



Caring For Our Community

**BROWN COUNTY COMMUNITY BOARD OF
ALCOHOL, DRUG ADDICTION AND MENTAL HEALTH SERVICES**

85 Banting Drive • Georgetown, Ohio 45121
(937) 378-3504 • Fax (937) 378-3027

January 14, 2014

Roy Pierson, MSA
Office of Quality, Planning & Research
Ohio Department of Mental Health & Addiction Services
30 E. Broad St., 8th Fl.
Columbus, OH 43215

Dear Mr. Pierson,

Please find the community plan for Brown County attached. Please contact me if you need anything further.

Sincerely:

Steve Dunkin
Executive Director

Attachment

**Ohio Mental Health and Addiction Services (OhioMHAS)
Brown County ADAMHS Community Plan SFY 2014**

Environmental Context of the Plan/Current Status

1. Describe the economic, social, and demographic factors in the Board area that will influence service delivery.
(NOTE: There will be an opportunity to discuss the possible effects of Medicaid expansion upon your local system in question #12.)

Brown County is a rural county on the border of Appalachia. Brown County offers access to the Ohio River on our southern border and is located one hour east of Greater Cincinnati. Brown County has a strong Appalachian background.

Brown County's population is 44,381. The population is comprised of Caucasians at a rate of 97.5%. Educationally 80.9% of the population is high school graduates and 10.4% have acquired a bachelor degree. There are 915 persons per mile. (U.S. Census Bureau)

24.5% of children in Brown County live below 100% of the Federal Poverty Level (Kids Count Data Center). 45.1% of Brown County Children live below 200% the Federal Poverty Level (Ohio Department of Health). 48.4% of births in Brown County are paid by Medicaid (ODJFS County Profiles). Ohio Department of Health indicates an infant mortality rate for Brown County at 16.4% compared to 7.7% for the State of Ohio.

GRAPH A (Graphs are found at end of document)

Substantiated cases of child abuse and neglect in Brown County have risen above state averages.

GRAPH B

Personal Income is below the state average in Brown County.

GRAPH C

The unemployment rate in Brown County has followed trends across Ohio though slightly higher.

GRAPH D

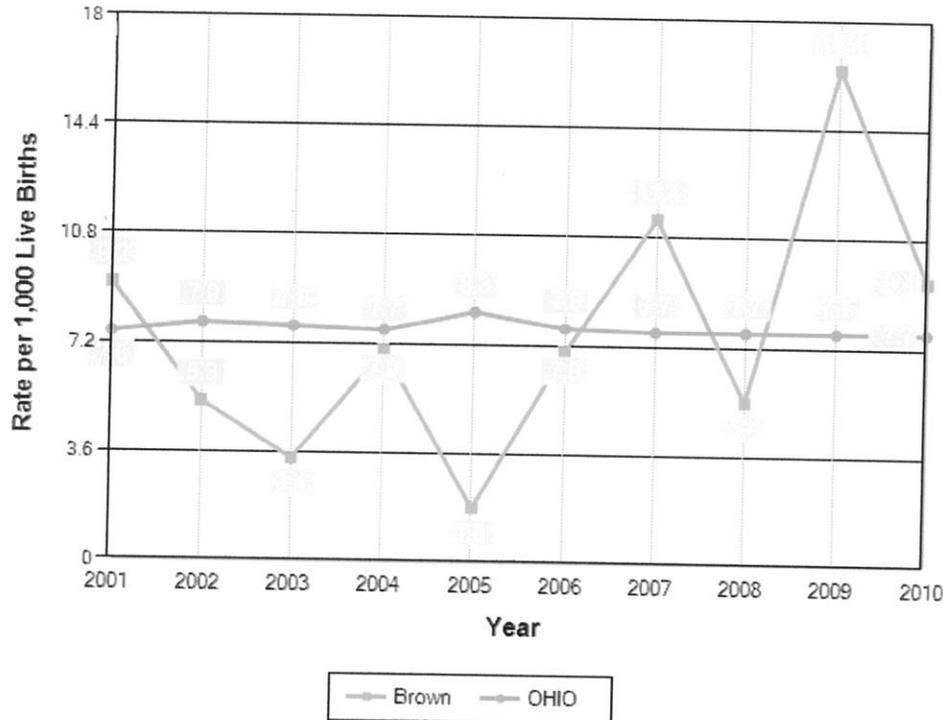
Brown County has been designated as a Health Professional Shortage Area. Recruitment of Mental Health and Addiction Specialists is problematic. Brown County is comprised of 490 square miles and does not have a public transportation system.

Local funding is an issue in regard to the social services/health care delivery system. Two levies have passed to support services: The Brown County Board of Developmental Disabilities and Senior Citizens. The Brown County ADAMHS Board operates without local funding/levy.

Medicaid Expansion offers several significant opportunities for our consumers. Certainly more access to primary care, dentistry services, and screening and preventative care should make an impact on the health status of Brown County. The availability of health providers available locally to meet service demands could be an issue. Medicaid expansion holds an opportunity for those consumers in need of addiction and mental

Demographic and Contextual Factors

Infant Mortality Rate County vs. Ohio



Infant mortality rate is used as an indicator of health and well-being within and among countries, states, and other geographic areas. Maternal tobacco and drug use increases the chances of negative pregnancy outcomes and infant death. However, infant mortality rates should not be used as one of the consequences indicators when assessing substance abuse trends across regions; instead this data should be viewed as additional contextual information about health and well-being in Ohio regions.

Definition: The number of deaths to infants under 1 year of age per 1,000 live births.

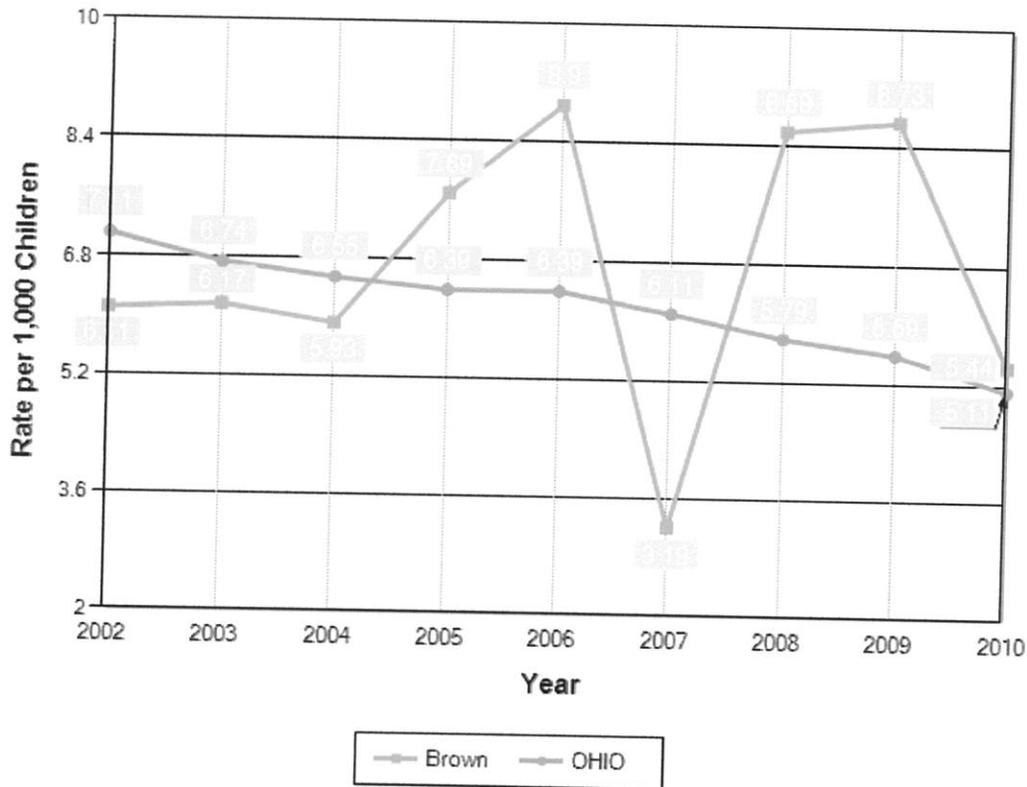
Data Sources: Ohio Department of Health (<http://www.odh.ohio.gov/odhPrograms/cfhs/imtf/imtf.aspx>)

[Click here to see a list of sources](#)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Brown	9.2	5.3	3.4	7	1.8	7	11.4	5.4	16.4	9.4
OHIO	7.6	7.9	7.8	7.7	8.3	7.8	7.7	7.7	7.7	7.7

Demographic and Contextual Factors

Substantiated Cases of Child Abuse County vs. Ohio and Neglect



According to the Center for Disease Control (2009), abuse encompasses a wide range of acts intended to bring physical, sexual or emotional harm to a child. In contrast, neglect describes an adult's failure to meet the basic needs of a child. Drug and alcohol abuse within a family increases the risk for both child abuse and neglect. Children under the age of four are at an increased risk for both abuse and neglect. In 2007, abuse and neglect rates were highest among African-American and Native American children.

Data Sources: Ohio Dept. of Job and Family Services

Center for Disease Control. Understanding Child Maltreatment. Spring 2009, [Electronic Version]. Retrieved October 10, 2009 from www.cdc.gov/violenceprevention.

[Click here to see a list of sources](#)

	2002	2003	2004	2005	2006	2007	2008	2009	2010
Brown	6.11	6.17	5.93	7.69	8.9	3.19	8.59	8.73	5.44
OHIO	7.11	6.74	6.55	6.39	6.39	6.11	5.79	5.59	5.11

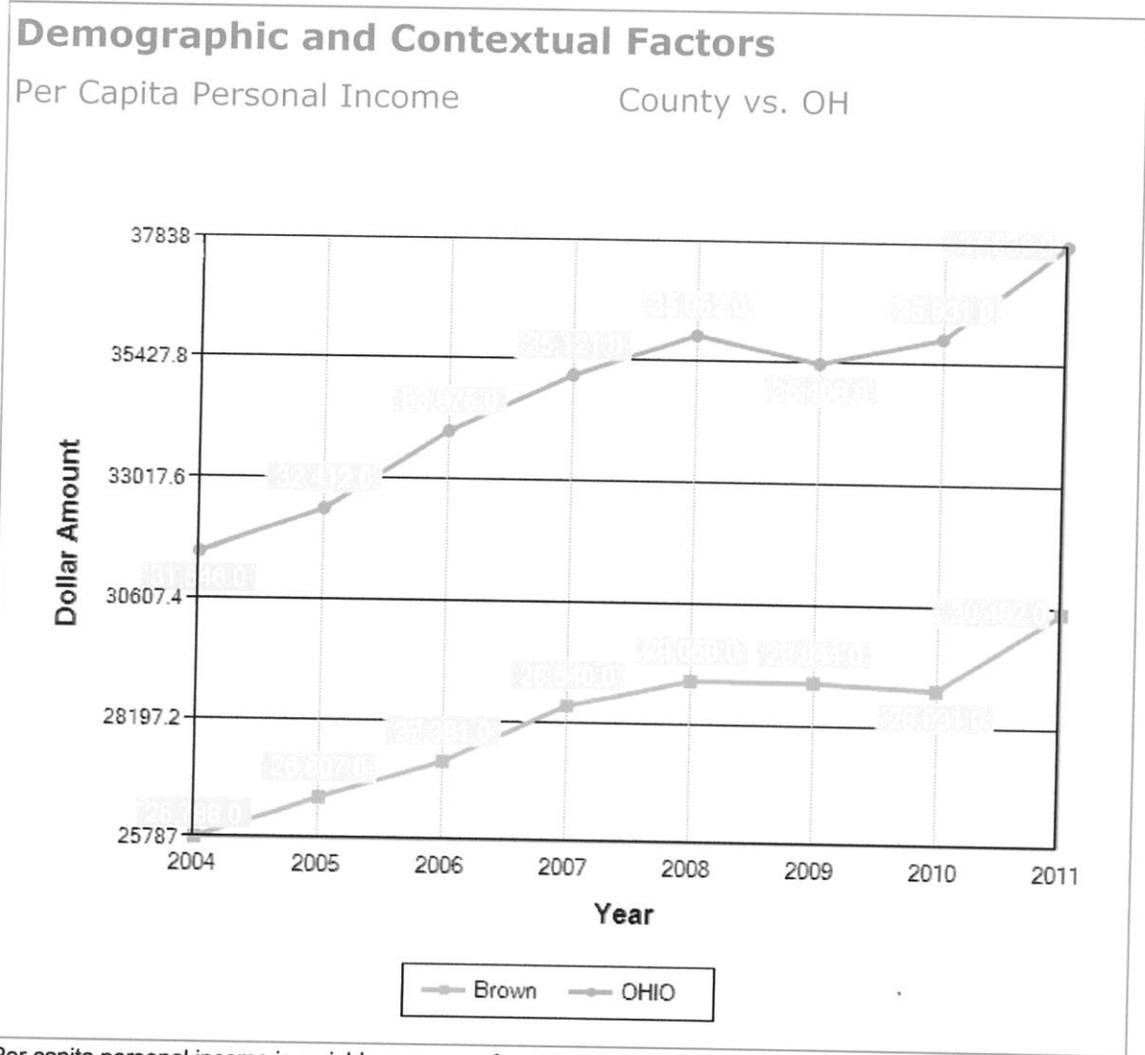
GRAPH C

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Per capita personal income is a viable measure of economics within a given area. The indicator includes several sources of income, including place of work, retirement benefits, rental properties, and unemployment.

Poverty has been associated with poor health outcomes including substance abuse and addiction. Poverty has also been shown to increase the negative impact of a chronic health problem upon one's mobility and activity levels.

Definition: Per capita personal income was computed using Census Bureau midyear population estimates. Estimates for 2000-2009 reflect county population estimates available as of April 2010.

Data Source: Bureau of Economic Analysis, Regional Economic Information System, CA1-3. <http://www.bea.gov>

Morbidity and Mortality Weekly Report (MMWR), May 30, 2008; www.cdc.gov/mmWR/preview/mmwrhtml/mm5721a5.htm

[Click here to see a list of sources](#)

	2004	2005	2006	2007	2008	2009	2010	2011
Brown	25788	26607	27381	28540	29058	29044	28931	30492
OHIO	31546	32412	33975	35121	35952	35408	35931	37836

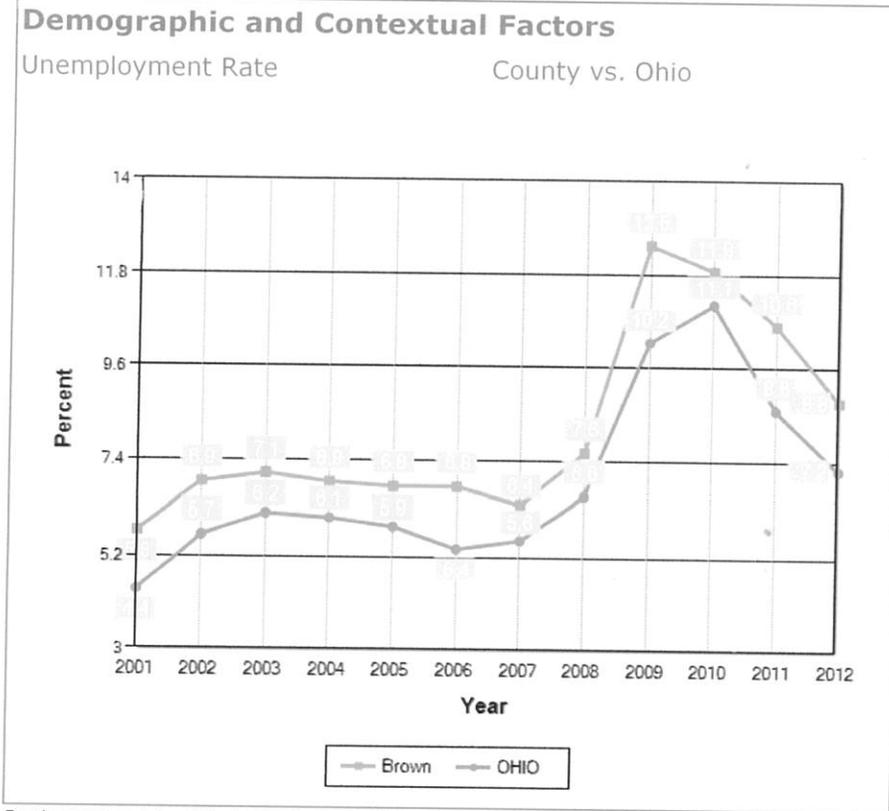
GRAPH D

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Previous research has linked unemployment with increased prevalence of alcohol and substance abuse. Overall, poverty and unemployment have been conceptualized as both potential causal factors and consequences of substance abuse.

Definition: Unemployment claims represent an unduplicated number of persons filing for unemployment benefits within the calendar year.

Data Sources: Ohio Department of Job and Family Services.

Mossakowski, K. N. (2008). Is the duration of poverty and unemployment a risk factor for heavy drinking?. *Social Science and Medicine*, 67, 947-955.

Khan, S., Murray, R. P., & Barnes, G. E. (2002). A structural equation model of the effect of poverty and unemployment on alcohol abuse. *Addictive Behaviors*, 27, 405-423.

[Click here to see a list of sources](#)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Brown	5.8	6.9	7.1	6.9	6.8	6.8	6.4	7.6	12.5	11.9	10.6	8.8
OHIO	4.4	5.7	6.2	6.1	5.9	5.4	5.6	6.6	10.2	11.1	8.6	7.2

health services to make the array of service more effective.

Assessment of Need and Identification of Gaps and Disparities

2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gap issues and disparities, if any. (NOTE: ORC 340.03 requires service needs review of: (1) child service needs resulting from finalized dispute resolution with Family & Children First Councils; and, (2) outpatient service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals)

Process of Needs Assessment

The Board utilizes a process of needs assessment that analyzes the community profile and demographics in conjunction with available epidemiological statistics, health department data, criminal justice data, service by type, utilization outlier data, and service demand data. This information is compiled from the U.S. Census Bureau, Ohio Department of Health, Ohio Department of Mental Health and Addiction Services, United Way, Interact for Health, the Pride Survey, the Ohio Department of Education, the Ohio State Patrol, The Ohio Children's Defense Fund and the Ohio OARRS report.

Additionally the Board utilizes data from MACSIS that is available from data sets provided by Behavioral Health Generations including diagnosis, service, cost and volume with comparisons to other county and statewide systems. Data available through the ODMHAS patient care system, the Ohio Data Mart and monthly reports from the Board's primary provider are used in the planning process.

During the past year the Board conducted a series of three Town Hall meetings on the issue of prescription drug abuse. In addition the Board has developed two drug free community coalitions. The combination of these efforts has provided an ongoing source of informal perceptions and opinions that serve to identify issues and opportunities in prevention, intervention and recovery. The Board has been able to include Family members and consumers through this process. The Board is also a member of the Coalition learning collaborative facilitated by the Ohio Association of Community Behavioral Health Authorities. This experience has helped to learn from the success of coalitions across Ohio.

During the past year the Board received a grant through the Health Foundation to study options for integrative health services for the population we serve. This grant provided an opportunity to survey consumers who are active in our system of care.

The Brown County ADAMH Board sponsored the development of a Strategic Prevention Framework during 2010-2011. This process provided valuable stakeholder input into the needs of our county. As part of this process the Board contracted with Colorado State University to conduct a Community Readiness Study. The results of the study indicated that the community recognized that a significant drug problem exists. Furthermore the community was aware of efforts to address the issue. The study did reveal a reluctance to join the effort to address the problem or to fund that effort.

Issues identified through Needs Assessment process

The needs assessment process has documented the comparative extent that Brown County is experiencing an opiate and prescription drug epidemic. Data provided through ODMHAS through the State Epidemiological

Outcomes Workgroup (SEOW) provides an accurate basis to view public health trends in Brown County. In 2010 Brown County had the highest unintentional drug death rate.

Graph E

Brown County data demonstrates a rate of opioid related poisonings that is above state average.

Graph F

The latest Quarterly OARRS Report, Quarter 3, 2013, indicates that a number of doses per patient for opiates and pain relievers for Brown County was 160.98 compared to 154.45 Ohio average. Does per capita was 20.59 in Brown County versus 16.96 Ohio average.

According to OhioMAS a portion of Brown County is included as a heroin cluster and prescription drug cluster.

Graph G

Graph H

Alcohol related consequences in Brown County indicate a suicide death rate higher than the state average, a chronic liver disease death rate that exceeds the Ohio state average and disturbing trends of motor vehicle crashes that are alcohol related, and an increasing trend of Hepatitis C.

Graph I

Graph J

Graph K

Graph L

Tobacco related consequences indicate a cardiovascular disease death rate that continues to exceed state averages.

Graph M

Brown County has a divorce rate that exceeds the state average.

Graph N

Strengths and Challenges in Addressing Needs of the Local System of Care

GRAPH E

Id 1020

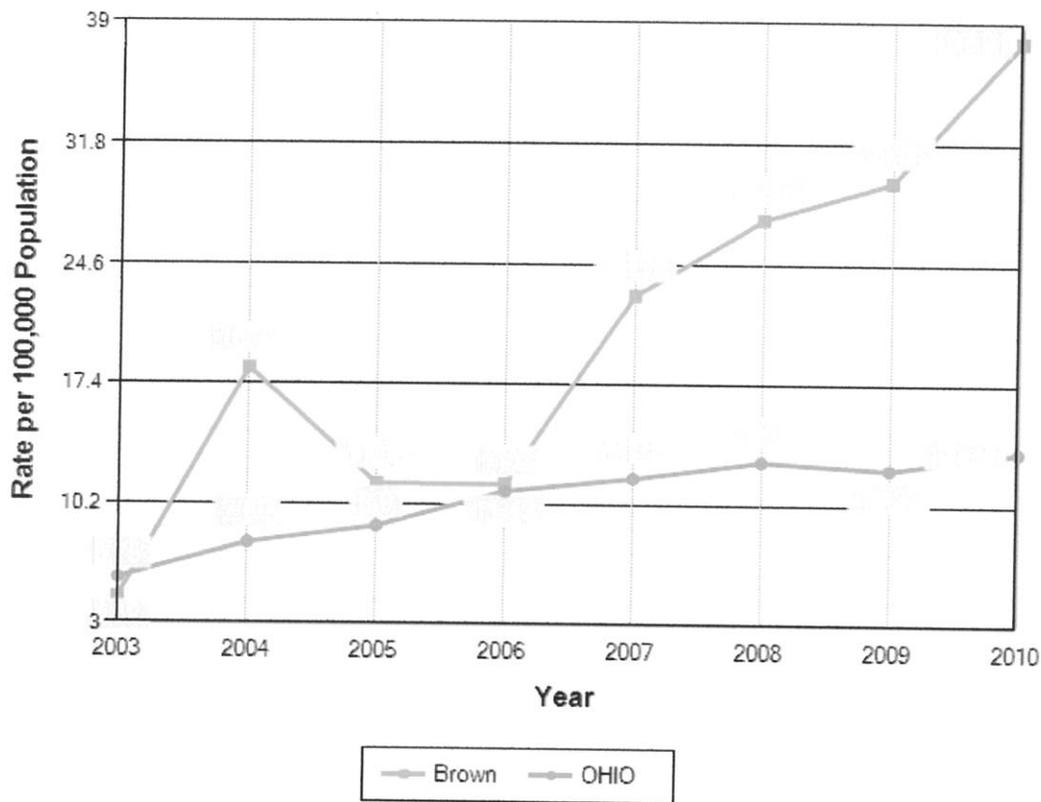
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Drug Related Consequences

Unintentional Drug Death Rate County vs. Ohio



Deaths directly attributable to drug use include drug psychoses, drug dependence, nondependent abuse of drugs, and polyneuropathy due to drug use. Indicator only includes deaths; illicit drug-related morbidity is not reflected. Deaths in which drugs may have been a contributing but not primary cause are not included.

Definition: Includes accidental poisoning by and exposure to the following: analgesics, antipyretics, and antirheumatics; antiepileptic, sedative-hypnotic, medications for parkinson's disease, and psychotropic medications; narcotics and hallucinogens; drugs acting upon the autonomic nervous system; and other, unspecified drugs or medications (World Health Organization, 2007). Deaths are recorded by county of residence.

Data Sources: Ohio Department of Health.

World Health Organization. (2007). International statistical classification of diseases and related health problems, 10th Vrs. Retrieved June 9, 2010, from <http://apps.who.int/classifications/apps/icd/icd10online/>.

[Click here to see a list of sources](#)

	2003	2004	2005	2006	2007	2008	2009	2010
Brown	4.59	18.33	11.44	11.42	22.75	27.33	29.54	37.91
OHIO	5.75	7.89	8.9	11	11.78	12.78	12.33	13.38

GRAPH F

Id 1172

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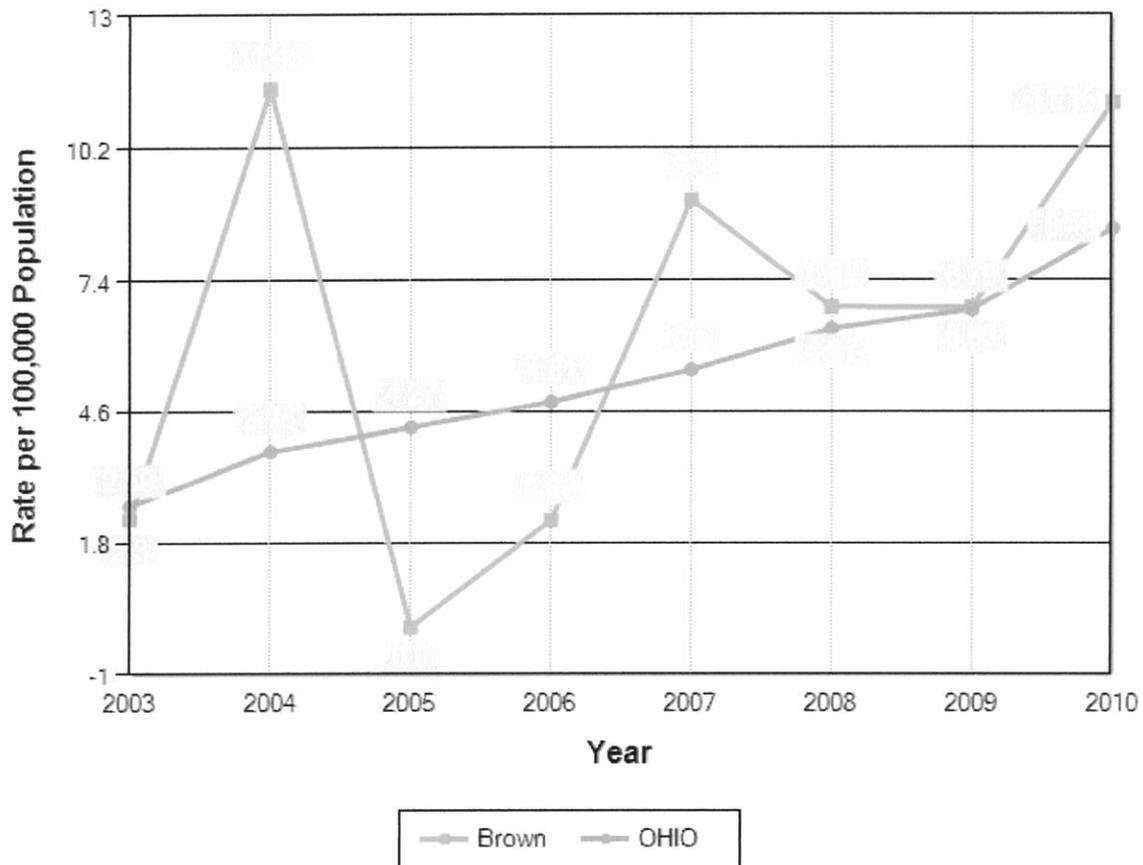
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Drug Related Consequences

Opioid-related Poisonings

County vs. Ohio



Unintentional drug overdose has accounted for the highest percentage of deaths in Ohio since 2007. Deaths directly attributable to prescription drug use include drug psychoses, drug dependence, nondependent abuse of drugs, and polyneuropathy due to drug use. Indicator only includes deaths; illicit drug-related morbidity is not reflected. Deaths in which drugs may have been a contributing but not primary cause are not included.

Definition: Indicator includes poisonings which involve opioids, methadone, and other synthetic narcotics. Deaths are recorded by county of residence.

Data Sources: Ohio Department of Health, Office of Vital Statistics

World Health Organization. (2007). International statistical classification of diseases and related health problems, 10th Vrs. Retrieved June 9, 2010, from <http://apps.who.int/classifications/apps/icd/icd10online/>.

Please note: Harrison county is not included within the dataset, as the county did not have any deaths within the given time period which were opioid-related.

[Click here to see a list of sources](#)

Priorities for (Brown County ADAMHS Board)

**Substance Abuse & Mental Health Block Grant Priorities
*Priorities Consistent OHIO MAS Strategic Plan**

Goals	Strategies	Measurement	Reason for not selecting
<p>I. Increase awareness of service availability</p> <p>II. Admit five I.V. drug users into the Vivitrol Program</p>	<p>I. Provide service/program information to I.V. drug users residing in the Brown County jail</p> <p>- Promote service for I.V. drug users in local media and online</p> <p>-Promote service/program information with community gatekeepers</p> <p>II. Provide Vivitrol program information to clients who has been admitted to treatment with an I.V. drug problem</p> <p>-Assist with program expenses for those who cannot meet cost of service</p>	<p>I. Pre and posttest of jail residents.</p> <p>-Community leaders annual survey</p> <p>II. Review agency reports for the number of clients admitted to the Vivitrol program</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<p>Increase capacity to identify and refer pregnant women with substance abuse disorders to appropriate intervention</p>	<p>Provide outreach/education materials to community gatekeepers.</p> <p>Target medical practices and children services.</p> <p>Provide a training program for children service workers on ID and referral</p>	<p>Pre and posttest community gatekeepers.</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<p>Assure individuals with substance abuse disorders who have dependent children are receiving treatment through Board contract providers. Assure that Brown County DJFS understands referral process for provider agency. Assure communication between contract agency and referral agency is</p>	<p>Provide outreach/education materials to community gatekeepers.</p> <p>Target Brown County DJFS with materials and training on referral.</p> <p>Communication with referral agencies will be an agenda item in contract agency meetings with Board.</p>	<p>Contract on file</p> <p>Training</p> <p>Number of referrals by type and agency</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>

					<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
					<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
s	Increase capacity of local businesses to promote wellness	Partner with local businesses to develop training programs, policies, and screening which promote a healthy employee pool. Co-sponsor activities with Brown County Chamber of Commerce	Participation of local business Memorandums of Agreement for Screening and service		<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
ng	Increase system capacity to identify individuals with problem gambling issues	Provide professional education opportunities for provider staff in the area of problem gambling	Report number of staff who have completed professional education in area of problem gambling		<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

Board Local System Priorities (add as many rows as needed)		
Goals	Strategies	Measurement

Hot Spot Analysis by Zip Code - Heroin

Unique Clients per 10,000 Persons - 2012

GRAPH G

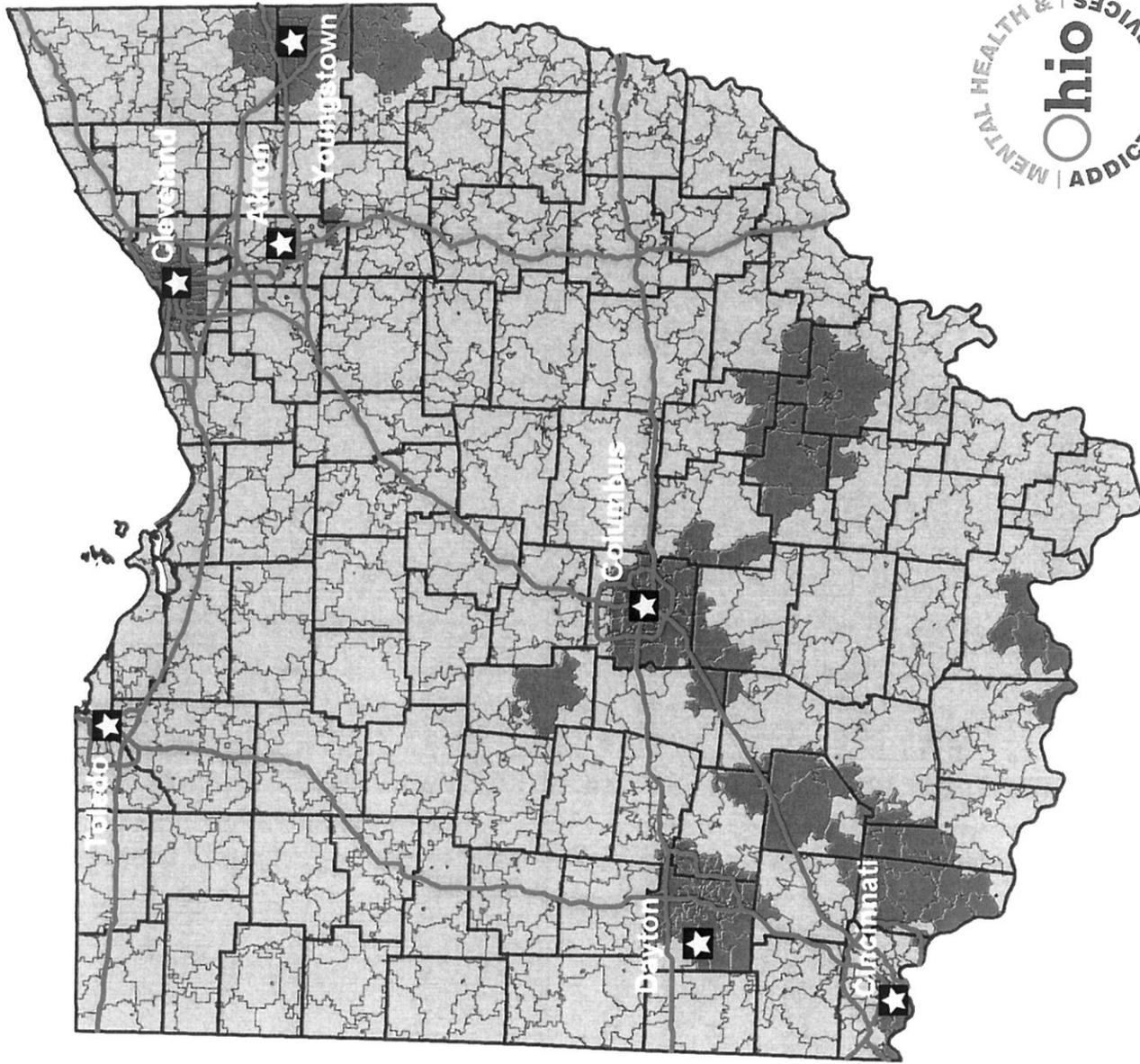
Legend

- Interstate
- Heroin Cluster
- No Cluster

Map Information:

This map uses hot spot analysis to display the rate of unique clients who list heroin as a primary, secondary or tertiary drug of choice per 10,000 persons. Hot spots represent clusters of statistically high values and are colored teal. The highest rates of unique clients per 10,000 persons are in zip codes from Dayton (45403; 99.29), Cincinnati (45202; 91.71), Dayton (45410; 89.31), Dayton (45404; 87.70) and Cleveland (44114; 72.73). Zip codes with rates based on fewer than 25 clients are not included in this list for purposes of confidentiality.

Data Source:
OhioMHAS Behavioral Health Module
Map produced August 2013



Hot Spot Analysis by Zip Code - Prescription Opioids

Unique Clients per 10,000 Persons - 2012

GRAPH H

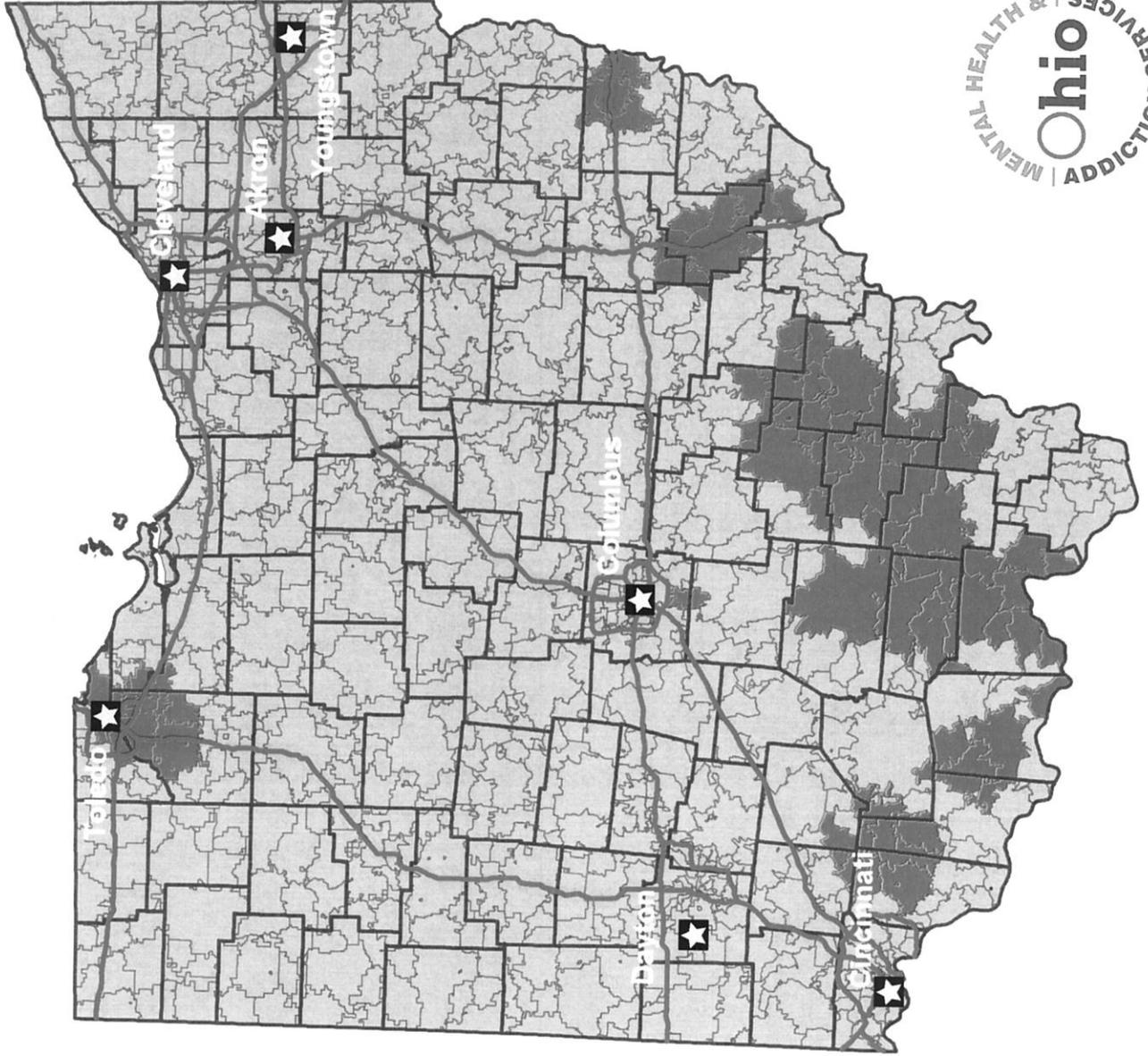
Legend

-  Interstate
-  Rx Opioid Cluster
-  No Cluster

Map Information:

This map uses hot spot analysis to display the rate of unique clients who list prescription opioids as a primary, secondary or tertiary drug of choice per 10,000 persons. Hot spots represent clusters of statistically high values and are colored teal. The highest rates of unique clients per 10,000 persons are in zip codes from Canton (44702; 246.91), Portsmouth (45662; 120.45), Wellston (45692; 109.43), McArthur (45651; 84.34) and Jackson (45640; 83.33). Zip codes with rates based on fewer than 25 clients are not included in this list for purposes of confidentiality.

Data Source:
OhioMHAS Behavioral Health Module
Map produced August 2013



GRAPH 1

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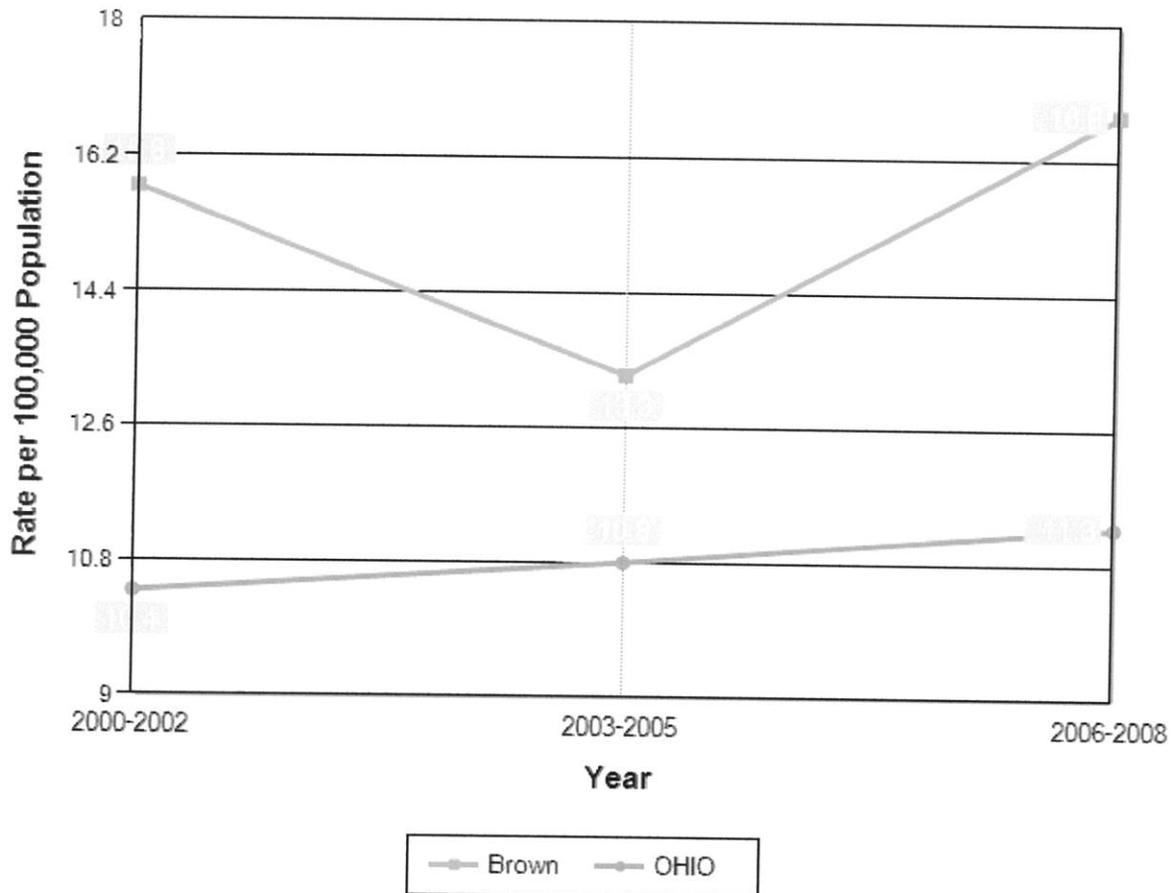
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Alcohol Related Consequences

Suicide Death Rate

County vs. Ohio



The association between alcohol use and suicide has been well documented. Suicidal individuals have high rates of alcohol use and abuse and alcohol abusers have high rates of suicidal behavior. This relationship persists when controlling for depression. The drug abuse warning network (2008) reported that 6.3% of ER visits by young adults which were reported as suicide attempts were in some way drug-related.

Definition: Number of deaths from suicide per 100,000 population. The rates displayed are the average annual rates across a three-year period, and are age-adjusted.

Suicide includes all means of self-inflicted injuries that result in death.

Data Sources: Ohio Department of Health (ODH),
http://www.epidcc.samhsa.gov/indicators/PDF_Files/Alcohol/Suicide_Death_Rate.pdf.

WISQARS, at <http://webappa.cdc.gov/cgi-bin/broker.exe>

Lejoyeux, M., Huet, F., Claudon, M., Fichelle, A., Casalino, E., & Lequen, V. (2008). Characteristics of suicide attempts preceded by alcohol consumption. *Archives of Suicide Research: Official Journal of the International Academy of Suicide Research*, 12(1),

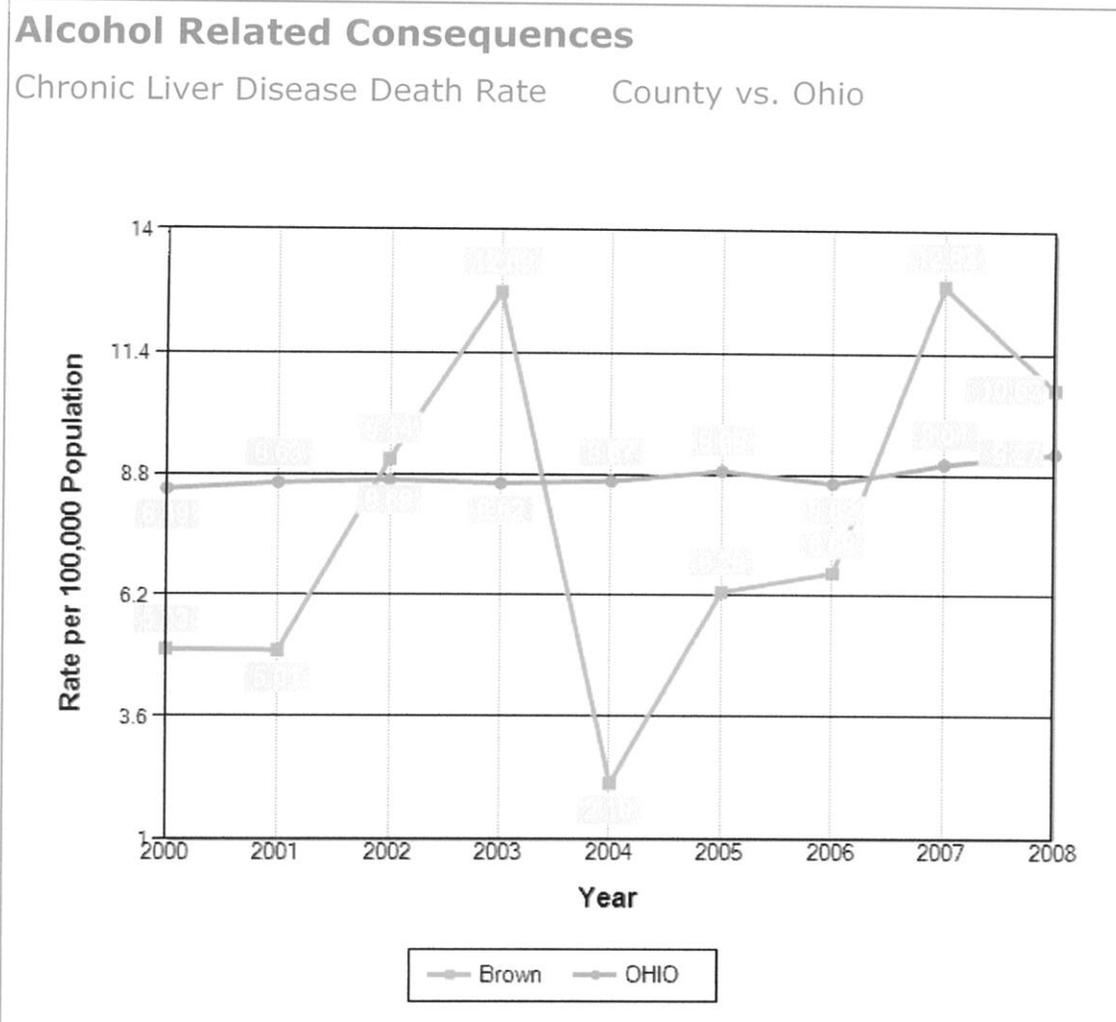
GRAPH J

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Long term, heavy alcohol consumption is the leading cause of chronic liver disease, in particular cirrhosis. one of the 12 leading causes of death. Approximately 15,000 people in the U.S. die from cirrhosis each year.

Definition: Number of deaths from chronic liver disease per 100,000 population. Rates are age-adjusted.

Data Sources: Ohio Department of Health (ODH)

[Click here to see a list of sources](#)

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Brown	5.03	5.01	9.14	12.69	2.19	6.28	6.69	12.82	10.63
OHIO	8.49	8.63	8.69	8.62	8.67	8.89	8.62	9.04	9.27

GRAPH K

Id 873

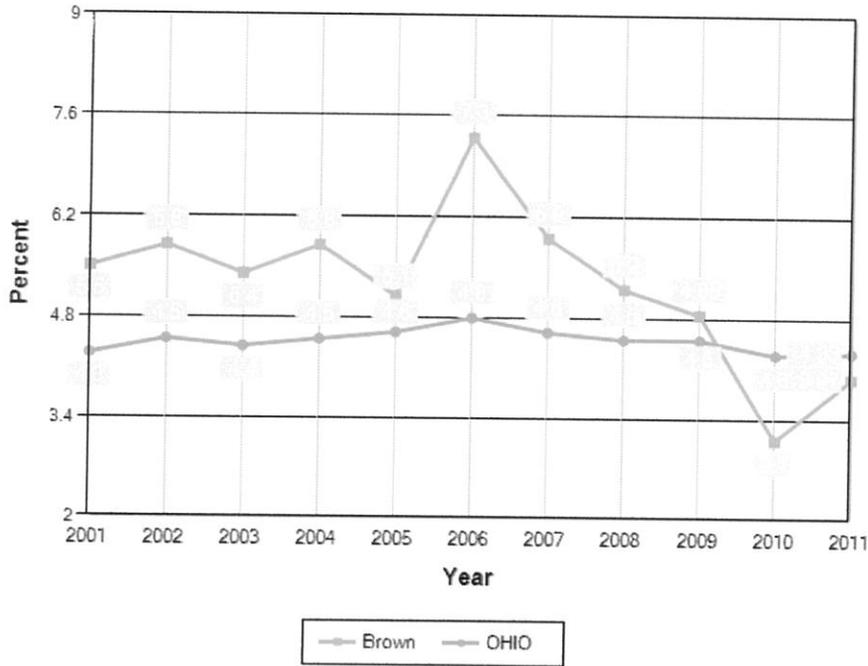
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Alcohol Related Consequences

Motor Vehicle Crashes that are Alcohol Related County vs. Ohio



Alcohol-related traffic crashes remain the single greatest cause of death among youth and young adults. This indicator measures one aspect of community harm from alcohol use. It is also an indirect measure of the prevalence of alcohol use while driving. Since fatal crashes are relatively rare events, they require a large population base for stable trends. Therefore, in order to compare county-level trends, data on the percent of all alcohol-related crashes (fatal and non-fatal) were used for this report.

Definition: Percent of motor vehicle crashes for which at least one driver, pedestrian, or cyclist had been drinking (Blood Alcohol Concentration >0.0)

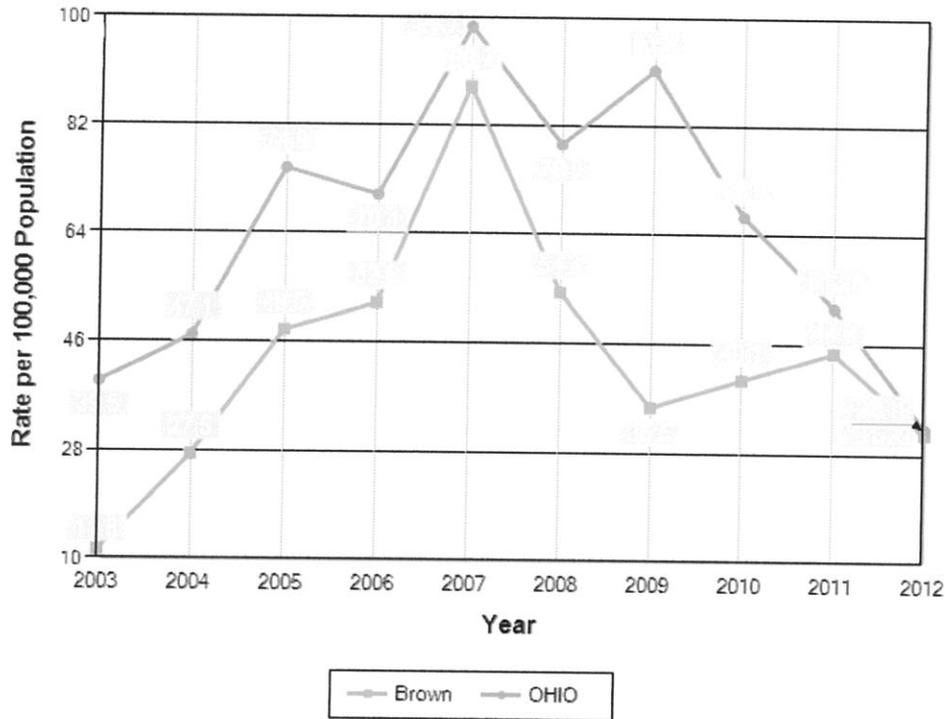
Data Source: Ohio Department of Public Safety

[Click here to see a list of sources](#)

	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Brown	5.5	5.8	5.4	5.8	5.1	7.3	5.9	5.2	4.85	3.1	3.97
OHIO	4.3	4.5	4.4	4.5	4.6	4.8	4.6	4.5	4.5	4.3	4.33

Alcohol Related Consequences

Hepatitis C, Past or Present County vs. Ohio



Hepatitis C is a liver disease caused by the hepatitis C virus (HCV). HCV infection sometimes may result in an acute illness, but in most cases Hepatitis C becomes a chronic condition that can lead to cirrhosis and liver cancer. According to the National Notifiable Diseases Surveillance System, Ohio reported the second highest number of confirmed Hepatitis C cases in the nation in 2009. Intravenous drug use is the leading risk factor for Hepatitis C infection.

Definition: Number of reported Hepatitis C cases (past or present, non-acute) per 100,000 population

Data Source: Ohio Department of Health, Reported Cases of Selected Notifiable Diseases

Morbidity and Mortality Weekly Report (MMWR), 58(SS-3); (2009). Surveillance for acute viral hepatitis-United States, 2007. Retrieved March 2009 from <http://www.cdc.gov/hepatitis/Statistics.htm>.

National Notifiable Diseases Surveillance System (2009). Retrieved February 21, 2012 from <http://www.cdc.gov/hepatitis/Statistics/2009Surveillance/Table4.3.htm>.

[Click here to see a list of sources](#)

	2003	2004	2005	2006	2007	2008	2009	2010	2011	2012
Brown	11.5	27.5	48	52.5	88.7	54.4	35.5	40.1	44.6	31.22
OHIO	39.5	47.1	74.9	70.4	98.7	79	91.4	66.9	51.95	32.19

Id 996

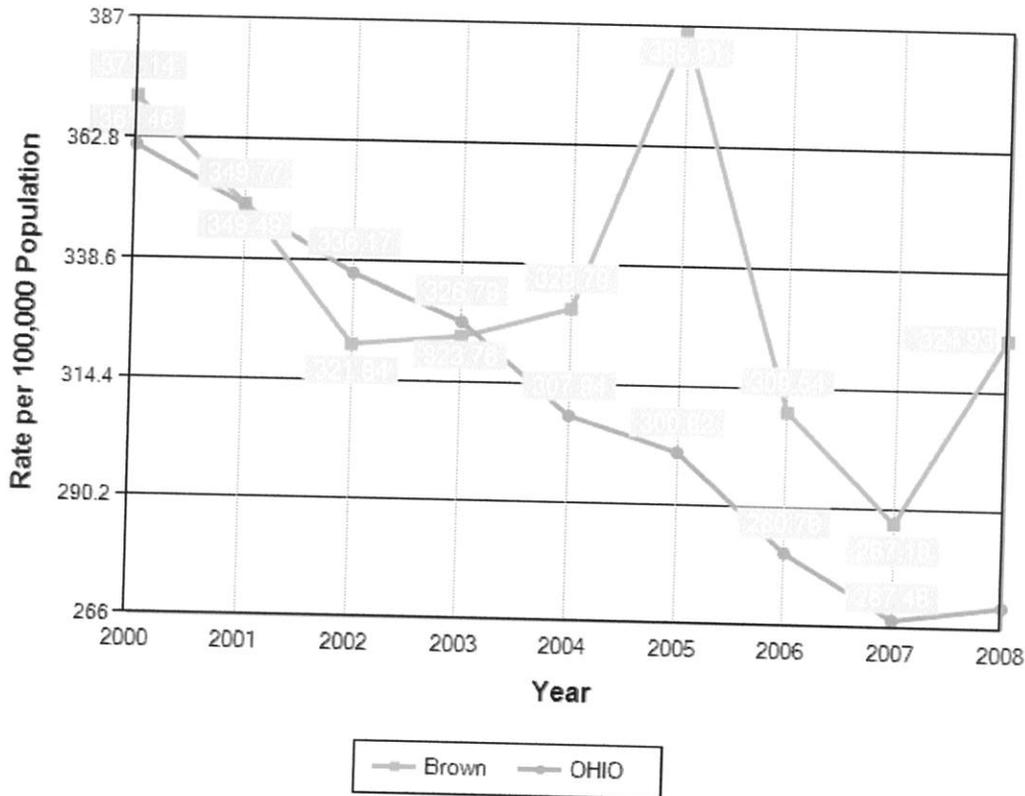
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Tobacco Related Consequences

Cardiovascular Disease Death Rate County vs. Ohio



Cigarette smoking is considered the most preventable cause of cardiovascular disease. There were approximately 126,000 smoking-attributable cardiovascular disease deaths per year between 2000 and 2004. The overall CVD death rate decreased by 19.5 percent between 2001 and 2006.

Definition: Number of deaths caused by cardiovascular disease per 100,000 population.

Data Sources: Ohio Department of Health. The rates are age-adjusted.

Center for Disease Control and Prevention (2008). Quickstats: Age-adjusted death rates for the five leading causes of death—United States, 2001-2006. Morbidity and Mortality Weekly Report, 57(24). Retrieved 10/01/2009 from http://www.cdc.gov/tobacco/data_statistics/tables/health/attrdeaths/index.htm.

Center for Disease Control and Prevention (2008). Smoking and tobacco. Morbidity and Mortality Weekly Report, 57(45), 1226-1228. Retrieved 10/01/2009 from http://www.cdc.gov/tobacco/data_statistics/tables/health/attrdeaths/index.htm.

[Click here to see a list of sources](#)

	2000	2001	2002	2003	2004	2005	2006	2007	2008
Brown	371.14	349.77	321.84	323.76	329.79	385.91	309.54	287.18	324.93
OHIO	361.46	349.49	336.17	326.79	307.94	300.82	280.78	267.48	270.36

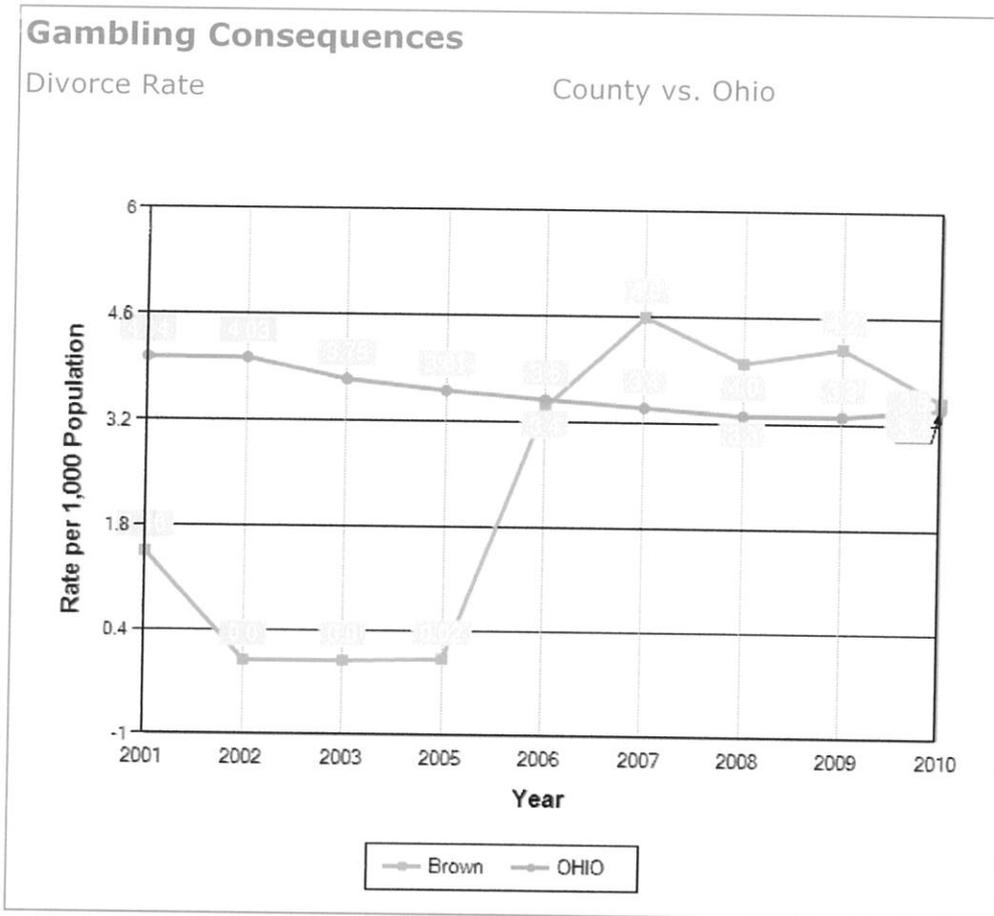
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Lorains, Cowlishaw, and Thomas (2011) performed a meta-analysis of current gambling studies which involved the general population, random sampling and estimates of at least one Axis 1 mental disorder. The researchers found that both problem and pathological gambling are highly correlated with increased divorce.

By disclosing a gambling problem, the individual often creates financial and emotional difficulties within the family. As a result, the spouse may develop several negative feelings toward the gambler, as well as depression, anxiety, confusion of their role within the family, and feelings of self-blame (Wenzel, Oren, & Bakken, 2008; McComb, Lee, & Sprenkle, 2009; Dowling, Smith, & Thomas, 2009). In addition, the spouse may experience feelings of self-blame and which can often lead to decreased quality of life and suicidal ideations (Wenzel, Oren, & Bakken, 2008; McComb, Lee, & Sprenkle, 2009). All of these effects can have a direct impact upon the marital relationship, which may explain the increased divorce rates among problem and pathological gamblers (McComb, Lee, & Sprenkle, 2009; Potenza, Fiellin, et al., 2003).

Definition: Number of divorces per 1,000 marriages.

Data Sources:

Ohio Department of Health

Ostermann, J., Sloan, F. A., & Tayloy, D. H. (2005). Heavy alcohol use and marital dissolution in the USA. *Social Science & Medicine*, 61, 2304-2316.

Floyd, F. J., Daugherty, M. K., Fitzgerald, H. H., Cranford, J. A., & Zucker, R. A. (2006). Marital interaction in alcoholic and nonalcoholic couples: Alcoholic subtype variations and wives' alcoholic status. *Journal of Abnormal Psychology*, 115(1), 121-130.

[Click here to see a list of sources](#)

	2001	2002	2003	2005	2006	2007	2008
Brown	1.45598008594979	0	0	0.0226044892515654	3.4	4.6	4
OHIO	4.04	4.03	3.75	3.61	3.5	3.4	3.3

In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development. (see definitions of "service delivery," "planning efforts" and "business operations" in Appendix 2).

3. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment? (see definition "local system strengths" in Appendix 2).
 - a. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.

Strengths and Challenges

The Brown County Mental Health and Addiction Services System does have foundational strengths as we address the needs of our community. Quality starts in the board room and we are fortunate to have a knowledgeable board that is committed to our mission. Our Executive Director has 37 years of executive leadership experience.

Brown County continues to utilize collaborative relationships to enhance our community services. We have an excellent working relationship with our primary contract provider, Talbert House. The board maintains service contracts with Mercy Health Partners and Child Focus, Inc. We are active in the Brown County Family and Children First Council. Our board has been the catalyst in the development of two drug free coalitions in our county. We have also developed a contractual arrangement with the Brown County Educational Service Center that has resulted in the development of a Forty Developmental Assets Program in five school districts. Our board has also developed a program with Brown County Common Pleas Court, Brown County Municipal Court, and the Brown County Sheriff Department to develop and maintain an educational/information program at the Brown County Jail.

The Brown County ADAMH Board also maintains active regional, State and National relationships which provide for coordination and collaboration.

We have received several grants through the Health Foundation in the past and anticipate continuing that relationship in the future as the Health Foundation has transitioned to become Interact for Health. Our board continues as a member of Behavioral Health Generations.

Our membership in the Ohio Association of Community Behavioral Health Authorities has played an important role in making our voice heard in Columbus while making local improvements. Board staff also hold memberships in the Community Anti-Drug Coalitions of America, The National Association of Social Workers and The National Council on Problem Gambling.

Our board staff is certainly available to assist other board addressing similar issues.

4. What are the challenges within your local system in addressing the findings of the needs assessment? (see definition of "local system challenges" in Appendix 2).
 - a. What are the current and/or potential impacts to the system as a result of those challenges?
 - b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

The key ongoing challenges that our board and community must face is lack of local funding, workforce issues, and

community engagement.

Brown County does not provide funding for our services through either a levy or general fund appropriations. Only two public systems (Senior Citizens and Brown County Developmental Disabilities) receive local levy support. The lack of local funding has resulted in an underfunded, underdeveloped and overburdened social service system in Brown County.

Brown County is located one hour east of Cincinnati. Historically mental health and addiction professionals from Greater Cincinnati have commuted to Brown County for employment in our system. The current lack of qualified professionals and higher gasoline prices has created a tough environment in regard to recruitment.

Developing and engaging community leaders and stakeholders in addressing the issue related to mental health and addiction continues to be challenging. A certain level of involvement is necessary to sustain improvements.

5. Describe the Board's vision to establish a culturally competent system of care in the Board area and how the Board is working to achieve that vision (*see definitions of "cultural competence" and "culturally competent system of care" in Appendix 2*).

Brown County is a rural Appalachian community with a declining economic base. Our Board is committed to cultural competence efforts through our policies and programs. The Executive Director and Associate Director of the Board are Appalachian.

Services are offered in a manner responsive to the consumers' culture and staff training has a focus on cultural issues.

Priorities

6. Considering the Board's understanding of local needs, the strengths and challenges of your local system, what has the Board set as its priorities for service delivery including treatment and prevention and for populations? Below is a table that provides federal and state priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board's priorities, and add the Board's unique priorities in the space provided. For those federal priorities that are mandatory for the OhioMHAS and not selected by the Board, please check one of the reasons provided (e.g., no assessed local need, lack of funds to meet need, lack of necessary professional staff) or briefly describe the applicable reason.

Collaboration

8. Describe the Board's accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years.

This plan addressed some of our collaborative efforts under the strengths question #3. Historically our board has initiated many collaborative efforts. Certainly the longevity of those efforts are dependent on the nature of the collaboration and the commitment of all stakeholders. Locally our board is directly linked through contract with Talbert House, Child Focus, Mercy Health Partners, and Brown County Educational Service Center. We are involved in ongoing collaborative efforts with Brown County Common Pleas Court, Brown County Municipal Court, Brown County Sheriff Department, Adams Brown Community Action, Brown County Health Department, Brown County Job and Family Service, Brown County Senior Citizens, Southern Hills Career and Technical Center, Georgetown Exempted Village Schools, Western Brown School District, Eastern Brown School District, Fayetteville School District, Ripley Union Lewis Huntington School District, Southwest Medical Center, and HealthSource.

Our board has been the leader in developing two local drug coalitions, the Georgetown Drug Free Coalition and the Community Coalition for a Drug Free Mt. Orab.

These collaborative relationships have played a significant role during the past two years. They have been instrumental in developing a Strategic Prevention Framework. Our relationship with area schools has resulted in the growth of the 40 Developmental Asset Program countywide. Our Drug Free coalitions have worked with consumers and families to start the first Alanon group in the county and the two Narcotics Anonymous Groups. Efforts with the courts and law enforcement have resulted in a jail education program. Talbert House has expanded vocational services and also started a Vivitrol Program to meet the treatment needs of opiate addicted consumers.

We have also collaborated with Clermont County MHRS and Warren Clinton County MHRS boards around "Hot Spot Funding". This effort has increased our collective ability to serve those consumers in residential facilities across the region and to expand the availability of residential services.

Inpatient Hospital Management

9. Describe the interaction between the local system's utilization of the State Hospital, Private Hospital(s) and/or outpatient services and supports. Discuss any changes in current utilization that you expect/foresee

The Board maintains a continual relationship with Mercy Health Partners to provide acute inpatient care. As our primary local providers, Talbert House manages consumer assessment care coordination and emergency services.

The board works with Summit Behavioral for those forensic and civil consumers who require that level of care. The board attends clinical meetings at the facility and is involved in planning discharges.

The local system has access to several housing options for consumers including independent living apartments.

Our board anticipates access issues at Summit Behavioral and Mercy Health Partners. Our board has an excellent track record in regard to minimal use of the state hospital but we are concerned about access in the future.

Innovative Initiatives (Optional)

10. Many boards have implemented innovative programs to meet local needs. Please describe strategies, policy, or programs implemented during the past two years that increase efficiency and effectiveness that you believe could benefit other Ohio communities in one or more of the following areas?

- a. Service delivery
- b. Planning efforts
- c. Business operations
- d. Process and/or quality improvement

Please provide any relevant information about your innovations that might be useful, such as: how long it has been in place; any outcomes or results achieved; partnerships that are involved or support it; costs; and expertise utilized for planning, implementation, or evaluation.

Advocacy (Optional)

11. Please share a story (or stories) that illustrate the vital/essential elements you have reported on in one or more of the previous sections.

Open Forum (Optional)

12. Please share other relevant information that may not have been addressed in the earlier sections. Report any other emerging topics or issues, including the effects of Medicaid Expansion, which you believe are important for your local system to share with the Departments or other relevant Ohio Communities.

Appendix 1: Alcohol & Other Drugs Waivers

A. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through OhioMHAS may not be used to fund inpatient hospital rehabilitation services. Under circumstances where rehabilitation services cannot be adequately or cost-efficiently produced, either to the population at large such as rural settings, or to specific populations, such as those with special needs, a Board may request a waiver from this policy for the use of state funds.

Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. **Medicaid-eligible recipients receiving services from hospital-based programs are exempted from this waiver as this wavier is intended for service expenditure of state general revenue and federal block funds.**

A. HOSPITAL	ODADAS UPID #	ALLOCATION

B. Request for Generic Services

Generic services such as hotlines, urgent crisis response, referral and information that are not part of a funded alcohol and other drug program may not be funded with OhioMHAS funds without a waiver from the Department. Each ADAMHS/ADAS Board requesting this waiver must complete this form and provide a brief explanation of the services to be provided

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION

Appendix 2: Definitions

Business Operations: Shared Resources, QI Business Plan, Financial Challenges, Pooled funding, Efficiencies, Strategic Planning, Contracts, Personnel Policies, etc.

Cultural Competence: (Ohio's State Inter-Departmental Definition) Cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.

Culturally Competent System of Care: The degree to which cultural competence is implemented as evidenced by the answers to these questions:

- Is leadership committed to the cultural competence effort?
- Are policies and procedures in place to support cultural competence within the system, including policies and procedures to collect, maintain and review caseload cultural demographics for comparison to the entire community?
- Are the recommended services responsive to each adult, child and family's culture?
- Is the client and family's cultural background taken into account in determining when, how, and where services will be offered?
- Is staff reflective of the community's racial and ethnic diversity?
- Is staff training regularly offered on the theory and practice of cultural competence?
- Are clients and families involved in developing the system's cultural competence efforts?
- Does Behavioral Health staff interact with adults, children and families in culturally and linguistically competent ways?
- Is staff culturally sensitive to the place and type of services made available to the adult, child and family?
- Does the system of care reach out to the diverse racial, ethnic, and cultural groups in the community?

Local System Strengths: Resources, knowledge and experience that is readily available to a local system of care.

Local System Challenges: Resources, knowledge and experience that is not readily available to a local system of care.

Planning Efforts: Collaborations, Grant opportunities, Leveraging Funds, Data Collection (e.g., Key Performance Indicators, Outcomes), Trainings

Service Delivery: Criminal Justice, School Based or Outreach, Crisis Services, Employment, Inpatient/Residential Services, Housing, Faith Communities, etc.