

**HAMILTON COUNTY MENTAL HEALTH
AND RECOVERY SERVICES BOARD
COMMUNITY PLAN FOR SFY 2012-2013**

[SEPTEMBER 1, 2011]

MISSION STATEMENT
VISION STATEMENT
VALUE STATEMENT

The mission of the Hamilton County Mental Health and Recovery Services Board is to develop and manage a system of high quality, cost effective alcohol, drug and mental health services responsive to individual and family needs and differences.

The primary goals of the Hamilton County Mental Health and Recovery Services Board (Board) are:

To manage a system of care in which children who have a substance abuse issue and/or a mental illness and their families overcome the problems associated with the disorder.

A system of care that:

- Provides prevention and/or treatment with a commitment to positive outcomes,
- Supports children and their families in expanding their development and use of existing community support networks,
- Fosters recovery, resiliency and facilitates successful transitions.

Children served may include those who are:

- Identified by the school as having substance abuse or mental health concerns,
- At high risk of abuse, neglect or abandonment,
- In the custody of the court.

To manage a system of care that provides the tools and the supports necessary for adults who have substance abuse disorders and/or severe mental illness to lead productive, satisfactory lives characterized by hope, empowerment, and a meaningful role in society. Adults served may include those having alcohol and other drug disorders who are also:

- Pregnant,
- IV drug abusers,
- Homeless.

Adults served may include those having severe mental illness who are also:

- Homeless and without treatment,
- Involved in the criminal justice system,
- Elderly.

Secondary to the goals stated above is the intent to provide alcohol, drug and mental health services, as resources allow, for those adults having less severe need.

I. Legislative & Environmental Context of the Community Plan

- A. Economic Conditions**
- B. Implications of Health Care Reform**
- C. Impact of Social and Demographic Changes**
- D. Major Achievements**
- E. Unrealized Goals**

SECTION I: LEGISLATIVE AND ENVIRONMENTAL CONTEXT OF THE COMMUNITY PLAN

Legislative Context of the Community Plan

Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards, Alcohol and Drug Addiction Services (ADAS) Boards and Community Mental Health Services (CMH) Boards are required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and/or the Ohio Department of Mental Health (ODMH) a plan for the provision of alcohol, drug addiction and mental health services in its service area. Three ADAS Boards submit plans to ODADAS, three CMH Boards submit plans to ODMH, and 47 ADAMHS Boards submit their community plan to both Departments. The plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS and ODMH. This plan covers state fiscal years (SFY) 2012 – 2013 (July 1, 2011 through June 30, 2013).

The requirements for the community plan are broadly described in state statute. In addition, federal requirements that are attached to state block grant dollars regarding allocations and priority populations also influence community planning.

Ohio Revised Code (ORC) 340.03 and 340.033 – Board Responsibilities

Section 340.03(A) of the ORC stipulates the Board's responsibilities as the planning agency for mental health services. Among the responsibilities of the Board described in the legislation are as follows:

1. Identify community mental health needs;
2. Identify services the Board intends to make available including crisis intervention services;
3. Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies;
4. Review and evaluate the quality, effectiveness, and efficiency of services; and
5. Recruit and promote local financial support for mental health programs from private and public sources.

Section 340.033(A) of the ORC stipulates the Board's responsibilities as the planning agency for alcohol and other drug addiction (AOD) services. Among the responsibilities of the Board described in the legislation are as follows:

1. Assess service needs and evaluate the need for programs;
2. Set priorities;
3. Develop operational plans in cooperation with other local and regional planning and development bodies;
4. Review and evaluate AOD programs;
5. Promote, arrange and implement working agreements with public and private social agencies and with judicial agencies; and
6. Assure effective services that are of high quality.

ORC Section 340.033(H)

Section 340.033(H) of the ORC requires ADAMHS and ADAS Boards to consult with county commissioners in setting priorities and developing plans for services for Public Children Services Agency service recipients referred for AOD treatment. The plan must identify monies the Board and County Commissioners have available to fund the services jointly. The legislation prioritizes services, as outlined in Section 340.15 of the ORC, to parents, guardians and care givers of children involved in the child welfare system.

Ohio Administrative Code (OAC) Section 5122-29-10(B)

A section of OAC addresses the requirements of crisis intervention mental health services. According to OAC Section 5122-29-10(B), crisis intervention mental health service shall consist of the following required elements:

1. Immediate phone contact capability with individuals, parents, and significant others and timely face-to-face intervention shall be accessible twenty-four hours a day/seven days a week with availability of mobile services and/or a central location site with transportation options. Consultation with a psychiatrist shall also be available twenty-four hours a day/seven days a week. The aforementioned elements shall be provided either directly by the agency or through a written affiliation agreement with an agency certified by ODMH for the crisis intervention mental health service;
2. Provision for de-escalation, stabilization and/or resolution of the crisis;
3. Prior training of personnel providing crisis intervention mental health services that shall include but not be limited to: risk assessments, de-escalation techniques/suicide prevention, mental status evaluation, available community resources, and procedures for voluntary/involuntary hospitalization. Providers of crisis intervention mental health services shall also have current training and/or certification in first aid and cardio-pulmonary resuscitation (CPR) unless other similarly trained individuals are always present; and
4. Policies and procedures that address coordination with and use of other community and emergency systems.

HIV Early Intervention Services

Eleven Board areas receive State General Revenue Funds for the provision of HIV Early Intervention Services. Boards that receive these funds are required to develop HIV Early Intervention goals and objectives and include: Butler ADAS, Eastern Miami Valley ADAMHS, Cuyahoga ADAS, Franklin ADAMHS, Hamilton ADAMHS, Lorain ADAS, Lucas ADAMHS, Mahoning ADAS, Montgomery ADAMHS, Summit ADAMHS and Stark ADAMHS Boards.

Federal Substance Abuse Prevention and Treatment Block Grant

The federal Substance Abuse Prevention and Treatment Block Grant requires prioritization of services to several groups of recipients. These include: women, pregnant women, injecting drug users, clients and staff at risk of tuberculosis, and individuals with or at risk for HIV disease. The Block Grant requires a minimum of twenty percent of federal funds be used for prevention services to reduce the risk of AOD abuse for individuals who do not require treatment for substance abuse.

Federal Mental Health Block Grant

The federal Mental Health Block Grant (MHBG) is awarded to states to establish or expand an organized community-based system for providing mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The MHBG is also a vehicle for transforming the mental health system to support recovery and resiliency of persons with SMI and SED. Funds may also be used to conduct planning, evaluation, administration, and educational activities related to the provision of services included in Ohio's Mental Health Block Grant Plan.

Environmental Context of the Community Plan

A. Economic Conditions

***Question 1.** Discuss how economic conditions, including employment and poverty levels, are expected to affect local service delivery. Include in this discussion the impact of recent budget cuts and reduced local resources on service delivery. This discussion may include cost-saving measures and operational efficiencies implemented to reduce program costs or other budgetary planning efforts of the Board.*

Similar to many other areas in the state of Ohio, the Midwest, and the nation, Hamilton County has experienced considerable difficulties as the result of the poor economic circumstances prevailing during the past decade. Poverty increased in the Greater Cincinnati area between 1999 and 2005, with Cincinnati ranking as the nation's eighth-poorest big city in 2005, with 25% of residents below the poverty line.

Hamilton County, like much of the rest of the state, continues to suffer considerable levels of unemployment, reported to exceed 9% as recently as October, 2010. Not unexpectedly, this has resulted in a significant increase in the number of individuals relying upon the public system for mental health services. This increase has occurred regardless of age group.

Between FY 2006 and FY 2010, those served under the age of 18 have increased by more than 9%; adults under age 65 have increased more than 20%, and seniors 65 and over have increased by more than 12%. During this same period the number of adults receiving AOD services has increased more than 6%. Such increases place considerable strain on an already over-burdened system subjected in recent years to reductions in funding.

**Demographic Characteristics of Persons
Receiving Mental Health Treatment Services**

	FY 2004	FY 2006	FY 2008	FY 2010
Black	3,701	3,858	3,889	4,304
White	2,301	2,398	2,321	2,442
Other	104	157	205	266
Male	3,639	3,862	3,919	4,321
Female	2,552	2,649	2,597	2,804
Black	5,061	5,426	5,852	6,719
White	5,753	5,530	5,795	6,485
Other	133	128	151	163
Male	4,804	4,804	5,368	5,951
Female	6,243	6,378	6,562	7,527
Black	313	272	289	324
White	457	447	445	496
Other	3	8	7	9
Male	204	177	208	234
Female	576	557	539	601

In FY 2010, total revenues for AOD funding for treatment and prevention services in Hamilton County were decreased by a total of \$939,096. Some programs simply served fewer clients, others were forced to discontinue services as the funds ceased to exist. The Board has made every effort to utilize funding in an effective, cost efficient manner. Despite the magnitude of recent budget cuts, the Board has demonstrated a willingness to work with contract agencies in an attempt to support local programs.

The Board continually monitors the flow of expenditures in an effort to efficiently and effectively manage a system of care in the midst of an unstable economy. A projected reduction in state or federal funding will further strain local levy resources and may lead to an eventual reduction in available services.

B. Implications of Health Care Reform

Question 2. *Based upon what is known to date, discuss implications of recently enacted health care reform legislation on the Board's system of care.*

Developing an understanding of the issues and complexities of national health care reform is currently being undertaken by many groups including state team leaders in Ohio who are studying every provision of the legislation. We know that of the 32 million uninsured adults in the US, 60% may qualify for Medicaid, currently the primary insurer of those with severe mental illness and/or substance abuse disorders. Eight million more children will qualify for the State Child Health Insurance Program (SCHIP), a program which will convert to Medicaid by 2018. Health insurance exchanges are now available in Ohio for those with pre-existing conditions, such as a mental illness, who have adequate income to purchase insurance. However, health insurance purchased through

an exchange will not cover wrap-around services such as housing or job support programs which will continue to need local levy support.

Health insurance coverage reform includes elimination of provisions which have disqualified persons with pre-existing conditions, 30% of which were mental illnesses and/or substance abuse disorders, from obtaining health insurance. These provisions begin with children and adolescents, but by 2014 specify that no adult with a mental health or substance abuse disorder will be seen as having a pre-existing condition. In 2014 Medicaid eligibility for adults will be based on increased income thresholds, although categorical eligibility will remain. Hamilton County through a Substance Abuse and Mental Health Services Administration (SAMHSA) grant has established a program for transitional age youth called JOURNEY which is creating a system of care for youth who have a history of mental illness and/or substance abuse disorders, are often African American, are impoverished, and are involved in difficulties across multiple systems including schools, criminal justice, and Job and Family Service (JFS) foster care homes. It is known that many individuals who developed mental illness and/or substance abuse problems as teenagers will as young adults receive little care for ten years before resurfacing, often in jails. With insurance reform allowing youth to remain on their parents' insurance plans until age 26, obtain insurance through the Exchange, or, in the case of those leaving foster care, maintain their Medicaid status until age 25, it is hoped that our system of care initiative will be firmly in place to transition these youth to an adult system ready to provide continued care. Hamilton County has been particularly concerned that African Americans have been nearly twice as likely to be uninsured as the rest of the county.

Most people work for small businesses and are often the least likely to have health insurance. National health care reform will provide tax credits for small businesses that obtain health coverage for their employees. Currently when these workers seek non-SMD outpatient counseling in Hamilton County, they often encounter long waiting lists at our agencies. With more individuals being provided health insurance, our agencies will be looking forward to expanding their outpatient services.

Integral to health reform is the concept of health homes for those suffering from mental illness and/or substance abuse. The fact that mental health clients often die 25 years earlier than the national average because of poorly coordinated, non-existent, or under-funded primary care can no longer be ignored. Free standing mental health centers and AOD clinics which treat only a single health concern of an individual will have to begin to conceptualize how they can transform themselves into integrated behavioral/medical health homes or partner with those who are. Many of our mental health agencies already employ clinical nurse specialists to provide ongoing monitoring of the physical health needs of their clientele. Locally the Health Foundation of Greater Cincinnati has established its Patient Centered Medical Home/Behavioral Health Service Integration Committee. Those in attendance include mental health practitioners, Board staff, local health department officials, health access personnel, and many others whose mission is to explore how better affiliations, mergers, or partnerships can be forged to meet the goals of creating sustainable health homes. At present difficulties in obtaining National Committee for Quality Assurance (NCQA) certification, billing incentives, information requirements as well as cultural barriers remain topics of discussion. However, the chief concern remains the availability of federal grants and the structure of ongoing reimbursement.

Disease prevention and health promotion are areas of emphasis within national health reform. Prevention of costly chronic illnesses such as diabetes, hypertension, and high cholesterol will

require changes in behavior and early medical monitoring. Our local emergency rooms cite these three conditions as the most commonly seen in our adult clients admitted to inpatient psychiatric units. Simple, effective screening tools, brief interventions, and rapid agency response for ongoing care will be necessary to effect change. Greater Cincinnati currently has eleven pilot clinics in the process of becoming NCQA certified to establish patient centered medical homes (PCMH). Two of Hamilton County's largest mental health agencies serving severely mentally ill clients have shown serious interest in becoming or partnering with PCMH clinics. Thus, the Board's system of care will include recognition that the goals of remaining recovery-oriented and client-centered continue to be important.

Health care reform with all of its rules and regulations, many of which have yet to be clearly defined, is very complex for the professional community. This is especially true for mental health clients. SMI clients may have little experience navigating the health care delivery system as "insured persons" who now have greater access to primary care physicians, psychiatrists, and acute care clinics. They are instead more accustomed to going to emergency rooms for primary care, often after an illness or injury has become serious. Thus, the Board's system of care recognizes that outreach to and education of these clients, especially young adults, needs to be ongoing and shared by Hamilton County's Mental Health Access Point (MHAP), our acute care emergency rooms, especially University Hospital's Psychiatric Emergency Service, as well as by our mental health agencies.

For persons suffering from a substance use disorder, healthcare reform may offer assistance with access issues. As it is presently understood, the new health care legislation is designed to expand the number of persons who are identified as Medicaid eligible and remove any pre-existing condition restrictions to healthcare coverage. The behavioral healthcare parity legislation may also produce greater reimbursement for Medicaid eligible services. These factors may expand resources for AOD clients and thereby contribute to growth for system agencies.

Recent national health care reform has expanded funding for Federally Qualified Health Centers (FQHC) to increase or create behavioral healthcare services. One local discussion has been the availability of physician and medication for Suboxone treatment through the FQHC. Current local AOD treatment agencies would provide therapy and case management while physician and medication would be provided by the FQHC. If national health care reform proceeds as planned, there could be new collaborations to provide services for the growing population of opiate dependent clients.

C. Impact of Social and Demographic Changes

Question 3. *Discuss the change in social and demographic factors in the Board area that will influence service delivery. This response should include a description of the characteristics of customers/ clients currently served including recent trends such as changes in services (e.g., problem gambling) and populations for behavioral health prevention, treatment and recovery services.*

Characteristics and Trends of Clients Receiving Treatment Services

While the Board has seen considerable growth in the number of individuals relying upon it for services (see Question #1, Economic Conditions), some disparity has been evidenced over the past several years in regard to the types of services utilized. Between FY 2006 and FY 2010, the number of individuals served through both individual counseling and pharmacologic management has increased by 19%. More critical is the growth observed in the area of individual community

psychiatric supportive treatment (CPST), which has increased 23% during that same period.

A current change in the AOD client population is an increase in opiate abuse and dependence. These diagnoses have grown in prevalence along with interesting changes in demographics for this segment of clients. The Board's claims data shows that opiate diagnoses on admission increased 13% from FY 2005 to FY 2007. The Center for Chemical Addictions Treatment reports the demand for detoxification services for all opiates has increased from 15% to 49% of its admissions over the past six years.

Admissions data from AOD treatment agencies from FY 2005 to FY 2009 shows a 51% increase in opiate diagnoses. Further the Board's claims data shows that from FY 2005 to FY 2008 clients with opiate diagnoses were 84.6% white, 50.2% male and 49.8% female. The mean age was 33.5 years with the most frequent age being 24. The general description of persons receiving services in the Board system is from the State of Ohio Data Mart. Reports from treatment agencies describe opiate abusing and dependent clients as having a relatively shorter drug use history, having some intact family relationships, and generally coming from a higher socioeconomic status.

Methadone, the long-standing method for medication-assisted treatment for opiate dependence, is most often used to support a maintenance program for long-term addicts with multiple treatment failures. In Hamilton County publicly funded methadone treatment is available at the Veterans Administration Medical Center (VAMC) and the Central Community Health Board (CCHB). The capacity at CCHB is approximately 100 clients, and the program is consistently serving more clients than its optimal capacity due to prioritizing treatment for pregnant women. There is another methadone program in Hamilton County, Opiate Addiction Recovery Services (OARS), as well as one just beyond the county line in Lawrenceburg, IN, the East Indiana Treatment Center. The OARS program is a joint effort with the Crossroads Center and the University of Cincinnati, College of Medicine, Department of Psychiatry Private Practice Group. The East Indiana Treatment Center and the OARS program are self pay. The OARS program is the first opiate treatment program to be certified by the State of Ohio in twenty-four years. It opened for services in 2006 and has rapidly grown to be the second largest methadone treatment program in the State of Ohio.

Board data as well as agency reports show an increase in opiate dependent clients in long-term women's treatment. An agency reported recently that more than half of the current residential clients had an opiate dependence diagnosis, and some came to treatment with an opiate replacement medication.

Trends and Future Treatment Implications

In examining the demographic characteristics of clients receiving mental health services as detailed in Question 1, it is quite evident that 16% more people are being served in FY 2010 than in FY 2004. The greatest increase has been in the 18 to 64 year age range (18%), followed by those birth to 17 years of age (13%). Clients over the age of 65 continue to be smaller in number. This trend may change over the next few years with increasing numbers of baby boomers turning 65 and with increasing emphasis on integration of physical and behavioral health.

Examination of the total number of clients served reveals that a relatively small percent declare a race other than black or white. It is important to note that the largest increase is for persons 17 years and younger (39%).

The above trend data has the following implications for future treatment planning and programming:

- Monitor the number of persons over 65 years of age being served and adjust programming as needed;
- Continue to focus on severely mentally disabled and seriously emotionally disturbed populations;
- Monitor the persons served declaring race in the “other” category and, if numbers increase, adjust resources to meet their cultural and linguistic needs.

Characteristics and Trends of Clients Receiving Prevention Services

The Board offers support for the delivery of mental health prevention, consultation, and education services that address the needs of various demographic populations. The Board contracts with Talbert House/Centerpoint Health to facilitate the delivery of these services. Through prevention services, 861 youth and 445 adults were served from January, through July, 2010. Additionally, 468 recipients of educational presentations and 363 recipients of professional training were served during the same time period.

The following tables reflect some of the characteristics of those customers and clients receiving mental health prevention, consultation, and education services from January through July 2010.

**Mental Health Prevention
Youth, Adult, Elderly Recipients
Total Served Prevention, Education, and Training: 2,339 persons**

# Served	1,250	973	98	18
Percentage	53.44%	41.6%	4.19%	.77%

**Youth Recipients: Prevention and Education
Total Youth Served (ages 0 to 17): 861 youth**

# Served	406	437	18
Percentage	47.2%	50.8 %	2.1%

# Served	493	209	154	4	1
Percentage	57.3%	24.3%	17.9%	.5%	.01%

Education Level	K to 6	7 to 8	9 to 12	College	Failed to Respond
# Served	664	88	38	9	62
Percentage	77.1%	10.2%	4.4%	1.1%	7.2%

Race	African American	Caucasian	Native American	Hispanic	Asian
# Served	557	155	17	67	1
Percentage	64.7%	18 %	1.97%	7.78%	.11%
		Bi-Racial/ Multiracial	Pacific Islander	Other	Failed to Respond
# Served		50	0	2	12
Percentage		5.8%	0	.23%	1.39%

Adult Recipients: Prevention and Education
Total Adults Served (ages 18 and older): 445 adults

Gender	Male	Female	Failed to Respond
# Served	186	259	0
Percentage	41.8%	58.2%	0

Age	9-12	13-17	18-64	65 and older	Failed to Respond
# Served	0	0	363	65	17
Percentage	0	0	81.6%	14.6%	3.8%

Education Level	Less than 8th	8 th Grade	Some High School	High School	Some College
# Served	1	15	104	123	105
Percentage	.2%	3.4%	23.4%	27.6%	23.6%
			4yr College		Failed to Respond
# Served			97		0
Percentage			21.8%		0

Race	African American	Caucasian	Native American	Hispanic	Asian
# Served	155	243	1	18	4
Percentage	34.8%	54.6%	.2%	4%	.9%
		Bi-Racial/ Multiracial	Pacific Islander	Other	Failed to Respond
# Served		19	1	4	0
Percentage		4.3%	.2%	.9%	0

Youth, Adult, and Elderly Recipients: Educational Presentations and Training
Educational Presentations

Total Served Educational Presentations: 468 persons

Gender	Male	Female	Failed to Respond
# Served	217	251	0
Percentage	46.4%	53.6%	0

Age	5-12	13-17	18-64	65 and older	Failed to Respond
# Served	266	124	49	29	0
Percentage	56.68%	26.49%	10.47%	6.19%	0

Education Level	K to 6	7 to 8	9 to 12	College	Failed to Respond
# Served	257	135	48	28	0
Percentage	55%	29%	10%	5%	0

Race	African American	Caucasian	Native American	Hispanic	Asian
# Served	276	135	5	47	0
Percentage	58.97%	28.85%	1.06%	10.04%	0
		Bi-Racial/ Multiracial	Pacific Islander	Other	Failed to Respond
# Served		5	0	0	0
Percentage		1.06%	0	0	0

Professional Training

Total Served Professional Training: 363 persons

Gender	Male	Female	Failed to Respond
# Served	100	263	0
Percentage	27.5%	72.5%	0

Age	5-12	13-17	18-64	65 and older	Failed to Respond
# Served	0	0	359	4	0
Percentage	0	0	98.8%	1.2%	0

Education Level	K to 6	7 to 8	9 to 12	College	Failed to Respond
# Served	0	0	70	293	0
Percentage	0	0	19.3%	80.7%	0

Race	African American	Caucasian	Native American	Hispanic	Asian
# Served	148	206	8	1	0
Percentage	41%	57%	2%	.2%	
		Bi-Racial/ Multiracial	Pacific Islander	Other	Failed to Respond
# Served		0	0	0	0
Percentage		0	0	0	0

Youth Demographic Trends

As described in the tables above, demographic trends indicate more youth were served by prevention and education services than adults. An equal number of male and female youth received prevention and education services. The majority of youth served were between the ages of 5 and 12 years old. A significant number of prevention and education services were delivered in school settings beginning with kindergarten through sixth grade, followed in descending order of frequency by 7th to 8th grade, 9th to 12th grade, and college. Older youth between the ages of 13 and 17 were also reached through community-based programs that address high risk adolescents such as groups at runaway shelters, juvenile court programs, and family programs. African American youth participated in prevention and education services significantly more often than Caucasians (possibly reflective of the high percentage of African American students in Cincinnati Public Schools and city charter schools). An increasing number of children who receive prevention services are bi-racial and Hispanic which reflects the changing demographic population in Hamilton County.

Adult Demographic Trends

Demographic trends also indicate more adult females participated in prevention and education services than males. However, there is a pattern of equal participation of adult males and females in educational presentations. The largest adult age group participating in prevention services is adults 25 to 34 years old, followed in descending order by adults 35 to 54 years old, adults 65 years old and older, and adults 55 to 64 years old. A developing trend is requests for prevention services targeting those 65 years and older.

The educational background of those participating in prevention services reflects that most have graduated from high school, attended college, or graduated from college. Almost one fourth of adult participants have attended but not graduated from high school with a small percentage having less than an eighth grade education. Grade level trends appear to be reflective of the type of prevention service. Support group services for individuals and families of persons with mental illness appear to have more highly educated participants. Professional trainings were attended primarily by college graduates, reflecting the professional workforce. Over half of prevention services participants were Caucasian adults, followed by a significant number of African American adults. A significant trend is the growing number of Hispanic adults participating in prevention services.

AOD Demographic Trends

Prevention agencies continued to struggle with the web-based Prevention Investment Planning and Reporting (PIPAR) system as a data entry tool. Therefore, data entered into the PIPAR system has been incomplete. However, a review of programming and how prevention specific resources are

spent gives valuable information for planning.

Changes for prevention target populations have focused on positive developments in community-based coalitions. Community coalition activities have begun to address drug sales and drug related street crime in certain neighborhoods in Cincinnati. These projects in concert with police and prevention professionals have been so successful that the Board is reviewing ways to address prevention needs in Hamilton County through this neighborhood approach. Local coalitions participated in Hamilton County's Red Ribbon celebration in October, 2010, as well as the Drug Enforcement Administration's National Drug Take Back program in October, and the American Medicine Chest Challenge Drug Take Back Day in November, 2010.

Despite the growth of local coalitions in Hamilton County, prevention agencies continue to spend considerable time and energy in school-based settings. The target population, high risk youth, receives the bulk of prevention services. Multiple agencies focus on the inner city and troubled neighborhoods in an attempt to engage youth and offer them alternatives to lifestyles that embrace substance use. The planning process in which agencies participated this past two years brought an awareness of the need for prevention services to all parts of Hamilton County and a need to plan for prevention efforts spanning youth, adults, and older adult populations.

Trends and Future Prevention Planning Implications

Trend data has the following implications for future planning around prevention, consultation, and education service programming:

- Continue to explore the best way to serve youth in school and community settings (e.g., utilize class periods that are conducive to bringing mental health topics to students; contract for more individual units to avoid taking whole groups from classes);
- Ensure services are offered to older, at risk youth, ages 13 to 17, in environments and community settings that reach this target population;
- Continue to examine the prevention needs of persons with mental illness and their family members;
- Ensure programs reflect the cultural and linguistic needs of the audience being served;
- Develop resources (e.g., materials in Spanish), agency relationships, and programming that are reflective of the growing Hispanic population;
- Design programming that is reflective of the growing audience of participants age 65 and older;
- Ensure that there continue to be a full range of professional education topics that are helpful in many different areas of services;
- Ensure prevention services are targeted at the young adult age group as this age group's use/abuse patterns demonstrate they are at high risk for abuse/misuse of prescription drugs and binge drinking.

D. Major Achievements of the SFY 2010-2011 Community Plan

Question 4. *Describe major achievements.*

The following are major achievements in FY 2010-2011:

- Passage of the Hamilton County Family Services and Treatment Levy provided continued support for programs previously funded with an expired levy and new support for the dedicated Drug Court Program and expansion of coalition activities throughout the County.

- The Board supported agencies using best clinical practices. One of our contract agencies, Lighthouse Youth Services, achieved fidelity with the Family Functional Therapy model to serve youth and families in Juvenile Mental Health Court. No youth participating in Family Functional Therapy were committed to the Department of Youth Services.
- In 2010, the Awareness and Advocacy project was funded and awarded to the Alcoholism Council of Greater Cincinnati. Guide materials were developed and produced to assist in community presentations to key referral sources by a volunteer staff of concerned presenters. The local Faces and Voices of Recovery organization and agencies were selected as presenting representatives. Initial presentations were for the criminal justice system to improve understanding of addictive disorders, the variety of their manifestations, and reasonable expectations for response to treatment of chronic disease conditions. Presentations were customized for judges, prosecutors, public defenders, and probation professionals. Additionally, this panel of experts was used to provide information to various groups and individuals who had questions about the Family Services and Treatment Levy.
- The Board, in collaboration with the Health Foundation of Greater Cincinnati, adult criminal justice system, and mental health agencies, implemented a Hamilton County Felony Mental Health Court for adults with severe mental illness.
- The Board was awarded a six year federal grant for nine million dollars by SAMHSA to facilitate a system of care for transitional age youth 14 to 21 years of age and their families.
- The Board and the Ohio Coordinating Center for Excellence supported Mental Health America of Southwest Ohio in implementing Crisis Intervention Team programs targeting campus law enforcement in addition to the police departments they were already serving.
- The Board supported contract agency Greater Cincinnati Behavioral Health Services' application for and subsequent receipt of funds from ODMH for a pilot project to serve homeless veterans through their Project for Assistance in Transition from Homeless.
- The Board, in collaboration with Hamilton County JFS, implemented the Family Access to Integrated Recovery project to address mental health and substance abuse issues of children and families referred by JFS. The children referred by JFS are at risk of neglect, abuse, and/or dependency, with one or more family members who clearly require behavioral health interventions in order to restore, provide, or maintain a safe and permanent environment for the children.
- The Board, in collaboration with the AOD treatment agencies, began community planning around medication-assisted treatment. In the treatment community the awareness of the needs of persons addicted to opiates led to a planning process to explore medication-assisted treatment. This produced many learning opportunities with agencies. A clear understanding of each agency's beliefs, practices, and future plans regarding buprenorphine-based medication was accomplished. The literature review brought the county treatment agencies current with recent research, policy, and best practices surrounding buprenorphine-based medication-assisted treatment. The process and product were truly collaborations of a wide variety of people from different agencies with diverse training and curricula vitae. Through the months of meetings, a

transformation occurred in the fiber of relationships among this group and in planning. The representatives began working on how they could collaborate for client care. A plan has been completed, and the Board and agencies are currently seeking funding opportunities.

- Strategic prevention planning continued as agencies developed targets, goals, and objectives. Practitioners and supervisors developed specific prevention goals with identified target populations. Senior agency administrators outlined principles and practices to guide the provision of prevention services throughout Hamilton County.
- Hamilton County prevention agencies joined together the past two years to plan a Red Ribbon week celebration for local youth. This effort was hosted by the Coalition for a Drug-Free Greater Cincinnati. In October, 2009 the event was held in a convention style atmosphere at Xavier University. The target group was younger school age students, and the event was attended by two hundred 2nd through 4th graders. In October, 2010 the Red Ribbon event was held at Paul Brown Stadium. It was attended by 200 high school students. Motivational performances culminated in a day of learning the use of small video devices and producing drug free video messages in small groups. The videos were posted on a web site which counted the number of times each video was viewed. The members of the group with the largest number of viewings won the video cameras. These drug messages were viewed more than 13,000 times.

Although Red Ribbon activities have been celebrated by prevention agencies throughout the years, efforts were not coordinated with the community at large. In the past two years prevention agencies have focused more on a collaborative effort that builds each year for community impact.

- During FY 2010, 55 individuals completed Wellness Management and Recovery classes.
- Additional data on recovery support indicated 53% of changes in clients' scores on Ohio Consumer Scales reflected feeling the same or better about their quality of life; 65% of clients reported decrease in problem severity; and 62% of clients reported improvement in functioning.
- The Board was awarded a Strategic Prevention Framework Grant from ODADAS in April 2011. Over the next three years, participants will focus on planning and population level change through the implementation of environmental strategies to address underage drinking and binge drinking for 18 to 25 year olds as well as impact prescription drug misuse in the 18 to 25 year old population.

E. Unrealized Goals of the SFY 2010-2011 Community Plan

Question 5. Describe significant unrealized goals and briefly describe the barriers to achieving them.

The Family Services and Treatment levy represents an important portion of funding for drug court and other community services. The levy provides new funding for the Coalition for a Drug-Free Greater Cincinnati, but the total amount was reduced through the process of constructing the levy. The results have been funding that is less than optimal for the development of new programming.

Some unrealized goals and barriers to achievement were identified in the medication-assisted treatment planning process. The most powerful and pervasive barrier identified was the expense of the medication. The recommended treatment design developed through this planning process was to include medication for 12 months or longer for each of 100 clients. The current cost for the preferred medication (Suboxone) is \$6 to \$8 for a 4 mg tablet. Dosing is dependent on patient characteristics and response and ranges from 8 to 24 mg per day. There are hopes that generic alternatives will soon be available for various buprenorphine-based treatment medications. Additionally, agencies are not able to bill medical somatic service for these drugs; thus creating a significant barrier for agency reimbursement.

Strategic planning for treatment services met insurmountable challenges related to system capacity. Proposed services for adults and adolescents in the criminal justice system were not possible due to a lack of funding.

II. Needs Assessment

- A. Needs Assessment Process**
- B. Needs Assessment Findings**
- C. Access to Services: Issues of Concern**
- D. Access to Services: Crisis Care Service Gaps**
- E. Access to Services: Training Needs**
- F. Workforce Development & Cultural Competence**
- G. Capital Improvements**

SECTION II: NEEDS ASSESSMENT

A. Needs Assessment Process

***Question 6.** Describe the process the Board utilized to determine its current behavioral healthcare needs including data sources and types, methodology, time frames and stakeholders involved.*

The Board determines its current behavioral healthcare needs through many processes, including:

- System data collection/data monitoring.
- The Vice President of System Performance meets monthly and quarterly with quality improvement staff from all agencies and reviews data mart information, including such things as diagnostic categories and outcomes, looking for trends and patterns that may have implications for current treatment and recovery support needs. The committee also periodically reviews trends with major unusual incidents.
- All agencies receiving funding for specialized programs such as transitional age youth, family peer support, and adult mental health court are required to submit annual reports on specific predetermined elements.
- The Board facilitates committees with agencies, youth, and families (such as the Children's Oversight Committee, or the Law Enforcement, Criminal Justice, Mental Health Interface Committee) whose minutes and members provide information for needs assessments. The regular meetings scheduled for planning and quality assurance provide qualitative data from front line practitioners and administrators. These insights become a regular source of information on the changing conditions in the arena of service provision for treatment and prevention.
- The Board received a SAMHSA grant whose workgroups and committees, which included agencies, community partners, families and youth, identified needs related to transitional age youth.
- Mental Health Access Point (MHAP), the front door for accessing mental health services in Hamilton County, produces monthly reports that identify system and client needs. Recovery

Health Access Center (RHAC) serves as the central assessment and referral entity for the Hamilton County system of AOD agencies. RHAC reports quarterly numbers of calls, contacts, assessments, and referrals. The actual placements from assessment are tracked, and these numbers are shared with system agencies. Amount of time waiting for assessment and waiting for admission to treatment is recorded. The percentage of persons keeping their scheduled assessment appointment is documented.

- Data related to length of stay and hospital days used at the state hospital is collected and reviewed monthly. Also, Board staff participate, as appropriate, in treatment team meetings at the state hospital to identify the treatment and recovery support needs of clients ready for discharge.
- The Board has many forums that elicit community involvement and participation in an ongoing way. For instance, there is Board representation on monthly county commissioner community committees. These forums allow the opportunity to elicit consistent and current feedback. In addition, there are opportunities in which specific community involvement and participation are solicited, such as when planning specific programs or system changes.
- To better understand issues, the Board uses focus groups on an as needed basis. For example, in February, 2010 a focus group was held with youth to better understand the issues they face as they move into adult services.
- The Board keeps abreast of local, state, and national trends that have implications for treatment and recovery support needs and resources. Board staff meet regularly with community partners and stakeholders, such as Hamilton County JFS, Developmental Disabilities Services, juvenile justice, adult criminal justice, schools, families, clients, agency staff, ODMH and ODADAS committees to elicit feedback and ongoing discussions of needs and resources.
- The Board's Trustees have annual retreats that result in review and update of mission, goals, and values, prioritization of populations, and targeted areas of need. The Trustees have planning and finance committees, as well as monthly meetings, to review needs, program planning efforts, and financial resources. The Board's executive management staff have annual retreats to identify goals for their units and meet weekly to share information related to utilization, outcomes, budget, and programs and to identify needs.
- The Board places a high priority on input provided by clients via the Ohio Consumer Outcomes Initiative for mental health services and the National Outcome Measures for AOD prevention and treatment services. The Board uses this data to examine effectiveness of services and to identify potential problem areas, which informs the planning process. The Board provides quarterly reports to agencies that indicate how they are performing in comparison to similar agencies within Hamilton County with the expectation that agencies will identify strengths and weakness to make necessary modifications to programming and services delivery.
- In addition to outcomes, the Board receives feedback from clients through satisfaction surveys that are compiled by agencies and submitted at least annually to the Board. Satisfaction results for mental health prevention and education services are also reviewed by an advisory board.

- The Board receives Behavioral Health Module (BH) data specific to AOD treatment. BH data has gone through transition to a web-based system and continues to present challenges for agencies regarding entry and subsequently for the Board for data retrieval. The types of information gathered in the BH Module are level of care, referral source, marital status, educational level, child birth within the past five years, stage of pregnancy, education enrollment, employment status, primary source of income, living arrangement, number of prior AOD treatment episodes, diagnosis type, opiate replacement therapy, number of children in the household under 18, primary diagnosis, secondary diagnosis, military status, primary, secondary and tertiary specific drug use, mode of administration, year of first use, number of arrests in the past 30 days, primary reimbursement, and participation in self-help groups in the past 30 days.

An ongoing challenge has been having BH data entered for every client in a timely fashion at admission, change of level of care, and discharge. A minority of agencies has completed this task for a consistently high percentage of the total number of clients. There has been progress on the percentage of admission BH data submitted, but discharge data submission continues to be incomplete.

- The Board receives data from the Student Drug Use Survey managed locally by the Coalition for a Drug-Free Greater Cincinnati. The Student Drug Use Survey performed every two years has a report which separates data for Hamilton County. A variety of information comes from this process, and for years it has served as a guiding document for prevention services. A few examples of what is available through the survey are: age of first use, prevalence of specific drug availability, and experimentation, use and abuse information by grade level. Risk and protective factors are also a major portion of the student drug use survey.

Local youth are using alcohol and tobacco at lower rates than youth nationally. According to the 2009-2010 Student Drug Use Survey, at a national level youth use alcohol at a rate of 19.6% as compared to the Cincinnati area's rate of 18%. Tobacco use is at 15.2% nationally, compared to 13% locally. Finally, the use rates for marijuana showed the smallest difference at 10.2% nationally and 10% locally.

The method of data processing is a flexible process of examining and comparing sources to determine issues and their severity. Client demographics, outcomes, specific AOD use frequency, and other evidence are compared over years to determine changes which could be significant for planning and execution of treatment and prevention services. Data is evaluated over time periods as much as possible to glean a sense of its importance.

- Juvenile TASC submits data reports for clients served that describe results of urine analysis, recidivism rates, and abstinence outcomes. The information in the reports as well as the agency and referral source feedback at meetings presents the opportunity to clearly identify specific gaps in services or barriers to engagement for the youthful offender population.
- Clients are able to provide feedback regarding their treatment experiences as well as their assessment of the effectiveness of a program. The results are used to target patterns, strengths, and weaknesses at the individual, agency or system level, which in turn informs prioritization and system planning. Feedback from clients regarding their experiences has proven to be a valuable tool for assessing best practices.

- The Board requires one of its contract agencies, Talbert House/Centerpoint Health, to conduct an annual mental health prevention services needs assessment survey. The survey tool is distributed to prevention service providers, recipients of services (including youth and family members), and other systems that serve at-risk populations.

B. Needs Assessment Findings

Question 7. Describe the findings of the needs assessment identified through quantitative and qualitative sources. In the discussion of findings please be specific to:

Question 7a. Adult residents of the district hospitalized at the Regional Psychiatric Hospitals (ADAMHS/CMH only);

Two unmet needs of adults being discharged from Summit Behavioral Health have repeatedly surfaced.

First, housing for registered sex offenders:

- It is difficult to plan discharge dispositions due to their legal status;
- These clients tend to remain in the hospital longer due to lack of available housing that meets the city's regulations;
- Group homes tend not to accept these clients due to their histories even if the group home is located in an acceptable area.

Second, housing for the dually diagnosed (mental illness and developmental disabilities):

- Housing is needed which addresses the unique needs of these clients;
- Mildly developmentally disabled clients who require high levels of supervision and structure tend not to be successful in mental health homes due to the limitations of these settings;
- There is a lack of understanding on the part of hospital treatment teams as well as community agency staff as to the complexities of regulations within developmental disabilities services. Consequently planning for coordination of care between mental health and developmental disability services can be prolonged.

Question 7b. Adults with severe mental disability (SMD) and children and youth with serious emotional disturbances (SED) living in the community (ADAMHS/CMH only);

The following are unmet needs of SMD and SED populations living in the community:

- Children and families may have intensive needs that are best met by accessing intensive in-home services, but there is limited capacity for this service;
- Children and adults who have dual diagnoses (developmental disabilities and serious emotional disturbance) experience service gaps and lack of workforce competency to meet their needs;
- Transitional age youth have a need for housing and independent living skill development.

Question 7c. Other Reports/Other Individuals receiving general outpatient community mental health services (ADAMHS/CMH only);

In surveying the lead outpatient agencies in Hamilton County that serve clients with Medicaid, Medicare or no insurance, our pharmacologic management services provided by psychiatrists, nurse practitioners, and/or clinical nurse specialists continue to have some delays averaging about two weeks. A few agencies, because of staff changes, had long delays exceeding 45 days. Because most

agencies now employ clinical nurse specialists, who have prescriptive authority, extensive delays are usually avoided.

In addition, for new clients our front door, Mental Health Access Point, which uses both psychiatrists and advanced nurse practitioners, provides CPST and pharmacologic management service until ongoing agencies pick up the cases. Outpatient individual counseling for non-SMD clients who have insurance is available in a timely manner of one to two weeks. However, for those without adequate insurance, the wait time for outpatient therapy is three to six months. Group psychotherapy is available in seven to thirty days for insured clients.

Question 7d. *Availability of crisis services to persons without Medicaid and/or other insurance. (ADAMH/CMH only);*

When an individual who presents in the community in a crisis situation comes to the attention of police, family or other citizens, University Hospital's Mobile Crisis team responds whether or not the person has insurance. This team is fully Board funded and is made up of health officers capable of starting the involuntary hospitalization procedure if needed. Inpatient psychiatric care is available at University Hospital and Summit Behavioral Healthcare for the indigent. Where a lower level of crisis care is indicated, Mobile Crisis staff can contact Mental Health Access Point, the Board's front door to services, and seek, when available, access to Crisis Stabilization or REST, both of which are Board funded residential facilities.

Question 7e. *Adults, children and adolescents who abuse or are addicted to alcohol or other drugs (ADAMHS/ADAS only);*

The Board reviewed claims data, agency reports, Behavioral Health Module data, the Suboxone planning process information, Recovery Health Access Center data, and data from the Student Drug Use Survey to determine the needs of the at risk, abusing, and addicted populations in Hamilton County.

625	Youth
4,422	Adults
27	Seniors (65+)
Total sum = 5,074	

According to the Surgeon General's office, on average 9% of the adult population has an addictive disorder which could benefit from treatment. In Hamilton County this 9% of the adult population would be approximately 59,000 people. In comparison to the 4,422 actually treated, we are far under capacity to meet the need for services. Board programs provide service for 7.5% of the estimated population of chemically dependent people. This is not surprising considering that statistics from the National Survey on Drug Use and Health reported that 23 million Americans met the criteria to be diagnosed with a substance abuse or dependence disorder, but only 4 million actually received treatment.

The increased reports of opiate addicted clients have been supported with other data sources and were the motivating factor in securing a planning grant to focus on medication-assisted treatment for indigent opiate addicted clients. The characteristics of this population are as follows; 84.6% white, 50.2% male, and 49.8% female. The mean age was 33.5 years with the most frequent age being 24. Opiate users in Hamilton County include almost as many females as males, are predominantly white, generally younger, and usually have some family relationships still intact. Heroin, as well as prescription opiate abuse, is more common among suburban youth and young adults who usually have shorter drug histories that offer the potential for meaningful family restoration that can serve as a powerful support for recovering addicts. As the number of opiate addicted clients served in the AOD system continues to increase, agencies, referral sources and the Board continue to plan to address the needs of this population.

Unmet needs for this population include access to medication (i.e., Suboxone) and housing. Most transitional housing does not accept clients using Suboxone or Methadone.

Recovery Health Access Center (RHAC) data indicated early on in the fiscal year that capacity in outpatient programming is full. RHAC reports described that from 1001 assessments, 548 clients were placed in treatment. Qualitative analysis of the data ascertained that the majority of these clients required an outpatient level of care.

Early age use of substances has been identified by the Center for Substance Abuse Prevention, SAMHSA, as a major risk factor in the development of later AOD problems. The data from the Hamilton County 2010 Student Drug Use Survey showed that in the previous 30 days alcohol use among youth was 18%, while marijuana use was 10%. Age of first use for alcohol was 13.5 and 14 for marijuana. Furthermore, any use within the last year was 37% for alcohol and 16% for marijuana.

The prevention/treatment needs of school aged children are obvious: a continuum that provides a clear message beginning with family, school, and neighborhood.

Question 7f. Children and Families receiving services through a Family and Children First Council;

The Hamilton County Family and Children First Council (FCFC) has many programs to meet the needs of children and families. The FCFC is charged by the Ohio Children's Trust Fund with developing and funding a county plan for addressing needs in the area of prevention of child abuse and neglect.

The FCFC also identified needs through its Family and Civic Engagement Needs Assessment. Listed below are some of the needs identified through this process:

- To facilitate positive school culture;
- To support different cultural groups within the schools.

Question 7g. Persons with substance abuse and mental illness (SA/MI);

According to the Surgeon General's office, the estimate for the number of dually diagnosed (i.e., substance abuse/mental illness or SAMI) adults in the general population is 3%. This would be approximately 19,700 adults in Hamilton County.

Hamilton County continues to note that 50% to 60% of our adult clients are dually diagnosed, have often experienced parallel services in the past which failed to adequately meet their needs, and are now responding to increased availability of evidence-based practices within our treatment system. Several of our lead agencies treating SMD clients offer programs which target the dually diagnosed, one of which is evidence-based. These programs include Integrated Dual Disorder Treatment, Motivational Interviewing, Helping Women Recover, Trauma, Recovery, and Empowerment Model, Stages of Change, Wellness Recovery Action Plan. Other programs offered by The Crossroads Center, an agency whose mission is AOD treatment, offers Cognitive Behavioral Therapy, Courage to Change, Cannabis Youth Treatment, Family Strengthening Network, and Seeking Safety. Agencies stress the need for:

- More treatment options for clients still in denial of the significance of their substance abuse;
- More residential care for the dually diagnosed suffering from chronic homelessness;
- Continued awareness that every program must have the capacity to deal with dually diagnosed clients;
- Obtaining quicker access to pharmacologic management.

Question 7h. Individuals involved in the criminal justice system (both adults and children);

Adults Involved in Criminal Justice System:

Drug Court Services

The Alcohol and Drug Addiction Partnership Treatment provides a comprehensive treatment program designed to serve drug and alcohol addicted men and women who have felony drug-driven offenses. The program was expanded and enhanced with a SAMHSA grant, thus reducing the wait list for services. Sustainability of the Drug Court treatment program is the current need.

Indigent Drivers Alcohol Treatment

The Indigent Drivers Alcohol Treatment Fund was established 15 years ago for municipal and juvenile courts to fund treatment services and alcohol monitoring devices. Utilization of this project is currently under review so that clients can be better tracked from probation referral to treatment agency.

Adult Treatment Accountability for Safer Communities (TASC)

The program provides assessment, referral, and non-intensive treatment services for men and women in the criminal justice system with primary substance use issues and/or co-occurring mental health and AOD disorders. Data reports give the Board information about capacity and outcomes. Adult TASC does not have sufficient capacity for the number of court referrals, and resources to pay for treatment remain limited.

Municipal Mental Health Court

A significant number of persons in jails and prisons have a history of mental illness, many with a dual diagnosis that includes substance abuse. Some of these have committed multiple misdemeanors, non-violent offenses such as vagrancy, trespassing, disorderly conduct, and public intoxication that can be related to their disconnection from the community resources necessary to maintain their mental, physical, and environmental stability. In 2001, the Board received a planning grant from the Health Foundation to convene a task force to develop a

municipal mental health court. A collaborative partnership was developed with mental health and AOD agencies as well as the probation department and the criminal justice system.

The Hamilton County Municipal Mental Health Court has been in operation since 2003. The program continues to be evaluated on a regular basis by community partners to identify strengths and areas needing improvement. Feedback regarding the program was collected from the treatment team, quarterly and annual reports as well as from criminal justice partners (Pretrial and Community Transitions Services, Probation Department, and Central Clinic's Court Clinic).

At this time, the needs assessment reveals:

- Challenges have been created in the identification and engagement of clients eligible for mental health court because of changes within the criminal justice system and early release procedures. These are being addressed with criminal justice system, but no solutions have yet been identified.
- Insufficient knowledge of court and criminal justice system personnel that requires ongoing education regarding mental health issues and eligible programs in order to confidently and accurately connect persons to appropriate mental health programs.

Felony Mental Health Court

Collaboration between the mental health and criminal justice systems has led to lower rates of re-arrest, higher rates of employment, and greater stability for mentally ill defendants. Mentally ill defendants charged with felonies frequently experience a complex criminal justice system that was not designed to respond to their mental health needs. Hamilton County saw an opportunity to meet the needs of persons who have a mental illness and who are charged with a felony by establishing a Felony Mental Health Court in 2010. It is too early to determine what additional needs there may be.

Crisis Intervention Team (CIT)

Approximately ten years ago there were several altercations between Cincinnati Police Officers and mentally ill persons. Unfortunately one such incident resulted in the death of a client who had a severe mental illness and had escaped from a local psychiatric unit. As a result, the Cincinnati Police Department requested and welcomed increased collaboration, communication, and training from the community mental health system. Initially, an eight hour course, Mental Health Response Team (MHRT) was developed and presented to the Cincinnati Police Department. In the last ten years this training has evolved into a 40-hour course that is offered to all of Hamilton County officers. In 2008, the Board collaborated with the Coordinating Center of Excellence to add CIT to the current model of law enforcement training. The new training program was named MHRT/CIT and was marketed not only to all Hamilton County officers but officers of local colleges and universities as well as the Sheriff's Department and first responders. The addition of the CIT model has enhanced the training overall and includes the role play element which is a strong trademark of CIT. Furthermore, the addition of CIT has provided Hamilton County an opportunity to be a part of the CIT statewide committee, forging collaborative partnerships with colleagues around the state. The Board contracts with Mental Health America of Southwest Ohio (MHA) to provide multiple 40-hour trainings per year in Hamilton County. MHA has recently requested an opportunity for the Coordinating Center of Excellence to complete a peer review to assess current training program for quality improvement and the ability to receive feedback from peers in order to further strengthen the

law enforcement training program. The MHRT program has trained 303 officers since 2003, and the MHRT/CIT program has trained 101 officers for a total of 404 officers trained in mental health law enforcement.

The Board in collaboration with MHA continues to evaluate the MHRT/CIT program on a regular basis. MHA provides an annual report to the Board that identifies strengths and areas needing improvement. At this time, the needs assessment revealed the need for:

- Increased knowledge and understanding of mental illness for those officers who have completed the 40-hour CIT course. Recommend the addition of a CIT advanced course.
- Formal evaluation of the CIT/MHRT program to assess the strengths of the program and ensure the needs of the audience are met. Recommend participation in the peer review process provided by the CIT state committee.
- Increased knowledge and understanding of mental illness for those officers in the Sheriff's Department and first time offenders.

Post Booking and Mental Health Jail Diversion Program (PB&J)

In 2006 the Board coordinated the development of a system-wide committee entitled Criminal Justice/Mental Health Interface comprised of partners from mental health, community hospitals, homeless community, Cincinnati Police, and the criminal justice community. The mission of the committee is to build a sustainable infrastructure among the systems in which there is ongoing communication among partners, networking, trouble shooting, planning and designing quality system responses to individuals connected to the mental health and criminal justice systems. The committee developed a program called Post Booking and Mental Health Jail Diversion Program (PB&J) to target those persons who are not appropriate for the Municipal Mental Health Court but who could benefit from diversion from the criminal justice system. The PB&J program was funded by a Bureau of Justice Assistance Grant that expired in December, 2010. The grant supported a part time position entitled Mental Health Specialist to coordinate and communicate between pretrial (referral base), the city prosecutor and CPST agencies. The length of the program varies from 2 to 6 months as determined by the city prosecutor. As part of the program, the client is required to continue to work with or re-engage with CPST and to decrease arrests. CPST staff is requested to complete a monthly report for the city prosecutor to provide ongoing status updates. If the client successfully completes the program, all charges are dismissed. Since February, 2010, PB&J has enrolled 42 clients out of 46 referrals. A total of 9 clients have graduated. The clients have had 100% compliance in attending their arraignment hearings which are scheduled approximately ten days from arrest in order to allow time for CPST staff to be present. Typically arraignments are scheduled within 24 to 48 hours of arrest, and there is a 50% no show rate for CPST staff at arraignments. For PB&J referrals, CPST staff have had a 100% show rate for the arraignment and 100% submission rate of monthly reports to the prosecutor. Anecdotal data from CPST staff and clients has been positive. The committee meets regularly to monitor the program and make adjustments as necessary.

Although it is speculated that the diversion program meets the needs of clients, an evaluation tool is being developed to more objectively measure the outcomes.

Youth Involved in Criminal Justice System

Juvenile Treatment Accountability for Safer Communities (TASC)

The Juvenile TASC program's quarterly reports to the ODADAS TASC office are made available to the Board for monitoring and planning purposes. The Juvenile TASC program has been charged with assessment and case management of the most severe juvenile criminal justice cases returning from the Department of Youth Service institutions and clients with severe charges (i.e., DYS placement possible) in Hamilton County Juvenile Court. Overall, TASC outcomes have been positive especially considering this difficult population. There remain significant gaps in services for these youth among them: mentoring services and transitional housing.

Juvenile Mental Health Court

In 2004, the Hamilton County Juvenile Court and the Board implemented a Juvenile Mental Health Court to provide special consideration and services to juvenile offenders who suffer from severe emotional disturbances and sometimes co occurring AOD disorders. Initially the focus was on juveniles who committed felonies. In early 2007, the program was expanded to include other severely emotionally disturbed youth through the misdemeanor Pretrial Diversion Docket. The goal was to intervene as early as possible to deter a youth from further interactions with the juvenile justice system.

An advisory board comprised of partners from Juvenile Court, the Board, NAMI, Mental Health Access Point, and Lighthouse Youth Services meets regularly to continue oversight of the specialized dockets and identify needs and trends of the program.

The needs assessment revealed that the families' ability to access services within the Juvenile Court system have been challenging due to recent structural changes within Juvenile Court. These are being addressed.

Question 7i. Veterans, including the National Guard, from the Iraq and Afghanistan conflicts.

It is estimated from the US Department of Veterans Affairs that 54,525 veterans reside in Hamilton County, Ohio. Iraq and Afghanistan veterans represent 7.5 percent of the veteran's population in the United States, which was estimated to be 22,972,246 in FY 2009.

According to the US Department of Veterans Affairs, 365,836 veterans with a primary or secondary diagnosis of post traumatic stress disorder received treatment at a VA facility in FY 2009. Of those, almost 20 percent were veterans of the Iraq and Afghanistan conflicts. Additionally, 19 percent of Iraq or Afghanistan veterans have experienced a probable traumatic brain injury during their deployment.

The estimated number of veterans who served in the Iraq or Afghanistan conflicts residing in Hamilton County, Ohio is 4,089.

Veterans who need to access AOD services have the same options available to them as non-veterans. The Recovery Health Access Center will screen, assess, provide interim services and connect them to the appropriate level of care for treatment. In addition to the Board's contract agencies, Hamilton County has two other resources available to veterans.

- Joseph House offers a halfway house, transitional and permanent housing as well as outpatient treatment for veterans suffering with substance use disorders. Joseph House is staffed with veterans who are able to offer support and counseling to the client seeking recovery.
- The Cincinnati Veterans Administration Medical Center, centrally located in Hamilton County, is a state of the art medical facility offering services to address AOD, mental health, and primary health concerns for veterans. An emergency room and pharmacy as well as special programs for families are on site.

Although programs are available to serve the veteran population, the Board has identified the following needs:

- Younger veterans are in the minority of homeless veterans who have been encountered by PATH. Those who have been encountered have typically been involved with the court system, many due to domestic violence charges. The unmet need for this group is a focused intervention around transitioning back into society upon discharge. This would involve learning appropriate coping mechanisms and problem solving skills. This need would be relatively new and specific to Iraq and Afghanistan war veterans.
- The remaining veterans who have been encountered are in the over 50 age range. The primary issue is that these older “unserved” homeless veterans do not readily accept services that are offered because of their mistrust of the system. Many of the individuals are Vietnam War veterans. A service such as PATH that focuses on long term outreach and the establishment of trusting relationships is the best intervention for this group.
- There has been a limited focus on veterans returning from Iraq or Afghanistan.

In July 2009, the Ohio Department of Mental Health issued a request for proposal to award additional federal PATH dollars to existing state funded PATH programs to target outreach and services to homeless veterans. Greater Cincinnati Behavioral Health Services (GCBHS), a mental health agency in Hamilton County, collaborated with Butler County Transitional Living to complete the application. Data collected to support this initiative was from the 2008 Ohio Homelessness Report produced by the Coalition on Homelessness and Housing in Ohio which counted 952 homeless veterans living in Ohio. In addition, the 2006 Veterans Administration Community Homeless Assessment, Local Education and Networking Groups Report stated that Ohio has 261 funded beds for homeless veterans and reports a total number of 1710 homeless veterans living in Ohio. In FY 2008, the eleven PATH programs reported serving a combined total of 105 veterans, identifying a gap in services to homeless veterans. The goal of the veteran’s project was to increase outreach, engagement and service efforts that are trauma informed and culturally appropriate to veterans in their natural environments. The outreach was to target those veterans not already connected to the local mental health system. The proposal requested the hiring of a veteran peer to facilitate relationship building and to assist with navigating the complexities of the Department of Veterans Affairs and other service, housing, and benefit systems.

The veteran’s PATH program is a partnership between GCBHS, Transitional Living Center in Butler County, Tender Mercies, and the Joseph House. All of these agencies including the Board make up the advisory committee that meets quarterly to review data and identify trends, strengths, and areas that need improvement. In fiscal year 2010, the veteran peer worker served 76 veterans. The following needs were identified by the PATH veteran peer worker:

- Limited focus on veterans returning from the Iraq and Afghanistan conflicts specific to learning how to transition back to civilian life;

- Limited focus on veterans from the Vietnam War. A different approach is needed with this group of veterans who have historically fallen through the cracks and have a strong mistrust of the system. A longer period of time is needed to engage these individuals. PATH is the most appropriate outreach for this population.

C. Access to Services: Issues of Concern

Question 8a. Identify the major issues or concerns for individuals attempting to access behavioral health prevention and treatment services in the Board area. In this response please include, when applicable, issues that may exist for clients who are deaf or hard of hearing, veterans, ex-offenders, problem gamblers, and individuals discharged from state regional psychiatric hospitals and released from state prisons without Medicaid eligibility.

Behavioral Health Prevention Services

The following identifies issues or concerns for individuals attempting to access behavioral health prevention services.

- There is an access issue with scheduling prevention programs for youth in school based settings so as not to interfere with their education. Specifically, parents and educators have expressed concern about utilizing classroom time for prevention services. Although the school has been identified as a primary location to deliver prevention services for youth, the pressure on teachers to prepare students for proficiency tests results in the teachers' reluctance to dismiss students for a prevention activity. When non-academic time is used, the child/families often do not want the child to miss the activity. Thus, there is a conflict between the recognized need, desire for getting help, and the reality of scheduling within the school day.
- There is an access issue with providing prevention services to different cultural groups including Spanish speaking audiences with qualified staff and translated materials.
- There are increased requests to provide prevention services to older adult audiences; however, there are not sufficient resources allocated to accommodate the requests.

Special Populations

Community Outreach Prevention and Education (COPE)

Hamilton County agencies have prevention programs that include special population groups. Agencies also collaborate with other community entities that have expertise in programming especially designed to serve these populations. With limited funding, COPE has not wanted to duplicate programs already in the community.

Deaf and hard of hearing persons are served through participation in the planning process and an annual Spring Health Fair/Conference. The Speech and Hearing Center and St Rita's School for the deaf are staffed to respond to persons who are deaf and hard of hearing; and these organizations run their own programs. COPE has not received requests in this area.

Veterans are served and welcomed into any of the COPE programs. COPE participates with the Veterans Administration Medical Center in the area of suicide prevention through the Hamilton County Suicide Prevention Coalition. The Veterans Administration Medical Center has hired a designated staff person to specifically work with suicide prevention in the veteran population. Support group facilitators report that veterans are sometimes in their group, although they are not a designated group.

Ex-offenders are served through the facilitation of groups for abusive men and adolescents at the YWCA, HIV/AIDS groups at Central Community Health Board, and the Hamilton County Juvenile Detention Center. Ministers in the African American community are trained to address mental health issues by Central Community Health Board. Upon request, COPE takes programs to halfway houses and other organizations that serve ex-offenders as a target population.

At this time, there are no known access issues for these special populations.

Behavioral Health Treatment Services

The following identify issues or concerns for individuals attempting to access behavioral health treatment services.

- Access to CPST services has been problematic.
- Hamilton County's CPST contract agencies continue to report increased numbers of clients presenting for care, many of whom are at higher risk of substance abuse, criminal justice involvement, and physical illness. Adequate CPST and psychiatrist staffing remains problematic.
- Our private inpatient hospitals that take most insurance plans plus the indigent have limited acute inpatient capacity for those adults under age sixty-five.
- The Board continues to hospitalize non-forensic patients at Summit Behavioral Healthcare and will monitor capacity issues.

Special Populations

Deaf and hard of hearing: Greater Cincinnati Behavioral Health Services does offer a therapy and CPST program for the deaf and hearing impaired which rarely experiences capacity problems.

Veterans: The Board works with our local Veterans Administration Medical Center to coordinate inpatient and case management care for veterans. For those veterans who are ineligible or refuse VA care, our community services are available. Board staff are participating in discussions around the development of the Ohio Project Vets Intervention Program.

Ex-offenders: Our local forensic ACT team (FACT) has been in place for seven years and serves SMD clients newly released from Ohio's prisons who are currently on parole or PRC supervision status and who are willing to participate. For those persons who do not qualify or refuse the ACT team approach, our traditional CPST services are available.

Problem gamblers: In the near future Cincinnati will begin building its first casino which may increase the demand for local practitioners specializing in gambling addictions. Outpatient therapy services have remained in short supply in Hamilton County for years, especially for non-SMD clients who lack funds to pay for care.

Hospital discharges: An issue that may present a challenge is discharge planning at Summit Behavioral Healthcare for those clients needing high intensity CPST and housing placement services given the new limits on adult CPST service.

Youth: An issue for youth is delivering timely, appropriate care to children and adolescents given the shortage of child psychiatrists in the community. This issue also was brought to the Board's attention from a variety of agencies that serve children and adolescents. The agencies expressed the continued difficulty in recruiting, hiring, and retaining child psychiatrists. Many of the recent child psychiatry fellow graduates have chosen to either go into private practice or leave the Cincinnati area. None has chosen to serve the public mental health population. In response to this dilemma, Board staff began meeting with our partner, Children's Hospital. These meetings were to discuss a program that they participated in which trained private pediatricians to manage and treat uncomplicated ADHD. This program has since progressed to include treatment of depression and anxiety disorders. Participation in this program would allow child psychiatrists to be freed up to treat more challenging cases. The Board is working to replicate this model for the public sector. At this time, Board staff continue to work with Children's Hospital as well as with representatives from MindPeace and the Cincinnati Health Department to develop a community based model.

Our focus is on working to:

- Identify a group of core pediatricians who are willing to work with this population of children;
- Develop a set of parameters/qualifications for this core group;
- Develop a core curriculum for participants;
- Develop outcomes from evidence-based practices.

Supportive housing is an additional issue for transitional age youth.

AOD Services

The primary AOD issue is a lack of capacity for persons seeking to access treatment for substance use disorders. The Board is committed to providing access to a full continuum of care for persons seeking treatment for substance use disorders.

A central access point for AOD services, RHAC has been reporting data to the Board on a quarterly basis over the past two years. Through the RHAC program, 1001 assessments led to 548 admissions for treatment in FY 2010. Prevention and treatment access concerns have identified cases of opiate dependence, deaf or hard of hearing, veterans, ex-offenders, and problem gambler issues as well as how the system addresses them.

RHAC has developed numerous services and systems to assist clients with access to treatment. RHAC provides interim services through its Clinical Triage Department which include case management, individual and group sessions. It is not unusual for clients who have no resources and need an outpatient level of care to be placed on a wait list and engaged in interim services. RHAC services focus on the use of Motivational Interviewing and the stages of change.

Special Populations

Deaf and hard of hearing: The Alcoholism Council of the Greater Cincinnati Area provides an interpreter for several regularly scheduled open Alcoholics Anonymous meetings. This service has been available to the community for several years. The Center for Chemical Addictions Treatment received a grant from the Deaf Off Drugs and Alcohol Project to purchase a web-cam so that an interpreter does not have to be present in the same room with the client.

Veterans: The greater Hamilton County community is fortunate to have a large Veterans Administration Medical Center (VAMC) which has a long term relationship with the College of Medicine at the University of Cincinnati. VAMC's various behavioral healthcare programs serve as a major resource to assist Hamilton County with access to treatment problems. Access remains a major concern due to the stringent admission criteria used by the VAMC.

Ex-offenders: Persons on probation or parole comprise the majority of clients receiving AOD services within the Hamilton County system. Over 60% of the adolescents treated are criminal justice referrals. Hamilton County Drug Court is a key place where individuals arrested on charges related to their substance abuse can receive treatment in Hamilton County. Hamilton County Drug Court provides both intensive outpatient services as well as residential treatment for men and women. Drug Court clients are engaged in services as long as a year.

Problem gambling: Services at the Central Community Health Board are a combination of educational presentations to clients currently in AOD treatment, an evaluation, short term motivational counseling, and treatment or a referral for problem gamblers. Cincinnati is one of the Ohio cities in which a casino is currently under development. The Board is readying itself to examine the frequency and severity of problem gambling in light of the casino scheduled to open in 2012.

Youth: There clearly remains a problem for the youth throughout Hamilton County essentially with alcohol and marijuana. Regular experimentation and early age of first use are both identified by the Center for Substance Abuse Prevention, SAMHSA as significant risk factors for the development of substance related problems.

In addition, the school has been identified as a primary location to deliver prevention services for youth. The pressure on teachers to prepare students for proficiency tests results in the teacher's reluctance to dismiss a child for a prevention activity. When non-academic time is used, the child/families often do not want the child to miss the activity, thus, there is a difference between the recognized need, desire for getting help, and the reality of scheduling within the school day.

D. Access to Services: Crisis Care Service Gaps

Question 8b. *Please discuss how the Board plans to address any gaps in the crisis care services indicated by OAC 5122-29-10(B). (ADAMHS/CMH only).*

Mobile Crisis serves both adults and children in Hamilton County; however, there is a significant gap in service delivery between the adult and child systems. In FY 2010, Mobile Crisis received referrals from 2,275 individuals, 90% or 2,027 of those individuals were adults and the remaining 10% or 228 were children.

Plan to Address Gap in Delivery of Child Services via Mobile Crisis

The Board plans to increase referrals by child systems. To that end the Board is developing a collaborative partnership with the Hamilton County Department of Jobs and Family Services and the Juvenile Court to implement best practice strategies developed through Georgetown University and Casey Family Programs. The Crossover Youth Practice Model aims to reduce and avoid juvenile justice contact among child welfare youth. Child welfare youth nationally are overrepresented in juvenile justice systems and have longer episodes of contact than the general

population. In further review of Hamilton County, it was learned that many youth placed in group homes and residential placements are more likely to come into contact with law enforcement during an episode of care than those in foster homes or other family settings.

The Crossover youth practice model will involve the use of the Mobile Crisis team as an alternate intervention to calling law enforcement and as a consultant for law enforcement, similar to what is currently in place for adult mental health calls involving the Cincinnati Police Department. In addition, the Mobile Crisis team will provide an educational component to group home and residential staff and administrators who deal in crisis intervention and de-escalation techniques. If a crisis situation escalates to the point that police would normally be called, the Mobile Crisis team could be an appropriate intervention. The goal is to limit the number of youth and frequency of youth in group homes and residential placements who have been sent to juvenile detention due to a crisis in their living environment.

E. Access to Services: Training Needs

Question 8c. Please discuss how the Board identified and prioritized training needs for personnel providing crisis intervention services, and how the Board plans to address those needs in SFY 2012-13. (ADAMHS/CMH only).

Several areas of need related to statement of belief, criminal justice, housing, probate, and police training became apparent to Board staff who attended various meetings with community agency staff.

Health Officer

The first area was a need for qualified persons to be trained as health officers. This arose out of two concerns voiced by agency staff:

- Who is qualified to sign a statement of belief (some MDs were unaware that they were able to sign a statement of belief);
- An MD is not always readily available.

Discussions were held with Mobile Crisis leadership about the possibility of training staff from agencies to become health officers. The training session includes specifics related to the responsibilities of being a health officer as well as developing an understanding of psychiatric presentations caused by medical diseases. The new health officers would be certified for one year and practice only within their mental health agencies. Two training sessions have been offered annually as well as one refresher course for those previously certified. The list of attendees includes staff with the following credentials: MSWs LISWs, APRNs, psychology, and recently added LPCCs. Training will continue.

Crisis Teams

- Provide training that targets crisis situations and needs experienced by children and older adults. Additionally, there is a need to improve the accessibility and collaboration of crisis team members.
- Train crisis team members about the needs of children and older adults in crisis situations.
- Expanding team membership to include practitioners who have expertise in serving different age groups.
- Increase collaboration between the district based crisis team and school/community based crisis teams.

Criminal Justice/Mental Health

Currently the Board provides training three times a year to CPST staff, supervisors, team leaders, and community living service workers. Training topics include Mental Health and Criminal Justice Collaboration, Understanding Probate Court Procedures, and Housing Training.

In 2008, the Law Enforcement/Criminal/Mental Health Interface Justice committee identified the need for a unified response from CPST agencies when working with clients who were frequently arrested. The committee agreed that an increased presence from CPST staff in the jail would improve communication and coordination with discharge planning.

Objectives for mental health and criminal justice collaboration

- Take a “virtual tour” of the Justice Center campus;
- Increase communication between the mental health and criminal justice systems;
- Strengthen partnerships between the mental health and criminal justice systems;
- Promote advocacy for the needs of incarcerated clients and their families.

Housing

The Board received much feedback from housing specialists within the mental health system that CPST staff have varying degrees of knowledge regarding the housing resources available to SMD clients. In order to provide a consistent and clear understanding of Board resources available to CPST workers for their clients, housing training was developed.

Objectives for housing training

- Increase knowledge of the housing system in order to effectively utilize available resources;
- Understand the differences between Community Mental Health Homes, Quick Access Housing, Excel and Homelink services;
- Increase awareness and understanding of supportive housing services;
- Increase understanding of how and when to complete required paperwork.

Probate

A need to train CPST staff regarding their role in managing clients in Outpatient Community Probate (OCP) was discovered primarily as a result of two situations:

- Numerous questions regarding Probate Court procedures pour in from CPST staff to Board staff;
- The documentation required for OCP full hearing was not being submitted in correct form or in a timely manner and in many cases was not being submitted at all.

In an effort to remedy this situation, a training program was designed to optimize understanding of basic Probate Court procedures which are frequently encountered by CPST staff serving clients who are severely mentally ill. The training program is offered once every four months (1.5 continuing education units are offered). A total of 60 to 70 CPST staff are trained each year. CPST staff with a working understanding of basic Probate Court procedures are more informed, better able to utilize the Probate Court as a resource, and can effectively manage court related documentation for their clients who are on OCP. The training program will continue.

Objectives for Probate Court Training

- Describe the process for filing a probate affidavit alleging that a person is mentally ill and subject to involuntary hospitalization;
- Differentiate between an initial probate hearing and a full probate hearing;
- Identify the documents required for an outpatient community probate hearing and describe the process for preparing the documents for the hearing;
- Explain the process for obtaining a motion requesting inpatient treatment for a patient on outpatient community probate;
- Discuss at least three basic principles for giving testimony, as a mental health professional, during a Probate Court hearing.

Crisis Intervention Training (CIT)

The first law enforcement training was provided in 2000, and consisted of an 8-hour class. Since then the training has evolved into a 40-hour class and includes role playing and shadowing experiences for all participants. The Board contracts with Mental Health America of Southwest Ohio to provide law enforcement training. In 2009, CIT was added to the curriculum and marketed to all Hamilton County law enforcement personnel including those at universities and colleges.

The Board contracts with Mental Health America of Southwest Ohio to provide CIT to local law enforcement including universities and colleges throughout Hamilton County. Mental Health America of Southwest Ohio provides approximately three 40 hour CIT trainings per year.

Objectives for Crisis Intervention Training

- Improve officer safety and the safety of the client and family;
- Increase access to mental health treatment, supports, and services;
- Decrease the frequency of encounters between the mentally ill and the criminal justice system;
- Increase collaboration and education between mental health and law enforcement.

Mental Health America of Southwest Ohio also collaborates with the Cincinnati Police Academy to provide continuing education units for their Citizens Police Academy. The program is designed to provide better understanding between citizens and the police through education.

AOD Training

The Board contracts with agencies for various treatment services. According to ODADAS rules; crisis intervention requires that staff providing these services be trained in CPR, first aid and de-escalation techniques. The Board only contracts with agencies certified by ODADAS; therefore, each certified agency has established compliance with certification standards. Additionally, trainings are made available quarterly for new employees to the system as well as for those staff who need to be re-certified.

F. Workforce Development and Cultural Competence

Question 9a. *Describe the Board's current role in working with the ODMH, ODADAS and providers to attract, retain and develop qualified direct service staff for the provision of behavioral health services. Does the local service system have sufficient qualified licensed and credentialed staff to meet its service delivery needs for behavioral health services? If "no", identify the areas of concern and workforce development needs.*

MENTAL HEALTH

Staff Recruitment

Research has demonstrated that persons with mental illness often experience a culture of their own and have a different perspective regarding services and programming from that of professionals. To assure that the client perspective is included in system oversight and planning, the Board continues to be committed to employing persons in recovery. Both the Board's Client Rights Officer and Coordinator of Wellness Management are or have been recipients of mental health services.

In recent years, the Board has emphasized the importance of peer support to its contract agencies and has encouraged the employment of persons in recovery in a variety of roles. While the Board cannot dictate hires for contract agencies, the Board does require that agencies be able to demonstrate the incorporation of standards of diversity management and cultural competence in all levels of planning and development of services and in resource management. Contract agencies are required to utilize written recruitment, selection, and promotion policies that are consistent with Equal Employment Opportunity requirements and conform to the agencies' affirmative action plans.

One of the Board's largest contract agencies has bilingual staff available to Spanish speaking clients as well as ACT teams for the deaf, forensic, and transitional youth populations. The Board also funds a culturally responsive program that focuses on outreach to young African American males and a program that has a team of practitioners who specialize in the needs of the elderly population.

At this time the local system appears to have less difficulty recruiting licensed and credentialed staff. Hamilton County will soon have a casino, and there may be a need for practitioners whose scope of treatment includes problem gambling. There is still a shortage of child psychiatrists. All contract agencies offer training on culturally responsive services.

AOD

The Board is committed to providing culturally competent professional development opportunities for AOD prevention, treatment, and recovery services practitioners in order to ensure a qualified professional workforce for the future. The Board plans to build workforce capacity and promote cultural competence as a core value in policy and practice in Hamilton County. The Board will support efforts to develop and maintain a skilled and culturally competent workforce for AOD prevention, treatment, and recovery services appropriate for the multi-ethnic, pluralistic, and linguistically diverse population of the County.

The University of Cincinnati, College of Education, Criminal Justice, and Human Services has a Substance Abuse Counseling bachelor's degree program which is available on campus or on-line. The convenience of on-line courses encourages advanced education for working persons. This degree program has assisted many in the workforce to advance their level of licensure.

Training programs in Hamilton County support the retention and development of treatment and prevention staff. Training sessions by the Alcoholism Council and Talbert House are offered multiple times each year to expand the skill sets and knowledge base of their staff and other community practitioners. In addition, the Alcohol and Chemical Abuse Council of Butler County, Assistance for Substance Abuse Prevention Center, Coalition for a Drug-Free Greater Cincinnati

and the Alcoholism Council formed Foundations in Prevention to provide education and support to individuals seeking the most current AOD prevention information or preparing to become Ohio Certified Prevention Specialists.

Question 9b. Describe the Board's current activities, strategies, successes and challenges in building a local system of care that is culturally competent: Please include in this response any workforce development and cultural competence issues, when applicable, related to serving the deaf and hard of hearing population, veterans, ex-offenders, problem gamblers and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.

MENTAL HEALTH

The Board disseminates all notices received of training related to cultural competence to contract agencies. In Hamilton County, more than 50% of the agencies contracted to provide mental health services to Hamilton County residents utilize the International Family Resource Center program that provides translation and interpretation services in more than 95 languages and dialects. Many agencies conduct training related to specific populations. For example, staff from Greater Cincinnati Behavioral Services' PATH program for veterans received specialized training about the culture of veterans.

In May, 2010, the Board offered training by an internationally know expert, Josepha Campinha-Bacote, related to developing cultural competence for the system of care SAMHSA grant participants. An effort is projected for FY 2012 to train the trainers in our local agencies so they can in turn train new staff to be culturally responsive. The Board sponsors free continuing education unit events on a monthly basis related to housing, probate, and the criminal justice system.

The Board recognizes that cultural competence is a continuous learning process that builds knowledge, awareness, skills, and capacity to identify, understand, and respect the unique beliefs, values, customs, language, and traditions of all persons in order to provide effective programs and services.

AOD

The Board has long standing activities/strategies to build cultural competence into AOD treatment and prevention services. The Crossroads Center's women's treatment program receives funding to provide culturally specific services to clients through the Chaney Allen Pregnant, Post Natal, and Continuum of Care programs. These programs integrate an Afro-centric worldview with evidence-based treatment practices. The programs focus on physical and sexual abuse, parenting and relationships in relation to addiction. Additionally, the Cincinnati Urban Minority Alcohol and Drug Abuse Outreach Program actively partners with local agencies to ensure that specific cultural dynamics of a group are addressed and included as part of the process. The curricula have been shown to be effective with African Americans and Appalachian women.

The number of Hispanic/Latino clients receiving treatment in Hamilton County has increased over the past several years. The Board funds a bilingual outreach worker at the Alcoholism Council who is responsible for providing interpretive services and conducting outreach to the Hispanic/Latino community. The outreach worker is a member of the Greater Cincinnati Latino

Coalition and has established a presence at the Su Casa Hispanic Resource Center. Half of her time is spent providing outreach services, and she has built a network of contacts in the Hispanic community to effectively serve as an access point for individuals and their families seeking AOD services. The Alcoholism Council is also available to other contract agencies and professional organizations for consultation and training on the Hispanic/Latino community. Outreach services have been so successful over the past three years that the Alcoholism Council is attempting to secure additional funding to expand the program to meet growing demand. The large number of undocumented individuals cannot gain full access to public funding for treatment. This has challenged the agency to build a private funding base so that these individuals can access treatment services without the need for public funds.

G. Capital Improvements

Question 10. *For the Board's local behavioral health service system, identify the Board's capital (construction and/or renovation) needs.*

The Board prioritizes capital improvements to facilities for treatment programs that are needed to meet building code regulations, enhance client health and safety, improve program efficiency, and increase program capacity.

The Board owns the Hamilton County ADAS Center, a converted psychiatric hospital that houses multiple residential and outpatient treatment programs operated by two different agencies. While recent renovations to windows and safety systems and the resurfacing of parking lots have improved the ADAS Center, additional basic infrastructure elements of the building still need work. The air conditioning chillers are at the end of their useful life and need to be replaced; the roof was installed in 1993 and should be replaced; and additional shower rooms are needed for residential programs to increase program functionality.

Hamilton County's agency-operated behavioral health treatment programs are generally located in older structures that need capital improvements in order to maintain and improve the physical environment. Examples of capital needs for programs providing services that meet the priorities of the Board are the following:

- Need for energy efficiency measures which may include replacement windows, new furnace and air conditioning, new roof, electrical upgrade, gutter work, exterior lighting, repair of handicap-accessible fixtures, carpet replacement; and
- Need for facility upgrade and renovation which may include conference rooms, storage areas, client common areas such as courtyard areas and recreation rooms.

The Board is constantly monitoring and evaluating capital needs and has put in place a continual process to identify client housing needs.

Based on the ten year Mental Health Housing Plan developed and approved by the Board and on ongoing assessment of housing needs in a variety of ways including weekly, monthly and quarterly monitoring of wait lists/access times/vacancies and on system meetings to review data from those monitoring efforts, the Board has prioritized local capital needs. The need continues for safe, clean affordable housing for mentally ill individuals. Priority populations for housing include individuals who are dually diagnosed with both mental illness and substance abuse, those identified as homeless, and transitional age youth in need of housing with common space. To the extent that funds allow,

the Board plans to continue to expand its successful housing programs through purchase and renovation of units to house the above-mentioned populations. This may be accomplished either by direct Board purchase or by Board support of purchase and renovation projects by contract agencies. The Board encourages its contract agencies to apply for state and federal funds to support these housing needs.

The Board provides ongoing assessment of crisis care services to determine system needs. It is a priority for the Board to invest mental health treatment and recovery support resources into crisis care services. As access to crisis residential beds decreases, the need remains constant.

III. Priorities, Goals and Objectives for Capacity, Prevention and Treatment and Recovery Services

- A. Determination Process for Investment and Resource Allocation
- B. Goals and Objectives: Needs Assessment Findings
- C. Goals and Objectives: Access and State Hospital Issues
- D. Goals and Objectives: Workforce Development and Cultural Competence
- E. Goals and Objectives: ORC 340.033(H) Programming
- F. HIV Early Intervention Goals
- G. Civilly and Forensically Hospitalized Adults
- H. Implications of Behavioral Health Priorities to Other Systems
- I. Contingency Planning Implications

Section III: Priorities, Goals and Objectives for Capacity, Prevention and Treatment and Recovery Services

A. Determination Process for Investment and Resource Allocation

Question 11. Describe the process utilized by the Board to determine its capacity, prevention, and treatment and recovery services priorities for SFY 2012 – 2013. In other words, how did the Board decide the most important areas in which to invest their resources?

The Board determined its behavioral health treatment and recovery services priorities by:

- Examining the results of the various needs assessments;
- Reviewing information from multiple data sources;
- Reviewing resources; and
- Obtaining feedback from clients, family members and stakeholders.

After reviewing all the input, the Board decided which areas to prioritize and in which to invest resources.

B. Goals and Objectives: Needs Assessment Findings

Question 12. Based upon the priorities listed above and available resources, identify the Board's behavioral health capacity, prevention, and treatment and recovery support goals and objectives for SFY 2012—2013.

Behavioral Health Capacity Goal

The Board's key behavioral health capacity goal is: "*Maintain access to services to all age, ethnic, racial and gender categories.*"

Strategies:

- Mental Health Access Point will continue to function as Hamilton County's front door for persons to access community mental health services.
- Recovery Health Access Center will continue to function as a primary access point for persons to access AOD services.

- The Board will monitor, with state data mart system, the demographic characteristics of persons accessing services.

Objectives:

- 100% of persons calling for services will be screened.
- 100% of persons screened and deemed appropriate for a diagnostic assessment will be scheduled for the assessment.
- 100% of the persons completing a diagnostic assessment who are determined to have SMD or SED or a substance use disorder for dependency or abuse will be connected to services.
- At least annually, the Board will review data related to demographic characteristics of persons accessing services.
- If there is a change in the pattern or trend of persons accessing services, the Board will discuss with relevant stakeholders and address appropriately.

Mental Health Prevention Priority

The Board's key mental health prevention priority is: *"Programs that decrease or eliminate stigma that are barriers to early intervention for emotional problems and mental illness."* As a result of the mental health prevention planning process Crisis Intervention Training (CIT) surfaced as a priority initiative.

Strategies:

- Contract with Mental Health of America of Southwest Ohio to provide four CIT trainings.
- Pilot a pre-booking jail diversion program through collaboration between the city prosecutor's office and the Board's committee on criminal justice/law enforcement/mental health interface.
- Support programs that encourage client involvement functions such as Mental Health Arts Collaborative, NAMI walk, suicide prevention walks and media interviews.

Objectives:

- Mental Health America of Southwest Ohio to provide a minimum of four CIT trainings to at least 100 law enforcement personnel.
- Continue implementation of the Post Booking and Jail Diversion program and measurement of its effectiveness by decrease in jail days.
- Continue involvement of individuals in recovery in system planning and training. Curricula topics that incorporate persons in recovery include client rights, client panel, role plays, and police officer shadowing.
- Continue the Mental Health Art Collaborative initiative that involves representation from adult and child serving agencies and hospitals, as well as the peer centers in Hamilton County. The Collaborative has conducted art exhibits in various community settings (museums, libraries, churches, galleries, etc.). One aspect of the exhibits is the "gallery talk," in which client artists share their experiences with mental illness and how they've used creative expression to facilitate their personal recovery. In addition to participating in the Collaborative, staff and members of Hamilton County peer centers are involved in numerous other activities designed to combat stigma.

Mental Health Treatment and Recovery Support Goal

The Board's key mental health treatment and recovery support goal is: *"Decrease homelessness"*.

Strategies:

- Continue PATH outreach program.
- Continue Board support for necessary housing services.

Objective:

- Increase PATH enrollments by 8 to 10% during the next biennium.

All Board goals are congruent with SAMHSA's National Outcome Measures. These measures are subject to data gathering procedures developed as a team effort between agencies and the Board. As much as possible these measures are used in all treatment settings for treatment and recovery goals, and in all prevention settings for prevention goals.

Prevention objectives are in the process of adjustment through continual planning efforts; however, the core principles which have emerged embrace community level collaboration with a focus on county wide messaging aimed at youth through the older adult populations.

Alcohol and Other Drug Prevention Priority

The Board's key alcohol and other drug prevention priority is: "*Programs that increase the number of persons who perceive alcohol, tobacco and other drug use as harmful.*" As a result of the alcohol and other drug prevention planning process, childhood/underage drinking populations surfaced as a priority initiative.

Strategies:

- Continue to encourage collaborative relationships between neighborhood coalitions and prevention agencies to develop a continuum of prevention messaging.
- Prevention agencies to become fully engaged in the PIPAR system.

Objective:

- Contract with agencies to serve 30,000 individuals in activities that assist in increasing perception of the harmful nature of alcohol, tobacco, and other drug use.

Alcohol and Other Drug Treatment and Recovery Services Goal

The Board's key alcohol and other drug treatment and recovery services goal is: "*Increase the number of persons who are abstinent at the completion of the program.*" Priority populations include: women, pregnant women, inter-venous drug users, clients and staff at risk of TB, and early intervention for individuals with/or at risk for HIV disease.

Strategies:

- Continue to promote the use of evidenced based practices (e.g., Cognitive Behavioral Therapy, Motivational Interviewing) with contract agencies.
- Continue to provide oversight of outcomes data through ongoing Quality Assurance meeting with treatment agencies and monitoring of BH data.

Objective:

- Demonstrate client abstinence through urine testing prior to program discharge.

C. Goals and Objectives: Access and State Hospital Issues: Access to Services

Question 13. *What are the Board's goals and objectives for addressing access issues for behavioral health services identified in the previous section of the Plan?*

MENTAL HEALTH

Prevention Services

Goal: *"Increase access for students needing prevention programs."*

Access Issue: Scheduling prevention programs for youth in school based settings that do not interfere with their education.

Objectives:

- Encourage agencies to schedule after-school prevention services.
- Participate in ongoing collaborative discussions between educators and behavioral health agencies to develop strategies that meet both their educational and behavioral health needs.

Goal: *"Provide culturally relevant prevention services."*

Access Issue: Providing prevention services to different cultural groups including Spanish speaking audiences with qualified staff and translated materials.

Objectives:

- Use qualified staff and relevant translated materials when providing prevention services.
- Conduct outreach to different cultural groups for potential referrals.

Goal: *"Increase the prevention services offered to older adult audiences."*

Access Issue: Increase requests to provide prevention services to older adult audiences, lack of resources allocated to accommodate the requests.

Objective:

- Work with Council on Aging and mental health agencies to provide prevention services to older adults.

Family and Children First Council

Goal: *"To address the access needs of children who are at risk for abuse and neglect."*

Access Issue: Needs of children at risk of abuse and neglect.

Objective:

- FCFC determined that strengthening families is a prevention strategy that shows great promise and as a result made a decision to bring the Strengthening Families framework to Hamilton County. The Consortium for Resilient Young Children was awarded a grant from FCFC to bring the Strengthening Families Initiative to western neighborhoods of Hamilton County to meet the needs of children who are at risk for abuse and neglect.

Treatment Issues

Goal: *"Increase access to CPST and pharmacologic management services for those clients who have serious or severe mental illnesses."*

Access Issue: Prevent wait lists for CPST and pharmacologic management services.

Objectives:

- Increase agency CPST staff by six for adult system and by one for child system.
- Monitor staffing for psychiatrists and advanced nurse practitioners and determine if there is a need to increase staff.

Goal: *"Increase access for persons needing hospitalization under age 65."*

Access Issue: Limited acute inpatient capacity for those adults under age 65.

Objectives:

- Form relationships with private hospitals to better serve clients under age 65.
- Work with local Veterans Administration Medical Center to coordinate inpatient care for veterans.

AOD

Treatment Services

Goal: *"Offer a continuum of care to the community in which clients are assessed and referred to clinically appropriate levels of care according to their needs in a timely manner."*

Access Issue: Lack of capacity for clients seeking treatment particularly in outpatient programming. For the AOD treatment system access issues have been studied through quarterly data reports from the Recovery Health Access Center, the central intake and assessment service provider for the county AOD system.

Objectives:

- Demonstrate quick access for client placement through Recovery Health Access Center's reports.
- Contract with agencies for services ranging from sub-acute care detoxification to out patient services.
- Develop Recovery Oriented Systems of care to fill gaps in the service continuum and provide ongoing support.

Prevention Services

Goal: *"Offer comprehensive plan of prevention strategies for youth, adults and older adults throughout Hamilton County."*

Access Issue: Target more than the youth population when addressing prevention needs and cover more neighborhoods in Hamilton County with prevention messages and community awareness. Prevention access issues have been reviewed through the strategic planning process.

Objectives:

- Build capacity throughout the county with new coalitions.
- Encourage prevention agencies to build collaborative partnerships with local coalitions so that prevention messaging and services target youth through the older adult population.

D. Goals and Objectives: Workforce Development and Cultural Competence

Question 14. *What are the Board's goals and objectives for SFY 2012 and 2013 to foster workforce development and increase cultural competence? Please discuss the areas of most salience or strategic importance to your system. What are the Board's plans for SFY 2012 and 2013 to identify, increase and assess cultural competence in the following areas: Consumer satisfaction with services and staff, staff recruitment (including persons in recovery) staff training, and addressing disparities in access and treatment outcomes. (Please reference Appendix D for ODMH definition of cultural competence.)*

MENTAL HEALTH

The Board's goals and objectives to foster workforce development and increase cultural competence: *"Explore opportunities for an increase in self-directed care, especially for those individuals who are*

actively engaged in their recovery and demonstrating significant progress and personal growth.”

Objectives:

- Identify, assess, and increase cultural competence.
- Staff recruitment: The Board and its contract agencies employ approximately 70 self-identified persons in recovery in a variety of roles (CPST staff, project coordinator, client rights officer, peer support specialist, evaluation, etc.) and service programs/settings (ACT and PATH teams, supported employment, housing support, administration, and peer centers). These individuals are trained in recovery-oriented service delivery, which emphasizes cultural competence. Fifteen staff/members of the Recovery Center and Warmline are certified peer specialists. As part of their certification, these individuals received significant training on various aspects of culturally competent service delivery. While most of these individuals are working at one of the peer centers, approximately a third of them are now working at community mental health agencies.

AOD

The Board's AOD goal to foster workforce development: *“A workforce of sufficient size and competence will be available and employed to serve the behavioral healthcare needs of Hamilton County.”*

Objectives:

- Assist in information dissemination regarding trainings and educational opportunities for workers in the behavioral services system.
- Construct collaborative relationships with institutions of higher education to assist in further education of practitioners.

The Board's AOD goal for cultural competence: *“Identify, increase, and assess cultural competence within the AOD system.”*

Objectives:

- Enable every member of the Board's system workforce to attend cultural competence training at a reduced cost.
- Commit to operate with cultural competency and enhance these skills through contracting with agencies.
- Assess agency cultural competence through the analysis of behavioral health module data and client satisfaction surveys.

E. Goals and Objectives: ORC 340.033(H) Programming

Question 15. *To improve accountability and clarity related to ORC 340.033(H) programming, ADAMHS and ADAS Boards are required to develop a specific goals and objectives related to this allocation.*

Goal: *“Streamline access, assessment, case management, and service coordination for families involved in the child welfare system.”* Historically the Board has prioritized line item 484 funds for programs that increase the number of clients involved in the child welfare system who access alcohol and other drug services. During FY 2009, and FY 2010, the Board and Hamilton County Job and Family Services planned and implemented an integrated project to serve child welfare system clients. The new project, Family Access to Integrated Recovery (FAIR) was formed to manage access to AOD and mental health services for families involved with the child welfare system. Hamilton County Job and Family Services funds are used to support FAIR and serve JFS clients. Child welfare system clients are assessed and case managed by the FAIR project at Central Clinic, a contract agency.

Objectives:

- Improve the existing system of care with a single point of entry for families and JFS caseworkers.
- Improve outcomes for child welfare families involved in AOD services, specifically measuring abstinence at program completion.

F. HIV Early Intervention Goals

Question 16. *ADAMHS and ADAS Boards receiving a special allocation for HIV Early Intervention Services need to develop a goal with measurable objective(s) related to this allocation.*

The key AOD treatment and recovery services goal is: “Increase abstinence for persons testing or at risk of testing positive for HIV/AIDS.”

Objectives:

- Target programs that increase the number of clients who perceive AOD use as harmful.
- Build awareness and knowledge in the community of HIV/AIDS and the effects of alcohol and other drug use.

G. Civily and Forensically Hospitalized Adults

Question 17. *ADAMHS and CMH Boards only: Address how the Board will meet the needs of civilly and forensically hospitalized adults, including conditional release and discharge planning processes. How will the Board address the increasingly high number of non-violent misdemeanants residing in state hospitals?*

Board staff and our Forensic Monitor meet monthly with the forensic department at Summit Behavioral Healthcare to address issues pertinent to patients under the legal status of Not Guilty by Reason of Insanity and Incompetent to Stand Trial-Court Jurisdiction. These meetings are instrumental in ensuring that identified risks are adequately addressed between the community and hospital while developing the patients’ Conditional Release Plans. The Forensic Monitor is an integral part of these meetings and provides information and education to the CPST staff and treatment teams regarding the role of the criminal courts.

H. Implications of Behavioral Health Priorities to Other Systems

Question 18. *What are the implications to other systems of needs that have not been addressed in the Board’s prioritization process?*

Even with the Board’s prioritization process, there are not enough resources to meet client needs. So system issues and client populations will be identified that will not be addressed in an effective manner.

Despite that, helping individuals access needed AOD services is a primary focus. To that end we continue to collaborate with agencies in efforts to remove barriers, leverage scarce resources, seek other funding opportunities, and promote stigma reduction whenever possible.

I. Contingency Planning Implications

Question 19. *Describe how priorities and goals will change in the event of a reduction in state funding of 10 percent of the Board’s current annual allocation (reduction in number of people served, reduction in volume of services, types of services reduced, impact on monitoring and evaluation etc). Please identify how this reduction in services affects specific*

populations such as minorities, veterans and "high-risk" groups.

MENTAL HEALTH

The Board's Trustees established basic priority populations of children with a severe emotional disturbance and adults with a serious mental disability. In the event a reduction occurs, services will first be reduced with the non priority populations. If the reduction is severe, it will affect all populations and impact all services. There would need to be a major reduction in services to all.

AOD

In the event of a reduction of funds for the coming fiscal years, the priorities and goals of AOD programming will not change. Programming for high risk groups will be impacted due to the fact that decreased funding results in fewer clients served. The Board is currently reviewing strategies around how to implement changes in the system of care that could better support treatment efforts without increasing costs. The Board and agencies are increasing knowledge of the Recovery Oriented Systems of Care model for service delivery. Each year, the Board carefully reviews expenditures, agency requests for additional funds as well as any funding that was underutilized so as to make the most efficient use of resources.

IV. Collaboration

- A. Key Collaborations**
- B. Customer and Public Involvement in the Planning Process**
- C. Regional Psychiatric Hospital Continuity of Care Agreements**
- D. County Commissioners Consultation Regarding Child Welfare System**

SECTION IV: COLLABORATION

A. Key collaborations

Question 20. What systems or entities did the Board collaborate with and what benefits/ results were derived from that intersystem collaboration? ADAMHS and CMH Boards should include discussion regarding the relationship between the Board and private hospitals.

MENTAL HEALTH

Ohio Department of Rehabilitation and Corrections (ODRC)

Since 2003, the Board has had in place a Forensic ACT team (FACT) which at any given time serves about fifty SMD high-risk clients recently released from Ohio's prisons. The tight collaboration among the Ohio Department of Rehabilitation and Correction staff, local parole personnel, Mental Health Access Point staff, Greater Cincinnati Behavioral Health Services (GCBHS) staff and a Board representative results in very good outcomes for these clients. A combination of monthly meetings where staff from all the above entities are present to discuss specific troublesome cases and larger policy issues as well as local weekly intake meetings to review newly referred cases greatly contributes to the high level of communication required to prevent cases from falling apart. Despite our best efforts, some clients do return to substance use and/or discontinue their psychiatric medications and decompensate. Board clinical staff who also work with the Probate Court can quickly assist GCBHS in returning clients to acute inpatient beds located in one of Cincinnati's private hospitals. The age of the clients, whether or not they have insurance, and their general physical condition determine which hospital is chosen. GCBHS's FACT team continue to focus on quick access to benefit status information for inmates about to leave prison, access to prison medical records, and the problem of finding local housing for sex offenders.

Summit Behavioral Healthcare

Consistency in Board presence within the state hospital has resulted in improved collaboration among the hospital, the Board, and the community agencies. A crucial aspect of this collaboration has been to assist community agencies in understanding the infrastructure and operations of the state hospital, utilizing designated staff to act as liaison between the hospital and the community. This arrangement has improved the Board's ability to problem solve on the system level as well as establish procedural changes that have effectively enhanced service delivery. Collaboratively working on system barriers to discharge such as residency issues, specialized housing needs, and access to medication has improved the Board's ability to effectively manage our bed days.

A variety of collaborative activities takes place among the Board, its agencies and the state hospital that enables us to operationalize critical elements of the Continuity of Care Agreement. Several collaborative meetings are held among the Board, the hospital and community agencies in order to discuss admission, treatment, and discharge planning for Board clients. An example of these activities includes the weekly Utilization Review meeting. The purpose of this meeting is to promote and facilitate conjoint planning and treatment between the state hospital and community mental health system by ensuring that patients' needs are met, minimizing lengthy hospital stays and promoting community based treatment options. This meeting addresses new admissions to the hospital, as well as provides the Board and CPST agencies updates on the progress and course of treatment of their inpatient clients. CPST agencies ensure that regular contact is maintained with clients assigned to them in adherence with expected standards of the agreement. The Board's representative and agency CPST staff attend treatment team meetings in order to address service coordination issues to avoid problems with discharge planning. However, in light of the recent language changes, Medicaid elevation, and service limits, these roles and collaborations are being reviewed and may change over the course of the year. Also the Continuity of Care Agreement will be reviewed and revised as needed.

Children – Child Welfare

MindPeace

This is a partnership of mental health professionals and agencies that is committed to improving access to school based mental health services for all students. The partnership assists schools, agencies, students, and their families in addressing students' behavioral health needs that may impact school success.

Benefits/results include:

- 44 out of 55 Cincinnati Public Schools have an identified mental health agency that provides school based mental health services to their students and families.
- Refined data collection tool and mechanism for the reporting of treatment and prevention access numbers for Cincinnati Public School students and families.

Growing Well

This is a collaborative of local child-serving agencies and health professionals who are interested in creating an integrated system that offers access to quality health and wellness services in Cincinnati Public Schools.

Benefits/results include:

- Improved access to behavioral and physical health services that promote physical and mental wellness for optimal learning in Cincinnati Public Schools.
- Developing pilots to address the shortage of child psychiatrists through the use of tele-psychiatry and a model to train and support pediatricians in their treatment of youth with ADHD.

Cincinnati Public Schools

Out of District Panel

This is a collaborative of representatives from Cincinnati Public Schools, Job and Family Services, the Board, and a family advocate who are committed to ensuring all available resources have been explored to maintain a child in Cincinnati Public Schools before recommending placement outside of the district.

Benefits/results include:

- Out of District Panel facilitates improved understanding of systems, identification of resources, and planning that addresses barriers to students' educational success.

Special Education Workgroup

This is a collaborative of Cincinnati Public School representatives and child serving agencies (legal, child welfare, and behavioral health) invested in problem solving system barriers and identifying resources for students with special needs in order to improve their overall well-being and academic outcomes.

Benefits/results include:

- Development of strategies to address the barriers to the educational success of students in foster care.
- Training of practitioners on how their information is integrated into the new Individualized Education Plan.

Structured and Transitional Resources in Diverse Educational Settings (STRIDES)

Cincinnati Public Schools designed STRIDES to provide individualized, instructional, and collaborative planning that infuses emotional and behavioral components within the learning environment to better address the needs of the whole child. In 2004, Talbert House entered into a partnership with Cincinnati Public Schools through Board funding to provide behavioral health supports and services within the STRIDES classroom. In 2007, and 2008, Talbert House redesigned its approach to include a wraparound philosophy to improve the lives and academic outcomes for youth and families with serious emotional and/or behavioral disturbances.

Benefits/results include:

- Combined educational and behavioral health interventions and support to prevent youth from being referred to educational placements outside of their districts and to improve transitions between classroom settings;
- 62 youth served through STRIDES program in FY 2010.

Intersystem Service Collaboration Committee

This is a collaborative committee comprised of representatives from Job and Family Services, Developmental Disabilities Services, the Board, Juvenile Court, Cincinnati Public Schools, Legal Aid, and the Hamilton County Educational Services Center that offers assistance to multi-system youth and families in need of more intensive service coordination. The committee provides a forum for youth, families, and agencies to problem solve system barriers and gaps through case consultation, planning, and information sharing.

Benefits/results include:

- Strengthened service coordination for multi-system youth (ages 0 to 22) and their families.
- Updated Hamilton County Service Coordination Mechanism plan.

Greater Cincinnati Healthcare Access Project

This is a collaborative of representatives from legal, hospital, advocacy, and behavioral health entities that addresses issues of access to quality health care.

Benefits/results include:

- Held community events to enroll eligible persons into Medicaid.
- Held forums to provide information and resources on healthcare reform.

Criminal Justice System

Post Booking and Jail Diversion Program (PB&J)

- Collaborative partnership between the city prosecutor and mental health system.
- A diversion program for SMD adults with misdemeanor charges.
- Program is voluntary; length of program varies from 2 to 6 months.
- Targets SMD clients already connected to CPST services and not eligible for the misdemeanor Mental Health Court.
- Clients are required to continue to work with their CPST staff; and they do not need to appear in court unless indicated.
- If clients comply with the program, at end of the 2 to 6 months their charges are dismissed.
- Clients receive a certificate at end of program and a PB&J lanyard.

Benefits/results include:

- Almost 100% of participants attend their arraignment. (Average show rate for arraignment is 50% for non program participants).
- CPST staff are attending the arraignment 100% of the time as well and completing the required monthly report that is sent to the city prosecutor.
- Clients are re-engaging in services.
- Clients have given positive feedback regarding this program.
- CPST staff have provided positive feedback regarding this program.
- Program is designed for the clients and meets them where they are currently in their treatment.

Misdemeanor Mental Health Court

- Collaborative partnership with the courts, probation, mental health, and AOD agencies.
- Target population is SMD clients.
- One year program, clients on probation, required to meet with Mental Health Court judge once a month.
- Intensive CPST services.
- Voluntary program.

Benefits/results include:

- Several steps to enter the program.
- Clients do not want to be on probation.
- Length of program is too long.
- Program is too difficult for clients who have a serious mental disorder.
- Partnership with agencies, court, and probation is critical for the success of the program and the client.
- Number of referrals high; however, limited number of participants enrolled for a variety of reasons (e.g., client refused, legal reasons, did not meet diagnostic criteria).

Solutions:

- Explore structure and current environment of the Mental Health Court to determine if needs of SMD clients are being met. For the general public, jail stays are shorter and individuals are arrested/released within hours on misdemeanor charges; probation time for Mental Health Court participants is significantly longer than imposed jail time.

- Explore eligibility requirements to allow the program to serve those high risk SMD clients who are cycling in and out of the jail and hospitals.

Felony Mental Health Court

- Collaborative partnership with the courts, probation, mental health, and AOD agencies.
- Target population is SMD clients.
- 1 to 3 year program, on probation, required to meet with Mental Health Court judge once a month.
- Intensive CPST services.

Benefits/results include:

- Length of program too long.
- Overall partners are very happy with the Felony Mental Health Court.
- Referrals high and appropriate.

Criminal Justice/Law Enforcement/Mental Health Interface

- Monthly committee that includes representatives from mental health, criminal justice, hospital, court, law enforcement, and homeless coalition.

Benefits/results include:

- Committee acquired a grant to develop the Post Booking and Jail Diversion Program.
- Committee helped develop a data sharing program between pretrial services and Mental Health Access Point, front door to community mental health system.
- Committee developed jail orientation training.

High Risk Committee

- Monthly committee that includes representatives from CPST agencies, pretrial, Court Clinic, Summit Behavioral Healthcare, University Hospital, and Mobile Crisis.

Benefits/results include:

- Opportunity for agencies to present high risk cases to the group of experts to explore alternate treatment interventions, coordinate care, and increase collaboration.
- With release of information, police are invited to strengthen the coordinated plan.
- Participants are forging strong working relationships and learning of possible alternatives for their clients.

Cincinnati Police Department/Board Collaboration

- This is a partnership with the Cincinnati Police Department that works collaboratively with high risk clients who have frequent arrests, limited jail time.

Benefits/results include:

- Increased communication, ability to coordinate a plan of intervention.
- Increased understanding and education between the Police Department and mental health agencies.
- Police officer encountered a disheveled individual lying on the street, contacted mental health agency and the CPST staff responded immediately to provide the client with food and needed medication.

Juvenile Mental Health Court

- Collaboration with Juvenile Court, Probation Department, and Lighthouse Youth Services.
- Mental Health Court for both diversion program and felony court.
- Target 80 youth per year.
- Provide an evidenced-based practice: Family Functional Therapy.

Benefits/results include:

- No youth who completed the program has ever been sent to the Department of Youth Services.
- High satisfaction rate with families and youth.

AOD

Adult Criminal Justice

Organizations:

- Drug Court
- Adult TASC
- Court Clinic
- IDAT

Benefits/results:

- Clients' needs are identified and linked to needed services.

Juvenile Criminal Justice

Organizations:

- Juvenile Court Probation Department
- Department of Youth Services
- Juvenile TASC

Benefits/results:

- Clients are assessed, placed in services, and case managed with the collaboration of criminal justice necessities and treatment.

Job and Family Services

Organization:

- Family Access to Integrated Treatment

Benefits/results:

- Improved access to treatment and collaboration for child welfare clients and their families.

Homeless Advocates

Organizations:

- Continuum of Care for the Homeless
- Partnership Center
- Homeless Outreach

Benefits/results:

- Homeless clients' access to treatment is expedited and case managed.
- Homeless addicts are identified and linked to services such as detoxification and housing.

Law Enforcement

Organizations:

- City of Cincinnati Police
- Hamilton County Sheriff's Department

Benefits/results:

- The Cincinnati Police Department was active in Red Ribbon planning process, thus contributing to AOD prevention in the community.

County School Systems

Organizations:

- Cincinnati Public Schools
- North College Hill Schools
- Forest Hills Schools

Benefits/results:

- Schools participated in Red Ribbon Planning Committee and the event.
- Working towards a county wide awareness of keeping youth drug free.

B. Customer and Public Involvement in the Planning Process

Question 21. Beyond regular Board/ committee membership, how has the Board involved customers and the general public in the planning process (including needs assessment, prioritization, planning, evaluation and implementation)?

MENTAL HEALTH

The Board has and will continue to involve customers and the general public in the planning process through a variety of mechanisms including focus groups, targeted work groups, task forces, and surveys.

For example, focus groups have been and will be used in assessing needs and with planning efforts related to transitional age youth, persons who are homeless, and persons with involvement in the criminal justice system.

Also, in the summer of 2010, three task forces were formed to complete an environmental scan of resources available for transitional age youth. The groups were comprised of youth, family members, general public, and persons representing child welfare, juvenile justice, developmental disabilities, social services agencies, schools, business, and Legal Aid. The groups reported on the gaps in the system and made recommendations for additional supports/services that were incorporated into the SAMHSA initiative strategic plan.

AOD

The Board regularly uses focus groups for many purposes to gain input from interested parties and the community at large. During Suboxone planning there were two valuable focus groups, one for clients and one for family members. The information gathered from the client focus group was helpful in determining barriers to access and other issues for clients seeking treatment, best practice standards for treatment and physicians, as well as identifying training needs for practitioners.

Client and referral source satisfaction surveys, parts of ODADAS Program Certification Standards,

are annually reported to the Board. These surveys have been powerful internal tools for agencies to use the feedback in the quality assurance process. Data from these surveys provides information for use in treatment and prevention planning.

Public information is also gained through the epidemiological project, Ohio Substance Abuse Monitoring Network. The Cincinnati affiliate of this organization studies substance abuse in a variety of ways primarily using client focus group data. Price, prevalence, and potency are a few of the items studied locally and state-wide by the Network.

C. Regional Psychiatric Hospital Continuity of Care Agreements

Question 22. *ADAMHS/CMH Boards Only: To ensure a seamless process to access and improve continuity of care in the admissions, treatment and discharge between state hospitals and community mental health providers, describe how Continuity of Care Agreements have been implemented and indicate when and how training was provided to pre-screening agency staff. Please indicate the number of system staff that has received training on the Continuity of Care Agreements.*

Although we have a Continuity of Care Agreement, it is currently in the process of revision, so some of the processes cited below may change. The Continuity of Care Agreement provides the contractual framework in which the Board and its community agencies interact with the state hospital in efforts to create an atmosphere of cooperation and collaboration. The Continuity of Care Agreement outlines specific responsibilities that Boards and Summit Behavioral Healthcare adhere to in their respective roles of planning, funding, monitoring, evaluating, and contracting for mental health services for the clients in their county.

The hospital discharge collaborative meeting is an example of the Board's efforts to operationalize the Continuity of Care Agreement. This meeting which involves community agencies, the hospital social work director, and Board liaison focuses on disseminating information and improving communication between the hospital and community at the CPST staff level. Issues and concerns are discussed in an effort to maintain continuity of care from the inpatient setting to the community. Clients in the hospital maintain priority one status to a variety of special housing resources such as traditional step down beds in our residential facilities, some of which are located out-of-county. This effort provides clients with the best possible chance for successful return to the community.

Quarterly CPST orientation trainings are held at Summit Behavioral Healthcare to provide new CPST staff information pertinent to the Continuity of Care Agreement, understanding how the hospital operates, and introducing them to departmental staff. Each CPST staff is provided a manual which describes the various hospital departments, patient privilege levels, an explanation of the different legal status levels, emergency procedures within the hospital, a listing of key unit staff and treatment team meetings. CPST line staff and their supervisors are invited to these orientation meetings. Over 50 CPST line staff and their supervisors have been trained.

The Board's Clinical Services unit staff under the supervision of the Systems Chief Clinical Officer do all prescreens triggered by the Probate Court affidavit process for persons who require inpatient care in our community and state hospitals.

D. County Commissioners Consultation Regarding Child Welfare System

Question 23. ADAMHS/ADAS Boards Only: Describe the Board's consultation with county commissioners regarding services for individuals involved in the child welfare system and identify monies the Board and county commissioners have available to fund the services jointly as required under Section 340.033(H) of the ORC.

The Hamilton County JFS and the Board began a planning process in 2009, to integrate two existing programs that were serving JFS involved clients with behavioral health issues. One program served the mental health needs of JFS clients and the other program provided AOD services. The result, Family Access to Integrated Recovery, is a single integrated system of care with improved administrative efficiencies and clinical effectiveness. The goals of this effort are to improve outcomes for JFS involved clients, reduce the number of administrative processes families have to engage with to obtain the services, and provide a financial savings. The Board has used line item 484 funds for this project as well as funds provided by JFS with the county commissioners' approval.

V. Evaluation of the Community Plan

- A. Description of Current Evaluation Focus
- B. Measuring Success of the Community Plan for SFY 2012-2013
- C. Engagement of Contract Agencies and the Community
- D. Milestones and Achievement Indicators
- E. Communicating Board Progress Toward Goal Achievement

SECTION V: EVALUATION OF THE COMMUNITY PLAN

A. Description of Current Evaluation Focus

Question 24. Briefly describe the Board's current evaluation focus in terms of a success and a challenge (other than funding cuts) in meeting the requirements of ORC 340.03(A)(4). Please reference evaluation criteria found in Appendix C with regard to your discussion of successes and challenges with measuring quality, effectiveness and efficiency. Note: An inability to audit services funded by Medicaid does not preclude examination and appraisal (evaluation) of those services in terms of their quality, effectiveness and efficiency.

MENTAL HEALTH

The Board continues to conduct quarterly analyses of data derived from the Ohio Consumer Outcomes/Ohio Youth Scales effort and the MACSIS Diamond claims database using the results from these analyses to develop a quarterly report for mental health services. Such analyses would not be possible without sufficiency of data, and as such, the Board has worked closely over the past nine years with contract agencies to ensure that outcomes data derived through the aforementioned effort is sufficient in both quantity and quality to permit these analyses.

Following is a listing and brief explanation of the information generated and contained in the quarterly reports issued by the Board and provided to each of its mental health contract agencies:

- System and agency-level reviews of clients served and clients represented by outcomes in the analyses contained in the report for Adult Consumer administrations and Youth Parent administrations.
- An agency profile (graphic and tabular) at the beginning of each section of the report detailing the composition of clients served by each agency based upon diagnostic category. Provision of this information allows for agency-by-agency comparisons and better informs agencies as to who their "peer" agencies are when reviewing results.

Adult Client Analyses

- The percentage of clients exhibiting improvement in the area of symptom distress over the course of an episode of care based upon their response to the Adult Consumer version of the Ohio Consumer Outcomes survey over two administrations. Results are provided for both system- and agency-level findings.

- The percentage of clients exhibiting improvement in overall quality of life as measured by the overall quality of life scale for the Adult Consumer version of the Ohio Consumer Outcomes survey completed over two administrations during the aforementioned period of time. Results are provided for both system- and agency-level findings.
- The percentage of clients reflecting improvement in financial quality of life as measured by that subscale contained in the Adult Consumer version of the Ohio Consumer Outcomes survey completed over two administrations during the aforementioned period of time. Results are provided for both system- and agency-level findings.
- The percentage of clients exhibiting an improvement in physical health as reported by a response to this single item contained in the Adult Consumer version of the Ohio Consumer Outcomes survey completed over two administrations during the aforementioned period of time. Results are provided for both system- and agency-level findings for those clients reporting less than optimal physical conditions at time1.
- The percentage of clients indicating an improvement in symptom recognition as reported by a response to this single item contained in the Adult Consumer version of the Ohio Consumer Outcomes survey completed over two administrations during the aforementioned period of time. Results are provided for both system- and agency-level findings for those clients reporting less than optimal symptom recognition at time1.
- The percentage of clients reporting respectful treatment by their provider through the analysis of an item designed for this purpose and contained in the Adult Consumer version of the Ohio Consumer Outcomes survey. Results are provided for both system- and agency-level findings for all respondent clients over two administrations during the aforementioned period.
- The percentage of clients reporting their medication concerns are adequately/appropriately addressed at the time of the second administration of the Adult Consumer version of the Ohio Consumer Outcomes survey. Results are provided for both system- and agency-level findings for all respondent clients over two administrations during the aforementioned period.
- The percentage of clients reporting the acquisition of employment as reported by a response to this single item contained in the Adult Consumer version of the Ohio Consumer Outcomes survey completed over two administrations during the aforementioned period of time. Results are provided for both system- and agency-level findings.
- The percentage of clients who experience favorable change in either or both of symptom distress or quality of life as measured by those two scales over two administrations during the aforementioned period of time. Results are provided for both system- and agency-level findings.
- Differences, if any, in findings on all of the aforementioned outcomes indicators based upon the race of the client.

- Differences, if any, in findings on all of the aforementioned outcomes indicators based upon the gender of the client.

Youth Parent Analyses

- The parent version of the instrument is analyzed for the parent's perceptions related to problem severity and functioning. Results are provided for both system- and agency-level findings.
- The percentage of parents reporting an improvement in the ability to deal with their child's problems as measured through the parent version of the Ohio Scales over the course of an episode of care. Results are provided for both system- and agency-level findings.
- The percentage of parents reporting an improvement in satisfaction in their relationship with their child as discerned through the parent version of the Ohio Scales over the course of an episode of care. Results are provided for both system- and agency-level findings.
- The percentage of parents reporting a reduction in stress as reported through the parent version of the Ohio Scales over the course of an episode of care. Results are provided for both system- and agency-level findings.
- The percentage of parents reporting increased optimism for their child's future as reported through the parent version of the Ohio Scales over the course of an episode of care. Results are provided for both system- and agency-level findings.
- The level of satisfaction with services received as reported by parents through the parent version of the Ohio Scales over the course of an episode of care. Results are provided for both system- and agency-level findings.
- The level of engagement parents experienced in the treatment planning process as reported by parents through the parent version of the Ohio Scales over the course of an episode of care. Results are provided for both system- and agency-level findings.
- The extent to which parents report feeling heard and valued during the treatment planning process as reported by parents through the parent version of the Ohio Scales over the course of an episode of care. Results are provided for both system- and agency-level findings.
- Similar to the youth client section, the parent section contains analyses that reflect progress achieved through a combining of the problem severity and functioning measures. Results are provided for both system- and agency-level findings.
- Differences, if any, in findings on all of the aforementioned outcomes indicators based upon the race of the client.
- Differences, if any, in findings on all of the aforementioned outcomes indicators based upon the gender of the client.

AOD

In regard to AOD services, the Board focuses upon two specific NOMs as indicators of service effectiveness: 1) abstinence; and 2) criminal justice involvement as measured by arrests. These two measures were selected for their consistency with federal and state requirements and because they serve as an opportunity to develop consistent practices in methods and measures among agencies under contract with the Board. Following are the guidelines established for collecting data on these two measures:

AOD Abstinence Measure: Data Collection Plan

Indicator: Abstinence

Measurement Statement: All clients receiving AOD treatment services funded through the Board will be assessed through a chemical test within 30 days of case closure to confirm abstinence at time of discharge.

- What data will be collected? Number of cases closed by disposition of test: negative for chemical use; positive for chemical use; unknown (unable to obtain test from client).
- When will data be reported? Annually, on or before July 31 following the end of the fiscal year.
- Who will collect the data? Agency personnel.
- How will the data be collected? Designated agency personnel will conduct test and document result in client case record.
- How will the data be analyzed? Determine from all cases closed during the fiscal year the number of clients having had the required test and the result for that test.
- How will the data be reported? The agency will provide a summary report illustrating the total number of cases with a negative (abstinent) chemical test finding, the number with a positive (not abstinent) chemical test finding, and the number unknown (agency unable to perform test). These three (negative, positive, and unknown) should sum to the total number of case closures for the fiscal year.

AOD Criminal Justice Measure: Data Collection Plan

Indicator: Criminal Justice Involvement

Measurement Statement: All clients receiving AOD treatment services funded through the Board will be assessed to determine number of arrests within the 30 day period prior to admission and again at discharge.

- What data will be collected? Number of arrests by client within 30 days prior to date of admission and again prior to date of discharge (consistent with collection of Behavioral Health Data as required by ODADAS).
- When will data be reported? Annually, on or before July 31 following the end of the fiscal year.
- Who will collect the data? Agency personnel.
- How will the data be collected? Designated agency personnel will use client self-report to determine. Agency personnel will contact probation or parole officers of those clients under justice system supervision to confirm. Findings for each client will be documented in the client case record.
- How will the data be analyzed? Determine from all cases closed during the fiscal year the number of arrests, by client, experienced for the aforementioned time periods.

- How will the data be reported? The agency will enter the data into the Behavioral Health data module as required by ODADAS for all clients with closed cases during the fiscal year no later than July 31 following the fiscal year. The Board will develop a summary report based upon this data following the close of the fiscal year.

The Board routinely analyzes data on service provision patterns utilizing both internal data systems as well as the state's MACSIS data mart. Analyses include average service amounts by service type and differentiate by diagnostic and demographic characteristics. Reports generated through these analyses are shared with agency leadership to facilitate system planning. This provides agencies with an understanding of their service provision patterns relative to other agencies and other Board areas thereby allowing them to address issues that might surface through this reporting. However, it is important to recognize that Boards in Ohio do not have the authority to directly intervene on service provision issues for Medicaid-funded services.

Additionally, the Board analyzes data to discern the costs of service by unit as well as by client and performs these analyses at the client, agency, and system level for comparison purposes. These analyses are further refined by differentiating findings by funding source (e.g., Medicaid vs. non-Medicaid). It is expected that these analyses will be significantly impacted by the state's adoption of standardized rates in FY 2011.

The Board has realized considerable success with its application of the Ohio Consumer Outcomes/Ohio Youth Scales program. In FY 2009, with the backing of eight years of data collection activity, the Board implemented a performance improvement initiative that provided agencies with a financial incentive for evidencing gains in client outcomes using the aforementioned measures. At the time of this writing the Board has issued two years of incentive payments to agencies based upon their respective demonstration of the effectiveness of their treatment services. Those funds go to enhance services and to encourage use of the most efficacious treatment practices available. Agencies have done an exemplary job in enhancing their performance between the two fiscal years, exhibiting a 35 percent increase in the number of cases reflecting the necessary two administrations to permit the analyses and a 33 percent increase in the number of cases evidencing an improvement in condition.

The Board has also been quite successful in adopting more advanced statistical models for evaluating efficacy of particular programs. A difficulty with such efforts when using non-experimental data is encountered due to the inability to control bias introduced as the result of the selection process. A technique known as propensity score matching, which utilizes logistic regression in the development of matching comparison subjects, corrects for the selection biases when making estimates of the effect of treatment, permitting more accurate assessments of those effects. The Board has introduced this method during the past year in several studies attempting to discern whether particular programs exhibit better, worse, or similar outcomes for those involved, relative to those engaged in other treatment interventions.

Certainly these efforts have not been without challenges, including the state's decision to terminate the Ohio Consumer Outcomes program during FY 2008, and the most recent (November, 2010) decision to replace the system with a much reduced alternative that is completely disparate from the previous state-mandated system. Introduction of the new mandate requiring mental health agencies to adopt the state's BH system (OH-BH) will expectedly result in considerably more administrative effort in collection and data entry while yielding a data set that is much more limited than the Ohio

Consumer Outcomes. According to the ODMH Numbered Advisory Memorandum dated November 12, 2010, the OH-BH system will be modified to include only four client-level National Outcome Measures consisting of employment status, school suspensions, living situations, and criminal justice involvement. These measures are severely limited by their age specificity (e.g., employment status is not particularly meaningful for children), and further limited by the decision to reduce reporting to SMD/SED populations only, when half of publicly-funded clients in the State of Ohio are not SMD/SED.

B. Measuring Success of the Community Plan for SFY 2012-2013

Question 25. *Based upon the Capacity, Prevention Services and Treatment and Recovery Services Goals and Objectives identified in this Plan, how will the Board measure success in achieving those goals and objectives? Identify indicators and/or measures that the Board will report on to demonstrate progress in achieving each of the goals identified in the Plan.*

Behavioral Health Capacity Goals

Goal: *“Maintain access to services to all age, ethnic, racial and gender categories.”*

Objectives: Mental Health Access Point (MHAP) serves as the Board’s front door for mental health services while Recovery Health Access Center (RHAC) serves as the Board’s front door for alcohol and other drug services. 100 percent of individuals seeking assistance through Board-contracted front doors will be screened to determine whether they are appropriate for a diagnostic assessment.

Measure: MHAP and RHAC will issue monthly reports to the Board reflecting the number of individuals contacting them for a screening and whether the screening was completed in each of those cases.

Objectives: 100 percent of those screened and deemed to be appropriate for a diagnostic assessment will be scheduled for a diagnostic assessment.

Measure: MHAP and RHAC will issue monthly reports to the Board reflecting the number of individuals screened and found to be in need of a diagnostic assessment and whether the diagnostic assessment was completed in each of those cases.

Objectives: 100 percent of those determined through diagnostic assessments to be appropriate for service will be connected to an agency following the completion of the diagnostic assessment.

Measure: MHAP and RHAC will issue monthly reports to the Board reflecting the number of individuals for whom a diagnostic assessment was completed indicating a need for intervention and whether the connection for service was established in each of those cases.

The Board will compose an annual report detailing differences in clients served by the demographic features of age, race, ethnicity and gender. Changes that appear to be significant will be brought to the attention of MHAP and RHAC and the community of agencies to determine if intervention is necessary.

Prevention Goals

AOD Goal: *“Programs that increase the number of persons who perceive alcohol, tobacco and other drug use as harmful.”*

Objectives: Contract agencies providing AOD prevention services will conduct pre- and post-exercise surveys to ensure that participants are impacted in the manner expected.
Measure: Contract agencies will report survey findings to the Board on a quarterly basis.

Mental Health Goal: *“Programs that decrease or eliminate stigma that are barriers to early intervention for emotional problems and mental illness.”*

Objectives: 100 law enforcement personnel will be trained through four CIT trainings during the year.
Measure: Mental Health America will report at year’s end on the total number of trainings and total number of law enforcement personnel having participated in those trainings.

Objectives: The Post Booking and Jail Diversion (PB&J) program will continue to be implemented and its effectiveness measured by a decrease in jail days.
Measure: PB&J program will report annually on effectiveness.

Objectives: Continued involvement of individuals in recovery in system planning and training. Curricula topics that incorporate persons in recovery include client rights, client panel, role plays, and police officer shadowing.
Measure: Mental Health America will provide updated curricula related to programming on an annual basis.

Objectives: Continue the Recovery Center and Mental Health Arts Collaborative’s efforts to combat stigma through their provision of a venue for client artists to connect with the larger community.
Measure: The Recovery Center will report on art activities annually.

Treatment and Recovery Support Goals

AOD Goal: *“Increase the number of persons who are abstinent at the completion of the program.”*

Objectives: Contract agencies providing AOD treatment services will investigate abstinence through inquiry and use of a confirmatory chemical test conducted within 30 days of case closure.
Measure: Contract agencies will report abstinence findings for closed cases at the end of each quarter.

Mental Health Goal: *“Decrease homelessness.”*

Objectives: Continue PATH Outreach program
Measure: PATH Outreach program will report annually on number of individuals enrolled in the program.

C. Engagement of Contract Agencies and the Community

Question 25a. *How will the Board engage contract agencies and the community in evaluation of the Community Plan for behavioral care prevention and treatment services?*

The System Performance unit of the Board maintains a schedule of monthly and quarterly quality assurance and outcomes meetings that serve as a forum for the development of initiatives and associated measures for evaluating the efficacy of interventions.

Additionally, communication between Board staff and agencies is frequent and purposeful. Board staff are quick to recognize and praise agency progress and also quick to voice concern and offer assistance when progress does not occur. A variety of forums is available to communicate goal achievement. Quality assurance meetings, targeted phone calls, agency meetings, and written letters are used most often.

D. Milestones and Achievement Indicators

Question 25b. *What milestones or indicators will be identified to enable the Board and its key stakeholders to track progress toward achieving goals? What methods will the Board employ to communicate progress toward achievement of goals?*

See response to each goal under question 25.

E. Communicating Board Progress Toward Goal Achievement

Question 25c. *What methods will the Board employ to communicate progress toward achievement of goals?*

The Board holds regular monthly and quarterly quality assurance and outcomes meetings with all contract agencies. Participants receive information on progress during these meetings. A written meeting synopsis is dispatched to the Hamilton County community of agencies following these meetings.

Additionally, the Board composes and disseminates a report on outcomes performance each quarter and major indicators are published on the Board's website.