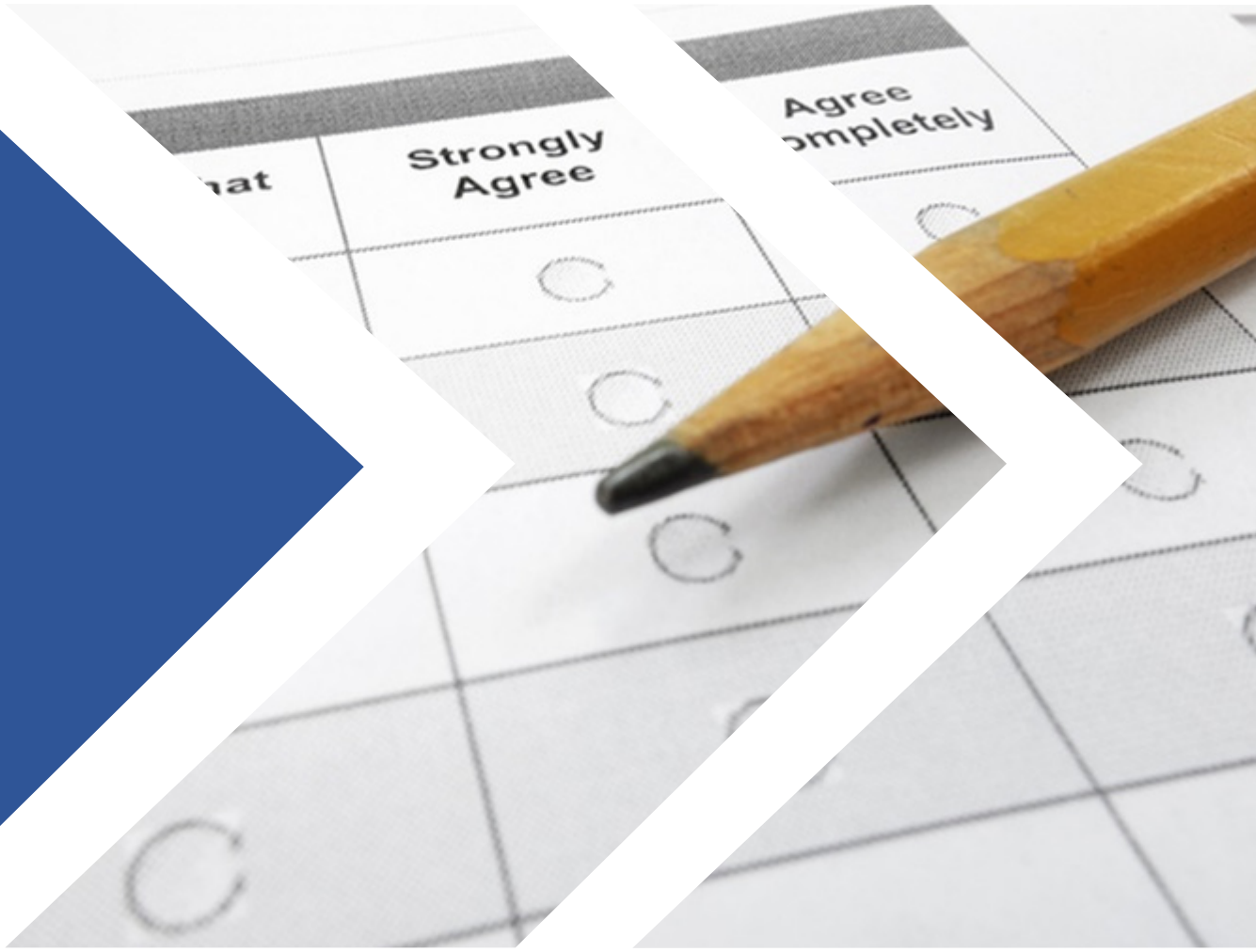
2020

LOCAL COORDINATING COUNCIL
SURVEY RESULTS



INDIANA CRIMINAL JUSTICE INSTITUTE

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INTRODUCTION

The Indiana Commission to Combat Drug Abuse (the Commission), established in 2016, is a group of 18 members from prevention, treatment, and enforcement who meet four times each year to collaborate and discuss actions and ideas to defeat the drug epidemic. Approved by the Commission, Local Coordinating Councils (LCC) preside in each of Indiana's 92 counties. These coalitions are countywide collaborative citizen bodies that are open to the public who plan, implement, monitor, and evaluate local comprehensive community plans.

Comprehensive Community Plans (CCP) are a systematic community-driven gathering, analysis, and reporting of community level indicators for the purpose of identifying and addressing local substance use problems. As a member of the Commission, the Indiana Criminal Justice Institute's (ICJI) Executive Director adheres to the requirements outlined in IC 4-3-25-15 below, benefitting the overall mission of the Commission. The Executive Director delegates these responsibilities to the ICJI's Behavioral Health Division (the division).

Therefore, the division is responsible for:

- implementing the commissioner's recommendations concerning LCCs;
- maintaining a system to provide technical assistance, guidance, and funding support to the LCCs;
- assisting in the development of LCCs to identify community drug programs, coordinate community initiatives, design comprehensive collaborative community strategies, and monitor anti-drug activities;
- approving comprehensive drug free community plans and funding requests submitted by LCCs; and
- providing quarterly reports to the Commission on comprehensive drug free community plans.

The division's mission is to support, enhance, and strengthen local communities' efforts to create drug free, recovery focused communities across the State of Indiana. This is accomplished through the adherence to the above statutory authority with the ultimate goal of reducing the incidence and prevalence of substance abuse and addictions among adults and children in our Hoosier state.

BACKGROUND

Upon entering the role in late 2018, the Division Director of the Behavioral Health Division performed an assessment of his division's processes and procedures. Most importantly, he gauged how and how well the division meets the requirements of the Commission with regard to the LCCs. After completing this assessment, gaps in data collection, records keeping, and, generally, institutional knowledge concerning the make-up, functionality, and wellness of the LCCs were identified. Improving upon these items were believed to enhance the capability of the division to adhere to the requirements of the Commission. After identifying these gaps, the Behavioral Health Division made it a priority to first better understand the LCCs for which they provide technical support and oversight. Demographic and operational data were collected, alongside their thoughts and opinions about what the ICJI can do to help them reach their goals. The division elicited the assistance of the Research and Planning Division to create a research strategy to accomplish this. A multi-methodological approach was chosen so that information collected would be well rounded, and include multiple audiences in multiple time frames. The table below explains the research strategy in full in accordance to the division's calendar:

Table 1: Research Strategy

Quarter	Time of Year	Methodological Strategy	Project or Tool Title
Quarter 1	April 1 - June 30	Secondary Data Analysis	Comprehensive Community Plan, Program Manager On-Site Tool
Quarter 2	July 1 - September 30	Focus Group	Annual Regional Local Coordinating Council Focus Groups
Quarter 3	October 1 - December 31	Reporting	Annual Behavioral Health Division Report
Quarter 4	January 1 - March 31	Survey	Annual Survey for the Local Coordinating Councils

The information to follow will concern the Quarter 4 project, the Annual Survey for the Local Coordinating Councils.

EXECUTIVE SUMMARY

The second annual survey for Local Coordinating Councils (LCC) was created to collect information regarding the current make-up, functionality, and wellness of Indiana's LCCs. Not only did this give LCC Coordinators—the respondents to the survey— an opportunity to voice their opinions, but it allows the Behavioral Health Division at the Indiana Criminal Justice Institute (ICJI) to better understand how they can assist the LCCs with their substance use reduction efforts.

Typically, LCCs are made up of 43 members, where 23 participate in more than 50% of regularly scheduled meetings. Persons representing the law enforcement sector are most broadly represented across coalitions, followed by those representing government, health, education, and human services. Generally, coalitions have unequal representation in terms of gender and race/ethnicity. Persons 30 to 59 years of age and who identify as Caucasian are most broadly represented.

Coordinators claim that the general substance use problem in their community is severe or moderate (scale: severe, moderate, mild, and normal). To combat this, LCCs are supporting evidence-based, recovery-oriented, and safety-enhancing efforts tailored to high-schoolers and adults ages 25-44. These efforts address marijuana, alcohol, methamphetamine, prescription drugs, and heroin-related substance use that fall into one of the following categories: prevention and education, treatment and intervention, and criminal justice services and activities. They also explain that substance use treatment services have an average level of accessibility, where counseling is most accessible and inpatient services are the least accessible.

The majority of LCCs are operating on Drug Free Community dollars alone, with a few exceptions, where certain portions of that funding have to be spent in the categories outlined above. Around two thirds of respondents planned to spend 25% in each of these funding areas this past year, ensuring compliance with the law. The remaining counties indicated that they planned to spend more or less than 25% of the fund in at least one funding area. Additionally, many coalitions believe that diversion programs decreased their funding in the past year by anywhere from 1% to 49%. Indiana's LCCs are connecting with a multitude of systems within their own counties to address substance abuse. However, LCCs typically do not take part in cross-county collaborative efforts due to limited time and/or resources.

LCCs believe that the overall model of the coalition is somewhat effective for addressing substance use. There are things that work well, such as the ability to collaborate within communities via the coalition; extend dedicated monies to local entities to address problems that the coalitions identified; and educate the community about substance use. There are things, however, that do not work so well. The LCCs report having limited and restrictive resources and having to endure bureaucracy as obstacles they face while doing this work.

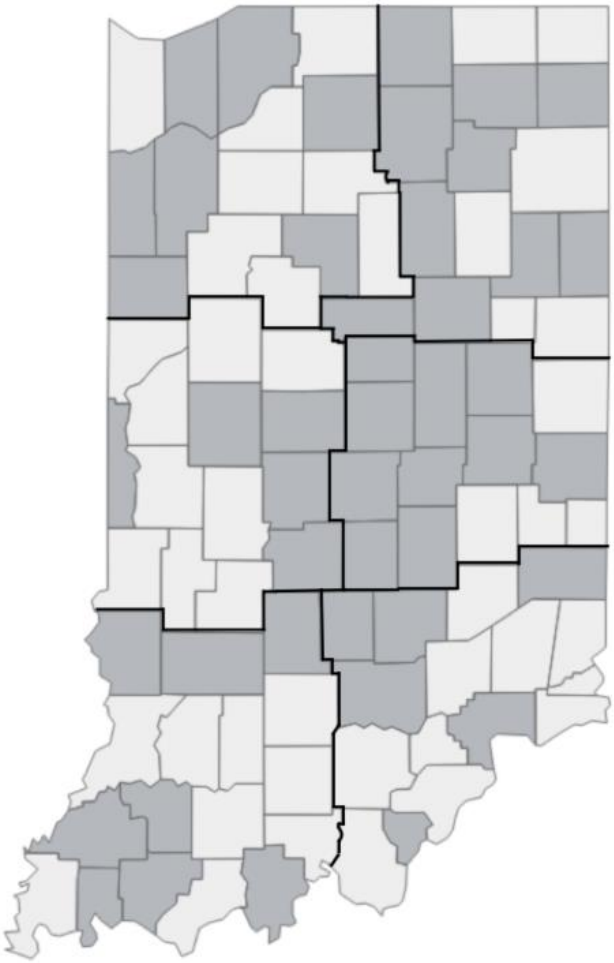
Most all LCCs believed that their coalition could be improved, where the most common ideas for improvement were having a membership that is active, abundant, and diverse; having the support of the state; better advertising their efforts; and obtaining more funding. When later asked which form of technical assistance would be most beneficial from the ICJI, many coordinators spelled out needing assistance with familiarization of requirements and understanding what efforts may be funded. Finally, on average, LCCs thought that most of the goals and objectives of the Behavioral Health Division were in alignment with their needs, and would simplify their efforts.

METHODOLOGY AND RESPONSE INFORMATION

The survey was disseminated to 82 LCC Coordinators who oversee the 92 substance use reduction coalitions in Indiana. If an LCC Coordinator oversees multiple counties, they were asked to take the survey multiple times—one per county. There were 51 responses to the survey; of those who started, 47 completed or partially completed the survey. If responses were submitted multiple times by the same county, the most recent survey was selected for analysis. 46 unique counties' data were analyzed, accounting for 50% of Indiana's LCCs.

Figure 1 to the right displays the counties who completed the survey, visible in dark grey. Seven (15%) responses came from Region 1; 10 (22%) came from Region 2; five (11%) came from Region 3; 10 (22%) came from Region 4; eight (17%) came from Region 5; and six (13%) came from Region 6.

Figure 1. Completed Surveys by County



LCC MEETINGS AND MAKE-UP

On average, an LCC holds about 9 regularly scheduled meetings in a standard calendar year, where each meeting lasts about an hour. Twenty-one (45%) LCCs are county entities, 13 (28%) are 501(c)(3)s, seven (15%) are volunteer entities, and two (4%) are public/private partnerships.

The number of active members is defined as those who attend regularly scheduled meetings more than 50% of the time, and the number of inactive members is defined as those who attend 50% or less of the time. Therefore, the total number of members is the sum of the active and inactive members. The average number of total members in an LCC was 43, where 23 are active members and 20 are inactive members; most members in the LCC are considered active members.

LCCs were asked which sectors' voices were represented in their active membership using the following list: Business, Community Activists/Volunteer Groups, Education, Government, Health, Housing/Development, Human Services, Law Enforcement, Media, Parents, Religion, and Youth. Across the 46 counties who provided information, law enforcement was most represented in active membership—in 40 of 46 coalitions. Government employees (37), health professionals (36), educators (35), and human services workers (32) followed closely behind. Members of the housing/development sector were least likely to be represented in active membership—5 of 46 coalitions. The average coalition hears the voice of 8 of the 12 provided sectors. Twenty (43%) coalitions claimed that men and women were not equally represented in their active membership, 18 (39%) said they were, 3 (7%) were unsure, and the remaining abstained from answering.

When asked which of seven age groups (10-19, 20-29, 30-39, 40-49, 50-59, 60-69, 70+) were represented in their active membership, 41 (89%) said 40-49 year-olds were represented, 40 (87%) said 50-59 year-olds were represented, and 39 (85%) said that 30-39 year-olds were represented. 10-19 year-olds were the least represented, where individuals in this age group were present in only 10 coalitions. The average coalition hears the voice of 5 of 7 different age groups.

Finally, coalitions were asked to enumerate the racial/ethnic make-up of their active membership, then discern if their coalition comprised of all racial/ethnic groups in their county. Overwhelmingly, coalitions have white members—41 of 46—followed by black (17), and Hispanic (15). Additionally, 10 counties suggested that the racial/ethnic make-up of their active membership does not match that of the population they serve, 2 suggest it does, 2 are unsure, and the remaining abstained from answering.

SUBSTANCE ABUSE CONCERNS AND EFFORTS

Respondents were asked to report the severity of their county's overall drug problem (scale: severe, moderate, mild, and normal), where 21 counties (46%) claimed that the problem is moderate and 20 counties (43%) claimed that it was severe. Respondents were then asked to select all forms of substance use the LCC was addressing. Forty-four (96%) counties claimed to be addressing alcohol and marijuana use, followed by 42 (91%) counties addressing prescription drug use, 40 (87%) addressing heroin use, and 37 (80%) addressing methamphetamine use. Coalitions also expressed that the use of vaping devices/e-cigarettes is being addressed. See the table below for more information.

Table 2. Substances Being Addressed by Local Coordinating Councils

Substance	Number of LCCs	Percent of Total
Alcohol	44	96%
Marijuana (Cannabis)	44	96%
Prescription Drugs	42	91%
Heroin	40	87%
Methamphetamine	37	80%
Tobacco/Nicotine	36	78%
Synthetic Drugs (e.g., spice, bath salts)	16	35%
Cocaine/Crack	16	35%
Inhalants	15	33%
Designer Drugs and Hallucinogens (e.g., ecstasy, LSD, PCP)	12	26%

Respondents were presented with an extensive list of substances, and asked to determine which five they believed their community should be the most aware of. Collectively, coalitions selected these substances as their top 5: methamphetamine (39), marijuana (38), alcohol (36), prescription opioids (32), and heroin (30). Respondents were then asked to select five of these substances that were the least relevant to the community at this time, to which they said: mescaline or peyote (22), ayahuasca (19), anabolic steroids (18), psilocybin (14), and LSD (14).

Finally, coalitions were asked to rate how accessible or inaccessible substance use treatment programs were in their county including inpatient; outpatient; drug court; coordinated multidisciplinary team for drug prevention, detection, and rehabilitation; jail-based; and counseling. When thinking about accessibility, we asked respondents to consider program or service cost, wait times, availability of staff, and ability to accept insurance, to name a few. Overall, respondents believe that all services have an average level of accessibility (scale: highly accessible, accessible, average, inaccessible, highly inaccessible). When broken out by service, substance use counseling is perceived to have the highest level of accessibility and inpatient treatment has the lowest level of accessibility. See the table below for more details.

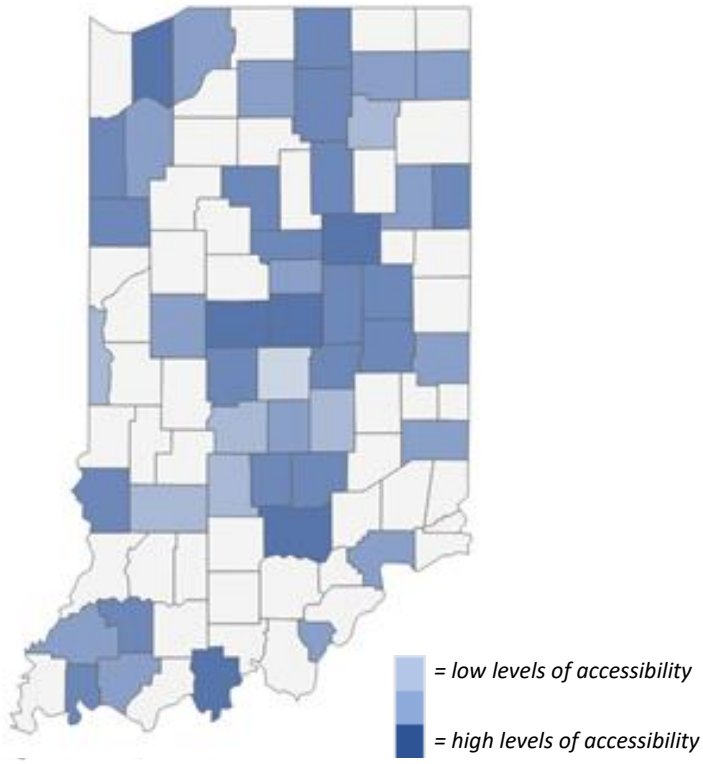
Table 3. Perceived Availability of Drug Treatment Services by Local Coordinating Councils

Drug Treatment Service	Average Rating	Accessibility Label
Substance Abuse Counseling	4	Accessible
Outpatient Drug Treatment Program(s)	3	Average
Drug Court	3	Average
Jail-Based Drug Treatment Program(s)	3	Average
Coordinated Multidisciplinary Team for Drug Prevention, Detection, and Rehabilitation	3	Average
Inpatient Drug Treatment Program(s)	2	Inaccessible

Grant, Porter, and Perry counties' average score across all listed substance use treatment services was the highest compared to other respondents—highly accessible. Conversely, Marion County's average score reflected that all treatment services are highly inaccessible. Additionally, Monroe, Shelby, Morgan, Vermillion, Green, and Whitley counties claimed their services were generally inaccessible. See Figure 2 to the right for a more in-depth look of counties' average accessibility score across substance use treatment services.

When asked to which age group are most of their efforts targeted, 21 (48%) claimed youth 12 to 17 years of age were the target population, 10 (22%) claimed that persons 25 to 34 years of age were the target population, and 6 (13%) claimed that persons 35 to 44 years of age were the target population.

Figure 2. Accessibility of Substance Use Treatment Services by County



FUNDING

Respondents were asked if the coordinator was paid, at least in part, by the administrative portion of the total Drug Free Community (DFC) fund. Thirty-seven (80%) said their coordinator was paid, and the remaining said they were not. The majority of the coordinators that are not paid through this fund lead coalitions in small counties—with a population of less than 40,000. Respondents were also asked if their board members or other, secondary staff were paid with this money. The overwhelming majority of coalitions boards and secondary staff are not paid with these funds, and often, secondary staff are non-existent. Next, coalition leaders were asked to report if they planned to spend more than, equal to, or less than 25% of the total DFC fund in each designated category—prevention and education, treatment and intervention, and justice services and activities—last year. Thirty-one (67%) coalitions planned to spend 25% in each category, ensuring compliance with the law. Thirteen counties planned to spend more than 25% in prevention and nine in both treatment and justice services. One county planned to spend less than 25% in both treatment and justice services.

The majority of LCCs (26) are operating only on DFC funds. However, nine counties are receiving funding from federal agencies (e.g., SAMHSA, CDC, BJA, etc.), five are receiving funding from state agencies (e.g., DMHA, DoH, etc.), and 12 are receiving funding from local entities. Two counties are receiving supplemental funding from all three of these entities, and five counties are receiving supplemental funding from any two of these entities. Finally, when asked if diversion programs were affecting the money in their DFC fund, 29 (63%) said that it had an effect. All but one claimed that their funding decreased as a response, typically by less than 50%.

COLLABORATION AND ADVERTISING

Respondents were asked if they have collaborated with counties within their region in the past year. Nineteen (41%) coalitions indicated that they had collaborated with a county in their region and 26 (57%) said they had not. Those who have not collaborated with counties within their region were asked to explain why. Many (19) claimed that limited time and/or resources discouraged them from collaborating. Seven counties cited that they did not think to collaborate, six claimed they aren't aware of other counties' issues, and two said they don't have contact information for other coalitions or the outlined duties of the LCC are not conducive to cross-county collaboration. When respondents were asked if they have collaborated with counties outside of their region, only 11 (24%) said they had. Thirty-two (70%) said they had not collaborated outside of their region. Of those who said they had not collaborated in this way, three quarters indicated that it was because they have limited time and/or resources. The remaining responses followed a similar pattern to the above question.

Overwhelmingly, LCCs report that they are interacting with systems such as law enforcement (83%), treatment (80%), recovery (76%), K-12 Education (74%), and public health to name a few. There were only four counties that claimed to not be interacting with a system. The least likely interaction was labor at about 4%, then housing at 11% and Education (College) at 22%. See the table below for a list of systems that LCCs are interacting with.

Table 4. LCC Systems Interaction

System	Number of LCCs	Percent of Total
Law Enforcement	38	83%
Treatment	37	80%
Recovery	35	76%
Education (K-12)	34	74%
Public Health	27	59%
Judiciary	26	57%
Local Government	24	52%
Religious Community	22	48%
Advocacy Organization	20	43%
Wellness	19	41%
Civic Organization	17	37%
Business	15	33%
Emergency Medical Services	15	33%
Medicine	14	30%
Education (College)	10	22%
Housing	5	11%
Labor	2	4%

When asked if community members were made aware of the efforts of the LCC via advertising, 24 (52%) said yes, while 18 (39%) said no. Those who do advertise their efforts were asked to select all advertising methods that they use. The most commonly used advertising methods were word of mouth and traditional media (e.g., television, radio, newspaper, magazine, etc.) by 20 (43%) counties, followed by new media (e.g., Facebook, Instagram, Twitter, etc.) by 19 (41%) counties. See the table below for a full list of advertising methods used.

Table 5. LCC Advertising Methods

Advertising Method	Number of LCCs	Percent of Total
Word of Mouth	20	43%
Traditional Media	20	43%
New Media	19	41%
Event Sponsorship	15	33%
Email	15	33%
Fliers	10	22%
Billboards	3	7%
Text	2	4%
Purchased Online Ads	2	4%

EFFECTIVENESS

The LCCs were asked to read their statutory requirements and a brief overview of their "on-paper" duties, then discern how effective or ineffective the current LCC model is (scale: extremely effective, 5; very effective, 4; somewhat effective, 3; not so effective, 2; not at all effective, 1). Based on these responses, a collective effectiveness score of 3.3 was applied to the LCC model; on average, respondents believe that the LCC model is somewhat effective. While the average score points to a neutral level of effectiveness, more respondents attribute effectiveness to the model as opposed to ineffectiveness when comparing the poles of the scale.

When asked to elaborate on what, if anything, works well about the LCC, many said that the opportunity to collaborate with one another to address substance use in their communities is essential to tackling this wicked problem. Coalitions take pride in the fact that their informed groups make decisions about which efforts should receive funding, ensuring alignment with the problem statements they created. Not only do they express impacting substance use by way of granting funding, but also in the form of educating the community.

When asked to elaborate on what, if anything, does not work well about the LCC, many claim that limited resources (e.g., time, money) is a huge barrier. The next item of concern was the rigidity of the spending requirements for the Drug Free Communities money. Many argued that this model simply doesn't work for them, and they would rather have discretional use. The last thing many LCCs discussed was the red tape associated with working in tandem with the state.

LCC IMPROVEMENT

About 42 (91%) of LCCs believe that their LCC could be improved. Of these, 37 shared their ideas for improvement. The top three ideas for improvement will be discussed. First, LCCs desire that membership be abundant, diverse, and active. LCCs explained that if they had more members, a larger representation from a certain agency, community organization, etc., or members generally participated to their full extent, their operation would greatly improve. Secondly, the LCCs desire general state or ICJI assistance with their efforts, operationalized by technical assistance; clear, transparent, and unified communication; and training opportunities. Tied for third, LCCs cited better advertisement and more funding as ideas for improvement. LCCs reported needing to do a better or more thorough job of advertising themselves to the community. They need to advertise what they do, show up for the community, and engage them to the best of their ability so that the LCC is known for assisting with these specific issues. Additionally, they talked about the importance of applying for more grant funding, and how receiving additional monies would generally allow them to improve and expand their impact.

LCCs were asked to select which service provided by ICJI would be most beneficial to their operation. Eleven coalitions cited assistance in familiarizing coordinators with requirements, nine cited program funding, six cited general technical assistance, five cited document submission, four cited training, and the rest were unsure. Finally, on average, LCCs thought that most of the goals and objectives of the Substance Abuse Division were in alignment with their needs, and would simplify their efforts. However, they believed that developing a coordinated vision for all LCCs and creating a structure where LCCs within the same region could collaborate would neither simplify nor complicate their efforts. Building a structure where LCCs from different regions could collaborate with one another is perceived to complicate their efforts.