	22%	19%	31%	16%	13%	28%
P	**Lack of specialized services for the elderly**	32	28%	16%	28%	22%	6%	28%
G	**Transient populations**	30	27%	27%	20%	17%	10%	27%
O	**Lack of treatment providers for minorities or individuals from other cultures**	32	28%	22%	28%	16%	6%	22%
S	**Lack of trained staff to provide treatment to clients**	32	31%	22%	25%	22%	0%	22%
U	**Other**	9	78%	0%	0%	11%	11%	22%
R	**No service available for client's issue**	32	22%	25%	38%	16%	0%	16%
T	**Lack of 24-hour emergency services**	32	44%	34%	9%	9%	3%	13%
C	**Clients who require services are incarcerated**	31	42%	19%	29%	6%	3%	10%
D	**Lack of guardianship in place**	30	30%	40%	20%	7%	3%	10%
H	**Language barriers**	32	31%	50%	9%	6%	3%	9%

Extent of Barriers for Clients Receiving Addiction and/or Mental Health Services (Ancillary Providers-Schools/Early Childhood Centers)								
	Need Area	N	1 Not a barrier	2 Somewhat of a barrier	3 Moderate barrier	4 Large barrier	5 Extreme barrier	Large to Extreme Barrier
J	**Clients unaware of existing services**	31	10%	10%	13%	52%	16%	68%
I	**Clients unable to pay for services**	30	10%	20%	13%	33%	23%	57%
Q	**Lack of specialized services for youth**	30	10%	13%	30%	27%	20%	47%
N	**Underinsured patients** (i.e., have insurance but does not provide enough coverage to pay for services)	31	19%	26%	13%	19%	23%	42%
M	**Lack of weekend or evening appointment times**	30	20%	13%	30%	33%	3%	37%
K	**Stigma related to seeking/receiving mental healthcare**	31	10%	16%	39%	19%	16%	35%
S	**Lack of trained staff to provide treatment to clients**	30	20%	23%	23%	23%	10%	33%
U	**Other**	6	67%	0%	0%	17%	17%	33%
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)	31	3%	19%	45%	32%	0%	32%
F	**Transportation issues**	31	16%	16%	35%	16%	16%	32%
R	**No service available for client's issue**	31	35%	23%	19%	19%	3%	23%
G	**Transient populations**	30	37%	27%	17%	13%	7%	20%
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)	30	17%	20%	47%	13%	3%	17%
E	**Clients have co-existing conditions**	30	17%	30%	37%	13%	3%	17%
T	**Lack of 24-hour emergency services**	30	33%	27%	23%	13%	3%	17%
D	**Lack of guardianship in place**	31	39%	35%	16%	6%	3%	10%
L	**Child care while client in treatment**	31	42%	19%	29%	10%	0%	10%
O	**Lack of treatment providers for minorities or individuals from other cultures**	30	63%	20%	7%	10%	0%	10%
H	**Language barriers**	30	60%	27%	7%	7%	0%	7%
C	**Clients who require services are incarcerated**	31	71%	16%	6%	6%	0%	6%
P	**Lack of specialized services for the elderly**	30	80%	3%	13%	3%	0%	3%

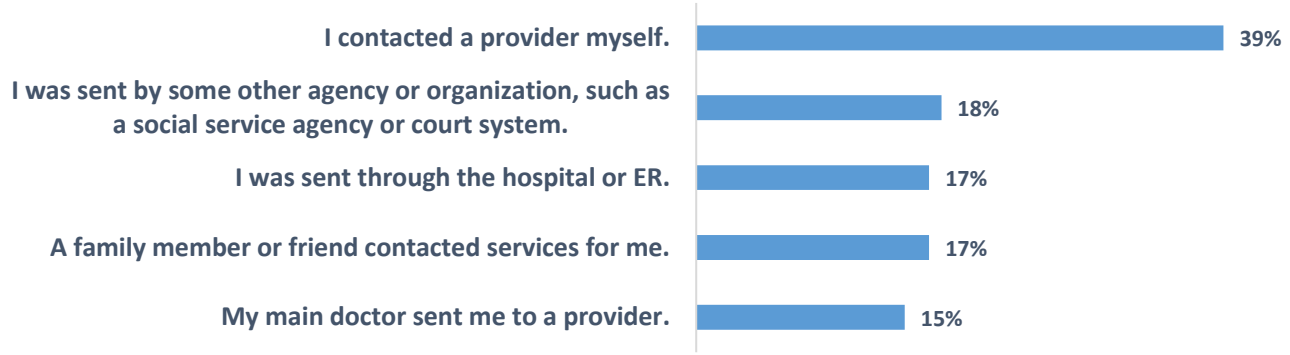
Extent of Barriers for clients receiving addiction and/or mental health services (Ancillary Provider- Other Organizations)								
	Need Area	N	1 Not a barrier	2 Somewhat of a barrier	3 Moderate barrier	4 Large barrier	5 Extreme barrier	Large to Extreme Barrier
I	**Clients unable to pay for services**	61	16%	16%	15%	23%	30%	52%
F	**Transportation issues**	61	7%	16%	26%	28%	23%	51%
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)	61	5%	16%	31%	28%	20%	48%
J	**Clients unaware of existing services**	61	7%	25%	21%	30%	18%	48%
N	**Underinsured patients** (i.e., have insurance but does not provide enough coverage to pay for services)	59	19%	12%	22%	19%	29%	47%
U	**Other**	10	60%	0%	0%	10%	30%	40%
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)	61	8%	33%	20%	30%	10%	39%
E	**Clients have co-existing conditions**	59	12%	17%	34%	24%	14%	37%
K	**Stigma related to seeking/receiving mental healthcare**	60	7%	27%	32%	27%	8%	35%
L	**Child care while client in treatment**	60	22%	25%	20%	17%	17%	33%
M	**Lack of weekend or evening appointment times**	60	23%	20%	23%	22%	12%	33%
T	**Lack of 24-hour emergency services**	60	37%	15%	15%	18%	15%	33%
G	**Transient populations**	61	23%	21%	25%	21%	10%	31%
S	**Lack of trained staff to provide treatment to clients**	60	25%	22%	27%	15%	12%	27%
C	**Clients who require services are incarcerated**	59	36%	20%	20%	14%	10%	24%
R	**No service available for client's issue**	60	30%	22%	30%	12%	7%	18%
Q	**Lack of specialized services for youth**	59	29%	34%	22%	12%	3%	15%
D	**Lack of guardianship in place**	58	36%	22%	28%	9%	5%	14%
P	**Lack of specialized services for the elderly**	61	31%	33%	28%	5%	3%	8%
H	**Language barriers**	61	52%	39%	3%	3%	2%	5%
O	**Lack of treatment providers for minorities or individuals from other cultures**	60	55%	28%	12%	0%	5%	5%

E. Client Survey

Data from clients receiving mental health and addiction services were examined to better understand how clients first accessed services and the potential problems they may have experienced. In addition, clients were also asked to identify what has helped them most while accessing these services. A description of the participants and data collection procedures was provided in Section 1. Results are presented below.

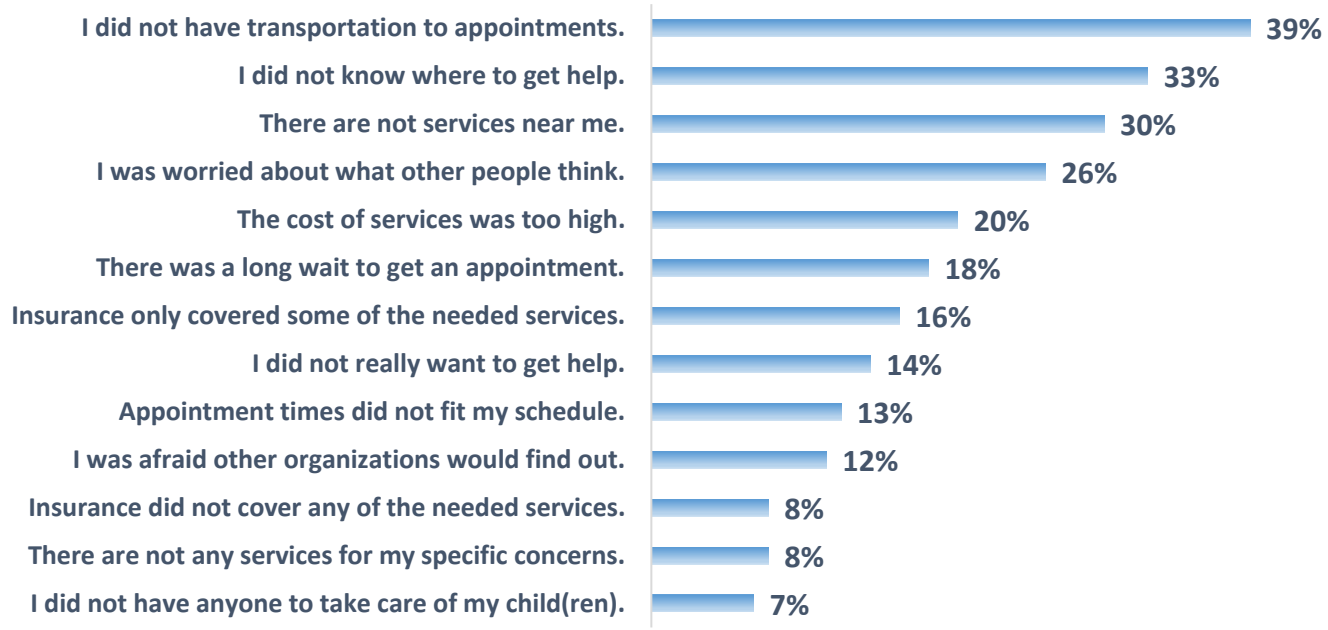
How do Clients Get Connected to Services?

Participants were asked how they were first connected with the services they received. Of the 111 participants with a valid response to the question, 39% reported contacting the provider themselves. (Note: In some cases, participants recorded two answers, so the percentage is based on the total number responding to the question.)



What Problems have Clients Experienced?

Participants were also asked to select from a list of possible problems they may have experienced in relation to the mental health or addiction services received. Of the 104 participants with a valid response to this question, 39% of participants reported not having transportation to appointments, while 33% did not know where to get help, 30% noted that there are not services near them, and 26% reported being worried about what others would think.



In addition to the ratings above, participants were also asked to identify any other problems experienced when getting help. This question was intended to capture any additional reasons that may not have been included with the rating scale. A total of 71 participants provided an answer to this question. Responses were grouped together to identify common themes. As a note, while participants were asked to identify any other problems experienced, analysis of themes suggests that some responses are linked with ratings presented above. However, narrative responses appear to be emphasizing problems experienced.

Based on this analysis, the most common themes included (a) financial concerns with the cost of services including insurance related issues, (b) transportation and distance to appointments, and (c) stigma associated with receiving services. Verbatim responses are provided below by identified themes.

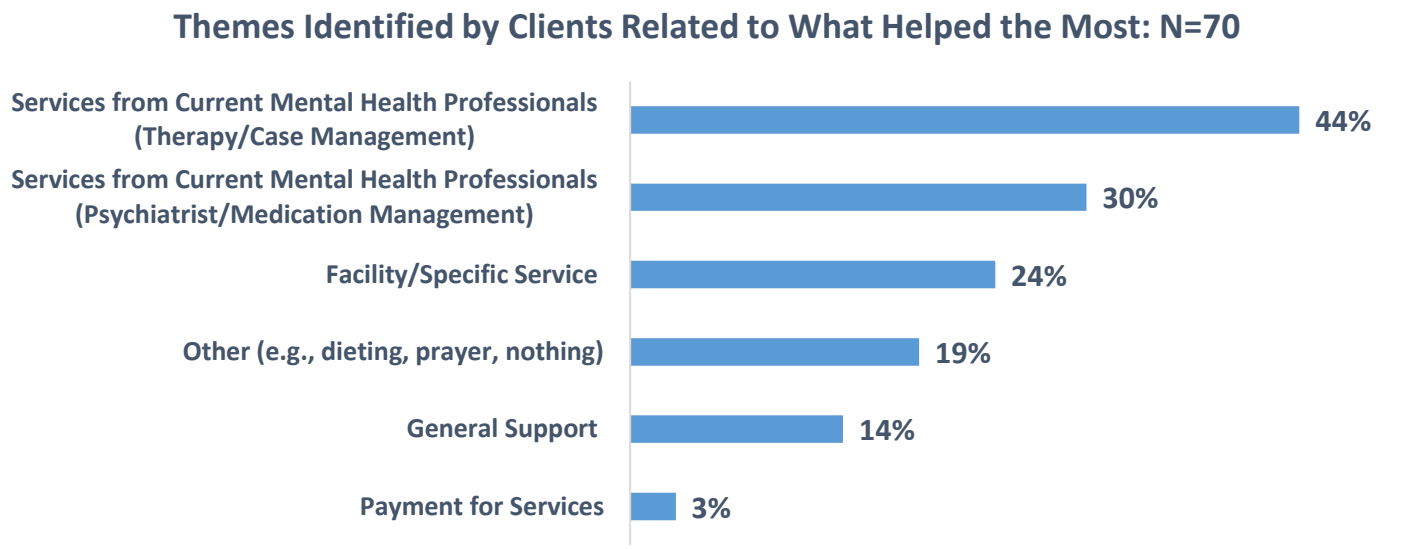
Verbatim Responses: Other Problems Experienced When Getting Help (N=71)
Specific Diagnosis (4 comments)
• Bipolar disorder/ Borderline personality
• Recovering drug addict
• Major depression, general anxiety, bipolar, diabetes, diverticulitis.
• Mental problems
Transportation (6 comments)
• Car
• Transportation (x2)
• Getting to other Dr's appt.
• Hard for me to depend on others to get me here. But thank God! I can!
• I don't have any money so I can't travel very far.
Distance (2 comments)
• Closing the Cuba office, made it harder on us that live down here.
• Distance to Dr. and therapist office
Appointment/Waiting Times (3 comments)
• Doctor runs behind
• Having to wait for the doctor 1-2 hrs.
• My work
Costs (13 comments)
• Co pay
• Financial concerns (x3)
• Funding does not seem to be available for financial needs.
• No health insurance
• No insurance
• No insurance, no job
• No Medicaid
• Paying for the services.
• Limited income
• Money (x2)
Housing (3 comments)
• Housing (x2)
• I'm homeless.
Awareness of Services (2 comments)
• Moved- did not know where to go.
• Not knowing where resources where to get help outside of therapy and psychiatry

Self-Awareness of Issues (3 comments)
I didn't realize that I needed help.
Didn't realize how serious my mental health issues were.
Was not ready
Stigma (6 comments)
Embarrassed to get help.
Fear of letting people know my problems.
Overall, there is a heavy stigma
My children have had a stigma put on them because of my services.
Myself, pride
Felt bad for requesting services and admitting that I needed help.
Lack of Perceived Empathy (4 comments)
I have a doctor that doesn't listen and still need therapy for some concerns
Doctor appointments are becoming problematic
Felt they didn't care or I was lying about my problems
Locating documentation
Other (5 comments)
Not getting meds
Just don't go
Just turned to prayer didn't reach out.
Boyfriend problems
My boyfriend a big part of my life

What has Helped the Most?

Participants were also asked to identify what has helped them the most with the concerns they have experienced. While 70 participants provided an answer to this question, a total of 94 unique ideas were expressed. Responses were grouped together to identify common themes.

The most common themes included (a) services received from their current mental health professional(s), such as their counselor, therapist or case manager, (b) services received from their psychiatrist or medication management, and (c) mention of a specific facility or treatment program (e.g., Pathways, Drug Court). Verbatim responses are first displayed below, followed by specific themes and verbatim comments.



Verbatim Responses: What Has Helped Most with Concerns (N=70)

Services from Current Mental Health Professionals (Therapy/Case Management) (31 comments-44%)

- Good therapist
- Good case worker
- Talking with counselors and therapist
- Therapy (x2)
- Talking to [name] helps.
- Assistance with scheduling.
- Therapists make me feel comfortable
- The case worker... and just going through it and continuing to adjust
- The anger management counseling I've received.
- Counseling (x5)
- Someone to talk to.
- Someone to help me get to Doctor appointments.
- My caseworker is a big help. They have all been wonderful.
- My case worker
- Having someone that will listen to me and cares about me
- One on one comm./ insight and exploring resources
- My worker- knowing somebody cares
- My therapist and [Name] (old case worker)
- Assisting in scheduling appointments.
- Caseworker coming to see me.
- Having someone to talk to about my concerns.
- Having a worker who educates me on my anxiety and lets me vent my problems and life issues.
- Caseworker
- Assistance with finding resources
- My therapist

Services from Current Mental Health Professionals (Psychiatrist/Medication Management) (21 comments-30%)

- Medication Management (x8)
- medication management positive support
- Weed (Medicinal)
- Talking to my psychiatrist
- Pathways Dr's make me feel comfortable
- Psychiatric services, medication, having someone to talk to, help with setting goals for myself.
- Psychiatric services, medication
- Receiving services for mental health issues, medication
- Psyche unit regulated meds
- Seeing Dr. and getting meds
- Medication to help with my depression, anxiety and hallucinations.
- I have medication now.
- Availability of medical provider @YCHC. YCHC helped with low or no cost medication.
- Being able to get his meds.

Facility/Specific Service (17 comments-24%)

- IHS
- PSS.
- Support doctors stress center
- Substance abuse education
- Pathways is wonderful at addressing ALL concerns that come up.
- Pathways
- Pathways. They have been a big help.
- Having IHS's coming to see me.
- People- workers IHS's People who ask can I help you.
- my drug court systems

- IHS
- The secretaries at pathways make me feel comfortable.
- IHS's have helped so much.
- seeing IHS all help w/ anxiety.
- Hospital staff
- Working with Pathways staff
- CPRC

Other (13 comments-19%)

- Been learning coping skills to deal with my mental problems.
- Started getting help. Prayer
- finally got married so I didn't have to plan my wedding anymore, finished my statistics class
- Nothing (x2)
- Organizing my life, scheduling appointments
- I have resources that could help me.
- Learning to control anger.
- Just getting on the right track.
- Ministry
- Having them addressed in a timely manner
- Every week in out of meds and I have to go without them till someone decides to do their job.
- Dieting

General Support (10 comments-14%)

- Positive support
- Other people trying to help me from their own.
- Other people in the program with me.
- My support system
- My support
- group support
- Doctor listened
- Dr. [name] has been great to work with.
- Family
- All of the services I have received

Payment for Services (2 comments-3%)

- Payment by insurance
- Being able to make payments.

Section 4 SECONDARY DATA: ADDICTION AND MENTAL HEALTH PREVALENCE

This section details selected secondary data sources related to addiction and mental health issues within the six-county study area. As noted earlier, the initial source document for this study was the most recent Community Health Needs Assessment provided by Phelps County Regional Medical Center, which highlighted key health needs in the community. This document served as guidance for data sources that may be included in the current study. To provide additional supporting evidence regarding mental health and addiction needs, a review of pertinent secondary data sources was conducted. Data were related to issues such as social determinants of mental health, prevalence of substance use, and utilization of treatment services.

The largest portion of data were obtained from (a) the Hospital Industry Data Institute (HIDI), which is the data company of the Missouri Hospital Association, and (b) the online data system provided by the Missouri Department of Mental Health. Data from the HIDI were compiled by Phelps County Regional Medical Center (PCRMC) Applications & Analytics. This data source included hospital admission reasons (e.g., diagnosis) specific to mental health and addiction issues identified by the planning team, as well as other information deemed important to examine (e.g., demographics, payment type, length of stay). Further, most data from the online data system provided by the Missouri Department of Mental Health were available at the county and state level. Additional data sources included County Health Rankings, CDC-Behavioral Risk Factor Surveillance System, and the U.S. Census Bureau.

Based on data available at the time of this report, the most recent selected secondary data indicators are provided below for each county, as available. Data from the HIDI related to both mental health and drug and alcohol addiction issues are first presented. Next, specific indicators related to drug and alcohol addiction generated from additional data sources are provided, followed by indicators specifically associated with mental health.

Importantly, while data are disaggregated by mental health and addiction concerns, it is understood that differences between the two are not always distinguishable. Further, the need for better understanding and treatment of co-occurring issues was identified as a need in this study.

Hospital Admissions for Mental Health and/or Addiction Issues

The following tables depict secondary data extracted from the Hospital Industry Data Institute (HIDI) on April 5, 2018 and compiled by Phelps County Regional Medical Center (PCRMC) Applications & Analytics. Data represent 2016 and 2017 fiscal years (October 1st through-September 30th). Further analyses were conducted to shed light on the prevalence of mental health and addiction issues within the community. Data represent individual hospital admissions (from clients who reside in Crawford, Dent, Maries, Phelps, Pulaski, and Texas counties) to various hospitals located in the six-county service area, as well as other areas in Missouri. Admissions are specific to mental health and addiction issues.

Mental Health/Addiction Hospital Admissions by Gender

- Overall, hospital admissions from individuals residing in Crawford, Dent, Maries, Phelps, Pulaski, or Texas counties have declined slightly. Further, differences were noted for males and females, with females having a higher rate of admission than males. The difference was especially pronounced in 2016.

Percent of Hospital Admissions by Gender: All Counties

Six County Area	2016			2017			Total		
	n	%	Rate per 10,000	n	%	Rate per 10,000	n	%	Rate per 10,000
Female	1190	55%	147.7	1054	51%	130.8	2244	53%	278.5
Male	990	45%	109.5	1025	49%	113.4	2015	47%	222.9
Total	2180	100%	127.5	2079	100%	121.6	4259	100%	249.0

Source: HIDI Data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center Applications & Analytics.

Mental Health/Addiction Hospital Admissions by Age

- Overall, the 19 to 29 year old age group has the highest percentage of hospital admissions for both 2016 and 2017. When specific diagnoses are coded as either primarily alcohol related or primarily mental health related, most admissions for this age group (along with other age groups) is a result of a mental health diagnosis. However, when addiction-related diagnoses are examined alone, the 19 to 29 year old age group accounted for 37% of all admissions in 2017. This did not seem to change much from 2016. Further, a notable finding concerns the high percent of 13-18 admissions. In 2017, this age group accounted for 22% of mental health admissions, which was tied with the 19-29 age group. Importantly, hospital admissions are based on the primary diagnosis and may not accurately reflect the presence of co-occurring issues.

Percent of Hospital Admissions by Age and Mental Health or Addiction Related: All Counties

Age	2016						2017					
	Addiction Related		Mental Health Related		Total		Addiction Related		Mental Health Related		Total	
	n	%	n	%	n	%	n	%	n	%	n	%
< 1	4	1%	1	0%	5	0%	5	1%	1	0%	6	0%
1 - 5	0	0%	3	0%	3	0%	0	0%	7	0%	7	0%
6 - 12	1	0%	155	9%	156	7%	0	0%	134	8%	134	6%
13 - 18	8	2%	361	21%	369	17%	11	3%	358	22%	369	18%
19 - 29	166	34%	338	20%	504	23%	164	37%	356	22%	520	25%
30 - 39	148	31%	275	16%	423	19%	120	27%	256	16%	376	18%
40 - 49	79	16%	247	15%	326	15%	79	18%	208	13%	287	14%
50 - 59	60	12%	188	11%	248	11%	43	10%	196	12%	239	11%
60 - 69	11	2%	85	5%	96	4%	13	3%	68	4%	81	4%
70 - 79	3	1%	30	2%	33	2%	4	1%	38	2%	42	2%
80 - 89	3	1%	12	1%	15	1%	1	0%	17	1%	18	1%
> 90	0	0%	2	0%	2	0%	0	0%	0	0%	0	0%
Total	483	100%	1697	100%	2180	100%	440	100%	1639	100%	2079	100%

Source: HIDI Data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center Applications & Analytics.

Mental Health/Addiction Hospital Admissions by County and Type

- For all counties, the count and rate of mental health-related hospital admissions was approximately three times higher than addiction-related admissions. Between 2016 and 2017, admissions for both reasons fell slightly for most counties. The rates for mental health-related admissions were highest for Crawford County, followed by Phelps and Dent Counties. The rates for addiction-related admissions were also highest for these three counties, with rates of approximately 33 to 39 per 10,000 population.

Percent of Hospital Admissions by County of Residence: Primary Diagnoses by Mental Health or Addiction Related												
County	Mental Health Related						Addiction Related					
	2016			2017			2016			2017		
	n	%	rate per 10,000	n	%	rate per 10,000	n	%	rate per 10,000	n	%	rate per 10,000
Crawford	304	18%	125.1	313	19%	129.9	94	19%	38.7	80	18%	33.2
Dent	178	10%	115.7	163	10%	105.3	60	12%	39.0	54	12%	34.9
Maries	83	5%	93.7	71	4%	80.1	22	5%	24.8	11	3%	12.4
Phelps	535	32%	119.9	473	29%	105.7	156	32%	35.0	163	37%	36.4
Pulaski	395	23%	75.0	421	26%	80.9	88	18%	16.7	97	22%	18.6
Texas	202	12%	78.4	198	12%	76.9	63	13%	24.4	35	8%	13.6
Total	1697	100%		1639	100%		483	100%		440	100%	

Source: HIDI Data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center Applications & Analytics.

Mental Health/Addiction Hospital Admissions by Primary Payer Method

- Across all counties, the percentage of clients utilizing Medicaid as the primary payment method represents nearly a third of all admissions.

Percent of Hospital Admissions by Primary Payer: All Counties						
Primary Payer	2016		2017		Total	
	n	%	n	%	n	%
Medicaid	654	30%	522	25%	1176	28%
Medicare	406	19%	335	16%	741	17%
Self Pay	362	17%	361	17%	723	17%
Medicaid Managed Care	299	14%	323	16%	622	15%
Commercial/Private	183	8%	143	7%	326	8%
Commercial/Private Managed Care	73	3%	124	6%	197	5%
Medicare Managed Care	44	2%	64	3%	108	3%
Blue Cross/Blue Shield	50	2%	43	2%	93	2%
Other Government	34	2%	47	2%	81	2%
Blue Cross/Blue Shield Managed Care	19	1%	28	1%	47	1%
Maternal Child Managed Care	0	0%	45	2%	45	1%
Commercial Exchange, Silver	15	1%	16	1%	31	1%
Other Government Managed Care	16	1%	14	1%	30	1%
Other	8	0%	5	0%	13	0%
Other Managed Care	7	0%	2	0%	9	0%
Workers' Comp Managed Care	5	0%	2	0%	7	0%
Charity/No Charge	3	0%	3	0%	6	0%
Commercial Exchange, Bronze	1	0%	1	0%	2	0%
Commercial Exchange, Unknown	1	0%	1	0%	2	0%
Total	2180	100%	2079	100%	4259	100%

Source: HIDI Data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center Applications & Analytics.

Mental Health/Addiction Hospital Admissions by Diagnosis and County

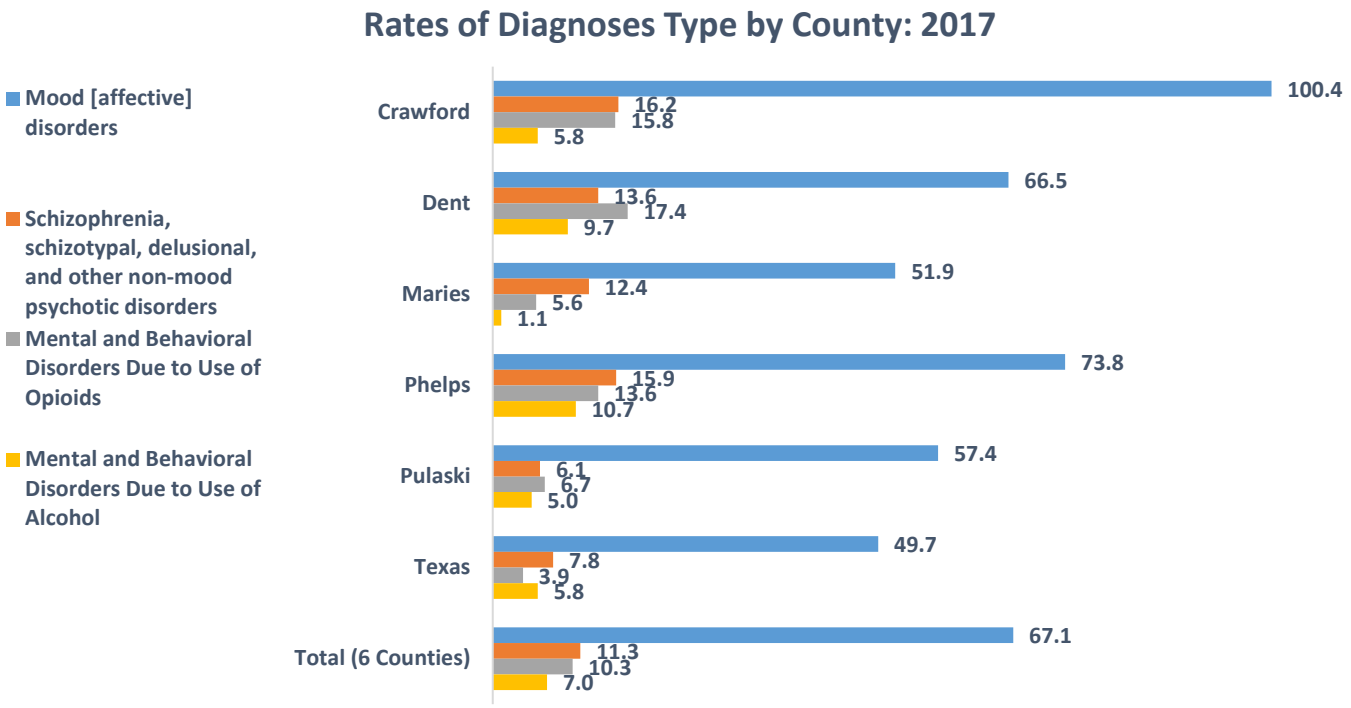
- Overall, across all counties, mood (affective) disorders accounted for more than half of all admissions (55%) in both 2016 (56%) and 2017 (55%). However, as noted previously, hospital admissions are based on the primary diagnosis and may not accurately reflect the presence of co-occurring issues.

- Within the mood (affective) disorder category for both 2016 and 2017, major depressive disorder and bipolar disorder accounted for 85% of diagnoses. In 2017, Crawford County had the highest rate of admissions for mood disorders. The Phelps County rate was also above the average for the six-county area. A similar trend occurred in 2016, with the Dent County rate also being above the region average.

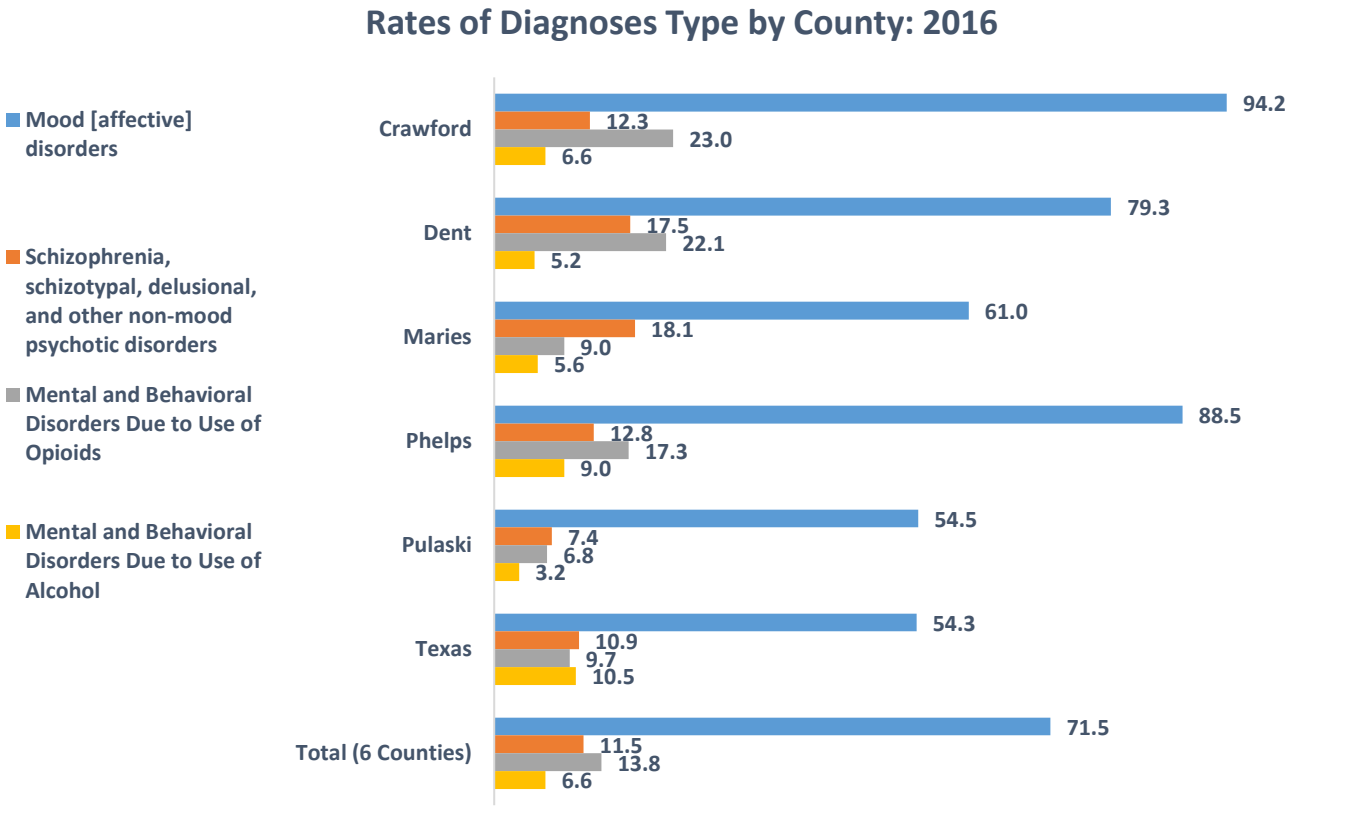
- When diagnoses related to addiction are examined, mental and behavioral disorders due to opioids was the highest diagnosis area, representing 8% of all diagnoses in 2017 and 11% in 2016. In 2017, Dent County had the highest rate of admission for opioids. The rates for Crawford and Phelps were also above the average for the six-county area. In 2016, Crawford had the highest rate, followed closely by Dent County.

- Mental and behavioral disorders due to alcohol was the second highest (6%) diagnoses type related to addiction. In 2017, Phelps County had the highest rate of admission for alcohol use, followed closely by Dent County. In 2016, Texas County had the highest rate of admission for alcohol, followed by Phelps County.

Rates for the top four diagnoses categories in 2016 and 2017 are displayed in the figures below, followed by detailed results for all diagnoses categories.



Source: HIDI Data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center Applications & Analytics.



Source: HIDI Data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center Applications & Analytics.

Primary Diagnosis by Hospital Admissions (Oct 1, 2016-Sep 30, 2017)-2017 (Note: Comparisons between counties should be based on rates displayed in the figure above)														
Diagnosis Category	Crawford		Dent		Maries		Phelps		Pulaski		Texas		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Mood [affective] disorders	**242**	**62%**	**103**	**47%**	**46**	**56%**	**330**	**52%**	**299**	**58%**	**128**	**55%**	**1148**	**55%**
Major depressive	143	---	64	---	28	---	190	---	193	---	77	---	695	---
Bipolar	68	---	19	---	11	---	88	---	56	---	26	---	268	---
Disruptive mood dysregulate.	12	---	13	---	3	---	16	---	26	---	18	---	88	---
Unspecified Mood	12	---	4	---	2	---	24	---	15	---	5	---	62	---
Other (e.g., dysthymia)	65	---	0	---	58	---	0	---	18	---	0	---	151	---
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	**39**	**10%**	**21**	**10%**	**11**	**13%**	**71**	**11%**	**32**	**6%**	**20**	**9%**	**194**	**9%**
Mental and Behavioral Disorders Due to Use of Opioids	**38**	**10%**	**27**	**12%**	**5**	**6%**	**61**	**10%**	**35**	**7%**	**10**	**4%**	**176**	**8%**
Mental and Behavioral Disorders Due to Use of Alcohol	**14**	**4%**	**15**	**7%**	**1**	**1%**	**48**	**8%**	**26**	**5%**	**15**	**6%**	**119**	**6%**
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	**10**	**3%**	**12**	**6%**	**3**	**4%**	**31**	**5%**	**31**	**6%**	**20**	**9%**	**107**	**5%**
Injury, poisoning and certain other consequences of external causes	**9**	**2%**	**6**	**3%**	**5**	**6%**	**13**	**2%**	**20**	**4%**	**16**	**7%**	**69**	**3%**
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	**4**	**1%**	**15**	**7%**	**5**	**6%**	**11**	**2%**	**16**	**3%**	**8**	**3%**	**59**	**3%**
Pregnancy, childbirth and the puerperium	**7**	**2%**	**5**	**2%**	**2**	**2%**	**20**	**3%**	**15**	**3%**	**0**	**0%**	**49**	**2%**
Mental and Behavioral Disorders Due to Use of Other Psychoactive Substance Abuse	**11**	**3%**	**3**	**1%**	**0**	**0%**	**16**	**3%**	**15**	**3%**	**1**	**0%**	**46**	**2%**
Mental and Behavioral Disorders Due to Use of Other Stimulants	**10**	**3%**	**2**	**1%**	**2**	**2%**	**12**	**2%**	**8**	**2%**	**4**	**2%**	**38**	**2%**
Disorders of adult personality and behavior	**3**	**1%**	**4**	**2%**	**0**	**0%**	**10**	**2%**	**8**	**2%**	**6**	**3%**	**31**	**1%**
Other	**6**	**2%**	**4**	**2%**	**2**	**2%**	**13**	**2%**	**13**	**3%**	**5**	**2%**	**43**	**2%**
Total	**393**	**100%**	**217**	**100%**	**82**	**100%**	**636**	**100%**	**518**	**100%**	**233**	**100%**	**2079**	**100%**

Primary Diagnosis by Hospital Admissions (Oct 1, 2015-Sep 30, 2016)-2016 (Note: Comparisons between counties should be based on rates displayed in the figure above)														
Diagnosis Category	Crawford		Dent		Maries		Phelps		Pulaski		Texas		Total	
	n	%	n	%	n	%	n	%	n	%	n	%	n	%
Mood [affective] disorders	**229**	**58%**	**122**	**51%**	**54**	**51%**	**395**	**57%**	**287**	**59%**	**140**	**53%**	**1227**	**56%**
Major depressive	*121*	---	*72*	---	*24*	---	*227*	---	*162*	---	*86*	---	*692*	---
Bipolar	*76*	---	*33*	---	*23*	---	*121*	---	*84*	---	*31*	---	*368*	---
Other persistent mood	*20*	---	*9*	---	*2*	---	*18*	---	*21*	---	*19*	---	*89*	---
Unspecified mood	*9*	---	*6*	---	*4*	---	*27*	---	*12*	---	*3*	---	*61*	---
Other (e.g., dysthymia)	*3*	---	*2*	---	*1*	---	*2*	---	*8*	---	*1*	---	*17*	---
Mental and behavioral disorders due to use of opioids	**56**	**14%**	**34**	**14%**	**8**	**8%**	**77**	**11%**	**36**	**7%**	**25**	**9%**	**236**	**11%**
Schizophrenia, schizotypal, delusional, and other non-mood psychotic disorders	**30**	**8%**	**27**	**11%**	**16**	**15%**	**57**	**8%**	**39**	**8%**	**28**	**11%**	**197**	**9%**
Mental and behavioral disorders due to use of alcohol	**16**	**4%**	**8**	**3%**	**5**	**5%**	**40**	**6%**	**17**	**4%**	**27**	**10%**	**113**	**5%**
Anxiety, dissociative, stress-related, somatoform and other nonpsychotic mental disorders	**17**	**4%**	**8**	**3%**	**3**	**3%**	**30**	**4%**	**25**	**5%**	**12**	**5%**	**95**	**4%**
Injury, poisoning and certain other consequences of external causes	**13**	**3%**	**10**	**4%**	**2**	**2%**	**23**	**3%**	**20**	**4%**	**13**	**5%**	**81**	**4%**
Pregnancy, childbirth and the puerperium	**9**	**2%**	**4**	**2%**	**3**	**3%**	**20**	**3%**	**15**	**3%**	**6**	**2%**	**57**	**3%**
Mental and behavioral disorders due to of Other Stimulants	**10**	**3%**	**9**	**4%**	**5**	**5%**	**10**	**1%**	**15**	**3%**	**4**	**2%**	**53**	**2%**
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	**7**	**2%**	**6**	**3%**	**5**	**5%**	**14**	**2%**	**11**	**2%**	**5**	**2%**	**48**	**2%**
Mental and behavioral disorders due to use of other psychoactive substance abuse	**3**	**1%**	**3**	**1%**	**0**	**0%**	**5**	**1%**	**5**	**1%**	**2**	**1%**	**18**	**1%**
Disorders of adult personality behavior	**2**	**1%**	**3**	**1%**	**1**	**1%**	**5**	**1%**	**2**	**0%**	**1**	**0%**	**14**	**1%**
Other	**6**	**2%**	**4**	**2%**	**3**	**3%**	**15**	**2%**	**11**	**2%**	**2**	**1%**	**41**	**2%**
Total	**398**	**100%**	**238**	**100%**	**105**	**100%**	**691**	**100%**	**483**	**100%**	**265**	**100%**	**2180**	**100%**

Source: HIDI Data extracted on April 5, 2018 and compiled by Phelps County Regional Medical Center Applications & Analytics.

Drug and Alcohol Addiction Secondary Data Indicators

High Risk Alcohol Consumption

- Based on data presented by County Health Rankings, almost one out of every five residents in the community engages in excessive drinking (binge or heavy drinking). The rate for Pulaski County is the highest of the six-county region.

County Health Rankings – Excessive Drinking					
County	2014	2015	2016*	2017*	2018*
Crawford	--	--	14%	16%	16%
Dent	--	--	14%	14%	16%
Maries	--	--	15%	16%	16%
Phelps	14%	14%	17%	17%	18%
Pulaski	22%	22%	20%	21%	22%
Texas	11%	11%	14%	15%	16%
Missouri	17%	17%	16%	18%	19%

*Data should not be compared to prior years due to changes in definitions/methods.
Source: Primary-CDC, Behavioral Risk Factor Surveillance System; Secondary-County Health Rankings

Drug-related Admissions

- **Alcohol:** The rate of substance use treatment admissions primarily for alcohol declined for all counties. The 2016 rates for Crawford, Dent, and Phelps were higher than the state of Missouri rate.

Substance Use Treatment Admissions Primarily for Alcohol – Rate Per 10,000 Population, 5 year aggregate					
County	2013	2014	2015	2016	2017
Crawford	50.36	44.43	38.58	31.47	24.76
Dent	45.54	40.44	35.43	32.02	29.53
Maries	17.49	14.47	15.16	16.56	17.36
Phelps	29.31	26.42	24.42	22.70	20.13
Pulaski	11.49	10.84	10.49	10.10	9.82
Texas	26.33	24.39	21.47	19.74	18.75
Missouri	25.27	23.91	22.33	20.93	19.48

Source: Missouri Department of Mental Health, Division of Behavioral Health

- **Prescription Drugs:** Admissions primarily for prescription drugs decreased for all counties between 2013 and 2016. The 2016 rates for Crawford, Dent, and Phelps were higher than the state of Missouri.

Substance Use Treatment Admissions Primarily for Prescription Drugs – Rate Per 10,000 Population, 5 year aggregate					
County	2013	2014	2015	2016	2017
Crawford	3.31	2.91	2.19	2.51	2.60
Dent	5.90	5.37	3.84	2.82	3.08
Maries	NA	NA	NA	NA	NA
Phelps	4.90	4.22	3.55	3.42	3.07
Pulaski	1.16	0.99	0.94	0.97	1.05
Texas	2.63	2.01	1.94	1.94	2.25
Missouri	2.35	2.29	2.19	2.25	2.25

Source: Missouri Department of Mental Health, Division of Behavioral Health

- **Methamphetamine:** Admissions primarily for methamphetamine increased for Dent, Pulaski, and Texas counties between 2013 and 2016 but decreased for Crawford, Maries, and Phelps. The 2016 rates were higher than the state of Missouri for all counties except Pulaski. The Crawford rate was approximately twice that of the state.

Substance Use Treatment Admissions Primarily for Methamphetamine – Rate Per 10,000 Population, 5 year aggregate					
County	2013	2014	2015	2016	2017
Crawford	20.93	19.18	18.4	18.49	17.59
Dent	10.39	10.11	11.64	13.19	14.76
Maries	10.49	9.43	9.67	9.27	12.01
Phelps	11.36	10.34	10.06	10.84	13.01
Pulaski	2.86	2.84	3.34	3.96	5.28
Texas	7.13	7.82	8.14	9.48	10.27
Missouri	6.96	7.58	8.29	9.07	10.08

Source: Missouri Department of Mental Health, Division of Behavioral Health

- **Marijuana:** Admissions primarily for marijuana decreased for all counties between 2013 and 2016. The 2016 rates for Crawford, Dent, and Phelps counties were higher than the state of Missouri rate.

Substance Use Treatment Admissions Primarily for Marijuana – Rate Per 10,000 Population, 5 year aggregate					
County	2013	2014	2015	2016	2017
Crawford	32.65	26.14	21.56	17.43	12.95
Dent	30.28	24.95	21.23	16.65	12.71
Maries	12.24	9.64	8.35	7.73	6.45
Phelps	24.19	19.85	17.5	14.35	13.58
Pulaski	4.49	3.49	3.19	3.63	3.67
Texas	14.25	11.61	10.77	9.87	10.27
Missouri	16.08	15.03	13.95	13.10	12.38

Source: Missouri Department of Mental Health, Division of Behavioral Health

- **Heroin:** Admissions primarily for heroin increased for Crawford, Dent, Phelps, and Pulaski counties. Data were unavailable for Maries and Texas. The 2016 rates for Dent, Phelps, and Pulaski were higher than the state of Missouri.

Substance Use Treatment Admissions Primarily for Heroin – Rate Per 10,000 Population, 5 year aggregate					
County	2013	2014	2015	2016	2017
Crawford	4.77	4.78	4.94	6.00	7.01
Dent	5.00	6.14	7.16	8.20	9.50
Maries	NA	NA	NA	NA	4.90
Phelps	4.46	5.46	6.96	8.09	9.89
Pulaski	5.80	6.78	7.27	9.06	10.39
Texas	NA	NA	NA	NA	NA
Missouri	5.00	5.42	5.80	6.30	6.76

Source: Missouri Department of Mental Health, Division of Behavioral Health

- **Any Substance Use Treatment:** Admissions primarily for any substance decreased between 2013 and 2016 for all counties except Pulaski. The 2016 rates for Crawford, Dent, and Phelps were higher than the state of Missouri.

Substance Use Treatment Admissions Primarily for Any Substance – Rate Per 10,000 Population, 5 year aggregate					
County	2013	2014	2015	2016	2017
Crawford	121.97	106.59	93.94	83.22	72.66
Dent	115.97	106.34	97.72	88.52	83.60
Maries	46.78	40.77	41.10	44.64	48.74
Phelps	86.78	79.25	75.02	71.06	70.04
Pulaski	28.63	27.77	27.92	30.01	32.59
Texas	60.42	55.98	52.02	50.21	49.73
Missouri	63.20	61.23	59.00	57.55	56.35

Source: Missouri Department of Mental Health, Division of Behavioral Health

Drug- and Alcohol-related Emergency Room Episodes

- **Alcohol Use Disorder:** Emergency room episodes with alcohol use disorder as the principal or secondary diagnosis increased slightly for Crawford, Maries, Pulaski, and Texas Counties but decreased for Dent and Phelps. The 2015 rate for all counties was lower than the state of Missouri rate.
- **Drug Use Disorder:** Emergency room episodes with drug use disorder as the principal or secondary diagnosis increased for all counties except Phelps. The 2015 rate for Crawford County was higher than the state of Missouri rate while all other counties were lower.

Emergency Room Episodes with Alcohol Use or Drug Use Disorder Principal or Secondary Diagnosis – Rate Per 10,000 Population, 3 year aggregate								
County	2012		2013		2014		2015	
	Alcohol	Drugs	Alcohol	Drugs	Alcohol	Drugs	Alcohol	Drugs
Crawford	58.07	61.71	60.43	67.31	61.53	73.02	60.41	71.00
Dent	57.77	53.72	53.96	55.66	54.59	59.71	50.54	59.50
Maries	31.71	29.52	30.39	27.46	31.35	29.87	38.84	31.81
Phelps	70.44	61.82	70.54	59.90	65.62	56.67	61.61	54.55
Pulaski	29.28	35.11	30.91	37.52	29.86	37.14	32.21	39.13
Texas	40.92	30.24	45.00	33.23	43.61	35.04	41.71	35.87
Missouri	73.72	61.26	76.48	64.46	78.66	65.87	77.20	67.65

Source: Missouri Department of Health and Senior Services

- **Alcohol Episode Counts:** The number of alcohol-related emergency room episodes increased between 2003 and 2012 for all counties. This trend was also noted across the state of Missouri.

Alcohol Related Emergency Room Episodes										
County	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Crawford	97	98	104	128	119	108	114	153	175	205
Dent	59	61	113	94	135	87	92	108	100	112
Maries	21	24	31	30	33	28	31	30	42	42
Phelps	182	186	253	304	344	279	270	348	403	416
Pulaski	102	132	130	183	180	187	142	181	232	166
Texas	87	95	88	103	117	124	101	99	132	127
Missouri	33971	37347	37854	41239	45553	49365	48745	48573	52949	59691

Source: Missouri Department of Health and Senior Services

- **Drug Episode Counts:** The number of drug-related emergency room episodes increased for all counties and the state of Missouri. For some locations, the number of episodes more than doubled between 2003 and 2012.

Drug Related Emergency Room Episodes										
County	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Crawford	82	79	82	107	154	113	130	146	200	285
Dent	48	84	95	103	113	76	83	98	96	106
Maries	12	15	17	29	22	22	30	41	40	43
Phelps	169	176	243	270	275	249	264	380	411	400
Pulaski	87	126	106	141	180	151	187	226	257	258
Texas	93	94	92	80	87	77	68	82	116	100
Missouri	22585	26835	28897	30650	33850	34442	36605	42232	51462	57792

Source: Missouri Department of Health and Senior Services

- **ER Visits Due to Opioid Misuse:** In terms of ER visits due to opioid misuse, Crawford and Phelps had the highest rates, ranking those counties in the top ten of all Missouri counties.

ER Visits Due to Opioid Misuse 2012-2016 (by county of residence)									
County	All Opioid Visits			Heroin-Related Visits			Non-Heroin-Related Visits		
	Counts	Crude Rate (per 1,000 population)	Rate Rank out of 115 Counties	Counts	Crude Rate (per 1,000 population)	Rate Rank out of 115 Counties	Counts	Crude Rate (per 1,000 population)	Rate Rank out of 115 Counties
Crawford	252	2.07	6	23	0.19	17	229	1.88	6
Dent	109	1.40	17	13	0.17*	19	96	1.23	17
Maries	30	0.21	114	1	0.01*	67	29	0.20	114
Phelps	389	1.73	10	45	0.20	15	344	1.53	8
Pulaski	285	1.07	33	52	0.20	15	233	0.88	44
Texas	83	0.65	77	3	0.02*	51	80	0.62	76

*Rate unreliable; numerator less than 20

Source: Bureau of Vital Statistics, Missouri Department of Health and Senior Services

Drug- and Alcohol-related Hospitalizations

- **Alcohol-related Hospitalization After ER Visit:** In line with the alcohol-related emergency room increases, the number that were followed by hospitalization also increased for all counties.

Alcohol Related Emergency Room Episodes Followed by Hospitalization										
County	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Crawford	40	50	56	70	62	53	41	60	62	81
Dent	25	19	33	26	35	41	30	34	39	42
Maries	12	15	19	18	16	11	15	19	24	18
Phelps	95	103	132	177	189	139	116	135	157	183
Pulaski	57	67	72	102	102	93	63	80	105	69
Texas	34	39	40	45	41	45	38	24	57	50
Missouri	16985	18637	18780	19803	20851	22054	22426	18852	21819	25142

Source: Missouri Department of Health and Senior Services

- **Alcohol-related Hospitalization Without ER Visit:** The increase in alcohol-related hospitalizations without emergency room services was most noticeable for Crawford, Dent, and Phelps Counties. Pulaski County experienced a peaked in 2010.

Alcohol Related Hospitalizations Without Emergency Room Services										
County	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Crawford	42	44	47	42	42	53	59	99	92	63
Dent	21	21	41	47	36	33	29	63	44	57
Maries	13	8	6	7	6	9	15	17	10	6
Phelps	44	54	69	79	81	78	87	107	89	82
Pulaski	59	55	61	63	60	83	96	121	60	49
Texas	28	49	33	36	48	44	39	57	39	42
Missouri	12426	11897	12218	12922	13089	13419	13894	19329	16972	14752

Source: Missouri Department of Health and Senior Services

- **Drug-related Hospitalization After ER Visit:** In line with the increase in drug-related emergency room episodes, the number that were followed by hospitalization increased for all counties except Texas.

Drug Related Emergency Room Episodes Followed by Hospitalization										
County	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Crawford	32	34	47	57	90	49	66	44	87	107
Dent	13	28	30	42	41	30	31	31	43	33
Maries	5	5	9	13	12	12	16	25	17	22
Phelps	81	91	132	159	162	150	120	151	187	199
Pulaski	43	57	54	71	91	64	78	87	121	121
Texas	52	52	42	31	28	20	25	20	40	45
Missouri	11570	13917	14576	15368	16723	17059	17999	16256	20302	24124

Source: Missouri Department of Health and Senior Services

- **Drug-related Hospitalization Without ER Visit:** Similar to the emergency room data, the number of episodes that have bypassed ER services and ended up in the hospital has increased for all locations.

Drug Related Hospitalizations Without Emergency Room Services										
County	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Crawford	36	40	38	41	58	46	51	94	108	87
Dent	29	37	44	33	42	51	49	65	52	59
Maries	9	10	11	11	6	5	7	23	14	20
Phelps	63	69	86	89	86	87	135	157	127	200
Pulaski	61	77	59	71	73	84	108	118	106	135
Texas	40	32	47	40	45	49	36	72	63	69
Missouri	11115	11771	12838	13331	13692	14174	14916	21502	19989	18598

Source: Missouri Department of Health and Senior Services

Arrests for Drug and Alcohol Violations

- **Possession or Sale/Manufacture of Illicit Drugs:** Arrests for possession or sale/manufacture of illicit drugs increased sharply for Maries and Pulaski Counties while Crawford and Dent showed decreases. The 2016 rates for all counties except Texas was higher than the state of Missouri rate.

Arrests for Possession or Sale/Manufacture of Illicit Drugs – Rate Per 10,000 Population, 3 year aggregate										
County	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Crawford	242.08	205.67	147.46	134.25	114.35	124.50	122.88	128.60	140.30	169.28
Dent	132.33	104.20	85.59	70.59	55.94	53.29	42.01	44.36	49.51	65.26
Maries	46.23	28.87	44.21	63.28	109.41	133.04	156.69	140.51	129.84	109.61
Phelps	85.60	78.32	65.09	55.87	57.09	53.49	51.19	53.64	71.85	89.88
Pulaski	46.20	36.51	32.81	40.78	48.61	56.86	66.50	73.17	82.53	92.50
Texas	49.32	46.81	38.89	30.49	31.25	31.01	36.21	41.14	49.23	50.33
Missouri	74.31	70.72	65.33	61.69	61.10	61.04	61.76	60.83	61.03	63.80

Source: Missouri Department of Public Safety, Missouri State Highway Patrol

- **Driving While Intoxicated (DWI):** The rate of arrests for driving under the influence of alcohol or drugs decreased for all counties except Crawford. The state of Missouri rate also showed declines. However, the 2016 rates for Crawford, Dent, Phelps, and Texas Counties remained higher than the state rate.

Arrests for Driving Under the Influence of Alcohol or Drugs (DWI Tracking System) – Rate Per 10,000 Population, 3 year aggregate									
County	2008	2009	2010	2011	2012	2013	2014	2015	2016
Crawford	75.24	65.24	64.76	83.37	96.74	99.28	90.74	87.15	87.43
Dent	76.31	70.50	63.96	53.17	53.72	50.76	50.12	46.07	49.16
Maries	33.57	29.72	29.83	33.08	41.19	49.79	42.04	36.25	24.97
Phelps	78.25	81.25	79.97	75.61	67.42	62.71	58.89	61.39	62.82
Pulaski	56.28	59.54	61.74	69.54	65.32	67.71	45.67	39.19	37.34
Texas	51.91	44.62	49.60	63.15	68.71	62.33	49.84	48.73	49.03
Missouri	66.94	64.24	61.26	58.02	56.69	53.37	49.20	43.18	39.29

Source: Missouri Department of Public Safety, Missouri State Highway Patrol

Arrests for Meth Lab Seizures

- The number of arrests for confiscation of meth labs, equipment, or dumpsites reached peak levels between 2010 and 2012. The most recent numbers have shown a significant decline.

Arrests: Confiscation of Methamphetamine Lab, Equipment, or Dumpsite											
County	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017
Crawford	13	24	26	37	54	51	51	37	18	7	2
Dent	1	1	0	3	1	5	4	6	6	6	1
Maries	5	1	16	14	17	11	13	4	5	0	1
Phelps	5	3	11	35	39	48	31	24	8	2	3
Pulaski	3	1	12	27	17	7	12	3	1	1	0
Texas	6	12	6	11	13	5	17	9	1	1	2
Missouri	1285	1487	1774	1960	2096	1985	1495	1045	507	207	91

Source: Missouri Department of Public Safety, Missouri State Highway Patrol

Criminal Justice System

- **Parole for Drug Conviction:** State parole admissions for drug conviction showed the greatest increases for Phelps, Pulaski, and Texas Counties while the state rate remained fairly consistent.

State Parole Admissions for Drug Conviction									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	23	30	31	34	18	20	21	25	37
Dent	20	13	14	8	15	12	9	17	22
Maries	4	3	3	1	4	0	7	5	6
Phelps	19	22	17	36	22	35	41	39	50
Pulaski	23	15	17	18	17	15	27	36	47
Texas	9	17	16	26	15	17	20	26	32
Missouri	4321	3942	3879	3923	3887	3917	3782	3708	4225

Source: Missouri Department of Corrections

- **Imprisonment for Drug Conviction:** State prison admissions for drug conviction increased for all counties, with the greatest increases for Phelps, Pulaski, and Texas Counties. The state rate also showed increases during the period.

State Prison Admissions for Drug Conviction										
County	FY2008	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	48	41	48	47	51	43	66	60	78	77
Dent	27	24	19	32	34	26	30	24	32	47
Maries	5	3	12	5	7	7	10	8	7	11
Phelps	32	35	31	41	68	67	89	101	108	113
Pulaski	25	25	23	24	38	31	60	60	73	96
Texas	19	29	27	20	25	35	29	28	41	61
Missouri	6237	5753	5389	5508	5557	5779	6165	6068	6152	6649

Source: Missouri Department of Corrections

- **Probation for Drug Conviction:** State probation admissions for drug conviction increased for all counties, with the greatest increases for Crawford, Phelps, and Pulaski. The state rate also increased during this period.

State Probation Admissions for Drug Conviction									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	69	76	74	83	110	118	104	129	156
Dent	37	31	50	46	34	42	33	50	52
Maries	4	12	9	20	16	12	12	11	16
Phelps	82	74	70	132	185	103	159	157	143
Pulaski	39	41	49	46	60	108	106	118	140
Texas	21	32	19	23	36	44	70	39	56
Missouri	8485	7682	7265	7670	8203	8899	9132	9311	10304

Source: Missouri Department of Corrections

Traffic Accidents Involving Alcohol and Drugs

- **Alcohol Impaired Driver:** Between 2012 and 2016, the rate of traffic crashes involving an alcohol impaired driver decreased for Crawford, Maries, Phelps, and Pulaski Counties but showed slight increases for Dent and Texas Counties. The state rate declined during this period, and the 2016 rate for Dent, Pulaski, and Texas Counties was higher than the state rate. The rate for Dent County was noticeably high.

Traffic Crashes Involving Alcohol Impaired Driver – Rate Per Billion Vehicle Miles Traveled, 5 year aggregate					
County	2012	2013	2014	2015	2016
Crawford	70.47	71.83	66.71	65.52	66.01
Dent	123.20	121.52	102.17	108.49	127.45
Maries	77.65	79.14	72.73	76.59	72.19
Phelps	81.21	77.84	71.84	72.62	67.23
Pulaski	102.64	100.40	89.86	88.56	85.01
Texas	93.22	88.80	94.11	90.70	93.41
Missouri	91.60	87.26	81.84	78.19	74.59

Source: Missouri Department of Public Safety, Missouri State Highway Patrol

- **Drug Impaired Driver:** Between 2012 and 2016, the rate of traffic crashes involving a drug impaired driver increased sharply for Crawford and slightly for Dent, Pulaski, and Texas. Phelps experienced an overall decrease during this time. In 2016, the rates for Dent, Phelps, and Texas were higher than the state of Missouri, with Dent noticeably higher than all counties in the region.

Traffic Crashes Involving Drug Impaired Driver – Rate Per Billion Vehicle Miles Traveled, 5 year aggregate					
County	2012	2013	2014	2015	2016
Crawford	8.57	10.03	12.20	15.42	17.26
Dent	37.71	43.12	35.42	32.83	39.56
Maries	NA	NA	NA	NA	NA
Phelps	26.05	25.69	23.16	22.30	25.46
Pulaski	16.36	16.84	17.97	17.58	16.79
Texas	15.35	16.40	18.35	14.91	18.55
Missouri	16.79	17.50	17.37	17.45	17.55

Source: Missouri Department of Public Safety, Missouri State Highway Patrol

Mortality Due to Alcohol and Drugs

- **Alcohol Induced:** Overall, the number of death that are alcohol induced is quite low across the six counties, though the state count has shown a noticeable increase.

Deaths Alcohol Induced										
County	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Crawford	1	1	0	1	1	3	3	1	3	1
Dent	0	1	2	0	1	0	0	0	1	1
Maries	0	0	0	0	0	0	0	0	0	0
Phelps	3	3	3	3	0	0	0	3	2	4
Pulaski	1	2	1	3	1	4	3	3	4	3
Texas	0	1	1	2	0	1	4	4	1	2
Missouri	379	316	387	372	396	366	449	444	475	509

Source: Missouri Department of Health and Senior Services

- **Smoking Attributed:** The number of deaths attributable to smoking increased for all counties. The rates of increase were considerably higher than the state for most counties.

Deaths Attributable to Smoking										
County	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Crawford	38	53	62	67	53	53	59	52	57	58
Dent	35	31	36	43	39	34	37	41	36	46
Maries	16	22	14	19	26	20	15	19	14	22
Phelps	62	73	92	70	64	74	82	70	84	82
Pulaski	49	51	54	54	46	57	56	62	63	58
Texas	53	52	57	51	66	46	59	52	49	55
Missouri	9490	9385	10073	9655	9686	9668	9869	10109	10121	10300

Source: Missouri Department of Health and Senior Services

- **Drug Induced:** The number of drug-induced deaths increased the most for Pulaski County between 2006 and 2015. The counts peaked for Phelps County in 2011. The counts for the state of Missouri have shown noticeable increases during the time period.

Deaths Drug Induced										
County	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Crawford	2	7	4	4	8	5	3	5	5	12
Dent	7	5	4	6	8	1	6	2	7	2
Maries	4	1	0	1	1	2	2	0	2	1
Phelps	7	6	5	6	12	16	11	5	6	5
Pulaski	7	6	9	7	6	14	10	9	10	13
Texas	2	6	2	2	1	2	2	5	1	3
Missouri	810	774	804	901	1019	994	952	1042	1121	1088

Source: Missouri Department of Health and Senior Services

- **Alcohol-Impaired Driving Deaths:** County Health Rankings indicates the percentage of driving deaths with alcohol involvement in each county. Maries County has shown a noticeable decline, whereas Texas has had an increase. The other counties have remained fairly consistent. The 2018 rates for Crawford, Pulaski, and Texas Counties are higher than the state of Missouri. Crawford and Pulaski have the highest rates of the six-county area.

County Health Rankings – Alcohol-Impaired Driving Deaths					
County	2014	2015	2016	2017	2018
Crawford	36%	37%	41%	29%	40%
Dent	10%	16%	17%	17%	21%
Maries	64%	55%	33%	38%	25%
Phelps	25%	28%	26%	25%	22%
Pulaski	42%	47%	46%	53%	44%
Texas	15%	17%	20%	26%	33%
Missouri	34%	35%	33%	32%	30%

Source: Primary-Fatality Analysis Reporting System (FARS); Secondary-County Health Rankings

Opioid Mortality Data

- **All Opioid Deaths:** Between 2013 and 2017, Crawford County had the highest rate of deaths due to opioid overdoses among the six counties, ranking it 6th out of all Missouri counties. Pulaski had the highest total count at 43 deaths. All counties in the six-county region were ranked in the top half of Missouri counties.
- **Heroin Overdose Deaths:** Between 2013 and 2017, Maries County had the highest rate of deaths due to heroin overdoses among the six counties, ranking it 5th out of all Missouri counties. Note that heroin overdoses is a subset of the opioid overdoses shown above. The count for Pulaski was quite high, which was almost as high as the other five counties combined. All counties except Texas were ranked in the top 20 of all Missouri counties.
- **Non-Heroin Opioid Overdose Deaths:** Between 2013 and 2017, Crawford County had the highest rate and Pulaski County had the highest count of non-heroin overdose deaths.

Deaths Due to Opioid Overdoses 2013-2017 (by county of residence)									
County	All Opioid Deaths			Heroin Overdose Deaths			Non-Heroin Opioid Overdose Deaths		
	Counts	Crude Rate (per 100,000 population)	Rate Rank out of 115 Counties	Counts	Crude Rate (per 100,000 population)	Rate Rank out of 115 Counties	Counts	Crude Rate (per 100,000 population)	Rate Rank out of 115 Counties
Crawford	22	18.04	6	7	5.74*	11	15	12.30*	8
Dent	12	15.42*	14	3	3.85*	17	9	11.56*	11
Maries	7	15.63*	13	4	8.93*	5	3	6.70*	35
Phelps	25	11.14	22	11	4.90*	15	14	6.24*	37
Pulaski	43	16.19	10	22	8.28	7	21	7.90	26
Texas	10	7.78*	37	0	0.00*	Tied for Last	10	7.78*	27

*Rate unreliable; numerator less than 20
Source: Bureau of Vital Statistics, Missouri Department of Health and Senior Services

State-Level Treatment Programs

- **Total Admissions:** Alcohol and drug use treatment data provided at the state level indicate overall declines in admission for residents of Crawford, Dent, Phelps, and Texas Counties but increases for Maries and Pulaski. Across the entire state, there has been a decline in admissions. It is not known whether this finding is based on need or available resources.

Alcohol and Drug Use Treatment Data – Admissions: Total Individuals Admitted to Substance Use Treatment Programs								
County	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	347	311	288	212	158	189	178	154
Dent	186	197	174	151	123	119	124	134
Maries	40	33	39	35	39	41	48	56
Phelps	374	437	376	319	279	281	344	349
Pulaski	148	126	129	160	170	160	183	196
Texas	162	167	145	133	116	110	142	138
Missouri	39873	37192	36565	35877	34829	33965	33406	33574

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

- **Heroin-Related Admissions:** Alcohol and drug use treatment data provided by state-level agencies show an increase in treatment for heroin for all counties except Texas. There was also an increase at the state level. Other substances such as alcohol and other illicit drugs did not show this same pattern of increase, thus indicating either an increase in need or change in treatment resources.

Alcohol and Drug Use Treatment Data – Primary Substance Problem: Heroin									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	12	9	11	17	10	12	11	24	29
Dent	0	0	12	9	13	11	11	20	19
Maries	0	0	0	0	0	0	0	7	9
Phelps	7	13	31	28	21	30	47	56	68
Pulaski	30	23	21	33	43	59	38	69	68
Texas	0	0	5	0	0	0	0	0	0
Missouri	2329	2846	3098	3195	3507	3673	4062	4681	4629

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

- **Methamphetamine-Related Admissions:** Data for another one of the primary drug issues in the community, methamphetamine use, show more stable patterns of treatment for the six counties. Note that some counties did reach their highest levels in 2017. The counts for the state as a whole have increased, however.

Alcohol and Drug Use Treatment Data – Primary Substance Problem: Methamphetamine									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	62	62	50	53	32	40	52	51	41
Dent	15	10	17	21	18	13	22	29	33
Maries	13	11	11	7	6	8	12	9	19
Phelps	79	45	51	37	43	57	39	68	85
Pulaski	14	16	16	13	15	15	30	33	48
Texas	16	18	15	23	20	25	22	32	33
Missouri	3577	3729	3963	4460	5104	5558	5973	6415	7625

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

- **Co-Occurring Mental Illness:** The table below indicates the number of individuals treated who have a substance and mental health co-occurring condition. Overall, counts have remained relatively stable over the last few years.

Alcohol and Drug Use Treatment – Populations with Special Focus: Co-Occurring Mental Illness									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	132	137	51	101	95	59	81	90	101
Dent	67	59	64	71	67	61	62	59	79
Maries	22	16	10	15	17	14	22	13	27
Phelps	206	186	142	148	129	139	127	125	107
Pulaski	46	53	35	45	54	72	76	66	91
Texas	62	66	42	48	66	42	60	88	93
Missouri	11775	12478	11670	12056	12683	12606	13305	12740	14155

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

- **Primary Recover Plus and CSTAR Admissions:** Primary Recover Plus and CSTAR are two of the main drug treatment programs offered across the state through the Missouri Division of Behavioral Health. Between 2010 and 2017, Crawford, Dent, Phelps, and Texas Counties showed declines in program participation, whereas Pulaski showed increases. Maries remained fairly consistent. Participation at the state level has somewhat declined, though recent counts have been fairly consistent.

Alcohol and Drug Use Treatment Data – Admissions: Individuals Admitted to General Population Programs Including Primary Recovery Plus and CSTAR General Adult								
County	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	295	264	231	150	107	130	133	143
Dent	162	195	158	136	102	105	111	115
Maries	30	27	34	30	26	31	39	44
Phelps	274	370	281	236	220	195	230	250
Pulaski	85	70	72	92	109	99	109	146
Texas	125	126	97	77	77	86	104	104
Missouri	26611	23594	21927	20931	20534	20742	20264	21344

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

Substance Abuse Traffic Offender Program (SATOP)

- The Substance Abuse Traffic Offender Program (SATOP) serves individuals who have had an alcohol- or drug-related traffic offense. Individuals enter different levels of programming depending on their specific situations and needs. The following tables provide data related to SATOP clinic treatment programs, offender education program, offender management unit, and the weekend intervention program.

Alcohol and Drug Use Treatment Data – Admissions: Individuals Admitted to SATOP Clinical Treatment Programs (CIP, YCIP, SROP)								
County	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	17	18	36	43	40	46	26	15
Dent	13	8	14	22	17	15	12	17
Maries	0	0	0	7	7	0	5	7
Phelps	38	29	42	47	45	32	39	30
Pulaski	28	29	28	39	38	35	27	25
Texas	12	17	30	32	32	14	24	15
Missouri	4767	4422	5449	5908	5667	5265	4753	4262

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

Alcohol and Drug Use Treatment Data – Admissions: Individuals Enrolling in SATOP Offender Education Program (OEP)								
County	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	47	30	46	46	34	26	31	28
Dent	16	14	15	19	14	20	21	11
Maries	9	9	13	0	8	8	8	10
Phelps	89	90	86	64	60	60	85	53
Pulaski	101	106	110	73	63	58	40	43
Texas	29	44	49	35	20	21	18	19
Missouri	11851	9840	10132	9280	8268	7545	6727	6328

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

Alcohol and Drug Use Treatment Data – Admissions: Individuals Enrolling in SATOP Offender Management Unit (OMU)								
County	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	134	83	147	146	121	113	110	88
Dent	71	50	50	67	52	57	55	50
Maries	24	19	29	22	29	18	36	24
Phelps	220	201	220	175	168	168	183	172
Pulaski	241	219	219	173	170	154	130	134
Texas	103	112	124	102	77	73	77	57
Missouri	30109	24511	25871	24423	22729	20936	18892	17445

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

Alcohol and Drug Use Treatment Data – Admissions: Individuals Enrolling in SATOP Weekend Intervention Program (WIP)								
County	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	32	20	26	28	24	24	24	16
Dent	10	10	12	9	10	9	7	9
Maries	7	8	0	5	9	0	0	8
Phelps	53	65	42	35	35	35	28	42
Pulaski	60	41	51	38	35	26	37	20
Texas	32	26	22	20	11	18	15	9
Missouri	7261	5589	5608	5240	4666	4166	3731	3620

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting (CIMOR) data system

Youth Prevalence Data: Alcohol

- **Past Month Use:** Prevalence data indicate that students report overall decreases in past-month alcohol use. The rate for Pulaski County has remained fairly consistent, and Texas County showed a spike in 2016. The overall decreases mirror the trend across the state. The 2016 rates for Pulaski and Texas were especially higher than the state.

Student Report of Past Month Alcohol Use – 1+ Days						
County	2006	2008	2010	2012	2014	2016
Crawford	33.58%	36.25%	24.02%	19.44%	15.30%	13.26%
Dent	27.54%	21.40%	15.26%	17.14%	1.86%	13.55%
Maries	NA	NA	NA	NA	NA	NA
Phelps	22.96%	27.27%	21.55%	20.54%	17.50%	15.41%
Pulaski	27.56%	29.35%	20.00%	25.93%	NA	25.26%
Texas	17.16%	34.75%	21.67%	13.40%	12.17%	22.01%
Missouri	27.06%	26.49%	19.83%	16.90%	13.85%	14.19%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Lifetime Use:** The data for lifetime alcohol use are similar to past-month use. Overall decreases in lifetime use were experienced between 2006 and 2016. The rates for Pulaski and Texas were especially higher than the state.

Student Lifetime Alcohol Use - Yes						
County	2006	2008	2010	2012	2014	2016
Crawford	69.32%	66.95%	52.72%	46.58%	37.78%	37.80%
Dent	52.69%	49.82%	40.45%	28.16%	12.42%	36.14%
Maries	NA	NA	NA	NA	NA	NA
Phelps	54.37%	55.74%	41.39%	41.04%	41.71%	37.43%
Pulaski	53.96%	59.84%	47.44%	55.18%	NA	45.63%
Texas	49.44%	66.74%	46.68%	36.86%	30.30%	50.14%
Missouri	56.32%	54.4%	42.85%	38.21%	33.33%	35.26%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Ease of Availability:** Students report an overall increase in the ease of obtaining alcohol. The increase is particularly noticeable in Pulaski County. The rate for Pulaski was particularly higher than the state.

Student Perception of Ease of Availability – Alcohol – Very Easy or Sort of Easy						
County	2006	2008	2010	2012	2014	2016
Crawford	49.06%	55.43%	63.03%	57.11%	51.45%	51.07%
Dent	46.95%	45.77%	49.36%	40.24%	33.13%	48.79%
Maries	NA	NA	NA	NA	NA	NA
Phelps	44.64%	52.76%	60.06%	56.70%	52.51%	51.06%
Pulaski	48.96%	54.29%	62.94%	64.39%	NA	63.31%
Texas	45.08%	50.80%	54.10%	44.68%	55.85%	53.61%
Missouri	48.74%	48.7%	58.64%	56.16%	51.07%	50.74%

Source: Missouri Student Survey, Missouri Department of Mental Health

Youth Prevalence Data: Prescription Drugs

- **Past Month Use:** Prescription drug misuse has shown some fluctuations, with an uptick in the 2016 data. Pulaski County has the highest levels of student prescription drug misuse, with levels higher than the state.

Student Report of Past Month Prescription Drug Misuse – 1+ Days				
County	2010	2012	2014	2016
Crawford	10.53%	7.09%	4.43%	7.69%
Dent	7.82%	2.03%	2.45%	6.77%
Maries	NA	NA	NA	NA
Phelps	7.57%	5.44%	7.97%	7.42%
Pulaski	8.74%	8.55%	NA	10.91%
Texas	6.43%	3.87%	2.65%	9.37%
Missouri	6.66%	4.65%	3.72%	9.98%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Lifetime Use:** From 2010 to 2016 lifetime use decreased for Crawford and Phelps Counties but increased for Pulaski and Texas Counties. While Dent County increased slightly when comparing 2010 to 2016, the overall trend was a decrease in lifetime use.

Student Lifetime Prescription Drug Misuse - Yes				
County	2010	2012	2014	2016
Crawford	16.37%	12.63%	9.56%	11.20%
Dent	11.73%	8.57%	4.29%	11.95%
Maries	NA	NA	NA	NA
Phelps	15.15%	8.66%	14.14%	12.88%
Pulaski	14.08%	15.18%	NA	16.67%
Texas	10.19%	8.53%	10.23%	14.68%
Missouri	11.08%	8.55%	7.44%	14.33%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Ease of Availability:** Students in Pulaski County report noticeably higher ease of availability in obtaining prescription drugs than the other counties and the state as a whole.

Student Perception of Ease of Availability – Prescription Drugs – Very Easy or Sort of Easy			
County	2012	2014	2016
Crawford	35.44%	31.50%	29.68%
Dent	21.22%	12.27%	25.00%
Maries	NA	NA	NA
Phelps	32.80%	35.17%	27.55%
Pulaski	40.44%	NA	43.66%
Texas	26.11%	24.53%	26.39%
Missouri	30.71%	28.62%	27.68%

Source: Missouri Student Survey, Missouri Department of Mental Health

Youth Prevalence Data: Marijuana

- **Past Month Use:** While marijuana use among students has shown fluctuations across time periods, the highest rate appears to be in Pulaski County, with a rate that is noticeably higher than the other counties and state.

Student Report of Past Month Marijuana Use – 1+ Days						
County	2006	2008	2010	2012	2014	2016
Crawford	6.42%	8.94%	10.78%	11.14%	7.75%	6.05%
Dent	8.33%	6.99%	6.54%	6.94%	0.62%	6.75%
Maries	NA	NA	NA	NA	NA	NA
Phelps	8.07%	7.05%	11.02%	8.53%	13.89%	3.89%
Pulaski	8.75%	7.65%	7.25%	12.55%	NA	9.97%
Texas	5.95%	6.03%	4.21%	5.41%	0.75%	5.52%
Missouri	8.52%	8.46%	9.43%	8.58%	7.59%	6.99%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Lifetime Use:** Between 2006 and 2016, lifetime use increased for all counties except Crawford. Note that there were fluctuations in the data over that time period. Rates for Dent, Pulaski, and Texas were higher than the state in 2016.

Student Lifetime Marijuana Use - Yes						
County	2006	2008	2010	2012	2014	2016
Crawford	16.98%	14.89%	17.77%	20.00%	15.87%	13.49%
Dent	14.29%	16.14%	12.79%	13.88%	1.85%	16.54%
Maries	NA	NA	NA	NA	NA	NA
Phelps	12.95%	17.83%	18.91%	15.70%	19.38%	13.75%
Pulaski	16.04%	17.43%	14.84%	22.66%	NA	23.55%
Texas	11.57%	13.84%	10.97%	8.76%	4.89%	21.27%
Missouri	18.80%	17.94%	17.71%	16.48%	15.21%	15.17%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Ease of Availability:** Overall, data have shown that 30-40% of students report that marijuana is very or sort of easy to obtain. The rate for Pulaski has increased considerably, where almost half of students reported ease of availability in 2016, which is noticeably higher than the other areas.

Student Perception of Ease of Availability – Marijuana – Very Easy or Sort of Easy						
County	2006	2008	2010	2012	2014	2016
Crawford	32.20%	36.96%	40.00%	38.52%	35.64%	33.87%
Dent	36.81%	34.15%	26.52%	23.36%	8.07%	32.24%
Maries	NA	NA	NA	NA	NA	NA
Phelps	32.48%	36.54%	38.81%	32.67%	40.89%	32.98%
Pulaski	37.79%	38.81%	36.38%	50.96%	NA	49.01%
Texas	32.06%	33.26%	28.69%	19.27%	32.32%	40.50%
Missouri	37.82%	36.89%	38.43%	37.28%	34.04%	37.08%

Source: Missouri Student Survey, Missouri Department of Mental Health

- In line with other prevalence data, Pulaski County has shown an increase in ease of availability of other illicit drugs. The rate is noticeably higher than the other counties and state.

Student Perception of Ease of Availability – Other Illicit Drugs – Very Easy or Sort of Easy						
County	2006	2008	2010	2012	2014	2016
Crawford	18.87%	17.10%	21.79%	20.87%	14.65%	13.44%
Dent	22.09%	16.25%	16.35%	7.76%	4.29%	13.31%
Maries	NA	NA	NA	NA	NA	NA
Phelps	18.67%	20.36%	25.71%	16.96%	21.78%	12.53%
Pulaski	20.00%	21.96%	23.60%	29.33%	NA	28.00%
Texas	21.07%	18.56%	14.05%	11.32%	15.65%	18.28%
Missouri	18.39%	17.43%	19.20%	17.04%	14.01%	13.90%

Source: Missouri Student Survey, Missouri Department of Mental Health

Juvenile Court Referrals

- **Alcohol Use Related:** Juvenile court referrals for law violations involving alcohol use decreased for all counties, though the change in Texas County was fairly minimal. That county had the highest rate in 2016, followed by Crawford County. Rates for those two counties are higher than the state.

Juvenile Court Referrals for Law Violations Involving Alcohol Use – Rate Per 10,000 Population Under 18, 10 year aggregate							
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Crawford	**17.04**	**15.51**	**14.69**	**14.25**	**14.13**	**12.68**	**12.26**
Dent	**18.83**	**14.8**	**13.45**	**11.82**	**10.76**	**6.91**	**5.55**
Maries	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**	**NA**
Phelps	**10.65**	**7.52**	**6.69**	**5.35**	**4.74**	**4.24**	**3.73**
Pulaski	**10.86**	**9.89**	**9.12**	**7.35**	**6.11**	**5.98**	**5.69**
Texas	**20.82**	**19.25**	**19.6**	**19.97**	**19.82**	**20.74**	**17.57**
Missouri	**9.71**	**9.40**	**9.14**	**8.90**	**8.65**	**8.51**	**7.96**

Source: Missouri Department of Social Services and Missouri Office of State Courts Administrator

- **Drug Use Related:** Juvenile court referrals for law violations involving drug use decreased for all counties. The 2016 rates for Crawford, Phelps, and Texas Counties were higher than the state of Missouri.

Juvenile Court Referrals for Law Violations Involving Drug Use – Rate Per 10,000 Population Under Age 18, 10 year aggregate							
County	**2010**	**2011**	**2012**	**2013**	**2014**	**2015**	**2016**
Crawford	**32.75**	**29.21**	**24.76**	**23.11**	**21.94**	**19.68**	**18.65**
Dent	**26.20**	**25.77**	**23.34**	**21.14**	**17.10**	**14.37**	**10.56**
Maries	**9.90**	**9.05**	**NA**	**NA**	**NA**	**NA**	**NA**
Phelps	**27.1**	**25.74**	**23.35**	**21.91**	**19.80**	**17.88**	**16.39**
Pulaski	**21.29**	**19.08**	**17.98**	**17.30**	**16.74**	**16.10**	**15.28**
Texas	**21.88**	**21.01**	**22.78**	**22.25**	**21.42**	**19.50**	**17.57**
Missouri	**21.40**	**20.49**	**19.68**	**18.71**	**17.78**	**16.98**	**16.02**

Source: Missouri Department of Social Services and Missouri Office of State Courts Administrator

Mental Health Secondary Data Indicators

Mental Health Provider Ratios

- Based on County Health Rankings data, Crawford, Maries, and Texas Counties have the highest provider to population ratios, which demonstrates the lack of mental health providers in those communities. In addition to those counties, the ratio for Dent is also worse than the state.

County Health Rankings – Mental Health Providers (Ratio)					
County	2014	2015	2016	2017	2018
Crawford	4139:1	3068:1	3080:1	2730:1	2700:1
Dent	1956:1	1049:1	980:1	970:1	960:1
Maries	4507:1	3006:1	3000:1	2990:1	2950:1
Phelps	750:1	419:1	400:1	360:1	350:1
Pulaski	1087:1	672:1	590:1	550:1	510:1
Texas	6453:1	2848:1	2330:1	2570:1	2580:1
Missouri	947:1	695:1	660:1	630:1	590:1

Source: Primary-CMS, National Provider Identification; Secondary-County Health Rankings

Mental Health Emergency Room Episodes

- The rate of emergency room episodes with mental disorder as a principal diagnosis increased between 2012 and 2015 for Crawford, Maries, Phelps, and Pulaski but slightly decreased for Dent and Texas Counties. The 2015 rates for Crawford, Dent, and Phelps were higher than the state of Missouri rate.

Emergency Room Episodes with Mental Disorder Principal Diagnosis – Rate Per 10,000 Population, 3 year aggregate				
County	2012	2013	2014	2015
Crawford	145.65	160.38	167.41	163.86
Dent	142.19	143.10	141.82	137.78
Maries	98.78	111.29	116.54	122.09
Phelps	154.58	160.65	175.56	168.78
Pulaski	65.32	69.43	73.48	72.46
Texas	87.24	79.92	82.80	86.81
Missouri	126.37	129.82	131.26	129.30

Source: Missouri Department of Health and Senior Services

- All counties showed increases in emergency room visits for mental disorders, with Crawford, Dent, and Phelps having the worst rates.

Missouri Resident Emergency Room Profile for Mental Disorders – Three Year Moving Average Rates (lower rate is better)												
Location	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2015 Rank of 115 counties
Crawford*	11.84	11.92	11.77	12.88	14.30	15.93	16.38	17.72	18.18	18.79	19.21	100
Dent*	15.85	16.60	17.75	17.49	18.61	18.54	19.36	19.35	19.34	19.29	18.50	93
Maries*	4.62	4.07	4.44	4.40	5.57	6.60	7.98	8.83	9.70	10.16	10.86	44
Phelps*	10.44	10.15	10.30	10.70	12.18	14.13	15.80	16.88	16.63	16.93	16.96	85
Pulaski*	4.30	4.86	4.90	5.31	5.54	6.28	7.08	7.47	7.67	7.83	8.05	16
Texas*	8.65	7.79	8.13	7.95	8.30	9.00	9.89	10.65	10.00	10.52	10.95	34
Missouri*	9.64	10.14	10.65	11.16	11.36	11.79	12.47	13.49	13.91	13.99	14.46	--

*Rate trend shows a statistically significant increase.
Source: Missouri Department of Health and Senior Services-MOPHIMS Community Data Profiles

- Specifically for anxiety-related disorders, all counties except Dent showed an increase in the rate of emergency room visits. Rates for Crawford, Dent, and Phelps were particularly high.

Missouri Resident Emergency Room Profile for Mental Disorders (Anxiety-Related) – Three Year Moving Average Rates (lower rate is better)												
Location	2003-2005	2004-2006	2005-2007	2006-2008	2007-2009	2008-2010	2009-2011	2010-2012	2011-2013	2012-2014	2013-2015	2015 Rank of 115 counties
Crawford*	4.40	4.35	4.41	4.86	5.55	5.63	5.48	5.59	5.55	5.51	5.47	100
Dent*	6.30	6.07	5.86	5.55	6.66	7.26	7.27	5.83	5.60	5.47	5.10	43
Maries*	1.52	1.23	1.10	1.01	1.41	2.14	2.20	2.56	2.70	3.12	2.89	28
Phelps*	2.89	2.65	2.41	2.59	2.89	3.71	4.26	5.02	5.20	5.72	5.44	74
Pulaski*	1.15	1.25	1.10	1.17	1.36	1.62	1.93	1.92	2.12	2.29	2.25	9
Texas*	2.72	2.32	2.53	2.52	2.97	3.08	3.07	3.12	2.89	3.18	3.61	68
Missouri*	2.65	2.73	2.77	2.85	2.88	2.97	3.09	3.30	3.44	3.50	3.62	--

*Rate trend shows a statistically significant increase.
Source: Missouri Department of Health and Senior Services-MOPHIMS Community Data Profiles

State Mental Health Program Utilization

- **All Mental Disorder Rate:** The rate of individuals receiving services for mental disorders through the state Department of Mental Health programs increased for all counties except Maries, which showed a decline. The 2017 rate of use for Crawford and Dent Counties was higher than the state of Missouri.

Consumers Receiving Services for Mental Disorders (Dept of Mental Health Programs) – Rate Per 10,000 Population, 3 year aggregate					
County	2013	2014	2015	2016	2017
Crawford	171.24	186.54	188.27	183.49	171.68
Dent	150.92	164.42	179.56	179.89	173.12
Maries	67.79	68.46	62.34	54.39	48.84
Phelps	108.08	117.51	120.11	117.6	115.02
Pulaski	53.47	59.08	64.59	71.76	75.73
Texas	92.76	108.88	111.13	101.48	93.91
Missouri	125.38	128.15	127.20	127.15	128.35

Source: Missouri Department of Mental Health

- **Voluntary Commitments:** Comprehensive psychiatric services treatment data provided at the state level show increases in voluntary commitment for most counties and the state of Missouri. The increase in voluntary commitments was particularly noticeable for Crawford and Pulaski Counties.

Comprehensive Psychiatric Services Treatment Data – Admission/Commitment Type: Voluntary Commitment									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	318	341	363	412	479	483	425	439	391
Dent	194	202	221	220	256	289	294	256	250
Maries	48	52	58	63	63	60	45	42	44
Phelps	423	411	425	493	532	555	527	489	515
Pulaski	196	253	269	272	298	368	362	411	420
Texas	184	178	178	217	319	298	230	244	238
Missouri	66013	69105	67481	75911	75499	73989	75042	75963	76733

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

- **Comprehensive Psychiatric Services by Disorder Type:** The following set of tables indicates the types of disorders for which individuals have accessed comprehensive psychiatric services. The highest counts are for mood disorders, anxiety disorders, psychotic disorders, and impulse control disorders. These are in line with the issues for which providers in the current needs assessment process indicated treating clients.

Comprehensive Psychiatric Services Treatment Data – Disorder Type: All Disorders									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	352	357	372	417	482	484	426	442	393
Dent	221	217	227	223	258	290	294	259	253
Maries	57	55	59	63	64	60	45	42	44
Phelps	472	430	435	498	534	559	529	495	520
Pulaski	233	278	276	276	301	371	366	415	426
Texas	198	186	180	220	321	301	234	246	244
Missouri	75122	73738	70287	75254	77539	75906	77165	78094	78740

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Mood Disorder									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	172	221	223	303	359	351	310	311	273
Dent	101	124	136	145	174	203	195	179	172
Maries	27	35	31	46	46	45	32	29	31
Phelps	259	279	272	335	378	384	368	327	339
Pulaski	136	187	171	197	216	256	275	302	317
Texas	123	117	103	161	225	207	143	144	132
Missouri	33111	35583	35200	43838	45193	45731	47484	47021	47536

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Anxiety Disorders									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	84	114	131	191	237	225	222	242	210
Dent	71	98	111	125	170	188	198	173	176
Maries	15	21	28	38	33	34	25	24	25
Phelps	140	173	205	268	315	342	343	328	325
Pulaski	61	85	104	132	165	221	248	292	283
Texas	52	51	56	92	151	160	120	107	122
Missouri	13414	15618	16554	21446	22842	24141	26854	27803	29739

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Psychotic Disorder									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	48	46	45	47	58	66	60	71	61
Dent	28	26	28	30	33	31	28	24	19
Maries	6	7	5	8	10	11	9	5	0
Phelps	66	62	64	73	65	59	55	56	58
Pulaski	24	31	21	30	31	33	39	58	51
Texas	12	19	18	19	25	26	23	23	14
Missouri	12496	13113	12726	14561	14602	14635	15154	15222	15133

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Impulse Control Disorder									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	57	61	37	70	60	86	89	101	78
Dent	29	37	30	42	46	49	53	38	43
Maries	13	13	9	11	6	6	13	11	12
Phelps	60	57	36	66	68	89	128	124	114
Pulaski	23	34	31	46	55	67	63	83	91
Texas	9	13	16	34	45	40	40	46	48
Missouri	8013	8988	8818	11498	11504	11707	12491	13020	13415

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Disorder Not Elsewhere Categorized									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	22	20	5	12	17	19	22	36	40
Dent	22	23	10	12	15	24	11	19	27
Maries	0	0	0	0	0	0	0	0	7
Phelps	38	38	15	24	26	41	44	38	49
Pulaski	23	33	28	27	34	48	36	55	57
Texas	0	8	0	11	22	19	14	20	12
Missouri	4567	4646	3492	4303	4462	4738	5217	7347	8167

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Disorder Unknown									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	81	44	80	21	23	29	15	13	14
Dent	65	34	32	12	9	9	10	9	14
Maries	15	6	13	5	5	0	0	0	0
Phelps	93	45	68	28	26	34	12	18	28
Pulaski	45	26	61	24	14	17	11	12	18
Texas	25	17	56	26	16	20	20	31	26
Missouri	21207	15942	14302	10098	8005	6961	6277	7224	6483

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Personality Disorder									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	18	18	13	14	12	16	18	19	14
Dent	19	19	9	8	12	14	14	14	15
Maries	0	0	0	9	6	5	6	5	0
Phelps	44	50	35	36	29	27	29	29	31
Pulaski	15	17	8	11	7	14	19	21	19
Texas	5	6	0	6	16	16	13	12	12
Missouri	7421	7192	3910	4513	4694	5016	5161	5269	5313

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Adjustment Disorders									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	16	15	6	14	17	25	21	36	29
Dent	0	5	5	0	5	6	8	6	11
Maries	0	0	0	0	0	0	0	0	0
Phelps	8	6	0	6	7	12	32	30	34
Pulaski	7	5	6	11	15	22	19	33	34
Texas	9	5	0	0	13	9	0	7	11
Missouri	3013	2687	2288	3027	2870	2973	3043	3069	3336

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Developmental Disorder									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	0	0	0	0	0	0	0	5	0
Dent	5	0	0	0	0	0	0	6	0
Maries	0	0	0	0	0	0	0	0	0
Phelps	11	10	0	6	0	10	13	17	11
Pulaski	0	0	0	0	5	10	7	10	10
Texas	0	0	0	0	0	0	0	0	0
Missouri	783	859	778	1001	1032	1070	1112	1115	852

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Disorder Type: Dementia									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	0	0	0	0	0	0	0	0	0
Dent	0	0	0	0	0	0	0	0	0
Maries	0	0	0	0	0	0	0	0	0
Phelps	0	0	0	0	0	0	0	0	0
Pulaski	0	0	0	0	0	0	0	0	0
Texas	0	0	0	0	0	0	0	0	0
Missouri	254	289	133	138	132	152	567	710	581

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

- **Comprehensive Psychiatric Services by Referral Source:** The following set of tables indicates the treatment referral source for comprehensive psychiatric services. While the largest group was defined as "Referral Source Not Elsewhere Categorized," many of the referral sources were health providers. This source increased for all counties except Maries between 2009 and 2016.

Comprehensive Psychiatric Services Treatment Data – Treatment Referral Source: Referral Source Not Elsewhere Categorized									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	62	56	59	65	56	50	40	37	28
Dent	20	26	24	20	17	15	15	9	12
Maries	18	15	18	21	17	18	6	9	8
Phelps	117	122	119	120	102	82	46	37	35
Pulaski	33	33	29	26	30	26	15	17	12
Texas	20	16	10	12	18	18	13	11	7
Missouri	14194	15177	15902	16429	15863	15804	16005	15614	16465

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Treatment Referral Source: Health Provider									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	22	19	24	40	49	51	38	51	47
Dent	15	13	26	21	29	24	29	37	42
Maries	7	6	9	13	8	6	0	7	8
Phelps	34	34	46	63	53	46	53	55	69
Pulaski	18	31	29	30	31	32	35	39	49
Texas	57	59	75	98	126	100	107	128	112
Missouri	6223	6287	7186	9843	10946	11221	12228	13073	13266

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Treatment Referral Source: Mental Health Provider									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	13	8	8	8	9	7	8	6	5
Dent	6	6	0	0	0	0	0	0	0
Maries	0	0	0	0	0	0	0	0	0
Phelps	16	9	7	5	7	5	0	5	5
Pulaski	19	20	20	16	10	6	7	5	0
Texas	37	22	15	17	17	8	0	8	0
Missouri	8067	7992	7456	7057	6490	6167	5758	5366	5356

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Comprehensive Psychiatric Services Treatment Data – Treatment Referral Source: Court or Criminal Justice Agency									
County	FY2009	FY2010	FY2011	FY2012	FY2013	FY2014	FY2015	FY2016	FY2017
Crawford	17	12	12	11	6	0	5	7	6
Dent	6	12	12	16	7	5	0	0	0
Maries	0	0	0	0	0	0	0	0	0
Phelps	15	20	20	19	17	8	11	11	8
Pulaski	19	24	6	7	9	8	0	0	6
Texas	18	16	8	8	8	15	11	6	5
Missouri	5990	5260	4117	4501	4234	3932	4150	4050	3730

Source: Missouri Department of Mental Health, Customer Information Management Outcomes and Reporting data system

Self-Inflicted Deaths and Injuries

- **Suicide:** The total number of deaths due to suicide remained fairly consistent for the six counties, while the overall state count somewhat increased between 2006 and 2016.

Deaths Due to Suicide											
County	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Crawford	1	8	3	4	3	6	4	2	5	7	8
Dent	1	2	6	3	4	2	2	3	3	2	2
Maries	1	1	1	1	1	3	3	3	3	3	0
Phelps	6	6	5	6	7	9	3	7	10	6	9
Pulaski	11	10	7	7	11	8	10	2	6	6	15
Texas	2	5	3	5	7	6	3	5	3	5	3
Missouri	798	810	775	857	850	921	901	958	1004	1043	1132

Source: Missouri Department of Health and Senior Services

- **Injuries:** Although there were fluctuations, the number of injuries that were intentionally self-inflicted remained fairly stable for the counties and the state of Missouri.

Injuries Intentionally Self-Inflicted										
County	2006	2007	2008	2009	2010	2011	2012	2013	2014	2015
Crawford	31	29	20	29	23	29	38	23	17	27
Dent	42	38	30	24	34	34	26	22	38	30
Maries	3	1	9	4	14	7	12	1	6	0
Phelps	50	58	67	84	85	55	67	47	43	43
Pulaski	30	33	44	57	30	53	30	46	31	30
Texas	37	18	25	25	32	31	20	29	21	20
Missouri	7240	7440	7915	7608	8186	8298	8122	7691	7494	6342

Source: Missouri Department of Health and Senior Services

Self-Reported Mental Health Wellness

- **Poor Mental Health Days:** County Health Rankings presents the average number of poor mental health days experienced by individuals in the past 30 days. On average, residents in the six-county region experience between 4.1 and 4.9 poor mental health days. Crawford has the highest rate, and Crawford, Dent, and Texas Counties are higher than the state average.

County Health Rankings – Poor Mental Health Days					
County	2014	2015	2016*	2017*	2018*
Crawford	4.0	4.0	4.2	4.6	4.9
Dent	--	--	4.1	4.4	4.6
Maries	--	--	3.8	4.3	4.4
Phelps	3.9	3.9	3.9	4.2	4.4
Pulaski	3.4	3.4	3.7	4.0	4.1
Texas	4.7	4.7	4.0	4.4	4.8
Missouri	3.8	3.8	3.7	4.2	4.4

*Data should not be compared to prior years due to changes in definitions/methods.
Source: Primary-CDC, Behavioral Risk Factor Surveillance System; Secondary-County Health Rankings

Youth Prevalence Data: Bullying

- **Past Year Victim of Bullying:** When asked whether they had been the victim of bullying at school (Yes or No), approximately one-third of students indicated that they had. Rates have increased slightly since 2010, and the 2016 rates for all counties was higher than the state of Missouri rate.

Student Report of Past Year Victim of Bullying at School – Version 2 - Yes				
County	2010	2012	2014	2016
Crawford	26.83%	30.85%	35.97%	32.10%
Dent	23.72%	43.09%	43.13%	29.64%
Maries	NA	NA	NA	NA
Phelps	29.59%	27.05%	29.62%	34.07%
Pulaski	25.41%	33.76%	NA	30.91%
Texas	30.60%	28.42%	32.32%	31.74%
Missouri	24.96%	30.02%	31.18%	28.78%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Victim of Emotional Bullying (Past 3 Months):** When asked whether someone else had spread rumors/lies, posted embarrassing/hurtful details online, made fun, or hit/shoved/pushed them, close to 60% of students reported experiencing such actions at least once in the past three months. The 2016 rates were higher than the state for all counties except Dent, which was slightly lower.

Student Report of Past 3 Month Victim of Emotional Bullying – 1+ Times				
County	2010	2012	2014	2016
Crawford	71.68%	62.94%	61.37%	61.38%
Dent	72.06%	66.53%	38.04%	57.09%
Maries	NA	NA	NA	NA
Phelps	68.26%	59.10%	62.37%	60.03%
Pulaski	69.80%	59.05%	NA	59.42%
Texas	71.02%	56.22%	62.78%	59.10%
Missouri	67.47%	60.37%	58.65%	58.84%

Source: Missouri Student Survey, Missouri Department of Mental Health

Youth Prevalence Data: Self-Injury

- For Dent, Phelps, and Texas Counties, one out of every five students had reported some form of self-injury in 2016. These rates are higher than the state of Missouri. Crawford and Pulaski Counties had slightly lower rates.

Student Report of Self-Injury - Yes			
County	2012	2014	2016
Crawford	17.56%	15.88%	16.00%
Dent	19.59%	5.52%	20.24%
Maries	NA	NA	NA
Phelps	16.58%	15.12%	20.99%
Pulaski	20.59%	NA	15.68%
Texas	11.81%	9.06%	20.33%
Missouri	13.10%	13.50%	17.88%

Source: Missouri Student Survey, Missouri Department of Mental Health

Youth Prevalence Data: Suicide Ideation

- **Seriously Considering Suicide:** When asked in 2016 whether they had seriously considered suicide in the past year, almost 18% of students in Phelps County said yes. This rate is noticeably higher than the state rate and most other counties.

Student Report of Past Year Seriously Considering Suicide - Yes						
County	2006	2008	2010	2012	2014	2016
Crawford	17.11%	21.23%	14.45%	14.50%	10.83%	11.05%
Dent	15.34%	13.57%	13.83%	13.47%	1.84%	8.00%
Maries	NA	NA	NA	NA	NA	NA
Phelps	12.85%	17.10%	14.54%	11.32%	16.15%	17.59%
Pulaski	15.09%	19.32%	17.31%	13.62%	NA	10.08%
Texas	18.80%	17.06%	11.73%	10.85%	6.04%	14.40%
Missouri	14.51%	14.82%	11.72%	11.87%	11.72%	13.85%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Planning or Attempting Suicide:** Phelps County also has the highest rates of planning and attempting suicide, both of which are higher than the state rate. All other counties are below the state rates.

Student Report of Past Year Planning Suicide - Yes						
County	2006	2008	2010	2012	2014	2016
Crawford	11.36%	16.85%	10.44%	11.20%	9.39%	6.49%
Dent	14.63%	10.68%	9.03%	4.90%	1.23%	7.20%
Maries	NA	NA	NA	NA	NA	NA
Phelps	9.57%	11.42%	9.28%	8.31%	11.49%	12.27%
Pulaski	13.39%	14.15%	12.79%	10.03%	NA	8.74%
Texas	14.39%	13.51%	10.45%	7.25%	1.14%	7.22%
Missouri	10.66%	10.76%	8.43%	8.71%	8.55%	9.88%

Source: Missouri Student Survey, Missouri Department of Mental Health

Student Report of Past Year Attempting Suicide – 1+ Times						
County	2006	2008	2010	2012	2014	2016
Crawford	7.20%	9.52%	7.32%	8.12%	5.40%	4.28%
Dent	7.83%	7.09%	6.43%	2.04%	0.62%	5.18%
Maries	NA	NA	NA	NA	NA	NA
Phelps	6.81%	6.96%	5.39%	3.86%	5.17%	8.49%
Pulaski	9.24%	8.80%	8.41%	7.20%	NA	6.09%
Texas	7.92%	7.11%	4.89%	6.70%	0.75%	4.44%
Missouri	6.75%	6.32%	5.50%	5.51%	4.96%	6.30%

Source: Missouri Student Survey, Missouri Department of Mental Health

Youth Prevalence Data: Depression Scale

- **Very Sad Often or Always:** When asked how often they were very sad in the last month, upwards of one quarter of students indicated often or always. The rate was highest in Dent County, with that location and Phelps and Texas having higher rates than the state of Missouri.

Depression Scale – Student Very Sad – Often or Always				
County	2010	2012	2014	2016
Crawford	8.65%	25.06%	20.94%	21.43%
Dent	9.29%	28.46%	8.59%	26.09%
Maries	NA	NA	NA	NA
Phelps	29.62%	16.98%	20.62%	24.03%
Pulaski	22.50%	23.73%	NA	19.98%
Texas	13.99%	15.21%	17.74%	25.41%
Missouri	19.71%	18.45%	20.18%	22.69%

Source: Missouri Student Survey, Missouri Department of Mental Health

- **Hopeless Often or Always:** When asked how often they felt hopeless in the past month, between 10-16% of students reported often or always. The rate for Texas was the highest of the five reporting counties, which was also higher than the state of Missouri rate.

Depression Scale – Student Feels Hopeless – Often or Always				
County	2010	2012	2014	2016
Crawford	7.35%	12.91%	12.04%	11.47%
Dent	6.37%	21.225	6.75%	10.24%
Maries	NA	NA	NA	NA
Phelps	19.44%	10.93%	13.04%	12.78%
Pulaski	11.52%	12.92%	NA	12.13%
Texas	12.19%	7.31%	8.30%	15.47%
Missouri	12.33%	10.94%	11.82%	13.47%

Source: Missouri Student Survey, Missouri Department of Mental Health

References

Anakwenze, U. & Zuberi D. (2013). Mental health and poverty in the inner city. *Health and Social Work*, 38(3), 147-157.

Aoun, S., Pennebaker, D., Wood, C. (2004). Assessing population need for mental health care: A review of approaches and predictors. *Mental Health Services Research, 6,* 33-46.

Barry, C. L., McGinty, E. E., Pescosolido, B. A., & Howard, G. H., (2014). Stigma, discrimination, treatment effectiveness, and policy: Public views about drug addiction and mental illness. *Psychiatric Services*, 65(10), 1269-1272 (published online October 2014). Retrieved June 29, 2018, from https://ps.psychiatryonline.org/doi/10.1176/appi.ps.201300550

Bebbington, P., & Rees, S. (2001). Assessing the need for psychiatric services at the district level: Using the results of community surveys. In G. Thornicroft (Ed.) *Measuring Mental Health Needs (2nd Ed.),* pp. 125-143. RCPsych Publications.

Bradshaw, J. (1972). The concept of social need. *New Society, 30,* 640-643.

Carter, M.F. (2003). The relationship of a self-reported assessment of need in mental illness to insight. *Journal of Mental Health, 12,* 81-89.

Chatterjee, A., Obando, A., Strickland, E., Nestler, A. Harrington-Levey, R., Williams, T., & LaCoursiere-Aucchero, T. (2017). Shelter-based opioid treatment: Increasing access to addiction treatment in a family shelter. *American Journal of Public Health*, 107(7), 1092-1094.

Cohen-Mansfield, J. & Frank, J. (2008). Relationship between perceived needs and assessed needs for services in community-dwelling older persons. *The Gerontologist, 48*, 505-516.

County Health Rankings. Retrieved August 2018 from http://www.countyhealthrankings.org/

Cunningham, P. J. (2009). Beyond parity: Primary care physicians' perspectives on access to mental health care. *Health Affairs*, 28(3), w490-501 (published online April 14, 2009). Retrieved June 19, 2018, from https://www.healthaffairs.org/doi/10.1377/hlthaff.28.3.w490

English, J.T., Sharfstein, S.S., Scherl, D.J., et al (1986). Diagnosis-related groups and general hospital psychiatry: The APA study. *American Journal of Psychiatry, 143,* 131–139.

Fryers, T. & Brugha, T. (2013). Childhood determinants of adult psychiatric disorder. *Clinical Practice and Epidemiology in Mental Health,* 9, 1-50.

Gustafson, D. T., Preston, K., & Hudson, J. (May 2009). Mental health: Overlooked and disregarded in rural America. *A Series Examining Health Care Issues in Rural America*, No. 4. Retrieved June 28, 2018, from http://files.cfra.org/pdf/Mental-Health-Overlooked-and-Disregarded-in-Rural-America.pdf

Hanson, L., Houde, D., McDowell, M., & Dixon, L. (2007). A population-based needs assessment for mental health services. *Administration Policy, Mental Health, and Mental Health Services Research, 34,* 233-242.

Hudson, C. G. (2005). Socioeconomic status and mental illness: Tests of the social causation and selection hypotheses. *American Journal of Orthopsychiatry*, 75(1), 3-18.

Kopel, D. B. & Cramer, C. E. (2015). Reforming mental health law to protect public safety and help the severely mentally ill. *Howard Law Journal*, 58(3), 715-78.

Kukla, M., McGuire, A. B., & Salyers, M. P. (2016). Rural and urban supported employment programs in the Veterans Health Administration: Comparison of barriers and facilitators to vocational achievement for veterans experiencing mental illnesses. *Psyciatric Rehabilitation Journal,* 39 (2), 129-136.

Meadows G, Burgess P, Bobevski I, Fossey E,Harvey C, Liaw S-T. (2002). Perceived need for mental health care: influences of diagnosis,demography and disability. *Psychological Medicine, 32*, 299–309.

Meaney, A., Croke, M., & Kirby, M. (2005). Needs assessment in dementia. *International Journal of Geriatric Psychiatry, 20*, 322-329.

Merikangas, K. R., Nakamura, E. F., Kessler, R. C. (2009). Epidemiology of mental disorders in children and adolescents. *Dialogues in Clinical Neuroscience*, 11(1), 7-20.

Missouri Department of Mental Health. Retrieved August 2018 from https://seow.dmh.mo.gov/

Palmer, C. J., Connor, C., Newton, B. J., Patterson, P., & Birchwood, M. (2017). **Early intervention** and identification strategies for young people at risk of developing **mental health** issues: Working in partnership with schools in Birmingham, UK. *Early Intervention in Psychiatry*, 11 (6), 471-480.

Richardson, L., Wood, E., Montaner, J., & Kerr, T. (2012). Addiction treatment-related employment barriers: The impact of methadone maintenance. *Journal of Substance Abuse Treatment*, 43, 2 76-284.

Schomerus, G., Schwahn, C., Holzinger, A., Corrigan, P. W., Grabe, H. J., Carta, M. G., & Angermeyer, M. C. (2012). Evolution of public attitudes about mental illness: A systematic review and meta-analysis. *Acta Psychiatrica Scandinavica*, 125, 440-452.

Screening for Mental Health, Inc. (2016, May 10). The Importance of Early Intervention in Mentally Healthy Communities [Web log post]. Retrieved June 19, 2018, from https://mentalhealth screening.org/blog/the-importance-of-early-intervention-in-mentally-healthy-communities

Smith, H. (1998). Needs assessment in mental health services: the DISC Framework. *Journal of Public Health Medicine, 20*, 154-159.

Substance Abuse and Mental Health Services Administration (2015). *Results from the 2014 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-50, HHS Publication No. (SMA) 15-4927. Rockville, MD: Substance Abuse and Mental Health Services Administration. Retrieved June 19, 2018 from http://www.samhsa.gov/data/sites/default/files/NSDUH-FRR1-2014/NSDUH-FRR1-2014.pdf

United State Census Bureau. Retrieved August 2018 from https://www.census.gov/

United States Department of Agriculture Economic Research Service: Rural poverty at a glance. Rural

Development Research Number 100, July 2004. Retrieved June 18, 2018, from https://www.ers.usda.gov/webdocs/publications/47002/30441_rdrr100_lowres_002.pdf?v=41479

United States Department of Justice Bureau of Justice Statistics: Recidivism of prisoners released in 30 states in 2005: Patterns from 2005 to 20110. Retrieved June 29, 2018, from https://www.bjs.gov/content/pub/pdf/rprts05p0510_st.pdf