

The ADAMHS Board of Allen Auglaize & Hardin Counties

Community Plan For SFY 2010-2011

5/1/2009

Mission Statement

The mission of the Mental Health & Recovery Services Board of Allen, Auglaize and Hardin Counties is "To reach out and provide vital prevention and treatment services to every resident."

Vision Statement

Vision: the Mental Health and Recovery Services Board of Allen, Auglaize and Hardin Counties will be the recognized leader in promoting and supporting superior behavioral health services.

Value Statements

- HOPE: Believe in Recovery for every person. Assist people to recognize their own strengths and assets so they can believe their future will be better than their present.
- HELP: Give each person immediate attention. Listen, assess, educate and take action.
- CARE: Give of yourself. Provide expertise, attention and compassion.

Section I: Current Circumstances / "As-Is" State

Legal Context of the Community Plan

The ADAMHS Board of Allen Auglaize & Hardin Counties is 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. Four ADAS Boards submit plans to ODADAS, four CMH Boards submit plans to ODMH, and 46 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 (SFYs) 2010 - 2011 (July 1, 2009 through June 30, 2011).

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 Ohio Revised Code (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
- 5) Recruit and promote local financial support for mental health programs from private and public sources

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

- 1) Assessing service needs and evaluating the need for programs;
- 2) Setting priorities;
- 3) Developing operational plans in cooperation with other local and regional planning and development bodies;
- 4) Reviewing and evaluating substance abuse programs;
- 5) Promoting, arranging and implementing working agreements with public and private social agencies and with judicial agencies; and
- 6) Assuring effective services that are of high quality.

ORC Section 340.033(H) (H.B. 484)

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 (PCSA) service recipients referred for alcohol and other drug 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.

OAC Section 5122-29-10(B)

An section of Ohio Administrative Code (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 (GRF) for the provision of HIV Early Intervention Services. Boards that receive these funds are required to develop an HIV Early Intervention Investor Target 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 (SAPT) Block Grant

The federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires prioritization of services to several groups of recipients. These include: pregnant women, women, injecting drug users, clients and staff at risk of tuberculosis, and early intervention for individuals with or at risk for HIV disease. The Block Grant requires a minimum of twenty (20) percent of federal funds be used for prevention services to reduce the risk of alcohol and other drug 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 MHBG Plan.

Environmental Context for the Community Plan

Board Area and Clients Served

Board Area and Clients Served including recent trends such as changes in services and populations

II.A.1 - The three counties served by the Board - Allen, Auglaize, and Hardin - are diverse in their character, needs, and resources. Allen County, Ohio is a moderately rural county located in the lower portion of the northwest corner of the state. With 106,873 residents, the county is centered around the city of Lima, a small city with slightly more than 40,000 residents. Lima is viewed as being very different from the other communities in the county - more violent, disadvantaged, and in greater need of supportive development services. Education in the community evidences struggling performance, with the largest district in the county, Lima City Schools, graduating just over half of its students and meeting only two of 23 state performance standards.

The city is known regionally for high crime, rundown neighborhoods, gang and drug activity, and lack of opportunity. Ackerman and Murray (2004) profiled the city and its crime patterns with an exhaustive spatial-

patterning methodology. They note that Lima has violent crime rates much higher than the average rates for similar-sized communities, and has crime rates equaling those of Ohio's largest cities, including the capital of Columbus - a city nearly 20 times its size. The current economic downturn has only served to exacerbate these concerns.

Approximately 13% of county residents are African American, with other races comprising an additional 4% (Ohio Department of Development, 2004). In the city of Lima, African Americans represent 26.5% and are disproportionately living in the areas of highest crime and poverty.

Auglaize County is statistically the most prosperous of the three with median household income being significantly higher than Allen or Hardin. Mental Health and substance abuse services are delivered out of a single site that co-houses multiple agencies and has high visibility and easy access in the community. Services are also delivered in the local jail and in schools throughout the county. The relative abundance of resources in the community is an asset, the resulting spirit of self-sufficiency often seeks to "care for your own" even when seeking help would be a better option.

Hardin County is the most depressed economically with median income being less than 85% of that in Auglaize. Challenges in Hardin County include a dramatic increase in opiate use. More than half of the referrals for opiate treatment (e.g. Suboxone) come from the county, even though it has just 16% of the Board's population.

Despite difficult economic and social times, the Board has collaborated to make significant progress on initiatives described in the FY 2009 Community Plan. The following are accomplishments of note: Changing Seasons - In July of 2008 the board awarded new funding for a peer support model based on a modified clubhouse approach. The center piece of the program was its artistic development as well as a work-ordered day. The program moved into a beautifully renovated building in downtown Lima and has experienced revitalization as a result of their wonderful space and innovative programming.

The Allen County Treatment Court (Drug Court / Mental Health Court) - since the last Community Plan this Court has become a significant entity in this system. Through the leadership of Judge Reed and the Common Pleas Court in Allen County, the Drug Court expanded to include a Mental Health Court and brought together treatment providers, criminal justice system, families and offenders very successfully.

The Allen County Parent Drug Court - was established as a result of the Ohio Summit on Children and its goal is to hold parents accountable and to get them into treatment.

Integrated behavioral health and physical health services - for the past year the family service agency has had an intention outreach to family physicians in the area in order to better coordinate care and to offer consultation services. This has resulted in better continuity of care and greater sense of confidence on the part of primary care physicians in treating young people with mental illness.

Auglaize County Jail - In the fall, the Auglaize County Jail was recognized as one of the six best practice programs in the country for reentry of prisoners into the community. Programming provided by Lutheran Social Services and ASTOP contributed to the treatment and engagement of prisoners while still incarcerated and then linked them effectively to services including employment services in the community.

Critical Incident Stress Management - the local behavioral health system has partnered with the emergency services CISM team to provide social workers and mental health workers to assist teams as they work with emergency services personnel in the aftermath of a disaster. At this point over 30 behavioral health staff have been trained and many are participating in the teams. We are also exploring the use of this model as a response tool when responding to a school or an industry in the aftermath of a tragedy.

Incident Command Structure - the University of Findlay worked with the local behavioral health system to develop an ICS in order to respond effectively to three different levels of a tragedy or disaster;

- Level one represents an isolated incident like a single school or industry that has experienced a tragedy
- Level two represents an emergency that takes in a wider area and impacts a greater number of people
- Level three represents a disaster and the Incident Commander of the behavioral health system works under the direction of the EOC.

Program Feasibility Analysis - beginning in FY 2008 the board implemented a process of identifying investment priorities and outcomes based on a program submission process that identified key elements for the system: Program features including evidence, populations served and staffing

- Connection with system strategic plan and priorities
- Costs including cost per participant
- Expected outcomes based on NOMS
- The PFA process has become a key component to contracting, developing new programming, and tracking investor outcomes.

Renaissance - In 2008 the 14 bed group home facility was transitioned to become a more acute care setting with medical services support. The intention of this service is to provide acute care needs for persons experiencing decompensation due to medical needs as an alternative to hospitalization as well as a step down for persons being discharged from the hospital.

As a result, services outreach and programming is very unique and tailored to the specific populations of each county's unique needs. Over the past five years the mental health and alcohol and drug treatment and prevention system providers have been meeting regularly to establish certain priorities:

- Improved Access to Services
- Eliminate duplication and provide for a full continuum of services in every county
- Engage key stakeholders:
 - o Criminal Justice System
 - o Faith-based Community
 - o Senior Citizens
 - o College-aged Population
- Implement greater expectation that clients participate financially in their own recovery
- Provide housing for women in recovery
- Assist clients in employment

Criminal Justice Coordinator - The Board identified the need to have a "system spanner" in place that was able to navigate both the treatment system and the criminal justice system. This position has been extremely effective in identifying problems and opportunities that have enhanced the ability of the system of care to respond effectively to the needs of offenders.

MRT Services - Moral Reconciliation Therapy is a nationally recognized, evidence-based practice that has been highly effective as an intervention with offenders. Based on cognitive behavioral therapy, staff from the jail, probation / parole, juvenile court, WORTH Center, ASTOP, Family Resource Centers, Lima UMADAOP, and Lutheran Social Services have all been trained. As a result, offenders in need to treatment have been successfully referred and engaged with astounding results - 48 graduates, after one year no re-offense and maintained abstinence. This has also resulted in a true collaboration among disparate systems.

Family Education and Intervention - a new focus has been on family education. LSS, ASTOP and Family Resource Centers have programs that have been successful in engaging and teaching families about the nature of addiction and abuse. Family education has expanded to include preparation of families of newly released offenders. In 2008, ASTOP introduced family intervention services to help families engage and outreach to loved ones suffering from addiction.

DV Screens - domestic violence is most often the result of addiction / abuse issues. Municipal Judges in Allen County have agreed to refer domestic violence offenders for screening to determine readiness for intervention. This is an important step in identifying and engaging persons in need, diverting them appropriately from incarceration, and keeping families together.

DV-MRT - Moral Reconciliation Therapy is a nationally recognized model of intervention based on the "Duluth Model". Staff members have been trained and is now implementing groups in Allen and Hardin Counties.

Characteristics of Clients Receiving Substance Abuse Prevention Services

II.A.2.a - Adults

70% male and 30% female,

Drug of choice: 30% alcohol 30% marijuana 30% crack/cocaine

5% opiates

4% prescription drugs 1% Other

Race:

60% Caucasian 30%African-American

10%: Hispanic, Asian', Am. Indian, Other

Age:

15% 18-25 60% 25-44 15%45-64

Impairments:

-2% hearing -2% English as second language -5% physical

Characteristics of Clients Receiving Substance Abuse Treatment and Recovery Support Services

II.A.2.b - 1. Racial / Ethnic

Caucasian 84%

African American 12%

Hispanic (Mexican) 1.5%

Hispanic (Other) 1.5%

Native Amer, Unknown, Multi-Racial 1%

2. Gender

Female 30%

Male 70%

3. Age

<18

<1%

18-30 38%

30-54 58%

>55 3.5%

4. Major Religious Groups: This data has not been tracked by client, however the population in AAH is generally of Christian faith. Staff are encouraged to use spirituality in their treatment of substance abuse clients, more than specific religions.

5. Major Language Groups: The majority of clients presenting for SA Program services are English speaking. However, we have a policy that provides for Limited English Proficient individuals to be provided avenues for communication for delivery of services.

6. Eligibility for admission to the Substance Abuse Treatment is a diagnosis of Substance Dependency. Those with Substance Abuse are referred to a sister agency that provides intervention/prevention services. That agency is to make appropriate referrals based on client needs.

7. Substance abuse outpatient services is moving from the "intensive

outpatient", (a one size fits all), model to services provided utilizing the "stages of change" model, developed by Prochaska & DiClemente with additional services based on need.

8. Because some clients do indeed need intensive services, through individualizing service plans, clients may not only be referred to the Stages of Change curriculum, but MRT, Thinking for a Change, Anger Management, Pharmacological Services, and other Mental Health groups as appropriate.

9. The philosophy is that treatment should be focused on meeting the client where he or she is, emphasizing the process of change with recovery as the goal. It is the counselor's challenge to motivate the client through change, whether the client is in denial or ready to take action to change lifestyle or situation. This approach allows for more individuality in treatment. It also lends itself to intensive services, if needed, by addressing the needs in the Individualized Service Plan.

10. Aftercare groups in Allen and Auglaize County have proven successful as a way of continuing services for clients who have completed treatment.

11. Within the last year buprenorphine (Suboxone) replacement therapy for opiate addiction was funded through a grant. Although this has been a learning process, it is definitely a need in the community and warrants continued support. Because of this service more clients with opiate addiction are presenting for help. As with any addiction there are pitfalls and ensuring that the service is not abused has been a challenge. It may be beneficial to work more closely with the local hospital to ensure detox services and appropriate referral / follow-up for these clients.

Characteristics of Clients Receiving Mental Health Prevention, Consultation & Education (P, C&E) Services including Crisis Intervention Teams

II.A.2.c - 1. The Outpatient Mental Health Psychoeducational Group Program is offered for community education, support, outreach, and prevention. Psychoeducational groups provide opportunities for caregivers, family, friends or others affected by a life situation or condition to gather for the purpose of discussing issues related to their problem. The psychoeducational groups will be led by a trained therapist who will facilitate group members in providing each other moral support, information, and advice related to their problems

The consumer engaged in support/education services may be adults or those in support of adults with severe mental illness, the dually diagnosed individual who is either MR/MI or MH/AoD, criminally involved adults with MI or dually diagnosed, families in danger of losing their children due to MI or dual diagnosis. This consumer may not meet the level of care for therapy or may have successfully completed therapy and now are in need of this service to receive support through the management of their recovery.

2. The single point of access for MHR SBV Emergency Response system is the HOPEline. The decision to activate MHR SBV Emergency Response teams will be made based on the decision of the Incident commander for the level of response needed and in coordination with emergency responders, local authorities, or the Emergency Operations Center. MHR SBV Emergency Response teams may be assigned to shelters, hospitals, or other emergency locations, and may establish rotating shifts to ensure adequate mental health coverage throughout the emergency

Characteristics of Clients Receiving Mental Treatment and Recovery Support Services

II.A.2.d - 1. The Home Monitoring Services and Erma Rose is an outside business that Lutheran Social Services contracts with to provide service to our clients within the community. Both facilities provide meals, monitoring, and supervision in a semi-independent living environment at a pre-authorized amount of money per resident. These facilities provide safe, semi-supervised living environment. The resident's are able to support one another in times of need. Positive relationships have been built that have improved motivation and self-esteem. Resident's that are

served will be able to better manage their mental health. Compliance in the program will reduce hospitalizations.

2. 14 Bed licensed by ODMH. Co-ed for adults with severe mental disabilities. The Renaissance model is one alternative being used as a way to help consumers experiencing a psychiatric crisis to remain in the community or a "home-like" setting instead of going into the hospital.

This program is also available to individuals being discharged from the hospital who can still benefit from a supervised setting. The 24 hour staffed facility provides assistance in increasing the resident's ability to manage their psychiatric symptoms in the least restrictive environment possible. The purpose of the crisis respite/residential services is to provide the individual in crisis with support in a calm, protected, and supervised non-hospital setting. During this period the person can stabilize, resolve problems, and link with possible sources of ongoing support. Consumers of this unit receive medication, counseling, referrals, and linkage to ongoing services. The goal of the unit is to stabilize the consumer and re-integrate him or her back into the community quickly.

3. O'Brien houses 4 severely mentally disabled men. More permanent housing, with stays averaging 2 years. Main St can house up to 8 severely mentally disabled men or women with an average stay of 2 years. FY09 will serve 20 different people with supportive independent living with minimal supervision.

LSS has been piloting a WRAP around service for individuals at their own apt/home/ Home Health Care. This service will be provided to those that need supportive supervision and support. Each individual will be diagnosed with a MI and will have to provide the need for service.

Each resident is a member of his/her own treatment team and makes the decision whether or not the facility is still necessary. The WRAP around services will be able to provide social support, medication reminders, observations of medical/psychiatric progress or regress, support with grocery and meals, comprehension of daily tasks and role modeling for such tasks.

Consumer Socialization services program offers educational, recreational, and social activities. Group and activities are structured but participation and attendance are voluntary. Although there is no evidenced-based practice, there is research to support drop-in centers. We incorporate elements of the recovery philosophy. We do offer peer to peer support. WRAP is research based and provided through this program. The program collaborates with the Northwest Ohio Literacy Council to provide literacy training to consumers. The program also has a contract with Lima YMCA to bring consumers one day per week at no cost to consumers.

Changing Seasons will be a community collaborative production where multiple services, along with family and friends, provide a safety net that enables recovery. The Peer Center will provide training for those interested in maintenance work, clerical/computer positions, and rental management. In addition, for those interested in working in a commercial kitchen, The Peer Center will offer both programming and employment opportunities to develop those interests. Provisions will be made for gaining job-hunting skills, including resume writing and filling out job applications, as well as participation in mock interviews. If needed, follow-up services, to increase the likelihood of retaining employment.

Changing Seasons will be developed to reflect programming and vision provided by The Club House Model. This Model has been identified to be an evidenced based peer supportive recovery program. Services identified to be incorporated in a club house program include the following: WRAP, BRIDGES, and Transitional Employment that includes a work-ordered day.

Club Houses are traditionally supported through multiple funding sources, including consumer operated business(s). In addition, this peer center will provide exposure to the arts community, increased community involvement, and the development of a consumer operated business

II.A.2.e Mental Health Crisis Care Services

Question	Available In SFY 09?	Planned For SFY 10?
Community Resources & Coordination		
24/7 Hotline	Yes	Yes
24/7 Warmline	No	No
Police Coordination/CIT	Yes	Yes
Disaster Preparedness	Yes	Yes
School Response	Yes	Yes
Respite Beds for Adults	Yes	Yes
Respite Beds for Children & Adolescents (C&A)	Yes	Yes
Face-to-Face Capacity for Adult Consumers		
24/7 On-Call Psychiatric Consultation	Yes	Yes
24/7 On-Call Staffing by Clinical Supervisors	Yes	Yes
24/7 On-Call Staffing by Case Managers	Yes	Yes
Mobile Response Team	Yes	Yes
Central Location Capacity for Adult Consumers		
Crisis Care Facility	Yes	Yes
Hospital Emergency Department	Yes	Yes
Hospital contract for Crisis Observation Beds	No	No
Transportation Service to Hospital or Crisis Care Facility	Yes	Yes
Face-to-Face Capacity for C&A Consumers		
24/7 On-Call Psychiatric Consultation	Yes	Yes
24/7 On-Call Staffing by Clinical Supervisors	Yes	Yes
24/7 On-Call Staffing by Case Managers	Yes	Yes
Mobile Response Team	Yes	Yes
Central Location Capacity for C&A Consumers		
Crisis Care Facility	Yes	Yes
Hospital Emergency Department	Yes	Yes
Hospital contract for Crisis Observation Beds	No	No
Transportation Service to Hospital or Crisis Care Facility	Yes	Yes

Community Resources & Coordination - Other

Face-to-Face Capacity for Adult Consumers - Other

Central Location Capacity for Adult Consumers - Other

Face-to-Face Capacity for C&A Consumers - Other

Central Location Capacity for C&A Consumers - Other

Board plans to address any gaps in the crisis care services indicated by ORC 5122-29-10(B):

II.A.2.d.i - The major gap in crisis care services is the availability of a child psychiatrist and on call staffing from the youth and family agency. Currently all crisis and on call services are provided by the adult mental health system with training. We are working with all agencies to enhance our crisis response to children and youth.

Identification and prioritization of training needs for personnel providing crisis intervention services and how the Board plans to address those needs in SFY 2010-11.

II.A.2.d.ii - The Board has taken an active role in assessing and training needs related crisis intervention. We participate as community partners in Critical Incident Stress Management/Debriefing teams and work with local emergency management agencies to address community needs. In September 2008, the Board contracted with the School of Environmental and Emergency Management from the University of Findlay to develop an Incident Command structure and plan, and train system staff on implementation.

The Board has identified the following training needs:

Critical Incident Stress Management

This area was identified through our ongoing Law Enforcement Task Force, our ongoing Crisis Center Services Task Force, and in dialogue with our contract agencies. A three-day training in CISM was held in January 2009. An additional training will be held in FY 2009.

Nonviolent Crisis Intervention

The Board is working with contract agency Lutheran Social Services to provide local training in nonviolent crisis intervention. The Board and agency have been in contact with the Crisis Prevention Institute (CPI). The Nonviolent Crisis Intervention® program, developed by the Crisis Prevention Institute teaches staff to respond effectively to the warning signs that someone is beginning to lose control, and also addresses how staff can deal with their own stress, anxieties, and emotions when confronted with these challenging situations.

EMDR

The Board has also begun initial exploration with Kay Werk of Netcare (Franklin County) to offer training in Eye Movement Desensitization and Reprocessing (EMDR). This intervention was overviewed to staff and agency team members attending the Joining Forces state training held in May 2007.

Capacity to Provide Services

Access to Services

Access to Alcohol and Drug Prevention and Treatment Services

II.B.1.a - The availability of alcohol and drug services in the Board area has been a concern. Services are frequently invisible, unknown to the community and consumers who need assistance. The services are parceled out to various agencies creating disorganization and confusion for consumers.

To address these concerns, the Board initiated a series of six focus groups with providers, law enforcement, family members, the faith community, consumers, law enforcement, referral sources, and board members. With the information from these groups, the Board contracted with Doug Wentz and Associates, Youngstown, Ohio, to develop a comprehensive plan for AOD services. The following themes related to access and programming were expressed by the more than 150 participants in the focus group process:

- A One Stop Center was the most common theme that emerged from every group we talked to and was enthusiastically endorsed was: An integrated system of care that is seamless and transparent to the community - comprehensive, competent, research-based, compassionate, easy to access, easy to identify, available when the person and family needs it in a one stop environment that is safe, professional, and welcoming.
- In terms of programming this was the second theme that emerged in every group: A flexible continuum of programming provided by competent and passionate professionals that are research based and can be individualized to meet the unique needs of each person and family. This programming includes access to mental health services for those with dual diagnosis and counseling for families who discover a need. Programming should also include an addictionologist and sober living environments / residential type treatment facilities.
- Staffing was identified in every group as an area that was essential to the success of this initiative: Staff who is competent, compassionate and well trained in the field of addiction. Staff needs ongoing training, development and mentoring so that their skill level is continuously improved and staff has resources they can utilize. This is particularly true for staff with specialized capabilities such as

fluency in ASL, experience with GLBT issues, and other areas of expertise.

- Staff is well paid and appreciated. Outreach to family was identified as a priority in every group: education for family members would include outreach and support that includes information about treatment and the treatment process, relapse prevention, family reactions, signs and symptoms, and crisis intervention. In addition family programming would include communication with family, family support groups, and improved communication between provider and family. Included in this discussion was the need for a family advocate or family liaison - a person who could assist families in navigating the system of care.
- Creating a system and services that are well-known a very important aspect of this enhanced program: This discussion included the need to implement very deliberate and intentional outreach, PR, advertising so that the place, the services, the programs are well known and understood and recognized and supported by the whole community. Having a single location that is well regarded by the community is an important aspect of this whole issue.
- An important aspect of every discussion was the need for getting people to the right service the first time: This discussion involved triage, screening, and an assessment system that was effective and competent and able to identify the level of service need. Participants discussed the need to feel confident in the competence of the staff that is providing the screening.
- Having an array of supportive services targeted to family and persons was key: Support groups were identified by most participants as a very important programming component especially targeted to persons who need a lower level of service and aftercare services as well as family supportive services.
- A holistic approach to programming is a key component to the new program: In the discussion participants identified the need to include attention to a person's well-being

Access to Mental Health Prevention, Recovery Support, and Treatment Services

II.B.1.b - Individuals who are seeking mental health services - prevention, recovery support, treatment - are faced with notable barriers in our area. Transportation is a significant obstacle. Public transportation only exists in the City of Lima, and the Regional Transit Authority bus service is very limited. Addition cutbacks in transportation routes have hampered consumers in their access to services.

Additionally, there are considerable wait times for psychiatry, particularly for children and youth. The Board meets regularly with primary system consumers of these services (e.g. schools, law enforcement, other social services agencies) to ensure that there are programs and services reflective of their needs. The Board recently convened focus groups with school personnel, including administrators, teachers, counselors, and support personnel, to determine the best possible service configuration for prevention, recovery support, and treatment services.

The Board is also concerned about the role of stigma in limiting access to mental health services. To combat stigma, the Board has an outstanding public relations network that promotes the positive contributions of persons with mental illness, offers timely information dissemination, facilitates relevant educational opportunities for consumers, family members, and community, and helps the community access available services.

Workforce Development and Cultural Competence

II.B.2.a - Like many areas of the state, Allen, Auglaize, and Hardin Counties continue to face a shortage of qualified providers. Often, staff that are underperforming at one agency will leave only to be hired by another local provider because they have licensure.

In order to improve the quality of providers, the Board is facilitating Provider Development Roundtables developed by our Board/Agency System Quality Improvement Committee. These Roundtables are simple discussions and hands-on trainings that encourage providers to develop new skills,

network with colleagues, and make recommendations for further discussions.

Examples of these programs include:

February 2009 - Issues in Clinical Supervision

March 2009 - Using SOQIC diagnostic assessments to inform the treatment planning (ISP) process

March 2009 - Substance abuse treatment providers' discussion and recommendations for transforming AOD services

April 2009 - Prevention 101 for mental health and AOD prevention providers

The following Roundtables are planned for FY 2010:

July/August 2009 - Kathryn Remer and Rob Nugen, Ohio Department of Mental Health discussion of client rights and grievance processes with area Client Rights Officers. This Roundtable will focus on consensus definitions of grievance vs. complaint, effective management of investigations, and appropriate documentation of concerns.

September/October 2009 - Dr. Deborah Wilcox, Wellness Management and Recovery CCOE Roundtable discussion of race, class, and culture within agencies and as expressed by and to consumers.

II.B.2.b.1 - See also

Section II.B.1.a Cultural Competence and Workforce Development

Section II.B.2.a Qualified Staff/Cultural Competence

The MHRSB has strategically developed community advisory committee's so that each community has an opportunity to represent its specific needs and identify specific population of community members that have identified needs. Serving three communities can be challenging, however, continuous community invitation to advocate for their needs allows both the board and the agencies insight into how to interact effectively with people of different cultures within those communities and what skills need developed to promote successful community members. The development of the faith based advisory committee, the multiple tasks forces, and continuous representation in community wide opportunities to collaborate with individuals from multiple cultures promotes awareness, understanding, and acknowledgment of our commitment to serve all community members.

II.B.2.b.2 - See also

Section II.B.1.a Cultural Competence and Workforce Development

Section II.B.2.a Qualified Staff/Cultural Competence

All staff providing substance abuse treatment services are required by ODADAS to have cultural competency training and are encouraged to focus on populations served. Lutheran Social Services has a Cultural Diversity Committee and has sponsored training in the past focusing on different populations ranging from African/American to sexual orientation.

II.B.2.b.3 - See also

Section II.B.1.a Cultural Competence and Workforce Development

Section II.B.2.a Qualified Staff/Cultural Competence

II.B.2.b.4 - See also

Section II.B.1.a Cultural Competence and Workforce Development

Section II.B.2.a Qualified Staff/Cultural Competence

Capital Improvements

II.B.3.a - Currently the greatest need is to establish a permanent location for our peer support services called Changing Seasons. The program is leasing space in a beautiful downtown Lima building and the purchase of this building would be an enhancement for our presence, reduce the stigma associated with mental illness and substance abuse and provide a permanency in the center of the downtown business district. The cost for purchase is @ \$500,000.

In addition, establishing sober living houses continues to be identified by providers, consumers and referral sources as the greatest need in our community. This environment, supported by local treatment providers would afford clients and their families the best situation for their recovery. The goal would be to purchase a number of homes throughout the community that would house 4 - 8 residents for a period of time in a safe and sober living environment. Home values locally are in the \$60,000 range and at least 4 of these homes would be needed. Finally, there is a need to purchase and renovate a central location for all addiction treatment services and treatment support services in Allen County.

Financial Status

Impact of reduction in services.

II.B.4.a - Based on the Board's priorities the services that will be reduced are those treatment services targeted to the general population of individuals suffering from mild or moderate emotional distress and those with substance abusing problems. For the most part individual counseling, psychiatric services, group counseling services will be impacted for this population.

Factors contributing to the costs of services.

II.B.4.b - Technology is a significant barrier to the delivery of community services. In addition, recruiting human resources that are able to effectively use and learn advanced technology in a field that is primarily relationship driven has been a challenge. Being able to use portable equipment has been challenging due to the sensitive information that could be compromised. Staff turnover has decreased some, however, the wages for entry level para-professionals in community mental health places us in competition against other occupations that require less responsibility, paperwork, computer skills, and regulations.

Training is a rather expensive investment every organization must commit to in order to prepare any level of professional to be successful.

Knowing the community resources and how to link to those resources takes time, learning what mental illness and or alcohol and drug addiction looks like and how to manage the variety of diagnosis for any person that would be having direct interface with consumers is a challenge. Understanding "client rights", ODMH rules, ODADAS rules, COA in order to perform according to standards takes time and training investment for everyone.

What cost-saving measures and operational efficiencies.

II.B.4.c - The Board has provided various topics and opportunities to expand the agencies it contracts with knowledge through coordinated trainings and peer-to-peer training opportunities among agencies. In addition, the MHRSB has invested in a renovation project allowing the adult system to place the majority of their services in one location.

This move allows clinical efficiencies as well as cost efficiencies and should reduce overhead expense for the adult provider.

Other budgetary planning efforts.

II.B.4.d - Currently the Board is planning on a 10% reduction in state funding in the next fiscal biennium. As a result the Board plans to reduce administrative costs by over \$100,000, decrease training funds available to the system and work with providers to gain efficiencies by collaborating with other community partners such as schools, criminal justice system, and faith partners.

Tables 1 and 2: Portfolio of Providers

Section II: Capacity Development

Access to Services

The board is actively planning in the following areas to improve access to care:

1. Continue to work with the one stop centers in Auglaize and Hardin Counties to enhance and expand the array of services offered
2. Work with providers to develop an increased skill in screening and triage so that clients have quicker access to the appropriate level of care
3. Develop a one stop access point for alcohol and drug treatment services and treatment support services in Allen County
4. Work with the local federally qualified health center to improve access to the full range of physical health care services for our clients
5. Continue to outreach to primary care physicians and offer consultation and support in developing capacity for children and youth and improved access
6. Moving all adult services onto a single campus for better access and efficiency in Allen County
7. Develop a crisis stabilization unit with 24 hour crisis staff in order to offer clients another level of care in the community
8. Working with schools to implement enhanced access to services throughout the 3 counties in order to intervene earlier in the lives of families and children
9. Working closely with the 4 major hospitals in our area to provide mobile crisis screening and evaluations on site.

Workforce Development and Cultural Competence

The Board views cultural competence as an integrated part of planning and service delivery. The Board operationally defines cultural competence as "the transformation of specific cultural knowledge, skills, attitudes, and behaviors into respectful service delivery, protecting the dignity and uniqueness of each consumer."

During biennium 2010 - 2011, the Board will formalize its plan for cultural competence base on this operational definition. The outcome is simple: people will come to our services as unique individuals, with contexts, histories, and dreams that will be celebrated and incorporated into their wellness and recovery.

The plan will:

Develop mechanisms that increase the provider's knowledge of what the community wants and needs, how and in what form it obtains new information, and its experiences with existing services;

Ensure that the location of behavioral health services shall be a joint decision between the Board, providers and consumers;

Document, before the development and delivery of new programs, how they assess and plan to apply information and knowledge about risk factors associated with consumers and their families;

Outline specific customer/informant focus groups with proportionate representation of consumers from various groups and culturally competent specialists to ensure that if irregularities or deficiencies in care are found, special quality studies and corrective actions shall be undertaken to identify causes and address root causes/processes;

Consumer satisfaction surveys, translated orally and in written format into accessible language, reading comprehension level, and cultural relevance will be implemented by the Board and provider agencies. Surveys will be available in various formats to facilitate the participation of consumers at all socioeconomic and educational levels.

Ensure that prevention, education, and outreach approaches include specific services for at-risk youth in the family of the primary consumer;

Identify learning experiences for providers on the differences in symptom expression, symptom language, and symptomatic patterns of individuals from various cultures, races, classes, ethnic groups, and gender expression with mental illness/emotional disturbance; Provide consumers and their families with education and information about the available service benefits and how to access them;

Ensure that prevention, education, and outreach approaches consider the family and community systems in which the primary consumer lives;

Design training to teach providers, planners, administrators, and staff how

class, ethnicity, social status, and racism influence behavior, attitudes, values, belief systems, and mental health of consumers;
Ensure that prevention, education, and outreach plans and methods include linkages with religious organizations in the community and training of members of the faith community to assist in educating consumers about mental health service;
Offer programs to educate professionals and consumers about how consumers and their families can be more responsible for their own health and preventing illness.

Capacity Development Targets

C.1 - ODADAS Capacity Targets

- Reduce stigma.
- An accessible, effective, seamless prevention/ intervention, treatment and recovery services continuum from childhood through adult.
- A highly effective workforce for the AOD system.
- Increase the use of "evidenced-based" policies, practices, strategies and programs in the AOD system.

C.2 - ODMH Capacity Development Targets

- Reduce the stigma of seeking care.
- Provide mental health and other physical health services in an integrated manner.
- Maintain access to services to all age, ethnic, racial and gender categories.
- Improve cultural competence of mental health system.
- Maintain access to services in rural areas.
- Adult and family of youth consumers report that they are satisfied with the quality of their care and participate in treatment planning.
- Increase availability of professionals through HPSA in areas with shortages.
- Increase the availability of school-based mental health services.
- Increase use of best practices:
 - o Wellness Management and Recovery;
 - o CIT

Section III: Prevention Services

Prevention Needs

Needs Assessment Methodology

A.1 - The Board has undertaken a comprehensive assessment and planning process to determine the AOD prevention needs, as well as the services provided by agencies for mental health education, consultation, and prevention.

The board retained Wentz and Associates to do a systems review that included both quantitative data - documentation of all service delivery in these categories; and a qualitative review of their efficacy.

The board convened six focus groups to discuss these needs, as well as the AOD treatment needs in our communities. Stakeholders representing providers, ADAMHS Board members, family members, consumers, schools, law enforcement, the faith community and others were included. The following is a summary of the findings of the 6 focus group meetings totaling more than 150 people which were held between October 2008 and February 2009 as well as the report and recommendations of the consultants' review of agencies in January 2009.

Needs Assessment Findings

A.2.a - All 6 focus groups clearly identified similar themes:

- 1.A separate, clearly identifiable one stop service center with extended operating hours to include evenings and weekends
- 2.Flexible and research-based prevention, education, consultation, and treatment programming.
- 3.Prevention services available across the life span.
- 4.Competent and compassionate staff who are well trained and well paid.
- 5.Intentional and deliberate outreach and engagement of family members.
- 6.Services that are well known and well regarded in the community.
- 7.An array of supportive services for families and clients.
- 8.A holistic approach that includes body, mind and spirit.

The consultants incorporated focus group and stakeholder feedback into their findings and recommendations:

- 1.Develop a comprehensive Prevention Plan for the system that utilizes the six CSAP Strategies by intention, design and need based on data.
- 2.Consider mental health education, prevention, consultation services for schools that utilize a Student Assistance Programming framework which would deliver Universal, Selected and Indicated services to school age children. A significant service array of AOD prevention services could be integrated into this model.
- 3.Consider involving the providers and investing in more Community Based Process activities such as coalition building, networking and collaboration efforts.
- 4.One of the providers may want to think about becoming a Bureau of Workers Compensation (BWC) Drug Free Workplace provider. This has the potential to be a robust revenue source as well and an opportunity to provide a much needed prevention service to businesses and their employees.
- 5.Consider investing in and placing for emphasis on Youth Led Prevention activities. Consider recruiting and sending youth as well as staff to the Ohio Teen Institute at Kenyon College in the summer of 2009. Having a nucleus of drug free youth that are representative of the Board's service area would be a considerable asset.
- 6.Offer your customers more choices of evidence-based primary prevention services. As effective as Life Skills and Active Parenting are, there are numerous other excellent prevention programs that will appeal to a broader range of customers.

A.2.b - See A.2.a

Prevention Priorities

Method for Determining Prevention Priorities

B.1 - Mental health prevention, consultation, and education is a primary priority of the Board. The Board sees these services as often integrated with AOD prevention services - given the natural crossover of many risk and protective factors. The Board espouses the following prevention standards which are based on SAMHSA directives and the National Outcome Measures (NOMs).

1. Prevention, education, and consultation programs should enhance protective factors and reverse or reduce risk factors.

The risk of developing mental health and/or substance abuse problem involves the relationship among the number and type of risk factors (e.g., deviant attitudes and behaviors, biological history of brain disorders, family disruption, trauma, abuse and neglect, etc.) and protective factors (e.g., parental support, access to resources, positive bonding to family, school, and community, etc.).

The potential impact of specific risk and protective factors changes with age. For example, risk factors within the family have greater impact on a younger child, while association with drug-abusing peers may be a more significant risk factor for an adolescent. Biological brain disorders often begin to emerge during adolescence and therefore require different PC&E approaches to engage consumers.

Early intervention with risk factors often has a greater impact than later intervention by changing a child's life path (trajectory) away from problems and toward positive behaviors.

While risk and protective factors can affect people of all groups, these factors can have a different effect depending on a person's age, gender, ethnicity, culture, and environment.

2. Prevention, education, and consultation programs should address the type of concerns for trauma, mental health disorder prevalence, and AOD concerns in the local community, target modifiable risk factors, and strengthen identified protective factors.

3. Prevention, education, and consultation programs should be tailored to address risks specific to population or audience characteristics, such as age, gender, and ethnicity, to improve program effectiveness.

4. Family-based prevention programs should enhance family bonding and relationships and include parenting skills. Family bonding is the bedrock of the relationship between parents and children. Bonding can be strengthened through skills training on parent supportiveness of children, parent-child communication, and parental involvement.

5. Prevention, education, and consultation programs can be designed to intervene as early as preschool to address risk factors for mental and emotional disorders and substance abuse.

6. Prevention, education, and consultation programs for elementary school children should target improving academic and social-emotional learning to address risk factors for drug abuse, such as early aggression, academic failure, and school dropout.

7. Prevention, education, and consultation programs for middle or junior high and high school students should increase academic and social competence, improve peer relationships, strengthen self-efficacy, and provide access to early intervention.

8. Community Prevention, education, and consultation programs that combine two or more effective programs, such as family-based and school-based programs, can be more effective than a single program alone. Community Prevention, education, and consultation programs reaching populations in multiple settings—for example, schools, clubs, faith-based organizations, and the media—are most effective when they present consistent, community-wide messages in each setting.

Grouping of Priorities (High, Medium and Low)

B.2.a - AOD Priorities

- (Low) Fetal Alcohol Spectrum Disorder
- (Medium) Childhood/Underage Drinking
- (High) Youth-Led Prevention
- (High) Evidenced-Based Practice
- (High) Stigma Reduction

B.2.b - Mental Health Priorities

- (High) Suicide Prevention
- (High) Depression Screenings, include Maternal Depression Screenings
- (High) Early Intervention programs
- (High) Faith-based and culturally specific initiatives
- (High) School-based mental health services/programs
- (High) Stigma Reduction activities
- (High) Crisis Intervention Training (CIT)

Implications of Identified Priorities to Other Systems

B.3 - The Board fosters and maintains multiple collaborations that support priorities and populations not specifically targeted by Board contracts. These include the Partnership for Violence-Free Families, the Teen Pregnancy Prevention Task Force, the MR/MI Coalition, and others. These collaborations allow the Board to have a presence in the planning and delivery of services not specifically under contract with the Board.

Prevention Investor Targets

C.1 - Alcohol and Other Drug Prevention Targets:

- Programs that increase the number of customers who avoid ATOD use and perceive non-use as the norm.
- Programs that increase the number of customers who perceive ATOD use as harmful.
- Programs that increase the number of customers who experience positive family management.
- Programs that increase the number of customers who demonstrate school bonding and educational commitment

Mental Health Prevention Targets:

- Programs that increase social connectedness
- Programs that promote mental health and wellness
- Programs that decrease the negative effects of mental illness
- Programs that decrease the number of persons at risk of developing mental health problems and/or at risk for suicide
- Programs that increase the number of persons that receive mental health screenings, assessments or referrals to services
- Programs that increase the number of formal and informal supports in diverse cultural/ethnic populations
- Programs that increase recovery, resiliency and protective factors
- Programs that increase the number of persons who demonstrate school bonding (success) and educational commitment
- Programs that decrease or eliminate stigma related to emotional problems and mental illness

Section IV: Treatment and Recovery Support Services

Treatment and Recovery Support Needs

Needs Assessment Methodology.

A.1 - The Board utilizes the data funnel methodology to collect, refine, and decide. This method is a multi-tiered process that has been highly successful in developing Board priorities and identifying gaps in the community system. The data funnel tiers bring together current research, broad-based community needs assessment, and key informant feedback. These elements reflect both quantitative data and qualitative analysis. The data is then filtered through key informants and then refined into Board policy, priorities, and contracts.

Tier One of the data funnel represents the meta-analysis of current research on best practices, trends in treatment and recovery supports, results of community needs assessments, and the realities of the current funding environment. The Board gathers this data throughout the planning year.

Tier Two of the data funnel represents the passing of the meta-analysis findings through the key informant process. The Board utilizes content-specific task forces and key informant focus groups to respond to the data and localize the findings. Examples of Tier Two process key informants include the Board's task force on Dual Diagnosis for Persons with Mental Retardation/Mental Illness, the standing task force on Mental Illness and Law Enforcement/ Criminal Justice, standing committees of the Family and Children First Councils, NAMI Hope Alliance and the Family Advisory Council, and Behavioral Health Advisory Councils in each county.

Tier Three of the data funnel represents the presentation of findings to Board committees and the Board committee of the whole. The Board utilizes two standing committees to review the information. The Joint Mental Health/AOD Planning Committee is the group charged with programmatic overview. The committee takes information from Tier One and Tier Two, as well as recommendations from the Alcohol and Other Drug Standing Committee, and reviews the information in light of current programming and needs. The Joint Mental Health/AOD Planning Committee then makes recommendations to the Finance Committee and ultimately the full Board.

Findings of the Needs Assessment

A.2.a - A workgroup with consultation from Coleman Services is working collaboratively to initiate a new level of crisis stabilization services combining crisis response and hot line services into a single entity. The board, hospital and designated agency are working to develop a model for the community. The goal of this unit is to prevent or reduce hospitalization in both state and private facilities. The designated agency also works closely with area Adult Care Facilities (ACFs) to create local placements, enabling consumers to remain in the community if appropriate.

The Board

A.2.b - The Board has partnered with the primary contract agency (Lutheran Social Services) and Synthesis, Inc. to begin implementation of the cluster-based planning methodology. We anticipate that this demonstration will assist us in addressing the needs of consumers with SMD with more deliberate and targeted approaches. The Board appreciates the opportunity to be part of the demonstration and is pleased with the receptivity of the agency for this framework.

Our quantitative data on homelessness indicate that there remain a significant number of persons with severe mental disability who do not have permanent housing. The Board has played a significant role in the Continuum of Care for Housing, a multi-agency initiative designed to ensure access to housing that reflects the needs and wants of the consumer.

The Board has been successful in working to meet the needs of consumers for peer support services. In October 2008, a new arts-based peer center opened -

replacing a drop in center that was underutilized and lacked recovery-oriented programming. The contract agency developed "Changing Seasons" and moved the program to a beautifully renovated building in downtown Lima, providing easy access for consumers and innovative programming. While the Board intends to maintain this service in FY 2010, additional dollars for programming must be identified.

Children with severe emotional disturbances are being assisted through home-based and traditional outpatient services, school-based services, and services collaborating with the juvenile justice system. While these services are largely successful, particularly when youth and families are engaged in their natural settings, there is a need for more services that are flexible and school-based. Given the Board's principle of early intervention, school/agency collaborations are essential.

In FY 2008, our largest hospital closed their children's partial hospitalization program. This closure significantly reduced our community options for managing children who are experiencing acute psychiatric symptoms, and for accessing immediate psychiatry. There remains a need for services at this intensity that are community-based.

A.2.c - The Board maintains an active role in the Family and Children First Councils in all three counties. Currently, staff are serving as the Council chairperson in Hardin County, as members of the Executive Council and Finance Committees in Allen County, and as senior leadership in Auglaize County. Key initiatives were developed for the Allen and Hardin County Councils as a result of the Governor's Ohio Summit on Children held in May 2008. The Board is concerned about the transition of FAST dollars to the Councils and is maintaining an active consultative role to ensure that services and funds are readily accessible.

The Allen County Family and Children First Council devised two surveys as a way to begin the process of needs assessment and community valuing. One survey was meant to assess the membership's perception of which of the child well-being commitments we need to focus on in the next biennium and the indicators that should be identified and prioritized.

The compliment to this survey for professionals was a Family Survey that was intended to gauge the concerns a broad base of parents in our community have about their children. We asked them to identify the indicators in each child well being area that they thought were of highest priority, as well as which of the six commitments they believed deserved our fullest attention. More than 230 community member Family Surveys were returned to us, and we were able to use 160 of these to inform our information-gathering and reporting process.

The Council has identified school success as the primary need for children in the county. The Council is concerned with literacy and poverty as primary indicators of school failure. In the process of addressing these indicators, the Council determined that many of the families and children who are not successful in school are failing due to mental health and substance abuse issues - either those of the child or caretaker.

Hardin County FCFC is currently in the first year of implementation for Partnerships for Success (PFS). The Council is in the initial needs assessment phase of the process and is noting that school-based services for youth with severe emotional disturbance and youth who are experiencing substance use are emerging as unmet needs. The Council will begin the Gaps Analysis segment of the PFS process in June, 2009.

The Auglaize County Council is completed a comprehensive needs assessment in CY 2008. The findings were published early in 2009. The assessment revealed the following:

- In 2008, 13% of Auglaize County youth reported seriously considering attempting suicide in the past twelve months compared to the 2007 YRBS rates of 15% for the U.S. and 13% for Ohio youth.
- In the past year, 6% of Auglaize County youth had attempted suicide and 2% had made more than one attempt. The 2007 YRBS reported a suicide attempt prevalence rate of 11% for the U.S. and 10% for Ohio youth.
- Almost one-fifth (21%) of youth reported they felt sad or hopeless almost every day for two weeks or more in a row that stopped them from doing some usual activities (2007 YRBS reported 25% for Ohio and 29% for the U.S.).

- Almost one-quarter (24%) of Auglaize County youth talked to no one when they were dealing with feelings of depression, personal problems or suicide. 55% talked to their best friend, 37% talked to their parents, 27% talked to their girlfriend/boyfriend, 20% talked to a sibling, 8% talked to a caring adult, 5% talked with their pastor/priest, 5% talked to their youth minister, 4% talked to their teacher, 4% talked to their school counselor, and 4% talked to a professional counselor.

A.2.d - Programming for persons with co-occurring substance abuse and mental illness are an area of significant program improvement concern. Findings from a system service review indicate that while the capability of provision of parallel treatment of co-occurring disorders is a system strength (due to co-location of alcohol and other drug treatment and mental health treatment services), it is not clear that truly integrated treatment (e.g. commitment to an evidence based model such as "Integrated Dual Disorder Treatment) is occurring.

A.2.e - Based on our Core Benefits Package, the Board has initiated and promoted adjunctive services that support the general outpatient experience. The Board believes that individual counseling - traditionally the heart of much of our service continuum - should be a targeted and time-limited intervention. Group counseling is becoming the supported norm in our system.

In addition to group therapy, the Board has provided training for more than 100 support group facilitators in our region. These facilitators, many of whom are affiliated with communities of worship, offer topical support groups for persons receiving outpatient services, and where appropriate, may even serve as an alternative. The Board recognizes that many low-acuity concerns may be best addressed in natural settings. To that end, the Board promotes free support groups such as Survivors of Suicide (SOS) for family members and friends of persons who have committed suicide; Celebrate Recovery, faith-based 12 step support groups; grief and loss groups; coping with HIV/AIDS; bipolar and depression support; emotional and informational groups for persons with Parkinson's disease and stroke; Family to Family; and NAMI Hope Alliance.

These groups offer adjunctive or alternative support for more traditional office-based services. The Board is strongly committed to making these groups available free of charge, and offers these as a first-tier safety net for people in the community. We believe that the need for such groups will only grow as people continue to face severe economic crisis and our resources continue to shrink.

A.2.f - Substance abuse services across the prevention-treatment-aftercare continuum are a primary focus for the Board in FY 2010. The Board has undertaken a comprehensive assessment and planning process to determine the AOD prevention and treatment needs in our communities. The board retained Wentz and Associates to do a systems review that included both quantitative data - documentation of all service delivery in these categories; and a qualitative review of their efficacy.

Utilizing the data funnel process, the board convened six focus groups to discuss prevention service needs and concerns, as well as the AOD treatment needs in our communities. The following is a summary of the findings of the 6 focus group meetings totaling more than 150 people which were held between October 2008 and February 2009 as well as the report and recommendations of the consultants' review of agencies in January 2009.

All 6 focus groups clearly identified similar themes:

1. A separate, clearly identifiable one stop service center with extended operating hours to include evenings and weekends
2. Flexible and research-based prevention, education, consultation, and treatment programming.
3. Prevention services available across the life span.
4. Competent and compassionate staff who are well trained and well paid.
5. Intentional and deliberate outreach and engagement of family members.
6. Services that are well known and well regarded in the community.

7. An array of supportive services for families and clients.
8. A holistic approach that includes body, mind and spirit.

Findings and recommendations for the AOD system include:

- There appear to be gaps in the treatment continuum for both adolescents and adults with substance related disorders. While there is recovery supportive housing with required abstinence and treatment for women at Phoenix House there are no residential treatment services for men. There was no intensive outpatient or partial hospitalization services offered at the programs visited. Lack of "rehabilitation level (IOP or higher) care" within the system is seen as a significant gap.
- The treatment services provided for both adults and adolescents are provided within organizations with broader mental health treatment missions. There appears to be little discrete alcohol and other drug treatment program identity for the services provided in these settings.
- The system has some committed skilled professionals and there are strengths, services and programs that constitute system "bright spots" in every organization. However, the organizations surveyed all seemed to feel that people fall through the cracks in moving from one organization and program or service to another. The system needs to address improvement role differentiation, ease of referral between organizations and inter-organization communication / awareness of each other's services.
- There is a need for clarification regarding the difference between screening and assessment at the organization that provides what appear to be otherwise excellent intervention services. This blurring of the distinction between prevention / intervention (problem identification and referral) and treatment (clinical assessment) services creates program certification as well as role differentiation issues for the system.
- Reportedly, there were no 12 step or other ongoing alcohol and other drug specific recovery support groups for adolescents in the community.
- The organization serving adolescents was not aware of any Alanon, Families Anonymous or similar ongoing support groups for family members of adolescents with substance related problems.
- There is a need for multi-family treatment groups in addition to the family counseling provided as part of adolescent treatment.

Treatment and Recovery Support Priorities

Method for Determining Treatment Priorities

B.1 - (See Core Benefits Brochure, Attachment A.) Beginning in FY 2008, the Board began a planning process to determine the benefits package available to consumers in the public system. The Board recognized that it has responsibilities for both persons with the most severe mental illness and addictions, and the public at large. The Board developed the following benefits package based on these principles:

- It is the mission of the Board to reach out and provide vital prevention and treatment services to every resident.
- The Board is committed to programs that focus on prevention of mental health and substance abuse concerns.
- The Board seeks initiatives and services intervene at an earlier stage of a person's illness.
- The Board must provide an expanded safety net for those with severe and persistent mental illness and/or addiction.
- Services must be delivered in a way that maximizes the use of public resources.
- The benefits offered through the public system must be determined annually by the board in cooperation with consumers, family members, and providers.

Grouping of Priorities (High, Medium and Low)

B.2 - In order to contract for services that fulfill these principles, the Board determined the following priorities. (Note: these areas are the highest priorities of the Board.)

- Youth with severe and persistent mental illness.
- Adults and seniors with severe and persistent mental illness and children with severe emotional disturbance.
- Persons dually diagnosed with mental illness and chemical dependency.
- Juveniles and adults in the criminal justice system who have mental illness and/or chemical dependency.

- Families in danger of losing their children because of mental illness and/or chemical dependency.
- Persons with mental retardation/developmental disabilities who have coexisting mental illness and/or chemical dependency.

The Board designed the Core Benefits Package in three parts. The center of the benefits package represents those services guaranteed to all residents. In times of financial restriction, these are the services the Board will preserve. The Board made the Core Benefits determination considering the services that are required by law or administrative policy, services that will reduce inpatient hospitalization, and services that support our priority populations.

Part One - Core Benefits (those benefits guaranteed all residents if needed, regardless of their ability to pay.)

Prevention/Education
 Screening
 Hotline
 Crisis Intervention
 Inpatient Hospitalization
 Alcohol/Drug Detoxification
 Central Pharmacy
 Medicaid Match

Part Two - Traditional Benefits (those benefits offered with current resources.)

All Core Services
 PLUS
 Diagnostic Assessment
 Group Counseling
 Community Psychiatric Supportive Treatment (CPST)
 Pharmacological Management

Part Three - Value Additions (those benefits the Board makes available through special resources - e.g. grants, or through community-based partnerships.)

All Core Services
 PLUS
 All Traditional Services
 PLUS
 Individual Counseling
 Housing
 Jail-Based Services
 Peer Support Services
 Criminal Justice Services
 Early Childhood Mental Health
 Vocational Support
 Mental Retardation/ Mental Illness Dual Diagnosis
 Traumatic Brain Injury Supportive Services
 Aging-Specific Services
 NAMI Hope Alliance
 Faith Community Partnerships

Implications of Identified Priorities to Other Systems

B.3 - The Board makes every effort to be an outstanding community partner, collaborating with other systems, agencies, organizations, and individuals to ensure that community behavioral health needs are met. The Board is aware, however, that there remains significant need in the criminal justice system, in local schools, and with persons who commit sex-related offenses.

Treatment and Recovery Support Investor Targets

Treatment and Recovery Support Investor Targets

C.1 - ODADAS

- Number of customers who are abstinent at the completion of the program.
- Number of customers who are gainfully employed at the completion of the program.
- Number of customers who incur no new arrests at the completion of the

program.

- Number of customers who live in safe, stable, permanent housing at the completion of the program.

ODMH

- Number of consumers reporting positively about their quality of life
- Decrease criminal and juvenile justice involvement
- Increase Access to Housing

ORC 340.033(H) (HB 484) Investor Target

C.2 - *Decrease criminal and juvenile justice involvement

*Number of customers who are abstinent at the completion of the program

HB 484 funds are currently being used to develop a Parent Drug Court in Allen County that is a collaboration of CSB, Juvenile Court, Family Resource Centers and the Board. It is a direct result of the Ohio Summit on Children convened by Governor Strickland and the Chief Justice in May 2008. The goal is to engage parents with addiction and abuse issues in danger of losing their children in treatment. The court then holds CSB, treatment providers and the parents accountable for follow through.

HIV Early Intervention Investor Target

C.3 - N/A

Section V: Collaboration

Continuity of Care Agreements

A - The Continuity of Care Agreement with Northcoast was approved by the Board on April 15, 2009. Forty prescreening staff will be trained by May 15.

Benefits/Results Derived from Collaborative Relationships

B - The Board has maintained a significant number of collaborative relationships.

- a. Family and Children First Councils in Allen, Auglaize and Hardin Counties
- b. Councils on Aging in Allen, Auglaize and Hardin Counties
- c. PSA 3 Area Agency on Aging
- d. Law Enforcement and Criminal Justice Task Force Allen County - including Law enforcement agencies, probation and parole, MRDD, State DRC representatives, Allen Correctional, Lutheran Social Services, Family Resource Centers, Alvis House, Juvenile Court, CSB, Drug Court, WORTH Center, Crisis Center, County Jail
- e. Criminal Justice Task Force Auglaize County - Agency Providers, County Jail, Probation and Parole
- f. Community Corrections Planning Boards Allen and Hardin Counties
- g. MIMRDD Task Force - Three county regional task force including superintendents, agency providers, family member, board staff, with plans to include Putnam County
- h. Faith Partners - agency staff, board staff, 32 church representatives, community providers
- i. Hospital Collaborations with St. Rita's Medical Center, Dettmer, Lincolnway Behavioral Healthcare
- j. Behavioral Health Advisory Councils in Allen and Auglaize Counties including human services directors, agency staff, board staff, board members, NAMI, corrections
- k. Autism Leadership Group - involves parents, professionals, agency staff, and MRDD in working collaboratively to discover the best programming to address the increasing demand.

Consultation with county commissioners regarding services for individuals involved in the child welfare system

C - HB 484 funds are currently being used to develop a Parent Drug Court in Allen County that is a collaboration of CSB, Juvenile Court, Family Resource Centers and the Board. It is a direct result of the Ohio Summit on Children convened by Governor Strickland and the Chief Justice in May 2008. The goal is to engage parents with addiction and abuse issues in danger of losing their children in treatment. The court then holds CSB, treatment providers and the parents accountable for follow through.

Involvement of customers and the general public in the planning for service provision

D - D. Customers and the Public have opportunities for involvement in a number of ways:

- a. The board has participated in county wide needs assessments in Auglaize and Allen Counties and is taking a significant role in the PFS process in Hardin County
- b. The board has initiated two special focus areas for planning and implementation:
 - i. AoD Services - The board involved over 150 consumers, families, providers, community leaders in an assessment of the AoD Services needs that resulted in a program model the board intends to implement in the next 6 - 18 months. An Advisory Committee is being established from the participants to oversee the implementation effort.
 - ii. School Programming - The board has engaged superintendents, teachers, social workers, guidance counselors, and agency providers in working to determine the best fit for behavioral healthcare in the schools. This process is still ongoing.
 - iii. Integrated Behavioral Healthcare - The board has initiated dialogue

between its designated agency and the local federally qualified health center to explore ways to better integrate primary care into the behavioral healthcare providers program. Jonas Thom from the center for excellence and Janice Bogner from the Cincinnati Health Foundation have provided invaluable assistance in this effort. Currently focus groups of consumers and family members are being developed to further study this process of integration. In the newly remodeled behavioral healthcare facility two exam rooms were developed to accommodate primary physical healthcare in the center.

iv. Autism - The board as part of the MIMRDD Task Force initiated a study group of parents, providers, and MRDD staff to work together to develop plans for providing services and programs to this special needs population. In the past two years the group has sponsored a conference to better understand this issue. The group continues to meet to assess, plan, and prioritize needs.

v. Crisis Services - A small workgroup with consultation from Coleman Services is working collaboratively to initiate a new level of crisis stabilization services combining crisis response and hot line services into a single entity. The board, hospital and designated agency are working to develop a model for the community.

c. All of the groups identified in "B" above serve to assess, prioritize, and evaluate the needs of the community and the role of behavioral healthcare.

Section VI: Evaluation

Board's Approach to Evaluating the Effectiveness and Efficiency of Services in the Overall System of Care

A - A. Two years ago the Board in collaboration with all of the agencies under contract with the board developed the Program Feasibility Analysis (PFA). The purpose of the PFA is to identify the programs the agency wishes to contract for in a particular year and helps the board as an investor to understand the scope and the outcome of each program under contract. All public funds expended by the board are required to be identified in a PFA by each agency. The PFA covers the following areas:

- a. Program Summary
 - b. Location of the Service
 - c. Cost of the program in Total
 - d. Number of persons to be served
 - e. Community need identified and how the need was identified
 - f. Evidence based or research based practice(s) to be utilized
 - g. National Outcome Measures (NOMS) to be addressed
 - h. Fit with the board's strategic plan
 - i. Fit with agency mission
 - j. Detailed program description including staff, credentials, services, etc.
 - k. Access
 - l. Collaboration with other agencies
 - m. Logic Model identifies the outcomes to be achieved
- Reports are submitted quarterly to the board and then reported at periodic board meetings to update board members and others about progress in achieving the goals. Occasionally an underperforming programming will be "tweaked" or "remodeled" to better achieve its goals as a mid course correction. Agency supervisors then use these outcomes as a management tool to assist direct service providers to "stay on task" with the outcomes they have identified to be achieved. In this way from top to bottom everyone is watching the same indicators.

Collaboration with the Agencies in Evaluating Services.

B - B. The board and the agencies work together to identify the programs to be implemented and the outcomes to be achieved each year. Implementation of the PFA's is an ongoing process that the board and agencies enter into each year prior to contracting and then serve as the basis for ongoing discussion throughout the contract year. Discussion is often focused on outcomes and what is working or not working so that together we invest resources where they are most needed and most productive.

Services or Programs Having the Highest Priority for the Evaluation of Effectiveness and/or Efficiency

C - C. The Board has established two "safety net" areas it considers of highest priority:

- a. High Acuity services - persons with severe and persistent mental illness and addiction especially those dually diagnosed - these services include
 - i. Psychiatry
 - ii. CPST
 - iii. Therapy
 - iv. Housing and Employment
 - v. Crisis Services
 - vi. Peer Support / Support Groups
 - vii. Hospitalization

- b. Early Intervention and Prevention Services
 - i. Early childhood
 - ii. School programming
 - iii. Educational programming
 - iv. Support Groups
 - v. Psychoeducational groups
 - vi. Crisis Services / hot line

Using the Results from the Evaluation of Programs/Services

D - D. Based on quarterly reporting of outcomes the board works with providers and various collaborative groups to determine whether a service is meeting or exceeding expectations and whether to continue or to expand services in that area (for example, school based services, integrated services with other physical health care, peer support programming). If programming is not meeting expectations then a change of directions is indicated (for example, AoD services have not met expectations with regard to volume or outcome and so a new program model is being developed in cooperation with collaborative groups and consultants to help modify and re-engineer the services program for Allen County - the same service is doing well in Auglaize and Hardin but there is need there for more community outreach and engagement). Contracting decisions then are made as to the form the program contract takes (fee for service, grant, performance grant or cost reimbursement.) For example, school programming seems to be doing well as a fee for service program and agencies are being encouraged to develop a core set of services that mix traditional outpatient programming with early intervention services, teacher outreach and family education programs and the working with each school building to tailor the services package to meet the unique needs of that school.

Strategies to Evaluate Child & Adolescent Services Versus Adult Services

E - E. No. The Board uses the PFA process and focus groups (as needed) to evaluate each program delivered to each population. There are enough ongoing collaborative groups meeting frequently enough to be able to make mid course corrections as well as to gain very quick feedback as to the effectiveness or ineffectiveness of programs as they are launching.

Section VII: Ohio Department of Alcohol and Drug Addiction Services Waivers

A. Waiver Request for Inpatient Hospital Rehabilitation Services

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

Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. Medicaid-eligible recipients receiving services from hospital-based programs are exempt from this waiver.

Agency	UPID	Allocation	Services
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B. Request for Generic Services

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

Agency	UPID	Allocation	Services
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Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level	e. Evidence-Based Practice (EBP)	f. Number of Sites	g. Located outside of board area	h. Funding Source		i. MACSIS UPI
								ODADAS	Medicaid Only	
				(Universal, Selected or Indicated)	(List the EBP name)		(Check the box if yes)			
Prevention										
Information Dissemination	Lima UMADAOP	Outreach	General	Universal		1	No	Yes	No	5004
	Family Resource Centers	General Info Dissemination	All	Universal		3	No	Yes	No	6370
	ASTOP	Outreach	General	Universal	N/A	2	No	Yes	No	10686
Alternatives	Lima UMADAOP	Teen Peer Educators	Youth	Universal		1	No	Yes	No	5004
Education	Lima UMADAOP	Teen Peer Educators	Youth	Universal		1	No	Yes	No	5004
	Family Resource Centers	Active Parenting	Parents	Universal	Active Parenting	3	No	Yes	No	6370
	Family Resource Centers	Life Skills	youth	Universal	Life Skills Training	15	No	Yes	No	6370
Community-Based Process	Lima UMADAOP	Teen Peer Educators	youth	Universal		1	No	Yes	No	5004
	ASTOP	Bridgebuilders	Coalition	Universal	N/A	1	No	Yes	No	10686
Environmental										
Problem Identification and Referral	Lima UMADAOP	Teen Peer Educators	Youth	Indicated		1	No	Yes	No	5004
	Family Resource Centers	School Based	Schools	Indicated	Student Assistance Programs	12	No	Yes	No	6370
	Family Resource Centers	Teen Screen	Youth	Universal	Columbia University Teen Screen	15	No	Yes	No	6370
	ASTOP	Family Intervention	Families	Indicated	N/A	1	No	Yes	No	10686
	ASTOP	Moral Reconciliation Therapy	Adult	Indicated	MRT	3	No	Yes	No	10686
	ASTOP	STEPS	Adults	Indicated	Prevention Research Institute	1	No	Yes	No	10686
Pre-Treatment (Level 0.5)										
Pre-Treatment										
Outpatient (Level 1)										

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level	e. Evidence-Based Practice (EBP)	f. Number of Sites	g. Located outside of board area	h. Funding Source		i. MACSIS UPI
								ODADAS	Medicaid Only	
				(Universal, Selected or Indicated)	(List the EBP name)		(Check the box if yes)			
Outpatient	Family Resource Centers	AoD Outpatient	Youth			3	No	Yes	No	6370
	Lutheran Social Services	AoD Outpatient	Adults		Stages of Change, Thinking for a Change, MRT	3	No	Yes	No	10441
Intensive Outpatient										
Day Treatment										
Community Residential (Level 2)										
Non-Medical										
Medical										
Subacute (Level 3)										
Ambulatory Detoxification										
23 Hour Observation Bed										
Sub-Acute Detoxification										
Acute Hospital Detoxification (Level 4)										
Acute Detoxification										

Promising, Best, or Evidence-Based Practice	Provider Name	MACSIS UPI	Number of Sites	Program Name	Funding Source (Check all that apply as funding source for practice)				Est. Number Served in SFY 09	Est. Number Planned for in SFY 10
					Medicaid + Match	GRF (Not as Medicaid Match)	Levy (Not as Medicaid Match)	Other (Not as Medicaid Match)		
Integrated Dual Diagnosis Treatment (IDDT)										
Assertive Community Treatment (ACT)										
Intensive Home-based Treatment (IHBT)	SAFY	10578	1		Yes	No	No	Yes	150	150
Multi-Systemic Therapy (MST)										
Functional Family Therapy (FFT)										
Supported Employment	Family Resource Centers	6370	1		Yes	Yes	Yes	Yes	75	75
Supported Housing	Lutheran Social Services	10441	1		Yes	Yes	Yes	Yes	80	80
Wellness Management & Recovery (WMR)										
Crisis Intervention Training (CIT)	ASTOP	10686	1		No	No	Yes	No	25	25
Therapeutic Foster Care										
Therapeutic Pre-School										
Transition Age Services										
Integrated Physical/Mental Health Services	Lutheran Social Services	10441	1		Yes	Yes	Yes	Yes	0	350
Older Adult Services										
Sexual Offender Services	Family Resource Centers	6370	1		Yes	Yes	Yes	Yes	30	30
Consumer Operated Service										
Clubhouse										
Peer Support Services	Lutheran Social Services	10441	1		No	No	Yes	No	500	500
MI/MR Specialized Services	Lutheran Social Services	10441	1		Yes	Yes	Yes	Yes	25	25

Promising, Best, or Evidence-Based Practice	Provider Name	MACSIS UPI	Number of Sites	Program Name	Funding Source (Check all that apply as funding source for practice)				Est. Number Served in SFY 09	Est. Number Planned for in SFY 10
					Medicaid + Match	GRF (Not as Medicaid Match)	Levy (Not as Medicaid Match)	Other (Not as Medicaid Match)		
Consumer/Family Psycho-Education	Family Resource Centers	6370	3		No	Yes	Yes	No	100	100
	Lutheran Social Services	10441	3		No	No	Yes	No	500	500