

**Ohio Mental Health and Addiction Services (OhioMHAS)
Community Plan Guidelines 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.)

The Crawford-Marion ADAMH board serves a two county area in north central Ohio with a total population of 110,285 persons. The majority of individuals are white (90.1%-Marion and 96.4% - Crawford), with 5.3% in the total area reporting their race as African American. We have seen an increase in the Hispanic/Latino population with 3.3% reporting that category for their race. An area not collected in the demographic survey but clearly important is that of the Appalachian Culture. Both counties have been populated with people moving from West Virginia, southern Pennsylvania and Kentucky to the area in the 1940's and 1950's because of an abundance of factory jobs. These individuals brought their culture with them. Part of the Appalachian way is to rely on self and families first and exhaust that as a resource before going to others for help. In addition, the tacit acceptance of alcohol and drug use -- specifically marijuana -- along with the increase in availability of prescription opiate medication, have played a role in this population. The historic economic problems and living on the edge of poverty contribute to an overall certainty in powerlessness. Poverty is clearly an issue in both counties with Marion's rate for the last reported period being 18.4% and Crawford's at 14.9%. When we look at rates specific to children the rates stand at 29.3% in Marion County and 26.1% in Crawford County. From a behavioral health standpoint, economic issues often increase the strain on families. Both unemployment and underemployment pose problems and often impact whether or not people in need seek care because of lack of resources. As of October of 2013, the unemployment rate in Marion was 7.5% and in Crawford -- 8.3%. Unstated in these numbers is the fact that underemployment and service sector employment continue to be significantly contributing factors to keeping poverty high and income low. Penetration rates for our board area are quite high and indicate a tremendous need for services. The penetration rate is 47 people served per one thousand in the combined counties; for Marion County it is 40; in Crawford County it is 58. The penetrations rates for the State of Ohio and the United States are 32 and 23 respectively. Both major provider agencies are double the national rate and Crawford County is getting close to doubling the rate for the State of Ohio. Clearly we are serving a lot of consumers with serious mental illnesses as well as drug and alcohol disorders.

While the crime rates in both counties have followed the state trend of decreasing, property crimes and crimes of opportunity have become more public issues as law enforcement have linked both to illegal drug use as people commit crimes in order to obtain money to purchase drugs. As of this writing, property crime in both counties remains above the state average. In addition to property crimes, it is significant to note that drug and alcohol abuse within a family has an impact on child abuse and neglect. Both counties have child abuse and neglect rates above the state average (Crawford -- 1 point higher; Marion -- 4 points higher). In our work with our CSB partners, they have shared that working with a population of opiate abusers presents more challenges in terms of engagement with services. In addition, family placement presents a variety of problems and is often deemed inappropriate because of opiate abuse.

While we believe this information paints an overall picture of the area, it is difficult to clearly state the impact of these factors on the community and, of more importance, the future of our children and youth. The opiate epidemic has resulted in a variety of social and economic factors but the human costs to families in loss, death and devastation cannot be fully calculated. In 2012, we lost 23 individuals from our area. Our rate of incarceration and recidivism continue to be very high as well as juvenile arrests.

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)

In both counties, we work with our community partners to conduct needs assessments. This partnership allows us to share the cost and to gather information in a way that reduces duplication and increases utility of the data gathered. In Marion County the Needs Assessment is conducted every 3 years so one was not completed in FY 13; Crawford County also has not completed a full needs assessment, however the Avita Health System conducted a health needs assessment and the ADAMH Board participated in that process. In addition, the director of the board serves on both the mental health and alcohol/drug sub committees that came about as a result of the assessment.

The Crawford County General Health District conducted a Health Assessment published in 2012 to measure the health of citizens in Crawford County. It was intended as a snapshot of the current health status of residents, using the most recent available data in each area discussed. Most of the data in the Crawford County report is collected from other sources, including the Ohio Department of Health, The Centers for Disease Control and the U.S. Census Bureau. At the time of the assessment, the number of those needing but not receiving treatment for illicit drug use in the past year among persons in Crawford County was estimated to be 1,204 individuals. Although many of the health status indicators (death rates, birth outcome) for Crawford County are slightly better than the rest of Ohio, the high rates of tobacco use, pain medication overdoses, and obesity-related health issues point to significant health care costs and needed care. For Crawford County, females have higher prevalence of death due to mental health disorders. Crawford County has a higher self-reported rate of mental distress than other Ohio rural counties which probably helps explain the high penetration rate mentioned earlier. In the past year, we have noticed an increase in consumers with symptoms that are significantly worse than in the past. In two specific cases this year, we have struggled to come up with the appropriate treatment modalities for these individuals. We have used more bed days at the state hospital than at any time since 1990 as a result. At one point this year we had 11 people in the state hospital at one time, which is unprecedented for our Board area.

Alcohol and drug use and abuse continue to threaten the health of Crawford County residents. Since the last health assessment conducted in this county in 2005, rates of unintentional fatal poisonings have been increasing at an alarming rate, largely due to unintentional drug overdoses and medication errors. According to the SEOWS report, Unintentional Drug Rate Death actually decreased in Crawford County in 2011 to 9.14 per 100,000 people which is below the rate for the state. According to the Ohio Substance Abuse Monitoring Network (January, 2012 – January, 2013; *Surveillance of Drug Abuse Trends in the State of Ohio*), community professionals in the central Ohio (which includes Crawford and Marion Counties) area expressed concern about the ages of younger heroin users as well as the number of users switching from prescription opiates to heroin. It is believed that heroin is easier and cheaper to obtain. Our treatment providers have also complained about how easy it is to purchase Suboxone on the street, primarily for the purpose of eliminating withdrawal symptoms when heroin is not available.

In Marion, the Needs Assessment provides an overview of health related data for Marion County adults (18 years of age and older), youth (ages 12-18 years), and children (ages 0-6 years) who participated in a county-wide health assessment survey during 2010-2011. The findings are based on self-administered surveys using a structured questionnaire. The questions were developed through a collaborative effort of members of the Community Advisory Committee (CAC)

beginning in early 2010. An over-sampling of 21 Hispanic, 59 African-American, and 22 homeless shelter residents was also conducted. A total of 594 surveys were returned, for a response rate of 19%. Youth surveys were administered via *Survey Monkey* to all 8th and 11th grade classes in Marion County. A total of 931 out of 1102 total 8th grade students answered the survey, for a response rate of 84%. Data collection and analysis for the Parents of Young Children and Youth surveys was performed by Rosemary Chaudry, PhD, RN in June 2011. Data collection and analysis for the adult survey was performed through July 2011 by The Ohio State University Statistical Consulting Service, led by Steven Naber, PhD. Secondary data and report development was completed by the Hospital Council of Northwest Ohio in January, 2012. According to the results, Marion residents are most concerned with unemployment (77%); Child Abuse & Neglect (72%); Crime (70%); Drug Abuse (69%); also both crime and drug abuse were concerns for our youth (70% & 77% respectively). Of course drug abuse and crime are often linked, especially with opiates.

Marion did not experience a drop in their rate of Unintentional Drug Related deaths as did Crawford County. The SEOWS report for 2011 indicates that Marion's rate has increased to 19.55 per 100,000 people compared to 15.3 for the State of Ohio. This statistic is up from 12.03 for 2010. According to the Marion County Needs Assessment it was estimated that 1,616 persons needed but did not receive treatment. In regard to drug use, there is no definitive "tsunami" or singling out one particular year or event but an abundance of factors that when taken together indicate a growing increase of the abuse of drugs (specifically opiates) in Marion County. Again, there appears to be a general trend in risk taking behavior which continues to build and has been expressed in the increased abuse of opiates.

In regard to outpatient services for people discharged from the state hospital, our providers report that consumers typically have an appointment with the psychiatrist or medical team within 5 days of discharge but no longer than 14 days. We believe providers are being very responsive to this need. Consumers are followed by the CPST team during their stay at the hospital so that a smooth transition can be assured. Adults hospitalized in a state psychiatric facility often need a level of care between the hospital and the community. We have the ability to provide short-term respite care to some of these individuals to help with the transition. However, four respite beds for a two county area present serious limitations, especially this year. Access to medication for individuals without insurance or Medicaid is sometimes a barrier, especially when the individual is new to our system of care. This year in particular, crisis staff has encountered major barriers in finding a hospital willing to admit some of our most seriously ill consumers. Hours and hours have been spent calling hospitals only to be turned down. No one wants individuals with such serious behavioral problems and private hospitals will not do forced medications. We have found ourselves frequently with only the state hospital to rely on and this situation has its own set of problems. There have been some issues with TVBH not wanting to admit patients in the middle of the night – we believe that the hospital is too understaffed during the night to manage admissions efficiently. We have had several discussions with the hospital on this issue and believe that the hospital is working hard to resolve our concern. Unfortunately consumers have remained in the ER for many hours which has created more problems in the community. Crisis staff is being pressured by hospital staff to get consumers out of their ER's but there is no place for them to go.

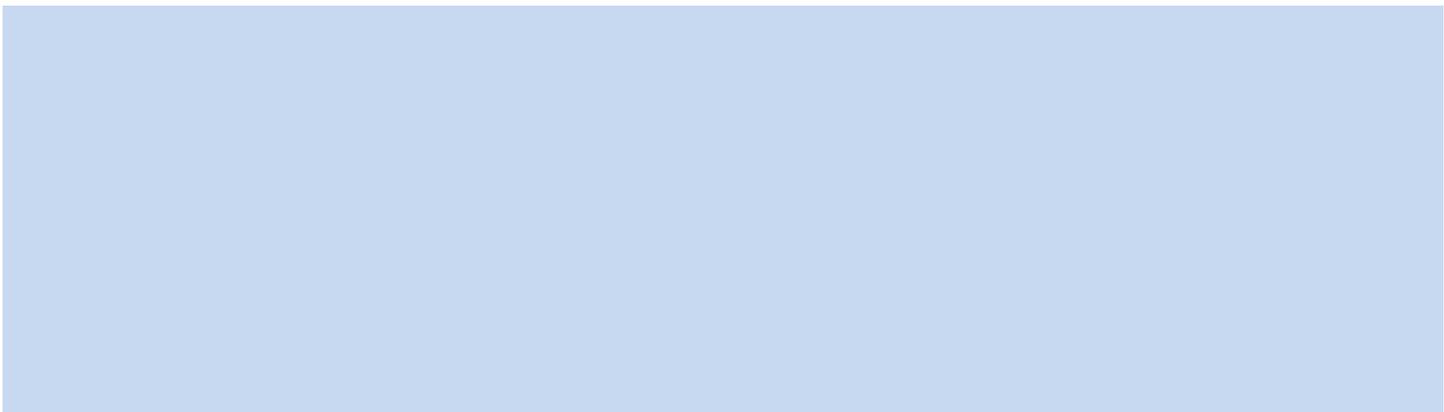
In FY 2009, Marion was identified as having the highest recidivism rate (52.1%) in Ohio for individuals being released from correctional institutions. In general the process of re-entry fails to prepare individuals for returning to the community, especially a community with one of the highest poverty rates in the state and a serious opiate problem. Nearly 50% of ex-offenders have a mental health or drug problem, sometimes both. Serving, linking and providing care for the reentering population continues to be a challenge because of lack of resources and overall lack of coordination. For those individuals leaving a state prison with a mental illness who have historically received services while incarcerated, there is an established path. We receive a completed referral packet and typically are able to schedule an appointment with a mental

health provider. Typically though, those individuals do not keep their appointments. If those individuals come out and are not on probation or parole, they may be lost between their release and the agency. By that we mean, that they may not be invested in continuing care or they may not have a sufficient support system that affords them the opportunity to get to an appointment. There is any number of things that may derail this process. It would be very helpful to have a full time reentry coordinator who could help facilitate this process by providing transportation, access to a bus pass, etc., to support treatment. If Medicaid Expansion moves forward and we see those involved in treatment move towards that payer source, we hope to make this position a reality. We believe that as a system of care, this population grows more critical by the day. Our failure to provide treatment simply digs us further into recidivism. In Marion County, we are fortunate to have a working Community Corrections Planning Committee as well as an active Mid Ohio Reentry Coalition. Both work to gather those individuals involved in the justice system and behavior health as well as employment to serve those reentering individuals. In addition, our Opiate Task Force/STAND Coalition has embraced the needs of those young ex-offenders who presently cycle through the local jail. The aforementioned grant will hopefully help increase access to treatment for these individuals.

Perhaps the most challenging aspect surrounding reentry is that ex-offenders come with a variety of needs beyond mental health and substance abuse treatment. They need housing, access to educational supports, links to employment and – often – an entire support system. Their employment issues are made worse by hiring practices. Our reentry coalition, in partnership with the Marion Matters - Bridges out of poverty agency, has established a Felony Assistance sub-committee whose focus has been employment, identification of barriers and increasing awareness about the employment problems ex-offenders have and the need for the community to respond to those barriers.

Our partnerships in this area have been many and varied. Clearly, we are working with probation and parole, provider agencies, courts and others. Our partnership has expanded widely in the faith community as well. This year, we are attempting to decrease the no-show rate and create a feedback loop for clients – including ex-offenders – that includes a support and engagement worker from the provider calling with reminders prior to appointments and following up after. These are non-billable services under a typical funding structure but we have granted a small amount of dollars to facilitate this pilot project. We will assess results in June of 2014.

Both Family and Children First Councils have existing dispute resolution process however we have not needed to use this process in the past six years.



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

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*).

3. The most effective strategy we have to bring efficiency to both agencies has been the implementation of Feedback Informed Treatment (FIT) – formally Client Directed Outcome Informed (CDOI) clinical work. Because we are monitoring client progress so closely, providers are able to identify those consumers not making progress and change the course of treatment sooner rather than later. They no longer have to keep clients in treatment for several months and in some cases - years. Rather clients move in and out of treatment based on progress, need and readiness to change. This board/provider partnership has been going on for over 4 years. All entities see this endeavor as a win/win for clients and the system as a whole.

We have also had the opportunity to partner with Opportunities for Ohioans with Disabilities to offer the Recovery to Work program to residents of our two counties suffering from opiate addiction for the past the past two years. This program also works well with ex-offenders. It has been a great addition to our efforts to provide treatment options for opiate addiction in the form of Medication Assisted Treatment which would not have been available to these individuals otherwise. We believe we found a way to make this program work very effectively in our board area, but there are serious concerns that the program will end due to federal regulations.

In addition our re-entry program - though limited – helps residents transition back into the community from prison which was explained in more detail in the previous section.

Finally, we are fortunate to have positive working relationships with our provider partners. We work in collaboration and enjoy good communication. This is an asset that does not have a dollar value but is worth more than we can adequately express.

- a. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.

We are always willing to assist other boards in whatever way we can. We frequently talk to other providers and Boards about rural re-entry and FIT.

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*).

Our Board lost 1.8 million dollars in funding in recent years and we are definitely feeling the effects of such a devastating loss. We have never had so many people in the state hospital as we have experienced this year. Our crisis calls have sky rocketed which is making it harder and harder to find staff willing to provide crisis services. Private hospitals are limited in who they can admit. If someone needs forced medications, the state hospital is our only option. Sometimes patients are so ill, that private hospitals cannot manage the behaviors they are exhibiting.

Patients' symptoms are more acute than any time in the past. Unfortunately the state hospitals are struggling with access issues too. We have had conversations with the state hospital where they expect more and more from our CPST staff that CPST cannot provide. Our Crawford County provider only has 2 adult CPST providers and for them to go to Columbus for every team meeting is impossible. We need the state hospital to use their telemedicine capabilities to help alleviate the need for so many trips to Columbus. Our Crawford County provider often has to use the sheriff to transport patients back to their County when discharged from the state hospital. This is not an ideal situation but providers don't have staff to do things differently. We believe the reduction in CPST workers and virtual elimination of such staff for children and youth has resulted in an increase in situations that often result in hospitalization because they are not known to providers sooner. While we look forward to the potential Medicaid expansion, not all necessary services fall under the medical necessity requirements. Because consumers often have limited support networks, there is reliance on the system of care to meet some of these needs.

What are the current and/or potential impacts to the system as a result of those challenges?

- a. We have consumers waiting in emergency rooms longer than ever in the past. ER staff is very frustrated and tend to take those frustrations out on the pre-screener. Access to private psychiatric beds is limited which can make a crisis situation worse. We receive many calls each week from consumers and family members seeking an opiate treatment program like Medication Assisted Treatment or detox programs. Those seeking care are frustrated and often angry. Our community partners (courts; law enforcement; other social service providers) are also discouraged by the lack of resources to address this issue.
- b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

None at this time, but we do not hesitate to reach out to other boards or state departments when assistance is needed.

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*).

First, the use of FIT really contributes the most to making our system culturally competent. It is easily accessible in many languages in the My Outcomes system which is used to track consumer progress. While our population is primarily English speaking and Appalachian, our providers do occasionally deliver services to a small number of Hispanics and African-Americans. They have access to interpreters when needed but it is rarely an issue. In addition providers offer training on the following topics: working with the elderly, gay/lesbian, and this year they learned about the self exploration of bias and cultural awareness; they also have had training on working with Appalachian, Hispanic, and African-American cultures. This year there will be more focus on working with the deaf and learning some basic sign language. Both agencies try to also make sure they hire diverse staff but sometimes that is a challenge in our rural counties. Providers, however, are committed to offering cultural diversity training for their staff.

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 Ohio MHAS 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.

Priorities for Crawford-Marion ADAMH Board

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

Priorities	Goals	Strategies	Measurement	Reason for not selecting
SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)	Decrease number of deaths from opiate addiction.	Increase the availability of Medication Assisted Treatment. Provide training to family members and community on how to administer Nasal Naloxone for treating opiate overdoses.	Number of people admitted to MAT programs in each county; Number of people who attend training on how to use Nasal Naloxone; Number of deaths as reported by the coroner's office in each county.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	Ensure treatment services are available for pregnant women who have a SUD.	Provide immediate access to services for pregnant women with a SUD.	Number of persons on a wait list seeking treatment services.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
SAPT-BG: Mandatory: Parents with substance abuse disorders who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Coordinate treatment services with Family Court's family dependency special court docket.	Collaborate and provide SUD/ MH treatment services to parents in the family dependency drug court.	Number of families in family dependency drug court receiving treatment services. Number of families and treatment providers attending team meetings.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases	Identify individuals seeking treatment who report having TB or a communicable disease.	Make referrals of individuals with TB or a communicable disease to public health or FQHC for medical intervention.	Number of individuals identified and referred.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Coordination of care with primary care physicians in for SED children and families in Marion. Increase opportunities for exercise and nutrition programs for SED children and families in Marion. Increase opportunities for training in trauma informed care for all providers.	Add another CPST staff specialist to work with SED children and families; Coordinate programs for exercise and nutrition with local YMCA. ADAMH and providers will work together to arrange for staff training pertinent to the needs of consumers being served.	Number of CPST staff; number of SED children and families who enroll in exercise and nutrition programs at YMCA. Documentation such as sign in sheets of types of workshops attended by provider staff related to trauma informed care.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Coordination of care with primary care physicians for adults with Serious Mental Illness (SMI) in Marion.	Increase opportunities for socialization, exercise and nutrition for SMI such as the YMCA. Emphasize integration and coordination of care with primary physicians.	Number of consumers who enroll in exercise and/or nutrition programs at the YMCA; number of contacts by CPST staff with primary care physicians.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> <u>Lack of funds</u> <input checked="" type="checkbox"/> <u>Workforce shortage</u> <input type="checkbox"/> Other (describe):
MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> <u>Lack of funds</u> <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> <u>Other (describe): Crawford county has a recovery group that meets regularly; we do not have funds to expand these support services.</u>
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant *Priorities Consistent OHIOMHAS Strategic Plan				
Treatment: Veterans				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> <u>Lack of funds</u> <input checked="" type="checkbox"/> <u>Workforce shortage</u> <input checked="" type="checkbox"/> <u>Other (describe): local VA also provides services to Veterans.</u>
Treatment: Individuals with disabilities				<input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

Treatment: Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*	Decrease number of deaths from opiate addiction.	Increase the availability of Medication Assisted Treatment	Number of people admitted to MAT programs; Number of deaths as reported by the coroner's office.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): We do have some housing but no ability at this time to add more or even update existing stock.
Treatment: Underserved racial and ethnic minorities and LGBTQ populations				<input checked="" type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Treatment: Youth/young adults in transition/adolescents and young adults				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input checked="" type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Early childhood mental health (ages 0 through 6)*				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input checked="" type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Adopt a public health approach (SPF) into all levels of the prevention infrastructure.	Using SPF to determine prevention priorities throughout M/C communities.	Promote positive youth development, reduce risk taking behaviors, increase resiliency and reduce risk factors among youth. Implement research based strategies to address underage alcohol use and use of illicit substances. Collaborate with community organizations to implement substance	Identify gaps in services and develop programs to address these gaps. Evaluate efforts to determine outcomes.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

		abuse prevention services.		
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*	<p>1. Provide youth-led prevention programming to middle school and high school aged youth. Utilize students involved in youth-led prevention programs to provide prevention programming in elementary schools. Utilize students involved in youth-led prevention programs to provide prevention programming to adults in the Marion & Crawford County communities.</p> <p>2. Ensure mental health first aid training is available across the county</p>	<p>1. Teen Institute & Junior Teen Institute programs are available to all students in Marion & Crawford counties. 6th grade days, Freshman Empowerment Days, OPTIONS and Hands on Museum are all activities conducted by students involved in youth-led prevention programs.</p> <p>2. Offer Mental Health First Aid training to various county agencies such as school employees, child serving agencies, criminal justice, and other community partners.</p>	<p>1. Students will be surveyed to determine knowledge gained at youth-led prevention events and behavior outcomes. Students will delay onset of first use until age 18.</p> <p>2. Number of trainings provided and number of participants.</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>
Prevention: Empower pregnant women and women of child-bearing age to engage in healthy life choices				<p><input type="checkbox"/> No assessed local need</p> <p><input checked="" type="checkbox"/> Lack of funds</p> <p><input checked="" type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
Prevention: Promote wellness in Ohio's workforce				<p><input type="checkbox"/> No assessed local need</p> <p><input checked="" type="checkbox"/> Lack of funds</p> <p><input checked="" type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*	<p>1. Provide gambling prevention programming to high school aged youth throughout Marion & Crawford County. Increase knowledge related to the risks</p>	<p>1. Provide gambling prevention workshop at Freshman Empowerment Days. Provide gambling prevention workshop</p>	<p>1. Determine numbers of students receiving gambling prevention programming. Compile end of workshop survey data related to increase in knowledge related</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>of problem gambling.</p> <p>2. Identify individuals receiving services from providers who may need gambling treatment.</p>	<p>at Youth-Led Prevention Conference.</p> <p>2. Provide gambling screenings to individuals receiving services at provider agencies who may also need gambling treatment.</p>	<p>to risks of problem gambling.</p> <p>2. Number of individuals screened by provider agencies.</p>	
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Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Adopt a Strategic Prevention Framework (SPF) approach into all levels of the treatment infrastructure in the Crawford-Marion Board area.	Provide training for providers and ADAMH Board in the use of the SPF approach for planning purposes.	Contract with consultant who is knowledgeable and experienced in using SPF.	Number of individuals who attend SPF training as evidenced by sign-in sheet. Evidence of use of SPF approach in planning efforts.

Priorities (continued)

7. What priority areas would your system have chosen had there not been resource limitations, and why? If you provide multiple priority areas, please prioritize.

Priority if resources were available	Why this priority would be chosen
(1)	
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	

(8)	
(9)	
(10)	
(11)	
(12)	
(13)	
(14)	
(15)	

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.

In addition to our providers, our board collaborates with several other programs and organizations. Our reentry program, Mid-Ohio Reentry Coalition, requires us to work closely with the courts, job programs like Goodwill, the homeless shelter, correctional institutions, legal aid, the judicial system & law enforcement, Family & Children First (FCF), and housing programs. Our director serves as the co-chair for the reentry coalition. We have a long history of collaboration with Family & Children First. We are currently the administrative agent for FCF in Crawford County and they are housed in the board office. The challenge is and will continue to be, full participation by all members – especially schools. And always, the issue of funding – or lack thereof – creates pressure for the council. Without funds to support an array of treatment options for children and families, some members see little benefit in participating. In addition, the basic structure of the council is a challenge. It is a part of county government – but not a real part of county government. Members are not required to participate financially. There is the expense of the audit which seems redundant since each council is part of another county entity. These structural issues need to be addressed by the State of Ohio.

An ADAMH Board employee is currently serving as the chairperson of the Marion County Continuum of Care to End Homelessness. This relationship allows the Board to work on projects with various agencies, local governments, and not for profit groups in Marion and Crawford to address housing issues for adults and families dealing with the effects of mental illness and drug dependency.

We began contracting with Opportunities for Ohioans with Disabilities about three years ago to offer the Recovery to Work VRP3 program for individuals suffering from drug addiction and/or mental illness. It has been a wonderful partnership. This program has helped provide treatment as well as helping people find jobs and become productive citizens once again. Employment can be therapeutic, especially for individuals who haven't been able to work in years because they couldn't stay sober long enough to pass a drug screen. We value this program and hope that it can continue.

Another very important collaborative effort we maintain is with the Faith Community. This is the third year we have collaborated with Restore Ministries in Galion, Ohio. This program was started by Pastor Joe Stafford of Wesley Chapel in Galion. The program is based on Galatians 6:2 "Share each other's burdens". All of their services are free and confidential. Members of Restore have been able to take on guardianships for two of our consumers in Crawford County. This ministry also provides case management services, individual counseling (Pastor Joe is an independently licensed counselor), mentoring, respite care, etc. This program has also assisted some of our AOD consumers find transportation to detox centers. We have given this program a small grant for the past three years to help defray travel expenses and acquire additional training in regard to working with mentally ill and addicted individuals and families. It has been a wonderful partnership and one that we want to continue.

Board staff presently sits on a variety of county committees as well as advisory committees for four different drug courts.

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
- We have used more hospital days this year than in the past.

At one point in October, we had 11 people in the state hospital at the same time. This number of admissions is unprecedented for our Board area. In addition to the state hospital, the Board paid for 12 different clients to be admitted to the mental health unit at Marion General Hospital in the month of October alone. Our funds will not allow us to keep up this pace. We are seeing individuals new to our system with some serious mental health problems often complicated by substance abuse and medical problems like dementia. Typically our interactions with TVBH are positive. We especially appreciate the liaison position at TVBH. Their staff seems to take our concerns seriously and is willing to work with us to provide the best care possible. However, team meetings and other discussions between the Board and hospital could be handled much more efficiently with the use of telemedicine. We have been prepared to participate in meetings using this technology for about 9 months. We hope that the hospital will soon be in a position to do the same. It is difficult for CPST staff to take so much time out of their busy schedules to drive to Columbus for these meetings. We also do not have control of forensic patients which adds to the number of bed days used by our board area. Currently we have one person on forensic status that may never be able to leave the state hospital. It is unfortunate to say that we do not foresee a decrease in state hospital utilization in the next two years. It will be interesting to see if Medicaid Expansion has an impact on reducing hospital use.

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?
- Service delivery:** Service delivery has been described in other sections of this plan.
 - Planning efforts:** Our efforts at planning involve the use of Family and Children First partners, the local health departments, United Way and other local social service entities as well as providers. We use those noted to identify needs and plan for services. Sometimes, this results in the co-funding of projects and programs. One effort of note is our partnership with a provider agency, United Way of Marion County and the Marion Community Foundation to fund the Signs of Suicide (SOS) program for the past 4 years. The program is delivered at every high school in Marion county and one middle school. This is an effort that we could not fund alone and through this partnership we have not had a youth suicide in Marion since we started this effort.
 - Business operations:** Since 1999, our Board has collaborated with the Delaware-Morrow and Fairfield Boards for IT services to be delivered by Public and Private Solutions (PPS). PPS is a consortium of our three Alcohol Drug and Mental Health Boards representing five Ohio counties (population: 465, 482). We have leveraged services by combining resources. Currently all major Information and Technology services are provided by PPS. PPS also provides our Board with the following services:

Claims Processing
MACSIS support
MACSIS reporting for enrollment, claim and finance
Secure Web site data transfer
E-Mail Services
24 hour Network monitoring & support
Network Design setup and support
Firewalls and intrusion prevention/detection
Telephony support
Personal Computer Support
Programming services
Purchase Order Database
Remittance Advice Utility
Ad Hoc Reporting
Mapping
Programming at Provider's location
Xaktsoft modifications
RA Utility
Family Drug Court/IDATF
Data Mining: Claims, Member, Outcomes, Behavioral Health, Patient Control System, Purchase Orders, Remittance, etc.

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.

Over four years ago, our Board area contracted with Dr. Scott Miller, co-founder for the Study of Therapeutic Change & more recently founder of the Center for Clinical Excellence, to begin implementing Feedback Informed Treatment (FIT). FIT contains no fixed techniques and no theory regarding the concerns that bring people into treatment. All interactions are client-directed and outcome-informed when we accept that the client's voice is the source of wisdom; therapists intentionally form strong partnerships with clients in order to achieve the following: enhance the factors that account for successful outcomes; use the client's ideas and preferences to guide choice of technique and model; inform the work with reliable and valid measures of the client's impression of the alliance and progress.

This work uses two outcomes scales called the Outcome Rating Scale (ORS) and the Session Rating Scale (SRS). They scales take about 1-2 minutes to complete. The ORS is completed at the beginning of each session and asks the client to rate their progress since their last session. This simple yet valid and reliable scale measures one's distress about areas of their life. It uses 4 individual scales: Individual (personal well-being), Interpersonal (family, close relationships), Social (work, school, friendships), and Overall (general sense of well-being). The SRS is completed at the end of each session and uses 4 scales to assess the therapeutic relationship: Relationship (I felt heard, understood, and respected), Goals & Topics (We worked on what I wanted to work on and talk about), Approach & Method (The therapist's approach is a good fit for me), Overall (Overall, today's session was right for me). FIT is a complete shift from the traditional medical model of therapy where the clinician is seen as the expert and prescribes treatment based on her or his expert knowledge. According to FIT, the things that make therapy work are about the client and the quality of the therapeutic relationship. The client is the true hero of therapeutic change. We believe it is a great service delivery model because it involves client feedback at each session. It provides clinicians with ongoing feedback from their clients regarding the therapeutic relationship and

progress, which increases success rates by an average of 65%; it is also cost effective.

The Partners for Change Outcome Management System (PCOMS) is the web based program use to track client feedback. PCOMS is designed to improve the retention of participants in treatment and to assist them in reaching reliable and clinically significant change. The program can be implemented by behavioral health care therapists as part of any behavioral health care intervention. PCOMS is disseminated through the International Center for Clinical Excellence (ICCE) and the Heart and Soul of Change Project. (The Readiness for Dissemination of each version was reviewed separately by NREPP) and is now listed on the SAMHSA website as an evidenced based practice. The cost is about \$50 per license for the web based program, depending on the number of licenses. Our total cost for FY 14 for all providers using PCOMS was \$7950. When the program is used correctly, agencies can track no shows and cancellations as well as planned discharges versus drop outs. It is especially useful with new therapists and case managers who often feel unsure of themselves. As research indicates, even seasoned therapists are poor at predicting whether or not their clients are making progress.

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.

Medicaid expansion will bring both relief and new challenges to our system of care. We are pleased that more people in Ohio will have access to health care. Expansion, however, is likely to create access issues, at least initially. When more people are given the opportunity to utilize private psychiatric units, hospitals could see a demand that they cannot meet. That will only increase the burden on state hospitals and they already have access/capacity issues. It will also create access issues for local providers that do not have the staff or space to expand services. We are also concerned about general work force issues. Rural areas are continually challenged to employ and retain both mental health and chemical dependency professionals and often have to compete with

urban areas for staff. Qualified, credentialed staff will be in high demand as Medicaid expansion moves forward. In addition, there is an emerging problem with consumers who have Medicaid because they are finding that services are limited or not covered (i.e., Medication Assisted Treatment).

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 waiver 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.