



***Ohio Department of
Mental Health***

**Mutual System Performance Agreement/
Community Plan Survey**

**Final Report
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**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

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**These sections include new information from the previous version (October 10, 2006).*

MSPA EXECUTIVE SUMMARY

Introduction

The purpose of the MSPA Community Plan Survey (CPS) is to guide the quality improvement process of the State of Ohio's system of services for persons with mental illness and serious emotional disturbances. In addition, the MSPA-CPS is designed to collect access and capacity information for budget advocacy and Federal Block Grant reporting purposes. The MSPA-CPS provides the only continuous statewide study of the mental health service system, identifying system-wide gaps, challenges, strengths, solutions and emerging issues within the system.

Both quantitative and qualitative methods were used to describe the current adult and child/adolescent mental health practice patterns in Ohio. All 50 Boards responded to the MSPA-CPS, allowing for a rich and detailed examination of the available services to individuals within and across communities in Ohio. At the request of the Executive Policy Management Committee (EPMC), some data have been analyzed by Boards' demographic classifications.

Limitations

Data collection at the Board level is a process of quality improvement in its own right, and some information should be interpreted with caution due to potential reporting errors. For example, some respondents might not have interpreted some items, such as item 7.5.4 about Medication, as intended (i.e., some percentages were reported at .25% versus possibly intending to report 25%). Consequently, when interpreting responses where percentages were reported by the Boards, please bear in mind the range of answers may be skewed. Another questionable result can be found in item 7.4.4 about Cluster-Based Planning due to confusion between the evidence-based practice associated with the Department's CCOE at Synthesis, Inc., and the more generic reference to System of Care coordination as "cluster-based planning."

In future editions of the MSPA-CPS, ODMH and OACBHA hope to improve the quality of data by asking for a numerator and denominator and/or providing better instructions on how to identify and collect the information.

Readers are advised to keep in mind that some MSPA-CPS questions involved planning for Fiscal Years (FY) 2008-2009, a biennium covered by the Calendar Years (CY) of July 1, 2007 through June, 30, 2009. In some cases, questions pertained to conditions that existed in FY 2005. The results of these questions are indicated by that FY. In other cases, questions pertained to conditions existing in CY 2006, CY 2004, or CY 2002. The results of these questions are indicated by the CY.

7.2 SERVICE POPULATIONS

In Board planning for FY 2008-2009 biennium, the projected adult service provision differed based on Medicaid status. According to the results of the MSPA survey, overall, Boards planned to support more services to non-Medicaid recipients.

Overall, there were no significant differences between child/adolescent services based on Medicaid status. On average, Boards planned to support as many services for children diagnosed with an SED as for those with a non-SED diagnosis.

Additional Approaches to Determining SMD/SED

Several Boards discussed using additional measures of SMD/SED other than the one provided by MACSIS for service planning. Areas of interest to these Boards included functioning scores from the Ohio Scales, inclusion of Personality Disorders, and less emphasis on hospitalization.

Medicare Subsidies

For the period of FY 2005, Boards reported providing Medicare subsidies to a total of 12,994 persons who were served in mental health agencies across Ohio. The Boards also supported services to 10,302 Medicare consumers who did not receive Medicare subsidies. Only two Boards, one in a Trans-Rural and one in a Metro-Urban community, reported having no Medicare consumers. Overall, 60% of the Boards reported spending money on Medicare subsidies. The total dollars reportedly spent on Medicare subsidies was \$6,469,234.

7.3 ADULT SERVICES

Hospitalization, Crisis, Intensive Services, and General Outpatient Care

Twenty-nine (29) Boards reported an increased demand for local and state hospital beds.

Twelve (12) Boards reported in CY 2006 no after-hours crisis care coverage by a psychiatrist, an increase of five (5) Boards reporting this capacity gap since CY 2002 when the number was seven (7). In addition, 12 Boards reported capacity gaps in access to crisis care facilities, community hospital emergency rooms, and crisis observation beds; in CY 2004, only two Boards reported capacity gaps in all three types of crisis care settings. Boards discussed a number of solutions for managing capacity gaps in crisis care, including implementation of CIT with local law enforcement.

The majority of Boards reported wait times of less than an hour for most adult crisis services. The services with the greatest wait times were transportation to state or local hospitals and respite beds or emergency shelter services.

Thirty-four (34) Boards reported the availability of time-limited partial hospitalization programs, a 28 percentage-point increase in the availability of such programs since CY 2004. Fewer Boards reported providing intensive CPST or ACT in CY 2006 than in CY 2004, but the majority of Boards providing these services reported wait times of 10 working days or less. Boards identified the change in ACT standards requiring non-Medicaid billable services as a significant reason for decreased availability.

CPST for the general outpatient population was not available in six (6) Board areas. However, overall system-wide general outpatient service capacity has remained stable since CY 2002. Access times for Psychiatry (Med-Somatic) service and CPST have increased to lengthier waits in the majority of Boards during that time. The majority of Boards stated that funding and staffing issues impacted their ability to provide general outpatient services.

Competitive Employment, Chronic Homelessness, and Housing

Sixty percent of Boards were able to estimate the percent of adult consumers with SMD who were competitively employed. Of those with data, the statewide percentage of consumers competitively employed was 11.4%, based on a high/low range of 10.0% and 26.0%.

Forty-three (43) Boards estimated that a total of 4,308 persons with SMD are chronically homeless in Ohio. The Homeless Management Information System (HMIS) was the most widely used database for estimating the number of chronically homeless persons with SMD.

Thirty-eight (38) Boards reported a total of 2,321 consumers waiting for supported housing, or an average of 61.1 consumers per Board area. The average time for the majority of consumers to access supported housing, statewide, was one to six months (43% of Boards), although some consumers waited more than one year in 19% of Board areas. Thirty-seven (37) Boards estimated a total of 2,995 consumers on are wait lists for Housing Assistance Program (HAP), or an average of 81 consumers per Board area. In the majority of Boards, consumers wait between one month and a year to access HAP. In 42 Boards, an estimated 5,876 consumers were on wait lists for public housing, or an average of 140 consumers per Board area. This difference represents a 12% increase since CY 2004 in the average number of consumers waiting for public housing. Consumers

wait well over a year in the majority of Board areas to access public housing.

Evidence-Based Practices (EBPs)

More than half of the Boards reported offering the following practices/services: Anger Management/ Domestic Violence (86.0%), Family to Family (80.0%), Peer Support Services (80.0%), Consumer Psycho-education (72.0%), Interpreter Services (68.0%), Consumer Operated Services (56.0%), Supported Employment (56.0%), Integrated Dual Diagnosis Treatment (54.0%), and Older Adult Services (50.0%). Less than one-third of Boards statewide reported offering ACT (30.0%), Clubhouse (28.0%), and Cluster-Based Planning (24.0%).

Boards also report increased pressure from regulators and payers to provide EBPs. Although Boards indicated a desire to provide these services, adoption was hindered by funding constraints and staff recruitment and retention. Trauma-informed care was the most frequently requested EBP for adults for which technical assistance was cited as needed.

7.4 CHILD AND ADOLESCENT SERVICES

Residential Care, Crisis, Intensive Services, and General Outpatient Care

Boards estimated 1,535 children were placed in residential treatment centers (RTCs) over a 12-month period in FY 2005. This change represents a 10 percentage-point decrease in the number of children reported placed in RTCs during FY 2003. Despite this decrease, two-thirds (66%) of Boards reported that 100% of children placed in RTCs went out-of-county for this service in FY 2005. Boards discussed a number of approaches to reducing the number of RTC placements, including FAST/ABC funds, pooled funding across agencies, increased coordination between service sectors, and implementation of EBPs like IHBT, wrap-around, and school-based models.

Sixteen (16) Boards reported in CY 2006 no 24/7 coverage by psychiatric staff, an increase of two (2) Boards with this capacity gap over the past two years. The largest capacity gaps in crisis care for C&A consumers were dedicated crisis care facilities and hospital contracts for observations beds, where 80% and 88% of Boards, respectively, reported no service capacity. The majority of Boards reported wait times of less than an hour for access to crisis care, except in the case of respite beds.

Twenty-five (25) Boards reported the availability of IHBT or MST in CY 2006, a decrease of four (4) Boards reporting this service in CY 2004.

Over the last two years, however, the number of Boards reporting access times of 10 working days or less for IHBT/MST increased from six (6) to 12. Access to time-limited partial hospitalization programs for C&A consumers decreased from 10 to six (6) Board areas between CY 2004 and CY 2006. This difference is a reverse of the upward trend in adult partial hospitalization access reported over the same time period.

The number of Boards reporting the availability of Treatment Foster Care has increased, but there has been a decrease in Board areas where Transitional Living service was available between CY 2004 and CY 2006.

All 50 Boards reported the availability of Med-Somatic and Non-Physician Diagnostic Assessments for C&A consumers in the general outpatient level of care in CY 2006. Nevertheless, over the past two years there has been no reduction in the number of Boards where consumers wait 11 working days or more for Med-Somatic service. In CY 2006, more Boards reported wait lengths in the 11+ working day category for Non-Physician Diagnostic Assessment than in CY 2004.

Despite the availability of FAST dollars in CY 2004, a common theme throughout Board comments about C&A service programming was the lack of funding. Boards, regardless of regional differences, reported a lack of funding and pending cutbacks in services due to funding shortfalls. Many Boards indicated a desire to enhance existing services to C&A consumers, but were not able to for financial reasons. To address the lack of funding, many of the Boards reported that an increase in System of Care collaboration through ABC planning is helping to ensure that the most-in-need C&A consumers receive services. A number of Boards reported low-cost alternatives to support C&A consumers and their families, such as the development of support groups, networks, and psycho-education.

Evidence-Based Practices (EBPs)

More than half of all Boards reported offering the following practices/services: School-based (98%), Family Therapy (80%), Interpreter Services (76%), Early Childhood Care (80%), Sexual Offender Treatment (66%), Family Psycho-education (64%), and Trauma-informed Care (50%).

School-based Services

Forty-seven Boards (47) supported mental health services in 380 Ohio school districts through funding and cross-system collaboration on resource alignment. As the total number of school districts is reported by Ohio Department of Education (ODE) at 611, these data indicate that 62% of all school districts in the state are open to some form of mental health programming. Services were located in 1,475 school buildings. As the

total number of school buildings is reported by ODE at 3,610, these data indicate that 41% of all school buildings in the state provide some form of mental health programming.

7.5 ADDITIONAL ACCESS ISSUES

Telemedicine

Five (5, 10%) Boards indicated that telemedicine was currently offered in their areas. Of these five (5) Boards currently utilizing this service delivery method, two (2) Boards specifically mentioned some benefits they are realizing or hope to realize due to the availability of telemedicine: the reduction in drive time for the providers, increased access to services when needed versus waiting for an appointment, and retention of staff.

Disaster Preparedness

There were five (5) main strategies/approaches to disaster and terrorism preparedness that the Boards utilized: training sessions, plans, collaboration with other entities, regular meetings, and mock drills/exercises.

Prevention, Consultation and Education (PC&E)

Boards reported a total of 462 separate activities in the Prevention, Consultation and Education (PC&E) Inventory. Boards ranked education as the most frequent activity (N=309), followed by prevention (N=273), and consultation (N=142). Keywords were used to organize PC&E activities into 30 separate categories, which were further aggregated into six broad domains.

The largest domain of aggregated categories was “Treatment and Intervention Issues,” which represented 28.6% of the entire sample. Falling within this domain, Suicide Prevention was the largest category of keyword-identified activities, representing 11% of the total responses.

Medications

The highest statewide medication funding was provided by Pharmaceutical Company Samples (\$8,591,313); half of all Boards reported utilizing samples. The average percentage of consumers receiving medication funded by samples was 34.5%. This figure represents a *potential* substantial vulnerability in the overall system of care should this funding option wane.

System Capacity and Stability

Twenty-three (23) Boards reported “No significant change” occurring in the number and type of ODMH-Certified providers. The majority of the remaining 27 Boards (16) reported additional Medicaid-only service providers, both in-county and out-of-county.

Average caseloads for med-somatic practitioners have decreased since CY 2002 for both adults and children, but continue to remain higher than recommended best practice. Average CSP caseloads for adult and C&A consumers increased slightly since CY 2002. The largest increase in average caseloads size occurred among counselors for C&A consumers.

The percentage of Boards reporting access to Advanced Nurse Practitioners (ANP) with prescriptive privileges more than doubled over the last two years. In CY 2006, 40% of Boards reported the availability of such staff; in CY 2004, only 18% of Boards reported ANP FTEs. It is unknown how many ANPs serve adult versus child and adolescent consumers.

7.6 QUALITY IMPROVEMENT

Recovery & Resiliency

Forty-eight (48) Boards answered the question about a consumer-driven service orientation toward recovery. This orientation to service delivery was expressed via a few specific themes:

- Consumer Involvement in Policy and Service Planning, which included a few specific areas of focus:
 - Recovery Focus,
 - Education and Training Focus, and
 - Employment Focus
- Consumer Questionnaires and Needs Assessments

Thirty-three (33) Boards specifically mentioned a commitment to recovery and/or a recovery focus in service delivery.

In total, the funding listed by the Boards in support of peer support and consumer operated services was \$7,766, 942. However, the Boards did not provide figures for the same fiscal year. Some provided dollar amounts for FY 2006 and some projected amounts for FY 2007, while others did not report a time frame for the funding.

Outcomes Based Performance Improvement

The Boards presented several activities and strategies they use to help providers meet the 80% threshold for Outcomes data submissions required by the Certification standards. Forty-nine (49) Boards answered this question. The most frequently mentioned strategy was technical assistance (N = 13 Boards).

In setting a target for submission of Outcomes data, some boards (N = 8) set their target above the 80% threshold (targets ranged from 90% to 100%). The majority (N = 34) of Boards set the target at the 80% threshold. Five (5) Boards did not report a target and three (3) Boards left this item blank.

There was a “continuum” of Outcomes data use for performance improvement presented in the 47 Boards’ responses, which ranged from lack of use of Outcomes data to use of Outcomes data in decision making. Eight (8) of the 47 Boards reported they were not able to use the Outcomes data because the data were not available to use or there were not enough data available for effective policy planning or evaluation. On the other end of the continuum, eight (8) Boards noted use of Outcomes information when making funding decisions, specifically, contracting based upon results.

Consumer and Family Empowerment

Boards reported engaging consumers and family members in a number of decision-making processes at the local level. Many Boards discussed engaging consumers in policy-making (98%), program evaluation (80%), and provider performance monitoring (66%). A number of boards also reported involving consumers and family members in governing boards (N=28), special committees (N=38), and to conduct needs assessments for program planning (N=15).

Consumer Grievances, Complaints and Other Feedback

Twenty-three (23) Boards provided examples of complaints and grievances which have impacted local systems. The most common complaints or grievances listed were about poor access to transportation, lengthy wait times, eligibility of non-Medicaid consumers for services, and infringements on client rights. A number of solutions were mentioned to address these problems, including: increasing mobile crisis outreach, developing new procedures for state hospital access, and a wait-list report. Boards also indicated that they were providing supplemental funding for non-Medicaid-eligible consumers.

Cultural Competence

Forty-nine (49) Boards reported engaging in processes to ensure culturally competent services were being provided by agencies. Board activities included: consumer and family involvement (N=24), staff training (N=23), formal agency reviews (N=15), recruiting culturally diverse staff (N=11), translation services (N=9), informal evaluation (N=7), and use of the Consolidated Culturalogical Assessment Toolkit (N=6).

7.7 CROSS-SYSTEM ISSUES

Coordination of Child-Serving Systems

Over 75% of Boards indicated significant collaboration activity with Families and Children First Councils (98%), Juvenile and Family Courts (94%), Public Child Service Agencies (88%), and School Boards and Schools (84%). The smallest percentage of Boards (30%) reported collaboration with Primary Care Physicians. Boards discussed a number of issues, impacts, and innovative solutions to cross-system collaboration in this area, including the significant role of the ABC planning process and collaborative funding opportunities.

Adult and Juvenile Criminal Justice

Fifty percent of Boards provided information on the number of incarcerated adult consumers. Boards estimated that 5% of all adult consumers and 7% of consumers with a diagnosed severe mental disorder were incarcerated over the past year. Additionally, Boards indicated that of the total number of Court-referred adults, 38% received mental health services. The Boards discussed a number of challenges to supporting adult consumers with criminal justice involvement, including: a lack of resources, poor workforce training, and the need for more collaboration between courts, jails, and the mental health system, and the need for increased recruitment of staff to work with persons with mental disorders.

Twenty Boards (40%) provided information about the number of Court-involved juveniles receiving services. These boards estimated that 2,926 consumers were court-involved in CY 2006. Fifty percent (50%) of the Boards reported funding services to county juvenile detention centers. Challenges to providing services to juveniles with criminal justice involvement were inadequate funding, inadequate treatment resources (i.e., needing to send children outside of their county of residence), and issues surrounding relinquishment of custody.

Integrated Physical Health Care

Boards defined four areas of physical and behavioral health care service integration in a variety of ways, allowing for open-ended exploration of a newly emerging issue. The most widely available service, Medication Compliance and Side-Effect Monitoring, was available in only 66% of

Boards. Physical Health Information and Referral was available in 56% of Boards, Physical Health Assessments in 38%, and Home Visiting Services in 26%. Boards described a number of approaches to the issues and challenges of physical health care integration, including prioritization of service populations, the use of inter-disciplinary teams, and service agreements with public health clinics.

Older Adult Services

Although 70% of Boards reported significant collaboration with Area Councils on Aging, nearly as many (60%) also reported working with local coalitions and networks. Boards indicated they were in the earliest stages of needs assessment and planning. Boards were not specific about older adult issues in their discussion of collaborative relationships with AOD Agencies, MR/DD Boards, County Health Departments, or the Courts and Judicial System.

Project Design

Participants

Fifty Boards were provided the survey to complete regarding their service provision to persons with a mental illness or serious emotional disturbance. All Boards were required to answer the quantitative portions of the survey. Respondents were also asked to voluntarily provide short, written narratives about their current strengths and needs as they pertained to mental health care and ancillary services within their communities. Not all Boards provided additional narratives. Nonetheless, the available responses were rich in detail and provide a number of repeated themes, painting a picture of the current state of services available for persons with mental illness in the State of Ohio.

Methods

This project utilized a mixed-methods evaluation design. Both quantitative and qualitative data (in the form of open-ended questions) were collected using the MSPA survey instrument distributed in February, 2006. Data collection took place from February, 2006 to May, 2006.

All 50 Boards responded to the survey and provided information indicating the mental health services that the local mental health system used and/or supported for FY 2005-2006 (a response rate of 100%). The review of the proposed mental health services focused on a population-based analysis of the following areas: Medicaid/Medicare service data, the adult service array, the child and adolescent service array, access issues, quality improvement, and cross-system issues. In total, Boards responded to 87 questions (including close-ended and open-ended) involving multiple response points.

Data Management and Analysis

Quantitative data from the MSPA surveys were abstracted by the project team into MS Access and then imported into MS Excel and SPSS 14.0 for analysis. Analyses were conducted by OPER staff trained in both quantitative and qualitative methods. Analyses included the use of common measures of central tendency (e.g., sums, percentages, means, and medians) to determine service penetration across counties based on geographic typology. For the purposes of this analysis, county typology included: Rural, Trans-Rural, Trans-Metro, Metro-Urban, and Urban (see Appendix A page 115 for breakdown of counties by geographical type).

Qualitative data (open-ended questions) were abstracted into an Access database and analyzed using ATLAS.ti software. Initially, OPER staff read and organized the data categorically by question and pre-selected categories. These coded passages were then discussed collaboratively to identify and report relevant themes. Examples of both typical and atypical responses were identified for inclusion in this report.

MSPA – Community Plan Survey

7.1 Background and Context

**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

7.1 Background and Context

The MSPA – Community Plan Survey was developed out of work guided by the Executive Policy Management Committee (EPMC), a joint Ohio Department of Mental Health (ODMH) and Ohio Association of County Behavioral Health Authorities (OACBHA) committee. The results of the survey are intended to provide the Department and Boards with information needed to determine whether current planning and actions are sufficient to ensure the viability of the public mental health system in Ohio. The EPMC intends to use the data in the Community Plan Survey report to:

- Identify areas of mutual statewide concern and success among ADAMH/CMH Boards and ODMH regarding adults with SMD and children and youth with SED.
- Identify changes in local systems since the last Safety Net Survey was completed.
- Identify critical gaps in planning and actions to deal with statewide and local fiscal pressures.
- Identify local systems that are maintaining and improving quality despite fiscal pressures.
- Identify technical assistance needs (not limited to those available at ODMH).
- Identify critical gaps in planning and action to deal with access and continuum of care issues between the ADAMH/CMH Boards and the Behavioral Health Organizations (BHOs).
- Provide data for effective budget advocacy and education locally and statewide.

The remaining sections of this report document the results of the MSPA – Community Plan Survey.

MSPA – Community Plan Survey

7.2 Service Populations

**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

BACKGROUND – Service Populations

This chapter details the service population served by Boards by SMD/SED status and by Medicaid/Non-Medicaid status for adults, and for children and adolescents. The following areas were the focus of this evaluation:

- 7.2.1 SMD/SED Medicaid/Non-Medicaid Population by Services
 - 7.2.2 Medicare Population
-

RESULTS

7.2.1 Services provided by SMD/SED status and by Medicaid status

This section outlines which mental health services Boards are planning to support for the SFY 2008-2009 for 1) Children and Adolescents, and 2) Adults. Importantly, the following data reflects only the information provided by the Boards in the MSPA survey.

NOTE: These data should be interpreted with caution. Results may be an artifact of discrepancies in how questions were interpreted and reported by the various Boards. For example, data was reported for services rendered to children in the adult matrix and adults in the children's matrix (e.g., 14% of Urban Boards are planning to support adults in foster care; 17% of Trans-Metro Boards are planning to support employment services to children and adolescents; and 22% of Trans-Rural Boards are planning to support subsidized housing to children and adolescents). Nonetheless, even with the existing incongruities, the data may provide an overall image of the services being provided to persons with psychiatric disabilities throughout the state of Ohio.

CHILD AND ADOLESCENT SERVICE PROVISION

Overall, there are no significant differences between children and adolescent services based on Medicaid status. On average, children diagnosed with an SED receive more services than those with a non-SED diagnosis. For example, more Boards plan to support IHBT services (40%) to SED children than non-SED children (24%). In addition, Boards report planning to support respite care more frequently to SED children (58%) than to non-SED children (42%).

All Boards (100%) report supporting Individual and Group Behavioral Health Counseling, Individual Community Psychiatric Supportive Treatment, Mental Health Assessment, and Pharmacological Management to SED children and adolescents. A large percentage of Boards also support Crisis Intervention Services (96%), MD Psychiatric Diagnostic Services (96%), and Behavioral Health Hotlines (84%) for SED children and adolescents.

A number of regional differences exist between the child and adolescent services the Boards plan to support in FY 2008-2009. Some of these differences are summarized below. For a breakdown of the geographic classifications, see Appendix A (page 115) for the Ohio Department of Mental Health Boards and Census 2000 Population Density Map created by the Ohio Department of Development's Office of Strategic Research in April 2004. For a complete list of services reported by geographic classification, refer to the Tables in Appendix B on pages 116-121).

Compared with all Boards:

- Rural, Trans-Metro, Metro-Urban, and Urban Boards report no school psychology services for any children and adolescents.¹
- Rural Boards plan to support less overall services than all other regions. For the SED population, Rural Boards plan to support fewer IHBT programs (23% less), behavioral health hotlines (34% less), crisis care (35% less), foster care (17% less), inpatient psychiatric services (27% less), and residential care (16% less) than the state's average in each of these areas.
- Trans-Rural Boards plan to support less overall services to SED children and adolescents than the state's average in most service areas. Trans-Rural Boards support fewer crisis services (11% less), respite care (11% less), and residential care (19% less) than the state's average in each of these areas.
- Trans-Metro Boards report supporting *more or about the same* amount of services to SED children and adolescents as the state's average for all services. For the SED population, Trans-Metro areas support 35% more IHBT services, 16% more hotline services, 23% more inpatient psychiatric services, and approximately 25% more crisis services than the state's overall average in each of these areas.
- Urban Boards reported planning to support less crisis intervention mental health services for SED children and adolescents than the state's average for this area (10% less). For the SED population, there is also less inpatient psychiatric services (13% less), prevention (3% less), and IHBT services (11% less). Yet, Urban Boards reported planning to support the utilization of foster care (23% more), residential services (20% more), and temporary housing assistance (21% more) than the state's average in all of these areas.

¹ This may be a result of school psychology being a service of the Ohio Department of Education and not one traditionally offered by mental health agencies.

ADULT SERVICE PROVISION

For SFY 2008-2009, adult service provision planning differed based on Medicaid status. According to the results of the MSPA survey, overall, Boards planned to support more services to non-Medicaid recipients. The results suggest that Boards plan to support more Hotlines (4% more), community residential programs (4% more), consumer operated services (6% more), forensic evaluations (6% more), inpatient psychiatric services (8% more), self-help services (12% more), subsidized housing (6% more), and temporary housing (6% more) to persons who were diagnosed as SMD and do not have Medicaid (see Table in Appendix C, page 122).

All Boards (100%) report planning to support Individual and Group Behavioral Counseling and Therapy, Individual Community Psychiatric Supportive Treatment, Mental Health Assessment, and Pharmacological Management regardless of Medicaid status. In addition, most Boards plan to support Individual Community Psychiatric Supportive Treatment, Crisis Intervention Mental Health Services, and Inpatient Psychiatric Services regardless of diagnosis or Medicaid status. Significant service gaps across all Boards include Adjunctive Therapy (10% or less), Occupational Therapy (6% or less), ACT (34% or less), Adult education (28% or less), and emergency crisis shelter (36% or less).

Regional differences also existed between mental health services the Boards plan to support for adults in SFY 2008-2009. Some of these differences are summarized below (for a complete list of services reported by region, refer to the Tables in Appendix C, pages 122-127):

Compared with all Boards:

- For the SMD population, Rural Boards report planning not to support ACT programming and Adjunctive therapy at all. Further, Rural Boards are planning less support for SMD services in the following areas: Adult Education (9% less), Hotline services (30% less), Consumer Operated Services (22% less), and Inpatient Psychiatric services (23% less) than the state's average for these areas. Yet, Rural Boards also report planning to support more Crisis Intervention services (2% more), Forensic Evaluations (11% more), Residential Care (26% more), and Respite Care (14% more), than the state's average for each of these areas.
- For the SMD population, Trans-Rural Boards reported planning to support fewer services than the state's average for the following services: ACT (4% less), Adjunctive Therapy (4% less), Hotlines (3% less), Community Residences (30% less), Employment (35% less), Forensic Evaluation (15% less), Mental Health Education (5% less), Residential Care (15% less), Peer Services (34% less).

- For the SMD population, Trans-Metro Boards report planning to support more services than the state's average in 18 of the identified 34 service areas (53%). Services that are significantly higher than the state's average are Employment (26% more), Mental Health Education (19% more), and Peer Services (34% more).
- For the SMD population, Metro-Urban Boards are planning to support less partial hospital services (19% less) than the state's average.
- For the SMD population, Urban Boards reported planning to support *more or about the same* amount of services as the state's average for all services. Urban areas plan to support more ACT (25% more), Adjunctive Therapy (19% more), Hotlines (6% more), Community Residences (17% more), Consumer Operated Services (30% more), Employment (5% more), Forensic Evaluation (15% more), and Self-Help or Peer Services (28% more) than the state's average for each of these services.

OTHER OPERATIONAL MEASURES OF SMD/SED SUPPLEMENTAL TO MACSIS

Seven Boards responded to the question about operationalized measures of SMD/SED other than the MACSIS definition. These Boards were Allen-Auglaize-Hardin, Clermont, Columbiana, Hancock, Mahoning, Portage, and Stark. Reasons provided by Boards for additional or supplemental measures of SMD/SED included the need to determine which consumers were eligible for a Board-supported benefit plan, changes in hospital use that made this aspect of treatment history increasingly irrelevant to newly-diagnosed consumers, the desire to target underserved populations in other systems, such as schools and juvenile courts, and the utility of the old 508 assessment by providers.

When describing criteria for additional and supplemental measures of SMD/SED, Boards typically described a combination of diagnoses and functional impairments as criteria, but did not always provide operational measures, i.e., a description of how the criteria were actually calculated. An example of an operational measure would be a cut-off score on the Ohio Outcomes System Adult Provider A Functioning Scale. Two Boards did report using functioning scores from the Ohio Outcomes System to help with determining eligibility. Hancock County Board provided explicit cut-off points for determining SED in combination with a set of target diagnoses and a threshold of service claims:

1. At least one target service claim in MACSIS with a target diagnosis;
2. At least four target service claims, excluding diagnostic assessment;
3. Client was under 18 at some time during the fiscal year;

4. Ohio Scales Problem Severity score of 30 and above;
5. Ohio Scales Functioning score of 40 and below.

Columbiana Board pointed out that the MACSIS-based definition of SMD omitted personality disorders in the current diagnostic criteria, despite the fact that these diagnoses are both severe and persistent. Because of this and the need to identify persons eligible for services, that Board and the Counseling Center had jointly decided to continue using the old 508 eligibility assessment. At the same time, Columbiana Board recognized that the current trend in limited hospital use made the “duration of services” measure in the old 508 assessment increasingly irrelevant. Central elements of Columbiana’s operational measure include:

“Any person receiving Social Security benefits related to a mental health disability: Any person with an Axis I or Axis II diagnosis or diagnoses other than: all V Codes, all Adjustment Disorders, Specific Phobias, Acute Stress Disorder, Sexual Dysfunctions, Sleep Disorders, Dysthymic Disorder, and all Anxiety Disorders, who: Are referred to community support services by another mental health provider, particularly by a psychiatric hospital, based on that provider’s assessment of the person’s need or, who deteriorate in functioning in spite of regular participation in psychotherapy or psychotherapy and psychiatric services; this is often characterized by frequent accessing of crisis and emergency services or Exhibit problems within one or more of the following DSM Axis IV categories that are severe enough to hinder progress in recovery.”

Allen-Auglaize-Hardin Board also reported having developed its own set of criteria for determining SMD, which included a targeted set of Axis I diagnoses, and “at least two psychiatric hospitalizations within the past five years or one psychiatric hospitalization with a stay of 15 days or more.” Like Columbiana County, Allen-Auglaize-Hardin Board also indicated that they use criteria to determine functional impairment, but did not specify how such criteria were actually measured.

7.2.2 Medicare Population in SFY 2005

This section summarizes the Boards’ reports of money expended on Medicare subsidies, and numbers of Medicare consumers served in Fiscal Year 2005 (see Tables in Appendix D, pages 128-129).

For SFY 2005, Boards reported providing Medicare subsidies to a total of 12,994 persons who were served in mental health agencies across Ohio (see Table in Appendix D, page 128). The Boards also supported services to 10,302 Medicare consumers who did not receive Medicare subsidies (see Table in Appendix D, page 129). Only two Boards, one in a Trans-Rural and one in a Metro-Urban community, reported having no Medicare

consumers. Overall, 60% of the Boards reported spending money on Medicare subsidies. The total dollars spent on Medicare subsidies was \$6,469,234. Regional differences between County Boards are summarized below:

- Fifty percent (n=3) of Rural Boards reported expending \$103,964 on Medicare subsidies. This represents the lowest dollar amount of any geographical region in Ohio.
- Sixty-one percent (n=10) of Trans-Rural Boards reported expending money on Medicare subsidies.
- Trans-Metro Boards represented the largest percentage of Boards (63%) providing subsidies to Medicare consumers to obtain mental health services.
- Metro-Urban Boards had the fewest number of Boards (n=2 or 25%) that supported services to Medicare consumers without a subsidy.
- When accounting for region, Urban Boards provided the largest amount of funds on Medicare subsidies (\$4,071,302).

MSPA – Community Plan Survey

7.3 Adult Mental Health Services

**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

BACKGROUND – Adult Services

Adults receive crisis care, intensive care, outpatient services, and other supportive services such as employment or housing supports; they receive services in a variety of settings including emergency rooms, hospitals, drop-in centers, and agencies.

This chapter details the adult services section of the 2006 Mutual Systems Performance Agreement study. The following areas were the focus of this evaluation:

- 7.3.1 Adult Crisis Care
 - 7.3.2 Adult Intensive Care Programs and Services
 - 7.3.3 Adult General Care
 - 7.3.4 Promising, Best and Evidence-Based Practices and Other Services
 - 7.3.5 Competitive Employment
 - 7.3.6 Supported Housing
 - 7.3.7 Chronic Homelessness
 - 7.3.8 The Housing Assistance Program (HAP)
 - 7.3.9 Public Housing
-

RESULTS

This section will outline results from the key research questions of the study. The following topics will be explored: adult crisis services, intensive care programs, general mental health care, and evidence-based practices. Each section will provide a brief overview of both the quantitative and qualitative results, followed by a brief discussion.

7.3.1 Adult Crisis Care

In this subsection Adult Crisis Services in the State of Ohio is profiled. For the purposes of this evaluation, the definition of crisis care for adults is the provision of short-term, acute care to stabilize a person experiencing psychiatric emergency. Services can be provided in a crisis care facility, through mobile response (crisis services to people in their environment as an alternative to treatment in a facility), or through respite or emergency shelter. These services include 24/7 on-call services from mental health professionals, mobile response teams, 24/7 central phone lines, crisis care facilities, hospital emergency room services and observation beds, and respite beds.

One Board implemented a crisis center on a hospital campus. The center staff also respond to ER crises which provides “seamless services to all residents. This has resulted in improved access to services, fewer unnecessary hospital admissions, and a more convenient/accessible service for law enforcement.”
– Allen, Auglaize, and Hardin Counties

ADULT CRISIS CARE SERVICES – AVAILABILITY OF SERVICES

A number of crisis services are available to adults throughout Ohio (see Table 1 below). More than 75% of Boards reported providing 24/7 on-call staffing by psychiatrists and clinical supervisors, a 24/7 central phone line, and Transportation to state or local hospitals. And more than 50% of Boards reported providing 24/7 on-call staffing by case managers, mobile response, and crisis care facilities. Less than half of Boards reported emergency room psychiatric staff, hospital contracts for crisis observation beds or respite beds/emergency shelter services. Some geographical differences are highlighted below (see Tables in Appendix E, pages 130-132).

Compared with all Boards:

- More Rural Boards reported no services for crisis observation beds (100%), Transportation services (66.7%), or mobile response (50%).
- More Trans-Rural Boards reported no services for crisis care facilities (52.9%) emergency room psychiatric staffing (70.6%), and respite beds/emergency shelter (70.6%). All Trans-Rural Boards reported providing a 24/7 central line.
- More Trans-Metro Boards reported no services for mobile response (58.3%), and crisis care (50.0%). More Trans-Metro Boards reported providing respite beds/emergency shelter (66.7%). All Trans-Metro Boards reported 24/7 on-call staffing by clinical supervisors, a 24/7 central phone line, and Transportation to state/local hospitals.
- More Urban Boards reported no services for 24/7 on-call staffing by case managers (57.1%) and Transportation to state/local hospitals (57.1%). More Urban Boards reported providing emergency room psychiatric staff (71.4%). All Urban Boards provide 24/7 on-call staffing by psychiatrists and clinical supervisors, and a 24/7 central phone line.
- All Metro-Urban Boards provide a 24/7 central phone line and a crisis care facility.

ADULT CRISIS CARE SERVICES – ACCESS

The majority of Boards reported wait times of less than an hour for most adult crisis services (see Table 1). Across all Boards, the services with the greatest wait times were Transportation to state or local hospitals (36.0%) and respite beds or emergency shelter services (28.0%).

Table 1. Adult Crisis Care Services (Total Boards)

| Question 7.3.1 Adult Crisis Care Service Availability for All Board Areas | | | | | | |
|---|----------------------|-------------------------|----------------------|-------------------------|------------|-------------------------|
| Approximately How Long Adult Consumers Wait for Adult Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Total Boards | Service Availability | Percent of Total Boards | No Service | Percent of Total Boards |
| 24/7 On-Call Staffing by Psychiatrists | 32 | 64.0% | 6 | 12.0% | 12 | 24.0% |
| 24/7 On-Call Staffing by Clinical Supervisors | 44 | 88.0% | 2 | 4.0% | 4 | 8.0% |
| 24/7 On-Call Staffing by Case Managers | 32 | 64.0% | 3 | 6.0% | 15 | 30.0% |
| Mobile Response | 23 | 46.0% | 7 | 14.0% | 20 | 40.0% |
| 24/7 Central Phone Line | 48 | 96.0% | 1 | 2.0% | 1 | 2.0% |
| Crisis Care Facility | 23 | 46.0% | 8 | 16.0% | 19 | 38.0% |
| Hospital Emergency Room with Psychiatric Staff | 17 | 34.0% | 5 | 10.0% | 28 | 56.0% |
| Hospital Contract for Crisis Observation Beds | 11 | 22.0% | 2 | 4.0% | 37 | 74.0% |
| Contract for Respite Beds/Emergency Shelter | 9 | 18.0% | 14 | 28.0% | 27 | 54.0% |
| Contract for Transport to State/Local Hospital | 21 | 42.0% | 18 | 36.0% | 11 | 22.0% |

1. Less Than One Hour/Percent of Total Boards: (Boards reporting that adult consumers wait less than one hour for admission) divided by (total Boards in state).
2. More Than One Hour/Percent of Total Boards: (Boards reporting that adult consumers wait for more than one hour for admission) divided by (total Boards in state).
3. No Service/Percent of Total Boards: (Boards reporting that service is unavailable) divided by (total Boards in state).

ADULT CRISIS CARE SERVICES ACROSS YEARS (2004 and 2006)

Eight of the services that comprise adult crisis care were measured in 2004 and 2006 (See Table 2). In every case, there is an increased percentage of boards where there is no service. For example, 24/7 On-Call Staffing by Psychiatrists was not available in 15% of Boards in 2004; by 2006, 24% of Boards reported capacity gaps in this service area. The largest decline in a specific service area occurred with mobile response, where the number of Boards reporting no such service doubled from 20% to 40% over a two-year period.

Several service areas in the adult crisis care matrix represent a service location with potential bed space. These are Crisis Care Facility; Hospital Emergency Room with Psychiatric Staff; Hospital Contract for Crisis

Observation Beds; and Contract for Respite Beds/Emergency Shelter. The first three of these service areas were measured in 2004 and again in 2006, when Respite Beds/Emergency Shelter was added to the list. The percentage of boards reporting capacity gaps in all three service areas quadrupled between 2004 and 2006, rising from 4% to 16% of Boards reporting place of service gaps in crisis care (See Table 3).

Table 2. Adult Crisis Care Services (Total Boards by Year)

| Adult Crisis Service for All Board Areas at Two Time Points Service Category | No Service Availability in Percent of Total Boards | |
|---|--|-------|
| | 2006 | 2004 |
| 24/7 On-Call Staffing by Psychiatrists | 24.0% | 15.2% |
| 24/7 On-Call Staffing by Clinical Supervisors | 8.0% | 4.3% |
| 24/7 On-Call Staffing by Case Managers | 30.0% | 19.6% |
| Mobile Response | 40.0% | 43.0% |
| 24/7 Central Phone Line | 2.0% | 0.0% |
| Crisis Care Facility | 38.0% | 37.0% |
| Hospital Emergency Room with Psychiatric Staff | 56.0% | 45.7% |
| Hospital Contract for Crisis Observation Beds | 74.0% | 63.0% |
| Contract for Respite Beds/Emergency Shelter | 54.0% | * |
| Contract for Transport to State/Local Hospital | 22.0% | * |

1. 2006 Total Number of Boards in Sample = 50; 2004 Total Number of Boards in Sample = 46.

2. * Indicates measure not taken in 2004.

Table 3. Adult Crisis Care Capacity Gaps in Adult Treatment Facilities (Total Boards by Year)

| Percent of Boards With Capacity Gaps in All of the Following Service Categories: | | |
|--|-------|------|
| | 2006 | 2004 |
| Crisis Care Facility, Hospital Emergency Room with Psychiatric Staff, Hospital Contract for Obs Beds, Contract for Respite/Emergency Shelter | 16.0% | 4.3% |

1. 2006 includes all four categories of services.

2. 2004 does not include contract for respite/emergency shelter.

3. 2006 Total Number of Boards in Sample = 50; 2004 Total Number of Boards in Sample = 46.

NARRATIVE COMMENTARY – Adult Crisis Care

Forty-three (43) Boards answered this question. The most problematic adult crisis care services were: 1) After hours care, 2) Emergency Room services, 3) Inpatient services, and 4) Law Enforcement and Criminal Justice related services. Additionally, Boards identified the following primary issues related to providing adult crisis care services: 1) Funding issues, 2) Staffing issues, and 3) Access (Transportation and Wait time).

“There have been at least four occasions where the crisis worker cannot find a hospital bed anywhere in the state for a client in need. The local hospital has put these patients in a medical bed as a last resort. This is a burden on our local hospital, crisis workers time, sometimes taking 5-6 hours for disposition, and most significantly bad clinical care for the client in need of psychiatric hospitalization.”
– Fairfield County

Most substantial adult crisis care services problem areas

After hours care. Twenty-one (21) Boards mentioned issues related to after-hours care or 24/7 care. Some Boards indicated that many after-hours calls have alcohol and drug issues in addition to mental health crises and some centers are unwilling to serve consumers who are not sober.

“No inpatient psychiatric or crisis stabilization units are located within the three county area.”
– Seneca, Sandusky, and Wyandot Counties

Solutions: A number of Boards provide a 24 hour hotline to respond to crises. One Board implemented a suicide prevention hotline, with cell phones to eliminate facility costs, which resulted in a decrease in suicides over the last three years (decrease from 34 to 21, 14 and 9 suicides post implementation). A few Boards indicated that they have moved from a staffing rotation to employing full-time staff dedicated to covering ‘after-hours’ calls.

Emergency Room services. Thirteen (13) Boards mentioned issues providing crisis care through the Emergency Room. Some Boards indicated that there are an increasing number of consumers who present at hospital emergency rooms for crisis care. Some Boards have asked hospitals to become more involved in admitting patients for inpatient care, while one Board wanted less hospital involvement, citing an increase in expenditures for hospital care.

Solutions: One (1) Board is implementing CIT training and a jail diversion behavioral health waiver to prevent emergency room visits. Some Boards are in the process of exploring alternatives, which included hospital personnel and Board members; one Board established a committee to develop solutions.

Inpatient care - hospitalization. The most common problem identified by Boards (29) was lack of inpatient beds. Boards stated that they have seen an increased demand for local and state hospital beds and that the number of available beds is insufficient. Some Boards indicated that their allocation of inpatient beds was exceeded before the end of the fiscal year. Boards also expressed frustration that both public and private hospital psychiatric inpatient units were at peak capacity year-round.

Solutions: Boards have contracted with local community hospitals; one Board reported sharing statistics from their system regularly with hospitals to facilitate discussion about potential availability of local beds. Some Boards are in the process of creating local care units that are free-standing or an addition to a local hospital. One Board received temporary emergency privileges to provide direct care at a private hospital when a normal provider was closed due to renovations. Two Boards increased numbers of 23-hour observation beds to evaluate need for hospitalization.

Law Enforcement and Criminal Justice issues. Eight (8) Boards identified law enforcement or criminal justice issues related to crisis intervention services. Some Boards indicated an increased demand for crisis services in the jails.

Solutions: Two (2) Boards reported having an Advisory Board/Committee comprised of criminal justice and Board personnel that operates jail diversion programs for MH consumers and provides CIT training to law enforcement personnel.

Issues related to providing adult crisis services

Funding. Seventeen (17) Boards mentioned that funding is a problem. Boards cited funding as a problem and that crisis care services are more expensive than other services. Boards indicated levy failures contributed to funding shortages. Three Boards reported their ability to provide crisis services was influenced by Medicaid.

Solutions: Five (5) Boards reported that Safety-Net funding has helped Boards maintain some crisis services.

Staffing. Fifteen (15) Boards indicated staffing concerns. Concerns included pay for on-call staff, training, staff turnover, and recruitment. Hancock County illustrates this problem, “Locating a psychiatrist willing to do ‘on call and inpatient services’ has been very challenging. Many of the potential candidates are seeking financial assistance with education loans as part of their benefit package. With the use of all available Board reserves, the Board is unable to assist with the expense without the assistance of the Department.”

Access. Seven (7) Boards mentioned Transportation barriers which impacted providing crisis services. Seven Boards indicated a variety of issues related to wait or response time. Transportation challenges included the cost of ambulance and law enforcement services, and inability of law enforcement officers to remain with consumers in emergency settings.

Boards mentioned wait time increases due to numbers of consumers, crisis providers contacted for non-crisis situations, and wait time related to on-call services. Geauga County reported that arranging for an inpatient bed can take hours, “waiting in the local emergency room can increase the level of agitation/anxiety/distress for the consumer.”

“Individuals with a severe and persistent mental illness, who do not qualify for Medicaid, have insurance, or cannot purchase services for themselves have fewer and fewer opportunities to receive the essential care they need. This results in an increase in the need for crisis intervention and crisis care.”
– Ashtabula County

Solutions: Three (3) Boards reported existing or new contracts with local law enforcement or ambulance providers for Transportation to the ER or out-of-county facilities; one Board reported contracting with off-duty officers for security and Transportation.

One (1) Board indicated changing appointment times to provide access to more consumers. “Our med-somatic unit recently made some changes regarding access to emergency Psychiatrist appointments by developing 30-minute slots on a daily basis for crisis patients only.” – Allen, Auglaize, and Hardin Counties

7.3.2 Adult Intensive Care

In this subsection Adult Intensive Care Programs and Services are profiled. For the purposes of this evaluation, intensive care implies substantial clinical contact with adults who have serious mental illness and impaired functioning to the extent that they require care beyond outpatient services. These services may include Assertive Community Treatment (ACT), partial hospitalization, intensive psychiatry, and intensive Community Support Psychiatric Treatment (CPST).

ADULT INTENSIVE CARE PROGRAMS AND SERVICES – CAPACITY AND ACCESS

Adult Intensive Care Service Areas measured include ACT, PH Programs (Types I and II), Intensive Psychiatry, and Intensive CPST. More than half of all Boards report access to each of these services in 10 working days or less. The most widely available service, PH Program Type I (short-term, time-limited), was reported by 68% of Boards. Consumers gain access to PH Program I in 10 or less working days in 82% of Board areas. ACT and Intensive Psychiatry are among the least available intensive care services, with 26% of Boards respectively reporting availability of these services (See Table in Appendix F, page 133).

ADULT INTENSIVE CARE PROGRAMS AND SERVICES ACROSS YEARS (2004 and 2006)

Five intensive care service areas were measured in 2004 and 2006 (See Table 4). In four of the five service areas, increased percentages of Boards reported length of wait for access to care in the range of 10 or less working days. PH Program I represented the largest gain in the percentage of Boards statewide reporting the availability of this service, although there also was an increase in the percentage of Boards reporting access to this service in the range of 11 or more working days.

There has been a decrease in statewide availability in two intensive service areas over the last two years: ACT and Intensive CPST. ACT was available in 42% of Board in 2004, and was available in only 26% of Boards in 2006. Intensive CPST was available in 65% of Boards in 2004, and was available in only 34% in 2006. However, the percentage of Boards reporting 10 working days or less wait times for these two services has increased in the last two years.

Table 4. Intensive Outpatient Services for Adults at Two Time Points

| Year | Type of Service | Number of Boards Reporting Presence of Service | Percent of Boards Reporting Presence of Service | Number of Boards Reporting Wait Lengths | Percent Reporting 10 or less working days | Percent Reporting 11 or more working days |
|------|----------------------|--|---|---|---|---|
| 2006 | ACT | 13 | 26% | 13 | 61.5% | 38.5% |
| 2004 | ACT | 20 | 42% | 18 | 38.9% | 61.1% |
| 2006 | PH Program Type I | 34 | 68% | 34 | 82.4% | 17.6% |
| 2004 | PH Program Type I | 10 | 21% | 6 | 100.0% | 0.0% |
| 2006 | PH Program Type II | 20 | 40% | 20 | 60.0% | 40.0% |
| 2004 | PH Program Type II | 21 | 44% | 17 | 82.4% | 17.6% |
| 2006 | Intensive Psychiatry | 13 | 26% | 13 | 76.9% | 23.1% |
| 2004 | Intensive Psychiatry | 10 | 21% | 9 | 44.4% | 55.6% |
| 2006 | Intensive CPST | 17 | 34% | 17 | 76.5% | 23.5% |
| 2004 | Intensive CPST | 31 | 65% | 25 | 56.0% | 44.0% |

1. 2006 Total Boards Reporting in Survey = 50; 2004 Total Boards = 48
2. Percent Reporting 10 or less = Number of Boards reporting wait lengths for the category divided by total number reporting wait lengths.
3. Percent Reporting 11 or more = Number of Boards reporting wait lengths for the category divided by total number reporting wait lengths.

“There are teams in Franklin County that meet or nearly meet ACT fidelity scale standards and many others who met ACT standards when the teams were established in the late 80’s to early 90’s but no longer do so due to service demand and financial barriers.”
 – Franklin County

NARRATIVE COMMENTARY – Adult Intensive Care

Forty-five (45) Boards answered this question. The most problematic areas within adult intensive care identified by Boards were 1) Difficulties with the new ACT standards and 2) Funding issues.

Most substantial adult intensive care problem areas

New ACT Standards. Fourteen (14) Boards said that new ACT standards proved to be problematic because they require additional services that agencies can’t bill to Medicaid. Many Boards indicated that they can’t find the supplemental funding to maintain full fidelity to the ACT model, and several indicated that they have lost ACT Certification. Rural Boards suggested that even if they had the money, they wouldn’t be able to recruit the necessary qualified staff, e.g., psychiatrists.

“The Board would like to be able to ensure the provision of Intensive Psychiatry Services for persons with complex symptoms. However, our county has barely enough medical somatic services to provide routine care.”
– *Columbiana County*

Solutions and Impacts. Using local funds to supplement Medicaid funds, several Boards have been able to keep ACT Certification. The Geauga Community Board reported that the additional funds to support ACT were worthwhile because of the great outcomes the program experienced. The new service “has proven to be a very effective service for most of the clients on the caseload and had a dramatic impact on several. Some consumers with multiple hospitalizations prior to participating with an ACT team have had no inpatient stays since their involvement with ACT.”

Funding Issues. Twelve (12) Boards reported difficulty acquiring funds to provide partial hospitalization, intensive psychiatry, and CPST services. Boards also report a steadily decreasing amount of funding for these services and increasing demand for these services. This inverse relationship has in turn led to an increasing caseload size among staff associated with adult intensive care. Here too, rural Boards state that qualified staff is difficult to find.

Solutions and Impacts. Some Boards have received grants from external groups to help provide adult intensive services, and other Boards relied on multiple agencies within the community to meet the demand for services. One Board targeted investment in partial hospitalization services, which reduced the need for more intense services. As one Board respondent said, “Six County, Inc. uses its partial hospitalization programming as a step-down service for persons being discharged from crisis stabilization or inpatient care. The service is also used as a tool to help prevent admissions to crisis care or the hospital.”

7.3.3 Adult General Care

In this subsection Adult General Care is profiled. Adult general care involves outpatient services of low to moderate intensity. Basic services may include diagnostic assessments, psychiatric services, counseling or psychotherapy, or Community Support Psychiatric Treatment (CPST).

ADULT GENERAL CARE CAPACITY AND ACCESS

Adult General Care Services measured include Diagnostic Assessment—Physician, Diagnostic Assessment—Non-Physician, Psychiatry/Med-Somatic, Counseling/Psychotherapy; and CPST. (See Appendix G, page 134). Three of these services, Diagnostic Assessment—Non-Physician, Med-Somatic, and Counseling/Psychotherapy are available through 100% of the Boards. Diagnostic Assessment—Physician is available in slightly less Board areas (92%), followed by CPST, which is available in 88% of Boards.

Only one service, Diagnostic Assessment—Non-Physician, is accessible in over half of all Boards in 10 working days or less. All other services require wait lengths of 11 working days or more in over 60% of Boards. The greatest percentages of Boards report the longest wait times for CPST and Counseling/Psychotherapy.

ADULT GENERAL CARE SERVICES ACROSS YEARS (2002, 2004 and 2006)

The four-year trend for CPST reflects a 6 percentage-point decline in statewide availability of this service (See Table 5). At the same time, the percentage of Boards reporting a wait length of 10 working days or less for this service has increased. Although service availability for Counseling/Psychotherapy and Diagnostic Assessment—Non-Physician has increased statewide in the last four years, larger percentages of Boards are reporting wait lengths of 11 working days or more for these services.

Table 5. General Care Outpatient Services for Adults at Three Time Points

| Year | Type of Service | Number of Boards Reporting Presence of Service | Percentage of Boards Reporting Presence of Service | Number of Boards Reporting Wait Lengths | Percent Reporting 10 or less working days | Percent Reporting 11 or more working days |
|------|------------------------------------|--|--|---|---|---|
| 2006 | Counseling/Psychotherapy | 50 | 100% | 50 | 34.0% | 66.0% |
| 2004 | Counseling/Psychotherapy | 45 | 94% | 43 | 46.5% | 53.5% |
| 2002 | Counseling/Psychotherapy | 45 | 96% | 29 | 34.5% | 65.5% |
| 2006 | CPST | 44 | 88% | 44 | 63.6% | 36.4% |
| 2004 | CPST | 45 | 94% | 44 | 22.7% | 77.3% |
| 2002 | CPST | 44 | 94% | 18 | 50.0% | 50.0% |
| 2006 | Diagnostic Assessment ² | 50 | 100% | 50 | 34.0% | 66.0% |
| 2004 | Diagnostic Assessment | 45 | 94% | 43 | 34.9% | 65.1% |
| 2002 | Diagnostic Assessment | 46 | 98% | 25 | 36.0% | 64.0% |
| 2006 | Psychiatry (Med-Somatic) | 50 | 100% | 50 | 16.0% | 84.0% |
| 2004 | Psychiatry (Med-Somatic) | 47 | 98% | 45 | 4.4% | 95.6% |
| 2002 | Psychiatry (Med-Somatic) | 46 | 98% | 40 | 7.5% | 92.5% |

1. 2006 Total Boards Reporting in Survey = 50; 2004 Total Boards = 48; 2002 Total Boards = 47.
2. 2006 Diagnostic Assessment = Non-physician assessment.
3. Percent Reporting 10 or less = Number of Boards reporting wait lengths for the category divided by total number reporting wait lengths
4. Percent Reporting 11 or more = Number of Boards reporting wait lengths for the category divided by total number reporting wait lengths

NARRATIVE COMMENTARY – Adult General Care

Forty-two (42) Boards answered this question. The most problematic outpatient services identified by Boards were 1) Prioritization or screening of patients, 2) Medication issues, and 3) Psychiatric care issues. The majority of Board comments identified common issues that impacted their ability to provide outpatient services: 1) Funding issues (both Medicaid and non-Medicaid), 2) Staffing issues, and 3) Access issues (wait time).

Most substantial adult outpatient services problem areas

“Many consumers have had to have their medications reduced, changed to generics or changed to other medications because the plan won’t reimburse them for the costs. This has created many difficulties with the consumers and has resulted in hospitalizations.”
– Mahoning County on confusion over Medicare Part D

Prioritization – Triage – Screening. Nine (9) Boards indicated that they have implemented a prioritization or triage screening protocol for clients based on SMD and SED status. Some Boards are unable to provide adequate services to consumers in the general population who are not designated as SMD or SED.

Solutions and Impacts. Implementing prioritization protocols has decreased wait times for some consumers with more serious problems while increasing wait times for consumers with less serious mental illnesses. One (1) Board implemented a web-based screening program that facilitates consumer-clinician interaction and will be available on the Board’s Web site (Allen, Auglaize, and Hardin Counties). As a result of changes in the triage protocol, one agency serving Delaware and Morrow Counties reported implementing a group process at intake that has made more efficient use of staff time.

Medication Issues. Six (6) Boards indicated challenges surrounding medication. Boards reported increased demand for medications, problems with allocation limits, issues with medication substitutions, and continuity of care issues between inpatient and community psychiatric services. Another challenge identified by Mahoning County was confusion over Medicare Part D coverage.

“The [Clermont County] Board discontinued funding for general population consumers two years ago, in order to put more funding toward meeting the needs of the increasing number of SMD consumers.”

Solutions and Impacts. Some Boards provided medication samples from pharmaceutical companies, emergency medication funds, and have worked with individual pharmacies to continue medication until alternatives are available. As a result, Boards reported longer periods of medication stability and consumers following through with appointments. Boards also suggested expanding the medication subsidy.

Psychiatric Care. Five (5) Boards identified issues pertaining to psychiatric care. The major challenge was lack of available psychiatric time. Additionally, some Boards indicated availability of psychiatric time was a challenge in Rural areas and in corrections populations.

“Psychiatry for adults is still problematic, and the doctors are hard to find and keep, as they leave for more money or less of a commute. We were able to last year get a full time doctor to commit to serving us for the first time in the 30 years the Board has operated.”
– Wayne and Holmes Counties

Solutions. Some temporary solutions identified by Boards included using an Advanced Practice Nurse where possible, having outpatients assessed by a practitioner prior to seeing a psychiatrist, and contracting with other providers.

Issues that impact Boards providing Outpatient Services.

Funding Issues. Twenty-four (24) Boards identified issues related to funding. Boards reported challenges related to levies, grant funding, Medicaid, Medicare, and insurance, all of which influence their ability to provide outpatient services to adults. Some Boards said they were struggling to provide basic services due to lack of funding; many Boards indicated that their local levies have not passed. Marion and Crawford Counties reported that they “are struggling to maintain basic services in our Counties. Our greatest challenge is getting a levy passed in this area...In FY 07 we will have to cut funds totaling \$600,000 if we do not pass the replacement levy.”

Boards indicated an increasing problem with attending to non-Medicaid clients; clients on Medicaid receive more timely treatment. For example, Washington County stated, “Our local system is now primarily a Medicaid system. The demand for Medicaid match reduces the availability of all non-Medicaid services.”

“The encouragement of collaboration between agencies seeking funding through foundation grants and other revenue sources has been innovative in a treatment culture where a ‘silo’ operational mentality has predominated over the past few years.”
– Butler County

Solutions. Many Boards indicated that Safety Net awards provided them with the ability to respond to individuals with greatest need. Other Boards reported looking for innovative funding alternatives.

Staffing Issues. Twenty-nine (29) Boards identified staffing issues related to providing adult outpatient services. Boards reported high staff turnover, losing qualified employees due to salary and benefit issues. In particular the Muskingum Area Board reported that “Licensed professionals tend to find that Rural areas are not able to offer attractive employment opportunities.”

Solutions. The primary solutions offered for staffing issues were funding increases, realignment of duties to other personnel, and contracting with other service providers. One alternative solution pursued by Preble County involves special designation as a Health Professional Shortage Area (HPSA), “The Board has applied to ODMH to be considered a Mental Health HPSA which we feel will improve our efforts in hiring qualified mental health staff to our Rural communities.”

Access – Wait time. Twenty (20) Boards indicated that wait time was a significant barrier for adults receiving outpatient services. Many Boards indicated that wait time varied by severity of the problem, by specific outpatient service, and whether consumers were on Medicaid or had insurance. Some Boards indicated that consumers can wait up to 3 months for an appointment.

Solutions. Boards reported restructuring appointment times in a variety of ways, such as instituting a rapid intake process which included initial paperwork and triage screenings, walk-in clinics, and shortened appointments for ongoing clients. For example, in Wood County, “Ongoing clients are scheduled for a combination of either 20-30 minutes; this has helped to free up some time for psychiatrists to see initial appointments sooner. Also, a walk-in clinic for clients who wish to have an assessment is provided.” Some Boards have suggested hiring Advanced Practice Nurses and Physician Assistants but indicated some Psychiatrists’ reluctance to work with these other professionals.

7.3.4 Promising, Best, and Evidence Based Practices

In this subsection Promising, Best, and Evidence-based Practices and other Adult Services are profiled. Boards may provide any number of practices, such as: Integrated Dual Diagnosis Treatment (IDDT), Supported Employment (SE), and Supported Housing.

AVAILABILITY OF EVIDENCE-BASED PRACTICES

A number of promising, best, and evidence-based practices are available to adults throughout Ohio (see Table 6 below and Tables in Appendix H, pages 135-140). The availability of these services varies. The most commonly reported services offered by Boards were:

- Anger Management/ Domestic Violence (86.0%)
- Family to Family (80.0%)
- Peer Support Services (80.0%)
- Consumer Psychoeducation (72.0%)

Additionally, more than half of the Boards reported offering:

- Interpreter Services (68.0%)
- Consumer Operated Services (56.0%)
- Supported Employment (56.0%)
- Integrated Dual Diagnosis Treatment (54.0%)
- Older Adult Services (50.0%)

Between one-third and one-half of Boards reported offering the following services:

- Mental Health Housing Institute (MHHI; 48.0%)
- General Transportation services (46.0%)
- Trauma-informed Care (42.0%)
- Specialized Services for MI/MR (38.0)
- Illness Management and Recovery (IMR; 36.0%)

Less than one-third of Boards statewide reported offering:

- ACT (30.0%)
- Clubhouse services (28.0%)
- Cluster-Based Planning (24.0%)

There were some differences by geographical classification. In each geographical classification, all services were offered with the exception of Clubhouse and Supported Employment in the Rural Board areas. Both the Metro-Urban and Urban Boards had higher percentages of offered services across the Boards than the other geographical classifications. Specific differences by geographical classification are provided below (also see Tables in Appendix H, pages 135-140):

- Rural Boards: The majority of Boards reported offering Anger Management/Domestic Violence services (83.3%). Less than 25% provide ACT, Cluster-Based Planning, IDDT, and IMR. No Rural Boards reported offering Clubhouse services or Supported Employment.
- Trans-Rural Boards: The majority of Boards reported offering Anger Management/Domestic Violence services (88.2%), Interpreter services (76.5%), and Peer Support (70.6%). Less than 25% provide IMR.
- Trans-Metro Boards: The majority of Boards reported offering Family to Family (91.7%), Anger Management/Domestic Violence services (83.3%), and Peer Support (83.3%). Less than 25% provided Clubhouse services and IMR.

- Metro-Urban Boards: All Boards reported providing Consumer Psychoeducation, Family to Family, and Older Adult services. Additionally a high percentage reported offering Anger Management/Domestic Violence (75%), Interpreter services (75%), MHHI (75%), Peer Support (87.5%), and Supported Employment (87.5%). Less than 25% reported providing Cluster-Based Planning and Consumer Operated Services.
- Urban Boards: All Boards reported providing Anger Management/Domestic Violence, Consumer Operated Services, Family to Family, and Peer Support. Additionally a high percentage reported offering Cluster-Based Planning (71.4%), Consumer Psychoeducation (85.7%), IDDT (85.7%), IMR (85.7%), and Supported Employment (85.7%). At least 40% of Urban Boards reported providing services across all the promising, best, and evidence-based practices.

Penetration Rate of Promising, Best, and Evidence-Based Practices

Additional data analyses by ODMH indicated the number of consumers receiving services per 1,000 adult clients. These numbers were averaged statewide, and by geographic classification (see Tables in Appendix H pages 135-140). Based on these penetration rates, most frequently utilized promising, best, and evidence-based practices were:

- General Transportation services
- Peer Support Services
- Older Adult Services
- Cluster-Based Planning
- Anger Management/Domestic Violence

There were some differences in penetration rates by geographical classification. In addition to the five practices listed above, other frequently utilized practices (based on number of adults receiving services) are included below:

- Rural Boards: Illness Management and Recovery and Trauma-informed Care.
- Trans-Rural Boards: IDDT and Interpreter services.
- Trans-Metro Boards: Peer Support services and Supported Employment
- Metro-Urban Boards: Interpreter services, Mental Health Housing Institute (MHHI), Older Adult services and Peer Support services.
- Urban Boards: ACT, Consumer Operated Services, Older Adult services and Peer Support services.

TECHNICAL ASSISTANCE ON EVIDENCE-BASED PRACTICES

Boards reported on their use of and need for Technical Assistance (TA) for various services (see Table 6 below).

Using TA

Of the Boards offering a particular practice, almost all (25 of 27, 92.6%) used TA for IDDT (see Tables in Appendix H, pages 141-146). At least half of Boards offering the following practices/services used TA:

- ACT (53.3%)
- Cluster-Based Planning (58.3%)
- IMR (50.0%)
- MHHI (54.2%)
- Supported Employment (57.1%)

There were some differences by geographical classification:

- Rural Boards: Because the percentage of Rural Boards offering promising, best, and evidence-based practices is so low, the percent of Boards offering the service and using TA is difficult to interpret. Two Rural Boards reported using TA for MHHI, and at least one Rural Board reported using TA for Cluster-Based Planning, Consumer Operated Services, Consumer Psychoeducation, Peer Support, and Specialized MI/MR services.
- Trans-Rural Boards: At least half of the Trans-Rural Boards that offered ACT, Cluster-Based Planning, IDDT, MHHI, and Trauma-informed Care used TA. No Trans-Rural Boards offering Supported Employment reported using TA.
- Trans-Metro Boards: All Trans-Metro Boards that offered ACT, IDDT, and IMR reported using TA. No Boards reported using TA for Cluster-Based Planning, MHHI, Older Adult Services, or Supported Employment. More than half of the Trans-Metro Boards that offered Consumer Operated Services used TA.
- Metro-Urban Boards: All Metro-Urban Boards that offered Cluster-Based Planning and IDDT used TA; at least half of the Metro-Urban Boards that offered Consumer Psychoeducation, Family to Family, and MHHI used TA. None of the Metro-Urban Boards offering Supported Employment or Anger Management reported using TA.
- Urban Boards: All Urban Boards that offered IDDT used TA; additionally, at least half of the Urban Boards that offered ACT, Cluster-Based Planning, Consumer Psychoeducation, IMR, Older Adult Services, and Trauma-informed Care used TA.

Needing TA

In addition to indicating whether they currently used Technical Assistance, Boards also indicated if they needed TA (see Tables in Appendix H, pages 147-152). Trauma-informed Care (n=11) and Older Adult Services (n=10) were the most common practices about which Boards indicated they needed TA.

For Boards currently offering the practice/service, common practices for which they reported needing TA were:

- Cluster-Based Planning (n=7)
- MHHI (n=6)
- Peer Support Services (n=5)
- Supported Employment (n=6)
- Trauma-informed Care (n=7)

For Boards not currently offering the practice/service, the common practices for which they reported needing TA were:

- ACT (n=4)
- Cluster-Based Planning (n=4)
- IDDT (n=6)
- Older Adult services (n=6)
- Specialized Services for MI/MR (n=6)
- Trauma-informed Care (n=4)

Board Levy Funds

Board levy dollars reported on the 2005 040 Form were regressed on total number of individual evidence-based practices (EBPs) reported by the Board in the Older Adult Services Matrix. Twenty-five percent (25%) of the variance (R^2 change) between amount of levy dollars and number of EBPs was explained by the linear regression with significance at $< .0001$. Amount of levy dollars predicts how many adult EBPs the Board supports.

Table 6. Use of Evidence-based Practices

| Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services | | | | | |
|--|-----------------------------------|-----------------------|-----------------------------------|--------------------------------|---|
| Levels of Service Being Provided by All Boards | | | | | |
| Service Area | Number of Boards Offering Service | Percent of All Boards | Number Using Technical Assistance | Percent of All Boards Using TA | Number Receiving Service Per 1,000 of Adult Clients |
| ACT | 15 | 30.0% | 8 | 16.0% | 7.46 |
| Anger Management/Domestic Violence | 43 | 86.0% | 7 | 14.0% | 22.21 |
| Cluster-Based Planning* | 12 | 24.0% | 7 | 14.0% | 24.79 |
| Clubhouse | 14 | 28.0% | 2 | 4.0% | 4.12 |
| Consumer Operated Service | 28 | 56.0% | 10 | 20.0% | 18.67 |
| Consumer Psycho-Education | 36 | 72.0% | 16 | 32.0% | 9.93 |
| Family-to-Family | 40 | 80.0% | 12 | 24.0% | 6.97 |
| General Transportation Services | 23 | 46.0% | 2 | 4.0% | 54.88 |
| Integrated Dual Diagnosis Tx (IDDT) | 27 | 54.0% | 25 | 50.0% | 16.96 |
| Illness Management and Recovery (IMR) | 18 | 36.0% | 9 | 18.0% | 5.59 |
| Interpreter Services | 34 | 68.0% | 3 | 6.0% | 14.99 |
| Mental Health Housing Institute | 24 | 48.0% | 13 | 26.0% | 10.65 |
| Older Adult Services | 25 | 50.0% | 4 | 8.0% | 32.93 |
| Peer Support Services | 40 | 80.0% | 12 | 24.0% | 35.17 |
| Specialized Services for MI/MR | 19 | 38.0% | 6 | 12.0% | 3.20 |
| Supported Employment | 28 | 56.0% | 16 | 32.0% | 13.95 |
| Trauma-Informed Care | 21 | 42.0% | 8 | 16.0% | 10.23 |

1. Number of Boards Offering Service is the number of Boards that indicated that they provided the specific service.
2. Percent of All Boards is (Number of Boards Offering Service) divided by 50 Boards.
3. Number of Boards Using Technical Assistance is the number of Boards that reported that they were using technical assistance.
4. Percent of Boards Using Technical Assistance is (Number of Boards Using Technical Assistance) divided by 50 Boards.
5. Number Served in SFY 2005 is the sum of people whose Board reported were receiving the service.
6. Number Receiving Service Per 1,000 of Adult Clients Served by All Boards is (Number Served in SFY 2005) divided by (total adult clients served by the 50 Boards in SFY 2005) multiplied by 1,000.
Denominator: Total Adult Clients Served by All Boards equals 293,394 adult clients Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006.
7. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

NARRATIVE COMMENTARY – Evidence-based practices

Forty-five (45) Boards answered the question about which areas of service were the most problematic or on which the Board was most focused. The best-practices services mentioned most often by Boards were:

1. ACT,
2. Consumer Operated services,
3. Peer Support services,
4. SA/MI and IDDT related services,
5. Supported Employment, and
6. Supported Housing.

Other best-practices services mentioned less frequently were:

1. Consumer Psychoeducation,
2. Family to Family,
3. Older Adult services,
4. Special MI/MR services, and
5. Trauma-informed Care.

Additionally, Boards identified the following primary issues related to providing these services:

1. Funding issues, and
2. Training and staffing issues.

Most common best-practices services

ACT. Ten (10) Boards indicated issues related to providing ACT services. In some Board areas ACT services were conducted in conjunction with other services such as CPST, Role Recovery, SA/MI or IDDT services, and Supported Employment. Many Boards indicated lack of funding to implement ACT services and struggled with providing ACT services, which are not billable to Medicaid.

Solutions. Some Boards reported thinking about re-designating themselves as other types of service providers, such as Intensive CPST/Intensive Psychiatry or are blending ACT services with other services to maximize funding options.

Consumer Operated Services/ Peer Support services. Fourteen (14) Boards discussed Consumer Operated Services and Peer Support services. Generally Boards indicated similar issues with both types of services, or did not distinguish between these services. Many Boards indicated that these services were provided through special outreach or drop-in centers and that these centers provided both formal and informal supports to consumers. Some of the barriers to providing consumer operated or peer support services included funding, training, and supervision.

Solutions. Some Boards contracted with Ohio Advocates for technical assistance, training and management of these services. One innovative solution that Hancock County plans to implement is a clinic to integrate medical and peer support services. The county was awarded a grant from a pharmaceutical company to provide medication management (injectible medications), as well as support, education, medical screening and nutritious meals to the clients.

***“It has been an enormous challenge for the agency and the ADAMH Board given the two very disparate philosophies of MH and AOD. We have found that the community and consumers have embraced this new integration more readily than staff”
- Medina County***

SA/MI and IDDT related services. Eighteen (18) Boards indicated challenges to providing treatment for consumers with dual disorders. Boards agreed on the need for providing special treatment for consumers with dual disorders because of the diversity and complexity of consumers’ problems.

Boards varied on the amount and quality of dual-disorder treatment options. Some Boards indicated providing some dual-disorder treatment, but not at a level that would qualify as an evidence-based practice. Some Boards specifically mentioned implementation of IDDT. While some Boards are implementing IDDT in stages, others were farther along in the implementation process and indicated that they have good fidelity ratings implementing the IDDT model.

Solutions. Most Boards indicated that they are in varying stages of implementation and were working with the SAMI CCOE for training and to increase fidelity to the IDDT model.

The Medina County Board reported redesigning its overall system and combining primary AoD and MH agencies. Although the Board noted some staff challenges (see quote at left) and ongoing staff turnover, which has created longer waiting lists than desirable, the Board “believe[s] that once the agency has ‘settled in’ and worked through some of the initial issues of integration, the redesigned service system will better meet consumer and community needs.”

Supported Employment (SE). Eighteen (18) Boards indicated issues about supported employment or sheltered workshops. Boards indicated the need to provide supported employment services but pointed to funding restrictions, since SE is not covered by Medicaid, and the need for trained staff.

Solutions. Some Boards indicated working with the Supported Employment CCOE and the Bureau of Vocational Rehabilitation to identify new strategies for providing employment experience; one Board worked with the CCOE on a grant proposal. Some Boards indicated contracting out Employment support services to other organizations such as COVA or working with private industries such as Goodwill to provide sheltered employment opportunities.

Supported Housing. Twelve (12) Boards commented about supported housing or the Mental Health Housing Institute. Many Boards discussed housing and employment supports together as important for consumer recovery. Boards indicated a wide range of implementation, with some indicating no supported housing due to funding issues.

Solutions. Boards indicated a variety of housing supports that include housing consultants to facilitate consumers locating housing, and housing complexes built by Boards.

In addition to providing a supported housing program, Hancock County, in conjunction with the Van Wert/Mercer/Paulding County Board, the Seneca/Sandusky/Wyandot County Board, and the Putnam County Board, received a NAMI Ohio grant from the Mental Health Housing Leadership Institute and a federal home loan grant, to build a 15-unit supported housing complex. The complex will have on-site peer support staffing.

Medina County is also building an innovative housing complex with money from NAMI Ohio, County Commissioners, and HUD that will have a resident manager, a housing specialist, and an employment specialist. Additionally, the Board developed a Housing Inter-Systems Collaborative Assessment Team (ICAT) to manage difficult housing cases. The Board is also developing a Centralized Data Initiative to collect data from all housing initiatives throughout the county.

Less common best practice services

Consumer Psychoeducation. Seven (7) Boards identified issues implementing WRAP and Bridges programs. Issues included funding, enlisting enough consumers to participate, and maintaining trainers to provide the programs. One Board had OAMH implement the programs, and another Board indicated increased advertisement of programs.

Family to Family. Eight (8) Boards mentioned issues surrounding Family to Family programming. Most Boards indicated supporting this NAMI program, although NAMI is more active in some counties than others.

Older Adult services. Eight (8) Boards mentioned issues with providing services to older adults. Two Boards indicated they have special teams to provide culturally competent supports to older adults. A few Boards indicated new services (Visiting Nurses Association) or new money to be invested in services for older adults. Other Boards participated in the Older Ohioans Policy Institute or the Older Adults Initiative.

Special MI/MR services. Seven (7) Boards indicated issues providing special services for persons with mental retardation and mental illness. Challenges include the need for cross-training of staff in both systems, collaboration, eligibility issues for consumers based on level of retardation or severity of mental illness, and funding. Boards indicated the need for service providers to meet regularly to foster collaboration; in some case formal groups (e.g., Task Force) were established. Some Boards indicated receiving technical assistance from the CCOE for MI/MRDD.

Trauma-informed Care. Seven (7) Boards identified a wide variety of issues surrounding providing trauma-informed care. The few common concerns were financial challenges and training of staff. One Board indicated they did not have a mechanism to identify professionals knowledgeable about trauma-informed care. One Board provided CBT services for those with PTSD and PSS. Another Board indicated grant funding to support specialization (trauma and other) of clinical staff.

Issues related to providing best practices

Funding issues. Twenty-seven (27) Boards identified funding as a barrier to providing promising, best, and evidence-based practices to adults. Generally this funding barrier was mentioned across all services.

Solutions. Many Boards indicated Safety Net funds were used to maintain services and indicated the need to pass levies for continued support. Other Boards indicated looking for alternative funding streams.

“Generally, the challenge is the lack of funding. It is not that we aren’t aware of these initiatives, can’t locate the technical support if we need it or don’t buy in philosophically. It takes personnel and resources to implement and we cannot re-commit existing resources.”
– Athens, Hocking, and Vinton Counties

Training and Staffing issues. Six (6) Boards identified training or staffing issues that prevented adequate implementation of best practices. Boards indicated issues with funding for training and problems with staffing turnover.

Solutions. Boards mentioned sharing staff, locating other funding mechanisms, and scheduling trainings.

7.3.5 Competitive Employment

In this subsection Competitive Employment is profiled. Competitive employment is defined as work in the community that anyone can apply for that pays at least a minimum wage. No minimum hours are specified. Competitive employment is reported on by Boards for persons age 18 and over with a serious mental illness.

Boards reported whether or not they had the data needed to calculate the percent of adult SMD consumers who were competitively employed (see Table 7 below). Sixty percent (n=30) of all Boards indicated that they had the ability to calculate the percentage. A smaller percentage of Metro-Urban (37.5%) and Trans-Rural (47.1%) Boards were able to calculate the percentage of consumers competitively employed compared with Rural (66.7%), Trans-Metro (83.3%) and Urban Boards (71.4%).

Boards estimated the percent of adult consumers who are SMD and who are competitively employed. Statewide, the average percentage was 11.4% (minimum: .10%; maximum: 26.0%; see Table 7 below and Table in Appendix I, page 153). The average percent of SMD consumers competitively employed was higher for Metro-Urban Boards (22.5%) and lower for Trans-Rural Boards (6.4%)

Table 7. Competitive Employment

| 7.3.5. Boards That Have Data Needed to Calculate the Number of Adult Consumers Who Are Severely Mentally Disabled (SMD) and Who Are Competitively Employed | | | | | |
|--|--|---|---|-----------|-----------|
| By Geographical Area Classification | | | | | |
| Boards by Geographical Area Classification | Number of Boards That Have Data to Calculate % of SMD Consumers Who Are Competitively Employed | % of Boards That Have Data for Calculation By Geographical Classification | Estimated % of Adult Consumers Who Are SMD and Who Are Competitively Employed | | |
| | | | Minimum % | Maximum % | Average % |
| Rural | 4 | 66.7% | 0.30% | 25.0% | 11.0% |
| Trans-Rural | 8 | 47.1% | 0.10% | 12.0% | 6.4% |
| Trans-Metro | 10 | 83.3% | 1.0% | 23.3% | 12.0% |
| Metro-Urban | 3 | 37.5% | 16.0% | 26.0% | 22.5% |
| Urban | 5 | 71.4% | 2.0% | 18.0% | 12.0% |
| Statewide | 30 | 60.0% | 0.10% | 26.0% | 11.4% |

1. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam and, Van Wert-Mercer-Paulding
Trans-Rural Boards: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
Trans-Metro Boards: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood
Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull
Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit
2. Number of Boards That Have Data to Calculate % of SMD Consumers Who Are Competitively Employed is the number of Boards that indicated for Question 7.3.5.1 to having data to calculate % of SMD consumers who are competitively employed.
3. % of Boards That Have Data for Calculation By Geographical Classification is (number of Boards that have data to calculate % of SMD consumers who are competitively employed) divided by (number of Boards within the geographical classification). The denominator by Board geographical area classification is as follows: Rural--6; Trans-Rural--17; Trans-Metro--12; Metro-Urban--8, Urban--7; Statewide--50.
4. Minimum % is the lowest value in the range provided by the Boards within the geographical classification for adult consumers who are SMD and who are competitively employed.
5. Maximum % is the highest value in the range provided by the Boards within the geographical classification for adult clients who are SMD and who are competitively employed.
6. Average % is (sum of estimated % of adult consumers who are SMD and who are competitively employed) divided by (the number of Boards that reported an estimated % within the geographical classification). The denominator by geographical area classification is as follows: Rural--6; Trans-Rural--17; Trans-Metro--12; Metro-Urban--8; Urban--7, and Statewide--50.
7. Competitive employment is defined as work in the community for which anyone can apply and that pays at least a minimum wage. No minimum hours per week or month are included in the definition. The target population is adults who are ages 18 and older and who have a persistent mental illness.

7.3.6 Supported Housing

In this subsection Supported Housing is profiled. Supported Housing represents a specific program model where a consumer lives in a house, apartment, or similar setting, alone or with others, and has considerable responsibility for residential maintenance. The residents receive periodic visits from mental health staff and family members.

Statewide, 88.0% (n=44) of Boards indicated that they offered Supported Housing. All Trans-Metro, Metro-Urban, and Urban Boards reported offering Supported Housing. Two-thirds of Rural Boards and over three-quarters of Trans-Rural Boards reported offering Supported Housing (see Table in Appendix J, page 154).

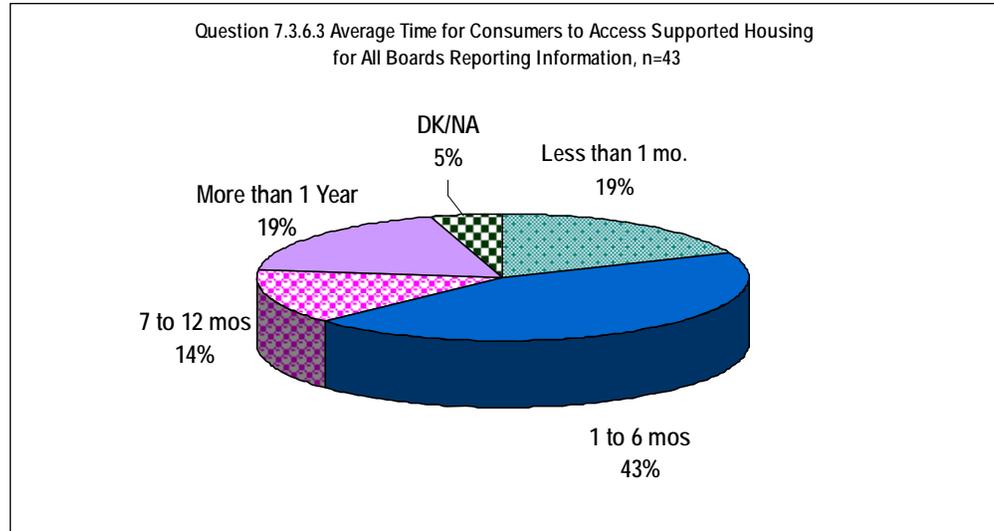
Statewide, 76.0% of Boards offering Supported Housing reported a wait list for this service. The percent of Boards indicating a wait list ranged from 50.0% to 100.0% by geographical area.

Statewide, the average number of consumers currently waiting for supported housing was 12.1 consumers. Urban Boards reported the largest average number of consumers (22.8). All other geographic regions indicated an average wait list of less than 10 persons, ranging from 0.8 to 6.8 consumers for Rural, Trans-Rural, Trans-Metro, and Metro-Urban Boards (see Table in Appendix J, page 154).

WAIT TIME

The average time the majority of consumers wait to access Supported Housing, statewide, is one to six months (43%), although some consumers (19%) wait more than one year (see Figure below). There were some differences by geographical classification (see Figures in Appendix K, pages 155-157).

- Approximately one-quarter of Rural and Urban Boards reported they did not know the average time consumers wait to access Supported Housing (25% of Rural Boards; 29% of Urban Boards).
- Trans-Metro Boards reported the lowest average percentage (9% of Trans-Metro Boards) of consumers waiting less than one-month for access to Supported Housing.
- Trans-Metro and Urban Boards reported an average of more than half of their consumers waiting between one and six months for access to Supported Housing (55% of Trans-Metro Boards; 57% of Urban Boards).
- Metro-Urban Boards reported the highest average percentage (37% of Metro-Urban Boards) of consumers waiting more than one year to access Supported Housing.



**7.3.7
Chronic
Homelessness**

**7.3.8
The Housing
Assistance
Program (HAP)**

**7.3.9
Public Housing**

In these subsections Boards reported on Chronic Homelessness, the Housing Assistance Program (HAP) and Public Housing. *Chronic homelessness* refers to individuals who are homeless because of a disabling condition (i.e., serious and persistent mental illness), and who either have been continuously homeless for a year or more OR have had at least four episodes of homelessness in the past three years. Boards reported on the estimated number of persons with SMD who were chronically homeless in their area. *HAP* provides temporary rental subsidies and no-interest loans to assist persons with severe mental disabilities and their families in obtaining permanent, safe, decent and affordable rental housing until a permanent housing solution can be obtained. *Public Housing* is housing subsidized by the federal government (e.g., Section 8). People on HAP are likely to be on public housing waiting lists, but HAP is not public housing.

HOUSING ISSUES ACROSS YEARS (Section 7.3.6 through 7.3.9)

Questions 7.3.6 through 7.3.9 are a series of inquiries about housing and homelessness developed by expert housing staff in ODMH’s Policy and Program Development Division for the 2004 Safety Net Survey (see Appendices L through O, pages 158-161). Housing staff used information collected and reported in 2004 to improve individual Boards’ administration of housing programs and their estimation of homeless counts of persons with serious mental disabilities. The use of the 2004 data by ODMH housing staff can be seen in what was viewed at the time by housing staff as an overestimation of 11,220 homeless in the statewide system of care. The 2006 estimate of 4,308 (reported as Question 7.3.7.1) is much closer to estimates available through other sources of data, such as Adult Outcomes. This improved estimation may be due to Boards’

increased use of HMIS as a source of information. The 2006 estimate of 4,308 individuals puts the percentage of homeless persons with SMD served by the public mental health system at the end of FY 2005 in the range of 2.3% of the total service population (N = 4,308/183,981). A convenience sample of 61,723 consumers from the Adult Outcomes surveys confirms that 2.4% of our current service population is homeless.

Estimates of consumers waiting for Supportive Housing (Question 7.3.6.4) show a slight improvement (decline) in the last two years, while estimates of the numbers waiting for HAP show an increase in the number waiting. The median length of wait is now 4 to 6 months, where it was 1 to 3 months in 2004. The estimated average number of consumers waiting for Public Housing (Question 7.3.9.3) has also increased over the last two years by 12% (N = 17/140).

MSPA – Community Plan Survey

7.4 Child and Adolescent Mental Health Services

**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

BACKGROUND – Child and Adolescent Services

Children and adolescents receive services for mental health related illnesses every year in Ohio from a variety of sources, including: mental health centers, schools, and short-term residential facilities

This report details the child and adolescent services section of the 2006 Mutual Systems Performance Agreement study. In this report each chapter will outline a specific area related to a spectrum of mental health care provided to children, adolescents, and their families in Ohio.

The following areas were the focus of this evaluation:

- 7.4.1 Child and Adolescent Crisis Care
 - 7.4.2 Child and Adolescent Intensive Care Programs and Services
 - 7.4.3 Child and Adolescent General Care
 - 7.4.4 Promising, Best and Evidence-Based Practices and Other Services
 - 7.4.5 School-based Services
-

RESULTS

This section will outline results from the key research questions relevant to the child and adolescent mental health services provided in Ohio. The following topics will be explored: child and adolescent crisis services, intensive care programs, residential treatment, general mental health care, evidence-based practices, and school-based services. Each section will provide a brief overview of both the quantitative and qualitative results, followed by a brief discussion.

7.4.1 Child and Adolescent Crisis Care

In this subsection, Child and Adolescent Crisis Services in the State of Ohio are profiled. For the purposes of this evaluation, the definition of crisis care for children and adolescents is the provision of short-term, acute care to stabilize a child or adolescent experiencing psychiatric emergency. These services include 24/7 on-call services from mental health professionals, mobile response teams, 24/7 central phone lines, crisis care facilities, hospital emergency room services and observation beds, and respite beds. Crisis services provided under multi-component treatments, such as Multi-Systemic Therapy (MST) and Intensive Home Based Therapy (IHBT), are excluded from this evaluation.

AVAILABILITY OF SERVICES

A number of crisis services are available to children and adolescents throughout Ohio (see Table 8 below). The MSPA data suggest the most frequent crisis service available to children and adolescents in crisis is

“There are no crisis services... a child must be hospitalized sometimes 1.5 hours from home. This, in turn, limits the amount of family intervention which can occur.”
– Warren and Clinton Counties

24/7 central phone lines (96%). The largest service gap in the crisis service array is the availability of facilities to care for children and adolescents experiencing acute life crisis. Eighty-eight percent of Boards report not having crisis observation beds available for children and adolescents in need of this service, and 80% report not having a general crisis care facility. Some geographical differences were evident and are presented below (see Tables in Appendix P, pages 162-164 for all differences by geographical region):

- Service gaps in crisis care for children and adolescents are especially pronounced in Trans-Metro areas. At present, no Trans-Metro counties report having contracts for crisis observation beds, and 92% do not have a crisis care facility).

ACCESS

The majority of Boards reported wait times of less than an hour for child and adolescent crisis services. As illustrated in Table 8 below, 62% of Boards indicate that child and adolescent consumers can receive services from case managers within an hour, while 64% suggest that psychiatric services are also available in their areas within an hour. The longest wait time for a crisis-related service was the use of respite beds, where 38% of Boards reported wait times of more than an hour.

CHILD AND ADOLESCENT CRISIS CARE SERVICES ACROSS YEARS (2004 and 2006)

In five areas of C&A crisis care (See Table 9), statewide availability in terms of percentage of Boards stayed the same between 2004 and 2006. In three service areas (24/7 On-Call Staffing by Case Managers, Crisis Care Facility, and Hospital Emergency Room with Psychiatric Staff), the percentage of Boards reporting availability of these services for child and adolescent consumers increased over the last two years.

More striking, however, is the increased availability of crisis care treatment locations throughout the state for child and adolescent consumers. The percentage of Boards reporting capacity gaps for three or more treatment settings (Crisis Care Facility, Hospital Emergency Room and Hospital Contract for Observation Beds) increased by 10 percentage points between 2004 and 2006 (See Table 10).

Table 8. Child and Adolescent Crisis Care Services (Total Boards)

| Question 7.4.1 C & A Crisis Care Service Availability for All Board Areas Approximately How Long Do C & A Consumers Wait for C & A Crisis Care Admission? | | | | | | |
|--|----------------------|-------------------------|----------------------|-------------------------|------------|-------------------------|
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Total Boards | Service Availability | Percent of Total Boards | No Service | Percent of Total Boards |
| 24/7 On-Call Staffing by Psychiatrists | 32 | 64.0% | 2 | 4.0% | 16 | 32.0% |
| 24/7 On-Call Staffing by Clinical Supervisors | 44 | 88.0% | 4 | 8.0% | 2 | 4.0% |
| 24/7 On-Call Staffing by Case Managers | 31 | 62.0% | 3 | 6.0% | 16 | 32.0% |
| Mobile Response for C& A Consumers | 22 | 44.0% | 8 | 16.0% | 20 | 40.0% |
| 24/7 Central Phone Line | 48 | 96.0% | 0 | 0.0% | 2 | 4.0% |
| Crisis Care Facility for Children and Adolescents | 8 | 16.0% | 2 | 4.0% | 40 | 80.0% |
| Hospital Emergency Room with Psychiatric Staff | 16 | 32.0% | 7 | 14.0% | 27 | 54.0% |
| Hospital Contract for C& A Crisis Observation Beds | 4 | 8.0% | 2 | 4.0% | 44 | 88.0% |
| C& A Respite Beds | 9 | 18.0% | 19 | 38.0% | 22 | 44.0% |

Less Than One Hour/Percent of Total Boards: (Boards reporting that C& A consumers wait less than one hour for admission) divided by (total Boards in state). More Than One Hour/Percent of Total Boards: (Boards reporting that C& A consumers wait for more than one hour for admission) divided by total Boards in state). No Service/Percent of Total Boards: (Boards reporting that service is C& A Crisis Care service is unavailable) divided by (total Boards in state).

Table 9. Child and Adolescent Crisis Services for All Board Areas at Two Time Points

| Child and Adolescent Crisis Services for All Board Areas at Two Time Points | No Service Availability in Percent of Total Boards | |
|---|--|-------|
| | 2006 | 2004 |
| 24/7 On-Call Staffing by Psychiatrists | 32.0% | 30.0% |
| 24/7 On-Call Staffing by Clinical Supervisors | 4.0% | 4.0% |
| 24/7 On-Call Staffing by Case Managers | 32.0% | 26.0% |
| Mobile Response | 40.0% | 41.0% |
| 24/7 Central Phone Line | 4.0% | 4.0% |
| Crisis Care Facility | 80.0% | 74.0% |
| Hospital Emergency Room with Psychiatric Staff | 54.0% | 48.0% |
| Hospital Contract for Crisis Observation Beds | 88.0% | 87.0% |
| Contract for Respite Beds/Emergency Shelter | 44.0% | 43.0% |

1. 2006 Total Number of Boards in Sample = 50; 2004 Total Number of Boards in Sample = 46.
2. * Indicates measure not taken in 2004.

Table 10. Capacity Gaps in C&A Crisis Treatment Facilities

| Percent of Boards With Capacity Gaps in All of the Following Service Categories: | | |
|--|-------|-------|
| | 2006 | 2004 |
| Crisis Care Facility, Hospital Emergency Room with Psychiatric Staff, Hospital Contract for Obs Beds | 48.0% | 36.0% |

1. 2006 Total Number of Boards in Sample = 50; 2004 Total Number of Boards in Sample = 47.

NARRATIVE COMMENTARY – Crisis Care

When asked to comment on which areas of crisis care were most problematic, Boards commented on the challenges associated with providing these services when: 1) distance from child and adolescent crisis care services was far; 2) there were few child psychiatrists to provide services; and 3) funding was cut.

*“All the hospitals are outside the Board area, coordination and Transportation pose additional difficulties.”
- Clermont County MH and Recovery Board*

Transportation. Thirty-four (34) Boards reported that when crisis beds and services are available, they are often located hours away from the child’s natural home setting. Consequently, Boards often must locate adequate Transportation for these children in crisis. Ten (10) Boards wrote that they have significant problems accessing Transportation for children and adolescents in crisis. As illustrated by the Allen-Auglaize Hardin ADAMH Board, when services are located far from the consumer’s home, Transportation can become time consuming and challenging: “Transportation for youth in crisis continues to be a problem to/from hospitals. We often spend much time trying to identify safe Transportation for youth in our three counties.”

Solution: To offset issues related to Transportation, one Board (Warren-Clinton) reduced their caseload sizes to ensure a more timely response to child/adolescent crisis cases. This improved response time while also reducing demands on the standard case management staff.

*“The Board, in collaboration with our children’s mental health agency, is willing to shift funds for more psychiatric time, but has had difficulty in locating any additional child psychiatrists to work in the system (we currently have less than 1 FTE).”
- Clermont County*

Child Psychiatric Services. While the quantitative results suggest a sufficient number of clinical responders in crisis care, this was not the case for child psychiatrists. When responding to an open-ended question about current challenges, 14 Boards reported a lack of child psychiatric services in their communities. The lack of child psychiatrists was notably present in the Trans-Rural and Trans-Metro communities throughout Ohio, where according to respondents, recruitment for specialty medical care, such as psychiatry, is particularly difficult.

Solution: Due to the lack of child psychiatrists in their Board areas, some Boards have contracted with non-psychiatric MDs, largely pediatricians, to provide psychiatric services. One Board reported using Pediatric Emergency Room services to ensure that children were provided an emergency service during a psychiatric crisis (*Mahoning County CMH Board*).

Funding. Another prevalent theme throughout the comments was the lack of funding in crisis care for children and adolescents. Twenty Boards reported having a difficult time providing crisis services at current funding levels. Many Boards suggested that “there is not enough money to fund any kids’ crisis services.” (*Tuscarawas-Carroll ADAMH Board*). Two Boards, Franklin and Fairfield County ADAMH Boards, have had to discontinue crisis services due to funding cuts.

Solution: Similar solutions to the conundrum of inadequate funding were repeated among the Boards. These include using FAST\$/ABC and Safety Net funds to support crisis services, the use of foundation grants, and an increase in the MH levy. The Tuscarawas-Carroll ADAMH Board is considering an increase in their mental health levy to improve funding for crisis services. While admittedly an unpopular resolution, the Board indicated it is one way to address the ongoing struggle to subsidize critical care for at-risk youth.

7.4.2 Child and Adolescent Intensive Care Programs and Services

In this subsection, Child and Adolescent Intensive Services are profiled. Intensive Programs and Services include: Residential Treatment (RTC), Intensive Care, Intensive Home Based Therapy (IHBT), Partial Hospitalization, Therapeutic Preschool, Treatment Foster Care (RFC), Family Therapy), Intensive Community Psychiatric Support Program (CPST), and Intensive Psychiatry.

RESIDENTIAL TREATMENT

Boards estimated 1,535 children were placed in residential treatment centers (RTCs) over a 12-month period (see Table 11 below).

Two-thirds (66%) of Boards reported that 100% of children placed in RTCs must go out of county for this service. Only one Board reported keeping 100% of children placed in an RTC within their county of residence. There were 16 Boards reporting a percentage of children placed out of county at less than 100% and more than zero; among this 32% of Boards, estimates on the percentages of children placed out of county ranged from 1% to 89% of all cases, for an average of 45%.

Table 11. Residential Treatment for Children and Adolescents

| 7.4.2.1 Children Placed in RTCs By Geographical Area Classification | | | |
|---|---|---|-----------------------|
| Geographical Classifications | Average Number by Geographical Classification | Total Number within Geographical Classification | Percent of all Boards |
| Rural | 25 | 149 | 9.71% |
| Trans-Rural | 25 | 426 | 27.75% |
| Trans-Metro | 24 | 287 | 18.70% |
| Metro-Urban | 48 | 385 | 25.08% |
| Urban | 41 | 288 | 18.76% |

1. Average Number by Geographical Classification is the total number reported within the geographical classification divided by the number of Boards within that classification. The denominator by Board geographical area classification is as follows: Rural--6; Trans-Rural--17; Trans-Metro--12; Metro-Urban--8, Urban--7; Statewide--50.
2. The Percent of All Boards: Numerator is the Total Number within Geographical Classification; Denominator is the total number of all children placed in RTCs (n = 1,535) Ex, for Rural 149/1535= 9.71%.

Twenty-eight percent (28%) of Boards said they were involved in the decision to place all children in out-of-county RTCs. Sixteen percent (16%) of Boards said they had no involvement in the decision to place children in out-of-county RTCs. The remaining 56% of Boards estimated their percentage of involvement in placement decisions in the range of 2% to 90% of all cases, for an average of 31%.

Forty-six percent (46%) of Boards reported that demand for RTC placements had remained the same over the past two years (see Table 12 below). An equal percentage (26%) of Boards reported that demand had either increased or decreased. One Board did not answer the question.

Table 12. Status of Change in Demand for RTC Placements by Percent of Board Type

| 7.4.2.1.3 From January 2004 up to the present time, how would you describe the local trend in placements at Residential Treatment Centers? | | | |
|--|----------------------|--------------------------|----------------------|
| | Demand is Increasing | Demand is About the Same | Demand is Decreasing |
| Rural | 20% | 40% | 40% |
| Trans-Rural | 29% | 35% | 35% |
| Trans-Metro | 25% | 66% | 8% |
| Metro-Urban | 25% | 38% | 38% |
| Urban | 29% | 57% | 14% |
| Statewide Average | 26% | 46% | 26% |

NARRATIVE COMMENTARY - Residential Treatment

Board Explanations for the use of Residential Treatment

“The Board and providers do not recommend residential treatment as a rule..... Residential continues to be accessed by court and children services agencies acting without our endorsement.”
– Ross-Pike-Pick-Fay-High Counties

In an open-ended question, Boards were asked to provide an explanation for the use of residential treatment placements for children and adolescents in their area. A number of themes emerged from the data to explain the use of residential treatment, including: funding issues, community pressure and safety, cross-system collaboration, and alternative programming and service availability.

Funding Issues. Fourteen (14) Boards suggested that funding often dictates the use of Residential Treatment. Reductions in funding mechanisms for Residential Treatment have reduced its use. According to the Boards, limitations placed on funding for Residential Treatment has reinforced the idea that this restrictive treatment option be considered a “last resort”. Boards further reported that Medicaid regulations inadvertently increase residential claims by requiring “providers to unbundle room and Board costs from treatment costs, which has increased the number of residential claims.” (Montgomery County ADAMH Board).

Community Pressure and Safety. Five (5) Boards indicated that pressure from the family, community, and politics have influenced the use of Residential Treatment in their areas. According to the Boards, this is especially pronounced with children sex offenders, who are considered a threat to community safety. Boards reported that when families come to agencies for services they often “come to the table asking for out-of-home placement” (Ashtabula County ADAMH Board). While the request is often not clinically appropriate, and alternative services are offered, there continues to be pressure exerted by families to remove children from the home due to problematic behavior.

“We are experiencing a rise in the number of children sex offenders. Community safety and the lack of available foster homes require many organizations to look for other residential alternatives. Local children service agencies and juvenile courts have few options for the placement of these children.”
- Mercer-VanWert-Paulding ADAMH Board

Cross-System Collaboration. Fifteen (15) Boards indicated both positive and negative aspects of cross-system collaboration on the use of Residential Treatment for children and adolescents with severe emotional disturbances. Some Boards have had success in bridging the gaps in communication and collaboration between different service systems. For instance, the Clermont County Board has reduced the number of out-of-home placements from 60 last year to 20 this year by using “shared responsibility for decision-making and planning” across systems. Conversely, other Boards report a lack of control over out-of-area placements that are made by other systems of care. Decisions about placement in Residential Treatment Centers are often made by the courts or the local child welfare agency without consultation from the mental health providers or Board.

Alternative Programming and Service Availability. Almost half of the Boards (24) reported issues around the availability of alternative programming for children and adolescents in or in need of Residential Treatment. Many of the comments suggested that the “kids present as ‘sicker’ and require more intensive services at higher costs.” (Stark County CMH Board). Yet, many of the Boards indicated that their systems were looking for ways to provide children and adolescents with services to reduce the need for restrictive placements. Some Boards, such as Crawford-Marion, are taking a multi-pronged approach, supporting a number of programs (e.g., Wrap Around, Strengthening Families Program, Capstone Enrichment Center, and Partial Hospital Programs) that will reduce the need for Residential Treatment. While some Boards report increasing community options, others suggest that even if there was a need for Residential Treatment, they would have to go out of their area for this level of care.

Innovative Practices to Reduce Residential Treatment

The Boards were asked to comment about what innovative practices were being used to reduce the need for high-cost Residential Treatment placements². The most frequently cited practices to reduce Residential Treatment were:

1. Intensive Home Based Services (IHBT) (23 Boards)
2. Wrap Around Services (13 Boards)
3. School-Based Services (8 Boards)
4. MST (6 Boards)
5. Therapeutic Foster Care (4 Boards)
6. Functional Family Therapy (2 Boards)
7. Cross-Functional Teams (2 Boards)

Several Boards also discussed mechanisms to enhance the use of these innovative practices, including:

1. FAST\$/ABC funds (9 Boards)
2. Pooled funding between agencies (6 Boards)
3. Increased Coordination Between Service Sectors (4 Boards)
4. Increased Utilization Review of Residential Treatment (4 Boards)
5. Use of Foundation Grants (2 Boards)

² As Boards were not required to answer open-ended questions, not all Boards are represented in the responses.

CHILD AND ADOLESCENT OUTPATIENT PROGRAMS AND SERVICES

Eleven service categories, including “Other,” comprised measurement of C&A Intensive Care Services access and capacity. (See Table in Appendix Q, page 165). Of these eleven, two services—Intensive CPST and Family Therapy—are available in 70% or more of Boards. A third service, IHBT/MST, is available in 50% of Boards. All other intensive service categories are available in less than 40% of Boards statewide.

Eight of the 11 services have wait lengths of 10 working days or less in 50% or more of Boards throughout the state. Three intensive services (Family Therapy, Intensive Psychiatry, and Therapeutic Pre-School) have wait lengths of 11 working days or more in approximately 60% of Boards.

CHILD AND ADOLESCENT OUTPATIENT PROGRAMS AND SERVICES ACROSS YEARS (2004 and 2006)

Four service categories (PH Program Type III, Treatment Foster Care, Intensive CPST, and Intensive Psychiatry) showed increased statewide availability in terms of percentage of Boards providing access, while statewide access remained stable in two other areas (PH Program Type II and Therapeutic Pre-School; See Table 13). Statewide access to IHBT/MST, PH Type I (Time Limited), and Transitional Living decreased in percentage of Boards reporting service provision between 2004 and 2006.

All services except Therapeutic Pre-School show a decrease in the percentage of Boards reporting wait times of 11 working days or more. Boards reporting a wait time of 11 working days or more for Therapeutic Pre-School increased by 13 percentage points between 2004 and 2006.

Table 13. Intensive Care Services for Adolescents and Children at Two Time Points

| Year | Type of Service | Number of Boards Reporting Presence of Service | Percent of Boards Reporting Presence of Service | Number of Boards Reporting Wait Lengths | Percent Reporting 10 or less working days | Percent Reporting 11 or more working days |
|------|---------------------------|--|---|---|---|---|
| 2006 | IHBT/MST | 25 | 50% | 23 | 52.2% | 47.8% |
| 2004 | IHCBS | 29 | 60% | 27 | 22.2% | 77.8% |
| 2006 | PH Type I (Time limited) | 6 | 12% | 6 | 83.3% | 16.7% |
| 2004 | PH Type I (Time limited) | 10 | 21% | 5 | 40.0% | 60.0% |
| 2006 | PH Type II (School-based) | 17 | 34% | 16 | 62.5% | 37.5% |
| 2004 | PH Type II (School-based) | 16 | 33% | 13 | 30.8% | 69.2% |
| 2006 | PH Type III | 14 | 28% | 14 | 64.3% | 35.7% |
| 2004 | PH Type III | 10 | 21% | 7 | 42.9% | 57.1% |
| 2006 | Treatment Foster Care | 30 | 60% | 15 | 60.0% | 40.0% |
| 2004 | Treatment Foster Care | 19 | 40% | 21 | 42.9% | 57.1% |
| 2006 | Therapeutic Pre-School | 9 | 18% | 8 | 37.5% | 62.5% |
| 2004 | Therapeutic Pre-School | 8 | 17% | 6 | 50.0% | 50.0% |
| 2006 | Transitional Living | 9 | 18% | 9 | 55.6% | 44.4% |
| 2004 | Transitional Living | 12 | 25% | 6 | 16.7% | 83.3% |
| 2006 | Intensive CPST | 35 | 70% | 35 | 65.7% | 34.3% |
| 2004 | Intensive CPST | 29 | 60% | 29 | 27.6% | 72.4% |
| 2006 | Intensive Psychiatry | 15 | 30% | 15 | 40.0% | 60.0% |
| 2004 | Intensive Psychiatry | 10 | 21% | 8 | 12.5% | 87.5% |

1. 2006 Total Boards Reporting in Survey = 50; 2004 Total Boards = 48.
2. Percent Reporting 10 or less = Number of Boards reporting wait lengths for the category divided by total number of Boards reporting wait lengths.
3. Percent Reporting 11 or more = Number of Boards reporting wait lengths for the category divided by total number of Boards reporting wait lengths.
4. Services with increased wait length highlighted with oval.
5. Services with decreased statewide availability highlighted with circle.

“Recent changes in Medicaid billing for Partial Hospital and the cost of national accreditation are causing one school-based program in Delaware County to reduce the mental health treatment component of their program.”
- Delaware Morrow County ADAMH Board

NARRATIVE COMMENTARY – Intensive Outpatient Programs and Services

Issues related to providing Intensive Outpatient Services

Boards were asked to comment on which areas of Intensive Outpatient Programs and Services were most problematic, Boards commented on the challenges associated with providing these services when: 1) funding is limited; 2) providers are difficult to find; and 3) inequities exist between the demand for services and the mental health systems’ capacity to provide them. A detailed description of these challenges is provided below.

Funding Issues. Fifteen (15) Boards indicated that providing intensive services in the current fiscal environment is a challenge. Some Boards further suggested that services may be cut or are being cut due to changes in Medicaid billing and the loss of other funding sources. Boards vocalized their concerns about the current changes in Medicaid Billing requirements for Partial Hospital programs. According to the Boards, these changes have reduced the ability of Boards and Agencies to bill for some of the services traditionally offered in Partial Hospital programs.

Human Resources. Eight (8) Boards reported having significant trouble recruiting and retaining qualified staff to provide child and adolescent mental health services. The Boards indicated the problem was one of finding “qualified, well trained staff”. These Boards indicated that positions remain unfilled for months. While the Boards consistently discussed this shortfall, no solutions to recruitment/retention were provided.

Demand vs. Capacity. Ten (10) Boards reported a considerable inequity between service demand and system capacity. Many Boards indicated that agencies are at capacity and do not have the resources to implement new Intensive Outpatient Programs. While all Boards indicated a need for Intensive Outpatient Services, many noted they could not currently provide this level of service.

Solutions: A number of Boards have attempted to increase the capacity of their Intensive Outpatient Services by implementing a number of innovative practices. These services, similar to previous examples, include: Wraparound (7 Boards), SA/MI programming (3 Boards), Family Therapy (13 Boards), Intensive CPST (8 Boards), IHBT (24 Boards), School-Based Programming (18 Boards), and Partial Hospital Services (18 Boards).

In this subsection, Child and Adolescent General Care Services are profiled. General Care involves service provisions of low to moderate intensity for the general population of child and adolescents who do not receive high-intensity services. General care services reported in this section include: Diagnostic assessment by a physician or non-physician, general Psychiatry, Counseling or Psychotherapy, and CPST.

SERVICES USED IN GENERAL CARE (CHILD AND ADOLESCENT)

Diagnostic Assessment—Non-Physician and Med-Somatic services are available in 100% of Boards (See Table in Appendix R, page 166). Over 90% of Boards report availability of Diagnostic Assessment—Physician and Counseling/Psychotherapy to general care outpatients. Child and

“All of our Agencies are operating at capacity or close to it; adding specialized services is beyond the present capacity of our CMHCs and no new funding sources have been identified to expand capacity.”
- Miami-Darke-Shelby Counties

7.4.3 Child and Adolescent General Care

Adolescent consumers have the least statewide access to general care CPST, with 86% of Boards reporting service availability.

Only CPST is available to consumers in 10 working days or less in 55% of Boards. Over 60% of Boards report that consumers wait 11 working days or more for Diagnostic Assessment—Physician & Non-Physician, Med-Somatic, and Counseling/Psychotherapy.

CHILD AND ADOLESCENT GENERAL CARE ACROSS YEARS (2004 and 2006)

Statewide access to Med-Somatic, Diagnostic Assessment—Non-Physician, and Counseling/Psychotherapy has remained stable or slightly improved in the percentage of Boards reporting availability over the last four years (See Table 14). However, CPST has declined by 12 percentage points in the percent of Boards offering the service to the general outpatient population.

Wait lengths for CPST and Med-Somatic have improved somewhat since 2002, with a greater percentage of Boards reporting waits of 10 working days or less in 2006 than 2002. At the same time, wait lengths for Non-Physician Diagnostic Assessment and Counseling/Psychotherapy have increased in the last four years, with a greater number of Boards reporting wait lengths of 11 working days or more in 2006 than in 2002.

Table 14. General Care Outpatient Services for C&A at Three Time Points

| Year | Type of Service | Number of Boards Reporting Presence of Service | Percentage of Boards Reporting Presence of Service | Number of Boards Reporting Wait Lengths | Percent Reporting 10 or less working days | Percent Reporting 11 or more working days |
|------|------------------------------------|--|--|---|---|---|
| 2006 | Counseling/Psychotherapy | 49 | 98% | 49 | 36.7% | 63.3% |
| 2004 | Counseling/Psychotherapy | 45 | 94% | 43 | 46.5% | 53.5% |
| 2002 | Counseling/Psychotherapy | 46 | 98% | 33 | 39.4% | 60.6% |
| 2006 | CPST | 43 | 86% | 42 | 54.8% | 45.2% |
| 2004 | CPST | 45 | 94% | 44 | 22.7% | 77.3% |
| 2002 | CPST | 46 | 98% | 23 | 39.1% | 60.9% |
| 2006 | Diagnostic Assessment ² | 50 | 100% | 49 | 34.7% | 65.3% |
| 2004 | Diagnostic Assessment | 45 | 98% | 43 | 34.9% | 65.1% |
| 2002 | Diagnostic Assessment | 46 | 98% | 29 | 51.7% | 48.3% |
| 2006 | Psychiatry (Med-Somatic) | 50 | 100% | 49 | 10.2% | 89.8% |
| 2004 | Psychiatry (Med-Somatic) | 47 | 98% | 45 | 4.4% | 95.6% |
| 2002 | Psychiatry (Med-Somatic) | 45 | 96% | 38 | 5.3% | 94.7% |

1. 2006 Total Boards Reporting in Survey = 50; 2004 Total Boards = 48; 2002 Total Boards = 47.
 2. 2006 Diagnostic Assessment = Non-physician assessment.
 3. Percent Reporting 10 or less = Number of Boards reporting wait lengths for the category divided by total number reporting wait lengths. Percent Reporting 11 or more = Number of Boards reporting wait lengths for the category divided by total number reporting wait lengths.

NARRATIVE COMMENTARY – General Care

Most problematic child and adolescent general care problem areas

Boards were asked to comment on areas of General Outpatient Services that were most problematic and to discuss any solutions to the challenges they faced.

Staff Recruitment and Retention. Seventeen (17) Boards mentioned recruitment and retention issues related to psychiatric and other clinical staff trained in the treatment of children and adolescents (C&A). While staffing issues are sometimes related to lack of funding to pay for additional psychiatric FTEs, the majority of Boards commenting on this issue described the problem of insufficient workforce capacity to meet the demand for C&A mental health services.

“Provider agencies are reporting difficulties in staff recruitment and retention which the Board is trying to address through network quality improvement initiatives, appreciation activities, and implementation of best practice models.”
- Lorain County

“More pressing is the need for staff with strong skills with children and adolescents, particularly young children and adolescents. Northeast Ohio Behavioral Health has not always been satisfied by the level of training and clinical maturity it finds with new graduates. We have our own training program that includes mentoring well after licensure. Lack of masters-level counselors is resulting in a 4-6 week wait.” (Stark County)

Solutions: Boards described a number of approaches to solving the problem of too few C&A psychiatrists. Five (5) Boards described using phone consultation between C&A psychiatrists and pediatricians and adult psychiatrists to fill the staffing gaps. Another three (3) Boards talked about recruiting Advanced Nurse Practitioners. Some Boards are applying for status as a Healthcare Professional Shortage Area (HPSA) to attract psychiatrists on a J-1 visa or those eligible for NHSC loan repayment benefits.

Access Issues. Ten (10) Boards discussed access problems that are not related to staff recruitment and turnover. These include the availability of evening and weekend appointments, transportation services, scheduling efficiencies, cultural barriers to mental health services, insurance coverage, and the distribution of access across all providers.

“As needs arise, we work with the non-Medicaid agencies to serve as many children as possible through a triage process.”
- Ashtabula County

Four (4) Boards talked about using a centralized triage and access strategy to ensure that those most in need received adequate, timely care. Butler County Board discussed “first come, first served” approach that had reduced consumer dissatisfaction with wait lists.

Seven (7) Boards talked about access issues in terms of insurance coverage, which alternately limited the ability of consumers to pay for services and the constraint that Medicaid's rate ceilings put on providers to expand access.

Solutions: Three (3) Boards talked about low-cost approaches designed to increase naturally occurring community supports for families and children with SED as a way to address gaps in access to clinic-based services.

*“Maintaining sliding fee schedules and helping providers deal with poorly constructed insurance plans are issues.”
- Brown County*

“General care behavioral health services to families has been enhanced by low-cost programs such as The National Parents Anonymous Program, funded by a Children Trust Fund Grant, (a program that) provides education and support for parents who may have few natural supports. This grant was applied for and received by Firelands Counseling and Recovery Services. A Parent Mentoring Program, provided by JFS, is for parents identified by FCFC organizations. A Masonic Model Student Assistance Program, funded by an Ohio Bridge-builders Grant and an ODADAS Grant, will be implemented in six school systems in the county to identify risk factors in students that schools can impact.” (Huron County)

7.4.4 Child and Adolescent Promising, Best and Evidence- based Practices

In this subsection, Promising, Best, and Evidence-based Practices for children and adolescents are profiled. Practices reported in this section include: Early Childhood Care; Family Psychoeducation; School-based Services; Specialized services for children and adolescents with MR/MI, SA/MI, or those adjudicated for sexual offending behaviors; Trauma-informed care; Trauma-Focused Cognitive Behavioral Therapy (TF-CBT); and Interpreter services.

AVAILABILITY OF EVIDENCE-BASED PRACTICES

A number of promising, best, and evidence-based practices are available to children and adolescents throughout Ohio (see Tables in Appendix S, pages 167-172). The availability of these services varies. According to the quantitative data, overall, Boards offered the following promising, best, or evidence-based practices:

- Cluster-Based Planning (38%)
- Early Childhood Care (80%)
- Family Psychoeducation (64%)
- Family Therapy (80%)
- IHBT (34%)
- Interpreter Services (76%)
- MR/MI Integrated Services (30%)
- MST (26%)

- SAMI Integrated Services (46%)
- School-Based Services (98%)
- Sexual Offender Services (66%)
- Trauma-focused CBT (26%)
- Trauma-informed Care (50%)
- Treatment Foster Care (40%)

There were some differences by geographical classification. In each geographical classification, all services were offered to varying degrees. The most frequent service supported was School-Based Mental Health Services. Both the Metro-Urban and Urban Boards had higher percentages of offered services across the Boards than the other geographical classifications. Specific differences by geographical classification are provided below (also see Tables in Appendix S, pages 167-172):

- Rural Boards: All of the Boards reported offering School-Based Services. Less than 16% provide IHBT, MST, Cluster-Based Planning, and Trauma-focused CBT.
- Trans-Rural Boards: The majority of Boards reported offering School-Based Services (94.1%), Interpreter services (82.4%), and Early Childhood Care (76.5%). Less than 11.8% provide Trauma-focused CBT and 23.5% provide MR/MI Integrated Services and MST.
- Trans-Metro Boards: All the Boards reported offering Family Therapy and School-Based Services. The majority of Trans-Metro Boards reported offering Interpreter Services (75%). Only 25% of Trans-Metro Boards offered MR/MI Integrated Services or MST.
- Metro-Urban Boards: All Metro-Urban Boards reported providing School-Based Services. The majority of Boards report offering Early Childhood Care (87.5%), Family Therapy (87.5%), and Family Psychoeducation (75%). Only 12% of the Metro-Urban Boards are providing SAMI Integrated services to children and adolescents.
- Urban Boards: All Boards reported providing Early Childhood Care, School-Based Services, and Sexual Offender Services. Additionally a high percentage reported offering Family Psychoeducation (85.7%), Family Therapy (85.7%), and Interpreter Services (85.7%). The lowest percentage of support provided for a service was MST. Only 28.6% of Urban Boards report supporting this service.

Penetration Rate of Promising, Best, and Evidence-Based Practices

Additional data analyses by ODMH indicated the number of consumers receiving these services per 1,000 child and adolescent consumers. These numbers were averaged statewide, and by geographic classification (see Tables in Appendix S pages 167-172). Based on these penetration rates, most frequently utilized promising, best, and evidence-based practices were:

- School-Based Services
- Early Childhood Care
- Family Therapy
- Family Psychoeducation

There were some differences in penetration rates by geographical classification. In addition to the four practices listed above, other frequently utilized practices (based on number of adults receiving services) are included below:

- Rural Boards: Trauma Informed Care.
- Trans-Rural Boards: Cluster-Based Planning.
- Trans-Metro Boards: Cluster-Based Planning, IHBT, SAMI Integrated Services.
- Metro-Urban Boards: Trauma-focused CBT, Trauma-informed Care, MST.
- Urban Boards: SAMI Integrated Services, Trauma-informed Care

TECHNICAL ASSISTANCE ON EVIDENCE-BASED PRACTICES

Boards reported on their use of and need for Technical Assistance (TA) for various services.

Using TA

The percentage of Boards offering service and using technical assistance is provided below (see Appendix S, pages 173-184):

- Cluster-Based Planning (25%)
- Early Childhood Care (42.9%)
- Family Psychoeducation (16.7%)
- Family Therapy (0%)
- IHBT (25%)
- Interpreter Services (0%)
- MR/MI Integrated Services (33.3%)
- MST (50%)
- SAMI Integrated Services (40%)
- School-Based Services (42.9%)

- Sexual Offender Services (14.3%)
- Trauma-focused CBT (25%)
- Trauma-informed Care (20%)
- Treatment Foster Care (0%)

There were some differences by geographical classification:

- Rural Boards: Only three Rural Boards reported using any TA. In these circumstances, TA was used for Early Childhood Care, School-Based Services, and Sexual Offender Services.
- Trans-Rural Boards: Almost half of the Trans-Rural Boards are receiving TA in Early Childhood care. Additionally, 6 Boards are using TA for School-Based Services.
- Trans-Metro Boards: No Boards reported using TA for Family Therapy, Interpreter Services, Sexual Offender Services, Trauma-focused CBT, Trauma-informed Care, and Treatment Foster Care. Three Boards report receiving TA for Early Childhood Care.
- Metro-Urban Boards: No Boards reported using TA for Cluster-Based Planning, IHBT, Interpreter Services, and Treatment Foster Care. Half of the Metro-Urban Boards receive TA for Early Childhood Care. Three (3) receive TA for Trauma-informed care.
- Urban Boards: No Boards reported using TA for Interpreter Services or Treatment Foster Care. Three (3) Boards report using TA for Early Childhood Care and School-Based Services.

Needing TA

In addition to indicating whether they currently used Technical Assistance, Boards also indicated if they needed TA (see Tables in Appendix S, pages 179-184). Trauma-focused CBT (n=10), Early Childhood Care (n=8), and Trauma-informed Care (n=8) were the most common practices about which Boards indicated they needed TA.

For Boards currently offering the practice/service, common practices for which they reported needing TA were:

- Early Childhood Care (n=8)
- School-Based Services (n=4)
- Trauma-informed Care (n=3)

For Boards not currently offering the practice/service, the common practices for which they reported needing TA were:

- Trauma-focused CBT (n=8)
- Trauma-informed Care (n=4)
- IHBT (n=5)

Board Levy Funds

Board levy dollars reported on the 2005 040 Form were regressed on total number of individual EBPs reported by the Board in the Other C&A Service Matrix. Twenty-four (24%) of the variance (R^2 change) between amount of levy dollars and number of EBPs was explained in the linear regression, with significance at $< .0001$. The amount of levy dollars predicts how many C&A EBPs the Board supports.

“The cost of implementing these is a factor, but a major concern is the often extensive training required and how to balance that with productivity expectations of agencies. In addition, maintaining the knowledge base as staff turn over is a challenge.”

***– Delaware Morrow
ADAMH Board***

“Use of evidence-based practices will require a financial and time investment that is not easily afforded by the agency at this time. Adopting MST, MFT, etc. is currently an unfunded suggestion that has not been as high a priority as compared to maintaining a well-trained stable work force, keeping waiting lists manageable and ensuring that records are “audit ready” at all times.”

***– Clermont County MH
and Recovery Board***

NARRATIVE COMMENTARY – Evidence-Based Practices

Issues related to providing Evidence-Based Practices

Boards were asked to comment about the challenges and solutions to providing Evidence-Based Practices. A number of themes emerged as salient problems with implementing and sustaining Evidence-Based Practices in Ohio, including: staff productivity requirements, recruitment and retention, training needs, and a lack of funding.

Staff Productivity. Eight (8) Boards discussed the impact of EBP uptake and training, suggesting that it leaves “little time for other training” (Geauga Community Board of MHRs). The demand placed on clinician time to be billable hours reduces the likelihood of implementation of EBPs.

Recruitment and Retention. Eleven (11) Boards reported that ongoing problems with recruitment and retention of staff also reduce the acceptability of EBPs to their local markets. As EBPs require extensive training and a qualified workforce, excessive turnover becomes a financial liability for the agency. Agencies are then required to expend resources to train new staff to maintain a highly skilled workforce for the EBPs.

Training Needs. Thirty-four (34) Boards commented on issues related to training in the provision of Evidence-Based Practices. As is evidenced in the previous areas, there was considerable overlap between most of the issues surrounding Evidence-Based Practices and the need for training. By far, the largest number of comments from the Boards was around the issue of training on Evidence-Based Practices. According to the Boards, the training required for the implementation and maintenance of Evidence-Based Practices is prohibitive given the current strains on the mental health system in local areas. While the adoption of Evidence-Based Practices is either being considered or has already happened by most Boards, many Boards suggested that due to the current business environment it is not as high a priority as it should be. Even with these limitations, Boards did have concerns, including: 1) access to training, 2)

the expense of training, and, as stated previously, 3) work productivity concerns, i.e., taking staff away from their daily work.

“As with everything else, funding is always an issue; however, we are working through the ABC Transition Plan process to access as much training and technical assistance as possible to provide clinicians with tools to treat children with innovative, best-practice models.”
– Ashtabula County ADAMH Board

Lack of Funding. Lack of funding was a prevalent theme throughout the comments on Evidence-Based Practices. Thirty-four (34) Boards commented on issues related to funding Evidence-Based Practices. The vast majority of these comments indicated that 1) EBPs are expensive, 2) they are not always funded, and 3) they take funding away from other therapeutic approaches.

Solution: Twenty-two (22) Boards commented on their use of outside funding (outside of ODMH) and FAST\$/ABC funds to implement Evidence-Based Practices in their areas. These funds will be used for both training and programmatic purposes. For instance Clark County has “received funding through a Federal set-aside grant with which to establish MST services, and (2) was awarded a SS/HS Federal grant to be administered through Springfield City Schools.” (Clark-Green-Madison County)

Solution: While the Boards identified a number of challenges to implementing EBPs, twenty (20) Boards suggested they were in the “planning” stages of implementing Evidence-Based Practices.

7.4.5 School-based Services

In this subsection, School-Based Services for children and adolescents are profiled. Boards reported on the following services: Mental Health Education and Promotion, Primary Prevention; Secondary Prevention; Assessments; and Interventions. Boards also reported services by type of school, Mainstream schools and Other schools (e.g., Alternative or Partial Hospital schools).

School-Based Mental Health Programming

Overall, according to the Boards, School-Based Mental Health Programming is available in mainstream schools more frequently than in other types of schools (e.g., alternative education schools; see Tables in Appendices T and U, pages 185-191). For instance, 90% of Boards report they are able to fund programming in mainstream schools for mental health intervention services, while only 66% of Boards report they are able to fund this modality in alternative schools. Additionally, 76% of the Boards are able to fund targeted prevention in mainstream schools, compared to 40% are able to fund this prevention in other school types.

In terms of *no service availability*, 18% of Boards are not able to fund assessment services in schools or secondary prevention programs; 10% are not able to fund mental health education or primary prevention, and 4% are not able to fund mental health intervention services in schools.

A number of regional differences exist between School-Based Mental Health Programming that the Boards plan to fund in FY 2008-2009. Some of these differences are summarized below (for a complete list of services reported by region, refer to the Tables in Appendix B on pages 116-121).

“The most problematic aspects of school-based services are the varying levels of support for mental health services among school districts and personnel and the resistance of some school administrators to allow mental health services in their buildings.”
– *Clermont County MH and Recovery Board*

Compared with all Boards:

- Rural Boards report they are able to fund less School-Based Mental Health Services than all other regions in all types of schools. In terms of mainstream schools the least frequent service able to be funded by the Boards in Rural areas is Assessment (66.7% of Boards), followed by Mental Health Education and Promotion (83% of Boards), Primary Prevention (83% of Boards), and Secondary Prevention (83% of Boards). All Rural Boards report they are able to fund Intervention Services in mainstream schools. In terms of other types of schools, only 16% of the Rural Boards are able to fund Primary Prevention services in schools.
- Trans-Rural Boards report they are able to fund slightly less services in schools to children and adolescents than the state’s average for school-based services. For instance, 65% of the Trans-Rural Boards report they are able to fund assessment services compared to 72% state-wide; 64% of Trans-Rural Boards report supporting Secondary Prevention services compared to 76% statewide; and 82% of Trans-Rural Boards report they are able to fund Intervention services compared to 90% state-wide.
- Trans-Metro Boards report they are able to fund more or about the same amount of services to children and adolescents than the state’s average for school-based services in any type of school setting. For instance, 100% of Trans-Metro Boards are able to fund intervention services in mainstream schools, while the state’s average is 90%. In terms of services not available, 25% of Trans-Metro Boards do not provide secondary prevention services.
- Urban Boards report they are able to fund about the same amount of school-based mental health services as the state’s average. In mainstream schools, 71% of Urban Boards are able to fund assessment services, 86% are able to fund intervention services and mental health education, and 100% are able to fund primary prevention services. Only one Board reports are not able to fund assessment, mental health education, or secondary prevention in any school setting.

NARRATIVE COMMENTARY – School Based Mental Health Services

“The Board funds a mental health liaison position in each county. This staff works on site with each school district, providing consultation services.” – Ashland County MHRS Board

Issues related to providing School Based Mental Health Services

Receptivity. Ten (10) Boards reported a lack of support or receptivity to mental health treatment in the schools. According to the Boards, this lack of receptivity comes in many forms, from lack of access to classrooms, and teacher resistance, to lack of support from school administration. Boards report a number of “bureaucratic” hurdles that make it difficult to provide services in the schools.

Solution: Some Boards reported providing education to the staff of schools. This education is geared to show how emotional issues impact a student’s ability to be successful. Some Boards have tried to “tailor” their curriculum to meet the needs of the schools.

***“We have received funding from the Health Foundation to improve access to mental healthcare for school-aged children. This grant will produce a body of information and a strategic plan we can utilize for the future.”
– Adams County***

Parental Involvement. Five (5) Boards reported a number of issues related to the receptivity and involvement of the parents of children who received school based services. Boards reported that parents are “frequently uncomfortable receiving services in the school.” (Allen-Auglaize-Hardin ADAMH Board). Additionally, Boards report that parents’ busy schedules often result in cancelled appointments and generally poor follow through on their children’s mental health treatment.

Solution: Boards have used mobile services that provide services in the home to address issues of confidentiality and scheduling.

Staffing Issues. Nine (9) Boards mentioned that they do not have the staff time to dedicate to prevention services in the schools. According to one Board, often the only mental health services provided to the schools is during a time of crisis intervention.

Solution: One Board, Ashland County MHRS Board, has hired one FTE to work on mental health issues in the schools. This staff person has been so successful that there is now a need to expand the staffing of this program.

Funding. Nineteen (19) Boards reported significant funding shortfalls for school-based services to children, especially with regard to prevention services. Many Boards indicated that “there is a limit to the amount of non-Medicaid funds that [Boards] can use, especially for consultation and prevention, which are not Medicaid-billable” (Cuyahoga County CMH Board). Many Boards suggested that the needs in the schools are too great, and the funding too limited to meet the needs of the schools.

Solution: A number of Boards have applied for additional funding through Foundation grants and other State Agencies (ODADAS). Generating funds from outside sources and increasing collaboration between other child-serving agencies has allowed the Boards to provide some level of support to the schools, especially during times of increased fiscal constraint.

School Districts Offering Services

In SFY 2006, there were 47 Boards (94%) that supported services in 380 School Districts or School Programs across Ohio. All Urban and Trans-Metro Boards provided support to School Districts to provide mental health services in schools. Geographical differences in the number and percentages of Boards supporting School Districts Mental Health Services are:

- Rural Boards: 83.3% of Rural Boards report supporting MH Services in 147 buildings.
- Trans-Rural Boards: 94% of Trans-Rural Boards report supporting MH Services in 405 buildings.
- Trans-Metro Boards: 100% of Trans-Metro Boards report Supporting MH Services in 378 buildings.
- Metro-Urban Boards: 87.5% of Metro-Urban Boards report supporting MH Services in 188 buildings.
- Urban Boards: 100% of Urban Boards report supporting MH Services in 357 buildings.

MSPA – Community Plan Survey

7.5 Other Access Issues

**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

BACKGROUND – Other Access Issues

This chapter provides results of the other access issues section of the 2006 Mutual Systems Performance Agreement study. The following topics are the focus of this chapter of the evaluation:

- 7.5.1 Telemedicine
 - 7.5.2 Disaster/Terrorism Preparedness
 - 7.5.3 Prevention, Consultation and Education (PC&E) Inventory
 - 7.5.4 Medication
 - 7.5.5 System Capacity and Stability
 - 7.5.5.1 ODMH-Certified providers
 - 7.5.5.2 Adult Care Staff Capacity
 - 7.5.5.3 Child and Adolescent Care Staff Capacity
 - 7.5.5.3.3 Recruitment and Retention
-

RESULTS

7.5.1 Telemedicine

“This physician, too, is pleased with the arrangement as it lessens his time on the road and he feels as though his patients are getting the care they need.”
– Scioto, Adams, Lawrence Counties

In this subsection Boards reported issues related to Telemedicine. Specifically, Boards were asked to indicate if interactive video conferencing was available in the area for behavioral health counseling and/or pharmacological management. Fifty (50) Boards answered this yes-no question. Five (5; 10%) Boards indicated that telemedicine was currently offered in their areas. Of these five (5) Boards currently utilizing this service delivery method, two (2) Boards specifically mentioned some benefits they are realizing or hope to realize due to the availability of telemedicine: the reduction in drive time for the providers, increased access to services when needed versus waiting for an appointment, and retention of staff. Two (2) other Boards reported that telemedicine will be offered in the future once the videoconferencing equipment is available and/or the staff is available.

7.5.2 Disaster/ Terrorism Preparedness

In this subsection Boards reported on their approaches to disaster and terrorism preparedness. Boards highlighted their solutions to preparedness issues and reported any funding issues related to disaster and terrorism preparedness. All 50 Boards answered this question. There were five (5) main strategies/approaches to disaster and terrorism preparedness that the Boards utilized: training sessions, plans, collaboration with other entities, regular meetings, and mock drills/exercises.

Forty-two (42) Boards mentioned some type of training that they either offered or in which they participated (e.g., All Hazards training, ODMH approved two-day disaster training, stress debriefing training, critical incident training, death notification training, “Spirituality & Disaster” training, recovery training, disaster preparedness and response training,

terrorism training, National Incident Management System (NIMS) training, and behavioral health needs training).

Thirty-three (33) Boards reported participating in the writing, reviewing and/or updating of some type of plan (e.g., disaster response plans, disaster preparedness plans, behavioral health response plans, emergency operations plans, and disaster mobilization plans).

Partnering and collaborating with other entities was another approach to disaster/terrorism preparedness. This approach was mentioned by 28 Boards. Some of the collaborating entities included ODMH, ODADAS, ODH, police and fire departments, emergency management agencies, 911 operations, the National Guard, local health departments, hospitals, schools, churches, and universities.

“Funding has allowed us to access training and network with other entities that would not otherwise have occurred.”
– Gallia, Jackson and Meigs Counties

Twelve (12) Boards mentioned participating in emergency response planning drills and table-top exercises as one of their strategies for disaster and terrorism preparedness. Eleven (11) Boards wrote about participating in regular disaster preparedness meetings.

Limitations in funding were mentioned by 15 Boards. Funding concerns surrounded difficulties in providing training and developing resources, in purchasing needed equipment, and in reimbursement for expenses and lost productivity. Seven (7) Boards noted positives surrounding funding (e.g., more community awareness of disaster preparedness; more training sessions, increased ability to purchase needed resources and materials, and ability to keep behavioral health staff “at the table”).

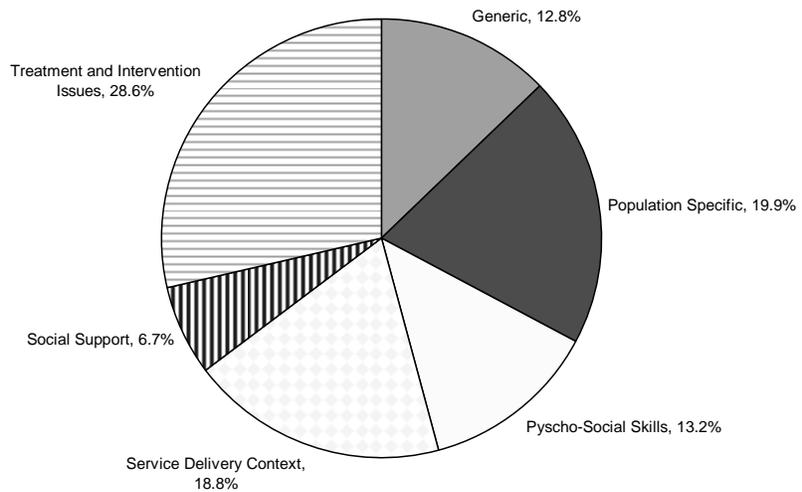
7.5.3 Prevention, Consultation and Education Inventory

In this subsection Boards listed the Prevention, Consultation, and Education (PC&E) programs and services Boards funded in Fiscal Year 2006, for children, adolescents, and adults. These programs included suicide prevention, school-based prevention, risk assessment/screening, depression awareness, and training and related programs. Boards also reported on the percent of their Fiscal Year 2006 budget that was allocated for PC&E services.

Mental Health Boards reported a total of 462 separate activities in the PC&E Inventory. Boards ranked education as the most frequent activity (N=309), followed by prevention (N=273), and consultation (N=142). Keywords were used to organize PC&E activities into 30 separate categories, which were further aggregated into six broad domains (see Figure 1 below).

The largest domain of aggregated categories was “Treatment and Intervention Issues,” which represented 28.6% of the entire sample. Falling within this domain, Suicide Prevention was the largest category of keyword-identified activities, representing 11% of the total responses (see Table in Appendix V, page 192). Other categories were aggregated into domains according to the population served, the context in which the activity is delivered, development of psycho-social skills, and the modality of social support. One domain, “Generic,” was formed by a single grouping of general activities that could not be categorized by unique keywords.

Figure 1. Domains of Prevention, Consultation and Education Programs



7.5.4 Medication

In this subsection Boards reported on approximately how much medication was disbursed through several funding sources (i.e., 419 Allocation, Local Indigent Programs, Pharmaceutical Company Assistance Programs, Pharmaceutical Company Samples, and Board funds) in Fiscal Year 2005.

Table 15 below presents the number of Boards reporting different information by source of medication funding, the amount funded and the estimated percent of adult consumers whose medication was funded by each source (see Table 15 below, and Tables in Appendix W, pages 193-198). *These results should be interpreted with caution due to both a wide range of percentages reported and the possibility that some Boards may have interpreted the question differently.*

- The highest statewide medication funding was provided by Pharmaceutical Company Samples (\$8,591,313); half of all Boards reported utilizing samples. The average percentage of consumers receiving medication funded by samples was 34.5%.
- The second highest medication funding was provided by the 419 Allocation (\$7,789,300); all 50 Boards reported receiving 419 Allocations. The average percentage of consumers receiving medication funded via 419 Allocation was 11.4%.
- The third highest medication funding was provided by Pharmaceutical Company Assistance Programs (\$5,583,056); almost half of Boards reported utilizing these programs. The average percentage of consumers receiving medication funded by the assistance programs was 6.36%.
- The fourth highest medication funding was provided by Board Funds (\$4,540,125); 34 Boards reported providing funds for medications. The average percentage of consumers receiving medication funded by the Boards was 10.41%.
- About one-quarter of Boards reported utilizing Local Indigent Programs (\$478,056). The average percentage of consumers receiving medication funded by the local programs was 3.29%.

There were some differences by geographical classification (see Tables in Appendix W, pages 193-198):

- For Metro-Urban, Trans-Metro, Trans-Rural, and Rural Boards the greatest amount of medication funding was provided by Pharmaceutical Company Samples.
- Urban Boards: 419 Allocations provided the largest source of medication funding for Urban Boards. All of the Urban Boards reported providing Board Funds for medications. None of the Urban Boards reported assistance from Local Indigent Programs.

Table 15. Medication Funding Sources

| Question 7.5.4.1: Approximately How Much Was Disbursed for Medication by Funding Source for All Boards? | | | | | | |
|---|------------------|-----------------|---------------|--|-----------|-----------|
| Medication Source | Number of Boards | % of All Boards | Amount Funded | Estimated % of Adult Consumers Whose Medication Was Funded by the Source | | |
| | | | | Minimum % | Maximum % | Average % |
| 419 Allocation | 50 | 100.0% | \$ 7,789,300 | 0.24% | 85.00% | 11.40% |
| Board Funds | 34 | 68.0% | \$ 4,540,125 | 0.29% | 52.00% | 10.41% |
| Local Indigent Programs | 12 | 24.0% | \$ 478,056 | 0.20% | 26.00% | 3.29% |
| Pharmaceutical Company Samples | 25 | 50.0% | \$ 8,591,313 | 0.90% | 95.00% | 34.50% |
| Pharmaceutical Company Assistance Programs | 22 | 44.0% | \$ 5,583,056 | 4.00% | 45.00% | 6.36% |

1. Number of Boards Reporting Source Provided Medication Funds to Consumers is the number of Boards that entered a dollar amount greater than zero for the amount funded.
2. % of Boards is (Number of Boards Reporting Funds Were Disbursed to Consumers) divided by 50 Boards.
3. Amount Funded is the sum of the Amount Funded for all Boards reporting funds were disbursed to consumers.
4. Minimum % is the lowest value in the range of estimates provided by the Boards for adult consumers whose medication was funded by the source. It excludes Boards that entered a dollar amount greater than zero for the amount funded but did not provide an estimate for the % of adult consumers whose medication was funded by the source. Number of Boards excluded by source is as follows: 419 Allocation--9; Board Funds--13; Local Indigent Programs--3; Pharmaceutical Company Samples--1; Pharmaceutical Company Assistance--2.
5. Maximum % is the highest value in the range of estimates provided by the Boards for adult consumers whose medication was funded by the source.
6. Average % is (sum of estimated % of adult consumers whose medication was funded by source for all Boards) divided by (the number of Boards that reported an estimated % for the funding source). Denominators by funding source are as follows: 419 Allocation Boards--41; Board Funds--21; Local Indigent Programs--9; Pharmaceutical Company Samples--24, and Pharmaceutical Company Assistance--20.
7. Cautionary Note: These results should be interpreted with caution due to both a wide range of percentages reported and the possibility that some Boards may have interpreted the question differently.

7.5.5 System Capacity and Stability

In this subsection Boards reported on past and anticipated changes in the number and type of certified providers, and the impact of these changes. Boards were also asked to report on child and adolescent care staff capacity, specifically the numbers of med-somatic practitioners currently under contract with the Board.

SYSTEM CAPACITY AND STABILITY – NARRATIVE COMMENTARY – ODMH Certified Providers

Twenty-three (23) Boards reported “No significant change” occurring in the Board area regarding the number and type of ODMH-Certified providers. Two (2) counties left this question blank. The majority (16) of the remaining 25 Boards saw provider additions in the way of Medicaid-only service providers (some in-county and some out-of-county providers). Six (6) Boards wrote about the loss of providers (e.g., discontinuing services and system restructuring). One Board mentioned a plan to add providers; one reported a total system redesign, and another

“As these[Medicaid certified] agencies come on line and submit significant dollars of claims into MACSIS the funding available for non-Medicaid eligible clients and services becomes more and more limited. These new services do not represent an expansion of capacity, but rather a diversion of behavioral health funding for specialty populations that had been funded through other monetary streams in the past.”
– Franklin County

Board mentioned adding and losing such that a balance in the number of providers was maintained.

Funding concerns related to the increased number of Medicaid Certified agencies (particularly out-of-county providers) seeking reimbursement was stressed by 13 Boards. Boards noted the effect of these changes in several ways, for example:

- Siphoning of the Medicaid match funds,
- Increased need to serve non-Medicaid clients,
- Reduced ability to plan and implement services with local providers, and
- Compromised continuity of care.

ADULT CARE STAFF CAPACITY

To better understand the range of medical professionals with prescriptive authority for psychiatric medications, Boards were asked to report the number of adult med-somatic practitioners currently under contract (See Tables in Appendix X, pages 199-204). Results show that 96% of Boards have access to a psychiatrist, while 40% also have access to Advanced Nurse Practitioners (ANPs). The reported number of Boards (N=20, 40%) with ANP FTEs has increased since 2002, when only 14 Boards reported access to ANPs. Data for 2002 and 2004 on number of ANPs cannot be compared to 2006, however, as the earlier count of ANPs did not specify how many of these staff were dedicated to adult versus child and adolescent consumers.

Comparison of Adult Staff Budgeted by the Boards

Average case load sizes for adult med-somatic practitioners, caseworkers, and counselors were calculated using the total number of budgeted FTEs for each staffing group reported by the Boards, divided by an unduplicated count of adult consumers with med-somatic, case management, and counseling service reported in MACSIS for 2002, 2004, and 2006 (see Tables in Appendix Y, page 205 and Figures in Appendix Z, page 206). In addition, budgeted FTEs for each staff group were standardized using rates per 1,000 adult consumers in 2002, 2004, and 2006.

Results of the average adult caseload size per FTEs by service types analyses show that caseloads for med-somatic practitioners decreased about 36% between 2002 and 2006. Adult caseload sizes for case managers rose slightly (9.5%) between 2002 and 2006, and counselor caseloads remained stable between 2004 and 2006. No data were available on adult counselor caseload sizes for 2002.

CHILD AND ADOLESCENT CARE STAFF CAPACITY

To better understand the range of medical professionals with prescriptive authority for psychiatric medications, Boards were asked to report the number of child and adolescent med-somatic practitioners currently under contract (see Tables in Appendix AA, pages 207-212). The reported number of Boards (N=13, 26%) with access to Advanced Nurse Practitioner (ANP) FTEs has increased since 2002, when only 14 Boards reported access to ANPs. Data for 2002 and 2004 on number of ANPs cannot be compared to 2006, however, as the earlier count of ANPs did not specify whether how many of these staff were dedicated to adult versus child and adolescent consumers.

Results show that 84% of Boards have access to a Child & Adolescent Psychiatrist; however, 18% of Boards are also using General Psychiatrists and 14% are using Pediatricians to make up for gaps in the available number of Child & Adolescent Psychiatrists.

Comparison of Child and Adolescent Staff Budgeted by the Boards

Average case load sizes for C&A med-somatic practitioners, caseworkers, and counselors were calculated using the total number of budgeted FTEs for each staffing group reported by the Boards divided by an unduplicated count of C&A consumers with med-somatic, case management, and counseling service reported in MACSIS for 2002, 2004, and 2006 (see Tables in Appendix BB, page 213 and Figures in Appendix CC, page 214). In addition, budgeted FTEs for each staff group were standardized using rates per 1,000 adult consumers in 2002, 2004, and 2006.

Results of the average C&A caseload size per FTEs by service types analyses show that caseloads for C&A med-somatic practitioners decreased about 12% between 2002 and 2006. C&A caseload sizes for case managers rose slightly (8.5%) between 2002 and 2006, and counselor caseloads rose about 22% between 2002 and 2006.

NARRATIVE COMMENTARY – Child and Adolescent Staff Recruitment and Retention Strategies

Thirty-six (36) Boards answered the question concerning development of successful recruitment and retention strategies with regard to med-somatic practitioners, case managers, or therapists for children and adolescents. The remaining 14 Boards left the question blank.

***“The presence of Ohio State University Mansfield and North Central State College in Richland County offers opportunities for student field placements which also helps with staff recruitment, especially entry level positions.”
– Richland County***

Seven (7) Boards noted they have *no strategies*. There were a few reasons for this response: two Boards viewed it as the Providers’ responsibility, and one Board noted that it had not found any strategy effective. Other Boards indicated they had “no plans” to develop a strategy.

Six (6) Boards reported strategies surrounding types of compensation and/or benefits. For example, competitive compensation packages were mentioned by two Boards. Other Boards reported providing salary increases, bonuses, tuition reimbursement, rewards programs, and assisting with payment of recruiter fees.

Various other recruitment and retention strategies mentioned by at least two Boards but no more than four Boards included:

- Forming a relationship (or contracting) with a nearby University,
- Hiring “other” professionals (especially, Advanced Practice Nurses),
- Training for employees,
- Qualifying as Health Professional Shortage Area (HPSA), and
- Utilizing staff turnover or retention/recruitment as a reportable indicator in a performance improvement plan.

MSPA – Community Plan Survey

7.6 Quality Improvement

**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

BACKGROUND – Quality Improvement

This chapter provides results of the quality improvement section of the 2006 Mutual Systems Performance Agreement study. The following topics are the focus of this chapter of the evaluation:

- 7.6.1 Recovery and Resiliency
 - 7.6.2 Outcomes-Based Performance Improvement
 - 7.6.3 Consumer and Family Empowerment
 - 7.6.4 Consumer Grievances, Complaints and Other Feedback
 - 7.6.5 Cultural Competence
-

RESULTS

7.6.1 Recovery and Resiliency

In this subsection Boards reported on what approaches or strategies they used or plan to use to ensure service delivery was consumer driven in its orientation to recovery. Boards were also asked to describe any peer support activities or consumer operated organizations to which they provided funding support.

The notion that recovery is a possibility for everyone was specifically mentioned in the President’s New Freedom Commission Report vision statement.

We envision a future when everyone with a mental illness will recover, a future when mental illnesses can be prevented or cured, a future when mental illnesses are detected early, and a future when everyone with a mental illness at any stage of life has access to effective treatment and supports — essentials for living, working, learning, and participating fully in the community.

The President’s *New Freedom Commission* (NFC) report is about a wholesale Transformation of the current mental health system. The NFC report lists six goals for a Transformed mental health system. The second goal is specific to the MSPA qualitative question addressed in this report subsection. Information about the NFC’s Goal 2 (Mental Health Care is Consumer and Family Driven) is concentrated on involving consumers and families fully in orienting the mental health system around recovery. Specifically the NFC document says:

“In a Transformed mental health system, a diagnosis of a serious mental illness or a serious emotional disturbance will set in motion a well-planned, coordinated array of services and treatments defined in a single plan of care. This detailed roadmap — a personalized, highly individualized health management

“... based on reports from BRIDGES teachers and participants, [BRIDGES] has had a profound impact on the lives of those who have participated in this innovative program. Our BRIDGES program utilizes consumers as teachers.... This model has worked extremely well and has enabled several consumer teachers to move on to gainful employment.”
 – Medina County ADAMH Board

“Since the majority of our flexible funding goes to Medicaid match, our system is not consumer driven, it is Medicaid driven. With no accountability in place for Medicaid spending, no ability to determine who will provide services, and no ability to sanction any provider who does not perform well or who over provides services to gain income, we just have to let the chips fall where they fall.”
 – Tuscarawas-Carroll Counties

program — will help lead the way to appropriate treatment and supports that are oriented toward recovery and resilience. **Consumers, along with service providers, will actively participate in designing and developing the systems of care in which they are involved.** (Emphasis added).

The analysis of the next MSPA question (7.6.1.1) speaks directly to ensuring mental health service delivery is consumer driven.

NARRATIVE COMMENTARY – Consumer-driven Services Oriented toward Recovery

Forty-eight (48) Boards answered this question. A consumer-driven orientation to service delivery was expressed via a couple specific themes in the Boards’ responses:

- Consumer Involvement in Policy and Service Planning, which included a few specific areas of focus;
 - Recovery Focus,
 - Education and Training Focus, and
 - Employment Focus
- Consumer Questionnaires and Needs Assessments

In addition, in their discussion of consumer-driven service delivery, several Boards mentioned concerns surrounding funding.

Consumer Involvement in Policy and Service Planning. Consumer involvement in policy and service planning took several forms:

- Consumers serving on Boards (7 Boards),
- Consumers attending meetings and serving on committees (12 Boards), and
- Consumer-operated services (9 Boards).

Board Identified Policy and Service Planning Focuses

Recovery Focus. Thirty-three (33) Boards specifically mentioned a commitment to recovery and/or a recovery focus in service delivery.

Education and Training Focus. Over 20 Boards discussed education and training opportunities. These responses centered on community education/training, consumer education/training, staff education/training and professional development, provider education/training, community education, and family education/training. Education and training opportunities included conferences and programs on: Recovery Conference, Recovery

Model, Recovery Project, WRAP, Peer Support, BRIDGES, IMR, FCF – Wraparound, Cluster models, FAST\$06, ABC, CQRT, and Employment.

Employment Focus. Seven (7) Boards mentioned employment in their responses to delivering consumer-oriented services. Generally, comments involved *promoting* employment for consumers and employment *successes* of consumers.

Consumer Questionnaires and Needs Assessments. Consumer questionnaires and/or needs assessments were mentioned by 12 Boards as a means to ensure consumer involvement in service planning.

Funding. Funding issues were mentioned by eight (8) Boards. Such topics included funding *uses*, funding *needs*, and funding *availability*. Specifically due to funding concerns, one Board noted it was not consumer-focused (see quote previous page).

NARRATIVE COMMENTARY – Peer Support Activities / Consumer Operated Services / Level of Funding

Forty-nine (49) Boards answered this question. One Board left it blank. One of the 49 Boards (Brown County) noted, “...most of our operational funds are used in matching Medicaid” and wrote that it did not support and/or fund any peer support or consumer operated organizations. The most commonly mentioned consumer operated service was a “Drop-in Center.” Board-supported drop-in centers were cited by 16 different Boards, with some larger Boards supporting more than one drop-in center. Support for “BRIDGES,” “NAMI,” and “WRAP” were mentioned by 13, 11 and ten (10) Boards, respectively.

In total, the funding listed by the Boards in support of peer support and consumer operated services was \$7,766, 942. However, the Boards did not provide figures for the same fiscal year. Some provided dollar amounts for FY 2006 and some projected amounts for FY 2007, while others did not report a time frame for the funding.

NARRATIVE COMMENTARY – Approaches or strategies to ensure service delivery is family driven in its orientation to resiliency

Forty-nine (49) Boards answered this question. One Board left it blank. Of the 49 Boards responding, only one Board stated that its approach was not consumer driven; rather, “it is Medicaid driven.” The 48 Boards who specifically noted their services were family driven mentioned several programs which demonstrated their commitment to such an approach:

7.6.2 Outcomes- Based Performance Improvement

Family and Children First Councils, Incredible Years, NAMI Family to Family, NAMI Hand to Hand, Super Kids Informed & Involved Parents (SKIIP), Wraparound approach, Parent Mentoring, Parent Advisory Council, FAST, ABC, Mental Health Drug Court Initiative with Juvenile Court, MST, and Devereux Early Childhood Assessment (DECA). The involvement of NAMI was the most frequently mentioned strategy or approach (N = 13 Boards) to ensuring services were family driven. The second most mentioned approach was the use of Family and Children First Councils (N = 12 Boards).

In this subsection Boards reported on what assistance they were providing to agencies to meet the 80% threshold for reporting Outcomes required by Certification standards (Outcomes Rule 5122-28-04). Boards also reported on targets set for Outcomes records submissions. Additionally, Boards commented on how they were using the Outcomes data for performance improvement in the areas of: Program and Policy Planning, Program and Policy Evaluation, Provider Performance, and Monitoring.

NARRATIVE COMMENTARY – Strategies for Boards to help Agencies become compliant with Outcomes Rule

The Boards presented several activities and strategies they use to help providers meet the 80% threshold for Outcomes record submissions required by the Certification standards. Forty-nine (49) Boards answered this question. The most frequently mentioned strategy was technical assistance (N = 13 Boards). The second most frequently utilized strategy was the dissemination of reports to the agencies (e.g., Missing Data Report and in-house reports). Regular meetings (monthly or quarterly) were reported by 11 Boards as an activity to encourage Outcomes record submissions. Some Boards (N = 8) reported technological changes/improvements, such as web-based screening, touch screens, electronic notifications when it is time to administer the Outcomes instrument, and software changes to facilitate reporting Outcomes data.

In setting a target for submission of Outcomes data, some boards (N = 8) set their target above the 80% threshold (targets ranged from 90% to 100%). The majority (N = 34) of Boards set the target at the 80% threshold. Five (5) Boards did not report a target and three (3) Boards left this item blank.

“We believe these [consumer Outcomes] data will provide a unique way of assessing who (agency and individual provider) is doing what, and with what degree of success. No mere academic exercise, this [process] will in large part determine our system’s ability to survive in the current financial environment.”
– Trumbull County

NARRATIVE COMMENTARY – How Boards are Using Outcomes Data for Performance Improvement

The Boards were specifically asked to comment on use of Outcomes data with respect to four performance improvement (PI) areas: Program & Policy Planning, Program & Policy Evaluation, Provider Performance Monitoring, and Other. In general, the Boards did not distinguish among these PI areas, as they indicated they were closely related and/or copied the same response under multiple areas. Consequently, results are presented in aggregate across the respective areas. Forty-seven (47) Boards answered this question. There was a “continuum” of Outcomes data use for performance improvement presented in the Boards’ responses *from* lack of use *to* use in decision making. Eight (8) of the 47 Boards reported they were *not* able to use the Outcomes data as the data were not available to use, or there were not enough data available for effective policy planning or evaluation. On the other end of the continuum, eight (8) Boards noted use of Outcomes information when making funding decisions, specifically, contracting based upon results. Some additional uses of data in performance improvement included using data in treatment planning (N = 8), for internal trending (N = 4), for informing performance reviews and/or determining corrective action (N = 4), for developing report cards (N = 2), and for setting performance targets (N = 2).

Eighteen (18) Boards specifically mentioned they were using or currently developing *reports* (Outcomes reports or other reports) to regularly review/monitor progress and compare individual agency performance with the State’s performance.

At the time the MSPA – CPS data collection was ending, the Outcomes Data Mart was just released (end of April 2006). Five (5) Boards mentioned they planned to use the Data Mart to aid in performance monitoring.

Two (2) Boards indicated a need for education or technical assistance since they were in the early stages of using Outcomes data for performance improvement and policy planning and the data were thought to be “relatively new”.

7.6.3 Consumer and Family Empowerment

In this subsection Boards reported the areas of consumer empowerment in which they were successfully engaging consumers and family members. Areas of consumer empowerment included: program and policy planning, program and policy evaluation, provider performance monitoring as well as “other” activities. Boards also could describe activities, in these areas, in which consumers and family members were engaged.

The highest percentage of engagement of consumers and family members reported by Boards was for program and policy planning.

- Almost all Boards indicated engaging both consumers (98%, N=49) and family members (94%, N=47) in program and policy planning (all 50 Boards responded yes or no).
- The majority of Boards indicated engaging both consumers (82%, N=41) and family members (80%, N=40) in program and policy evaluation (46 of the 50 Boards responded yes or no).
- The majority of the Boards indicated engaging both consumers (68%, N = 34) and family members (66%, N = 66) in provider performance monitoring (40 of the 50 Boards responded yes or no).
- A few other Boards also indicated engaging consumers (14%, N=7) and family members (12%, N=6) in other empowerment activities.

Specific Activities

Boards were asked to indicate specific planning, evaluation, and monitoring activities in which they involved consumers and family members. Boards mentioned similar activities across planning, evaluation, and monitoring (49 Boards responded to this question).

- 28 Boards specifically mentioned that consumers and family members serve on the governing board.
- 32 Boards mentioned that consumers and family members serve in an advisory capacity on special committees (e.g., CIT, Employment, Housing, Human Resources, Recovery Services, FCFC).
- 15 Boards mentioned they conducted consumer and family member interviews, surveys, focus groups, or needs assessments for direct feedback.
- 14 Boards mentioned active contact with NAMI groups through Board membership or other activities.
- One Board reported seeking feedback from a specially created Consumer and Family Advisory Council.
- Other Boards reported seeking feedback from drop-in centers funded by the Boards.

7.6.4 Consumer Grievances, Complaints and Other Feedback

DESCRIPTIONS OF CONSUMER GRIEVANCES AND COMPLAINTS

In this subsection Boards described their responses to consumer grievances and complaints from up to four different perspectives: 1) if there was an impact on the local system, 2) if there was an impact on policy or procedural changes, 3) if they required outside consultation, or 4) if it was the most challenging grievance/complaint within the last year. Forty-two (42) Boards responded to this question; three (3) Boards indicated that they had no grievances or complaints filed and provided no examples for any of the potential situations.

Resulted in an impact on the local system

Twenty-three (23) Boards provided examples of complaints and grievances which have impacted local systems.

- The most common complaint or grievance listed was about access to care such as transportation, wait times, and eligibility of non-Medicaid consumers for services. Some solutions mentioned by the Boards included implementing new processes such as a new protocol for family members needing help for consumers through Mobile Crisis, developing a flow chart for access to the state hospital, and a waiting list report. Some Boards agreed to fund additional services such as supplemental funding for non-Medicaid eligible consumers and transportation; one Board reported changing its mission statement.
- Other Boards indicated complaints/grievances about how consumers were treated and client rights. Boards responded with training on ethics, cultural competence, and customer service.
- Other changes to the system included implementing a Smoking Cessation Grant and a process to document and substantiate or unsubstantiate complaints.

Resulted in policy or procedural changes

Twenty-three (23) Boards responded that grievances and complaints resulted in policy or procedural changes. The majority of these changes occurred as a result of the complaints and grievances listed above. Specific policy or procedural changes mentioned included sensitivity training and monitoring of patient/staff interactions, specified procedures to access FAST dollars, development of a standard policy with Mobile Crisis to fill out a Significant Other form, development of policies/consequences for program violation, development of a no smoking policy to be implemented in FY2007, and development of more user friendly reports.

Required outside consultation

Sixteen (16) Boards provided brief descriptions of complaints or grievance situations that required outside consultation. Many Boards indicated that agencies had consulted with the Board's Client Rights Officer or other Board Staff, and that Boards had contacted staff at ODMH for consultation as well. Some Boards reported consulting with Ohio Legal Rights. Other Boards reported consulting with other individuals (e.g., doctors or lawyers). One Board mentioned concern with how a grievance was mishandled and about the "political safety" of reporting grievances. "As we work to make consumers ever more aware of their rights, the number of grievances increases, and that potentially puts [The Board] in a bad light with the state."

Most challenging among all cases in last year

Twenty-three (23) Boards responded about their most challenging case. In many instances Boards indicated it was the same case that required outside consultation. Other characteristics across Board responses included challenges associated with complaints against the agency or Board management due to conflicts of interest, challenges with multiple complaints, challenges with multiple roles of a Consumer and Family Advocate operating also as a client rights officer, challenges with maintaining objectivity when judging complaints, and complaints where there often is no good solution to the problem.

USE OF CONSUMER FEEDBACK TO IMPROVE DELIVERY OF MENTAL HEALTH SERVICES

In this section Boards reported on how they were using consumer feedback, such as satisfaction surveys, to improve their delivery of mental health services. Almost all of the Boards responded to this question (N=49). The majority of the comments provided by the Boards were about the process of collecting consumer feedback and whether they used focus groups, interviews, satisfaction surveys, grievances/complaints, or other types of feedback. Additionally, Boards' reports of how they used the feedback were very different, with very few commonalities. About half of the Boards responding mentioned that consumer feedback was provided to the Boards, but did not provide additional details. The most common use of consumer feedback reported by Boards was quality improvement (N=17). Nine (9) Boards indicated feedback was used to adjust access to services, and service delivery. Five (5) Boards indicated they had made changes to physical facilities (i.e., waiting rooms) to accommodate consumers' wishes.

7.6.5 Cultural Competence

In this subsection Boards reported on how they evaluate the ability of their agencies to provide culturally competent services. Boards were asked to identify whether their process for evaluating cultural competence included consumers and family members.

NARRATIVE COMMENTARY – Cultural Competence

Forty-nine (49) Boards responded to this question. Boards indicated a wide range of processes to ensure culturally competent services were provided by agencies, ranging from no cultural competence evaluation activities to Boards which have a formal review process for agencies as part of continuous quality improvement. Boards also provided information about their activities to become more culturally aware and to provide information, guidance, or training to their agencies.

Consumer and family involvement. Half of the Boards (24) included consumer and family involvement in evaluating cultural competence; Boards indicated consumers and family members were involved in an advisory capacity, through consumer surveys, or some other type of involvement.

Staff Training. The most common practice Boards mentioned for ensuring cultural competence was staff training (23 Boards).

Consumer surveys. Boards (17) indicated that they ask about cultural competence in interviews with consumers or in consumer satisfaction surveys.

Formal review processes. Boards (15) have some form of formal review process of agencies; these review processes include chart reviews, quality improvement plans required from agencies to provide continued services, or other review process such as Medicaid review, or utilization reviews.

Staff representation. Boards (11) mentioned that agency staff was representative of local demographics according to race, language issues and culture. Also, Boards noted diversity was a priority in staff recruitment.

Translation. Boards (9) provide some type of Translation/interpretation services for Spanish or hearing impaired, for both the consumer and the provider. Additionally some Boards provide informational materials or forms that have been translated into other languages.

Informal evaluation. Some Boards (7) evaluated cultural competence informally, though feedback from clients such as attending to the presence or absence of culture-related grievances.

Advisory committee. Some Boards (6) indicated they had some form of advisory council or steering committee that informed Board policy regarding cultural competence.

Cultural assessment tool. Some Boards (6) utilize some form of assessment tool designed to measure cultural competence (e.g., Consolidated Cultural Assessment Toolkit C-CAT).

Participation in cultural organizations. Some Boards (5) mentioned that the Boards or provider agencies were involved in local or state organizations that provide awareness or training on cultural competence (e. g., Multiethnic Advocates for Cultural Competence – MACC, or Ohio Committee on African American Males).

Four (4) Boards stated that they do not evaluate cultural competence; two Boards indicated that this was due to the demographic characteristics of their counties (less than 2% minority populations).

NARRATIVE COMMENTARY – Strategies to reduce disparities associated with race, ethnicity, language, age, gender, sexual orientation, and/or geography in the delivery of services

Forty-nine (49) Boards responded to this item. Two (2) Boards reported no problems with disparities in their areas. There were several different populations mentioned in the Boards’ responses to this item: Amish, African American, Appalachian, Seniors/Elderly, Deaf, Poor, and those involved in the criminal justice system. The most frequently mentioned strategy for reducing disparities was training (N = 13). Seven (7) Boards reported offering interpreters or having materials translated in order to ensure access to services. Other less frequently mentioned efforts to reduce disparities included recruiting (or attempting to recruit) staff who were able to service the populations; writing or having in place specific plans and policies to address non-discrimination, and setting up a branch or satellite office close to the population in need.

MSPA – Community Plan Survey

7.7 Cross–System Issues

**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

BACKGROUND – Cross–System Issues

This chapter details the cross-system services section of the 2006 Mutual Systems Performance Agreement study. The following topics are the focus of this chapter of the evaluation:

- 7.7.1 Coordination of Child Serving Systems – Law Enforcement
 - 7.7.2 Adult and Juvenile Criminal Justice
 - 7.7.2.1 Criminal Justice Coordination – Adults
 - 7.7.2.2 Criminal Justice Coordination – Juvenile Justice
 - 7.7.3 Integrated Physical Health Care
 - 7.7.4 Older Adults
-

RESULTS

7.7.1 Coordination of Child Serving Systems

This section will outline results from the key research questions of the study. The following topics are to be explored: coordination of child serving systems, and adult and juvenile criminal justice, integrated physical health care, and older adults.

COORDINATION OF CHILD SERVING SYSTEMS – Collaboration Matrix; Collaboration Issues, Impacts and Solutions

“The biggest challenge is addressing the variety of state FCFC requirements and separate fund sources for development of local meaningful and productive programs. The service coordination under the Help Me Grow has been particularly challenging since the funding level allocated is far less than the need from the newborn population growth.”
– Delaware-Morrow Board

Boards were asked to indicate the agencies and entities with which they were most engaged in building stronger collaborative relationships with regard to children and adolescents. Boards also were asked to discuss areas of collaboration that were problematic or on which the Board was particularly focused. Further, Boards were asked to comment about the impact of funding issues and innovative solutions. Results are presented in Table 16)

Family and Children First Councils (FCFC)

Ninety-eight (98%) of Boards indicated collaboration activity with county Families and Children First Councils (FCFC; see Table 16). Boards frequently stressed the important role of planning grants in facilitating service planning coordination. The ABC planning process received frequent mention. Organizational and staffing activities typically included participation on FCFC Executive Boards and being the fiscal agent to FCFC offices. Boards discussed numerous joint grant writing and funding activities through FCFC, including FAST, Partnership for Success (PfS), and Juvenile Justice. At the same time, a number of Boards commented on difficulties meeting funding requirements and the inadequacy of funding to meet the demand for services.

Despite the frequency with which Boards identified collaboration on organizational and staffing activities, a smaller but significant group of Boards talked about organizational problems associated with under-funding of the county’s FCFC. Solutions ranged from Boards providing additional funding for FCFC staffing to dedicating Board staff to increased involvement.

“Two of our counties are using staff within the local Department of Jobs and Family Services to serve as part-time coordinators for FCFC. This has required ADAMHS Board staff to be more involved due to the lack of attention.” (Mercer-Paulding-Van Wert Board)

Table 16. Collaborative Relationships with Child Serving Systems

| 7.7.1.1. Child Serving Systems | | |
|--------------------------------|------------------------|------------------------|
| Child Serving Agency | # Boards Collaborating | % Boards Collaborating |
| Families & Children First | 49 | 98% |
| Juvenile/Family Court | 47 | 94% |
| Public Child Serving Agencies | 44 | 88% |
| School Boards & Schools | 42 | 84% |
| Law Enforcement | 37 | 74% |
| MR/DD Boards | 37 | 74% |
| Health Departments | 34 | 68% |
| Other | 16 | 32% |
| Primary Care Physicians | 15 | 30% |
| Other | # of Other | % of Other |
| Service & Program Providers | 6 | 38% |
| United Way | 3 | 19% |
| Unspecified | 3 | 19% |
| ADAS Boards | 2 | 13% |
| County Commissioners | 1 | 6% |
| Chamber of Commerce | 1 | 6% |

1. Percent of Boards Collaborating = # of Boards divided by 50.
2. Percent of Other = # of Boards specifying other kinds of activities divided by 16.

Juvenile and Family Courts

Ninety-four percent (94%) of Boards indicated significant collaborative involvement with Juvenile and Family Courts (see Table 16). Major themes included care coordination and joint funding for services, staff, and projects. Boards also discussed collaborating on the development of diversion programs and mental health and drug courts.

“We have a need for more collaboration between Juvenile Court and Treatment Provider Agencies. There exists a mindset perhaps that some youth are not amenable to treatment or to lower levels of treatment. We have worked diligently with the courts to educate them on the treatment options available to many youth and the great impacts that can be made. We are encouraged that the courts will refer to our Intensive Home-Based Treatment program.”
– Preble County

“Collaboration on grants and health education has provided data driven planning, which helped to secure more grant funding and has placed mental health in the public’s view as a public health issue.”
– Hancock County

“This is an area that the Board is most successful. The Board and Juvenile Court has collaborated on many partnerships (Reclaiming Futures, BH/JJ Grant (CITP), Care Coordination Team Intervention, etc.). The Board and Juvenile Court since 1998 has cost-shared for juveniles who need residential placement. The Board funds behavioral health staff 24/7 in the Juvenile Court to screen and provide behavioral health interventions of all juveniles brought to Juvenile Court and/or detained.” (Montgomery County)

Boards also stressed the importance of collaborating with Juvenile Courts on the adoption of best practices, such as community-based treatment for sex offenders, MST, Functional Family Therapy, Brief Strategic Family Therapy, Family Drug Court, wraparound and intensive home-based services.

School Boards and Schools

Eighty-four percent (84%) of Boards said they were collaborating with School Boards and Schools, with the greatest number of comments involving prevention and early intervention programs, followed by planning and needs assessment activities (see Table 16). Despite successes, Boards also discussed the difficulties associated with engaging schools in conversations about meeting the mental health needs of students. Identified problems include lack of funding, stigma, and pressure for schools to meet state proficiency and school safety standards.

Solution: “Because of funding issues with schools, the Board found that paying for the cost of substitute teachers, so that educators can attend training, is necessary for many school systems to participate in training.” (Huron County)

Boards reported finding funding for school collaboration through the ABC/FAST initiative, PfS, and federal and 503(c) grants. The role of local levies in supporting Board collaboration with schools was also noted.

Law Enforcement

Seventy-four percent (74%) of Boards indicated active collaboration with Law Enforcement officials, with Crisis Intervention Training (CIT) being the most commonly mentioned area of joint activity (see Table 16). Beyond specific mention of CIT, other Boards reported a focus on crisis services, participation on advisory boards, and training of law enforcement personnel.

MR/DD Boards

Seventy-four percent (74%) of Boards also indicated active collaboration with MR/DD Boards, with most attention focused on joint service planning and coordination, shared funding, and cross-system training (see Table 16). Boards also mentioned the important role of the MI/MR CCOE in supporting their efforts to adopt best practices for the dually-diagnosed population.

Health Departments

Sixty-eight percent (68%) of Boards reported limited but important collaborative activity with county Health Departments, including disaster preparedness, child fatality review, suicide prevention, needs assessment, and early childhood mental health programs (see Table 16). A handful of Boards discussed specific collaboration with Health Departments that was focused on a joint funding initiative.

Primary Care Physicians

Thirty percent (30%) of Boards reported collaborative activity with Primary Care Physicians, with training of primary care physicians and pediatricians in mental health issues most frequently mentioned as an area of programmatic activity (see Table 16). Despite promising reports of progress in collaboration, not all Boards reported success in this area. Only one urban Board indicated collaborative activity, and the majority of the collaborating Boards served rural, trans-rural, and trans-metro populations.

Thirty-two percent (32%) of Boards reported Other collaborative entities, primarily service and program providers (see Table 16).

NARRATIVE COMMENTARY – Coordination of Child Serving Systems – Law Enforcement

In this subsection Boards reported on the other child-serving systems with which they are cultivating a stronger collaborative relationship. Boards were asked to identify problems or innovative solutions related to their collaboration efforts. Twenty-two (22) Boards responded to this question. Most Board comments were solution-oriented.

Challenges

Funding. Two (2) Boards indicated funding was an issue for providing training.

Solutions

Crisis Intervention Training (CIT). The most common collaboration reported by Boards (10) was CIT for law enforcement personnel. Eight (8) Boards reported already providing the training while two Boards would like to offer training, one of which will implement CIT within the next year. Two other Boards reported focusing on crisis services but did not specify CIT.

Training. Four (4) Boards indicated other (non-CIT) training for law enforcement personnel.

Collaboration teams. Three (3) Boards reported forming an Advisory Board or Committee, or that Law Enforcement personnel sit on their Boards.

Other solutions. Four (4) Boards indicated other miscellaneous solutions. One (1) Board reported collaborating with jail personnel. One (1) Board established a diversion program. One (1) Board reported that they provide special services to officers and their family members when officers have been exposed to trauma. One Board provided services to children rescued by law enforcement officers from drug labs.

7.7.2 Adult and Juvenile Criminal Justice

ADULT CRIMINAL JUSTICE

In this subsection Boards reported on the areas of adult criminal justice and mental health on which they were most focused, which areas that were the most problematic, or innovative solutions they had used.

NARRATIVE COMMENTARY – Adult Criminal Justice Coordination

Forty-three (43) Boards responded to this question. Most Board comments were solution-oriented.

Challenges

Funding. Eight (8) Boards identified funding concerns. Two (2) Boards indicated a need for funding to provide mental health staff in jails. Two (2) Boards were concerned that Medicaid funding was lost upon incarceration even though the need for services still exists.

There was a concern about who is responsible for payment, depending on if the criminal justice consumer is a local resident or out-of-county and whether to provide and/or bill for services to other counties who contract with their county to provide jail beds.

One (1) Board reported increased demand for drug and alcohol services for indigent consumers. The Board found a surplus in the court budget but reported they were using the money at a faster rate than replacement.

Jail Services. Some Boards (8) indicated issues with mental health services in jails. Issues included an increase in referrals to community providers by jails, the need for more mental health providers in the jails, and the need for cross-training of jail and community mental health providers. One (1) Board indicated that the local jail did not believe they should house individuals with mental health issues; the Board reported they will be addressing this concern over the next year through CIT.

Courts. One (1) Board indicated that their mental health court lacks direction and focus.

Solutions

Advisory Committees. The most common solution reported by Boards (22 Boards) was the continued utilization of some form of an Advisory Board, Committee, Task Force, or collaborative meeting that focused on criminal justice and mental health issues, and was comprised of a variety of law enforcement, court, and mental health personnel.

For example, the collaboration among Geauga County personnel has led to a pilot project that provided a greater number of services than previously available, including “pre- and post-hearing assessments, therapy, in-jail and probationary supports, diversion protocols and programs, emergency services, in-jail psychiatric services, anger management, and drug and alcohol assessment and treatment.” Reportedly, this one-stop system of care has resulted in increased cooperation of judges to follow and enforce therapeutic recommendations during sentencing.

CIT and other Training. Seventeen (17) Boards indicated they provide training for law enforcement personnel; the most common training reported was CIT (11 Boards).

Some counties offered additional training; for example, over the last year, Medina County offered training on, “topics such as Understanding Mental Illness, Uses of Psychiatric Medication, Suicide Prevention, Stress Management, The Etiology and Profiles of Sex Offenders, Substance Abuse, Identification of Symptoms of Chemical Abuse Withdrawal, as well as general training about the mental health and substance abuse treatment services within the county.” Another Board is planning to cross train law enforcement personnel with their ACT team.

Diversion Programs. Some Boards (7) provided, or are in the process of establishing, jail diversion programs for mental health consumers.

Re-entry. Some Boards (7) coordinate services upon release from jails. This coordination included follow-up with mental health agencies, coordination other supports such as job skills training or employment services, and supported housing.

Courts. Some Boards (6) reported having specialty courts, such as a Mental Health Courts or Drug Courts; these courts were instrumental in providing specialized diversion strategies and services for mental health consumers within the criminal justice system. Three Boards reported they were in the process of developing mental/behavioral health courts.

Funding. One (1) Board is pursuing local and federal grant opportunities, and two Boards have acquired funding from other sources: one (1) Board from the Health Foundation of Greater Cincinnati, and another Board acquired a SAMHSA grant to assist with capacity for dual disorder clients.

NARRATIVE COMMENTARY – Adult Recidivism and Diversion Strategies

Recidivism. Thirty-three (33) Boards responded to this open-ended question regarding the types of strategies used to reduce recidivism in the criminal justice system. All strategies involved either intensive services with a community linkage component. Many Boards suggested that they are working in close connection with the criminal justice system in their areas to address the problems around recidivism of mental health consumers. Some of the suggested strategies included developing alternative probation ideas, mental health courts, offender treatment, various community linkage programs, forensic Intensive Case Management/ACT/IDDT.

A number of challenges were also identified, including: the need for more resources (funding), housing, increased collaboration between agencies and the criminal justice system, and technical assistance.

Diversion. Thirty-eight (38) Boards responded to this open-ended question regarding the types of diversion strategies used in communities across Ohio. Almost all reporting Boards indicated the use of CIT, MH or AOD Courts, and the initiation of diversion programs.

Challenges identified include: a need for training, more collaboration between the courts/jails/mental health system, increased recruitment of trained staff to work with persons with mental disorders.

BOARD ESTIMATES OF INCARCERATED ADULT CONSUMERS

Data Collection Method: Twenty Four Boards (50%) provided information on how they obtained estimates for the number of Court-involved adults expected to receive services. Ten Boards (10) used agency records, 2 Boards used Behavioral Health Mod. Data, 2 Boards used MACSIS data, and the remaining boards used estimates based on criminal justice agencies. The results of these estimates are presented below.

Adult Consumers: Twenty-four Boards (50%) reported that they could estimate the number of adult consumers who were incarcerated in local jails over the past year. These Boards estimated that five percent (5%) of consumers within their catchment area were incarcerated over the past year.

SMD Consumers: In terms of persons with a diagnosable SMD, only 13 Boards (26%) could accurately estimate how many had been incarcerated in local jails over the past year. These Boards estimated that seven percent (7%) of SMD consumers within their Board area had been incarcerated over the past year.

Referrals of Court-Involved Adults: 36% of Boards (N=18) indicated that they could estimate the number of referrals involving court-involved adults. The Boards reported that of these referrals, 38% received services in SFY 2006.

JUVENILE JUSTICE

In this subsection Boards reported on the areas of juvenile justice and mental health on which they were most focused, which areas that were the most problematic, or innovative solutions they had used.

NARRATIVE COMMENTARY – Juvenile Justice Coordination

Forty-four (44) Boards responded to this question.

Challenges

Funding. Some Boards (9) identified funding concerns. Because of funding shortages, Boards reported that some teens must wait to participate in residential placement or diversion programs. In Geauga County, funding shortages have resulted in separating children from families, “the Juvenile Judge has now started to turn over custody of children to JFS in order to facilitate treatment. As funding tightens, we anticipate this situation will get worse instead of better.” With more

money, one Board indicated it would hire a MH staff person to work in the courts.

Other challenges. Two (2) Boards indicated custody issues – that custody of children was relinquished for the purpose of obtaining behavioral health treatment. Some Boards reported that youth were not sent to appropriate treatment facilities (e.g., sent to detention rather than treatment), were ‘sentenced’ to inappropriate treatment, or were sent outside the community when there were community resources for these youth.

Solutions

Advisory Committees. The most common solution reported by Boards (14 Boards) was the continued utilization of some form of Advisory Board, Committee, Task Force, or collaborative meeting that focuses on juvenile justice, mental health, and substance abuse issues. One Board is in the process of creating a MH/JJ steering committee.

These advisory councils were comprised of a variety of law enforcement, court, and mental health personnel from: Juvenile Court, Department of Youth Services, Probation, Truancy, Family and Children First, AoD Board, MR/DD Board, and the Drug Court.

Specialty Courts. Some Boards (10) have/are creating specialty courts (e.g., Multi-Agency Family Court, Dual Diagnosis Drug Court, Intervention Court, Juvenile Sex Offenders docket) to meet the multiple needs of the community, and the families and youth.

Staff sharing. Some Boards (4) share staff – staff have dual appointments in the mental health and juvenile justice system.

Funding. Two (2) Boards indicated that the Juvenile Court provided some funding for mental health related programming (e.g., MST/FFT program).

NARRATIVE COMMENTARY – Juvenile Recidivism and Diversion Strategies

Recidivism. Twenty-nine (29) Boards responded to this open-ended question regarding the types of strategies used to reduce recidivism of juveniles in the criminal justice system. Repeated strategies included Juvenile Intervention Courts, Multi-Systemic Therapy, Wrap-Around Services, Functional Family Therapy, and “Children’s System of Care”. As with adults, many Boards suggested that they are working in close connection with the criminal justice system and families to address juvenile recidivism of mental health consumers.

7.7.3 Integrated Physical Health Care

Diversion. Thirty-three (33) Boards responded to this open-ended question regarding the types of diversion strategies used with juveniles in communities across Ohio. A number of the strategies proposed for diversion were also used for recidivism. Boards discussed the use of intensive home-based services, prevention programs in schools, juvenile and family courts, diversion teams, and Multi-Systemic therapy as methods to increase the diversion of juveniles from the criminal justice system.

BOARD ESTIMATES OF JUVENILE JUSTICE CONSUMERS

Data Collection Method: Twenty Boards (40%) provided information on how they obtained estimates for the number of Court-involved juveniles expected to receive services. Nine Boards (9) used agency records, 7 Boards used estimates based on criminal justice agencies, and the remaining Boards used a combination of these techniques.

Fifteen MH Boards (30%) reported that they could estimate the number of juvenile consumers who were court-involved over the past year. These Boards' estimated that 2,926 consumers were court-involved over the past year. Twenty-four (50%) MH Boards reported that they funded services to county juvenile detention centers over the past year.

In this subsection Boards were asked to report on the availability of services in four areas of physical and behavioral health care service integration. These areas included home visiting, medication compliance and side effect monitoring, physical health assessments, and physical health information and referrals. The individual categories of service integration were not defined in the Community Plan Survey, which allowed Boards greater latitude regarding identification and discussion of issues, challenges and solutions.

Home Visiting

Twenty-six percent (N =13) of Boards reported the availability of Home Visiting services for adults. About half that number (N =6) report the service is available for children and adolescents. Five Boards noted that Home Visiting services are provided through collaboration with home health agencies, some of which also provide mental health services. Three Boards described Home Visiting services provided by nursing staff with intensive CPST or ACT programs, but did not specify whether physical health monitoring was included in the service. In one case, consumers who had been recently discharged from the hospital or those who had been newly diagnosed were specifically targeted for Home Visiting service.

“Consumers who need long term medications such as insulin often have a difficult time managing their medications (and medical conditions) given their mental illness.”
– Medina County

“The challenge has been in retaining psychiatrists. When they cut their time, it is sometimes difficult for clients to see the psychiatrist as often as they would like or sometimes need.”
– Preble County

Medication Compliance & Side Effect Monitoring

Sixty-six percent (N =33) of Boards reported the availability of Medication Compliance and Side-Effect Monitoring for adults aged 19 to 59. Slightly fewer Boards (N = 32; N =27) reported the availability of this service for older adults or children and adolescents, respectively.

One Board commented that side-effects monitoring was viewed as part of physical health care. This may partially account for the one-third of Boards that did not report the availability of medication compliance and side-effects monitoring, as two Boards specifically noted plans to coordinate compliance and side-effects monitoring with primary health care providers.

Several Boards discussed the difficulty of monitoring the side effects of medications within the resource and time constraints of psychiatric care, but did not specify whether this involved only psychotropic medications or all medications. In some cases, it was unclear whether Boards view psychotropic medication compliance and side-effect monitoring as an integral component of med-somatic service.

“Agencies work with primary care physicians whenever possible, but this coordination is often difficult (many times due to confidentiality issues) and very expensive when it involves the psychiatrist’s time to do a consult.” (Geauga County)

Solution: “Medication compliance and side effects) are monitored closely by CPST staff and psychiatrists through community outreach, training of clients in self medication, Illness Management Recovery (IMR) groups and pill minders. These efforts are coordinated in a multi-disciplinary approach with all service providers.” (Lorain)

Physical Health Assessments

Thirty-eight percent of Boards (N = 19) report the availability of this service for adults 19 to 59. Slightly fewer Boards (N = 17; N = 15) report the availability of physical health assessments for older adults or children and adolescents, respectively.

Among Boards where this service is provided, several indicated it was provided “as needed” by nursing staff, particularly for clients on CPST teams. One Board noted that “many providers have established informal relationships with physical health providers...who serve indigent clients.” Innovative ways to provide physical health assessments were among the most frequent solutions discussed by Boards that prioritized attention on this issue.

Solution: “Greater Cincinnati Behavioral Health, a primary CSP provider, houses the Consumer Wellness Clinic which also operates in two other agencies and sees some 2,100 consumers per year. The clinic is staffed with advanced practice clinical nurse specialists who have prescriptive authority and do physical assessments, order lab work, conduct health education sessions as well as ordering medications. The physical conditions most often treated are asthma, diabetes, hypercholesterolemia, and hypertension. Two consumers are hired as part time clinic assistants, whose salaries are paid for by the Board. Because the project must be self sustaining, consumers must be currently receiving CSP services and almost without exception, must have some type of insurance.” (Hamilton County)

Solution: “The ADAMH Board has partnered with the Medina County Health Department for the past seven years, funding mental health screenings at the Health Department’s Well Child and Adolescent Health Clinics. This has been a very beneficial partnership, addressing the youth and their family’s physical and mental health needs and providing information and referrals as appropriate.” (Medina County)

Solution: “The Center for Individual and Family Services has recently arranged to provide some mental health staffing at the Third Street Clinic, our major public health clinic in Mansfield. This maintains a good referral relationship for mental health clients needing physical health assessments. None of the mental health agencies deliver health assessments directly.” (Richland County)

Solution: “The adult serving agency has received a grant to have a physical health clinic at the agency from The Health Foundation. Southern Ohio Healthcare is the physical health provider. The challenge will be to sustain the program once grant funds end. However, there is belief that Medicaid and Southern Ohio’s funds may be sufficient down the road, with assistance from the mental health system for case management support for those consumers involved. The program will start in FY 2007 and the Board will be closely watching its results and impact on consumers.” (Clermont County)

“Despite our ongoing efforts to educate and integrate physical and mental health last year, fully 14% of consumers reported that their family physician did not know about their mental disability”
– Geauga County

Physical Health Information and Referral

Fifty-six percent of Boards (N = 28) reported the availability of physical health information and referral services for adults and older adults. Slightly fewer (N = 26) reported this service is available for children and adolescents.

Many Boards said information about physical health is collected during intake and assessment, with appropriate referrals following and/or the physical health issues addressed in the development of individual service plans. However, these Boards did not discuss whether the information was taken by a nurse or other medically-trained professional. Responsibility for providing physical health information and referral to consumers was often described as the responsibility of case management.

The availability of health clinics for low-income, uninsured or under-insured consumers varies from Board to Board area.

Many Boards discussed strategies for increasing access to physical health services in the community, as increased attention to consumers' physical health needs goes hand-in-hand with access to health care. Boards noted that coordination with physical health providers was an important part of their strategy in the area of physical health care, but that access to care is limited because there are not enough primary care providers (PCPs) accepting Medicaid patients. In addition, it is difficult to find PCPs skilled at working with people with the sort of cognitive deficits associated with the SMD condition.

“A serious challenge for the system is providing adequate dental care for clients who are unable to access it on their own due to lack of funds, transportation, and availability of dental providers who will provide low cost services to the SMD population. There is also a difficulty in finding specialty physicians to work with the SMD adult population. Chronic illness management is a difficult challenge for persons who, due to cognitive impairment of mental illness are unable to manage their own medical regimens.”
(Summit County)

While coordination of care between behavioral health agencies and PCPs was mentioned by many Boards as their strategy to address the issue of physical and mental health, one Board described achieving limited outcomes with this approach:

Solutions: “Family Guidance Center is participating in the National Diabetic Collaborative as it relates to mental health. This initiative is, partially, funded by the ODH, primarily, for diabetic supplies. The long term goal is to engage the community, at large, in the project with the ultimate hope of a healthier community.”
(Adams, Lawrence and Scioto Counties)

7.7.4 Older Adults

In this subsection Boards were asked to indicate the agencies with which they were most engaged in building stronger collaborative relationships *with regard to older adults*, defined as individuals aged 60 and older. Boards also were asked to discuss areas of collaboration that were problematic or on which the Board was particularly focused. Further, Boards were asked to comment about the impact of funding issues and innovative solutions to interagency collaboration.

Area Agency on Aging (AAA)

Seventy percent (70%) of Boards indicated collaboration activity with their Area Agency on Aging (AAA; see Table 17). Collaborative activities included seeking grant funding for projects, consultation and education on geriatric mental health, improving transportation services in rural counties, cross-system training of staff, conducting needs assessments, and engaging in strategic planning.

Many Boards indicated they were in the beginning phase of cross-system collaboration on older adult mental health; however, some Boards provided detailed information about their planning initiatives.

“Warren County MHRS is participating in the Southwestern Ohio-Older Ohioans Behavioral Health Network that is a collaborative team lead by the region’s Council on Aging. This Network began on March 17, 2006 with the goals of: 1) Completing an inventory of programs and initiatives in existence to address mental health and alcohol/drug issues of older adults. 2) To host a regional meeting of stakeholders which includes: the aging network, behavioral health systems, Adult Protective Services, health care, non-profits, faith-based and long term entities and consumers, families and caregivers. This meeting will identify local priorities and problem-solve about how to address the priorities collaboratively. Through this network and the resulting regional meeting, further collaboration with the other noted entities will be established or enhanced. The anticipated impact will be added emphasis on the growing older adult population as well as the identification of best practices to provide appropriate and accessible behavioral health services.” (Warren County)

Table 17. Collaborative Relationship Serving Older Adults

| 7.7.4.1. Older Adults | | |
|----------------------------|------------------------|------------------------|
| Older Adult Serving Agency | # Boards Collaborating | % Boards Collaborating |
| Council on Aging | 35 | 70% |
| AOD Agencies | 29 | 58% |
| County Senior Svcs Agency | 29 | 58% |
| Adult Protective Services | 28 | 56% |
| Housing Authorities | 28 | 56% |
| MR/DD | 26 | 52% |
| Health Department | 26 | 52% |
| Courts/Judicial System | 26 | 52% |
| Law Enforcement | 20 | 40% |
| Other: | 20 | 40% |
| Other | # of Other | % of Other |
| Local & State Coalitions | 13 | 65% |
| Nursing Homes | 3 | 15% |
| Not Specified | 4 | 20% |

1. Percent of Boards Collaborating = # of Boards divided by 50.
2. Percent of Other = # of Boards specifying other kinds of agencies divided by 20.

“The Board has traditionally funded a prevention program specifically for senior adults that addresses issues related to prescription medications. This program has been made available to senior centers throughout the catchment area. A continuum of alcohol and drug treatment options is also available.”
 – Geauga County

Alcohol and Other Drug (AOD)

Although 58% of Boards indicated cross-system collaboration with Alcohol and Other Drug (AOD) agencies, the majority of comments about this collaboration was general and not specific to the drug and alcohol abuse issues of older adults (see Table 17).

County Senior Services Agency (CSSA)

Fifty-eight percent (58%) of Boards also talked about providing service access to older adults through collaboration with the County Senior Services Agency (CSSA; see Table 17). In some cases, Mental Health Board directors have developed close working relationships through a seat on the boards of the CSSA. Boards collaborate with CSSAs to provide home-based counseling and nursing services, transportation, support groups, nutrition programs, case management and crisis intervention.

Adult Protective Services (APS)

Fifty-six percent (56%) of Boards said they collaborate with Adult Protective Services (APS; see Table 17). In describing collaboration with APS, Boards discussed the development of guardianship programs, opportunities for consultation, supervision, and cross-system training, and the development of service protocols. One Board mentioned the negative impact that reduced funding for APS staff has had on collaboration.

***“[The Board funded a] part-time mental health professional ...located at the Senior Services Agency to reduce stigma and increase willingness to use the service. The staff member is a nurse because that is a professional readily accepted by older adults. The program is well received by those involved and a welcome asset to Senior Services staff – would really like to expand to reach more seniors.””
– Clermont County***

Housing Authorities

Fifty-six percent (56%) of Boards said they collaborate with Housing Authorities (see Table 17). Comments about collaboration with Housing Authorities focused on meeting the needs of older adults in the context of the Board’s overall housing strategy. Several Boards discussed assisted living services for older adults as an approach to supported housing.

MR/DD Boards

Although 52% of Boards said they collaborate with MR/DD agencies, very few Boards discussed issues specific to older adults when commenting on that collaboration (see Table 17). Board comments indicated that collaboration occurs in the context of joint case planning and other jointly funded services; however, one Board mentioned disagreement on “turf responsibilities.”

County Health Departments

Boards also identified collaborative activities, such as tobacco cessation and disaster preparedness, with County Health Departments that were not specific to older adults. Nevertheless, 52% of Boards said they collaborate with the County Health Department on older adult issues (see Table 17).

Courts and the Judicial System

Similarly, Boards discussed collaboration with Courts and the Judicial System in terms of general population issues; again, 52% of Boards indicated collaborative activity on older adult issues (see Table 17).

Law Enforcement

Forty percent (40%) of Boards said they collaborate with Law Enforcement on older adult issues (see Table 17). With regard to Law Enforcement, CIT—which has a training component on older adults with dementia and organic brain disease--was the most frequently mentioned area of cross-system collaboration.

Other

Forty percent (40%) of Boards indicated collaboration with Other older adult serving agencies (see Table 17). The majority provided wide-ranging descriptions of local and state coalitions.

“The Board is a founding member of TAPN, the Trumbull Advocacy and Protection Network. Modeled on our Children’s Cluster, TAPN is comprised of the major senior-serving public systems (AD/MH, MR/DD, AAA, DJFS/APS, Probate Court, TC Office of Elderly Affairs, TMHA), elected officials, law enforcement, and non-profit and for-profit service providers in the county. Perhaps TAPN’s greatest success has been in clarifying what its members can and cannot do for seniors in need. Especially important has been the development of our shared

understanding of the limitations on Adult Protective Services, mental health providers and the criteria for involuntary commitment through Probate Court. Based on these shared understandings, we have developed a closely connected network of agencies and individual providers. This network has successfully collaborated on a number of difficult cases over the past two years. The greatest challenge facing TAPN is the lack of a dedicated funding pool to provide needed coordination, case management, and “wraparound” linkage. Public-system members have made financial contribution to cover the costs of TAPN’s coordinator. Trumbull County’s voters passed a first-ever, .75 mill senior services levy in November 2005. TAPN has applied to the Senior Services Advisory Council for funds to address some of these service needs.” (Trumbull County)

MSPA – Community Plan Survey

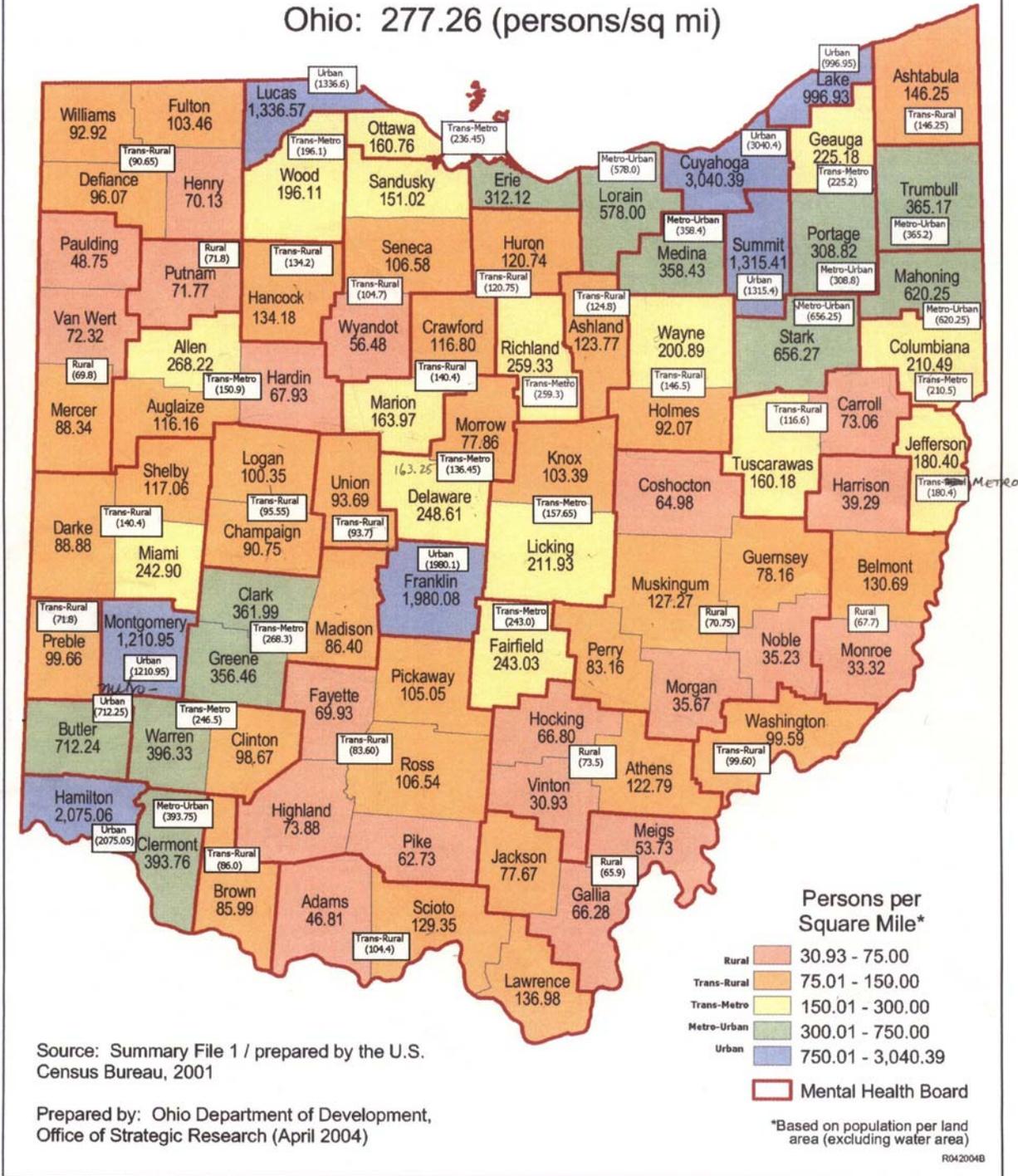
Appendices

**The Office of Program Evaluation and Research
Ohio Department of Mental Health**

Appendix A – Figure of Geographical Classifications

Ohio Department of Mental Health Boards and Census 2000 Population Density

Ohio: 277.26 (persons/sq mi)



Appendix B – Tables for Question 7.2.1.1 A (Child and Adolescent)

| Question 7.2.1.1 A. Child & Adolescent Mental Health Services | | | | |
|--|----------|---------|--------------|---------|
| Percent of Boards Indicating Planned Service Provision | | | | |
| by Severely Emotional Disabled (SED) Mental Health Status and Medicaid Eligibility | | | | |
| Eligibility Criteria: | Medicaid | | Non-Medicaid | |
| Mental Health Status: | SED | Non-SED | SED | Non-SED |
| Service Category | | | | |
| ACT/IHBT | 40% | 24% | 42% | 24% |
| Adjunctive Therapy | 12% | 10% | 10% | 8% |
| Adult Education | 8% | 8% | 8% | 8% |
| Behavioral Health Hotline Service | 84% | 84% | 88% | 88% |
| BH Counseling and Therapy (Grp.) | 100% | 98% | 100% | 94% |
| BH Counseling and Therapy (Ind.) | 100% | 100% | 100% | 96% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | 90% | 70% | 86% | 62% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | 100% | 78% | 100% | 70% |
| Community Resident | 8% | 4% | 10% | 4% |
| Consultation | 74% | 70% | 80% | 76% |
| Consumer Operated Service | 0% | 0% | 2% | 2% |
| Crisis Care | 52% | 50% | 54% | 50% |
| Crisis Intervention MH Services | 96% | 96% | 96% | 96% |
| Employment | 8% | 4% | 10% | 4% |
| Forensic Evaluation | 12% | 10% | 12% | 12% |
| Foster Care | 34% | 22% | 34% | 20% |
| Information and Referral | 56% | 54% | 60% | 56% |
| Inpatient Psychiatric Service | 60% | 50% | 62% | 50% |
| Mental Health Education | 64% | 68% | 68% | 72% |
| MH Assessment | 100% | 98% | 100% | 96% |
| Occupational Therapy Service | 2% | 2% | 0% | 2% |
| Other MH Service, Non-healthcare Service | 46% | 36% | 52% | 42% |
| Partial Hospitalization, less than 24 hrs. | 54% | 36% | 46% | 30% |
| PASARR | 0% | 0% | 0% | 0% |
| Pharmacological Management | 100% | 94% | 100% | 88% |
| Prevention | 74% | 72% | 82% | 82% |
| Psychiatric Diagnostic Int. (Physician) | 96% | 94% | 92% | 86% |
| Residential Care | 66% | 34% | 64% | 34% |
| Respite Care | 58% | 42% | 62% | 46% |
| School Psychology | 2% | 2% | 2% | 2% |
| Self-Help/Peer Services | 8% | 8% | 14% | 12% |
| Social & Recreational Service | 22% | 20% | 20% | 18% |
| Subsidized Housing | 12% | 6% | 14% | 8% |
| Temporary Housing | 8% | 6% | 10% | 8% |

1. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Boards)

Question 7.2.1.1. A. Child & Adolescent Mental Health Services
Percent of Boards Indicating Planned Service Provision
by Severely Emotional Disabled (SED) Mental Health Status and Medicaid Eligibility
by Rural Boards (n=6)

| Service Category | Eligibility Criteria: Mental Health Status: | | Medicaid | | Non-Medicaid | |
|--|--|---------|----------|---------|--------------|---------|
| | SED | Non-SED | SED | Non-SED | SED | Non-SED |
| ACT/IHBT | 17% | 17% | 17% | 17% | 17% | 17% |
| Adjunctive Therapy | 0% | 0% | 0% | 0% | 0% | 0% |
| Adult Education | 0% | 0% | 0% | 0% | 0% | 0% |
| Behavioral Health Hotline Service | 50% | 50% | 50% | 50% | 50% | 50% |
| BH Counseling and Therapy (Grp.) | 100% | 83% | 100% | 83% | 100% | 83% |
| BH Counseling and Therapy (Ind.) | 100% | 100% | 100% | 100% | 100% | 100% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | 83% | 83% | 83% | 83% | 83% | 83% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | 100% | 83% | 100% | 83% | 100% | 83% |
| Community Resident | 0% | 0% | 0% | 0% | 0% | 0% |
| Consultation | 67% | 67% | 67% | 67% | 67% | 67% |
| Consumer Operated Service | 0% | 0% | 0% | 0% | 0% | 0% |
| Crisis Care | 17% | 17% | 17% | 17% | 17% | 17% |
| Crisis Intervention MH Services | 83% | 83% | 83% | 83% | 83% | 83% |
| Employment | 0% | 0% | 0% | 0% | 0% | 0% |
| Forensic Evaluation | 17% | 17% | 17% | 17% | 17% | 17% |
| Foster Care | 17% | 17% | 17% | 17% | 17% | 17% |
| Information and Referral | 50% | 50% | 50% | 50% | 50% | 50% |
| Inpatient Psychiatric Service | 33% | 33% | 33% | 33% | 33% | 33% |
| Mental Health Education | 83% | 83% | 83% | 83% | 83% | 83% |
| MH Assessment | 100% | 83% | 100% | 83% | 100% | 83% |
| Occupational Therapy Service | 0% | 0% | 0% | 0% | 0% | 0% |
| Other MH Service, Non-healthcare Service | 50% | 50% | 50% | 50% | 50% | 50% |
| Partial Hospitalization, less than 24 hrs. | 67% | 33% | 67% | 33% | 67% | 33% |
| PASARR | 0% | 0% | 0% | 0% | 0% | 0% |
| Pharmacological Management | 100% | 83% | 100% | 83% | 100% | 83% |
| Prevention | 67% | 67% | 67% | 67% | 67% | 67% |
| Psychiatric Diagnostic Int. (Physician) | 100% | 100% | 100% | 100% | 100% | 100% |
| Residential Care | 50% | 33% | 50% | 33% | 50% | 33% |
| Respite Care | 50% | 33% | 50% | 33% | 50% | 33% |
| School Psychology | 0% | 0% | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | 0% | 0% | 0% | 0% | 0% | 0% |
| Social & Recreational Service | 33% | 33% | 33% | 33% | 33% | 33% |
| Subsidized Housing | 17% | 17% | 17% | 17% | 17% | 17% |
| Temporary Housing | 0% | 0% | 0% | 0% | 0% | 0% |

1. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, Van Wert-Mercer-Paulding.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Rural Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Rural Boards)

Question 7.2.1.1. A. Child & Adolescent Mental Health Services
Percent of Boards Indicating Planned Service Provision
by Severely Emotional Disabled (SED) Mental Health Status and Medicaid Eligibility
by Trans-Rural Boards (n=17)

| Eligibility Criteria: Mental Health Status: | Medicaid | | Non-Medicaid | |
|--|----------|---------|--------------|---------|
| | SED | Non-SED | SED | Non-SED |
| Service Category | | | | |
| ACT/IHBT | 35% | 24% | 41% | 24% |
| Adjunctive Therapy | 6% | 6% | 6% | 6% |
| Adult Education | 12% | 12% | 12% | 12% |
| Behavioral Health Hotline Service | 77% | 77% | 88% | 88% |
| BH Counseling and Therapy (Grp.) | 100% | 100% | 100% | 88% |
| BH Counseling and Therapy (Ind.) | 100% | 100% | 100% | 88% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | 94% | 76% | 82% | 65% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | 100% | 82% | 100% | 71% |
| Community Resident | 0% | 0% | 0% | 0% |
| Consultation | 71% | 65% | 82% | 77% |
| Consumer Operated Service | 0% | 0% | 0% | 0% |
| Crisis Care | 41% | 41% | 47% | 41% |
| Crisis Intervention MH Services | 100% | 100% | 100% | 100% |
| Employment | 6% | 6% | 6% | 6% |
| Forensic Evaluation | 12% | 12% | 12% | 12% |
| Foster Care | 24% | 24% | 24% | 18% |
| Information and Referral | 53% | 47% | 59% | 53% |
| Inpatient Psychiatric Service | 59% | 59% | 71% | 65% |
| Mental Health Education | 59% | 65% | 71% | 77% |
| MH Assessment | 100% | 100% | 100% | 94% |
| Occupational Therapy Service | 0% | 0% | 0% | 0% |
| Other MH Service, Non-healthcare Service | 41% | 24% | 53% | 35% |
| Partial Hospitalization, less than 24 hrs. | 47% | 35% | 29% | 29% |
| PASARR | 0% | 0% | 0% | 0% |
| Pharmacological Management | 100% | 100% | 100% | 88% |
| Prevention | 71% | 65% | 88% | 82% |
| Psychiatric Diagnostic Int. (Physician) | 94% | 94% | 94% | 82% |
| Residential Care | 47% | 35% | 53% | 35% |
| Respite Care | 47% | 35% | 59% | 41% |
| School Psychology | 6% | 6% | 6% | 6% |
| Self-Help/Peer Services | 6% | 6% | 18% | 12% |
| Social & Recreational Service | 28% | 22% | 28% | 22% |
| Subsidized Housing | 22% | 11% | 22% | 11% |
| Temporary Housing | 11% | 6% | 11% | 6% |

1. Trans-Rural Boards: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Trans-Rural Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Trans-Rural Boards).

Question 7.2.1.1. A. Child & Adolescent Mental Health Services
Percent of Boards Indicating Planned Service Provision
by Severely Emotional Disabled (SED) Mental Health Status and Medicaid Eligibility
by Trans-Metro Boards (n=12)

| Service Category | Eligibility Criteria: | Medicaid | | Non-Medicaid | |
|--|-----------------------|----------|---------|--------------|---------|
| | Mental Health Status: | SED | Non-SED | SED | Non-SED |
| ACT/IHBT | | 75% | 33% | 75% | 33% |
| Adjunctive Therapy | | 17% | 17% | 17% | 17% |
| Adult Education | | 8% | 8% | 8% | 8% |
| Behavioral Health Hotline Service | | 100% | 100% | 100% | 100% |
| BH Counseling and Therapy (Grp.) | | 100% | 100% | 100% | 100% |
| BH Counseling and Therapy (Ind.) | | 100% | 100% | 100% | 100% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | | 92% | 58% | 92% | 58% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | | 100% | 67% | 100% | 67% |
| Community Resident | | 8% | 8% | 8% | 8% |
| Consultation | | 83% | 75% | 83% | 75% |
| Consumer Operated Service | | 0% | 0% | 0% | 0% |
| Crisis Care | | 75% | 75% | 75% | 75% |
| Crisis Intervention MH Services | | 100% | 100% | 100% | 100% |
| Employment | | 17% | 8% | 17% | 8% |
| Forensic Evaluation | | 0% | 0% | 0% | 0% |
| Foster Care | | 50% | 33% | 50% | 33% |
| Information and Referral | | 58% | 58% | 58% | 58% |
| Inpatient Psychiatric Service | | 83% | 58% | 75% | 50% |
| Mental Health Education | | 83% | 83% | 83% | 83% |
| MH Assessment | | 100% | 100% | 100% | 100% |
| Occupational Therapy Service | | 0% | 0% | 0% | 0% |
| Other MH Service, Non-healthcare Service | | 42% | 33% | 42% | 33% |
| Partial Hospitalization, less than 24 hrs. | | 50% | 33% | 50% | 33% |
| PASARR | | 0% | 0% | 0% | 0% |
| Pharmacological Management | | 100% | 100% | 100% | 92% |
| Prevention | | 83% | 83% | 83% | 83% |
| Psychiatric Diagnostic Int. (Physician) | | 92% | 92% | 83% | 83% |
| Residential Care | | 92% | 33% | 67% | 33% |
| Respite Care | | 75% | 50% | 67% | 50% |
| School Psychology | | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | | 0% | 0% | 0% | 0% |
| Social & Recreational Service | | 17% | 17% | 17% | 17% |
| Subsidized Housing | | 8% | 8% | 8% | 8% |
| Temporary Housing | | 8% | 8% | 8% | 8% |

1. Trans-Metro Boards: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Trans-Metro Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Trans-Metro Boards).

**Question 7.2.1.1. A. Child & Adolescent Mental Health Services
Percent of Boards Indicating Planned Service Provision
by Severely Emotional Disabled (SED) Mental Health Status and Medicaid Eligibility
by Metro-Urban Boards (n=8)**

| Service Category | Eligibility Criteria: | Medicaid | | Non-Medicaid | |
|--|-----------------------|----------|---------|--------------|---------|
| | Mental Health Status: | SED | Non-SED | SED | Non-SED |
| ACT/IHBT | | 13% | 13% | 13% | 13% |
| Adjunctive Therapy | | 0% | 0% | 0% | 0% |
| Adult Education | | 13% | 13% | 13% | 13% |
| Behavioral Health Hotline Service | | 88% | 88% | 88% | 88% |
| BH Counseling and Therapy (Grp.) | | 100% | 100% | 100% | 100% |
| BH Counseling and Therapy (Ind.) | | 100% | 100% | 100% | 100% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | | 75% | 75% | 75% | 63% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | | 100% | 75% | 100% | 88% |
| Community Resident | | 0% | 0% | 0% | 0% |
| Consultation | | 75% | 75% | 75% | 75% |
| Consumer Operated Service | | 0% | 0% | 0% | 0% |
| Crisis Care | | 38% | 38% | 38% | 38% |
| Crisis Intervention MH Services | | 100% | 100% | 100% | 100% |
| Employment | | 13% | 0% | 13% | 0% |
| Forensic Evaluation | | 13% | 13% | 13% | 13% |
| Foster Care | | 25% | 13% | 25% | 13% |
| Information and Referral | | 75% | 75% | 75% | 75% |
| Inpatient Psychiatric Service | | 50% | 38% | 50% | 38% |
| Mental Health Education | | 50% | 50% | 50% | 50% |
| MH Assessment | | 100% | 100% | 100% | 100% |
| Occupational Therapy Service | | 0% | 0% | 0% | 13% |
| Other MH Service, Non-healthcare Service | | 50% | 50% | 50% | 50% |
| Partial Hospitalization, less than 24 hrs. | | 38% | 25% | 25% | 13% |
| PASARR | | 0% | 0% | 0% | 0% |
| Pharmacological Management | | 100% | 88% | 100% | 88% |
| Prevention | | 75% | 75% | 75% | 88% |
| Psychiatric Diagnostic Int. (Physician) | | 100% | 88% | 100% | 88% |
| Residential Care | | 50% | 38% | 50% | 38% |
| Respite Care | | 50% | 50% | 50% | 50% |
| School Psychology | | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | | 25% | 25% | 25% | 25% |
| Social & Recreational Service | | 38% | 25% | 25% | 14% |
| Subsidized Housing | | 0% | 0% | 0% | 0% |
| Temporary Housing | | 0% | 0% | 0% | 0% |

1. Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Metro-Urban Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Metro-Urban Boards).

Question 7.2.1.1. A. Child & Adolescent Mental Health Services
Percent of Boards Indicating Planned Service Provision
by Severely Emotional Disabled (SED) Mental Health Status and Medicaid Eligibility
by Urban Boards (n=7)

| Service Category | Eligibility Criteria: | | Medicaid | | Non-Medicaid | |
|--|-----------------------|------|----------|------|--------------|---------|
| | Mental Health Status: | SED | Non-SED | SED | Non-SED | Non-SED |
| ACT/IHBT | | 29% | 29% | 29% | 29% | 29% |
| Adjunctive Therapy | | 29% | 29% | 14% | 14% | 14% |
| Adult Education | | 0% | 0% | 0% | 0% | 0% |
| Behavioral Health Hotline Service | | 86% | 86% | 86% | 86% | 86% |
| BH Counseling and Therapy (Grp.) | | 100% | 100% | 100% | 100% | 100% |
| BH Counseling and Therapy (Ind.) | | 100% | 100% | 100% | 100% | 100% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | | 100% | 71% | 100% | 57% | 57% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | | 100% | 71% | 100% | 57% | 57% |
| Community Resident | | 29% | 14% | 43% | 14% | 14% |
| Consultation | | 71% | 71% | 86% | 86% | 86% |
| Consumer Operated Service | | 0% | 0% | 14% | 14% | 14% |
| Crisis Care | | 71% | 71% | 71% | 71% | 71% |
| Crisis Intervention MH Services | | 86% | 86% | 86% | 86% | 86% |
| Employment | | 0% | 0% | 14% | 0% | 0% |
| Forensic Evaluation | | 29% | 14% | 29% | 29% | 29% |
| Foster Care | | 57% | 14% | 57% | 14% | 14% |
| Information and Referral | | 43% | 43% | 57% | 43% | 43% |
| Inpatient Psychiatric Service | | 43% | 29% | 43% | 29% | 29% |
| Mental Health Education | | 43% | 57% | 43% | 57% | 57% |
| MH Assessment | | 100% | 100% | 100% | 100% | 100% |
| Occupational Therapy Service | | 14% | 14% | 0% | 0% | 0% |
| Other MH Service, Non-healthcare Service | | 57% | 57% | 71% | 71% | 71% |
| Partial Hospitalization, less than 24 hrs. | | 86% | 57% | 86% | 43% | 43% |
| PASARR | | 0% | 0% | 0% | 0% | 0% |
| Pharmacological Management | | 100% | 86% | 100% | 86% | 86% |
| Prevention | | 71% | 71% | 86% | 86% | 86% |
| Psychiatric Diagnostic Int. (Physician) | | 100% | 100% | 86% | 86% | 86% |
| Residential Care | | 86% | 29% | 100% | 29% | 29% |
| Respite Care | | 57% | 43% | 71% | 57% | 57% |
| School Psychology | | 0% | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | | 14% | 14% | 29% | 29% | 29% |
| Social & Recreational Service | | 14% | 14% | 14% | 14% | 14% |
| Subsidized Housing | | 14% | 0% | 29% | 14% | 14% |
| Temporary Housing | | 29% | 29% | 43% | 43% | 43% |

1. Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, & Summit.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Urban Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Urban Boards).

Appendix C – Tables for Question 7.2.1.1 B (Adult)

| Question 7.2.1.1 B. Adult Mental Health Services Percent of Boards Indicating Planned Service Provision by Severely Mentally Disabled (SMD) Mental Health Status and Medicaid Eligibility | | | | |
|---|----------|---------|--------------|---------|
| Eligibility Criteria: | Medicaid | | Non-Medicaid | |
| Mental Health Status: | SMD | Non-SMD | SMD | Non-SMD |
| Service Category | | | | |
| ACT/IHBT | 32% | 16% | 34% | 14% |
| Adjunctive Therapy | 10% | 8% | 10% | 8% |
| Adult Education | 26% | 20% | 28% | 20% |
| Behavioral Health Hotline Service | 80% | 80% | 84% | 84% |
| BH Counseling and Therapy (Grp.) | 100% | 96% | 100% | 90% |
| BH Counseling and Therapy (Ind.) | 100% | 96% | 100% | 90% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | 94% | 66% | 92% | 58% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | 100% | 76% | 100% | 68% |
| Community Resident | 54% | 24% | 60% | 24% |
| Consultation | 64% | 58% | 68% | 60% |
| Consumer Operated Service | 56% | 30% | 62% | 32% |
| Crisis Care | 66% | 62% | 68% | 62% |
| Crisis Intervention MH Services | 98% | 96% | 98% | 96% |
| Employment | 66% | 32% | 70% | 34% |
| Forensic Evaluation | 56% | 44% | 62% | 48% |
| Foster Care | 2% | 0% | 2% | 0% |
| Information and Referral | 56% | 56% | 60% | 60% |
| Inpatient Psychiatric Service | 82% | 68% | 90% | 72% |
| Mental Health Education | 64% | 64% | 66% | 68% |
| MH Assessment | 100% | 98% | 100% | 96% |
| Occupational Therapy Service | 4% | 4% | 6% | 4% |
| Other MH Service, Non-healthcare Service | 48% | 42% | 50% | 44% |
| Partial Hospitalization, less than 24 hrs. | 44% | 30% | 40% | 24% |
| PASARR | 88% | 66% | 90% | 70% |
| Pharmacological Management | 100% | 94% | 100% | 90% |
| Prevention | 52% | 52% | 56% | 58% |
| Psychiatric Diagnostic Int. (Physician) | 94% | 86% | 92% | 82% |
| Residential Care | 74% | 34% | 78% | 34% |
| Respite Care | 36% | 24% | 36% | 24% |
| School Psychology | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | 58% | 30% | 70% | 38% |
| Social & Recreational Service | 40% | 24% | 42% | 22% |
| Subsidized Housing | 86% | 30% | 92% | 32% |
| Temporary Housing | 58% | 28% | 64% | 30% |

1. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Boards)

Question 7.2.1.1. B. Adult Mental Health Services
Percent of Boards Indicating Planned Service Provision
By Severely Mentally Disabled (SMD) Mental Health Status and Medicaid Eligibility
by Rural Boards (n=6)

| Eligibility Criteria: Mental Health Status: | Medicaid | | Non-Medicaid | |
|--|----------|---------|--------------|---------|
| | SMD | Non-SMD | SMD | Non-SMD |
| ACT/IHBT | 0% | 0% | 0% | 0% |
| Adjunctive Therapy | 0% | 0% | 0% | 0% |
| Adult Education | 17% | 17% | 17% | 17% |
| Behavioral Health Hotline Service | 50% | 50% | 50% | 50% |
| BH Counseling and Therapy (Grp.) | 100% | 100% | 100% | 100% |
| BH Counseling and Therapy (Ind.) | 100% | 100% | 100% | 100% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | 83% | 83% | 83% | 83% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | 100% | 83% | 100% | 83% |
| Community Resident | 50% | 33% | 50% | 33% |
| Consultation | 67% | 67% | 67% | 67% |
| Consumer Operated Service | 33% | 33% | 33% | 33% |
| Crisis Care | 67% | 67% | 67% | 67% |
| Crisis Intervention MH Services | 100% | 100% | 100% | 100% |
| Employment | 50% | 33% | 50% | 33% |
| Forensic Evaluation | 67% | 67% | 67% | 67% |
| Foster Care | 0% | 0% | 0% | 0% |
| Information and Referral | 50% | 50% | 50% | 50% |
| Inpatient Psychiatric Service | 50% | 50% | 50% | 50% |
| Mental Health Education | 67% | 67% | 67% | 67% |
| MH Assessment | 100% | 100% | 100% | 100% |
| Occupational Therapy Service | 0% | 0% | 0% | 0% |
| Other MH Service, Non-healthcare Service | 67% | 67% | 67% | 67% |
| Partial Hospitalization, less than 24 hrs. | 50% | 33% | 50% | 33% |
| PASARR | 100% | 100% | 100% | 100% |
| Pharmacological Management | 100% | 100% | 100% | 100% |
| Prevention | 50% | 50% | 50% | 50% |
| Psychiatric Diagnostic Int. (Physician) | 83% | 83% | 83% | 83% |
| Residential Care | 100% | 100% | 100% | 100% |
| Respite Care | 50% | 50% | 50% | 50% |
| School Psychology | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | 50% | 33% | 50% | 33% |
| Social & Recreational Service | 33% | 33% | 33% | 33% |
| Subsidized Housing | 83% | 67% | 83% | 67% |
| Temporary Housing | 50% | 33% | 50% | 33% |

1. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, Van Wert-Mercer-Paulding.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Rural Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Rural Boards)

**Question 7.2.1.1. B. Adult Mental Health Services
Percent of Boards Indicating Planned Service Provision
By Severely Mentally Disabled (SMD) Mental Health Status and Medicaid Eligibility
by Trans-Rural Boards (n=17)**

| Service Category | Eligibility Criteria: Mental Health Status: | | Medicaid | | Non-Medicaid | |
|--|--|---------|----------|---------|--------------|---------|
| | SMD | Non-SMD | SMD | Non-SMD | SMD | Non-SMD |
| ACT/IHBT | 29% | 24% | 35% | 24% | | |
| Adjunctive Therapy | 6% | 6% | 6% | 6% | | |
| Adult Education | 29% | 29% | 35% | 29% | | |
| Behavioral Health Hotline Service | 77% | 77% | 88% | 88% | | |
| BH Counseling and Therapy (Grp.) | 100% | 94% | 100% | 82% | | |
| BH Counseling and Therapy (Ind.) | 100% | 94% | 100% | 82% | | |
| Cmty. Psychiatric Supportive Tx. (Grp.) | 100% | 82% | 94% | 77% | | |
| Cmty. Psychiatric Supportive Tx. (Ind.) | 100% | 88% | 100% | 82% | | |
| Community Resident | 24% | 18% | 35% | 18% | | |
| Consultation | 71% | 71% | 82% | 77% | | |
| Consumer Operated Service | 47% | 41% | 59% | 41% | | |
| Crisis Care | 59% | 53% | 65% | 53% | | |
| Crisis Intervention MH Services | 100% | 94% | 100% | 94% | | |
| Employment | 41% | 24% | 47% | 24% | | |
| Forensic Evaluation | 41% | 29% | 53% | 35% | | |
| Foster Care | 0% | 0% | 0% | 0% | | |
| Information and Referral | 53% | 53% | 59% | 59% | | |
| Inpatient Psychiatric Service | 82% | 77% | 100% | 82% | | |
| Mental Health Education | 59% | 59% | 71% | 71% | | |
| MH Assessment | 100% | 100% | 100% | 94% | | |
| Occupational Therapy Service | 0% | 0% | 6% | 0% | | |
| Other MH Service, Non-healthcare Service | 29% | 24% | 29% | 24% | | |
| Partial Hospitalization, less than 24 hrs. | 47% | 29% | 41% | 24% | | |
| PASARR | 71% | 59% | 77% | 59% | | |
| Pharmacological Management | 100% | 94% | 100% | 88% | | |
| Prevention | 47% | 47% | 59% | 65% | | |
| Psychiatric Diagnostic Int. (Physician) | 94% | 82% | 94% | 77% | | |
| Residential Care | 59% | 41% | 65% | 35% | | |
| Respite Care | 29% | 29% | 24% | 24% | | |
| School Psychology | 0% | 0% | 0% | 0% | | |
| Self-Help/Peer Services | 24% | 12% | 47% | 24% | | |
| Social & Recreational Service | 35% | 24% | 41% | 18% | | |
| Subsidized Housing | 77% | 29% | 88% | 29% | | |
| Temporary Housing | 59% | 29% | 71% | 29% | | |

1. Trans-Rural Boards: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Trans-Rural Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Trans-Rural Boards).

**Question 7.2.1.1. B. Adult Mental Health Services
Percent of Boards Indicating Planned Service Provision
By Severely Mentally Disabled (SMD) Mental Health Status and Medicaid Eligibility
by Trans-Metro Boards (n=12)**

| Eligibility Criteria: Mental Health Status: | Medicaid | | Non-Medicaid | |
|--|----------|---------|--------------|---------|
| | SMD | Non-SMD | SMD | Non-SMD |
| ACT/IHBT | 42% | 17% | 42% | 17% |
| Adjunctive Therapy | 8% | 8% | 8% | 17% |
| Adult Education | 33% | 17% | 33% | 17% |
| Behavioral Health Hotline Service | 100% | 100% | 100% | 100% |
| BH Counseling and Therapy (Grp.) | 100% | 100% | 100% | 100% |
| BH Counseling and Therapy (Ind.) | 100% | 100% | 100% | 100% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | 92% | 42% | 92% | 42% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | 100% | 58% | 100% | 58% |
| Community Resident | 67% | 25% | 67% | 25% |
| Consultation | 58% | 50% | 58% | 50% |
| Consumer Operated Service | 58% | 25% | 58% | 25% |
| Crisis Care | 58% | 50% | 58% | 50% |
| Crisis Intervention MH Services | 100% | 100% | 100% | 100% |
| Employment | 92% | 50% | 92% | 50% |
| Forensic Evaluation | 67% | 42% | 67% | 42% |
| Foster Care | 0% | 0% | 0% | 0% |
| Information and Referral | 50% | 50% | 50% | 50% |
| Inpatient Psychiatric Service | 83% | 83% | 75% | 83% |
| Mental Health Education | 83% | 83% | 75% | 83% |
| MH Assessment | 100% | 100% | 100% | 100% |
| Occupational Therapy Service | 8% | 8% | 8% | 8% |
| Other MH Service, Non-healthcare Service | 42% | 33% | 42% | 33% |
| Partial Hospitalization, less than 24 hrs. | 33% | 33% | 33% | 33% |
| PASARR | 100% | 75% | 100% | 75% |
| Pharmacological Management | 100% | 100% | 100% | 100% |
| Prevention | 75% | 75% | 75% | 75% |
| Psychiatric Diagnostic Int. (Physician) | 92% | 92% | 92% | 92% |
| Residential Care | 67% | 17% | 67% | 17% |
| Respite Care | 42% | 17% | 42% | 17% |
| School Psychology | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | 92% | 42% | 100% | 50% |
| Social & Recreational Service | 42% | 17% | 42% | 17% |
| Subsidized Housing | 92% | 25% | 92% | 25% |
| Temporary Housing | 58% | 33% | 58% | 33% |

1. Trans-Metro Boards: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Gauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Trans-Metro Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Trans-Metro Boards).

Question 7.2.1.1. B. Adult Mental Health Services
Percent of Boards Indicating Planned Service Provision
by Severely Mentally Disabled (SMD) Mental Health Status and Medicaid Eligibility
by Metro-Urban Boards (n=8)

| Service Category | Medicaid | | Non-Medicaid | |
|--|----------|---------|--------------|---------|
| | SMD | Non-SMD | SMD | Non-SMD |
| ACT/IHBT | 25% | 13% | 25% | 13% |
| Adjunctive Therapy | 13% | 0% | 13% | 0% |
| Adult Education | 25% | 13% | 25% | 13% |
| Behavioral Health Hotline Service | 75% | 75% | 75% | 75% |
| BH Counseling and Therapy (Grp.) | 100% | 88% | 100% | 75% |
| BH Counseling and Therapy (Ind.) | 100% | 88% | 100% | 75% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | 88% | 50% | 88% | 38% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | 100% | 75% | 100% | 63% |
| Community Resident | 88% | 50% | 88% | 50% |
| Consultation | 50% | 38% | 50% | 38% |
| Consumer Operated Service | 63% | 38% | 63% | 38% |
| Crisis Care | 88% | 88% | 88% | 88% |
| Crisis Intervention MH Services | 100% | 100% | 100% | 100% |
| Employment | 88% | 50% | 88% | 50% |
| Forensic Evaluation | 50% | 50% | 50% | 50% |
| Foster Care | 0% | 0% | 0% | 0% |
| Information and Referral | 88% | 88% | 88% | 88% |
| Inpatient Psychiatric Service | 100% | 75% | 100% | 75% |
| Mental Health Education | 50% | 50% | 50% | 50% |
| MH Assessment | 100% | 88% | 100% | 88% |
| Occupational Therapy Service | 0% | 0% | 0% | 0% |
| Other MH Service, Non-healthcare Service | 63% | 50% | 63% | 50% |
| Partial Hospitalization, less than 24 hrs. | 25% | 13% | 13% | 0% |
| PASARR | 100% | 63% | 88% | 75% |
| Pharmacological Management | 100% | 88% | 100% | 75% |
| Prevention | 38% | 38% | 38% | 38% |
| Psychiatric Diagnostic Int. (Physician) | 100% | 75% | 100% | 75% |
| Residential Care | 88% | 25% | 88% | 25% |
| Respite Care | 25% | 25% | 25% | 25% |
| School Psychology | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | 63% | 38% | 63% | 38% |
| Social & Recreational Service | 50% | 25% | 50% | 25% |
| Subsidized Housing | 100% | 38% | 100% | 38% |
| Temporary Housing | 75% | 38% | 75% | 38% |

1. Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Metro-Urban Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Metro-Urban Boards).

**Question 7.2.1.1. B. Adult Mental Health Services
Percent of Boards Indicating Planned Service Provision
By Severely Mentally Disabled (SMD) Mental Health Status and Medicaid Eligibility
by Urban Boards (n=7)**

| Service Category | Eligibility Criteria: | Medicaid | | Non-Medicaid | |
|--|-----------------------|----------|---------|--------------|---------|
| | Mental Health Status: | SMD | Non-SMD | SMD | Non-SMD |
| ACT/IHBT | | 57% | 14% | 57% | 0% |
| Adjunctive Therapy | | 29% | 29% | 29% | 29% |
| Adult Education | | 14% | 14% | 14% | 14% |
| Behavioral Health Hotline Service | | 86% | 86% | 86% | 86% |
| BH Counseling and Therapy (Grp.) | | 100% | 100% | 100% | 100% |
| BH Counseling and Therapy (Ind.) | | 100% | 100% | 100% | 100% |
| Cmty. Psychiatric Supportive Tx. (Grp.) | | 100% | 71% | 100% | 43% |
| Cmty. Psychiatric Supportive Tx. (Ind.) | | 100% | 71% | 100% | 43% |
| Community Resident | | 71% | 0% | 86% | 0% |
| Consultation | | 71% | 57% | 71% | 57% |
| Consumer Operated Service | | 86% | 0% | 100% | 14% |
| Crisis Care | | 71% | 71% | 71% | 71% |
| Crisis Intervention MH Services | | 86% | 86% | 86% | 86% |
| Employment | | 71% | 0% | 86% | 14% |
| Forensic Evaluation | | 71% | 57% | 86% | 71% |
| Foster Care | | 14% | 0% | 14% | 0% |
| Information and Referral | | 43% | 43% | 57% | 57% |
| Inpatient Psychiatric Service | | 86% | 43% | 100% | 57% |
| Mental Health Education | | 57% | 57% | 57% | 57% |
| MH Assessment | | 100% | 100% | 100% | 100% |
| Occupational Therapy Service | | 14% | 14% | 14% | 14% |
| Other MH Service, Non-healthcare Service | | 71% | 71% | 86% | 86% |
| Partial Hospitalization, less than 24 hrs. | | 71% | 43% | 71% | 29% |
| PASARR | | 86% | 43% | 100% | 57% |
| Pharmacological Management | | 100% | 86% | 100% | 86% |
| Prevention | | 43% | 43% | 43% | 43% |
| Psychiatric Diagnostic Int. (Physician) | | 100% | 100% | 86% | 86% |
| Residential Care | | 86% | 0% | 100% | 14% |
| Respite Care | | 43% | 0% | 57% | 14% |
| School Psychology | | 0% | 0% | 0% | 0% |
| Self-Help/Peer Services | | 86% | 43% | 100% | 57% |
| Social & Recreational Service | | 43% | 29% | 43% | 29% |
| Subsidized Housing | | 86% | 0% | 100% | 14% |
| Temporary Housing | | 43% | 0% | 57% | 14% |

1. Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, & Summit.
2. Percent of Boards Indicating Planned Service Provision is calculated as follows: (# of Urban Boards that indicated planned service provision for Eligibility/Mental Health Status) divided by (total # of Urban Boards).

Appendix D – Tables for Question 7.2.2

| Question 7.2.2. Medicare Population Served | | | | | |
|---|---|--|--|--|--|
| Boards Which Expended Money on Medicare Subsidies in SFY 2005 | | | | | |
| Comparison By Geographical Type | | | | | |
| Boards By Geographical Type | Question 7.2.2.1. How much money did the Board Spend on Medicare Subsidies in SFY 2005? | | | Question 7.2.2.2. How Many Medicare Consumers Were Served in SFY 2005? | |
| | Number of Boards Which Expended Money | % of Boards Expending Money by Geographical Type | Total Amount of Funds Expended for Geographical Type | Medicare Consumers Served by Boards Expending Money on Medicare Subsidies | Average Number of Medicare Consumers Served by Boards Expending Money on Medicare Subsidies |
| Rural | 3 | 50.0% | \$ 103,964 | 1,593 | 531 |
| Trans-Rural | 10 | 61.1% | 881,713 | 2,585 | 259 |
| Trans-Metro | 8 | 63.6% | 671,982 | 2,378 | 297 |
| Metro-Urban | 5 | 62.5% | 740,273 | 1,446 | 289 |
| Urban | 4 | 50.0% | 4,071,302 | 4,992 | 1,248 |
| Statewide | 30 | 60.0% | \$ 6,469,234 | 12,994 | 433 |

1. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Vinton, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van-Wert, Mercer-Paulding.
2. Trans-Rural Boards: Ashland, Brown, Paint Valley, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Preble, Defiance-Fulton-Henry-Williams, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
3. Trans-Metro Board: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
4. Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
5. Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
6. Number of Boards Which Expended Money is the number of Boards that answered Question 7.2.2.1. for the geographical type.
7. % of Boards Expending Money by Geographical Type is the (number of Boards that answered Question 7.2.2.1. for the geographical type) divided by (total number of Boards within the geographical type). Total Rural Boards=6; Total Trans-Rural Boards=17; Total Trans-Metro Boards=12; Total Metro-Urban Boards=8; Total Urban Boards=7.
8. Total Amount of Funds Expended for Geographical Type is total amount of dollars spent by all Boards within the geographical type for Medicare subsidies in SFY 2005.
9. Medicare Consumers Served by Boards Expending Money on Medicare Subsidies is the total number of Medicare Consumers served by all Boards which spent money on Medicare Subsidies in SFY 2005 within the geographical type.
10. Average Number of Medicare Consumers Served by Boards Expending Money on Medicare Subsidies is the (Medicare consumers served by Boards expending money on Medicare subsidies within the geographical type) divided by (number of Boards which expended money within the geographical type).
11. Per Capita Amount of Board Funds Spent on Medicare Subsidies is the (total amount of funds expended for geographical type) divided by (Medicare consumers served by Boards expending money on Medicare subsidies).

| Question 7.2.2. Medicare Population Served | | | | | | | | | |
|---|---|-------------|---------------------------|---|---|-------------|---------------------------|---|-----------------------------------|
| Comparison of Boards that Expended Money on Medicare Subsidies and Boards That Did Not Expend Money on Medicare Subsidies | | | | | | | | | |
| Comparison of By Geographical Type | | | | | | | | | |
| Boards By Geographical Type | Boards Which Expended Money on Medicare Subsidies | | | | Boards Which Did Not Expend Money on Medicare Subsidies But Served Medicare Consumers | | | | No Service |
| | Number of Boards | % of Boards | Medicare Consumers Served | Average Number of Medicare Consumers Served | Number of Boards | % of Boards | Medicare Consumers Served | Average Number of Medicare Consumers Served | Boards with No Medicare Consumers |
| Rural | 3 | 50.0% | 1,593 | 531 | 3 | 50.0% | 1,428 | 476 | 0 |
| Trans-Rural | 11 | 61.1% | 2,585 | 235 | 6 | 33.3% | 2,089 | 348 | 1 |
| Trans-Metro | 7 | 63.6% | 2,378 | 340 | 4 | 36.4% | 1,450 | 363 | 0 |
| Metro-Urban | 5 | 62.5% | 1,446 | 289 | 2 | 25.0% | 584 | 586 | 1 |
| Urban | 4 | 50.0% | 4,992 | 1,248 | 3 | 42.9% | 4,751 | 1,584 | 0 |
| Statewide | 30 | 60.0% | 12,994 | 2,643 | 18 | 36.0% | 10,302 | 572 | 2 |

1. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Vinton, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van-Wert, Mercer-Paulding.
2. Trans-Rural Boards: Ashland, Brown, Paint Valley, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Preble, Defiance-Fulton-Henry-Williams, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
3. Trans-Metro Board: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
4. Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
5. Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
6. Number of Boards Which Expended Money is the number of Boards that answered Question 7.2.2.1. for the geographical type.
7. % of Boards Expending Money by Geographical Type is the (number of Boards that answered Question 7.2.2.1. for the geographical type) divided by (total number of Boards within the geographical type). Total Rural Boards=6; Total Trans-Rural Boards=17; Total Trans-Metro Boards=12; Total Metro-Urban Boards=8; Total Urban Boards=7.
8. Medicare Consumers Served by Boards Expending Money on Medicare Subsidies is the total number of Medicare Consumers served by all Boards which spent money on Medicare Subsidies in SFY 2005 within the geographical type.
9. Average Number of Medicare Consumers Served by Boards Expending Money on Medicare Subsidies is the (Medicare consumers served by Boards expending money on Medicare subsidies within the geographical type) divided by (number of Boards which expended money within the geographical type).
10. Number of Boards Which Did Not Expend Money on Medicare Subsidies but served Medicare Consumers is the number of Boards that entered "0" for Question 7.2.2.1 and entered the number of Medicare consumers for Question 7.2.2.2.
11. % of Boards Not Expending Money by Geographical Type is the number of (Boards that did not expend money on Medicare subsidies but served Medicare consumers within geographical type) divided by (total number of Boards within the geographical type). Total Rural Boards=6; Total Trans-Rural Boards=18; Total Trans-Metro Boards=11; Total Metro-Urban Boards=8; Total Urban Boards=7.
12. Average Number of Medicare Consumers Served By Boards That Did not Expend Money on Medicare Subsidies is the (sum of Medicare consumers served Boards not expending money on Medicare subsidies for the geographical type) divided by (total number of Boards within the geographical type).
13. Boards Which Did not Serve Medicare Consumers is the number of Boards that answered "0" for Question 7.2.2.1 and "0" for Question 7.2.2.2.

Appendix E – Tables for Question 7.3.1

| Question 7.3.1 Adult Crisis Care Service Availability for All Board Areas Approximately How Long Adult Consumers Wait for Adult Crisis Care Admission | | | | | | |
|--|----------------------|-------------------------|----------------------|-------------------------|------------|-------------------------|
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Total Boards | Service Availability | Percent of Total Boards | No Service | Percent of Total Boards |
| 24/7 On-Call Staffing by Psychiatrists | 32 | 64.0% | 6 | 12.0% | 12 | 24.0% |
| 24/7 On-Call Staffing by Clinical Supervisors | 44 | 88.0% | 2 | 4.0% | 4 | 8.0% |
| 24/7 On-Call Staffing by Case Managers | 32 | 64.0% | 3 | 6.0% | 15 | 30.0% |
| Mobile Response | 23 | 46.0% | 7 | 14.0% | 20 | 40.0% |
| 24/7 Central Phone Line | 48 | 96.0% | 1 | 2.0% | 1 | 2.0% |
| Crisis Care Facility | 23 | 46.0% | 8 | 16.0% | 19 | 38.0% |
| Hospital Emergency Room with Psychiatric Staff | 17 | 34.0% | 5 | 10.0% | 28 | 56.0% |
| Hospital Contract for Crisis Observation Beds | 11 | 22.0% | 2 | 4.0% | 37 | 74.0% |
| Contract for Respite Beds/Emergency Shelter | 9 | 18.0% | 14 | 28.0% | 27 | 54.0% |
| Contract for Transport to State/Local Hospital | 21 | 42.0% | 18 | 36.0% | 11 | 22.0% |

1. Less Than One Hour/Percent of Total Boards: (Boards reporting that adult consumers wait less than one hour for admission) divided by (total Boards in state).
2. More Than One Hour/Percent of Total Boards: (Boards reporting that adult consumers wait for more than one hour for admission) divided by (total Boards in state).
3. No Service/Percent of Total Boards: (Boards reporting that service is unavailable) divided by (total Boards in state).

| Question 7.3.1 Adult Crisis Care Service Availability for Rural Board Areas (n=6) Approximately How Long Adult Consumers Wait for Crisis Care Admission | | | | | | |
|--|----------------------|-------------------------|----------------------|-------------------------|------------|-------------------------|
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Rural Boards | Service Availability | Percent of Rural Boards | No Service | Percent of Rural Boards |
| 24/7 On-Call Staffing by Psychiatrists | 4 | 66.7% | 1 | 16.7% | 1 | 16.7% |
| 24/7 On-Call Staffing by Clinical Supervisors | 4 | 66.7% | 1 | 16.7% | 1 | 16.7% |
| 24/7 On-Call Staffing by Case Managers | 4 | 66.7% | 1 | 16.7% | 1 | 16.7% |
| Mobile Response | 1 | 16.7% | 2 | 33.3% | 3 | 50.0% |
| 24/7 Central Phone Line | 5 | 83.3% | 0 | 0.0% | 1 | 16.7% |
| Crisis Care Facility | 3 | 50.0% | 1 | 16.7% | 2 | 33.3% |
| Hospital Emergency Room with Psychiatric Staff | 2 | 33.3% | 0 | 0.0% | 4 | 66.7% |
| Hospital Contract for Crisis Observation Beds | 0 | 0.0% | 0 | 0.0% | 6 | 100.0% |
| Contract for Respite Beds/Emergency Shelter | 1 | 16.7% | 2 | 33.3% | 3 | 50.0% |
| Contract for Transport to State/Local Hospital | 1 | 16.7% | 1 | 16.7% | 4 | 66.7% |

1. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van Wert-Mercer-Paulding.
2. Less Than One Hour/Percent of Rural Boards: (Rural Boards reporting that adult consumers wait less than one hour for admission) divided by (total Rural Boards).
3. More Than One Hour/Percent of Rural Boards: (Rural Boards reporting that adults consumers wait for more than one hour for admission) divided by total Rural Boards).
4. No Service/Percent of Rural Boards: (Boards reporting that service is unavailable) divided by (total Rural Boards).

| Question 7.3.1. Adult Crisis Care Service Availability for Trans-Rural Board Areas (n=17) Approximately How Long Adult Consumers Wait for Crisis Care Admission | | | | | | |
|--|----------------------|-------------------------------|----------------------|-------------------------------|------------|-------------------------------|
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Trans-Rural Boards | Service Availability | Percent of Trans-Rural Boards | No Service | Percent of Trans-Rural Boards |
| 24/7 On-Call Staffing by Psychiatrists | 11 | 64.7% | 2 | 11.8% | 4 | 23.5% |
| 24/7 On-Call Staffing by Clinical Supervisors | 15 | 88.2% | 0 | 0.0% | 2 | 11.8% |
| 24/7 On-Call Staffing by Case Managers | 10 | 58.8% | 1 | 5.9% | 6 | 35.3% |
| Mobile Response | 10 | 58.8% | 1 | 5.9% | 6 | 35.3% |
| 24/7 Central Phone Line | 16 | 94.1% | 1 | 5.9% | 0 | 0.0% |
| Crisis Care Facility | 5 | 29.4% | 3 | 17.6% | 9 | 52.9% |
| Hospital Emergency Room with Psychiatric Staff | 3 | 17.6% | 2 | 11.8% | 12 | 70.6% |
| Hospital Contract for Crisis Observation Beds | 3 | 17.6% | 0 | 0.0% | 14 | 82.4% |
| Contract for Respite Beds/Emergency Shelter | 2 | 11.8% | 3 | 17.6% | 12 | 70.6% |
| Contract for Transport to State/Local Hospital | 7 | 41.2% | 8 | 47.1% | 2 | 11.8% |

1. Trans-Rural Boards: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Less Than One Hour/Percent of Trans-Rural Boards: (Trans-Rural Boards reporting that adult consumers wait less than one hour for admission) divided by (total Trans-Rural Boards).
3. More Than One Hour/Percent of Trans-Rural Boards: (Trans-Rural Boards reporting that adult consumers wait for more than one hour for admission) divided by (total Trans-Rural Boards in state).
4. No Service/Percent of Trans-Rural Boards: (Trans-Rural Boards reporting that service is unavailable) divided by (total Trans-Rural Boards)

| Question 7.3.1. Adult Crisis Care Service Availability for Trans-Metro Board Areas (n=12) Approximately How Long Adult Consumers Wait for Crisis Care Admission | | | | | | |
|--|----------------------|-------------------------------|----------------------|-------------------------------|------------|-------------------------------|
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Trans-Metro Boards | Service Availability | Percent of Trans-Metro Boards | No Service | Percent of Trans-Metro Boards |
| 24/7 On-Call Staffing by Psychiatrists | 6 | 50.0% | 2 | 16.7% | 4 | 33.3% |
| 24/7 On-Call Staffing by Clinical Supervisors | 11 | 91.7% | 1 | 8.3% | 0 | 0.0% |
| 24/7 On-Call Staffing by Case Managers | 9 | 75.0% | 0 | 0.0% | 3 | 25.0% |
| Mobile Response | 5 | 41.7% | 0 | 0.0% | 7 | 58.3% |
| 24/7 Central Phone Line | 12 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Crisis Care Facility | 5 | 41.7% | 1 | 8.3% | 6 | 50.0% |
| Hospital Emergency Room with Psychiatric Staff | 4 | 33.3% | 2 | 16.7% | 6 | 50.0% |
| Hospital Contract for Crisis Observation Beds | 4 | 33.3% | 2 | 16.7% | 6 | 50.0% |
| Contract for Respite Beds/Emergency Shelter | 1 | 8.3% | 7 | 58.3% | 4 | 33.3% |
| Contract for Transport to State/Local Hospital | 5 | 41.7% | 7 | 58.3% | 0 | 0.0% |

1. Trans-Metro Boards: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Less Than One Hour/Percent of Trans-Metro Boards: (Trans-Metro Boards reporting that adult consumers wait less than one hour for admission) divided by (total Trans-Metro Boards).
3. More Than One Hour/Percent of Trans-Metro Boards: (Trans-Metro Boards reporting that adult consumers wait for more than one hour for admission) divided by (total Trans-Metro Boards in state).
4. No Service/Percent of Trans-Metro Boards: (Trans-Metro Boards reporting that service is unavailable) divided by (total Trans-Metro Boards)

| Question 7.3.1. Adult Crisis Care Service Availability for Metro-Urban Board Areas (n=8) | | | | | | |
|--|----------------------|-------------------------------|----------------------|-------------------------------|------------|-------------------------------|
| Approximately How Long Adult Consumers Wait for Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Metro-Urban Boards | Service Availability | Percent of Metro-Urban Boards | No Service | Percent of Metro-Urban Boards |
| 24/7 On-Call Staffing by Psychiatrists | 4 | 50.0% | 1 | 12.5% | 3 | 37.5% |
| 24/7 On-Call Staffing by Clinical Supervisors | 7 | 87.5% | 0 | 0.0% | 1 | 12.5% |
| 24/7 On-Call Staffing by Case Managers | 6 | 75.0% | 1 | 12.5% | 1 | 12.5% |
| Mobile Response | 4 | 50.0% | 2 | 25.0% | 2 | 25.0% |
| 24/7 Central Phone Line | 8 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Crisis Care Facility | 5 | 62.5% | 3 | 37.5% | 0 | 0.0% |
| Hospital Emergency Room with Psychiatric Staff | 3 | 37.5% | 1 | 12.5% | 4 | 50.0% |
| Hospital Contract for Crisis Observation Beds | 2 | 25.0% | 0 | 0.0% | 6 | 75.0% |
| Contract for Respite Beds/Emergency Shelter | 3 | 37.5% | 0 | 0.0% | 5 | 62.5% |
| Contract for Transport to State/Local Hospital | 6 | 75.0% | 1 | 12.5% | 1 | 12.5% |

1. Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Less Than One Hour/Percent of Metro-Urban Boards: (Metro-Urban Boards reporting that adult consumers wait less than one hour for admission) divided by (total Metro-Urban Boards).
3. More Than One Hour/Percent of Metro-Urban Boards: (Metro-Urban Boards reporting that adult consumers wait for more than one hour for admission) divided by (total Metro-Urban Boards in state).
4. No Service/Percent of Metro-Urban Boards: (Metro-Urban Boards reporting that service is unavailable) divided by (total Metro-Urban Boards)

| Question 7.3.1. Adult Crisis Care Service Availability for Urban Board Areas (n=7) | | | | | | |
|--|----------------------|-------------------------|----------------------|-------------------------|------------|-------------------------|
| Approximately How Long Adult Consumers Wait for Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Urban Boards | Service Availability | Percent of Urban Boards | No Service | Percent of Urban Boards |
| 24/7 On-Call Staffing by Psychiatrists | 7 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| 24/7 On-Call Staffing by Clinical Supervisors | 7 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| 24/7 On-Call Staffing by Case Managers | 3 | 42.9% | 0 | 0.0% | 4 | 57.1% |
| Mobile Response | 3 | 42.9% | 3 | 42.9% | 1 | 14.3% |
| 24/7 Central Phone Line | 7 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Crisis Care Facility | 5 | 71.4% | 0 | 0.0% | 2 | 28.6% |
| Hospital Emergency Room with Psychiatric Staff | 5 | 71.4% | 0 | 0.0% | 2 | 28.6% |
| Hospital Contract for Crisis Observation Beds | 2 | 28.6% | 0 | 0.0% | 5 | 71.4% |
| Contract for Respite Beds/Emergency Shelter | 2 | 28.6% | 2 | 28.6% | 3 | 42.9% |
| Contract for Transport to State/Local Hospital | 2 | 28.6% | 1 | 14.3% | 4 | 57.1% |

1. Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Less Than One Hour/Percent of Urban Boards: (Urban Boards reporting that adult consumers wait less than one hour for admission) divided by (total Urban Boards).
3. More Than One Hour/Percent of Metro-Urban Boards: (Urban Boards reporting that adult consumers wait for more than one hour for admission) divided by (total Urban Boards in state).
4. No Service/Percent of Urban Boards: (Urban Boards reporting that service is unavailable) divided by (total Urban Boards).

Appendix F – Table for Question 7.3.2.1

| Question 7.3.2.1. Services Used for Adult Intensive Care | | | | | | | | | | |
|--|-------------------------------|-----------------------------------|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------|
| Service Area | Total Boards Offering Service | Percent of Total Boards in Survey | Percent of Boards by Average Number of Working Days Adult Consumers Wait | | | | | | | |
| | | | # Boards Reporting Wait Times | Up to 10 working days | 11 to 15 working days | 16 to 20 working days | 21 to 30 working days | 31 to 60 working days | 61 to 90 working days | 91 working days or more |
| ACT | 13 | 26% | 13 | 62% | 8% | 0% | 15% | 8% | 0% | 8% |
| PH Program Type I | 34 | 68% | 34 | 82% | 9% | 0% | 6% | 0% | 3% | 0% |
| PH Program Type II | 20 | 40% | 20 | 60% | 25% | 0% | 5% | 5% | 0% | 5% |
| Intensive Psychiatry | 13 | 26% | 13 | 77% | 15% | 0% | 0% | 8% | 0% | 0% |
| Intensive CPST | 17 | 34% | 17 | 76% | 12% | 0% | 6% | 6% | 0% | 0% |

1. Percent of Total Boards in Survey = Total Boards Offering Services divided by 50

2. Percent of Boards by Average Number of Working Days C&A Consumers Wait = Number of Boards reporting in a wait length category divided by Total Number of Boards Reporting Wait Times

Appendix G – Table for Question 7.3.3.1

| Question 7.3.3.1. Services Used in General Care for Adult Consumers | | | | | | | | | | |
|---|-------------------------------|-----------------------------------|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------|
| Service Area | Total Boards Offering Service | Percent of Total Boards in Survey | Percent of Boards by Average Number of Working Days Adult Consumers Wait | | | | | | | |
| | | | # Boards Reporting Wait Times | Up to 10 working days | 11 to 15 working days | 16 to 20 working days | 21 to 30 working days | 31 to 60 working days | 61 to 90 working days | 91 working days or more |
| Diagnostic Assessment - Physician | 46 | 92% | 46 | 13% | 15% | 13% | 26% | 24% | 7% | 2% |
| Diagnostic Assessment – Non-Physician | 50 | 100% | 50 | 34% | 28% | 24% | 8% | 6% | 0% | 0% |
| Psychiatry (Med-Somatic) | 50 | 100% | 50 | 16% | 14% | 14% | 24% | 22% | 6% | 4% |
| Counseling/Psychotherapy | 50 | 100% | 50 | 34% | 32% | 16% | 10% | 4% | 2% | 2% |
| CPST | 44 | 88% | 44 | 64% | 18% | 5% | 11% | 2% | 0% | 0% |

1. Percent of Total Boards in Survey = Total Boards Offering Services divided by 50

2. Percent of Boards by Average Number of Working Days Adult Consumers Wait = Number of Boards reporting in a wait length category divided by Total Number of Boards Reporting Wait Times

Appendix H – Tables for Question 7.3.4.1

| Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services | | | | |
|--|-----------------------------------|-----------------------|---------------------------|--|
| Levels of Service Being Provided by All Boards | | | | |
| Service Area | Number of Boards Offering Service | Percent of All Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Adult Clients Served by All Boards |
| ACT | 15 | 30.0% | 2,189 | 7.46 |
| Anger Management/Domestic Violence | 43 | 86.0% | 6,516 | 22.21 |
| Cluster-Based Planning* | 12 | 24.0% | 7,274 | 24.79 |
| Clubhouse | 14 | 28.0% | 1,209 | 4.12 |
| Consumer Operated Service | 28 | 56.0% | 5,478 | 18.67 |
| Consumer Psycho-Education | 36 | 72.0% | 2,912 | 9.93 |
| Family-to-Family | 40 | 80.0% | 2,046 | 6.97 |
| General Transportation Services | 23 | 46.0% | 16,100 | 54.88 |
| Integrated Dual Diagnosis Tx (IDDT) | 27 | 54.0% | 4,975 | 16.96 |
| Illness Management and Recovery (IMR) | 18 | 36.0% | 1,639 | 5.59 |
| Interpreter Services | 34 | 68.0% | 4,397 | 14.99 |
| Mental Health Housing Institute | 24 | 48.0% | 3,126 | 10.65 |
| Older Adult Services | 25 | 50.0% | 9,660 | 32.93 |
| Peer Support Services | 40 | 80.0% | 10,320 | 35.17 |
| Specialized Services for MI/MR | 19 | 38.0% | 938 | 3.20 |
| Supported Employment | 28 | 56.0% | 4,094 | 13.95 |
| Trauma-Informed Care | 21 | 42.0% | 3,001 | 10.23 |

1. Number of Boards Offering Service is the number of Boards that indicated that they provided the specific service.
2. Percent of All Boards is (Number of Boards Offering Service) divided by 50 Boards.
3. Number Served in SFY 2005 is the sum of people whose Board reported was receiving the service.
4. Number Receiving Service Per 1,000 of Adult Clients Served by All Boards is (Number Served in SFY 2005) divided by (total adult clients served by the 50 Boards in SFY 2005) multiplied by 1,000. Denominator: Total Adult Clients Served by All Boards equals 293,394 adult clients. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006.
5. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Levels of Service Being Provided by Rural Boards; n=6

| Service Area | Number of Rural Boards Offering Service | Percent of All Rural Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Adult Clients Served by Rural Boards |
|---------------------------------------|---|-----------------------------|---------------------------|--|
| ACT | 1 | 16.7% | - | N/A |
| Anger Management/Domestic Violence | 5 | 83.3% | 720 | 111.58 |
| Cluster-Based Planning | 1 | 16.7% | 1,045 | 161.94 |
| Clubhouse | 0 | 0.0% | - | N/A |
| Consumer Operated Service | 2 | 33.3% | 20 | 3.10 |
| Consumer Psycho-Education | 4 | 66.7% | 74 | 11.47 |
| Family-to-Family | 3 | 50.0% | 62 | 9.61 |
| General Transportation Services | 3 | 50.0% | 6,622 | 1,026.20 |
| Integrated Dual Diagnosis Tx (IDDT) | 1 | 16.7% | - | N/A |
| Illness Management and Recovery (IMR) | 1 | 16.7% | 894 | 138.54 |
| Interpreter Services | 4 | 66.7% | 137 | 21.23 |
| Mental Health Housing Institute | 2 | 33.3% | 50 | 7.75 |
| Older Adult Services | 2 | 33.3% | 276 | 26.50 |
| Peer Support Services | 4 | 66.7% | 215 | 42.77 |
| Specialized Services for MI/MR | 4 | 66.7% | 171 | 33.32 |
| Supported Employment | 0 | 0.0% | - | N/A |
| Trauma-Informed Care | 2 | 33.3% | 1,152 | 178.52 |

1. Rural Boards are Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van-Wert-Mercer-Paulding.
2. Number of Rural Boards Offering Service is the number of Rural Boards that indicated that they provided the specific service.
3. Percent of All Rural Boards is (Number of Rural Boards Offering Service) divided by 6 Rural Boards.
4. Number Served in SFY 2005 is the sum of people whose Rural Board reported was receiving the service.
5. Number Receiving Service Per 1,000 of Adult Clients Served by Rural Boards is (Number Served in SFY 2005) divided by total adult clients served by the 6 Rural Boards in SFY 2005) multiplied by 1,000. Denominator: Total Adult Clients Served by 6 Rural Boards equals 20,870 adult clients. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Levels of Service Being Provided by Trans-Rural Boards; n=17

| Service Area | Number of Trans-Rural Boards Offering Service | Percent of All Trans- Rural Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Adult Clients Served by Trans-Rural Boards |
|---------------------------------------|--|---|----------------------------------|---|
| ACT | 4 | 23.5% | 301 | 6.13 |
| Anger Management/Domestic Violence | 15 | 88.2% | 902 | 18.36 |
| Cluster-Based Planning | 4 | 23.5% | 1,663 | 33.86 |
| Clubhouse | 5 | 29.4% | 202 | 4.11 |
| Consumer Operated Service | 10 | 58.8% | 768 | 15.64 |
| Consumer Psycho-Education | 11 | 64.7% | 554 | 11.28 |
| Family-to-Family | 11 | 64.7% | 121 | 2.46 |
| General Transportation Services | 6 | 35.3% | 4,107 | 83.61 |
| Integrated Dual Diagnosis Tx (IDDT) | 7 | 41.2% | 1,004 | 20.44 |
| Illness Management and Recovery (IMR) | 6 | 35.3% | 106 | 2.16 |
| Interpreter Services | 13 | 76.5% | 1,604 | 32.66 |
| Mental Health Housing Institute | 8 | 47.1% | 156 | 3.18 |
| Older Adult Services | 6 | 35.3% | 807 | 6.58 |
| Peer Support Services | 12 | 70.6% | 622 | 16.43 |
| Specialized Services for MI/MR | 6 | 35.3% | 323 | 12.66 |
| Supported Employment | 7 | 41.2% | 526 | 10.71 |
| Trauma-Informed Care | 5 | 29.4% | 171 | 3.48 |

1. Trans-Rural Boards are Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Number of Trans-Rural Boards Offering Service is the number of Trans-Rural Boards that indicated that they provided the specific service.
3. Percent of All Trans-Rural Boards is (Number of Trans-Rural Boards Offering Service) divided by 17 Trans-Rural Boards.
4. Number Served in SFY 2005 is the sum of people whose Trans-Rural Board reported were receiving the service.
5. Number Receiving Service Per 1,000 of Adult Clients Served by Trans-Rural Boards is (Number Served in SFY 2005) divided by (total adult clients served by the 17 Trans-Rural Boards in SFY 2005) multiplied by 1,000. Denominator: Total Adult Clients Served by 17 Trans-Rural Boards equals 52,296 adult clients. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Levels of Service Being Provided by Trans-Metro Boards; n=12

| Service Area | Number of Trans-Metro Boards Offering Service | Percent of All Trans- Metro Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Adult Clients Served by Trans-Metro Boards |
|---------------------------------------|---|------------------------------------|---------------------------|--|
| ACT | 3 | 25.0% | 137 | 2.87 |
| Anger Management/Domestic Violence | 10 | 83.3% | 2,095 | 43.84 |
| Cluster-Based Planning | 1 | 8.3% | - | N/A |
| Clubhouse | 4 | 33.3% | 449 | 9.40 |
| Consumer Operated Service | 5 | 41.7% | 858 | 17.96 |
| Consumer Psycho-Education | 7 | 58.3% | 1,156 | 24.19 |
| Family-to-Family | 11 | 91.7% | 1,089 | 22.79 |
| General Transportation Services | 7 | 58.3% | 4,119 | 86.20 |
| Integrated Dual Diagnosis Tx (IDDT) | 8 | 66.7% | 560 | 11.72 |
| Illness Management and Recovery (IMR) | 2 | 16.7% | 110 | 2.30 |
| Interpreter Services | 7 | 58.3% | 832 | 17.41 |
| Mental Health Housing Institute | 5 | 41.7% | 1,311 | 27.44 |
| Older Adult Services | 5 | 41.7% | 815 | 17.06 |
| Peer Support Services | 10 | 83.3% | 2,550 | 53.37 |
| Specialized Services for MI/MR | 3 | 25.0% | 71 | 1.49 |
| Supported Employment | 8 | 66.7% | 1,264 | 26.45 |
| Trauma-Informed Care | 6 | 50.0% | 736 | 15.40 |

1. Trans-Metro Boards are Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Number of Trans-Metro Boards Offering Service is the number of Trans-Metro Boards that indicated that they provided the specific service.
3. Percent of All Trans-Metro Boards is (Number of Trans-Metro Boards Offering Service) divided by 12 Trans-Metro Boards.
4. Number Served in SFY 2005 is the sum of people whose Trans-Metro Board reported were receiving the service.
5. Number Receiving Service Per 1,000 of Adult Clients Served by Trans-Metro Boards is (Number Served in SFY 2005) divided by (total adult clients served by the 12 Trans-Metro Boards in SFY 2005) multiplied by 1,000. Denominator: Total Adult Clients Served by 12 Trans-Metro Boards equals 44,606 adult clients. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Levels of Service Being Provided by Metro-Urban Boards; n=8

| Service Area | Number of Metro-Urban Boards Offering Service | Percent of All Metro-Urban Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Adult Clients Served by Metro-Urban Boards |
|---------------------------------------|---|-----------------------------------|---------------------------|--|
| ACT | 3 | 37.5% | 151 | 3.21 |
| Anger Management/Domestic Violence | 6 | 75.0% | 1,343 | 28.59 |
| Cluster-Based Planning | 1 | 12.5% | 987 | 21.01 |
| Clubhouse | 1 | 12.5% | 83 | 1.77 |
| Consumer Operated Service | 4 | 50.0% | 14 | 0.30 |
| Consumer Psycho-Education | 8 | 100.0% | 620 | 13.20 |
| Family-to-Family | 8 | 100.0% | 466 | 9.92 |
| General Transportation Services | 4 | 50.0% | 912 | 19.42 |
| Integrated Dual Diagnosis Tx (IDDT) | 5 | 62.5% | 683 | 14.54 |
| Illness Management and Recovery (IMR) | 3 | 37.5% | 119 | 2.53 |
| Interpreter Services | 6 | 75.0% | 1,653 | 35.19 |
| Mental Health Housing Institute | 6 | 75.0% | 309 | 6.58 |
| Older Adult Services | 8 | 100.0% | 5,716 | 121.69 |
| Peer Support Services | 7 | 87.5% | 3,000 | 63.87 |
| Specialized Services for MI/MR | 3 | 37.5% | 48 | 1.02 |
| Supported Employment | 7 | 87.5% | 922 | 19.63 |
| Trauma-Informed Care | 4 | 50.0% | 145 | 3.09 |

1. Metro-Urban Boards are Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Number of Metro-Urban Boards Offering Service is the number of Metro-Urban Boards that indicated that they provided the specific service.
3. Percent of All Metro-Urban Boards is (Number of Metro-Urban Boards Offering Service) divided by 8 Metro-Urban Boards.
4. Number Served in SFY 2005 is the sum of people whose Metro-Urban Board reported were receiving the service.
5. Number Receiving Service Per 1,000 of Adult Clients Served by Metro-Urban Boards is (Number Served in SFY 2005) divided by (total adult clients served by the 8 Metro-Urban Boards in SFY 2005) multiplied by 1,000. Denominator: Total Adult Clients Served by 8 Metro-Urban Boards equals 46,793 adult clients. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Levels of Service Being Provided by Urban Boards; n=7

| Service Area | Number of Urban Boards Offering Service | Percent of All Urban Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Adult Clients Served by Urban Boards |
|---------------------------------------|---|-----------------------------|---------------------------|--|
| ACT | 4 | 57.1% | 1,600 | 12.44 |
| Anger Management/Domestic Violence | 7 | 100.0% | 1,456 | 11.32 |
| Cluster-Based Planning | 5 | 71.4% | 3,579 | 27.82 |
| Clubhouse | 4 | 57.1% | 475 | 3.69 |
| Consumer Operated Service | 7 | 100.0% | 3,818 | 29.68 |
| Consumer Psycho-Education | 6 | 85.7% | 508 | 3.95 |
| Family-to-Family | 7 | 100.0% | 308 | 2.39 |
| General Transportation Services | 3 | 42.9% | 340 | 2.64 |
| Integrated Dual Diagnosis Tx (IDDT) | 6 | 85.7% | 2,728 | 21.2 |
| Illness Management and Recovery (IMR) | 6 | 85.7% | 410 | 3.19 |
| Interpreter Services | 4 | 57.1% | 171 | 1.33 |
| Mental Health Housing Institute | 3 | 42.9% | 1,300 | 10.11 |
| Older Adult Services | 4 | 57.1% | 2,046 | 15.90 |
| Peer Support Services | 7 | 100.0% | 3,933 | 30.57 |
| Specialized Services for MI/MR | 3 | 42.9% | 325 | 3.19 |
| Supported Employment | 6 | 85.7% | 1,382 | 10.74 |
| Trauma-Informed Care | 4 | 57.1% | 797 | 6.20 |

1. Urban Boards are Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Number of Urban Boards Offering Service is the number of Urban Boards that indicated that they provided the specific service.
3. Percent of All Urban Boards is (Number of Urban Boards Offering Service) divided by 7 Urban Boards.
4. Number Served in SFY 2005 is the sum of people whose Urban Board reported was receiving the service.
5. Number Receiving Service Per 1,000 of Adult Clients Served by Urban Boards is (Number Served in SFY 2005) divided by (total adult clients served by the 7 Urban Boards in SFY 2005) multiplied by 1,000. Denominator: Total Adult Clients Served by 7 Urban Boards equals 128,649 adult clients. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Number of Boards Using Technical Assistance for a Specific Service Area

| Service Area | Boards Offering Service | | Boards Using Technical Assistance | |
|---------------------------------------|-----------------------------------|-----------------------|---|---|
| | Number of Boards Offering Service | Percent of All Boards | Number of Boards Using Technical Assistance | Percent of Boards Offering Service and Using Technical Assistance |
| ACT | 15 | 30.0% | 8 | 53.3% |
| Anger Management/Domestic Violence | 43 | 86.0% | 7 | 16.3% |
| Cluster-Based Planning | 12 | 24.0% | 7 | 58.3% |
| Clubhouse | 14 | 28.0% | 2 | 14.3% |
| Consumer Operated Service | 28 | 56.0% | 10 | 35.7% |
| Consumer Psycho-Education | 36 | 72.0% | 16 | 44.4% |
| Family-to-Family | 40 | 80.0% | 12 | 30.0% |
| General Transportation Services | 23 | 46.0% | 2 | 8.7% |
| Integrated Dual Diagnosis Tx (IDDT) | 27 | 54.0% | 25 | 92.6% |
| Illness Management and Recovery (IMR) | 18 | 36.0% | 9 | 50.0% |
| Interpreter Services | 34 | 68.0% | 3 | 8.8% |
| Mental Health Housing Institute | 24 | 48.0% | 13 | 54.2% |
| Older Adult Services | 25 | 50.0% | 4 | 16.0% |
| Peer Support Services | 40 | 80.0% | 12 | 30.0% |
| Specialized Services for MI/MR | 19 | 38.0% | 6 | 31.6% |
| Supported Employment | 28 | 56.0% | 16 | 57.1% |
| Trauma-Informed Care | 21 | 42.0% | 8 | 38.1% |

1. Number of Boards Offering Service is the number of Boards that indicated that they provided the specific service.
2. Percent of All Boards is (Number of Boards Offering Service) divided by 50 Boards.
3. Number of Boards Using Technical Assistance is the number of Boards that reported that they were using technical assistance.
4. Percent of Boards Offering Services and Using Technical Assistance is (Number of Boards Using Technical Assistance) divided by (Number of Boards Offering Service).
5. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Number of Rural Boards Using Technical Assistance for a Specific Service Area

| Service Area | Rural Boards Offering Service | | Rural Boards Using Technical Assistance | |
|---------------------------------------|---|-----------------------------|---|---|
| | Number of Rural Boards Offering Service | Percent of All Rural Boards | Number of Rural Boards Using Technical Assistance | Percent of Rural Boards Offering Service and Using Technical Assistance |
| ACT | 1 | 16.7% | - | 0.0% |
| Anger Management/Domestic Violence | 5 | 83.3% | - | 0.0% |
| Cluster-Based Planning | 1 | 16.7% | 1 | 100.0% |
| Clubhouse | 0 | 0.0% | - | 0.0% |
| Consumer Operated Service | 2 | 33.3% | 1 | 50.0% |
| Consumer Psycho-Education | 4 | 66.7% | 1 | 25.0% |
| Family-to-Family | 3 | 50.0% | - | 0.0% |
| General Transportation Services | 3 | 50.0% | - | 0.0% |
| Integrated Dual Diagnosis Tx (IDDT) | 1 | 16.7% | - | 0.0% |
| Illness Management and Recovery (IMR) | 1 | 16.7% | - | 0.0% |
| Interpreter Services | 4 | 66.7% | - | 0.0% |
| Mental Health Housing Institute | 2 | 33.3% | 2 | 100.0% |
| Older Adult Services | 2 | 33.3% | - | 0.0% |
| Peer Support Services | 4 | 66.7% | 1 | 25.0% |
| Specialized Services for MI/MR | 4 | 66.7% | 1 | 25.0% |
| Supported Employment | 0 | 0.0% | - | 0.0% |
| Trauma-Informed Care | 2 | 33.3% | - | 0.0% |

1. Rural Boards are Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van Wert-Mercer-Paulding.
2. Number of Rural Boards Offering Service is the number of Rural Boards that indicated that they provided the specific service.
3. Percent of All Rural Boards is (Number of Rural Boards Offering Service) divided by 6 Boards.
4. Number of Rural Boards Using Technical Assistance is the number of Rural Boards that reported that they were using technical assistance.
5. Percent of Rural Boards Offering Services and Technical Assistance is (Number of Rural Boards Using Technical Assistance) divided by (Number of Rural Boards Offering Service).
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Number of Trans-Rural Boards Using Technical Assistance for a Specific Service Area

| Service Area | Trans-Rural Boards Offering Service | | Trans-Rural Boards Using Technical Assistance | |
|---------------------------------------|---|-----------------------------------|---|---|
| | Number of Trans-Rural Boards Offering Service | Percent of All Trans-Rural Boards | Number of Trans-Rural Boards Using Technical Assistance | Percent of Trans-Rural Boards Offering Service and Using Technical Assistance |
| ACT | 4 | 23.5% | 2 | 50.0% |
| Anger Management/Domestic Violence | 15 | 88.2% | 3 | 20.0% |
| Cluster-Based Planning | 4 | 23.5% | 2 | 50.0% |
| Clubhouse | 5 | 29.4% | 1 | 0.0% |
| Consumer Operated Service | 10 | 58.8% | 4 | 40.0% |
| Consumer Psycho-Education | 11 | 64.7% | 5 | 45.5% |
| Family-to-Family | 11 | 64.7% | 4 | 36.4% |
| General Transportation Services | 6 | 35.3% | 2 | 33.3% |
| Integrated Dual Diagnosis Tx (IDDT) | 7 | 41.2% | 6 | 85.7% |
| Illness Management and Recovery (IMR) | 6 | 35.3% | 1 | 16.7% |
| Interpreter Services | 13 | 76.5% | 2 | 15.4% |
| Mental Health Housing Institute | 8 | 47.1% | 4 | 50.0% |
| Older Adult Services | 6 | 35.3% | 1 | 16.7% |
| Peer Support Services | 12 | 70.6% | 4 | 33.3% |
| Specialized Services for MI/MR | 6 | 35.3% | 2 | 33.3% |
| Supported Employment | 7 | 41.2% | 4 | 0.0% |
| Trauma-Informed Care | 5 | 29.4% | 3 | 60.0% |

1. Trans-Rural Boards are Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Number of Trans-Rural Boards Offering Service is the number of Trans-Rural Boards that indicated that they provided the specific service.
3. Percent of All Trans-Rural Boards is (Number of Trans-Rural Boards Offering Service) divided by 17 Boards.
4. Number of Trans-Rural Boards Using Technical Assistance is the number of Trans-Rural Boards that reported that they were using technical assistance.
5. Percent of Trans-Rural Boards Offering Services and Using Technical Assistance is (Number of Trans-Rural Boards Using Technical Assistance) divided by (Number of Trans-Rural Boards Offering Service).
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services

Number of Trans-Metro Boards Using Technical Assistance for a Specific Service Area

| Service Area | Trans-Metro Boards Offering Service | | Trans-Metro Boards Using Technical Assistance | |
|---------------------------------------|---|-----------------------------------|---|---|
| | Number of Trans-Metro Boards Offering Service | Percent of All Trans-Metro Boards | Number of Trans-Metro Boards Using Technical Assistance | Percent of Trans-Metro Boards Offering Service and Using Technical Assistance |
| ACT | 3 | 25.0% | 3 | 100.0% |
| Anger Management/Domestic Violence | 10 | 83.3% | 2 | 20.0% |
| Cluster-Based Planning | 1 | 8.3% | - | 0.0% |
| Clubhouse | 4 | 33.3% | - | 0.0% |
| Consumer Operated Service | 5 | 41.7% | 3 | 60.0% |
| Consumer Psycho-Education | 7 | 58.3% | 3 | 42.9% |
| Family-to-Family | 11 | 91.7% | 1 | 9.1% |
| General Transportation Services | 7 | 58.3% | - | 0.0% |
| Integrated Dual Diagnosis Tx (IDDT) | 8 | 66.7% | 8 | 100.0% |
| Illness Management and Recovery (IMR) | 2 | 16.7% | 2 | 100.0% |
| Interpreter Services | 7 | 58.3% | - | 0.0% |
| Mental Health Housing Institute | 5 | 41.7% | - | 0.0% |
| Older Adult Services | 5 | 41.7% | - | 0.0% |
| Peer Support Services | 10 | 83.3% | 4 | 40.0% |
| Specialized Services for MI/MR | 3 | 25.0% | 1 | 33.3% |
| Supported Employment | 8 | 66.7% | 5 | 0.0% |
| Trauma-Informed Care | 6 | 50.0% | 1 | 16.7% |

1. Trans-Metro Boards are Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Number of Trans-Metro Boards Offering Service is the number of Trans-Metro Boards that indicated that they provided the specific service.
3. Percent of All Trans-Metro Boards is (Number of Trans-Metro Boards Offering Service) divided by 12 Boards.
4. Number of Trans-Metro Boards Using Technical Assistance is the number of Trans-Metro Boards that reported that they were using technical assistance.
5. Percent of Trans-Metro Boards Offering Services and Using Technical Assistance (Number of Trans-Metro Boards Using Technical Assistance) divided by (Number of Trans-Metro Boards Offering Service).
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

| Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services | | | | |
|--|---|-----------------------------------|---|---|
| Number of Metro-Urban Boards Using Technical Assistance for a Specific Service Area | | | | |
| Service Area | Metro-Urban Boards Offering Service | | Metro-Urban Boards Using Technical Assistance | |
| | Number of Metro-Urban Boards Offering Service | Percent of All Metro-Urban Boards | Number of Metro-Urban Boards Using Technical Assistance | Percent of Metro-Urban Boards Offering Service and Using Technical Assistance |
| ACT | 3 | 37.5% | 1 | 33.3% |
| Anger Management/Domestic Violence | 6 | 75.0% | - | 0.0% |
| Cluster-Based Planning | 1 | 12.5% | 1 | 100.0% |
| Clubhouse | 1 | 12.5% | - | 0.0% |
| Consumer Operated Service | 4 | 50.0% | 1 | 25.0% |
| Consumer Psycho-Education | 8 | 100.0% | 4 | 50.0% |
| Family-to-Family | 8 | 100.0% | 4 | 50.0% |
| General Transportation Services | 4 | 50.0% | - | 0.0% |
| Integrated Dual Diagnosis Tx (IDDT) | 5 | 62.5% | 5 | 100.0% |
| Illness Management and Recovery (IMR) | 3 | 37.5% | 1 | 33.3% |
| Interpreter Services | 6 | 75.0% | - | 0.0% |
| Mental Health Housing Institute | 6 | 75.0% | 3 | 50.0% |
| Older Adult Services | 8 | 100.0% | 1 | 12.5% |
| Peer Support Services | 7 | 87.5% | 2 | 28.6% |
| Specialized Services for MI/MR | 3 | 37.5% | 1 | 33.3% |
| Supported Employment | 7 | 87.5% | 3 | 0.0% |
| Trauma-Informed Care | 4 | 50.0% | 1 | 25.0% |

1. Metro-Urban Boards are Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Number of Metro-Urban Boards Offering Service is the number of Metro-Urban Boards that indicated that they provided the specific service.
3. Percent of All Metro-Urban Boards is (Number of Metro-Urban Boards Offering Service) divided by 8 Boards.
4. Number of Metro-Urban Boards Using Technical Assistance is the number of Metro-Urban Boards that reported that they were using technical assistance.
5. Percent of Metro-Urban Boards Offering Services and Technical Assistance is (Number of Metro-Urban Boards Using Technical Assistance) divided by (Number of Metro-Urban Boards Offering Service).
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

| Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services | | | | |
|--|---|-----------------------------|---|---|
| Number of Urban Boards Using Technical Assistance for a Specific Service Area | | | | |
| Service Area | Urban Boards Offering Service | | Urban Boards Using Technical Assistance | |
| | Number of Urban Boards Offering Service | Percent of All Urban Boards | Number of Urban Boards Using Technical Assistance | Percent of Urban Boards Offering Service and Using Technical Assistance |
| ACT | 4 | 57.1% | 2 | 50.0% |
| Anger Management/Domestic Violence | 7 | 100.0% | 2 | 28.6% |
| Cluster-Based Planning | 5 | 71.4% | 3 | 60.0% |
| Clubhouse | 4 | 57.1% | 1 | 0.0% |
| Consumer Operated Service | 7 | 100.0% | 1 | 14.3% |
| Consumer Psycho-Education | 6 | 85.7% | 3 | 50.0% |
| Family-to-Family | 7 | 100.0% | 3 | 42.9% |
| General Transportation Services | 3 | 42.9% | - | 0.0% |
| Integrated Dual Diagnosis Tx (IDDT) | 6 | 85.7% | 6 | 100.0% |
| Illness Management and Recovery (IMR) | 6 | 85.7% | 5 | 83.3% |
| Interpreter Services | 4 | 57.1% | 1 | 25.0% |
| Mental Health Housing Institute | 3 | 42.9% | 1 | 33.3% |
| Older Adult Services | 4 | 57.1% | 2 | 50.0% |
| Peer Support Services | 7 | 100.0% | 1 | 14.3% |
| Specialized Services for MI/MR | 3 | 42.9% | 1 | 33.3% |
| Supported Employment | 6 | 85.7% | 4 | 0.0% |
| Trauma-Informed Care | 4 | 57.1% | 3 | 75.0% |

1. Urban Boards are Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Number of Urban Boards Offering Service is the number of Urban Boards that indicated that they provided the specific service.
3. Percent of All Urban Boards is (Number of Urban Boards Offering Service) divided by 7 Boards.
4. Number of Urban Boards Using Technical Assistance is the number of Urban Boards that reported that they were using technical assistance.
5. Percent of Urban Boards Offering Services and Using Technical Assistance is (Number of Urban Boards Using Technical Assistance) divided by (Number of Urban Boards Offering Service).
6. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

| Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services | | | | | | | | |
|--|-----------------------------------|--|--|---------------------------------------|--|---|-----------------------------------|------------------------------|
| Number of Boards Needing Technical Assistance for a Specific Service Area | | | | | | | | |
| Service Area | Boards Offering Service | | | Boards Not Currently Offering Service | | | Statewide | |
| | Number of Boards Offering Service | Percent of All Boards Offering Service | Number of Boards Offering Service and Needing TA | Number of Boards Not Offering Service | Percent of All Boards Not Offering Service | Number of Boards Not Offering Service, but Needing TA | Total Number of Boards Needing TA | Percent of Boards Needing TA |
| ACT | 15 | 30.0% | 2 | 35 | 70.0% | 4 | 6 | 12.0% |
| Anger Management/Domestic Violence | 43 | 86.0% | 7 | 7 | 14.0% | - | 7 | 14.0% |
| Cluster-Based Planning | 12 | 24.0% | - | 38 | 76.0% | 4 | 4 | 8.0% |
| Clubhouse | 14 | 28.0% | 2 | 36 | 72.0% | 1 | 3 | 6.0% |
| Consumer Operated Service | 28 | 56.0% | 3 | 22 | 44.0% | - | 3 | 6.0% |
| Consumer Psycho-Education | 36 | 72.0% | 2 | 14 | 28.0% | - | 2 | 4.0% |
| Family-to-Family | 40 | 80.0% | 2 | 10 | 20.0% | 1 | 3 | 6.0% |
| General Transportation Services | 23 | 46.0% | 2 | 27 | 54.0% | - | 2 | 4.0% |
| Integrated Dual Diagnosis Tx (IDDT) | 27 | 54.0% | 1 | 23 | 46.0% | 6 | 7 | 14.0% |
| Illness Management and Recovery (IMR) | 18 | 36.0% | 2 | 32 | 64.0% | 3 | 5 | 10.0% |
| Interpreter Services | 34 | 68.0% | 3 | 16 | 32.0% | 1 | 4 | 8.0% |
| Mental Health Housing Institute | 24 | 48.0% | 6 | 26 | 52.0% | 2 | 8 | 16.0% |
| Older Adult Services | 25 | 50.0% | 4 | 25 | 50.0% | 6 | 10 | 20.0% |
| Peer Support Services | 40 | 80.0% | 5 | 10 | 20.0% | 1 | 6 | 12.0% |
| Specialized Services for MI/MR | 19 | 38.0% | 2 | 31 | 62.0% | 6 | 8 | 16.0% |
| Supported Employment | 28 | 56.0% | 6 | 22 | 44.0% | 3 | 9 | 18.0% |
| Trauma-Informed Care | 21 | 42.0% | 7 | 29 | 58.0% | 4 | 11 | 22.0% |

1. Number of Boards Offering Service is the number of Boards that indicated that they provided the specific service.
2. Percent of All Boards Offering Service is (Number of Boards Offering Service) divided by 50 Boards.
3. Number of Boards Offering Service and Needing Technical Assistance is the number of Boards that reported that they offered the service and needed technical assistance for the specific service area.
4. Number of Boards Not Offering Service is the number of Boards that indicated that they did not provide the specific service.
5. Percent of All Boards Not Offering Service is (Number of Boards Not Offering Service) divided by 50.
6. Number of Boards Not Offering Service and Needing TA is the number of Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
7. Total Number of Boards Needing TA is the sum of all Boards that reported that they needed technical assistance for the specific service area.
8. Percent of Boards Needing TA is (Total Number of Boards Needing TA) divided by 50.
9. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

**Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services
Number of Rural Boards Needing Technical Assistance for a Specific Service Area**

| Service Area | Rural Boards Offering Service | | | Rural Boards Not Currently Offering Service | | | Total Rural Boards | |
|---------------------------------------|---|------------------------------------|--|---|--|---|-------------------------------|------------------------------|
| | Number of Rural Boards Offering Service | % of Rural Boards Offering Service | Number of Rural Boards Offering Service and Needing TA | Number of Rural Boards Not Offering Service | % of Rural Boards Not Offering Service | Number of Rural Boards Not Offering Service, but Needing TA | Total Rural Boards Needing TA | % of Rural Boards Needing TA |
| ACT | 1 | 16.7% | - | 5 | 83.3% | - | - | 0.0% |
| Anger Management/Domestic Violence | 5 | 83.3% | - | 1 | 16.7% | - | - | 0.0% |
| Cluster-Based Planning | 1 | 16.7% | - | 5 | 83.3% | - | - | 0.0% |
| Clubhouse | 0 | 0.0% | - | 6 | 100.0% | - | - | 0.0% |
| Consumer Operated Service | 2 | 33.3% | - | 4 | 66.7% | - | - | 0.0% |
| Consumer Psycho-Education | 4 | 66.7% | - | 2 | 33.3% | - | - | 0.0% |
| Family-to-Family | 3 | 50.0% | - | 3 | 50.0% | 1 | 1 | 16.7% |
| General Transportation Services | 3 | 50.0% | - | 3 | 50.0% | 2 | 2 | 33.3% |
| Integrated Dual Diagnosis Tx (IDDT) | 1 | 16.7% | - | 5 | 83.3% | - | - | 0.0% |
| Illness Management and Recovery (IMR) | 1 | 16.7% | - | 5 | 83.3% | - | - | 0.0% |
| Interpreter Services | 4 | 66.7% | 1 | 2 | 33.3% | - | 1 | 16.7% |
| Mental Health Housing Institute | 2 | 33.3% | 1 | 4 | 66.7% | 1 | 2 | 33.3% |
| Older Adult Services | 2 | 33.3% | - | 4 | 66.7% | - | - | 0.0% |
| Peer Support Services | 4 | 66.7% | 1 | 2 | 33.3% | - | 1 | 16.7% |
| Specialized Services for MI/MR | 4 | 66.7% | 1 | 2 | 33.3% | - | 1 | 16.7% |
| Supported Employment | 0 | 0.0% | - | 6 | 100.0% | 1 | 1 | 16.7% |
| Trauma-Informed Care | 2 | 33.3% | - | 4 | 66.7% | - | - | 0.0% |

1. Rural Boards are Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van Wert-Mercer-Paulding.
2. Number of Rural Boards Offering Service is the number of Rural Boards that indicated that they provided the specific service.
3. % of All Rural Boards Offering Service is (Number of Rural Boards Offering Service) divided by 6 Boards.
4. Number of Rural Boards Offering Service and Needing Technical Assistance is the number of Rural Boards that reported that they offered the service and needed technical assistance for the specific service area.
5. Number of Rural Boards Not Offering Service is the number of Rural Boards that indicated that they did not provide the specific service.
6. % of All Rural Boards Not Offering Service is (Number of Rural Boards Not Offering Service) divided by 6.
7. Number of Rural Boards Not Offering Service and Needing TA is the number of Rural Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
8. Total Rural Boards Needing TA is the sum of all Rural Boards that reported that they needed technical assistance for the specific service area.
9. % of Rural Boards Needing TA is (Total Number of Rural Boards Needing TA) divided by 6.
10. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

**Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services
Number of Trans-Rural Boards Needing Technical Assistance for a Specific Service Area**

| Service Area | Trans-Rural Boards Offering Service | | | Trans-Rural Boards Not Currently Offering Service | | | Total Trans-Rural Boards | |
|---------------------------------------|---|--|--|---|--|---|-------------------------------------|------------------------------------|
| | Number of Trans-Rural Boards Offering Service | % of Trans-Rural Boards Offering Service | Number of Trans-Rural Boards Offering Service and Needing TA | Number of Trans-Rural Boards Not Offering Service | % of Trans-Rural Boards Not Offering Service | Number of Trans-Rural Boards Not Offering Service, but Needing TA | Total Trans-Rural Boards Needing TA | % of Trans-Rural Boards Needing TA |
| ACT | 4 | 23.5% | - | 13 | 76.5% | 2 | 2 | 11.8% |
| Anger Management/Domestic Violence | 15 | 88.2% | 2 | 2 | 11.8% | - | 2 | 11.8% |
| Cluster-Based Planning | 4 | 23.5% | - | 13 | 76.5% | 3 | 3 | 17.6% |
| Clubhouse | 5 | 29.4% | - | 12 | 70.6% | - | - | 0.0% |
| Consumer Operated Service | 10 | 58.8% | 1 | 7 | 41.2% | - | 1 | 5.9% |
| Consumer Psycho-Education | 11 | 64.7% | - | 6 | 35.3% | - | - | 0.0% |
| Family-to-Family | 11 | 64.7% | - | 6 | 35.3% | - | - | 0.0% |
| General Transportation Services | 6 | 35.3% | - | 11 | 64.7% | - | - | 0.0% |
| Integrated Dual Diagnosis Tx (IDDT) | 7 | 41.2% | - | 10 | 58.8% | 1 | 1 | 5.9% |
| Illness Management and Recovery (IMR) | 6 | 35.3% | 1 | 11 | 64.7% | 2 | 3 | 17.6% |
| Interpreter Services | 13 | 76.5% | - | 4 | 23.5% | - | - | 0.0% |
| Mental Health Housing Institute | 8 | 47.1% | 2 | 9 | 52.9% | 1 | 3 | 17.6% |
| Older Adult Services | 6 | 35.3% | 1 | 11 | 64.7% | 3 | 4 | 23.5% |
| Peer Support Services | 12 | 70.6% | - | 5 | 29.4% | - | - | 0.0% |
| Specialized Services for MI/MR | 6 | 35.3% | - | 11 | 64.7% | 3 | 3 | 17.6% |
| Supported Employment | 7 | 41.2% | 1 | 10 | 58.8% | 1 | 2 | 11.8% |
| Trauma-Informed Care | 5 | 29.4% | 2 | 12 | 70.6% | 2 | 4 | 23.5% |

1. Trans-Rural Boards are Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Number of Trans-Rural Boards Offering Service is the number of Trans-Rural Boards that indicated that they provided the specific service.
3. % of All Trans-Rural Boards Offering Service is (Number of Trans-Rural Boards Offering Service) divided by 17 Boards.
4. Number of Trans-Rural Boards Offering Service and Needing Technical Assistance is the number of Trans-Rural Boards that reported that they offered the service and needed technical assistance for the specific service area.
5. Number of Trans-Rural Boards Not Offering Service is the number of Trans-Rural Boards that indicated that they did not provide the specific service.
6. % of All Trans-Rural Boards Not Offering Service is (Number of Trans-Rural Boards Not Offering Service) divided by 17.
7. Number of Trans-Rural Boards Not Offering Service and Needing TA is the number of Trans-Rural Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
8. Total Trans-Rural Boards Needing TA is the sum of all Trans-Rural Boards that reported that they needed technical assistance for the specific service area.
9. % of Trans-Rural Boards Needing TA is (Total Number of Trans-Rural Boards Needing TA) divided by 17.
10. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

**Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services
Number of Trans-Metro Boards Needing Technical Assistance for a Specific Service Area**

| Service Area | Trans-Metro Boards Offering Service | | | Trans-Metro Boards Not Currently Offering Service | | | Total Trans-Metro Boards | |
|---------------------------------------|---|--|--|---|--|---|-------------------------------------|------------------------------------|
| | Number of Trans-Metro Boards Offering Service | % of Trans-Metro Boards Offering Service | Number of Trans-Metro Boards Offering Service and Needing TA | Number of Trans-Metro Boards Not Offering Service | % of Trans-Metro Boards Not Offering Service | Number of Trans-Metro Boards Not Offering Service, but Needing TA | Total Trans-Metro Boards Needing TA | % of Trans-Metro Boards Needing TA |
| ACT | 3 | 25.0% | - | 9 | 75.0% | 1 | 1 | 8.3% |
| Anger Management/Domestic Violence | 10 | 83.3% | 3 | 2 | 16.7% | - | 3 | 25.0% |
| Cluster-Based Planning | 1 | 8.3% | - | 11 | 91.7% | 1 | 1 | 8.3% |
| Clubhouse | 4 | 33.3% | 1 | 8 | 66.7% | - | 1 | 8.3% |
| Consumer Operated Service | 5 | 41.7% | 1 | 7 | 58.3% | - | 1 | 8.3% |
| Consumer Psycho-Education | 7 | 58.3% | 1 | 5 | 41.7% | - | 1 | 8.3% |
| Family-to-Family | 11 | 91.7% | - | 1 | 8.3% | - | - | 0.0% |
| General Transportation Services | 7 | 58.3% | 1 | 5 | 41.7% | - | 1 | 8.3% |
| Integrated Dual Diagnosis Tx (IDDT) | 8 | 66.7% | - | 4 | 33.3% | 1 | 1 | 8.3% |
| Illness Management and Recovery (IMR) | 2 | 16.7% | - | 10 | 83.3% | 1 | 1 | 8.3% |
| Interpreter Services | 7 | 58.3% | 1 | 5 | 41.7% | 1 | 2 | 16.7% |
| Mental Health Housing Institute | 5 | 41.7% | 1 | 7 | 58.3% | 1 | 2 | 16.7% |
| Older Adult Services | 5 | 41.7% | 2 | 7 | 58.3% | 3 | 5 | 41.7% |
| Peer Support Services | 10 | 83.3% | 2 | 2 | 16.7% | - | 2 | 16.7% |
| Specialized Services for MI/MR | 3 | 25.0% | - | 9 | 75.0% | 2 | 2 | 16.7% |
| Supported Employment | 8 | 66.7% | 1 | 4 | 33.3% | 1 | 2 | 16.7% |
| Trauma-Informed Care | 6 | 50.0% | 2 | 6 | 50.0% | 2 | 4 | 33.3% |

1. Trans-Metro Boards are Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Number of Trans-Metro Boards Offering Service is the number of Trans-Metro Boards that indicated that they provided the specific service.
3. % of All Trans-Metro Boards Offering Service is (Number of Trans-Metro Boards Offering Service) divided by 12 Boards.
4. Number of Trans-Metro Boards Offering Service and Needing Technical Assistance is the number of Trans-Metro Boards that reported that they offered the service and needed technical assistance for the specific service area.
5. Number of Trans-Metro Boards Not Offering Service is the number of Trans-Metro Boards that indicated that they did not provide the specific service.
6. % of All Trans-Metro Boards Not Offering Service is (Number of Trans-Metro Boards Not Offering Service) divided by 12.
7. Number of Trans-Metro Boards Not Offering Service and Needing TA is the number of Trans-Metro Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
8. Total Trans-Metro Boards Needing TA is the sum of all Trans-Metro Boards that reported that they needed technical assistance for the specific service area.
9. % of Trans-Metro Boards Needing TA is (Total Number of Trans-Metro Boards Needing TA) divided by 12.
10. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

**Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services
Number of Metro-Urban Boards Needing Technical Assistance for a Specific Service Area**

| Service Area | Metro-Urban Boards Offering Service | | | Metro-Urban Boards Not Currently Offering Service | | | Total Metro-Urban Boards | |
|---------------------------------------|---|--|--|---|--|---|-------------------------------------|------------------------------------|
| | Number of Metro-Urban Boards Offering Service | % of Metro-Urban Boards Offering Service | Number of Metro-Urban Boards Offering Service and Needing TA | Number of Metro-Urban Boards Not Offering Service | % of Metro-Urban Boards Not Offering Service | Number of Metro-Urban Boards Not Offering Service, but Needing TA | Total Metro-Urban Boards Needing TA | % of Metro-Urban Boards Needing TA |
| ACT | 3 | 37.5% | 1 | 5 | 62.5% | 1 | 2 | 25.0% |
| Anger Management/Domestic Violence | 6 | 75.0% | 2 | 2 | 25.0% | - | 2 | 25.0% |
| Cluster-Based Planning | 1 | 12.5% | - | 7 | 87.5% | - | - | 0.0% |
| Clubhouse | 1 | 12.5% | 1 | 7 | 87.5% | - | 1 | 12.5% |
| Consumer Operated Service | 4 | 50.0% | 1 | 4 | 50.0% | - | 1 | 12.5% |
| Consumer Psycho-Education | 8 | 100.0% | 1 | - | 0.0% | - | 1 | 12.5% |
| Family-to-Family | 8 | 100.0% | - | - | 0.0% | 2 | 2 | 25.0% |
| General Transportation Services | 4 | 50.0% | 1 | 4 | 50.0% | - | 1 | 12.5% |
| Integrated Dual Diagnosis Tx (IDDT) | 5 | 62.5% | 1 | 3 | 37.5% | 2 | 3 | 37.5% |
| Illness Management and Recovery (IMR) | 3 | 37.5% | - | 5 | 62.5% | - | - | 0.0% |
| Interpreter Services | 6 | 75.0% | 1 | 2 | 25.0% | - | 1 | 12.5% |
| Mental Health Housing Institute | 6 | 75.0% | 1 | 2 | 25.0% | - | 1 | 12.5% |
| Older Adult Services | 8 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| Peer Support Services | 7 | 87.5% | 2 | 1 | 12.5% | 1 | 3 | 37.5% |
| Specialized Services for MI/MR | 3 | 37.5% | 1 | 5 | 62.5% | 1 | 2 | 25.0% |
| Supported Employment | 7 | 87.5% | 3 | 1 | 12.5% | - | 3 | 37.5% |
| Trauma-Informed Care | 4 | 50.0% | 2 | 4 | 50.0% | - | 2 | 25.0% |

1. Metro-Urban Boards are Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Number of Metro-Urban Boards Offering Service is the number of Trans-Metro Boards that indicated that they provided the specific service.
3. % of All Metro-Urban Boards Offering Service is (Number of Metro-Urban Boards Offering Service) divided by 8 Boards.
4. Number of Metro-Urban Boards Offering Service and Needing Technical Assistance is the number of Metro-Urban Boards that reported that they offered the service and needed technical assistance for the specific service area.
5. Number of Metro-Urban Boards Not Offering Service is the number of Metro-Urban Boards that indicated that they did not provide the specific service.
6. % of All Metro-Urban Boards Not Offering Service is (Number of Metro-Urban Boards Not Offering Service) divided by 8.
7. Number of Metro-Urban Boards Not Offering Service and Needing TA is the number of Metro-Urban Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
8. Total Metro-Urban Boards Needing TA is the sum of all Metro-Urban Boards that reported that they needed technical assistance for the specific service area.
9. % of Metro-Urban Boards Needing TA is (Total Number of Metro-Urban Boards Needing TA) divided by 8.
10. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

**Question 7.3.4.1. Promising, Best, and Evidence-Based Practices and Other Adult Services
Number of Urban Boards Needing Technical Assistance for a Specific Service Area**

| Service Area | Urban Boards Offering Service | | | Urban Boards Not Currently Offering Service | | | Total Urban Boards | |
|---------------------------------------|---|------------------------------------|---|---|--|---|-------------------------------|------------------------------|
| | Number of Urban Boards Offering Service | % of Urban Boards Offering Service | % of Urban Boards Offering Service and Needing TA | Number of Urban Boards Not Offering Service | Percent of Urban Boards Not Offering Service | Number of Urban Boards Not Offering Service, but Needing TA | Total Urban Boards Needing TA | % of Urban Boards Needing TA |
| ACT | 4 | 57.1% | 1 | 3 | 42.9% | - | 1 | 14.3% |
| Anger Management/Domestic Violence | 7 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| Cluster-Based Planning | 5 | 71.4% | - | 2 | 28.6% | - | - | 0.0% |
| Clubhouse | 4 | 57.1% | - | 3 | 42.9% | 1 | 1 | 14.3% |
| Consumer Operated Service | 7 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| Consumer Psycho-Education | 6 | 85.7% | - | 1 | 14.3% | - | - | 0.0% |
| Family-to-Family | 7 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| General Transportation Services | 3 | 42.9% | - | 4 | 57.1% | - | - | 0.0% |
| Integrated Dual Diagnosis Tx (IDDT) | 6 | 85.7% | - | 1 | 14.3% | - | - | 0.0% |
| Illness Management and Recovery (IMR) | 6 | 85.7% | 1 | 1 | 14.3% | - | 1 | 14.3% |
| Interpreter Services | 4 | 57.1% | - | 3 | 42.9% | - | - | 0.0% |
| Mental Health Housing Institute | 3 | 42.9% | - | 4 | 57.1% | - | - | 0.0% |
| Older Adult Services | 4 | 57.1% | 1 | 3 | 42.9% | - | 1 | 14.3% |
| Peer Support Services | 7 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| Specialized Services for MI/MR | 3 | 42.9% | - | 4 | 57.1% | - | - | 0.0% |
| Supported Employment | 6 | 85.7% | 1 | 1 | 14.3% | - | 1 | 14.3% |
| Trauma-Informed Care | 4 | 57.1% | 1 | 3 | 42.9% | - | 1 | 14.3% |

1. Urban Boards are Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Number of Urban Boards Offering Service is the number of Urban Boards that indicated that they provided the specific service.
3. % of All Urban Boards Offering Service is (Number of Urban Boards Offering Service) divided by 7 Boards.
4. Number of Urban Boards Offering Service and Needing Technical Assistance is the number of Urban Boards that reported that they offered the service and needed technical assistance for the specific service area.
5. Number of Urban Boards Not Offering Service is the number of Urban Boards that indicated that they did not provide the specific service.
6. % of All Urban Boards Not Offering Service is (Number of Urban Boards Not Offering Service) divided by 7.
7. Number of Urban Boards Not Offering Service and Needing TA is the number of Urban Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
8. Total Urban Boards Needing TA is the sum of all Urban Boards that reported that they needed technical assistance for the specific service area.
9. % of Urban Boards Needing TA is (Total Number of Urban Boards Needing TA) divided by 7.
10. "Cluster-based" may have been misinterpreted by the Boards (i.e., not indicative of Cluster-based Planning Evidence-based Practice); consequently, the data may not be representative of Boards offering "Cluster-Based Planning" services.

Appendix I – Table for Question 7.3.5

| 7.3.5. Boards That Have Data Needed to Calculate the Number of Adult Consumers Who Are Severely Mentally Disabled (SMD) and Who Are Competitively Employed | | | | | |
|--|--|---|---|---------|-----------|
| By Geographical Area Classification | | | | | |
| Boards by Geographical Area Classification | Number of Boards That Have Data to Calculate % of SMD Consumers Who Are Competitively Employed | % of Boards That Have Data for Calculation By Geographical Classification | Estimated % of Adult Consumers Who Are SMD and Who Competitively Employed | | |
| | | | Minimum % | Maximum | Average % |
| Rural | 4 | 66.7% | 0.30% | 25.0% | 11.0% |
| Trans-Rural | 8 | 47.1% | 0.10% | 12.0% | 6.4% |
| Trans-Metro | 10 | 83.3% | 1.0% | 23.3% | 12.0% |
| Metro-Urban | 3 | 37.5% | 16.0% | 26.0% | 22.5% |
| Urban | 5 | 71.4% | 2.0% | 18.0% | 12.0% |
| Statewide | 30 | 60.0% | 0.10% | 26.0% | 11.4% |

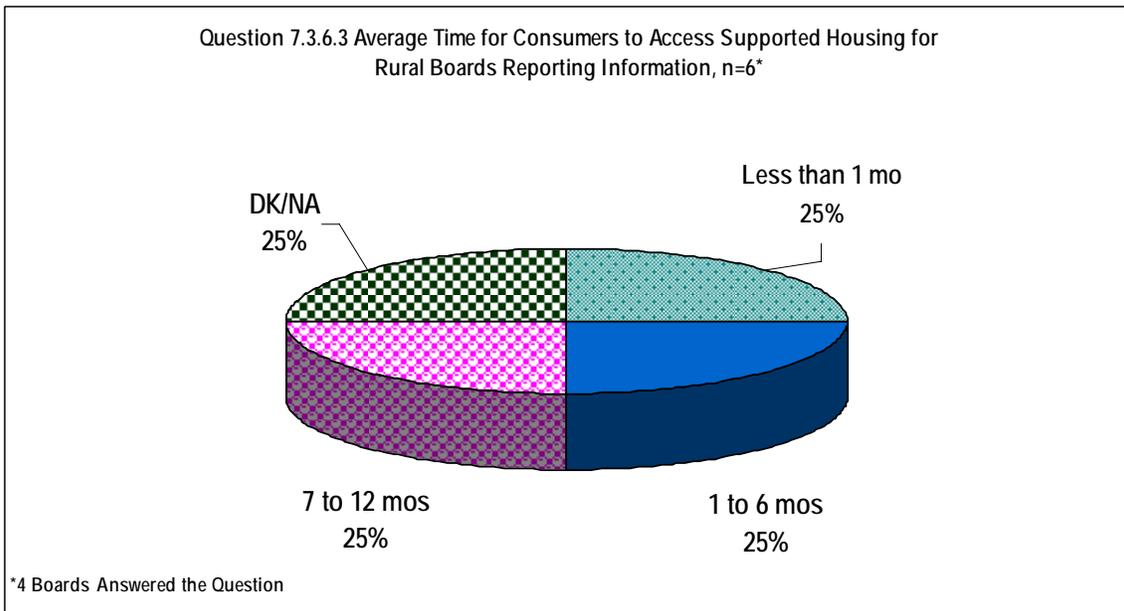
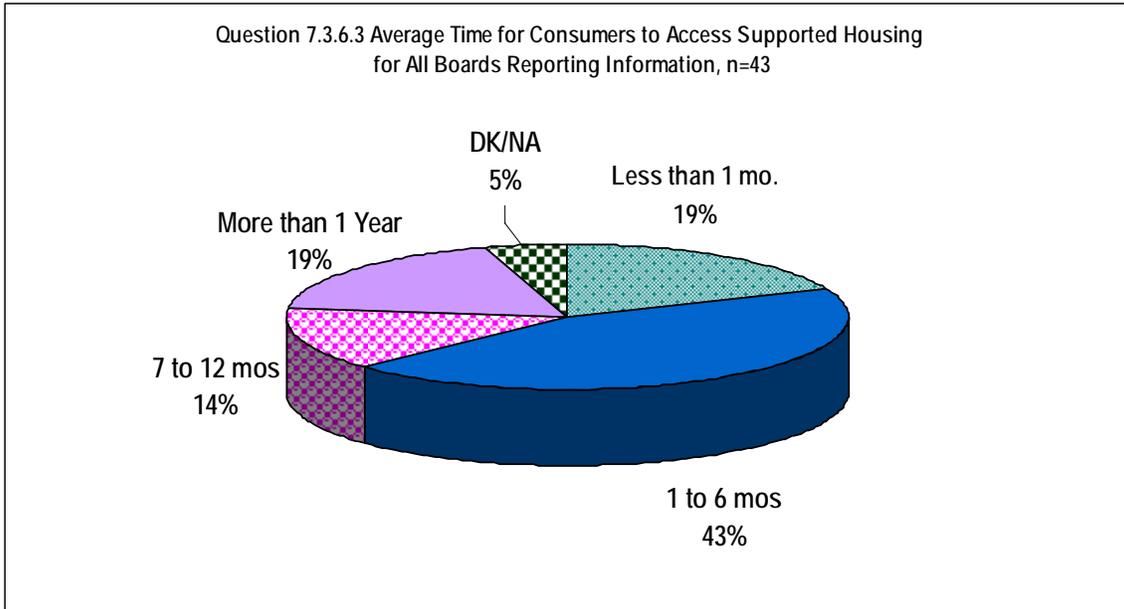
1. Geographical Classifications:
 - o Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam and, Van Wert-Mercer-Paulding
 - o Trans-Rural Boards: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
 - o Trans-Metro Boards: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood
 - o Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull
 - o Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit
2. Number of Boards That Have Data to Calculate % of SMD Consumers Who Are Competitively Employed is the number of Boards that indicated for Question 7.3.5.1 to having data to calculate % of SMD consumers who are competitively employed.
3. % of Boards That Have Data for Calculation by Geographical Classification is (number of Boards that have data to calculate % of SMD consumers who are competitively employed) divided by (number of Boards within the geographical classification). The denominator by Board geographical area classification is as follows: Rural--6; Trans-Rural--17; Trans-Metro--12; Metro-Urban--8, Urban--7; Statewide--50.
4. Minimum % is the lowest value in the range provided by the Boards within the geographical classification for adult consumers who are SMD and who are competitively employed.
5. Maximum % is the highest value in the range provided by the Boards within the geographical classification for adult clients who are SMD and who are competitively employed.
6. Average % is (sum of estimated % of adult consumers who are SMD and who are competitively employed) divided by (the number of Boards that reported an estimated % within the geographical classification). The denominator by geographical area classification is as follows: Rural--6; Trans-Rural--17; Trans-Metro--12; Metro-Urban--8; Urban--7, and Statewide--50.
7. Competitive employment is defined as work in the community for which anyone can apply and that pays at least a minimum wage. No minimum hours per week or month are included in the definition. The target population is adults who are ages 18 and older and who have a persistent mental illness.

Appendix J – Table for Questions 7.3.6.1, 7.3.6.2, and 7.3.6.4

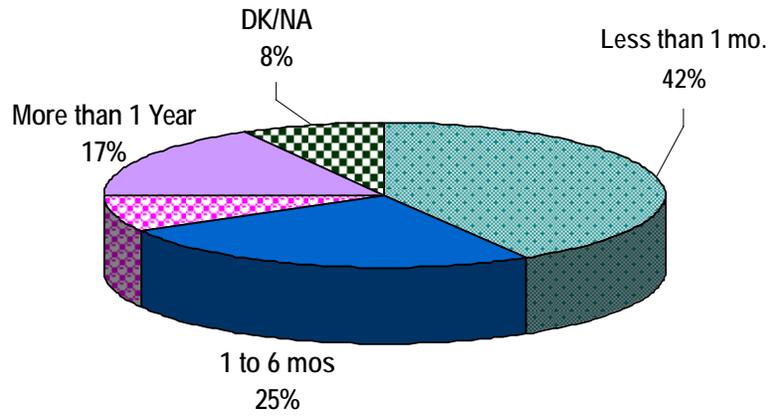
| Question 7.3.6 Supportive Housing Availability | | | | | | |
|--|----------------------------------|---|---|---|---|--|
| Comparison of By Geographical Type | | | | | | |
| | Question 7.3.6.1. | | Question 7.3.6.2. | | Question 7.3.6.4. | |
| | Do you offer supportive housing? | | If yes, do you have wait lists for supported housing? | | How many are currently waiting for supported housing? | |
| Boards By Geographical Type | Number Offering Service | % of Boards Offering Service by Geographical Type | Number Offering Service with Wait List | % of Boards with Wait List by Geographical Type | Total Consumers on Wait List by Geographical Type | Total Consumers on Wait List Per 1,000 Adult Consumers Served by Boards With a Wait List |
| Rural | 4 | 66.7% | 3 | 50.0% | 12 | 0.8 |
| Trans-Rural | 13 | 76.5% | 11 | 64.7% | 70 | 1.8 |
| Trans-Metro | 12 | 100.0% | 10 | 83.3% | 146 | 4.6 |
| Metro-Urban | 8 | 100.0% | 8 | 100.0% | 206 | 6.8 |
| Urban | 7 | 100.0% | 6 | 85.7% | 1,899 | 22.8 |
| Statewide | 44 | 88.0% | 38 | 86.4% | 2,333 | 12.1 |

1. Geographical Areas:
 - a. Rural Boards are as follows: Athens-Hocking-Vinton, Belmont-Harrison-Vinton, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van-Wert, Mercer-Paulding.
 - b. Trans-Rural Boards are as follows: Ashland, Brown, Paint Valley, Hancock, Huron, Jefferson, Logan-Champaign, Medina, Miami-Darke-Shelby, Preble, Defiance-Fulton-Henry-Williams, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
 - c. Trans-Metro Boards are as follows: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Knox-Licking, Richland, Warren-Clinton, and Wood.
 - d. Metro-Urban Boards are as follows: Butler, Clermont, Lorain, Mahoning, Marion-Crawford, Portage, Stark, and Trumbull.
 - e. Urban Boards are as follows: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Number Offering Service is the number of Boards that answered "Yes" to Question 7.3.6.1 on the MSPA.
3. % of Boards Offering Service by Geographical Type: (number offering service for the geographical type) divided by (total number of Boards within geographical type). Total Rural Boards=6; Total Trans-Rural Boards=18; Total Trans-Metro Boards=11; Total Metro-Urban Boards=8; Total Urban Boards=7.
4. Number Offering Service with Wait List is the number of Boards that answered "Yes" to Question 7.3.6.1 and "Yes" to Question 7.3.6.2 on the MSPA.
5. % of Boards with Wait List by Geographical Type: (number of Boards offering service with Wait for geographical type) divided by (number offering service by geographical type).
6. Total Consumers on Wait List by Geographical Type is the sum of consumers for which answered Question 7.3.6.4 for geographical type.
7. Total Consumers on Wait List Per 1,000 of Adult Consumers Served by Boards With a Wait List is (total consumers on wait list by geographical type) divided by (number of adult consumers served by Boards with a wait list) *1,000.

Appendix K – Figures for Question 7.3.6.3

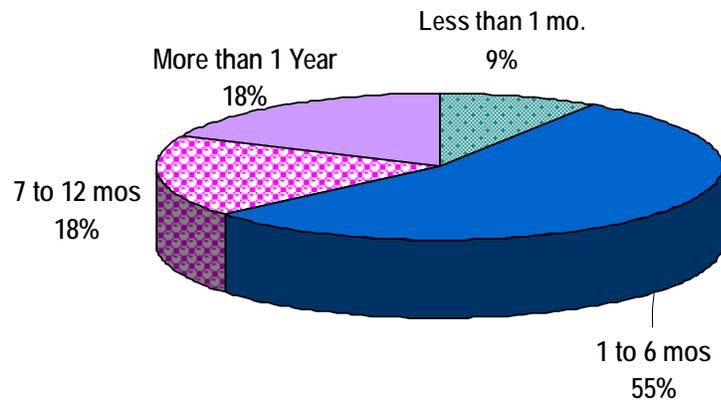


Question 7.3.6.3 Average Time for Consumers to Access Supported Housing for Trans-Rural Boards Reporting Information, n=17*



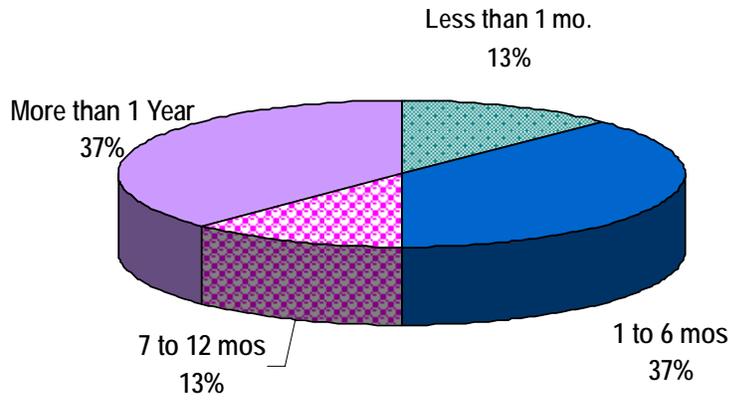
*12 Boards Answered the Question

Question 7.3.6.3 Average Time for Consumers to Access Supported Housing for Trans-Metro Boards Reporting Information, n=12*

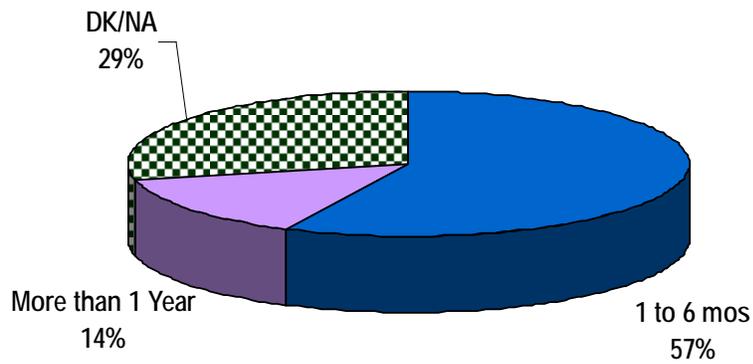


* 11 Boards Answered Question

Question 7.3.6.3 Average Time for Consumers to Access Supported Housing for Metro-Urban Boards Reporting Information, n=8



Question 7.3.6.3 Average Time for Consumers to Access Supported Housing for Urban Boards Reporting Information, n=7



Appendix L – Tables for Questions 7.3.6 by Survey Year

| Question 7.3.6 Supportive Housing Availability | | | | | | | | |
|--|---|-------------------------|------------------------------|--|----------------------------|--|------------------------------|---------------------------|
| Comparison of By Survey Year | | | | | | | | |
| | Question 7.3.6.1. Do you offer supportive housing? | | | Question 7.3.6.2. If yes, do you have wait lists? | | Question 7.3.6.4. How many are currently waiting for supported housing? | | |
| Year | Number of Boards Responding to Question | Number Offering Service | % of Boards Offering Service | Number Offering Service with Wait List | % of Boards with Wait List | Number of Boards Responding to Question | Total Consumers on Wait List | Average Consumers Waiting |
| 2006 | 50 | 44 | 88.0% | 38 | 86.4% | 38 | 2,333 | 61.4 |
| 2004 | 43 | 35 | 88.4% | 35 | 100.0% | 35 | 2,372 | 67.8 |

| Question 7.3.6.3. Average Time for Consumers to Access Supported Housing | | | | | | |
|--|---|---------------------|---------------|----------------|--------------------|-------|
| Percent of Boards by Wait Length Categories by Survey Year | | | | | | |
| Year | Number of Boards Responding to Question | Less than One Month | 1 to 6 Months | 7 to 12 Months | More than One Year | DK/NA |
| 2006 | 43 | 19% | 43% | 14% | 19% | 5% |
| 2004 | 39 | 18% | 41% | 18% | 18% | 5% |

1. Year is the time frame survey data were collected and reported.
2. Number of Boards Responding to Question by providing data in that year's survey.
3. Number Offering Service is the number of Boards that answered "Yes" to Question 7.3.6.1 on the MSPA.
4. % of Boards Offering Service: Number of Boards offering service divided by total number of Boards reporting data.
5. Number Offering Service with Wait List is the number of Boards that answered "Yes" to Question 7.3.6.1 and "Yes" to Question 7.3.6.2.
6. % of Boards with Wait List: Number of Boards offering service with wait lists divided by number of Boards offering service.
7. Total Consumers on Wait List is the sum of consumers for Boards which answered Question 7.3.6.4.
8. Average Consumers Waiting is total consumers on wait list divided by number offering service with wait list.

Appendix M – Tables for Questions 7.3.7 by Survey Year

| Question 7.3.7.1 | | | |
|-----------------------------------|---|------------------------------|----------------------------|
| Chronically Homeless SMD Estimate | | | |
| Year | Number of Boards Responding to Question | Estimated Number of Homeless | Average Number of Homeless |
| 2006 | 45 | 4,308 | 95.7 |
| 2004 | 37 | 11,220 | 303.2 |

| Question 7.3.7.2 Sources of Homeless Estimate | | | | | | |
|---|---|-------------------------------------|------------------------|--------------------------|------------------------|---------------------------------|
| Year | Number of Boards Responding to Question | % of Boards Using Continuum of Care | % of Boards Using PATH | % of Boards Using BH Mod | % of Boards Using HMIS | % of Boards Using Other Sources |
| 2006 | 45 | 62% | 31% | 7% | 29% | 44% |
| 2004 | 37 | 57% | 27% | 11% | 8% | 62% |

1. Year is the time frame survey data were collected and reported.
2. Number of Boards Responding to Question is those Boards that provided data through the survey question.
3. Sources of Homeless Estimate can be multiple response categories.
4. % of Boards Using: Number of Boards indicating category as data source divided by number responding to question.

Appendix N – Table for Questions 7.3.8 by Survey Year

| Question 7.3.8 Housing Assistance Program (HAP) | | | | | | |
|---|---|----------------------------|-----------------------------|---|------------------------------|-------------------------------------|
| Comparison by Survey Year | | | | | | |
| Question 7.3.8.1. | | | | Question 7.3.8.3. | | |
| Do you have wait lists for HAP? | | | | How many are currently waiting for HAP? | | |
| Year | Number of Boards Responding to Question | Number with HAP Wait Lists | % of Boards with Wait Lists | Number of Boards Responding to Question | Total Consumers on Wait List | Average Number of Consumers Waiting |
| 2006 | 50 | 39 | 78% | 37 | 2,996 | 81.0 |
| 2004 | 47 | 35 | 74% | 33 | 2,164 | 65.6 |

| Question 7.3.8.2. Average Time for Consumers to Access HAP | | | | | | | | | |
|--|----------------------------------|----------------------|---------------|---------------|---------------|---------------|-----------------|--------|-------|
| Percent of Boards by Wait Length Categories by Survey Year | | | | | | | | | |
| Year | Number of Boards Reporting Waits | 10 work days or less | Up to 1 month | 1 to 3 months | 4 to 6 months | 7 to 9 months | 10 to 12 months | Year + | DK/NA |
| 2006 | 47 | 15% | 6% | 15% | 21% | 13% | 15% | 15% | 6% |
| 2004 | 35 | 11% | 6% | 26% | 17% | 20% | 6% | 20% | 20% |

1. Year is the time frame survey data were collected and reported.
2. Number of Boards Responding to Question is those that provided data.
3. Percent of Boards with Wait Lists: Number of Boards reporting wait lists divided by number of Boards responding to question.
4. Average Number of Consumers Waiting: Total number of consumers on wait lists divided by number of Boards responding to question.
5. Number of Boards Reporting Wait Lengths is the total number that provided data.
6. Percent of Boards in each wait length category: Number of Boards reporting that length divided by number of Boards answering "yes" to 7.3.8.2.

Appendix O – Table for Questions 7.3.9 by Survey Year

| Question 7.3.9 Public Housing | | | | | | |
|-------------------------------|--|------------------------|-----------------------------|---|------------------------------|---------------------------|
| Comparison by Survey Year | | | | | | |
| | Question 7.3.9.1. | | | Question 7.3.9.3. | | |
| | Do you have wait lists for public housing? | | | How many are currently waiting? | | |
| Year | Number of Boards Responding to Question | Number with Wait Lists | % of Boards with Wait Lists | Number of Boards Responding to Question | Total Consumers on Wait List | Average Consumers Waiting |
| 2006 | 50 | 46 | 92% | 42 | 5,876 | 139.9 |
| 2004 | 48 | 45 | 92% | 38 | 4,668 | 122.8 |

| Question 7.3.9.2. Average Time for Consumers to Access Public Housing | | | | | | | | |
|---|---|--------------|---|-----------|-----------|-----------|----------|-------|
| Percent of Boards by Wait Length Categories by Survey Year | | | | | | | | |
| Year | Number of Boards Responding to Question | Up to 1 Year | 1-2 Years | 3-4 Years | 5-6 Years | 7-8 Years | 9+ Years | DK/NA |
| 2006 | 43 | 2% | 49% | 35% | 2% | 0% | 0% | 2% |
| 2004 | 46 | 22% | 72% reported more than one year wait time | | | | | 7% |

1. Year is the time frame survey data were collected and reported.
2. Number of Boards Responding to Question is those that provided data.
3. Number Offering Service with Wait List is the number of Boards that answered "Yes" to Question 7.3.9.1.
4. % of Boards with Wait List: Number of Boards offering service with Wait divided by number responding to question.
5. Total Consumers on Wait List is the sum of consumers for which answered Question 7.3.9.3.
6. Average Consumers Waiting is total consumers on wait list divided by number offering service with wait list.

Appendix P – Tables for Question 7.4.1

| Question 7.4.1 C & A Crisis Care Service Availability for All Board Areas | | | | | | |
|---|----------------------|-------------------------|----------------------|-------------------------|------------|-------------------------|
| Approximately How Long C & A Consumers Wait for C & A Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Total Boards | Service Availability | Percent of Total Boards | No Service | Percent of Total Boards |
| 24/7 On-Call Staffing by Psychiatrists | 32 | 64.0% | 2 | 4.0% | 16 | 32.0% |
| 24/7 On-Call Staffing by Clinical Supervisors | 44 | 88.0% | 4 | 8.0% | 2 | 4.0% |
| 24/7 On-Call Staffing by Case Managers | 31 | 62.0% | 3 | 6.0% | 16 | 32.0% |
| Mobile Response for C& A Consumers | 22 | 44.0% | 8 | 16.0% | 20 | 40.0% |
| 24/7 Central Phone Line | 48 | 96.0% | 0 | 0.0% | 2 | 4.0% |
| Crisis Care Facility for Children and Adolescents | 8 | 16.0% | 2 | 4.0% | 40 | 80.0% |
| Hospital Emergency Room with Psychiatric Staff | 16 | 32.0% | 7 | 14.0% | 27 | 54.0% |
| Hospital Contract for C& A Crisis Observation Beds | 4 | 8.0% | 2 | 4.0% | 44 | 88.0% |
| C& A Respite Beds | 9 | 18.0% | 19 | 38.0% | 22 | 44.0% |

1. Less Than One Hour/Percent of Total Boards: (Boards reporting that C& A consumers wait less than one hour for admission) divided by (total Boards in state).
2. More Than One Hour/Percent of Total Boards: (Boards reporting that C& A consumers wait for more than one hour for admission) divided by total Boards in state).
3. No Service/Percent of Total Boards: (Boards reporting that service is C& A Crisis Care service is unavailable) divided by (total Boards in state).

| Question 7.4.1 C & A Crisis Care Service Availability By Rural Board Areas, n=6 | | | | | | |
|---|----------------------|-------------------------|----------------------|-------------------------|------------|-------------------------|
| Approximately How Long C & A Consumers Wait for C & A Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Rural Boards | Service Availability | Percent of Rural Boards | No Service | Percent of Rural Boards |
| 24/7 On-Call Staffing by Psychiatrists | 4 | 66.7% | 1 | 16.7% | 1 | 16.7% |
| 24/7 On-Call Staffing by Clinical Supervisors | 4 | 66.7% | 1 | 16.7% | 1 | 16.7% |
| 24/7 On-Call Staffing by Case Managers | 3 | 50.0% | 1 | 16.7% | 2 | 33.3% |
| Mobile Response for C& A Consumers | 1 | 16.7% | 2 | 33.3% | 3 | 50.0% |
| 24/7 Central Phone Line | 5 | 83.3% | 0 | 0.0% | 1 | 16.7% |
| Crisis Care Facility for Children and Adolescents | 0 | 0.0% | 1 | 16.7% | 5 | 83.3% |
| Hospital Emergency Room with Psychiatric Staff | 2 | 33.3% | 0 | 0.0% | 4 | 66.7% |
| Hospital Contract for C& A Crisis Observation Beds | 0 | 0.0% | 1 | 16.7% | 5 | 83.3% |
| C& A Respite Beds | 1 | 16.7% | 2 | 33.3% | 3 | 50.0% |

1. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van Wert-Mercer-Paulding.
2. Less Than One Hour/Percent of Rural Boards: (Rural Boards reporting that C& A consumers wait less than one hour for admission) divided by (total Rural Boards).
3. More than One Hour/Percent of Rural Boards: (Rural Boards reporting that C& A consumers wait for more than one hour for admission) divided by total Rural Boards).
4. No Service/Percent of Rural Boards: (Boards reporting that C& A Crisis Care service is unavailable) divided by (total Rural Boards).

| Question 7.4.1. C & A Crisis Care Service Availability By Trans-Rural Board Areas, n=17 | | | | | | |
|---|----------------------|-------------------------------|----------------------|-------------------------------|------------|-------------------------------|
| Approximately How Long C & A Consumers Wait for C& A Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Trans-Rural Boards | Service Availability | Percent of Trans-Rural Boards | No Service | Percent of Trans-Rural Boards |
| 24/7 On-Call Staffing by Psychiatrists | 10 | 58.8% | 1 | 5.9% | 6 | 35.3% |
| 24/7 On-Call Staffing by Clinical Supervisors | 15 | 88.2% | 1 | 5.9% | 1 | 5.9% |
| 24/7 On-Call Staffing by Case Managers | 11 | 64.7% | 2 | 11.8% | 4 | 23.5% |
| Mobile Response for C& A Consumers | 10 | 58.8% | 1 | 5.9% | 6 | 35.3% |
| 24/7 Central Phone Line | 16 | 94.1% | 0 | 0.0% | 1 | 5.9% |
| Crisis Care Facility for Children and Adolescents | 2 | 11.8% | 0 | 0.0% | 15 | 88.2% |
| Hospital Emergency Room with Psychiatric Staff | 3 | 17.6% | 3 | 17.6% | 11 | 64.7% |
| Hospital Contract for C& A Crisis Observation Beds | 2 | 11.8% | 1 | 5.9% | 14 | 82.4% |
| C& A Respite Beds | 2 | 11.8% | 7 | 41.2% | 8 | 47.1% |

1. Trans-Rural Boards: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Less Than One Hour/Percent of Trans-Rural Boards: (Trans-Rural Boards reporting that C& A consumers wait less than one hour for admission) divided by (total Trans-Rural Boards).
3. More Than One Hour/Percent of Trans-Rural Boards: (Trans-Rural Boards reporting that C& A consumers wait for more than one hour for admission) divided by (total Trans-Rural Boards in state).
4. No Service/Percent of Trans-Rural Boards: (Trans-Rural Boards reporting that C& A Crisis Care service is unavailable) divided by (Trans-Rural Boards).

| Question 7.4.1. C & A Crisis Care Service Availability By Trans-Metro Board Areas, n=12 | | | | | | |
|---|----------------------|-------------------------------|----------------------|-------------------------------|------------|-------------------------------|
| Approximately How Long C & A Consumers Wait for C & A Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Trans-Metro Boards | Service Availability | Percent of Trans-Metro Boards | No Service | Percent of Trans-Metro Boards |
| 24/7 On-Call Staffing by Psychiatrists | 5 | 41.7% | 0 | 0.0% | 7 | 58.3% |
| 24/7 On-Call Staffing by Clinical Supervisors | 10 | 83.3% | 2 | 16.7% | 0 | 0.0% |
| 24/7 On-Call Staffing by Case Managers | 7 | 58.3% | 0 | 0.0% | 5 | 41.7% |
| Mobile Response for C& A Consumers | 3 | 25.0% | 1 | 8.3% | 8 | 66.7% |
| 24/7 Central Phone Line | 12 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Crisis Care Facility for Children and Adolescents | 0 | 0.0% | 1 | 8.3% | 11 | 91.7% |
| Hospital Emergency Room with Psychiatric Staff | 2 | 16.7% | 4 | 33.3% | 6 | 50.0% |
| Hospital Contract for C& A Crisis Observation Beds | 0 | 0.0% | 0 | 0.0% | 12 | 100.0% |
| C& A Respite Beds | 2 | 16.7% | 5 | 41.7% | 5 | 41.7% |

1. Trans-Metro Boards: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Less Than One Hour/Percent of Trans-Metro Boards: (Trans-Metro Boards reporting that C& A consumers wait less than one hour for admission) divided by (total Trans-Metro Boards).
3. More Than One Hour/Percent of Trans-Metro Boards: (Trans-Metro Boards reporting that C& A consumers wait for more than one hour for admission) divided by (total Trans-Metro Boards in state).
4. No Service/Percent of Trans-Metro Boards: (Trans-Metro Boards reporting that C& A Crisis Care service is unavailable) divided by (total Trans-Metro Boards).

| Question 7.4.1. C & A Crisis Care Service Availability By Metro-Urban Board Areas, n=8 | | | | | | |
|--|----------------------|-------------------------------|----------------------|-------------------------------|------------|-------------------------------|
| Approximately How Long C & A Consumers Wait for C & A Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Metro-Urban Boards | Service Availability | Percent of Metro-Urban Boards | No Service | Percent of Metro-Urban Boards |
| 24/7 On-Call Staffing by Psychiatrists | 6 | 75.0% | 0 | 0.0% | 2 | 25.0% |
| 24/7 On-Call Staffing by Clinical Supervisors | 8 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| 24/7 On-Call Staffing by Case Managers | 6 | 75.0% | 0 | 0.0% | 2 | 25.0% |
| Mobile Response for C& A Consumers | 3 | 37.5% | 2 | 25.0% | 3 | 37.5% |
| 24/7 Central Phone Line | 8 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Crisis Care Facility for Children and Adolescents | 1 | 12.5% | 0 | 0.0% | 7 | 87.5% |
| Hospital Emergency Room with Psychiatric Staff | 4 | 50.0% | 0 | 0.0% | 4 | 50.0% |
| Hospital Contract for C& A Crisis Observation Beds | 1 | 12.5% | 0 | 0.0% | 7 | 87.5% |
| C& A Respite Beds | 1 | 12.5% | 2 | 25.0% | 5 | 62.5% |

1. Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Less Than One Hour/Percent of Metro-Urban Boards: (Metro-Urban Boards reporting that C& A consumers wait less than one hour for admission) divided by (total Metro-Urban Boards).
3. More Than One Hour/Percent of Metro-Urban Boards: (Metro-Urban Boards reporting that C& A consumers wait for more than one hour for admission) divided by (total Metro-Urban Boards in state).
4. No Service/Percent of Metro-Urban Boards: (Metro-Urban Boards reporting that C& A Crisis Care service is unavailable) divided by (total Metro-Urban Boards).

| Question 7.4.1. C & A Crisis Care Service Availability By Urban Board Areas, n=7 | | | | | | |
|--|----------------------|-------------------------|----------------------|-------------------------|------------|-------------------------|
| Approximately How Long C & A Consumers Wait for C& A Crisis Care Admission | | | | | | |
| Service | Less Than One Hour | | More Than One Hour | | No Service | |
| | Service Availability | Percent of Urban Boards | Service Availability | Percent of Urban Boards | No Service | Percent of Urban Boards |
| 24/7 On-Call Staffing by Psychiatrists | 7 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| 24/7 On-Call Staffing by Clinical Supervisors | 7 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| 24/7 On-Call Staffing by Case Managers | 4 | 57.1% | 0 | 0.0% | 3 | 42.9% |
| Mobile Response for C& A Consumers | 5 | 71.4% | 2 | 28.6% | 0 | 0.0% |
| 24/7 Central Phone Line | 7 | 100.0% | 0 | 0.0% | 0 | 0.0% |
| Crisis Care Facility for Children and Adolescents | 5 | 71.4% | 0 | 0.0% | 2 | 28.6% |
| Hospital Emergency Room with Psychiatric Staff | 5 | 71.4% | 0 | 0.0% | 2 | 28.6% |
| Hospital Contract for C& A Crisis Observation Beds | 1 | 14.3% | 0 | 0.0% | 6 | 85.7% |
| C& A Respite Beds | 3 | 42.9% | 3 | 42.9% | 1 | 14.3% |

1. Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Less Than One Hour/Percent of Urban Boards: (Urban Boards reporting that C& A consumers wait less than one hour for admission) divided by (total Urban Boards).
3. More Than One Hour/Percent of Metro-Urban Boards: (Urban Boards reporting that C& A consumers wait for more than one hour for admission) divided by (total Urban Boards in state).
4. No Service/Percent of Urban Boards: (Urban Boards reporting that C& A Crisis Care service is unavailable) divided by (total Urban Boards in state).

Appendix Q – Table for Question 7.4.2.2

| Question 7.4.2.2.1 Services Used in Intensive Care for Child and Adolescent Consumers | | | | | | | | | | |
|---|--------------------------------|-----------------------------------|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|---------------|
| Service Area | Total Boards Offering Services | Percent of Total Boards in Survey | Percent of Boards by Average Number of Working Days C&A Consumers Wait | | | | | | | |
| | | | # Boards Reporting Wait Times | Up to 10 working days | 11 to 15 working days | 16 to 20 working days | 21 to 30 working days | 31 to 60 working days | 61 to 90 working days | 91 wd or more |
| IHBT/MST | 25 | 50% | 23 | 52% | 17% | 13% | 0% | 9% | 4% | 4% |
| PH Type I (Time limited) | 6 | 12% | 6 | 83% | 17% | 0% | 0% | 0% | 0% | 0% |
| PH Type II (School based) | 17 | 34% | 16 | 63% | 13% | 19% | 0% | 6% | 0% | 0% |
| PH Type III | 14 | 28% | 14 | 64% | 14% | 7% | 0% | 0% | 7% | 7% |
| Transitional Living | 9 | 18% | 9 | 56% | 11% | 0% | 11% | 11% | 0% | 11% |
| Therapeutic Pre-School | 8 | 16% | 8 | 38% | 25% | 25% | 0% | 13% | 0% | 0% |
| Treatment Foster Care | 19 | 38% | 15 | 60% | 27% | 0% | 7% | 0% | 7% | 0% |
| Intensive CPST | 35 | 70% | 35 | 66% | 23% | 9% | 3% | 0% | 0% | 0% |
| Intensive Psychiatry | 15 | 30% | 15 | 40% | 20% | 7% | 33% | 0% | 0% | 0% |
| Family Therapy | 39 | 78% | 39 | 41% | 33% | 15% | 5% | 5% | 0% | 0% |
| Other | 12 | 24% | 12 | 67% | 25% | 25% | 8% | 0% | 0% | 0% |

1. Percent of Total Boards in Survey = Total Boards Offering Services divided by 50.

2. Percent of Boards by Average Number of Working Days C&A Consumers Wait = Number of Boards reporting in a wait length category divided by total number of Boards reporting wait times.

Appendix R – Table for Question 7.4.3.1

| Question 7.4.3.1 Services Used in General Care for Child and Adolescent Consumers | | | | | | | | | | |
|---|-------------------------------|-----------------------------------|--|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-----------------------|-------------------------|
| Service Area | Total Boards Offering Service | Percent of Total Boards in Survey | Percent of Boards by Average Number of Working Days C&A Consumers Wait | | | | | | | |
| | | | # Boards Reporting Wait Times | Up to 10 working days | 11 to 15 working days | 16 to 20 working days | 21 to 30 working days | 31 to 60 working days | 61 to 90 working days | 91 working days or more |
| Diagnostic Assessment – Physician | 48 | 96% | 47 | 13% | 13% | 9% | 26% | 34% | 2% | 4% |
| Diagnostic Assessment – Non-Physician | 50 | 100% | 49 | 35% | 39% | 10% | 8% | 8% | 0% | 0% |
| Psychiatry (Med-Somatic) | 50 | 100% | 49 | 10% | 12% | 12% | 29% | 31% | 2% | 4% |
| Counseling/Psychotherapy | 49 | 98% | 49 | 37% | 35% | 12% | 6% | 8% | 0% | 2% |
| CPST | 43 | 86% | 42 | 55% | 17% | 10% | 12% | 5% | 0% | 2% |

1. Percent of Total Boards in Survey = Total Boards Offering Services divided by 50

2. Percent of Boards by Average Number of Working Days C&A Consumers Wait = Number of Boards reporting in a wait length category divided by Total Number of Boards Reporting Wait Times

Appendix S – Tables for Question 7.4.4.1

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|-----------------------------------|-----------------------|---------------------------|--|
| Levels of Service Being Provided by All Boards | | | | |
| Service Area | Number of Boards Offering Service | Percent of All Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Child Clients Served by All Boards |
| Cluster-Based Planning | 19 | 38.0% | 1,583 | 16.16 |
| Early Childhood Care | 40 | 80.0% | 17,031 | 173.91 |
| Family Psycho-Education | 32 | 64.0% | 9,363 | 95.61 |
| Family Therapy | 40 | 80.0% | 14,059 | 143.56 |
| IHBT | 17 | 34.0% | 1,459 | 14.90 |
| Interpreter Services | 38 | 76.0% | 398 | 4.06 |
| MR/MI Integrated Services | 15 | 30.0% | 629 | 6.42 |
| MST | 13 | 26.0% | 351 | 3.58 |
| SAMI Integrated Services | 23 | 46.0% | 1,569 | 16.02 |
| School-Based Services | 49 | 98.0% | 96,685 | 987.30 |
| Sexual Offender Services | 33 | 66.0% | 806 | 8.23 |
| Trauma-focused CBT | 13 | 26.0% | 1,103 | 11.26 |
| Trauma-informed Care | 25 | 50.0% | 1,900 | 19.40 |
| Treatment Foster Care | 20 | 40.0% | 524 | 5.35 |

1. Number of Boards Offering Service is the number of Boards that indicated that they provided the specific service.
 2. Percent of All Boards is (Number of Boards Offering Service) divided by 50 Boards.
 3. Number Served in SFY 2005 is the sum of people whose Board reported was receiving the service.
 4. Number Receiving Service Per 1,000 of Child Clients Served by All Boards is (Number Served in SFY 2005) divided by (Total child clients served by the 50 Boards in SFY 2005) multiplied by 1,000. Denominator: Total Child Clients Served by All Boards.
- Source of Total Child Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------|---------------------------|--|
| Levels of Service Being Provided by Rural Boards; n=6 | | | | |
| Service Area | Number of Rural Boards Offering Service | Percent of All Rural Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Child Clients Served by Rural Boards |
| Cluster-Based Planning | 1 | 16.7% | - | N/A |
| Early Childhood Care | 5 | 83.3% | 1,335 | 196.06 |
| Family Psycho-Education | 4 | 66.7% | 346 | 50.82 |
| Family Therapy | 4 | 66.7% | 731 | 107.36 |
| IHBT | 1 | 16.7% | 31 | 4.55 |
| Interpreter Services | 4 | 66.7% | 6 | 0.88 |
| MR/MI Integrated Services | 2 | 33.3% | 5 | 0.73 |
| MST | 1 | 16.7% | 56 | 8.22 |
| SAMI Integrated Services | 3 | 50.0% | 78 | 11.46 |
| School-Based Services | 6 | 100.0% | 3,243 | 476.28 |
| Sexual Offender Services | 3 | 50.0% | 144 | 21.15 |
| Trauma-focused CBT | 1 | 16.7% | 5 | 0.73 |
| Trauma-informed Care | 3 | 50.0% | 600 | 88.12 |
| Treatment Foster Care | 3 | 50.0% | 261 | 33.33 |

1. Rural Boards are Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van-Wert-Mercer-Paulding.
2. Number of Rural Boards Offering Service is the number of Rural Boards that indicated that they provided the specific service.
3. Percent of All Rural Boards is (Number of Rural Boards Offering Service) divided by 6 Rural Boards.
4. Number Served in SFY 2005 is the sum of people whose Rural Board reported was receiving the service.
5. Number Receiving Service Per 1,000 of Child Clients Served by Rural Boards is (Number Served in SFY 2005) divided by (Total child clients served by the 6 Rural Boards in SFY 2005) multiplied by 1,000. Denominator: Total Child Clients Served by 6 Rural Boards Source of Total Child Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006.

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------------|---------------------------|--|
| Levels of Service Being Provided by Trans-Rural Boards; n=17 | | | | |
| Service Area | Number of Trans-Rural Boards Offering Service | Percent of All Trans-Rural Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Child Clients Served by Trans-Rural Boards |
| Cluster-Based Planning | 7 | 41.2% | 1,080 | 70.38 |
| Early Childhood Care | 13 | 76.5% | 6,500 | 423.59 |
| Family Psycho-Education | 10 | 58.8% | 693 | 45.16 |
| Family Therapy | 11 | 64.7% | 2,463 | 160.51 |
| IHBT | 6 | 35.3% | 378 | 24.63 |
| Interpreter Services | 14 | 82.4% | 85 | 5.54 |
| MR/MI Integrated Services | 4 | 23.5% | 41 | 2.67 |
| MST | 4 | 23.5% | 178 | 11.60 |
| SAMI Integrated Services | 8 | 47.1% | 233 | 15.18 |
| School-Based Services | 16 | 94.1% | 38,653 | 2,518.93 |
| Sexual Offender Services | 11 | 64.7% | 145 | 9.45 |
| Trauma-focused CBT | 2 | 11.8% | 63 | 4.11 |
| Trauma-informed Care | 6 | 35.3% | 258 | 16.81 |
| Treatment Foster Care | 5 | 29.4% | 13 | 0.85 |

1. Trans-Rural Boards are Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Number of Trans-Rural Boards Offering Service is the number of Trans-Rural Boards that indicated that they provided the specific service.
3. Percent of All Trans-Rural Boards is (Number of Trans-Rural Boards Offering Service) divided by 17 Trans-Rural Boards.
4. Number Served in SFY 2005 is the sum of people whose Trans-Rural Board reported were receiving the service.
5. Number Receiving Service Per 1,000 of Child Clients Served by Trans-Rural Boards is (Number Served in SFY 2005) divided by (Total child clients served by the 17 Trans-Rural Boards in SFY 2005) multiplied by 1,000. Denominator: Total Child Clients Served by 17 Trans-Rural Boards Source of Total Child Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------------|---------------------------|--|
| Levels of Service Being Provided by Trans-Metro Boards; n=12 | | | | |
| Service Area | Number of Trans-Metro Boards Offering Service | Percent of All Trans-Metro Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Child Clients Served by Trans-Metro Boards |
| Cluster-Based Planning | 5 | 41.7% | 358 | 22.28 |
| Early Childhood Care | 8 | 66.7% | 3,595 | 223.74 |
| Family Psycho-Education | 6 | 50.0% | 4,700 | 292.51 |
| Family Therapy | 12 | 100.0% | 3,722 | 231.64 |
| IHBT | 4 | 33.3% | 609 | 37.90 |
| Interpreter Services | 9 | 75.0% | 41 | 2.55 |
| MR/MI Integrated Services | 3 | 25.0% | 13 | 0.81 |
| MST | 3 | 25.0% | 28 | 1.74 |
| SAMI Integrated Services | 6 | 50.0% | 315 | 19.6 |
| School-Based Services | 12 | 100.0% | 20,543 | 1,278.50 |
| Sexual Offender Services | 7 | 58.3% | 98 | 6.10 |
| Trauma-focused CBT | 2 | 16.7% | - | 0.00 |
| Trauma-informed Care | 6 | 50.0% | 58 | 3.61 |
| Treatment Foster Care | 4 | 33.3% | 23 | 1.43 |

1. Trans-Metro Boards are Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Number of Trans-Metro Boards Offering Service is the number of Trans-Metro Boards that indicated that they provided the specific service.
3. Percent of All Trans-Metro Boards is (Number of Trans-Metro Boards Offering Service) divided by 12 Trans-Metro Boards.
4. Number Served in SFY 2005 is the sum of people whose Trans-Metro Board reported were receiving the service.
5. Number Receiving Service Per 1,000 of Child Clients Served by Trans-Metro Boards is (Number Served in SFY 2005) divided by (Total child clients served by the 12 Trans-Metro Boards in SFY 2005) multiplied by 1,000. Denominator: Total Child Clients Served by 12 Trans-Metro Boards. Source of Total Child Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006.

Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services

Levels of Service Being Provided by Metro-Urban Boards; n=8

| Service Area | Number of Metro-Urban Boards Offering Service | Percent of All Metro-Urban Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Child Clients Served by Metro-Urban Boards |
|---------------------------|--|--|----------------------------------|---|
| Cluster-Based Planning | 2 | 25.0% | 42 | 2.60 |
| Early Childhood Care | 7 | 87.5% | 3,750 | 231.98 |
| Family Psycho-Education | 6 | 75.0% | 1,946 | 120.38 |
| Family Therapy | 7 | 87.5% | 2,173 | 134.43 |
| IHBT | 2 | 25.0% | 191 | 11.82 |
| Interpreter Services | 5 | 62.5% | 197 | 12.19 |
| MR/MI Integrated Services | 3 | 37.5% | 170 | 10.52 |
| MST | 3 | 37.5% | 89 | 5351 |
| SAMI Integrated Services | 1 | 12.5% | 43 | 2.66 |
| School-Based Services | 8 | 100.0% | 29,946 | 1,852.52 |
| Sexual Offender Services | 5 | 62.5% | 131 | 8.10 |
| Trauma-focused CBT | 4 | 50.0% | 744 | 46.03 |
| Trauma-informed Care | 5 | 62.5% | 432 | 26.72 |
| Treatment Foster Care | 4 | 50.0% | 65 | 4.02 |

1. Metro-Urban Boards are Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Number of Metro-Urban Boards Offering Service is the number of Metro-Urban Boards that indicated that they provided the specific service.
3. Percent of All Metro-Urban Boards is (Number of Metro-Urban Boards Offering Service) divided by 8 Metro-Urban Boards.
4. Number Served in SFY 2005 is the sum of people whose Metro-Urban Board reported were receiving the service.
5. Number Receiving Service Per 1,000 of Child Clients Served by Metro-Urban Boards is (Number Served in SFY 2005) divided by (Total child clients served by the 8 Metro-Urban Boards in SFY 2005) multiplied by 1,000. Denominator: Total Child Clients Served by 8 Metro-Urban Boards. Source of Total Child Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006.

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------|---------------------------|--|
| Levels of Service Being Provided by Urban Boards; n=7 | | | | |
| Service Area | Number of Urban Boards Offering Service | Percent of All Urban Boards | Number Served in SFY 2005 | Number Receiving Service Per 1,000 of Child Clients Served by Urban Boards |
| Cluster-Based Planning | 4 | 57.1% | 103 | 2.37 |
| Early Childhood Care | 7 | 100.0% | 1,851 | 42.51 |
| Family Psycho-Education | 6 | 85.7% | 1,678 | 38.54 |
| Family Therapy | 6 | 85.7% | 4,970 | 114.14 |
| IHBT | 4 | 57.1% | 250 | 5.74 |
| Interpreter Services | 6 | 85.7% | 69 | 1.58 |
| MR/MI Integrated Services | 3 | 42.9% | 400 | 9.19 |
| MST | 2 | 28.6% | - | N/A |
| SAMI Integrated Services | 5 | 71.4% | 900 | 20.67 |
| School-Based Services | 7 | 100.0% | 4,300 | 98.76 |
| Sexual Offender Services | 7 | 100.0% | 288 | 6.61 |
| Trauma-focused CBT | 4 | 57.1% | 291 | 6.68 |
| Trauma-informed Care | 5 | 71.4% | 552 | 12.68 |
| Treatment Foster Care | 4 | 57.1% | 162 | 3.72 |

1. Urban Boards are Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Number of Urban Boards Offering Service is the number of Urban Boards that indicated that they provided the specific service.
3. Percent of All Urban Boards is (Number of Urban Boards Offering Service) divided by 7 Urban Boards.
4. Number Served in SFY 2005 is the sum of people whose Urban Board reported was receiving the service.
5. Number Receiving Service Per 1,000 of Child Clients Served by Urban Boards is (Number Served in SFY 2005) divided by (Total child clients served by the 7 Urban Boards in SFY 2005) multiplied by 1,000. Denominator: Total Child Clients Served by 7 Urban Boards. Source of Total Child Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|-----------------------------------|-----------------------|---|---|
| Number of Boards Using Technical Assistance for a Specific Service Area | | | | |
| Service Area | Boards Offering Service | | Boards Using Technical Assistance | |
| | Number of Boards Offering Service | Percent of All Boards | Number of Boards Using Technical Assistance | Percent of Boards Offering Service and Using Technical Assistance |
| Cluster-Based Planning | 19 | 38.0% | 6 | 31.6% |
| Early Childhood Care | 40 | 80.0% | 19 | 47.5% |
| Family Psycho-Education | 32 | 64.0% | 6 | 18.8% |
| Family Therapy | 40 | 80.0% | 8 | 20.0% |
| IHBT | 17 | 34.0% | 5 | 29.4% |
| Interpreter Services | 38 | 76.0% | 2 | 5.3% |
| MR/MI Integrated Services | 15 | 30.0% | 5 | 33.3% |
| MST | 13 | 26.0% | 8 | 61.5% |
| SAMI Integrated Services | 23 | 46.0% | 7 | 30.4% |
| School-Based Services | 49 | 98.0% | 13 | 26.5% |
| Sexual Offender Services | 33 | 66.0% | 6 | 18.2% |
| Trauma-focused CBT | 13 | 26.0% | 5 | 38.5% |
| Trauma-informed Care | 25 | 50.0% | 8 | 32.0% |
| Treatment Foster Care | 20 | 40.0% | - | 0.0% |

1. Number of Boards Offering Service is the number of Boards that indicated that they provided the specific service.
2. Percent of All Boards is (Number of Boards Offering Service) divided by 50 Boards.
3. Number of Boards Using Technical Assistance is the number of Boards that reported that they were using technical assistance.
4. Percent of Boards Offering Services and Using Technical Assistance is (Number of Boards Using Technical Assistance) divided by (Number of Boards Offering Service).

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------|---|---|
| Number of Rural Boards Using Technical Assistance for a Specific Service Area | | | | |
| Service Area | Rural Boards Offering Service | | Rural Boards Using Technical Assistance | |
| | Number of Rural Boards Offering Service | Percent of All Rural Boards | Number of Rural Boards Using Technical Assistance | Percent of Rural Boards Offering Service and Using Technical Assistance |
| Cluster-Based Planning | 1 | 16.7% | - | 0.0% |
| Early Childhood Care | 5 | 83.3% | 1 | 20.0% |
| Family Psycho-Education | 4 | 66.7% | - | 0.0% |
| Family Therapy | 4 | 66.7% | - | 0.0% |
| IHBT | 1 | 16.7% | - | 0.0% |
| Interpreter Services | 4 | 66.7% | - | 0.0% |
| MR/MI Integrated Services | 2 | 33.3% | - | 0.0% |
| MST | 1 | 16.7% | - | 0.0% |
| SAMI Integrated Services | 3 | 50.0% | - | 0.0% |
| School-Based Services | 6 | 100.0% | 1 | 16.7% |
| Sexual Offender Services | 3 | 50.0% | 1 | 33.3% |
| Trauma-focused CBT | 1 | 16.7% | - | 0.0% |
| Trauma-informed Care | 3 | 50.0% | - | 0.0% |
| Treatment Foster Care | 3 | 50.0% | - | 0.0% |

1. Rural Boards are Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van Wert-Mercer-Paulding.
2. Number of Rural Boards Offering Service is the number of rural Boards that indicated that they provided the specific service.
3. Percent of All Rural Boards is (Number of Rural Boards Offering Service) divided by 6 Boards.
4. Number of Rural Boards Using Technical Assistance is the number of rural Boards that reported that they were using technical assistance.
5. Percent of Rural Boards Offering Services and Technical Assistance is (Number of Rural Boards Using Technical Assistance) divided by (Number of Rural Boards Offering Service).

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------------|---|---|
| Number of Trans-Rural Boards Using Technical Assistance for a Specific Service Area | | | | |
| Service Area | Trans-Rural Boards Offering Service | | Trans-Rural Boards Using Technical Assistance | |
| | Number of Trans-Rural Boards Offering Service | Percent of All Trans-Rural Boards | Number of Trans-Rural Boards Using Technical Assistance | Percent of Trans-Rural Boards Offering Service and Using Technical Assistance |
| Cluster-Based Planning | 7 | 41.2% | 4 | 57.1% |
| Early Childhood Care | 13 | 76.5% | 8 | 61.5% |
| Family Psycho-Education | 10 | 58.8% | 2 | 20.0% |
| Family Therapy | 11 | 64.7% | 4 | 0.0% |
| IHBT | 6 | 35.3% | 2 | 33.3% |
| Interpreter Services | 14 | 82.4% | 2 | 14.3% |
| MR/MI Integrated Services | 4 | 23.5% | 2 | 50.0% |
| MST | 4 | 23.5% | 4 | 100.0% |
| SAMI Integrated Services | 8 | 47.1% | 3 | 37.5% |
| School-Based Services | 16 | 94.1% | 6 | 37.5% |
| Sexual Offender Services | 11 | 64.7% | 3 | 27.3% |
| Trauma-focused CBT | 2 | 11.8% | 2 | 100.0% |
| Trauma-informed Care | 6 | 35.3% | 4 | 66.7% |
| Treatment Foster Care | 5 | 29.4% | - | 0.0% |

1. Trans-Rural Boards are Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Number of Trans-Rural Boards Offering Service is the number of trans-rural Boards that indicated that they provided the specific service.
3. Percent of All Trans-Rural Boards is (Number of Trans-Rural Boards Offering Service) divided by 17 Boards.
4. Number of Trans-Rural Boards Using Technical Assistance is the number of trans-rural Boards that reported that they were using technical assistance.
5. Percent of Trans-Rural Boards Offering Services and Using Technical Assistance is (Number of Trans-Rural Boards Using Technical Assistance) divided by (Number of Trans-Rural Boards Offering Service).

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------------|---|---|
| Number of Trans-Metro Boards Using Technical Assistance for a Specific Service Area | | | | |
| Service Area | Trans-Metro Boards Offering Service | | Trans-Metro Boards Using Technical Assistance | |
| | Number of Trans-Metro Boards Offering Service | Percent of All Trans-Metro Boards | Number of Trans-Metro Boards Using Technical Assistance | Percent of Trans-Metro Boards Offering Service and Using Technical Assistance |
| Cluster-Based Planning | 5 | 41.7% | 1 | 20.0% |
| Early Childhood Care | 8 | 66.7% | 3 | 37.5% |
| Family Psycho-Education | 6 | 50.0% | 1 | 16.7% |
| Family Therapy | 12 | 100.0% | - | 0.0% |
| IHBT | 4 | 33.3% | 2 | 50.0% |
| Interpreter Services | 9 | 75.0% | - | 0.0% |
| MR/MI Integrated Services | 3 | 25.0% | 1 | 33.3% |
| MST | 3 | 25.0% | 1 | 33.3% |
| SAMI Integrated Services | 6 | 50.0% | 1 | 16.7% |
| School-Based Services | 12 | 100.0% | 1 | 8.3% |
| Sexual Offender Services | 7 | 58.3% | - | 0.0% |
| Trauma-focused CBT | 2 | 16.7% | - | 0.0% |
| Trauma-informed Care | 6 | 50.0% | - | 0.0% |
| Treatment Foster Care | 4 | 33.3% | - | 0.0% |

1. Trans-Metro Boards are Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Number of Trans-Metro Boards Offering Service is the number of trans-metro Boards that indicated that they provided the specific service.
3. Percent of All Trans-Metro Boards is (Number of Trans-Metro Boards Offering Service) divided by 12 Boards.
4. Number of Trans-Metro Boards Using Technical Assistance is the number of trans-metro Boards that reported that they were using technical assistance.
5. Percent of Trans-Metro Boards Offering Services and Using Technical Assistance is (Number of Trans-Metro Boards Using Technical Assistance) divided by (Number of Trans-Metro Boards Offering Service).

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------------|---|---|
| Number of Metro-Urban Boards Using Technical Assistance for a Specific Service Area | | | | |
| Service Area | Metro-Urban Boards Offering Service | | Metro-Urban Boards Using Technical Assistance | |
| | Number of Metro-Urban Boards Offering Service | Percent of All Metro-Urban Boards | Number of Metro-Urban Boards Using Technical Assistance | Percent of Metro-Urban Boards Offering Service and Using Technical Assistance |
| Cluster-Based Planning | 2 | 25.0% | - | 0.0% |
| Early Childhood Care | 7 | 87.5% | 4 | 57.1% |
| Family Psycho-Education | 6 | 75.0% | 2 | 33.3% |
| Family Therapy | 7 | 87.5% | 2 | 0.0% |
| IHBT | 2 | 25.0% | - | 0.0% |
| Interpreter Services | 5 | 62.5% | - | 0.0% |
| MR/MI Integrated Services | 3 | 37.5% | 1 | 33.3% |
| MST | 3 | 37.5% | 2 | 66.7% |
| SAMI Integrated Services | 1 | 12.5% | 1 | 100.0% |
| School-Based Services | 8 | 100.0% | 2 | 25.0% |
| Sexual Offender Services | 5 | 62.5% | 1 | 20.0% |
| Trauma-focused CBT | 4 | 50.0% | 2 | 50.0% |
| Trauma-informed Care | 5 | 62.5% | 3 | 60.0% |
| Treatment Foster Care | 4 | 50.0% | - | 0.0% |

1. Metro-Urban Boards are Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Number of Metro-Urban Boards Offering Service is the number of metro-urban Boards that indicated that they provided the specific service.
3. Percent of All Metro-Urban Boards is (Number of Metro-Urban Boards Offering Service) divided by 8 Boards.
4. Number of Metro-Urban Boards Using Technical Assistance is the number of metro-urban Boards that reported that they were using technical assistance.
5. Percent of Metro-Urban Boards Offering Services and Technical Assistance is (Number of Metro-Urban Boards Using Technical Assistance) divided by (Number of Metro-Urban Boards Offering Service).

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | |
|---|---|-----------------------------|---|---|
| Number of Urban Boards Using Technical Assistance for a Specific Service Area | | | | |
| Service Area | Urban Boards Offering Service | | Urban Boards Using Technical Assistance | |
| | Number of Urban Boards Offering Service | Percent of All Urban Boards | Number of Urban Boards Using Technical Assistance | Percent of Urban Boards Offering Service and Using Technical Assistance |
| Cluster-Based Planning | 4 | 57.1% | 1 | 25.0% |
| Early Childhood Care | 7 | 100.0% | 3 | 42.9% |
| Family Psycho-Education | 6 | 85.7% | 1 | 16.7% |
| Family Therapy | 6 | 85.7% | 2 | 0.0% |
| IHBT | 4 | 57.1% | 1 | 25.0% |
| Interpreter Services | 6 | 85.7% | - | 0.0% |
| MR/MI Integrated Services | 3 | 42.9% | 1 | 33.3% |
| MST | 2 | 28.6% | 1 | 50.0% |
| SAMI Integrated Services | 5 | 71.4% | 2 | 40.0% |
| School-Based Services | 7 | 100.0% | 3 | 42.9% |
| Sexual Offender Services | 7 | 100.0% | 1 | 14.3% |
| Trauma-focused CBT | 4 | 57.1% | 1 | 25.0% |
| Trauma-informed Care | 5 | 71.4% | 1 | 20.0% |
| Treatment Foster Care | 4 | 57.1% | - | 0.0% |

1. Urban Boards are Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Number of Urban Boards Offering Service is the number of urban Boards that indicated that they provided the specific service.
3. Percent of All Urban Boards is (Number of Urban Boards Offering Service) divided by 7 Boards.
4. Number of Urban Boards Using Technical Assistance is the number of urban Boards that reported that they were using technical assistance.
5. Percent of Urban Boards Offering Services and Using Technical Assistance is (Number of Urban Boards Using Technical Assistance) divided by (Number of Urban Boards Offering Service).

Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services

Number of Boards Needing Technical Assistance for a Specific Service Area

| Service Area | Boards Offering Service | | | Boards Not Currently Offering Service | | | Statewide | |
|---------------------------|-----------------------------------|--|--|---------------------------------------|--|---|-----------------------------------|------------------------------|
| | Number of Boards Offering Service | Percent of All Boards Offering Service | Number of Boards Offering Service and Needing TA | Number of Boards Not Offering Service | Percent of All Boards Not Offering Service | Number of Boards Not Offering Service, but Needing TA | Total Number of Boards Needing TA | Percent of Boards Needing TA |
| Cluster-Based Planning | 19 | 38.0% | 1 | 31 | 62.0% | 4 | 5 | 10.0% |
| Early Childhood Care | 40 | 80.0% | 8 | 10 | 20.0% | - | 8 | 16.0% |
| Family Psycho-Education | 32 | 64.0% | 1 | 18 | 36.0% | 2 | 3 | 6.0% |
| Family Therapy | 40 | 80.0% | 1 | 10 | 20.0% | 1 | 2 | 4.0% |
| IHBT | 17 | 34.0% | 1 | 33 | 66.0% | 5 | 6 | 12.0% |
| Interpreter Services | 38 | 76.0% | - | 12 | 24.0% | - | - | 0.0% |
| MR/MI Integrated Services | 15 | 30.0% | 1 | 35 | 70.0% | 2 | 3 | 6.0% |
| MST | 13 | 26.0% | 1 | 37 | 74.0% | 4 | 5 | 10.0% |
| SAMI Integrated Services | 23 | 46.0% | 2 | 27 | 54.0% | 3 | 5 | 10.0% |
| School-Based Services | 49 | 98.0% | 4 | 1 | 2.0% | - | 4 | 8.0% |
| Sexual Offender Services | 33 | 66.0% | 2 | 17 | 34.0% | 3 | 5 | 10.0% |
| Trauma-focused CBT | 13 | 26.0% | 2 | 37 | 74.0% | 8 | 10 | 20.0% |
| Trauma-informed Care | 25 | 50.0% | 3 | 25 | 50.0% | 5 | 8 | 16.0% |
| Treatment Foster Care | 20 | 40.0% | - | 30 | 60.0% | - | - | 0.0% |

1. Number of Boards Offering Service is the number of Boards that indicated that they provided the specific service.
2. Percent of All Boards Offering Service is (Number of Boards Offering Service) divided by 50 Boards.
3. Number of Boards Offering Service and Needing Technical Assistance is the number of Boards that reported that they offered the service and needed technical assistance for the specific service area.
4. Number of Boards Not Offering Service is the number of Boards that indicated that they did not provide the specific service.
5. Percent of All Boards Not Offering Service is (Number of Boards Not Offering Service) divided by 50.
6. Number of Boards Not Offering Service and Needing TA is the number of Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
7. Total Number of Boards Needing TA is the sum of all Boards that reported that they needed technical assistance for the specific service area.
8. Percent of Boards Needing TA is (Total Number of Boards Needing TA) divided by 50.

Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services

Number of Rural Boards Needing Technical Assistance for a Specific Service Area

| Service Area | Rural Boards Offering Service | | | Rural Boards Not Currently Offering Service | | | Total Rural Boards | |
|---------------------------|---|------------------------------------|--|---|--|---|-------------------------------|------------------------------|
| | Number of Rural Boards Offering Service | % of Rural Boards Offering Service | Number of Rural Boards Offering Service and Needing TA | Number of Rural Boards Not Offering Service | % of Rural Boards Not Offering Service | Number of Rural Boards Not Offering Service, but Needing TA | Total Rural Boards Needing TA | % of Rural Boards Needing TA |
| Cluster-Based Planning | 1 | 16.7% | - | 5 | 83.3% | 1 | 1 | 16.7% |
| Early Childhood Care | 5 | 83.3% | 1 | 1 | 16.7% | - | 1 | 16.7% |
| Family Psycho-Education | 4 | 66.7% | - | 2 | 33.3% | 1 | 1 | 16.7% |
| Family Therapy | 4 | 66.7% | - | 2 | 33.3% | - | - | 0.0% |
| IHBT | 1 | 16.7% | - | 5 | 83.3% | 1 | 1 | 16.7% |
| Interpreter Services | 4 | 66.7% | - | 2 | 33.3% | - | - | 0.0% |
| MR/MI Integrated Services | 2 | 33.3% | - | 4 | 66.7% | - | - | 0.0% |
| MST | 1 | 16.7% | - | 5 | 83.3% | - | - | 0.0% |
| SAMI Integrated Services | 3 | 50.0% | - | 3 | 50.0% | 1 | 1 | 16.7% |
| School-Based Services | 6 | 100.0% | 1 | - | 0.0% | - | 1 | 16.7% |
| Sexual Offender Services | 3 | 50.0% | - | 3 | 50.0% | - | - | 0.0% |
| Trauma-focused CBT | 1 | 16.7% | - | 5 | 83.3% | - | - | 0.0% |
| Trauma-informed Care | 3 | 50.0% | - | 3 | 50.0% | 1 | 1 | 16.7% |
| Treatment Foster Care | 3 | 50.0% | - | 3 | 50.0% | - | - | 0.0% |

1. Rural Boards are Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van Wert-Mercer-Paulding.
2. Number of Rural Boards Offering Service is the number of rural Boards that indicated that they provided the specific service.
3. % of All Rural Boards Offering Service is (Number of Rural Boards Offering Service) divided by 6 Boards.
4. Number of Rural Boards Offering Service and Needing Technical Assistance is the number of rural Boards that reported that they offered the service and needed technical assistance for the specific service area.
5. Number of Rural Boards Not Offering Service is the number of rural Boards that indicated that they did not provide the specific service.
6. % of All Rural Boards Not Offering Service is (Number of Rural Boards Not Offering Service) divided by 6.
7. Number of Rural Boards Not Offering Service and Needing TA is the number of rural Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
8. Total Rural Boards Needing TA is the sum of all rural Boards that reported that they needed technical assistance for the specific service area.
9. % of Rural Boards Needing TA is (Total Number of Rural Boards Needing TA) divided by 6.

| Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services | | | | | | | | |
|---|---|--|--|---|--|---|-------------------------------------|------------------------------------|
| Number of Trans-Rural Boards Needing Technical Assistance for a Specific Service Area | | | | | | | | |
| Service Area | Trans-Rural Boards Offering Service | | | Trans-Rural Boards Not Currently Offering Service | | | Total Trans-Rural Boards | |
| | Number of Trans-Rural Boards Offering Service | % of Trans-Rural Boards Offering Service | Number of Trans-Rural Boards Offering Service and Needing TA | Number of Trans-Rural Boards Not Offering Service | % of Trans-Rural Boards Not Offering Service | Number of Trans-Rural Boards Not Offering Service, but Needing TA | Total Trans-Rural Boards Needing TA | % of Trans-Rural Boards Needing TA |
| Cluster-Based Planning | 7 | 41.2% | 1 | 10 | 58.8% | 2 | 3 | 17.6% |
| Early Childhood Care | 13 | 76.5% | 3 | 4 | 23.5% | - | 3 | 17.6% |
| Family Psycho-Education | 10 | 58.8% | - | 7 | 41.2% | 1 | 1 | 5.9% |
| Family Therapy | 11 | 64.7% | - | 6 | 35.3% | 1 | 1 | 5.9% |
| IHBT | 6 | 35.3% | - | 11 | 64.7% | 1 | 1 | 5.9% |
| Interpreter Services | 14 | 82.4% | - | 3 | 17.6% | - | - | 0.0% |
| MR/MI Integrated Services | 4 | 23.5% | - | 13 | 76.5% | 2 | 2 | 11.8% |
| MST | 4 | 23.5% | - | 13 | 76.5% | - | - | 0.0% |
| SAMI Integrated Services | 8 | 47.1% | 1 | 9 | 52.9% | 2 | 3 | 17.6% |
| School-Based Services | 16 | 94.1% | 2 | 1 | 5.9% | - | 2 | 11.8% |
| Sexual Offender Services | 11 | 64.7% | 1 | 6 | 35.3% | 1 | 2 | 11.8% |
| Trauma-focused CBT | 2 | 11.8% | 1 | 15 | 88.2% | 3 | 4 | 23.5% |
| Trauma-informed Care | 6 | 35.3% | 2 | 11 | 64.7% | 2 | 4 | 23.5% |
| Treatment Foster Care | 5 | 29.4% | - | 12 | 70.6% | - | - | 0.0% |

1. Trans-Rural Boards are Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Number of Trans-Rural Boards Offering Service is the number of trans-rural Boards that indicated that they provided the specific service.
3. % of All Trans-Rural Boards Offering Service is (Number of Trans-Rural Boards Offering Service) divided by 17 Boards.
4. Number of Trans-Rural Boards Offering Service and Needing Technical Assistance is the number of trans-rural Boards that reported that they offered the service and needed technical assistance for the specific service area.
5. Number of Trans-Rural Boards Not Offering Service is the number of trans-rural Boards that indicated that they did not provide the specific service.
6. % of All Trans-Rural Boards Not Offering Service is (Number of Trans-Rural Boards Not Offering Service) divided by 17.
7. Number of Trans-Rural Boards Not Offering Service and Needing TA is the number of trans-rural Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
8. Total Trans-Rural Boards Needing TA is the sum of all trans-rural Boards that reported that they needed technical assistance for the specific service area.
9. % of Trans-Rural Boards Needing TA is (Total Number of Trans-Rural Boards Needing TA) divided by 17.

Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services

Number of Trans-Metro Boards Needing Technical Assistance for a Specific Service Area

| Service Area | Trans-Metro Boards Offering Service | | | Trans-Metro Boards Not Currently Offering Service | | | Total Trans-Metro Boards | |
|---------------------------|---|--|--|---|--|---|-------------------------------------|------------------------------------|
| | Number of Trans-Metro Boards Offering Service | % of Trans-Metro Boards Offering Service | Number of Trans-Metro Boards Offering Service and Needing TA | Number of Trans-Metro Boards Not Offering Service | % of Trans-Metro Boards Not Offering Service | Number of Trans-Metro Boards Not Offering Service, but Needing TA | Total Trans-Metro Boards Needing TA | % of Trans-Metro Boards Needing TA |
| Cluster-Based Planning | 5 | 41.7% | - | 7 | 58.3% | 1 | 1 | 8.3% |
| Early Childhood Care | 8 | 66.7% | 3 | 4 | 33.3% | - | 3 | 25.0% |
| Family Psycho-Education | 6 | 50.0% | 1 | 6 | 50.0% | - | 1 | 8.3% |
| Family Therapy | 12 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| IHBT | 4 | 33.3% | 1 | 8 | 66.7% | 3 | 4 | 33.3% |
| Interpreter Services | 9 | 75.0% | - | 3 | 25.0% | - | - | 0.0% |
| MR/MI Integrated Services | 3 | 25.0% | 1 | 9 | 75.0% | - | 1 | 8.3% |
| MST | 3 | 25.0% | - | 9 | 75.0% | 3 | 3 | 25.0% |
| SAMI Integrated Services | 6 | 50.0% | - | 6 | 50.0% | - | - | 0.0% |
| School-Based Services | 12 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| Sexual Offender Services | 7 | 58.3% | - | 5 | 41.7% | 2 | 2 | 16.7% |
| Trauma-focused CBT | 2 | 16.7% | - | 10 | 83.3% | 3 | 3 | 25.0% |
| Trauma-informed Care | 6 | 50.0% | - | 6 | 50.0% | 2 | 2 | 16.7% |
| Treatment Foster Care | 4 | 33.3% | - | 8 | 66.7% | - | - | 0.0% |

1. Trans-Metro Boards are Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood.
2. Number of Trans-Metro Boards Offering Service is the number of trans-metro Boards that indicated that they provided the specific service.
3. % of All Trans-Metro Boards Offering Service is (Number of Trans-Metro Boards Offering Service) divided by 12 Boards.
4. Number of Trans-Metro Boards Offering Service and Needing Technical Assistance is the number of trans-metro Boards that reported that they offered the service and needed technical assistance for the specific service area.
5. Number of Trans-Metro Boards Not Offering Service is the number of trans-metro Boards that indicated that they did not provide the specific service.
6. % of All Trans-Metro Boards Not Offering Service is (Number of Trans-Metro Boards Not Offering Service) divided by 12.
7. Number of Trans-Metro Boards Not Offering Service and Needing TA is the number of trans-metro Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.
8. Total Trans-Metro Boards Needing TA is the sum of all trans-metro Boards that reported that they needed technical assistance for the specific service area.
9. % of Trans-Metro Boards Needing TA is (Total Number of Trans-Metro Boards Needing TA) divided by 12.

Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services

Number of Metro-Urban Boards Needing Technical Assistance for a Specific Service Area

| Service Area | Metro-Urban Boards Offering Service | | | Metro-Urban Boards Not Currently Offering Service | | | Total Metro-Urban Boards | |
|---------------------------|---|--|--|---|--|---|-------------------------------------|------------------------------------|
| | Number of Metro-Urban Boards Offering Service | % of Metro-Urban Boards Offering Service | Number of Metro-Urban Boards Offering Service and Needing TA | Number of Metro-Urban Boards Not Offering Service | % of Metro-Urban Boards Not Offering Service | Number of Metro-Urban Boards Not Offering Service, but Needing TA | Total Metro-Urban Boards Needing TA | % of Metro-Urban Boards Needing TA |
| Cluster-Based Planning | 2 | 25.0% | - | 6 | 75.0% | - | - | 0.0% |
| Early Childhood Care | 7 | 87.5% | 1 | 1 | 12.5% | - | 1 | 12.5% |
| Family Psycho-Education | 6 | 75.0% | - | 2 | 25.0% | - | - | 0.0% |
| Family Therapy | 7 | 87.5% | 1 | 1 | 12.5% | - | 1 | 12.5% |
| IHBT | 2 | 25.0% | - | 6 | 75.0% | - | - | 0.0% |
| Interpreter Services | 5 | 62.5% | - | 3 | 37.5% | - | - | 0.0% |
| MR/MI Integrated Services | 3 | 37.5% | - | 5 | 62.5% | - | - | 0.0% |
| MST | 3 | 37.5% | 1 | 5 | 62.5% | - | 1 | 12.5% |
| SAMI Integrated Services | 1 | 12.5% | 1 | 7 | 87.5% | - | 1 | 12.5% |
| School-Based Services | 8 | 100.0% | 1 | - | 0.0% | - | 1 | 12.5% |
| Sexual Offender Services | 5 | 62.5% | - | 3 | 37.5% | - | - | 0.0% |
| Trauma-focused CBT | 4 | 50.0% | 1 | 4 | 50.0% | - | 1 | 12.5% |
| Trauma-informed Care | 5 | 62.5% | 1 | 3 | 37.5% | - | 1 | 12.5% |
| Treatment Foster Care | 4 | 50.0% | - | 4 | 50.0% | - | - | 0.0% |

1. Metro-Urban Boards are Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.

2. Number of Metro-Urban Boards Offering Service is the number of trans-metro Boards that indicated that they provided the specific service.

3. % of All Metro-Urban Boards Offering Service is (Number of Metro-Urban Boards Offering Service) divided by 8 Boards.

4. Number of Metro-Urban Boards Offering Service and Needing Technical Assistance is the number of metro-urban Boards that reported that they offered the service and needed technical assistance for the specific service area.

5. Number of Metro-Urban Boards Not Offering Service is the number of metro-urban Boards that indicated that they did not provide the specific service.

6. % of All Metro-Urban Boards Not Offering Service is (Number of Metro-Urban Boards Not Offering Service) divided by 8.

7. Number of Metro-Urban Boards Not Offering Service and Needing TA is the number of metro-urban Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.

8. Total Metro-Urban Boards Needing TA is the sum of all metro-urban Boards that reported that they needed technical assistance for the specific service area.

9. % of Metro-Urban Boards Needing TA is (Total Number of Metro-Urban Boards Needing TA) divided by 8.

Question 7.4.4.1. Promising, Best, and Evidence-Based Practices and Other Children's Services

Number of Urban Boards Needing Technical Assistance for a Specific Service Area

| Service Area | Urban Boards Offering Service | | | Urban Boards Not Currently Offering Service | | | Total Urban Boards | |
|---------------------------|---|------------------------------------|--|---|--|---|-------------------------------|------------------------------|
| | Number of Urban Boards Offering Service | % of Urban Boards Offering Service | Number of Urban Boards Offering Service and Needing TA | Number of Urban Boards Not Offering Service | Percent of Urban Boards Not Offering Service | Number of Urban Boards Not Offering Service, but Needing TA | Total Urban Boards Needing TA | % of Urban Boards Needing TA |
| Cluster-Based Planning | 4 | 57.1% | - | 3 | 42.9% | - | - | 0.0% |
| Early Childhood Care | 7 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| Family Psycho-Education | 6 | 85.7% | - | 1 | 14.3% | - | - | 0.0% |
| Family Therapy | 6 | 85.7% | - | 1 | 14.3% | - | - | 0.0% |
| IHBT | 4 | 57.1% | - | 3 | 42.9% | - | - | 0.0% |
| Interpreter Services | 6 | 85.7% | - | 1 | 14.3% | - | - | 0.0% |
| MR/MI Integrated Services | 3 | 42.9% | - | 4 | 57.1% | - | - | 0.0% |
| MST | 2 | 28.6% | - | 5 | 71.4% | 1 | 1 | 14.3% |
| SAMI Integrated Services | 5 | 71.4% | - | 2 | 28.6% | - | - | 0.0% |
| School-Based Services | 7 | 100.0% | - | - | 0.0% | - | - | 0.0% |
| Sexual Offender Services | 7 | 100.0% | 1 | - | 0.0% | - | 1 | 14.3% |
| Trauma-focused CBT | 4 | 57.1% | - | 3 | 42.9% | 1 | 1 | 14.3% |
| Trauma-informed Care | 5 | 71.4% | - | 2 | 28.6% | - | - | 0.0% |
| Treatment Foster Care | 4 | 57.1% | - | 3 | 42.9% | - | - | 0.0% |

1. Urban Boards are Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.

2. Number of Urban Boards Offering Service is the number of urban Boards that indicated that they provided the specific service.

3. % of All Urban Boards Offering Service is (Number of Urban Boards Offering Service) divided by 7 Boards.

4. Number of Urban Boards Offering Service and Needing Technical Assistance is the number of urban Boards that reported that they offered the service and needed technical assistance for the specific service area.

5. Number of Urban Boards Not Offering Service is the number of urban Boards that indicated that they did not provide the specific service.

6. % of All Urban Boards Not Offering Service is (Number of Urban Boards Not Offering Service) divided by 7.

7. Number of Urban Boards Not Offering Service and Needing TA is the number of urban Boards that reported that they did not offer the service, but needed technical assistance for the specific service area.

8. Total Urban Boards Needing TA is the sum of all urban Boards that reported that they needed technical assistance for the specific service area.

9. % of Urban Boards Needing TA is (Total Number of Urban Boards Needing TA) divided by 7.

Appendix T – Tables for Question 7.4.5.1

| Question 7.4.5.1 Boards Reporting the Availability of School-Based Programs at Mainstream and Other Schools in the Board Area | | | | | | |
|--|--|---|--|---|---|--|
| Service | Mainstream Schools | | Other Schools | | No Service | |
| | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting No Service Available | Percent of Boards Reporting No Service Available |
| Assessment | 36 | 72.0% | 30 | 60.0% | 9 | 18.0% |
| Intervention | 45 | 90.0% | 33 | 66.0% | 2 | 4.0% |
| Mental Health Education & Promotion | 42 | 84.0% | 30 | 60.0% | 5 | 10.0% |
| Primary Prevention | 44 | 88.0% | 25 | 50.0% | 5 | 10.0% |
| Secondary (Targeted) Prevention | 38 | 76.0% | 20 | 40.0% | 9 | 18.0% |

1. Mainstream Schools--Number of Boards Reporting Service Available: Number of Boards that indicated that service is available in a mainstream school in the Board area.
2. Mainstream Schools--Percent of Boards Reporting Service Available: (Number of Boards Reporting Service Available in mainstream schools) divided by 50.
3. Other Schools--Number of Boards Reporting Service Available: Number of Boards that indicated that service is available in other schools in the Board area.
4. Other Schools--Percent of Boards Reporting Service Available: (Number of Boards Reporting Service Available in other schools) divided by 50.
5. No Service--Number of Boards Reporting No Service Available: Number of Boards that indicated that service is not available in any schools in the Board area.
6. No Service--Percent of Boards Reporting No Service Available: (Number of Boards Reporting No Service Available) divided by 50.

Question 7.4.5.1 Rural Boards Reporting the Availability of School-Based Programs

at Mainstream and Other Schools in the Rural Board Areas, n=6

| Service | Mainstream Schools | | Other Schools | | No Service | |
|-------------------------------------|--|---|--|---|---|--|
| | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting No Service Available | Percent of Boards Reporting No Service Available |
| Assessment | 4 | 66.7% | 2 | 33.3% | 2 | 33.3% |
| Intervention | 6 | 100.0% | 3 | 50.0% | 0 | 0.0% |
| Mental Health Education & Promotion | 5 | 83.3% | 3 | 50.0% | 0 | 0.0% |
| Primary Prevention | 5 | 83.3% | 1 | 16.7% | 1 | 16.7% |
| Secondary (Targeted) Prevention | 5 | 83.3% | 2 | 33.3% | 1 | 16.7% |

1. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam and, Van Wert-Mercer-Paulding
2. Mainstream Schools--Number of Rural Boards Reporting Service Available: Number of Rural Boards that indicated that service is available in a mainstream school in Rural Board area.
3. Mainstream Schools--Percent of Rural Boards Reporting Service Available: (Number of Rural Boards Reporting Service Available in mainstream schools) divided by 6.
4. Other Schools--Number of Rural Boards Reporting Service Available: Number of Rural Boards that indicated that service is available in other schools in the Rural Board area.
5. Other Schools--Percent of Rural Boards Reporting Service Available: (Number of Rural Boards Reporting Service Available in other schools) divided by 6.
6. No Service--Number of Rural Boards Reporting No Service Available: Number of Rural Boards that indicated that service is not available in any schools in the Rural Board area.
7. No Service--Percent of Rural Boards Reporting No Service Available: (Number of Rural Boards Reporting No Service Available) divided by 6.

Question 7.4.5.1 Trans-Rural Boards Reporting the Availability of School-Based Programs

at Mainstream and Other Schools in the Trans-Rural Board Areas, n=17

| Service | Mainstream Schools | | Other Schools | | No Service | |
|-------------------------------------|--|---|--|---|---|--|
| | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting No Service Available | Percent of Boards Reporting No Service Available |
| Assessment | 11 | 64.7% | 12 | 70.6% | 3 | 17.6% |
| Intervention | 14 | 82.4% | 12 | 70.6% | 1 | 5.9% |
| Mental Health Education & Promotion | 13 | 76.5% | 12 | 70.6% | 2 | 11.8% |
| Primary Prevention | 15 | 88.2% | 9 | 52.9% | 1 | 5.9% |
| Secondary (Targeted) Prevention | 11 | 64.7% | 7 | 41.2% | 3 | 17.6% |

1. Trans-Rural Boards: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
2. Mainstream Schools--Number of Trans-Rural Boards Reporting Service Available: Number of Trans-Rural Boards that indicated that service is available in a mainstream school in Trans-Rural Board area.
3. Mainstream Schools--Percent of Trans-Rural Boards Reporting Service Available: (Number of Trans-Rural Boards Reporting Service Available in mainstream schools) divided by 17.
4. Other Schools--Number of Trans-Rural Boards Reporting Service Available: Number of Trans-Rural Boards that indicated that service is available in other schools in the Trans-Rural Board area.
5. Other Schools--Percent of Trans-Rural Boards Reporting Service Available: (Number of Trans-Rural Boards Reporting Service Available in other schools) divided by 17.
6. No Service--Number of Trans-Rural Boards Reporting No Service Available: Number of Trans-Rural Boards that indicated that service is not available in any schools in the Trans-Rural Board area.
7. No Service--Percent of Trans-Rural Boards Reporting No Service Available: (Number of Trans-Rural Boards Reporting No Service Available) divided by 17.

Question 7.4.5.1 Trans-Metro Boards Reporting the Availability of School-Based Programs

at Mainstream and Other Schools in the Trans-Metro Board Areas, n=12

| Service | Mainstream Schools | | Other Schools | | No Service | |
|-------------------------------------|--|---|--|---|---|--|
| | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting No Service Available | Percent of Boards Reporting No Service Available |
| Assessment | 9 | 75.0% | 6 | 50.0% | 2 | 16.7% |
| Intervention | 12 | 100.0% | 8 | 66.7% | 0 | 0.0% |
| Mental Health Education & Promotion | 11 | 91.7% | 5 | 41.7% | 1 | 8.3% |
| Primary Prevention | 10 | 83.3% | 4 | 33.3% | 2 | 16.7% |
| Secondary (Targeted) Prevention | 9 | 75.0% | 4 | 33.3% | 3 | 25.0% |

1. Trans-Metro Boards: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood
2. Mainstream Schools--Number of Trans-Metro Boards Reporting Service Available: Number of Trans-Metro Boards that indicated that service is available in a mainstream school in Trans-Metro Board area.
3. Mainstream Schools--Percent of Trans-Metro Boards Reporting Service Available: (Number of Trans-Metro Boards Reporting Service Available in mainstream schools) divided by 12.
4. Other Schools--Number of Trans-Metro Boards Reporting Service Available: Number of Trans-Metro Boards that indicated that service is available in other schools in the Trans-Metro Board area.
5. Other Schools--Percent of Trans-Metro Boards Reporting Service Available: (Number of Trans-Metro Boards Reporting Service Available in other schools) divided by 12.
6. No Service--Number of Trans-Metro Boards Reporting No Service Available: Number of Trans-Metro Boards that indicated that service is not available in any schools in the Trans-Metro Board area.
7. No Service--Percent of Trans-Metro Boards Reporting No Service Available: (Number of Trans-Metro Boards Reporting No Service Available) divided by 12.

Question 7.4.5.1 Metro-Urban Boards Reporting the Availability of School-Based Programs

at Mainstream and Other Schools in the Metro-Urban Board Areas, n=8

| Service | Mainstream Schools | | Other Schools | | No Service | |
|-------------------------------------|--|---|--|---|---|--|
| | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting No Service Available | Percent of Boards Reporting No Service Available |
| Assessment | 7 | 87.5% | 6 | 75.0% | 1 | 12.5% |
| Intervention | 7 | 87.5% | 5 | 62.5% | 1 | 12.5% |
| Mental Health Education & Promotion | 7 | 87.5% | 6 | 75.0% | 1 | 12.5% |
| Primary Prevention | 7 | 87.5% | 6 | 75.0% | 1 | 12.5% |
| Secondary (Targeted) Prevention | 7 | 87.5% | 3 | 37.5% | 1 | 12.5% |

1. Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull
2. Mainstream Schools--Number of Metro-Urban Boards Reporting Service Available: Number of Metro-Urban Boards that indicated that service is available in a mainstream school in Metro-Urban Board area.
3. Mainstream Schools--Percent of Metro-Urban Boards Reporting Service Available: (Number of Metro-Urban Boards Reporting Service Available in mainstream schools) divided by 8.
4. Other Schools--Number of Metro-Urban Boards Reporting Service Available: Number of Metro-Urban Boards that indicated that service is available in other schools in the Metro-Urban Board area.
5. Other Schools--Percent of Metro-Urban Boards Reporting Service Available: (Number of Metro-Urban Boards Reporting Service Available in other schools) divided by 8.
6. No Service--Number of Metro-Urban Boards Reporting No Service Available: Number of Metro-Urban Boards that indicated that service is not available in any schools in the Metro-Urban Board area.
7. No Service--Percent of Metro-Urban Boards Reporting No Service Available: (Number of Metro-Urban Boards Reporting No Service Available) divided by 8.

Question 7.4.5.1 Urban Boards Reporting the Availability of School-Based Programs

at Mainstream and Other Schools in the Urban Board Areas, n=7

| Service | Mainstream Schools | | Other Schools | | No Service | |
|-------------------------------------|--|---|--|---|---|--|
| | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting Service Available | Percent of Boards Reporting Service Available | Number of Boards Reporting No Service Available | Percent of Boards Reporting No Service Available |
| Assessment | 5 | 71.4% | 4 | 57.1% | 1 | 14.3% |
| Intervention | 6 | 85.7% | 5 | 71.4% | 0 | 0.0% |
| Mental Health Education & Promotion | 6 | 85.7% | 4 | 57.1% | 1 | 14.3% |
| Primary Prevention | 7 | 100.0% | 5 | 71.4% | 0 | 0.0% |
| Secondary (Targeted) Prevention | 6 | 85.7% | 4 | 57.1% | 1 | 14.3% |

1. Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit
2. Mainstream Schools--Number of Urban Boards Reporting Service Available: Number of Urban Boards that indicated that service is available in a mainstream school in Urban Board area.
3. Mainstream Schools--Percent of Urban Boards Reporting Service Available: (Number of Urban Boards Reporting Service Available in mainstream schools) divided by 7.
4. Other Schools--Number of Urban Boards Reporting Service Available: Number of Urban Boards that indicated that service is available in other schools in the Urban Board area.
5. Other Schools--Percent of Urban Boards Reporting Service Available: (Number of Urban Boards Reporting Service Available in other schools) divided by 7.
6. No Service--Number of Urban Boards Reporting No Service Available: Number of Urban Boards that indicated that service is not available in any schools in the Urban Board area.
7. No Service--Percent of Urban Boards Reporting No Service Available: (Number of Urban Boards Reporting No Service Available) divided by 7.

Appendix U – Table for Question 7.4.5.2

| 7.4.5.2. School Districts in Which Boards Provided Services in SFY 2006 | | | | |
|---|---|---|-------------------------------------|---------------------|
| By Geographical Area Classification | | | | |
| Geographical Classifications | Number of Boards Offering Services in School Districts/ School Programs | % of Boards Offering Services in School Districts/School Programs | Number of School Districts/Programs | Number of Buildings |
| Rural | 5 | 83.3% | 35 | 147 |
| Trans-Rural | 16 | 94.1% | 146 | 405 |
| Trans-Metro | 12 | 100.0% | 109 | 378 |
| Metro-Urban | 7 | 87.5% | 48 | 188 |
| Urban | 7 | 100.0% | 42 | 357 |
| Statewide | 47 | 94.0% | 380 | 1,475 |

1. Geographical Classifications:
 - a. Rural Boards: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam and, Van Wert-Mercer-Paulding
 - b. Trans-Rural Boards: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
 - c. Trans-Metro Boards: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood
 - d. Metro-Urban Boards: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull
 - e. Urban Boards: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit
2. Number of Boards That Offer Services in School Districts is the number of Boards that reported that they provided at least one service in at least one school district or program in SFY 2006.
3. % of Boards Offering Services in School Districts is (number of Boards that reported that they provided at least one service in at least one school district or program) divided by (number of Boards within the geographical classification).
4. The denominator by Board geographical area classification is as follows: Rural--6; Trans-Rural--17; Trans-Metro--12; Metro-Urban--8, Urban--7; Statewide--50.
5. Number of School Districts/Programs is the count of school districts or Board area school programs where Boards offered services in SFY 2006.
6. Caveats: While the question asked Boards to identify school districts, 13 Boards identified special community-wide school programs in which Boards provide services. Also, 5 Boards listed school district names in one record rather providing a record for each individual school district. The listings in a single record were not necessarily complete since the Boards listed a few district names followed by "etc."
7. Number of buildings is the count of buildings where the Board provided services in SFY 2006. Caveat: Six Boards identified the school district but were unable to provide the number of buildings where Boards offered the service within the school district or special community-wide school program.

Appendix V – Table for Question 7.5.3.1

| Question 7.5.3.1. Prevention, Consultation & Education (P, C & E) Inventory | | | | | | | |
|---|---------------------------------|---------------------|--------------------------|----------------------|---------|----------------|-------------|
| Categories | Domains | | | | | | Total |
| | Treatment & Intervention Issues | Population Specific | Service Delivery Context | Psycho-Social Skills | Generic | Social Support | % of Sample |
| Suicide Prevention | 39% | | | | | | 11.00% |
| Violence/Trauma | 30% | | | | | | 8.00% |
| Depression | 13% | | | | | | 4.00% |
| AOD | 11% | | | | | | 3.00% |
| Health | 5% | | | | | | 1.00% |
| Stigma | 2% | | | | | | 1.00% |
| ECMH | | 49% | | | | | 10.00% |
| Youth | | 21% | | | | | 4.00% |
| Culture Specific | | 12% | | | | | 2.00% |
| Older Adults | | 10% | | | | | 2.00% |
| MR/DD | | 8% | | | | | 2.00% |
| Homeless | | 1% | | | | | 0.00% |
| School-based | | | 54% | | | | 10.00% |
| Crisis/CIT | | | 18% | | | | 3.00% |
| Justice | | | 11% | | | | 2.00% |
| Cluster/FCFC | | | 10% | | | | 2.00% |
| Other Context | | | 6% | | | | 1.00% |
| Parenting | | | | 36% | | | 5.00% |
| Other Program | | | | 18% | | | 2.00% |
| Recovery | | | | 13% | | | 2.00% |
| Conflict Resolution | | | | 10% | | | 1.00% |
| Life Skills | | | | 8% | | | 1.00% |
| Stress Management | | | | 8% | | | 1.00% |
| Relationships | | | | 7% | | | 1.00% |
| Unclassified | | | | | 100% | | 13.00% |
| Family/NAMI | | | | | | 29% | 2.00% |
| Mentoring/BBBC | | | | | | 26% | 2.00% |
| Grief & Loss | | | | | | 23% | 2.00% |
| Advocacy | | | | | | 13% | 1.00% |
| Peer | | | | | | 10% | 1.00% |
| | | | | | | | |
| | | | | | | | |
| Total N | 132 | 92 | 87 | 61 | 59 | 31 | 462 |
| | | | | | | | |
| % Total | 29% | 20% | 19% | 13% | 13% | 7% | 100% |

Appendix W – Tables for Question 7.5.4.1

| Question 7.5.4.1: Approximately How Much Was Disbursed on Medication by Funding Source for All Boards? | | | | | | |
|--|---|-----------------|---------------|--|-----------|----------|
| Medication Source | Number of Boards Reporting Source Provided Medication Funds | % of All Boards | Amount Funded | Estimated % of Adult Consumers Whose Medication Was Funded by the Source | | |
| | | | | Minimum % | Maximum % | Average% |
| 419 Allocation | 50 | 100.00% | \$ 7,789,300 | 0.24% | 85.00% | 11.40% |
| Board Funds | 34 | 68.00% | \$ 4,540,125 | 0.29% | 52.00% | 10.41% |
| Local Indigent Programs | 12 | 24.00% | \$ 478,056 | 0.20% | 26.00% | 3.29% |
| Pharmaceutical Company Samples | 25 | 50.00% | \$ 8,591,313 | 0.90% | 95.00% | 34.50% |
| Pharmaceutical Company Assistance Programs | 22 | 44.00% | \$ 5,583,056 | 4.00% | 45.00% | 6.36% |

1. Number of Boards Reporting Source Provided Medication Funds to Consumers is the number of Boards that entered a dollar amount greater than zero for the amount funded.
2. % of Boards is (Number of Boards Reporting Funds Were Disbursed to Consumers) divided by 50 Boards.
3. Amount Funded is the sum of the Amount Funded for all Boards reporting funds were disbursed to consumers.
4. Minimum % is the lowest value in the range of estimates provided by the Boards for adult consumers whose medication was funded by the source. It excludes Boards that entered a dollar amount greater than zero for the amount funded but did not provide an estimate for the % of adult consumers whose medication was funded by the source. Number of Boards excluded by source is as follows: 419 Allocation--9; Board Funds--13; Local Indigent Programs--3; Pharmaceutical Company Samples--1; Pharmaceutical Company Assistance--2.
5. Maximum % is the highest value in the range of estimates provided by the Boards for adult consumers whose medication was funded by the source.
6. Average % is (sum of estimated % of adult consumers whose medication was funded by source for all Boards) divided by (the number of Boards that reported an estimated % for the funding source). Denominators by funding source are as follows: 419 Allocation Boards--41; Board Funds--21; Local Indigent Programs--9; Pharmaceutical Company Samples--24, and Pharmaceutical Company Assistance--20.
7. Cautionary Note: These results should be interpreted with caution due to both a wide range of percentages reported and the possibility that some Boards may have interpreted the question differently.

| Question 7.5.4.1: Approximately How Much Was Disbursed on Medication by Funding Source for Rural Boards? | | | | | | |
|--|---|-------------------|---------------|--|-----------|-----------|
| Medication Source | Number of Rural Boards Reporting Source Provided Medication Funds | % of Rural Boards | Amount Funded | Estimated % of Adult Consumers Whose Medication Was Funded by the Source | | |
| | | | | Minimum % | Maximum % | Average % |
| 419 Allocation | 6 | 100.00% | \$ 457,351 | 0.90% | 23.00% | 7.10% |
| Board Funds | 4 | 66.67% | \$ 87,700 | 6.00% | 6.00% | 6.00% |
| Local Indigent Programs | 3 | 50.00% | \$ 85,105 | 0.90% | 1.00% | 0.93% |
| Pharmaceutical Company Samples | 3 | 50.00% | \$ 538,600 | 1.00% | 70.00% | 26.30% |
| Pharmaceutical Company Assistance Programs | 1 | 16.67% | \$ 300,000 | 5.00% | 5.00% | 5.00% |

1. Number of Rural Boards Reporting Source Provided Medication Funds to Consumers is the number of Boards that entered a dollar amount greater than zero for the amount funded.
2. % of Rural Boards is (Number of Rural Boards Reporting Funds Were Disbursed to Consumers) divided by 6 Boards.
3. Amount Funded is the sum of the Amount Funded for Rural Boards reporting funds were disbursed to consumers.
4. Minimum % is the lowest value in the range of estimates provided by the Rural Boards for adult consumers whose medication was funded by the source. It excludes Rural Boards that entered a dollar amount greater than zero for the amount funded but did not provide an estimate for the % of adult consumers whose medication was funded by the source. Number of Rural Boards excluded by source is as follows: 419 Allocation--2; Board Funds--3; Local Indigent Programs--0; Pharmaceutical Company Samples--0; Pharmaceutical Company Assistance--0.
5. Maximum % is the highest value in the range of estimates provided by the Rural Boards for adult consumers whose medication was funded by the source.
6. Average % is (sum of estimated % of adult consumers whose medication was funded by source for Rural Boards) divided by (the number of Rural Boards that reported an estimated % for the funding source). Denominators by funding source are as follows: 419 Allocation Boards--4; Board Funds--1; Local Indigent Programs--3; Pharmaceutical Company Samples--3, and Pharmaceutical Company Assistance--1.
7. Rural Boards are as follows: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Van Wert-Mercer-Paulding.
8. Cautionary Note: These results should be interpreted with caution due to both a wide range of percentages reported and the possibility that some Boards may have interpreted the question differently.

| Question 7.5.4.1: Approximately How Much Was Disbursed on Medication by Funding Source for Trans-Rural Boards? | | | | | | |
|--|---|-------------------------|---------------|--|-----------|----------|
| Medication Source | Number of Trans-Rural Boards Reporting Source Provided Medication Funds | % of Trans-Rural Boards | Amount Funded | Estimated % of Adult Consumers Whose Medication Was Funded by the Source | | |
| | | | | Minimum % | Maximum % | Average% |
| 419 Allocation | 17 | 100.00% | \$ 1,122,686 | 0.40% | 26.00% | 7.87% |
| Board Funds | 8 | 47.06% | \$ 847,555 | 0.30% | 7.00% | 2.20% |
| Local Indigent Programs | 5 | 29.41% | \$ 175,603 | 0.20% | 26.00% | 7.30% |
| Pharmaceutical Company Samples | 10 | 58.82% | \$ 2,428,390 | 0.90% | 83.00% | 32.20% |
| Pharmaceutical Company Assistance Programs | 10 | 58.82% | \$ 1,164,802 | 4.00% | 33.00% | 13.33% |

1. Number of Trans-Rural Boards Reporting Source Provided Medication Funds to Consumers is the number of Boards that entered a dollar amount greater than zero for the amount funded.
2. % of Trans-Rural Boards is (Number of Trans-Rural Boards Reporting Funds Were Disbursed to Consumers) divided by 17 Boards.
3. Amount Funded is the sum of the Amount Funded for Trans-Rural Boards reporting funds were disbursed to consumers.
4. Minimum % is the lowest value in the range of estimates provided by the Trans-Rural Boards for adult consumers whose medication was funded by the source. It excludes Trans-Rural Boards that entered a dollar amount greater than zero for the amount funded but did not provide an estimate for the % of adult consumers whose medication was funded by the source. Number of Trans-Rural Boards excluded by source is as follows: 419 Allocation--3; Board Funds--4; Local Indigent Programs--0; Pharmaceutical Company Samples--1; Pharmaceutical Company Assistance--2.
5. Maximum % is the highest value in the range of estimates provided by the Trans-Rural Boards for adult consumers whose medication was funded by the source.
6. Average % is (sum of estimated % of adult consumers whose medication was funded by source for Trans-Rural Boards) divided by (the number of Trans-Rural Boards that reported an estimated % for the funding source). Denominators by funding source are as follows: 419 Allocation Boards--14; Board Funds--4; Local Indigent Programs--5; Pharmaceutical Company Samples--9, and Pharmaceutical Company Assistance--8.
7. Trans-Rural Boards are as follows: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, Washington, and Wayne-Holmes.
8. Cautionary Note: These results should be interpreted with caution due to both a wide range of percentages reported and the possibility that some Boards may have interpreted the question differently.

| Question 7.5.4.1: Approximately How Much Was Disbursed on Medication by Funding Source for Trans-Metro Boards? | | | | | | |
|--|---|-------------------------|---------------|--|-----------|----------|
| Medication Source | Number of Trans-Metro Boards Reporting Source Provided Medication Funds | % of Trans-Metro Boards | Amount Funded | Estimated % of Adult Consumers Whose Medication Was Funded by the Source | | |
| | | | | Minimum % | Maximum % | Average% |
| 419 Allocation | 12 | 100.00% | \$ 1,164,553 | 0.30% | 20.00% | 8.24% |
| Board Funds | 8 | 66.67% | \$ 492,311 | 1.00% | 52.00% | 11.80% |
| Local Indigent Programs | 2 | 16.67% | \$ 46,700 | 1.30% | 1.30% | 1.30% |
| Pharmaceutical Company Samples | 5 | 41.67% | \$ 2,755,076 | 12.00% | 85.00% | 43.40% |
| Pharmaceutical Company Assistance Programs | 4 | 33.33% | \$ 1,021,254 | 11.00% | 45.00% | 23.50% |

1. Number of Trans-Metro Boards Reporting Source Provided Medication Funds to Consumers is the number of Boards that entered a dollar amount greater than zero for the amount funded.
2. % of Trans-Metro Boards is (Number of Trans-Metro Boards Reporting Funds Were Disbursed to Consumers) divided by 12 Boards.
3. Amount Funded is the sum of the Amount Funded for Trans-Metro Boards reporting funds were disbursed to consumers.
4. Minimum % is the lowest value in the range of estimates provided by the Trans-Metro Boards for adult consumers whose medication was funded by the source. It excludes Trans-Metro Boards that entered a dollar amount greater than zero for the amount funded but did not provide an estimate for the % of adult consumers whose medication was funded by the source. Number of Trans-Metro Boards excluded by source is as follows: 419 Allocation--1; Board Funds--3; Local Indigent Programs--1; Pharmaceutical Company Samples--0; Pharmaceutical Company Assistance--0.
5. Maximum % is the highest value in the range of estimates provided by the Trans-Metro Boards for adult consumers whose medication was funded by the source.
6. Average % is (sum of estimated % of adult consumers whose medication was funded by source for Trans-Metro Boards) divided by (the number of Trans-Metro Boards that reported an estimated % for the funding source). Denominators by funding source are as follows: 419 Allocation Boards--11; Board Funds--5; Local Indigent Programs--1; Pharmaceutical Company Samples--5, and Pharmaceutical Company Assistance--4.
7. Trans-Metro Boards are as follows: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood
8. Cautionary Note: These results should be interpreted with caution due to both a wide range of percentages reported and the possibility that some Boards may have interpreted the question differently.

| Question 7.5.4.1: Approximately How Much Was Disbursed on Medication by Funding Source for Metro-Urban Boards? | | | | | | |
|--|---|-------------------------|---------------|--|-----------|----------|
| Medication Source | Number of Metro-Urban Boards Reporting Source Provided Medication Funds | % of Metro-Urban Boards | Amount Funded | Estimated % of Adult Consumers Whose Medication Was Funded by the Source | | |
| | | | | Minimum % | Maximum % | Average% |
| 419 Allocation | 8 | 100.00% | \$ 1,193,114 | 6.00% | 85.00% | 23.40% |
| Board Funds | 7 | 87.50% | \$ 201,581 | 2.00% | 50.00% | 14.40% |
| Local Indigent Programs | 2 | 25.00% | \$ 170,648 | NA | NA | NA |
| Pharmaceutical Company Samples | 5 | 62.50% | \$ 1,723,316 | 10.00% | 95.00% | 39.40% |
| Pharmaceutical Company Assistance Programs | 4 | 50.00% | \$ 1,273,656 | 5.00% | 31.00% | 18.25% |

1. Number of Metro -Urban Boards Reporting Source Provided Medication Funds to Consumers is the number of Boards that entered a dollar amount greater than zero for the amount funded.
2. % of Metro-Urban Boards is (Number of Metro-Urban Boards Reporting Funds Were Disbursed to Consumers) divided by 8 Boards.
3. Amount Funded is the sum of the Amount Funded for Metro-Urban Boards reporting funds were disbursed to consumers.
4. Minimum % is the lowest value in the range of estimates provided by the Metro-Urban Boards for adult consumers whose medication was funded by the source. It excludes Metro-Urban Boards that entered a dollar amount greater than zero for the amount funded but did not provide an estimate for the % of adult consumers whose medication was funded by the source. Number of Metro-Urban Boards excluded by source is as follows: 419 Allocation--1; Board Funds--2; Local Indigent Programs--2; Pharmaceutical Company Samples--0; Pharmaceutical Company Assistance--0.
5. Maximum % is the highest value in the range of estimates provided by the Metro-Urban Boards for adult consumers whose medication was funded by the source.
6. Average % is (sum of estimated % of adult consumers whose medication was funded by source for Metro-Urban Boards) divided by (the number of Metro-Urban Boards that reported an estimated % for the funding source). Denominators by funding source are as follows: 419 Allocation Boards--7; Board Funds--5; Local Indigent Programs--not applicable; Pharmaceutical Company Samples--5, and Pharmaceutical Company Assistance--4.
7. Metro-Urban Boards are as follows: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
8. Cautionary Note: These results should be interpreted with caution due to both a wide range of percentages reported and the possibility that some Boards may have interpreted the question differently.

| Question 7.5.4.1: Approximately How Much Was Disbursed on Medication by Funding Source for Urban Boards? | | | | | | |
|--|---|-------------------|---------------|--|-----------|----------|
| Medication Source | Number of Urban Boards Reporting Source Provided Medication Funds | % of Urban Boards | Amount Funded | Estimated % of Adult Consumers Whose Medication Was Funded by the Source | | |
| | | | | Minimum % | Maximum % | Average% |
| 419 Allocation | 7 | 100.00% | \$ 3,851,596 | 0.20% | 24.43% | 15.30% |
| Board Funds | 7 | 100.00% | \$ 2,910,978 | 13.00% | 38.00% | 14.92% |
| Local Indigent Programs | 0 | 0.00% | \$ - | NA | NA | NA |
| Pharmaceutical Company Samples | 2 | 28.57% | \$ 1,145,931 | 11.20% | 35.00% | 23.10% |
| Pharmaceutical Company Assistance Programs | 3 | 42.86% | \$ 1,823,344 | 6.36% | 43.00% | 23.10% |

1. Number of Urban Boards Reporting Source Provided Medication Funds to Consumers is the number of Boards that entered a dollar amount greater than zero for the amount funded.
2. % of Boards is (Number of Urban Boards Reporting Funds Were Disbursed to Consumers) divided by 7 Boards.
3. Amount Funded is the sum of the Amount Funded for all Boards reporting funds were disbursed to consumers.
4. Minimum % is the lowest value in the range of estimates provided by the Urban Boards for adult consumers whose medication was funded by the source. It excludes Urban Boards that entered a dollar amount greater than zero for the amount funded but did not provide an estimate for the % of adult consumers whose medication was funded by the source. Number of Urban Boards excluded by source is as follows: 419 Allocation--2; Board Funds--2; Local Indigent Programs--NA; Pharmaceutical Company Samples--0, and Pharmaceutical Company Assistance Programs--0.
5. Maximum % is the highest value in the range of estimates provided by the Urban Boards for adult consumers whose medication was funded by the source.
6. Average % is (sum of estimated % of adult consumers whose medication was funded by source for Urban Boards) divided by (the number of Boards that reported an estimated % for the funding source). Denominators by funding source are as follows: 419 Allocation Boards--5; Board Funds--5; Local Indigent Program--NA, Pharmaceutical Company Samples--2, and Pharmaceutical Company Assistance--3.
7. Urban Boards are as follows: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
8. Cautionary Note: These results should be interpreted with caution due to both a wide range of percentages reported and the possibility that some Boards may have interpreted the question differently.

Appendix X – Tables for Question 7.5.5.2

| Question 7.5.5.2. How Many of Adult Med-Somatic Practitioners Are Currently Under Contract in the Board Area? | | | | | | | |
|---|------------------|-------------------|------------|--------------|---------|---------|-------------------|
| by Type of Practitioner, by All Boards | | | | | | | |
| Type of Med-Somatic Practitioner | Number of Boards | Percent of Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 Adults |
| Psychiatrist FTEs | 48 | 96.00% | 248.70 | 5.20 | 0.20 | 55.60 | 0.27 |
| General Practice Physician FTEs | 3 | 6.00% | 1.40 | 0.50 | 0.01 | 1.00 | 0.02 |
| Advanced Nurse Practitioner FTEs | 20 | 40.00% | 60.30 | 3.00 | 0.22 | 15.00 | 0.16 |
| Other MD or DO FTEs | 3 | 6.00% | 4.20 | 1.40 | 0.20 | 3.44 | 0.07 |

1. Number of Boards equal total Boards that reported FTEs for the Type of Med-Somatic Practitioner.
2. Percent of Boards is the number of Boards for the Type of Med-Somatic Practitioner divided by 50 Boards.
3. Total FTEs is the sum of all FTEs reported by Boards for the Type of Med-Somatic Practitioner.
4. Average FTEs is the (Total FTEs) divided by number of Boards reporting FTEs for Type of Med-Somatic Practitioner.
5. Minimum is the lowest number of FTEs reported by a Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
6. Maximum is the highest number of FTEs reported by a Board for the Type of Med-Somatic Practitioner.
7. Per 10,000 Adult Clients = (Average FTEs divided by total number of Adult clients for 50 Boards) multiplied by 10,000.
8. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.2. How Many of Adult Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Rural Boards

| Type of Med-Somatic Practitioner | Number of Rural Boards | Percent of Rural Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 Adults |
|----------------------------------|------------------------|-------------------------|------------|--------------|---------|---------|-------------------|
| Psychiatrist FTEs | 6 | 100.00% | 12.00 | 2.00 | 0.35 | 2.80 | 1.45 |
| General Practice Physician FTEs | 1 | 16.67% | 0.40 | 0.40 | 0.40 | 0.40 | 0.29 |
| Advanced Nurse Practitioner FTEs | 2 | 33.33% | 2.10 | 1.05 | 0.60 | 1.50 | 0.76 |
| Other MD or DO FTEs | 1 | 16.67% | 0.20 | 0.20 | 0.20 | 0.20 | 0.14 |

1. Rural Boards include: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Mercer-Van Wert-Paulding.
2. Number of Rural Boards equal total Rural Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Rural Boards is the number of Rural Boards for the Type of Med-Somatic Practitioner divided by 6 Rural Boards.
4. Total FTEs is the sum of all FTEs reported by Rural Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by number of Rural Boards reporting FTEs for Type of Med-Somatic Practitioner.
6. Minimum is the lowest number of FTEs reported by a Rural Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by a Rural Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 Adult Clients = (Average FTEs divided by total number of Adult clients for 6 Rural Boards) multiplied by 10,000.
9. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.2. How Many of Adult Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Trans-Rural Boards

| Type of Med-Somatic Practitioner | Number of Trans-Rural Boards | Percent of Trans-Rural Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 Adults |
|----------------------------------|------------------------------|-------------------------------|------------|--------------|---------|---------|-------------------|
| Psychiatrist FTEs | 17 | 100.00% | 28.88 | 2.41 | 0.20 | 5.00 | 0.57 |
| General Practice Physician FTEs | 1 | 5.88% | 0.00 | 0.00 | 0.00 | 1.00 | 0.00 |
| Advanced Nurse Practitioner FTEs | 4 | 23.53% | 8.80 | 2.93 | 0.80 | 2.40 | 0.35 |
| Other MD or DO FTEs | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

1. Trans-Rural Boards include: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, and Washington.
2. Number of Trans-Rural Boards equal total Trans-Rural Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Trans-Rural Boards is the number of Trans-Rural Boards for the Type of Med-Somatic Practitioner divided by 17 Trans-Rural Boards.
4. Total FTEs is the sum of all FTEs reported by Trans-Rural Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by number of Trans-Rural Boards reporting FTEs for Type of Med-Somatic Practitioner.
6. Minimum is the lowest number of FTEs reported by a Trans-Rural Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by a Trans-Rural Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 Adult Clients = (Average FTEs divided by total number of Adult clients for 17 Trans-Rural Boards) multiplied by 10,000.
9. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.2. How Many of Adult Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Trans-Metro Boards

| Type of Med-Somatic Practitioner | Number of Trans-Metro Boards | Percent of Trans-Metro Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 Adults |
|----------------------------------|------------------------------|-------------------------------|------------|--------------|---------|---------|-------------------|
| Psychiatrist FTEs | 10 | 83.33% | 27.78 | 2.78 | 1.98 | 4.38 | 0.77 |
| General Practice Physician FTEs | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Advanced Nurse Practitioner FTEs | 2 | 16.67% | 8.00 | 4.00 | 3.00 | 5.00 | 0.94 |
| Other MD or DO FTEs | 1 | 8.33% | 0.56 | 0.56 | 0.56 | 0.56 | 0.18 |

1. Trans-Metro Boards include: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood
2. Number of Trans-Metro Boards equal total Trans-Metro Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Trans-Metro Boards is the number of Trans-Metro Boards for the Type of Med-Somatic Practitioner divided by 12 Trans-Metro Boards.
4. Total FTEs is the sum of all FTEs reported by Trans-Metro Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by number of Trans-Metro Boards reporting FTEs for Type of Med-Somatic Practitioner.
6. Minimum is the lowest number of FTEs reported by a Trans-Metro Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by a Trans-Metro Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 Adult Clients = (Average FTEs divided by total number of Adult clients for 12 Trans-Metro Boards) multiplied by 10,000.
9. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.2. How Many of Adult Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Metro-Urban Boards

| Type of Med-Somatic Practitioner | Number of Metro-Urban Boards | Percent of Metro-Urban Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 Adults |
|----------------------------------|------------------------------|-------------------------------|------------|--------------|---------|---------|-------------------|
| Psychiatrist FTEs | 7 | 87.50% | 34.68 | 4.95 | 1.00 | 8.50 | 1.64 |
| General Practice Physician FTEs | 1 | 12.50% | 0.01 | 0.01 | 0.01 | 0.01 | 0.00 |
| Advanced Nurse Practitioner FTEs | 6 | 75.00% | 19.98 | 3.33 | 0.48 | 15.00 | 1.11 |
| Other MD or DO FTEs | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

1. Metro-Urban Boards include: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Number of Metro-Urban Boards equal total Metro-Urban Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Metro-Urban Boards is the number of Metro-Urban Boards for the Type of Med-Somatic Practitioner divided by 8 Metro-Urban Boards.
4. Total FTEs is the sum of all FTEs reported by Metro-Urban Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by number of Metro-Urban Boards reporting FTEs for Type of Med-Somatic Practitioner.
6. Minimum is the lowest number of FTEs reported by a Metro-Urban Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by a Metro-Urban Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 Adult Clients = (Average FTEs divided by total number of Adult clients for 8 Metro-Urban Boards) multiplied by 10,000.
9. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.2. How Many of Adult Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Urban Board

| Type of Med-Somatic Practitioner | Number of Urban Boards | Percent of Urban Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 Adults |
|----------------------------------|------------------------|-------------------------|------------|--------------|---------|---------|-------------------|
| Psychiatrist FTEs | 6 | 85.71% | 141.39 | 23.57 | 2.28 | 55.60 | 2.38 |
| General Practice Physician FTEs | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Advanced Nurse Practitioner FTEs | 5 | 71.43% | 24.75 | 4.95 | 1.50 | 12.75 | 0.59 |
| Other MD or DO FTEs | 1 | 14.29% | 3.44 | 3.44 | 3.44 | 3.44 | 0.41 |

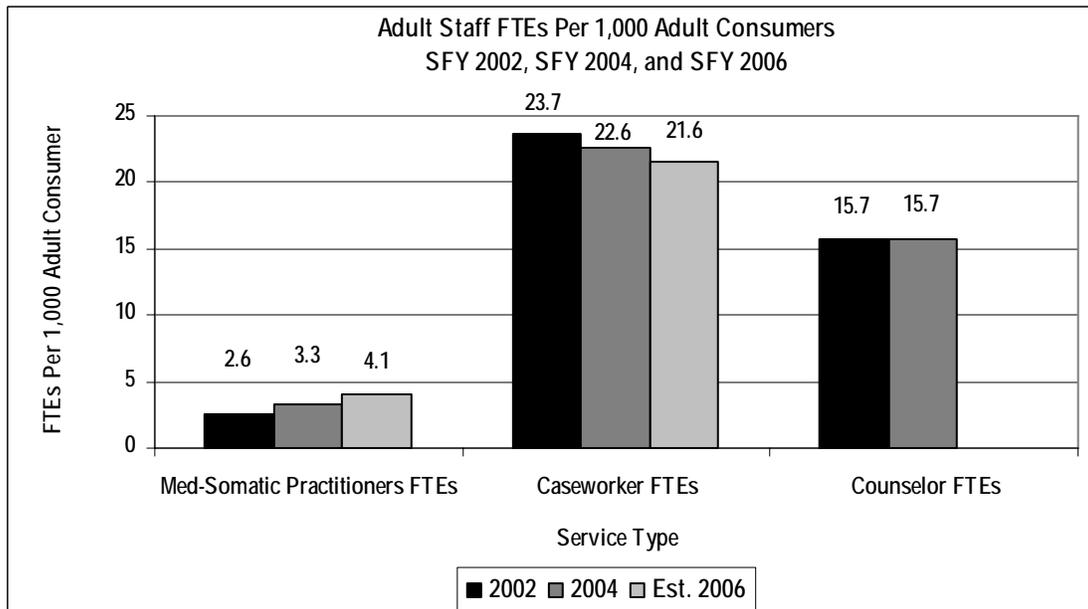
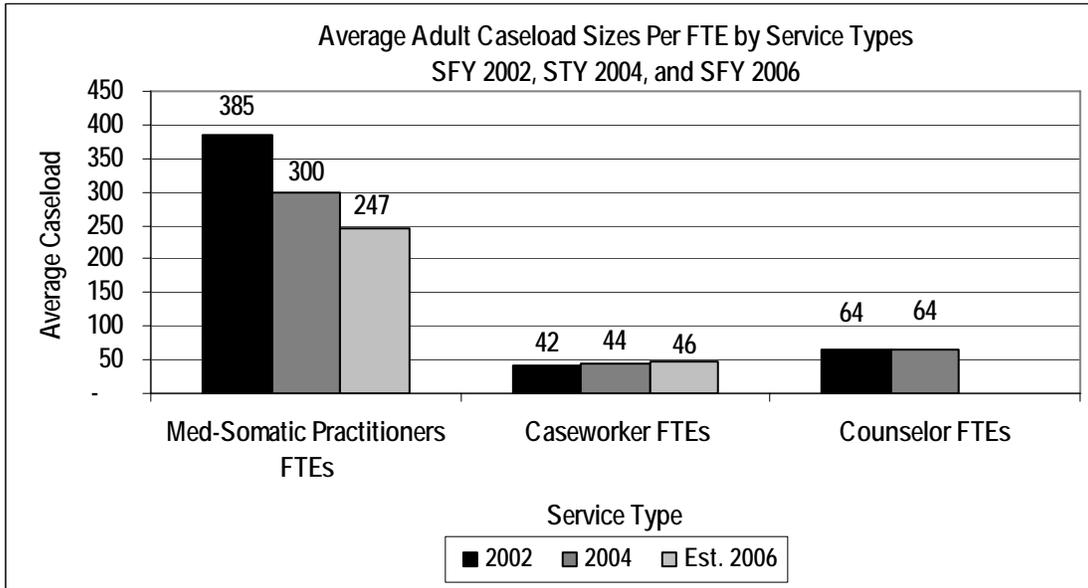
1. Urban Boards include: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Number of Urban Boards equal total Urban Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Urban Boards is the number of Urban Boards for the Type of Med-Somatic Practitioner divided by 7 Urban Boards.
4. Total FTEs is the sum of all FTEs reported by Urban Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by number of Urban Boards reporting FTEs for Type of Med-Somatic Practitioner.
6. Minimum is the lowest number of FTEs reported by an Urban Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by an Urban Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 Adult Clients = (Average FTEs divided by total number of Adult clients for 7 Urban Boards) multiplied by 10,000.
9. Source of Total Adult Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Appendix Y – Table for Question 7.5.5.2.2

| 7.5.5.2.2. Comparison of Adult Staff Budgeted by the Board for Adult Services | | | | | | | | |
|---|---------------------------|---------------------------------|---|-------------------------------------|--------------------------------|-------------------------------|--|--|
| SFY 2002, SFY 2004, and SFY 2006 | | | | | | | | |
| SFY | Service Type | Number of Boards Reporting FTEs | Number of Adult Consumers Receiving Service | Number of Budgeted Adult Staff FTEs | Minimum FTEs Reported by Board | Maximum FTEs Reports by Board | Average Adult Caseload Per FTE by Service Type | Adult Staff FTEs Per 1,000 Adult Consumers |
| 2002 | Med-Somatic Practitioners | 44 | 78,854 | 204.79 | 0.30 | 42.50 | 385.05 | 2.60 |
| 2004 | | 43 | 84,857 | 282.45 | 0.20 | 96.10 | 300.43 | 3.33 |
| Est. 2006 | | 48 | 112,059 | 454.44 | 0.35 | 92.52 | 246.59 | 4.06 |
| 2002 | Caseworkers | 43 | 58,320 | 1,382.50 | 2.00 | 235.50 | 42.18 | 23.71 |
| 2004 | | 44 | 64,859 | 1,463.00 | 1.00 | 280.90 | 44.33 | 22.56 |
| Est. 2006 | | 49 | 84,699 | 1,832.99 | 3.00 | 278.61 | 46.21 | 21.64 |
| 2002 | Counselor/Therapists | N/A | N/A | N/A | N/A | N/A | N/A | N/A |
| 2004 | | 45 | 59,267 | 932.00 | 3.00 | 123.70 | 63.59 | 15.73 |
| Est. 2006 | | 49 | 76,465 | 1,196.40 | 2.80 | 163.50 | 63.91 | 15.65 |

1. Number of Boards Reporting FTEs is the number of Boards that reported budgeted FTEs for the service type on their plans.
2. Med-Somatic Practitioners include clinical staff licensed to prescribe medications, i.e., medical doctors, osteopaths, and nurse practitioners. Counselor/Therapists include psychologists, LPC/LPCC, LSW/LISW.
3. Number of Adult Consumers Receiving Service is total adult consumers that received the service as reported by the MACSIS Data Mart for SFY 2002, SFY 2004, and SFY 2005 as of 4/2/2006. When new consumer counts for SFY 2006 are available, the SFY 2006 Number of Adult Consumers Receiving Services will be revised.
4. Number of Budgeted Adult Staff FTEs is the number of Adult Staff FTEs that the Board reported for the service type in response to question 7.5.2.2.
5. Minimum FTEs Budgeted by Board is the smallest number of FTEs for which a Board budgeted for the service.
6. Maximum FTEs Budgeted by Board is the largest number of FTEs for which a Board budgeted for the service.
7. Average Adult Caseload Per FTE by Service Type is (Number of Adult Consumers Receiving the Service) divided by the (Number of Budgeted Adult Staff FTEs for the Service Type).
8. Number of Adult Staff FTEs Per 1,000 Adult Consumers is (Number of Budgeted Adult Staff FTEs for the service type) divided by the (Number of Adult Consumers Receiving the Service) multiplied by 1,000.

Appendix Z – Figures for Question 7.5.5.2.2



Appendix AA – Tables for Question 7.5.5.3

| Question 7.5.5.3. How Many of C & A Med-Somatic Practitioners Are Currently Under Contract in the Board Area? | | | | | | | |
|---|------------------|-------------------|------------|--------------|---------|---------|-------------------|
| by Type of Practitioner, by All Boards | | | | | | | |
| Type of Med-Somatic Practitioner | Number of Boards | Percent of Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 C & As |
| Pediatrician | 7 | 14.00% | 4.10 | 0.59 | 0.05 | 1.20 | 0.06 |
| Family Physician | 3 | 6.00% | 1.40 | 0.05 | 0.15 | 1.00 | 0.00 |
| Other Physician | 2 | 4.00% | 1.22 | 0.61 | 0.22 | 1.00 | 0.06 |
| C & A Psychiatrist | 42 | 84.00% | 62.05 | 1.48 | 0.10 | 10.80 | 0.15 |
| General Psychiatrist | 9 | 18.00% | 6.79 | 0.75 | 0.05 | 2.68 | 0.08 |
| Advanced Nurse Practitioner | 13 | 26.00% | 34.45 | 2.65 | 0.22 | 18.56 | 0.27 |

1. Number of Boards equal total Boards that reported FTEs for the Type of Med-Somatic Practitioner.
2. Percent of Boards is the number of Boards for the Type of Med-Somatic Practitioner divided by 50 Boards.
3. Total FTEs is the sum of all FTEs reported by Boards for the Type of Med-Somatic Practitioner.
4. Average FTEs is the (Total FTEs) divided by Boards that reported Med-Somatic Practitioner FTEs.
5. Minimum is the lowest number of FTEs reported by a Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
6. Maximum is the highest number of FTEs reported by a Board for the Type of Med-Somatic Practitioner.
7. Per 10,000 C & A Clients = (Average FTEs divided by total number of C & A clients for 50 Boards) multiplied by 10,000.
8. Source of Total C & A Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.3. How Many of C & A Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Rural Boards

| Type of Med-Somatic Practitioner | Number of Rural Boards | Percent of Rural Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 C & As |
|----------------------------------|------------------------|-------------------------|------------|--------------|---------|---------|-------------------|
| Pediatrician | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Family Physician | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Other Physician | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| C & A Psychiatrist | 4 | 66.67% | 3.13 | 0.78 | 0.50 | 1.13 | 1.15 |
| General Psychiatrist | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Advanced Nurse Practitioner | 3 | 50.00% | 2.20 | 0.73 | 0.50 | 1.00 | 1.07 |

1. Rural Boards include: Athens-Hocking-Vinton, Belmont-Harrison-Monroe, Gallia-Jackson-Meigs, Muskingum Area, Putnam, and Mercer-Van Wert-Paulding.
2. Number of Rural Boards equal total Rural Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Rural Boards is the number of Rural Boards for the Type of Med-Somatic Practitioner divided by 6 Rural Boards.
4. Total FTEs is the sum of all FTEs reported by Rural Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by 6 Rural Boards.
6. Minimum is the lowest number of FTEs reported by a Rural Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by a Rural Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 C & A Clients = (Average FTEs divided by total number of C& A clients for 6 Rural Boards) multiplied by 10,000.
9. Source of Total C & A Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.3. How Many of C & A Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Trans-Rural Boards

| Type of Med-Somatic Practitioner | Number of Trans-Rural Boards | Percent of Trans-Rural Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 C & As |
|----------------------------------|------------------------------|-------------------------------|------------|--------------|---------|---------|-------------------|
| Pediatrician | 4 | 23.53% | 2.75 | 0.69 | 0.25 | 1.00 | 0.45 |
| Family Physician | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Other Physician | 1 | 5.88% | 1.00 | 1.00 | 1.00 | 1.00 | 0.65 |
| C & A Psychiatrist | 15 | 88.24% | 9.81 | 3.27 | 0.17 | 1.80 | 2.13 |
| General Psychiatrist | 4 | 23.53% | 3.27 | 0.82 | 0.07 | 1.20 | 0.53 |
| Advanced Nurse Practitioner | 4 | 23.53% | 21.28 | 5.32 | 0.22 | 18.56 | 3.47 |

1. Trans-Rural Boards include: Ashland, Ashtabula, Brown, Defiance-Fulton-Henry-Williams, Hancock, Huron, Logan-Champaign, Marion-Crawford, Miami-Darke-Shelby, Paint Valley, Preble, Scioto-Adams-Lawrence, Seneca-Sandusky-Wyandot, Tuscarawas-Carroll, Union, and Washington.
2. Number of Boards equal Trans-Rural Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Boards is the number of Trans-Rural Boards for the Type of Med-Somatic Practitioner divided by 17 Trans-Rural Boards.
4. Total FTEs is the sum of all FTEs reported by Trans-Rural Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by Trans-Rural Boards that reported Med-Somatic Practitioner FTEs.
6. Minimum is the lowest number of FTEs reported by a Trans-Rural Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by a Trans-Rural Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 C & A Clients = (Average FTEs divided by total number of C & A clients for 17 Trans-Rural Boards) multiplied by 10,000.
9. Source of Total C & A Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.3. How Many of C & A Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Trans-Metro Boards

| Type of Med-Somatic Practitioner | Number of Trans-Metro Boards | Percent of Trans-Metro Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 C & As |
|----------------------------------|------------------------------|-------------------------------|------------|--------------|---------|---------|-------------------|
| Pediatrician | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Family Physician | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| Other Physician | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| C & A Psychiatrist | 11 | 91.67% | 11.25 | 1.02 | 0.10 | 2.40 | 0.63 |
| General Psychiatrist | 2 | 16.67% | 0.20 | 0.10 | 0.05 | 0.15 | 0.06 |
| Advanced Nurse Practitioner | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |

1. Trans-Metro Boards include: Allen-Auglaize-Hardin, Clark-Greene-Madison, Columbiana, Delaware-Morrow, Erie-Ottawa, Fairfield, Geauga, Jefferson, Knox-Licking, Richland, Warren-Clinton, and Wood
2. Number of Trans-Metro Boards equal total Trans-Metro Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Trans-Metro Boards is the number of Trans-Metro Boards for the Type of Med-Somatic Practitioner divided by 12 Trans-Metro Boards.
4. Total FTEs is the sum of all FTEs reported by Trans-Metro Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by Trans-Metro Boards that reported Med-Somatic Practitioner FTEs.
6. Minimum is the lowest number of FTEs reported by a Trans-Metro Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by a Trans-Metro Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 C & A Clients = (Average FTEs divided by total number of C & A clients for 12 Trans-Metro Boards) multiplied by 10,000.
9. Source of Total C & A Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.3. How Many of C & A Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Metro-Urban Boards

| Type of Med-Somatic Practitioner | Number of Metro-Urban Boards | Percent of Metro-Urban Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 C & As |
|----------------------------------|------------------------------|-------------------------------|------------|--------------|---------|---------|-------------------|
| Pediatrician | 2 | 25.00% | 0.15 | 0.08 | 0.05 | 0.10 | 0.05 |
| Family Physician | 2 | 25.00% | 1.25 | 0.63 | 0.10 | 1.15 | 0.39 |
| Other Physician | 0 | 0.00% | 0.00 | 0.00 | 0.00 | 0.00 | 0.00 |
| C & A Psychiatrist | 7 | 87.50% | 13.30 | 1.90 | 0.40 | 3.60 | 1.18 |
| General Psychiatrist | 2 | 25.00% | 0.64 | 0.32 | 0.20 | 0.44 | 0.20 |
| Advanced Nurse Practitioner | 3 | 37.50% | 5.15 | 1.72 | 1.00 | 2.35 | 1.06 |

1. Metro-Urban Boards include: Butler, Clermont, Lorain, Mahoning, Medina, Portage, Stark, and Trumbull.
2. Number of Boards equal total Metro-Urban Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Boards is the number of Metro-Urban Boards for the Type of Med-Somatic Practitioner divided by 8 Metro-Urban Boards.
4. Total FTEs is the sum of all FTEs reported by Metro-Urban Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by Metro-Urban Boards that reported Med-Somatic Practitioner FTEs.
6. Minimum is the lowest number of FTEs reported by a Metro-Urban Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by a Metro-Urban Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 C & A Clients = (Average FTEs divided by total number of C & A clients for 8 Metro-Urban Boards) multiplied by 10,000.
9. Source of Total C & A Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Question 7.5.5.3. How Many of C & A Med-Somatic Practitioners Are Currently Under Contract in the Board Area?

by Type of Practitioner, by Urban Board

| Type of Med-Somatic Practitioner | Number of Urban Boards | Percent of Urban Boards | Total FTEs | Average FTEs | Minimum | Maximum | Per 10,000 C & As |
|----------------------------------|------------------------|-------------------------|------------|--------------|---------|---------|-------------------|
| Pediatrician | 1 | 14.29% | 1.20 | 1.20 | 1.20 | 1.20 | 0.28 |
| Family Physician | 1 | 14.29% | 0.15 | 0.15 | 0.15 | 0.15 | 0.03 |
| Other Physician | 1 | 14.29% | 0.22 | 0.22 | 0.22 | 0.22 | 0.05 |
| C & A Psychiatrist | 5 | 71.43% | 24.56 | 6.14 | 1.00 | 10.80 | 1.41 |
| General Psychiatrist | 1 | 14.29% | 2.68 | 2.68 | 2.68 | 2.68 | 0.62 |
| Advanced Nurse Practitioner | 3 | 42.86% | 5.82 | 1.94 | 0.82 | 4.00 | 0.45 |

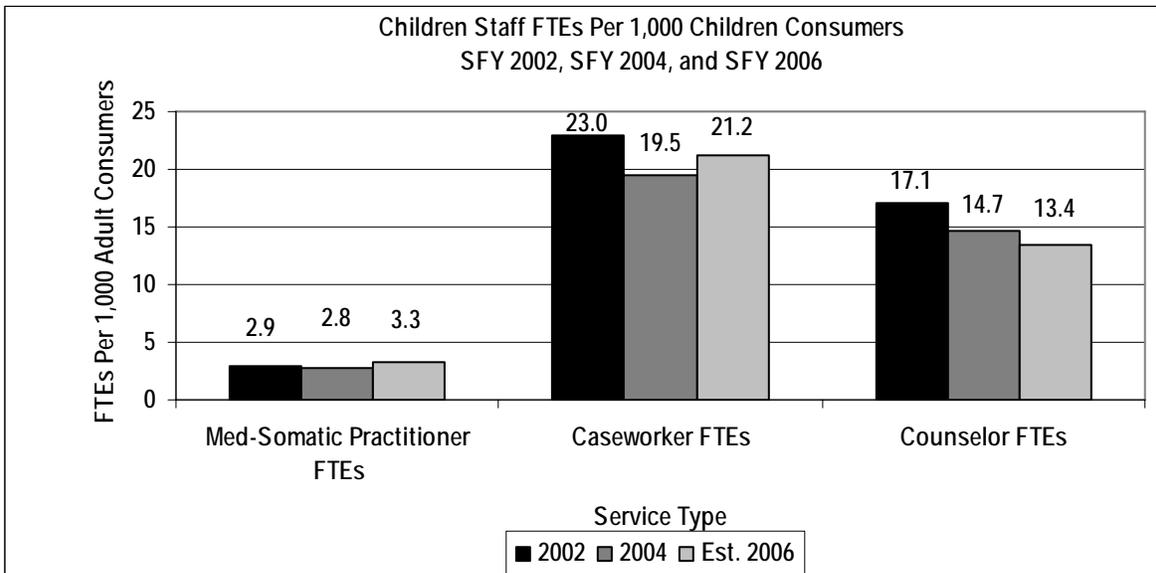
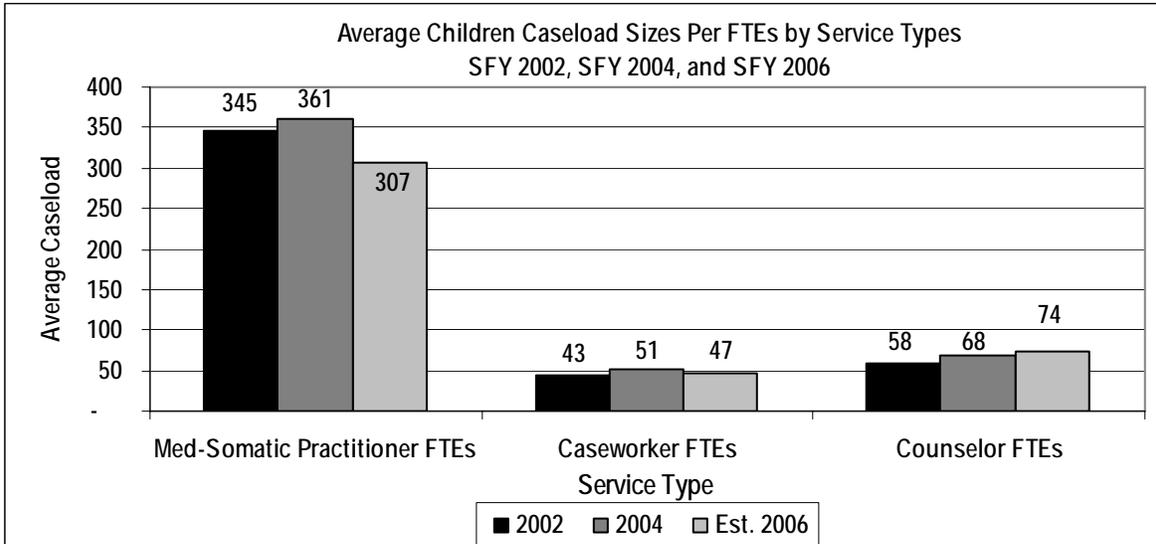
1. Urban Boards include: Cuyahoga, Franklin, Hamilton, Lake, Lucas, Montgomery, and Summit.
2. Number of Urban Boards equal total Urban Boards that reported FTEs for the Type of Med-Somatic Practitioner.
3. Percent of Urban Boards is the number of Urban Boards for the Type of Med-Somatic Practitioner divided by 7 Urban Boards.
4. Total FTEs is the sum of all FTEs reported by Urban Boards for the Type of Med-Somatic Practitioner.
5. Average FTEs is the (Total FTEs) divided by 7 Urban Boards.
6. Minimum is the lowest number of FTEs reported by an Urban Board for the Type of Med-Somatic Practitioner; minimum excludes FTE counts that either equaled 0 or were reported as "null".
7. Maximum is the highest number of FTEs reported by an Urban Board for the Type of Med-Somatic Practitioner.
8. Per 10,000 C & A Clients = (Average FTEs divided by total number of C & A clients for 7 Urban Boards) multiplied by 10,000.
9. Source of Total C & A Client Counts: MACSIS Data Mart for SFY 2005 as of 4/2/2006

Appendix BB – Table for Question 7.5.5.3.3

| 7.5.5.3.2. Comparison of Children Staff Budgeted by the Board for Children's Services | | | | | | | | |
|---|---------------------------|---------------------------------|--|--------------------------------|-------------------------------|--|---|--|
| SFY 2002, SFY 2004, and SFY 2006 | | | | | | | | |
| SFY | Service Type | Number of Boards Reporting FTEs | Number of Children Consumers Receiving Service | Minimum FTEs Reported by Board | Maximum FTEs Reports by Board | Number of Budgeted Children Staff FTEs | Average Children Caseload Per FTE by Service Type | Children Med-Somatic Staff FTEs Per 1,000 Children Consumers |
| 2002 | Med-Somatic Practitioners | 38 | 20,470 | 0.24 | 19.20 | 59.36 | 344.85 | 2.90 |
| 2004 | | 40 | 27,223 | 0.10 | 18.15 | 75.33 | 361.38 | 2.77 |
| Est. 2006 | | 47 | 37,075 | 0.15 | 15.50 | 120.75 | 307.04 | 3.26 |
| 2002 | Caseworkers | 40 | 18,326 | 1.00 | 44.00 | 422.00 | 43.43 | 23.03 |
| 2004 | | 42 | 28,429 | 0.45 | 106.70 | 553.70 | 51.34 | 19.48 |
| Est. 2006 | | 49 | 38,773 | 0.45 | 140.64 | 822.12 | 47.16 | 21.20 |
| 2002 | Counselor/Therapists | 39 | 32,532 | 1.50 | 54.00 | 557.40 | 58.36 | 17.13 |
| 2004 | | 40 | 48,963 | 2.00 | 133.40 | 721.60 | 67.85 | 14.74 |
| Est. 2006 | | 49 | 66,566 | 2.50 | 110.11 | 893.60 | 74.49 | 13.42 |

1. Number of Boards Reporting FTEs is the number of Boards that reported budgeted FTEs for the service type on their plans.
2. Med-Somatic Practitioners include clinical staff licensed to prescribe medications, i.e., medical doctors, osteopaths, and nurse practitioners. Counselor/Therapists include psychologists, LPC/LPCC, LSW/LISW.
3. Number of Children Consumers Receiving Service is total children consumers that received the service as reported by the MACSIS Data Mart for SFY 2002, SFY 2004, and SFY 2005 as of 4/2/2006. When new consumer counts for SFY 2006 are available, the SFY 2006 Number of Children Consumers Receiving Services will be revised.
4. Number of Budgeted Children Staff FTEs is the number of Children Staff FTEs that the Board reported for the service type in response to question 7.5.3.2.
5. Minimum FTEs Budgeted by Board is the smallest number of FTEs for which a Board budgeted for the service.
6. Maximum FTEs Budgeted by Board is the largest number of FTEs for which a Board budgeted for the service.
7. Average Children Caseload Per FTE by Service Type is (Number of Children Consumers Receiving the Service) divided by the (Number of Budgeted Children Staff FTE s for the Service Type).
8. Number of Children Staff FTEs Per 1,000 Children Consumers is (Number of Budgeted Children Staff FTEs for the service type) divided by the (Number of Children Consumers Receiving the Service) multiplied by 1,000.

Appendix CC – Figures for Question 7.5.5.3.3



Appendix DD – Glossary of Terms

**These glossary terms were pulled directly from the MSPA
Section Seven: Community Plan Survey.**

Adult Care Med-Somatic Practitioners include all clinical staff licensed to prescribe medications; i.e., Medical Doctors (MDs) and Osteopaths (DOs) such as gerontologists, general medicine practitioners, psychiatrists, and advanced nurse practitioners.

Anger Management & Domestic Violence Programs for adults are designed to teach parents and domestic partners positive coping skills. Relationships, behavior, and communication patterns are the focus of cognitive-behavioral interventions.

Assertive Community Treatment (ACT) is an evidenced-based practice with a new certification rule, 5122-29-29. ACT is a coordinated, interdisciplinary team service, available in the community 24/7, for adults with high functional impairment from severe and persistent mental illness. ACT is intended to reduce homelessness and high use of psychiatric emergency services, hospitals, crisis stabilization, nursing homes, jails, prisons and adult care facilities. ACT uses the fidelity scale; technical assistance and training are available at no charge from the Ohio Coordinating Center for ACT.

Assessment programs involve on-site screening and diagnostic assessment.

C&A Family Psycho-Education involves teaching parents and children about psychiatric disorders, their treatments, and how to work effectively with mental health and school systems. Parents also learn and practice problem-solving and communication skills for symptom management. Children learn and practice problem-solving, anger management, and communication skills. NAMI Hand-to-Hand training is an example, but inclusion criteria are not limited to this program.

C&A Med-Somatic Practitioners include all clinical staff licensed to prescribe medications; i.e., Medical Doctors (MDs) and Osteopaths (DOs) such as general practitioners, pediatricians, psychiatrists, and advanced nurse practitioners.

Chronic homelessness refers to individuals who are homeless because of a disabling condition (i.e., serious and persistent mental illness), and who either have been continuously homeless for a year or more OR have had at least four (4) episodes of homelessness in the past three years.

Clubhouse / Psychosocial Rehabilitation Center provides persons with serious and persistent mental illness with a network of social support, educational opportunities, housing and employment. Fountain House is the prototype.

Cluster-based Planning involves the use of clinical profiles for the purpose of case management, treatment planning, utilization review, and ODMH Outcomes analysis. The Cluster-based Planning Alliance is the CCOE that provides consultation and training.

Competitive employment is defined as work in the community that anyone can apply for that pays at least minimum wage. No minimum hours per week or month are included in the definition. The target population is adults, age 18 and older, with serious and persistent mental illness.

Consumer Operated Service is an independent, self-governed program in which a majority of staff and Board of Trustees are consumers of mental health services.

Consumer Psycho-education includes programs like Bridges and Wellness Recovery Action Plan (WRAP). The Adult Recovery Network provides consultation and training.

Court-involved adult is defined as an adult adjudicated for misdemeanors and/or felonies. Court-involved adult consumers may be on parole or probation; they may also be former prisoners or forensic patients who have returned to the community and are receiving services.

Court-involved juvenile is defined as a child or adolescent adjudicated for unruly and/or delinquent behavior. The definition DOES NOT include children and adolescents involved with courts due to abuse, neglect, or dependency.

Criminal Justice Coordination is an active planning committee or collaborative process involving the Board, providers, law enforcement, and the adult criminal and/or juvenile justice system.

Crisis Care Facility is the provision of short-term, acute care to stabilize a child/adolescent/person experiencing psychiatric emergency. It is staffed 24/7 and is offered as an alternative to an inpatient psychiatric unit. It includes 23-hour observation and short-term, acute care beds. Treatment services are billed separately.

Diversion Strategies involve CIT, mental health courts, and court liaison/boundary-spanner services designed to decrease the number of mental health consumers incarcerated in jail, youth detention, prison, and youth correctional centers.

Early Childhood Care is defined as any service or program provided to children from birth to six years old. It can include programs like Incredible Years, Help Me Grow, play therapy, or early detection and intervention, psychiatry, psychological testing, case management, and family counseling. This measurement EXCLUDES therapeutic preschool / early childhood day treatment.

Family Psycho-education is defined in this document as NAMI Family-to-Family Training. NAMI Ohio provides training and consultation.

Family Therapy is a treatment modality with interventions aimed at increasing parental effectiveness and family cohesion. It is primarily concerned with resolving interpersonal conflict rather than teaching parents and children how to manage the impact of a psychiatric condition. It can be conducted in a clinic or as a home-based model. Treatment intensity varies from as few as eight to as many as 30 one-hour sessions over 90 days.

General Care involves service provision of low to moderate intensity. (For children and adolescents: It is appropriate for the general population of C&A consumers for whom high-intensity service need has not been identified.)

General Transportation Services enable consumers to get to mental health and medical appointments, as well as places providing other essential life activities. It is separate from case management service and is not a community Medicaid billable service.

The **Housing Assistance Program (HAP)** provides temporary rental subsidies and no-interest loans to assist persons with severe mental disabilities and their families with obtaining permanent, safe, decent and affordable rental housing until a permanent subsidy can be obtained (Section 8 voucher), or until a person's income increases sufficiently so that a rental subsidy is not needed, or until person owns their own home.

Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness a set of strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapse and re-hospitalization, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, "behavioral tailoring" to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to manage distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training.

Integrated dual diagnosis treatment (IDDT) combines or integrates mental health and substance abuse interventions at the level of the clinical encounter. Integrated treatment means the same clinicians or teams of clinicians working in one setting provide appropriate mental health and substance abuse interventions in a coordinated fashion. The caregivers take responsibility for combining the interventions into one coherent package.

For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations.

Intensive care implies substantial clinical contact with adults/youth who have serious mental illness/serious emotional disabilities, characterized by significantly impaired functioning and/or symptoms of significant duration to warrant a service or programmatic intensity greater than general outpatient care.

Intensive Community Psychiatric Support (CPST) – 7.4.2 is case management service with caseloads in the range of 15 consumers and service contacts of greater frequency than once per month.

Intensive Community Psychiatric Support Treatment (CPST) – 7.3.2 provides an array of services delivered by community-based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. Intensive CPST is appropriate for individuals with low or variable functioning who would benefit from more frequent CPST contact than occurs in usual practice. These consumers may not meet ACT criteria, but would benefit from intensive community support. Caseloads are typically in the range of 15 clients per one CPST worker, and contact occurs more frequently than once per month.

Intensive Home-Based Therapy (IHBT) provides an array of services to youth needing time-limited interventions designed to preserve their tenure in the community. IHBT includes a coordinated group of services that consolidate the following: Community Psychiatric Treatment Services, Crisis Services, Diagnostic/Assessment, Counseling/Psychotherapy, and Partial Hospitalization. Med-somatic services may be provided in addition to IHBT. Additional services which may be included are behavioral management, problem solving, social skills, communications, coping, household management, parenting skills and any other services which directly or indirectly improve the mental health of the youth. MST Therapy is considered an IHBT, and the Center for Innovative Practice provides MST consultation and training.

Intensive Psychiatry – 7.3.2 is appropriate for persons with unstable and/or complex symptoms who would benefit from more frequent or lengthier psychiatric contact than occurs in usual practice. It entails a lower psychiatric care caseload, and doctor/patient contact will be longer than 15 minutes and/or more frequent than once per month. Intensive Psychiatry includes assessment and med somatic service.

Intensive Psychiatry- 7.4.2 involves med-somatic service contacts of great frequency and duration than general psychiatric care. It is characterized by smaller caseloads and/or more lengthy psychiatric contact than general med-somatic service.

Interpreter Services for Deaf, Hispanic, or other non-English-speaking populations include competency with cultural constructions of health and mental illness as well as linguistic fluency.

Intervention programs include referral, counseling, crisis response, and CPST.

Mainstream Schools are defined as any public, parochial, charter, or private school that serves the mainstream population of students.

Medicaid Consumers are defined as all consumers (adults, children, and adolescents) who receive services regardless of SMD or SED status and whose primary payer is Medicaid. Estimating the number of Medicaid Consumers for which the Board expects to provide match in SFY 2008-2009 should be based on a calculation of trends in specified services over the last three years and knowledge of recent changes in agencies' provision patterns.

Medicare Consumers are defined as all consumers (children, adolescents and adults) who receive services regardless of SMD/SED status and whose primary payer source is Medicare.

MH Education & Promotion programs provide students with information, skills, and/or strategies for enhancing positive mental health, getting help, and supporting others with mental health issues.

Mobile Response – 7.3 is the provision of short-term, on-site crisis service to people in their natural environment. It is offered as an alternative to an inpatient psychiatric unit or a crisis care facility. It DOES NOT include community EMS or response by law enforcement officers with mental health training.

Mobile Response – 7.4 is the provision of short-term, home-based crisis service to children and adolescents. Mobile response can also include on-site crisis service to schools, homes, sheriff/police departments, and juvenile detention centers. It DOES NOT INCLUDE: Multi-Systemic Therapy (MST) or Intensive Home-Based Treatment (IHBT) teams, community Emergency Medical Service (EMS), response by law enforcement officers with mental health training.

Non-Medicaid Consumers are defined as all consumers (adults, children, and adolescents) who receive services regardless of SMD or SED status and do not receive Medicaid benefits. Estimating the number of non-Medicaid Consumers the Board expects to provide services for in SFY 2008-09 should be based on a calculation of trends in specified services over the last three years, and planning for non-Medicaid-billable services such as pharmacy, housing, and peer-support.

Older Adults Services involve integrated services across systems of care and clinical best practices for the service population, particularly with regard to prescriptive practices and physical health care. Program elements include cross-system involvement with Area Agencies on Aging, Health Departments, and Ohio Department of Jobs & Family Services (ODJFS). The Older Ohioans Behavioral Health Network, housed by Ohio Association of County Behavioral Health Authorities (OACBHA), provides consultation and policy leadership.

Other Schools are defined as any public, charter, or private school that primarily services children with behavioral and emotional disabilities. Other Schools include Alternative, SBH/SED, and Partial Hospital Schools.

Partial Hospitalization (PH) Program Type I – 7.3.2 is an intensive form of medically managed outpatient treatment that is time limited (two to six weeks) and goal-oriented. PH Program Type I typically serves the function of step-down from inpatient care or inpatient diversion. The major goals of PH Program Type I are symptom reduction and functional improvement.

Partial Hospitalization (PH) Program Type I – 7.4.2 is an intensive form of medically managed outpatient treatment that is time limited (two to six weeks) and goal-oriented. PH Program Type I allows youth to return home at night and typically serves the function of step-down from inpatient and residential care or diversion from inpatient and residential care. The major goals of PH Program Type I are symptom reduction and functional improvement.

PH Program Type II – 7.3.2 is a long-term form of intensive outpatient care designed to maintain symptom stability and daily living in the community. PH Program Type II is of indeterminate duration, with a general goal of increasing social functioning and coping skills. Clients in PH Program Type II typically do not require an intense level of medical management and are not at imminent risk of hospitalization or hospital re-admission.

PH Program Type II – 7.4.2 is defined as a school-based partial hospitalization program that provides an integrated curriculum combining education, counseling, medication management, CSP, and family interventions. The overarching goal of PH Program Type II is functional improvement and school success, and it is typically longer term, with Transitions and discharge occurring on a semester basis and at the end of the school year.

PH Program Type III – 7.4.2 is defined as intensive, structured outpatient treatment in a setting such as a public or private clinic or at a RTC. PH Program Type III differs from school-based PH Program Type II because it does not provide an integrated curriculum of treatment and education. In PH Program Type III, treatment activity occurs outside of or apart from educational activity. It is typically longer term, with improved social skills as the overarching treatment goal.

Peer Support is a service offered by mental health consumers, persons with addictions, or others who provide support to one another. Peer support services can include drop-in centers, warm lines, peer respite care, or support groups.

Primary Prevention programs aim to prevent the development of mental health problems. Learning to identify and modify behavioral responses to stress is an example of primary prevention.

Public Housing is defined as housing subsidized by the federal government, such as but not limited to Section 8. People on HAP are likely to be on public housing wait lists, but HAP is not public housing.

Recidivism Strategies involve services to jails, youth detention and state correctional centers, and community re-entry programs designed to decrease the number of mental health consumers who return to jail, prison, or youth correctional centers.

Residential Treatment Center (RTC) is a licensed 24-hour/7-day facility which provides room and Board with mental health treatment, including (but not limited to) medication management, psycho-educational counseling, case management, behavior management, individual and family counseling, group therapy, and socio-cultural peer support. In some cases, treatment is based in a charter school or academy associated with the RTC; in other cases, treatment is based in the facility and is provided before and after school programming. In some cases, treatment is provided both in school and after school. Although room and Board at the RTC may be paid through child welfare or other public funds, the RTC must be licensed by ODMH to provide outpatient mental health services.

Respite Beds/Emergency Shelter is the provision of short-term housing with staff trained in the care of persons with psychiatric symptoms.

Respite is temporary, short-term care for children and adolescents with serious emotional disturbance. It is designed to provide family members, custodians, or foster parents with temporary relief of caregiver burden and prevent out-of-home placement. Respite may be family or agency arranged. It DOES NOT INCLUDE group care facilities such as runaway shelters.

School-based Services include staff consultation and education, on-site diagnostic assessment and referral, mobile crisis response, school-wide prevention programs (i.e., bullying prevention), on-site counseling and CPST. The Center for Learning Excellence CCOE provides training and consultation.

Secondary Prevention programs target high-risk children and adolescents. Programs for youth experiencing loss or traumatic events is an example of secondary prevention.

Serious Emotional Disability (SED) is a psychiatric condition with symptoms meeting criteria for a DSM-IV diagnosis attended by substantial impact on the psychosocial development of children and adolescents (C&A). The behavioral, emotional, and developmental problems associated with SED are of a chronic, persistent nature.

Serious Mental Disability (SMD) is a psychiatric condition with symptoms meeting criteria for a DSM-IV diagnosis attended by substantial impact on psychosocial functioning of adults. The symptoms and functional deficits associated with SMD are severe and persistent.

Specialized services for C&A consumers adjudicated for sexual offending behaviors involve integrated services across systems of care and clinical best practices for the service population.

Specialized services for C&A consumers with MR/MI involve integrated services across systems of care and clinical best practices for the service population.

Specialized services for C&A consumers with SA/MI involve integrated services across systems of care and clinical best practices for the service population.

Specialized services for persons with mental retardation and mental illness (MI/MR) involve integrated services across systems of care and clinical best practices for the service population. Best practices in the assessment and diagnosis of mental health disorders in people with MR/DD require ongoing, comprehensive, and thorough assessments conducted in multiple settings. This comprehensive assessment process must include the review of clinical records, prolonged behavioral observation, and interviews with multiple informants who know the individual and his or her level of functioning. Training and systems integration support are provided by the MI/MR CCOE.

Supported Employment (SE) is an evidence-based practice to promote rehabilitation for persons with serious mental illness and their return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all the vocational services from intake through follow-along. Job placements are community-based (i.e., NOT sheltered workshops, NOT on-site at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to the public), in normalized settings, and utilize multiple employers. The SE team has a small client/staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance, but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing include: housing choice, functional separation of housing from service provision, affordability, integration with persons who do not have mental illness, right to tenure, service choice, service individualization, and service availability. The Mental Health Housing Leadership Institute operated by NAMI Ohio provides consultation and training.

Therapeutic Pre-School / Early Childhood Day Treatment (EC Day TX) is partial hospitalization programming for young children up to six years old.

Transitional Living Program is a comprehensive, youth-driven program that includes the following essential service elements: employment services, education support, independent living, socialization/recreation, and Transition facilitation, e.g., service coordination.

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based practice that addresses the needs of C&A consumers with Post Traumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers. TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication. The National Child Traumatic Stress Network provides consultation and training.

Trauma-informed Care uses staff appropriately trained to conduct trauma assessments and provide interventions/therapies to address the trauma.

Treatment Foster Care (TFC) is a home where trained foster parents who have access to other support services provide care to a child with serious emotional disturbance. TFC parents receive a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed. The intended length of this care is usually from six to 12 months. Multidimensional and Teaching Parent are examples of evidence-based TFC. In both models, consultants provide consultation and certification training. ODMH certified foster care service does not meet criteria as TFC.

Appendix EE – Copy of Section Seven: Community Plan Survey

SECTION SEVEN: Community Plan Survey

7.1 Background and Context: This section includes content developed out of work guided by the EPMC and includes information to be provided by the Boards needed to determine whether planning and action are occurring sufficient to ensure the viability of the public mental health system in Ohio. The EPMC will use the data provided in this section to:

- 7.1.1 Identify areas of mutual statewide concern and success among ADAMH/CHM Boards and ODMH regarding adults with SMD and children and youth with SED.
- 7.1.2 Identify changes in the local system since the last Safety Net Survey was completed;
- 7.1.3 Identify critical gaps in planning and actions to deal with statewide and local fiscal pressures;
- 7.1.4 Identify local systems that are maintaining and improving quality despite fiscal pressures;
- 7.1.5 Identify technical assistance needs (not limited to those available at ODMH);
- 7.1.6 Identify critical gaps in planning and action to deal with access and continuum of care issues between the ADAMH/CMH Boards and the BHO's, and;
- 7.1.7 Provide data for effective budget advocacy and education locally and statewide

7.2 Service Populations

7.2.1 Definitions and Operational Criteria

Serious Mental Disability (SMD) is a psychiatric condition with symptoms meeting criteria for a DSM-IV diagnosis attended by substantial impact on psychosocial functioning of adults. The symptoms and functional deficits associated with SMD are severe and persistent.

Serious Emotional Disability (SED) is a psychiatric condition with symptoms meeting criteria for a DSM-IV diagnosis attended by substantial impact on the psychosocial development of children and adolescents (C&A). The behavioral, emotional, and developmental problems associated with SED are of a chronic, persistent nature.

The operational definitions of SMD and SED used for administration of the MACSIS claims system are based on only two of the definitional criteria: diagnosis and duration of treatment for the condition. Diagnostic inclusion in SMD/SED designation is based on the last diagnoses assigned on a claims record. Duration is based on a minimum number of treatment episodes for any of the nine Medicaid-eligible clinical services, excluding crisis intervention.

ODMH recommends that Boards use the MACSIS Data Mart operational measurement of SMD and SED when estimating number of consumers to be served in **SFY 2008-2009**. However, ODMH recognizes that some Boards may use additional sources of information when estimating the number of SMD and SED consumers they plan to serve. Boards that use supplemental criteria in their operational definitions of SMD and SED are expected to provide information about their methodology.

Medicaid Consumers are defined as all consumers (adults, children, and adolescents) who receive services regardless of SMD or SED status and whose primary payer is Medicaid. Estimating the number of Medicaid Consumers for which the Board expects to provide match in **SFY 2008-2009** should be based on a calculation of trends in specified services over the last three years and knowledge of recent changes in agencies' provision patterns.

Non-Medicaid Consumers are defined as all consumers (adults, children, and adolescents) who receive services regardless of SMD or SED status and do not receive Medicaid benefits.

Estimating the number of non-Medicaid Consumers the Board expects to provide services for in **SFY 2008-09** should be based on a calculation of trends in specified services over the last three years, and planning for non-Medicaid-billable services such as pharmacy, housing, and peer-support.

7.2.1.1 **SMD/SED/Medicaid/Non-Medicaid Population by Services in SFY 2008-2009**

Instructions: Please indicate (x) in the charts below which mental health services the Board is planning to support for **SFY 2008-2009** for A) Children & Adolescents, and B) Adults.

Service Definitions are found in Ohio Administrative Code (OAC) 5122-22-03 to 29. The complete index of these rules is found at:

<http://www.mh.state.oh.us/licensurecert/general/lc.community.rules.html>

| A. Child & Adolescent Mental Health Services in SFY 2008-2009 | Medicaid | | Non-Medicaid | |
|---|----------|---------|--------------|---------|
| | SED | Non-SED | SED | Non-SED |
| Pharmacological Management | | | | |
| MH Assessment | | | | |
| Psychiatric Diagnostic Int. (Physician) | | | | |
| BH Counseling and Therapy (Ind.) | | | | |
| BH Counseling and Therapy (Grp.) | | | | |
| Crisis Intervention MH Services | | | | |
| Partial Hospitalization, less than 24 hrs. | | | | |
| Cmty. Psychiatric Supportive Tx. (Ind.) | | | | |
| Cmty. Psychiatric Supportive Tx. (Grp.) | | | | |
| ACT/IHBT | | | | |
| Behavioral Health Hotline Service | | | | |
| Self-Help/Peer Services | | | | |
| Adjunctive Therapy | | | | |
| Adult Education | | | | |
| Consultation | | | | |
| Consumer Operated Service | | | | |
| Employment | | | | |
| Information and Referral | | | | |
| Mental Health Education | | | | |
| Occupational Therapy Service | | | | |
| Other MH Service, Non-healthcare | | | | |
| Service | | | | |
| Prevention | | | | |
| School Psychology | | | | |
| Social & Recreational Service | | | | |
| Community Residence | | | | |
| Crisis Care | | | | |
| Foster Care | | | | |
| Residential Care | | | | |
| Respite Care | | | | |
| Subsidized Housing | | | | |
| Temporary Housing | | | | |
| Forensic Evaluation | | | | |
| PASARR | | | | |
| Inpatient Psychiatric Service | | | | |
| *Other MH Service, not otherwise spec. | | | | |
| *Please specify services listed as "Other": | | | | |

| B. Adult Mental Health Services in <u>SFY 2008 – 2009</u> | Medicaid | | Non-Medicaid | |
|--|----------|---------|--------------|---------|
| | SMD | Non-SMD | SMD | Non-SMD |
| Pharmacological Management MH Assessment Psychiatric Diagnostic Int. (Physician) BH Counseling and Therapy (Ind.) BH Counseling and Therapy (Grp.) Crisis Intervention MH Services Partial Hospitalization, less than 24 hrs. Cnty. Psychiatric Supportive Tx. (Ind.) Cnty. Psychiatric Supportive Tx. (Grp.) ACT/IHBT Behavioral Health Hotline Service Self-Help/Peer Services Adjunctive Therapy Adult Education Consultation Consumer Operated Service Employment Information and Referral Mental Health Education Occupational Therapy Service Other MH Service, Non-healthcare Service Prevention School Psychology Social & Recreational Service Community Residence Crisis Care Foster Care Residential Care Respite Care Subsidized Housing Temporary Housing Forensic Evaluation PASARR Inpatient Psychiatric Service | | | | |
| *Other MH Service, not otherwise spec. *Please specify services listed as “Other”: | | | | |

7.2.1.2 If the Board uses operational measures other than or supplemental to the MACSIS operational definition of SMD/SED, please discuss your methodology:

Other Measures Board uses to Operationalize SMD/SED

7.2.2 **Medicare Population in SFY 2005**

Medicare Consumers are defined as all consumers (children, adolescents and adults) who receive services regardless of SMD/SED status and whose primary payer source is Medicare.

7.2.2.1 How much money did the Board expend on Medicare subsidies in **SFY 2005**?

\$ _____ **SFY 2005 Medicare Subsidies**

7.2.2.2 How many Medicare consumers were served in **SFY 2005**?

_____ **SFY 2005 Medicare Consumers Served**

7.3 Adult Services

7.3.1 Adult Crisis Care: Definitions

Crisis services provided through ACT Programs should be EXCLUDED from the measurement of 24/7 on-call staffing.

***Crisis Care Facility** is the provision of short-term, acute care to stabilize a person experiencing psychiatric emergency. It is staffed 24/7 and is offered as an alternative to an inpatient psychiatric unit. It includes 23-hour observation and short-term, acute care beds. Treatment services are billed separately.*

***Mobile Response** is the provision of short-term, on-site crisis service to people in their natural environment. It is offered as an alternative to an inpatient psychiatric unit or a crisis care facility. It DOES NOT include community EMS or response by law enforcement officers with mental health training.*

***Respite Beds/Emergency Shelter** is the provision of short-term housing with staff trained in the care of persons with psychiatric symptoms.*

7.3.1.1 Crisis Care Services

For each of the following services that are available in the Board area, please indicate approximately how long consumers wait for admission. If the service is not available, write "NO" in the "Service Available?" column.

| Service Area | Access Time? | | Service Available? |
|--|--------------------|--------------------|--------------------|
| | Less than one hour | More than one hour | |
| 24/7 On-Call Staffing by Psychiatrists | | | |
| 24/7 On-Call Staffing by Clinical Supervisors | | | |
| 24/7 On Call Staffing by Case Managers | | | |
| Mobile Response | | | |
| 24/7 Central Phone Line | | | |
| Crisis Care Facility | | | |
| Hospital Emergency Room with Psychiatric Staff | | | |
| Hospital Contract for Crisis Observation Beds | | | |
| Contract for Respite Beds/Emergency Shelter | | | |
| Contract for Transport to State/Local hospital | | | |

- 7.3.1.2 **Narrative (Optional).** Which areas of crisis care are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

Challenges, Solutions, Impacts

7.3.2 Adult Intensive Care Services and Programs: Definitions

Intensive care implies substantial clinical contact with adults who have serious mental illness, characterized by significantly impaired functioning and/or symptoms of significant duration to warrant a service or programmatic intensity greater than general outpatient care.

Assertive Community Treatment (ACT) is an evidenced-based practice with a new certification rule, 5122-29-29. ACT is a coordinated, interdisciplinary team service, available in the community 24/7, for adults with high functional impairment from severe and persistent mental illness. ACT is intended to reduce homelessness and high use of psychiatric emergency services, hospitals, crisis stabilization, nursing homes, jails, prisons and adult care facilities. ACT uses the fidelity scale; technical assistance and training are available at no charge from the Ohio Coordinating Center for ACT.

Partial Hospitalization (PH) Program Type I is an intensive form of medically managed outpatient treatment that is time limited (two to six weeks) and goal-oriented. PH Program Type I typically serves the function of step-down from inpatient care or inpatient diversion. The major goals of PH Program Type I are symptom reduction and functional improvement.

PH Program Type II is a long-term form of intensive outpatient care designed to maintain symptom stability and daily living in the community. PH Program Type II is of indeterminate duration, with a general goal of increasing social functioning and coping skills. Clients in PH Program Type II typically do not require an intense level of medical management and are not at imminent risk of hospitalization or hospital re-admission.

Intensive Psychiatry is appropriate for persons with unstable and/or complex symptoms who would benefit from more frequent or lengthier psychiatric contact than occurs in usual practice. It entails a lower psychiatric care caseload, and doctor/patient contact will be longer than 15 minutes and/or more frequent than once per month. Intensive Psychiatry includes assessment and med somatic service.

Intensive Community Support Psychiatric Treatment (CPST) provides an array of services delivered by community-based, mobile individuals or multidisciplinary teams of professionals and trained others. Services address the individualized mental health needs of the client. Intensive CPST is appropriate for individuals with low or variable functioning who would benefit from more frequent CPST contact than occurs in usual practice. These consumers may not meet ACT criteria, but would benefit from intensive community support. Caseloads are typically in the range of 15 clients per one CPST worker, and contact occurs more frequently than once per month.

7.3.2.1 **Adult Intensive Care Programs & Services**

For each of the following services that are available in the Board area, please mark (X) under the column indicating approximately how many working days (wd) adult consumers wait for admission. If the service is not available, place write "NO" in the "Service Available?" column.

| Service Area | Service Available? | Up to 10 wd | 11 to 15 wd | 16 to 20 wd | 21 to 30 wd | 31 to 60 wd | 61 to 90 wd | 91 wd or more |
|----------------------|--------------------|-------------|-------------|-------------|-------------|-------------|-------------|---------------|
| ACT | | | | | | | | |
| PH Program Type I | | | | | | | | |
| PH Program Type II | | | | | | | | |
| Intensive Psychiatry | | | | | | | | |
| Intensive CPST | | | | | | | | |

7.3.2.2 **Narrative (Optional).** Which areas of intensive service are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

Challenges, Solutions, Impacts

7.3.3 Adult General Care

General Care involves outpatient service provision of low to moderate intensity.

7.3.3.1 **Basic services used in General Care**
 For each of the following services that are available in the Board area, please indicate approximately how many working days (wd.) consumers wait for admission. If the service is not available, write "NO" in the "Service Available?" column.

| Service | Service Available ? | Up to 10 wd | 11 to 15 wd | 16 to 20 wd | 21 to 30 wd | 31 to 60 wd | 61 to 90 wd | 91 wd or more |
|---------------------------------------|---------------------|-------------|-------------|-------------|-------------|-------------|-------------|---------------|
| Diagnostic Assessment--Physician | | | | | | | | |
| Diagnostic Assessment – Non-Physician | | | | | | | | |
| Psychiatry (Med-Somatic) | | | | | | | | |
| Counseling/Psychotherapy | | | | | | | | |
| CPST | | | | | | | | |

7.3.3.2 **Narrative (Optional).** Which areas of general outpatient services are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

Challenges, Solutions, Impacts

Promising, Best, and Evidence-based Practices and Other Adult Services: Definitions
(Use definitions for “Other Adult Services Matrix” on following pages.)

Integrated dual diagnosis treatment (IDDT) combines or integrates mental health and substance abuse interventions at the level of the clinical encounter. Integrated treatment means the same clinicians or teams of clinicians working in one setting provide appropriate mental health and substance abuse interventions in a coordinated fashion. The caregivers take responsibility for combining the interventions into one coherent package. For the individual with a dual diagnosis, the services appear seamless, with a consistent approach, philosophy, and set of recommendations.

Answer “YES” or mark (X) to the “Service Available?” column on the Other Adult Services Matrix if the program in the Board area has received a fidelity rating from the Ohio Substance Abuse and Mental Illness CCOE. Answer “YES” or mark (X) to the SA/MI CCOE involvement column if a provider in the Board area has consulted with the SA/MI CCOE for training and assistance with implementation.

Supported Employment (SE) is an evidence-based practice to promote rehabilitation for persons with serious mental illness and their return to productive employment. SE programs use a team approach for treatment, with employment specialists responsible for carrying out all the vocational services from intake through follow-along. Job placements are community-based (i.e., NOT sheltered workshops, NOT on-site at SE or other treatment agency offices), competitive (i.e., jobs are not exclusively reserved for SE clients, but open to the public), in normalized settings, and utilize multiple employers. The SE team has a small client/staff ratio. SE contacts occur in the home, at the job site, or in the community. The SE team is assertive in engaging and retaining clients in treatment, especially utilizing face-to-face community visits, rather than phone or mail contacts. The SE team consults/works with family and significant others when appropriate. SE services are frequently coordinated with Vocational Rehabilitation benefits.

Answer “YES” or mark (X) in the “Service Available?” column on the Other Adult Services Matrix if the program in the Board area has received a fidelity rating from the SA/MI CCOE. Answer “YES” or mark (X) in the SA/MI CCOE involvement column if a provider in the Board area has consulted with the SA/MI CCOE for training and assistance with implementation.

Supported Housing is a specific program model in which a consumer lives in a house, apartment or similar setting, alone or with others, and has considerable responsibility for residential maintenance, but receives periodic visits from mental health staff or family for the purpose of monitoring and/or assisting with residential responsibilities. Criteria identified for supported housing include: housing choice, functional separation of housing from service provision, affordability, integration with persons who do not have mental illness, right to tenure, service choice, service individualization, and service availability. The Mental Health Housing Leadership Institute operated by NAMI Ohio provides consultation and training.

Illness Self-Management (also called illness management or wellness management) is a broad set of rehabilitation methods aimed at teaching individuals with mental illness a set of strategies for collaborating actively in their treatment with professionals, for reducing their risk of relapse and re-hospitalization, for reducing severity and distress related to symptoms, and for improving their social support. Specific evidence-based practices that are incorporated under the broad rubric of illness self-management are psycho-education about the nature of mental illness and its treatment, “behavioral tailoring” to help individuals incorporate the taking of medication into their daily routines, relapse prevention planning, teaching coping strategies to manage distressing persistent symptoms, cognitive-behavior therapy for psychosis, and social skills training.

Answer “YES” to the “Service Available?” column on the Other Adult Services Matrix if the program in the Board area has received a fidelity rating from the Illness Management and Recovery CCOE. Answer “YES” to the CCOE Involvement column if a provider in the Board area has consulted with the IMR CCOE for training and assistance with implementation.

Older Adults Services involve integrated services across systems of care and clinical best practices for the service population, particularly with regard to prescriptive practices and physical health care. Program elements include cross-system involvement with Area Agencies on Aging, Health Departments, and Ohio Department of Jobs & Family Services (ODJFS). The Older Ohioans Behavioral Health Network, housed by Ohio Association of County Behavioral Health Authorities (OACBHA), provides consultation and policy leadership.

Specialized services for persons with mental retardation and mental illness (MI/MR) involve integrated services across systems of care and clinical best practices for the service population. Best practices in the assessment and diagnosis of mental health disorders in people with MR/DD require ongoing, comprehensive, and thorough assessments conducted in multiple settings. This comprehensive assessment process must include the review of clinical records, prolonged behavioral observation, and interviews with multiple informants who know the individual and his or her level of functioning. Training and systems integration support are provided by the MI/MR CCOE.

Cluster-based Planning involves the use of clinical profiles for the purpose of case management, treatment planning, utilization review, and ODMH Outcomes analysis. The Cluster-based Planning Alliance is the CCOE that provides consultation and training.

Family Psycho-education is defined in this document as NAMI Family-to-Family Training. NAMI Ohio provides training and consultation.

Consumer Psycho-education includes programs like **Bridges** and **Wellness Recovery Action Plan (WRAP)**. The Adult Recovery Network provides consultation and training.

Clubhouse / Psychosocial Rehabilitation Center provides persons with serious and persistent mental illness with a network of social support, educational opportunities, housing and employment. Fountain House is the prototype.

Peer Support is a service offered by mental health consumers, persons with addictions, or others who provide support to one another. Peer support services can include drop-in centers, warm lines, peer respite care, or support groups.

Consumer Operated Service is an independent, self-governed program in which a majority of staff and Board of Trustees are consumers of mental health services.

General Transportation Services enable consumers to get to mental health and medical appointments, as well as places providing other essential life activities. It is separate from case management service and is not a community Medicaid billable service.

Anger Management & Domestic Violence Programs for adults are designed to teach parents and domestic partners positive coping skills. Relationships, behavior, and communication patterns are the focus of cognitive-behavioral interventions.

Interpreter Services for Deaf, Hispanic, or other non-English-speaking populations include competency with cultural constructions of health and mental illness as well as linguistic fluency.

Trauma-informed Care uses staff appropriately trained to conduct trauma assessments and provide interventions/therapies to address the trauma.

7.3.4.1 **Other Adult Services Matrix**
(Use definitions on preceding pages to complete this matrix.)

Service Available Column: Write “NO” if the Board does not provide the service. Place a mark (X) or “YES” if the Board provides the service.

Using Technical Support Column: Place a mark (X) or “YES” if the Board has used the relevant CCOE, Network or other Technical Support for consultation, training, or other assistance with implementation. Leave the box blank or write “NO” to indicate lack of Technical Support.

Want Technical Support Column: If the Board or a provider wants technical support for a promising, best or evidence-based practice, but is not currently using a CCOE, Network or other support service, write “YES.” Leave the box blank or write “NO” to indicate lack of desire for Technical Support services.

Number of Consumers Column: Please estimate how many consumers received this service in **SFY 2005**. If you cannot make a reasonably informed estimate, enter “N/A” into the Number of Consumers Service Column.

How the Board Estimated Column: How did the Board arrive at its estimate of number served in **SFY 2005**? E.g., “Agency report.”

SEE DEFINITIONS ON PRECEDING PAGES TO COMPLETE THIS MATRIX

| Service Area | Service Available? | Using Technical Support? | Want Technical Support? | Number Served in SFY 2005 | How the Board Estimated |
|---|--------------------|--------------------------|-------------------------|----------------------------------|-------------------------|
| ACT | | | | | |
| Integrated Dual Diagnosis Tx (IDDT) | | | | | |
| Supported Employment | | | | | |
| Mental Health Housing Institute | | | | | |
| Illness Mgt. & Recovery (IMR) | | | | | |
| Older Adult services | | | | | |
| Specialized services for MI/MR | | | | | |
| Cluster-based Planning | | | | | |
| Family-to-Family | | | | | |
| Consumer Psycho-education | | | | | |
| Clubhouse | | | | | |
| Peer Support Service | | | | | |
| Consumer Operated Service | | | | | |
| General Transportation Service | | | | | |
| Anger Management / Domestic Violence | | | | | |
| Interpreter Services | | | | | |
| Trauma-Informed Care | | | | | |
| Other (Specify) | | | | | |

- 7.3.4.2 **Narrative (Optional):** Which areas of promising, best, and evidence-based practices or other services are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

| |
|------------------------------|
| Challenges/Solutions/Impacts |
|------------------------------|

7.3.5 **Competitive Employment**

Competitive employment is defined as work in the community that anyone can apply for that pays at least minimum wage. No minimum hours per week or month are included in the definition. The target population is adults, age 18 and older, with serious and persistent mental illness.

- 7.3.5.1 Based on this definition of competitive employment, do you have data needed to calculate the number of persons with SMD in your service area who are employed at this point in time? (Check one)

| | |
|-----|----|
| Yes | No |
| | |

- 7.3.5.2 If yes, what percentage of consumers do you estimate are currently employed? (Numerator = number competitively employed; Denominator = total number of adult consumers served)

% **Consumers employed**

7.3.6 **Housing (See Definition on Preceding Pages for Supported Housing)**

- 7.3.6.1 Do you offer **supported housing** service?

Yes No

- 7.3.6.2 If yes, do you have wait lists for **supported housing**?

| | |
|-----|----|
| Yes | No |
| | |

- 7.3.6.3 With regard to **supported housing**, which of the following categories comes closest to the average access time for most consumers?

| <i>10 working days or less</i> | <i>Up to 1 month</i> | <i>1-3 mos.</i> | <i>4-6 mos.</i> | <i>7-9 mos.</i> | <i>10-12 mos.</i> | <i>More than One Year</i> | <i>DK/NA</i> |
|--------------------------------|----------------------|-----------------|-----------------|-----------------|-------------------|---------------------------|--------------|
| | | | | | | | |

7.3.6.4 Of all consumers for whom supported housing would be an appropriate service, how many are currently waiting for **supported housing**?

_____ **Consumers waiting**

7.3.7 **Chronic homelessness** refers to individuals who are homeless because of a disabling condition (i.e., serious and persistent mental illness), and who either have been continuously homeless for a year or more OR have had at least four (4) episodes of homelessness in the past three years.

7.3.7.1 What is the estimated number of persons with SMD among the chronically homeless in your area?

_____ **Chronically homeless with SMD**

7.3.7.2 How did you arrive at your estimate of chronically homeless persons with serious mental disability? (Mark "X" for all that apply.)

| | |
|--------------|--|
| | Continuum of Care |
| | PATH |
| | BH Mod (Behavioral Health Module) |
| | HMIS (Homeless Management Information System) |
| Other | Specify: |

7.3.8 The **Housing Assistance Program (HAP)** provides temporary rental subsidies and no-interest loans to assist persons with severe mental disabilities and their families with obtaining permanent, safe, decent and affordable rental housing until a permanent subsidy can be obtained (Section 8 voucher), or until a person's income increases sufficiently so that a rental subsidy is not needed, or until person owns their own home.

7.3.8.1 Do you have wait lists for HAP?

| | |
|-----|----|
| Yes | No |
| | |

7.3.8.2 For most consumers waiting for access to HAP in your area, which of the following categories comes closest to the average access time?

| | | | | | | | |
|--------------------------------|----------------------|-----------------|-----------------|-----------------|-------------------|---------------------------|--------------|
| 10 working days or less | Up to 1 month | 1-3 mos. | 4-6 mos. | 7-9 mos. | 10-12 mos. | More than One Year | DK/NA |
| | | | | | | | |

7.3.8.3 Of all consumers for whom HAP is appropriate, how many are currently waiting for access?

_____ Consumers waiting

7.3.9 **Public Housing** is defined as housing subsidized by the federal government, such as but not limited to Section 8. People on HAP are likely to be on public housing wait lists, but HAP is not public housing.

7.3.9.1 Do you have wait lists for public housing?

| | |
|-----|----|
| Yes | No |
| | |

7.3.9.2 For most consumers waiting for public housing in your area, which of the following categories comes closest to the average access time?

| <i>Up to 1 year</i> | <i>1-2 yrs.</i> | <i>3-4 yrs.</i> | <i>5-6 yrs.</i> | <i>7-8 yrs.</i> | <i>9 yrs. or more</i> | <i>DK/NA</i> |
|---------------------|-----------------|-----------------|-----------------|-----------------|-----------------------|--------------|
| | | | | | | |

7.3.9.3 Of all consumers for whom public housing is appropriate, how many are currently waiting for a place to live?

_____ Consumers waiting

7.4 Child & Adolescent Services

7.4.1 **Child & Adolescent (C&A) Crisis Care: Definitions**

***Crisis Care Facility** is the provision of short-term, acute care to stabilize a child or adolescent experiencing psychiatric emergency. It is staffed 24/7 and is offered as an alternative to an inpatient psychiatric unit. It includes 23-hour observation and short-term, acute care beds. Treatment services are billed separately.*

***Mobile Response** is the provision of short-term, home-based crisis service to children and adolescents. Mobile response can also include on-site crisis service to schools, homes, sheriff/police departments, and juvenile detention centers. It DOES NOT INCLUDE: Multi-Systemic Therapy (MST) or Intensive Home-Based Treatment (IHBT) teams, community Emergency Medical Service (EMS), response by law enforcement officers with mental health training.*

***Respite** is temporary, short-term care for children and adolescents with serious emotional disturbance. It is designed to provide family members, custodians, or foster parents with temporary relief of caregiver burden and prevent out-of-home placement. Respite may be family or agency arranged. It DOES NOT INCLUDE group care facilities such as runaway shelters.*

7.4.1.1 **C&A Crisis Care Services**

Crisis services provided through Multi-Systemic Therapy (MST) or Intensive Home - based Therapy (IHBT) should be EXCLUDED from measurement of 24/7 on-call staffing.

For each of the following services that are available in your area, please indicate approximately how long C&A consumers wait for admission. If the program or service is not available, write "NO" in the "Service Available?" column.

| Service Area | Access Time? | | Service Available? |
|---|--------------------|--------------------|--------------------|
| | Less than one hour | More than one hour | |
| 24/7 On-Call Staffing by Psychiatrists | | | |
| 24/7 On-Call Staffing by Clinical Supervisors | | | |
| 24/7 On-Call Staffing by Case Managers | | | |
| Mobile Response for C&A Consumers | | | |
| 24/7 Central Phone Line | | | |
| Crisis Care Facility for Children and Adolescents | | | |
| Hospital Emergency Room with Psychiatric Staff | | | |
| Hospital contract for C&A Crisis Observation Beds | | | |
| C&A Respite Beds | | | |

7.4.1.2 **Narrative (Optional):** Which areas of crisis care are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

| |
|------------------------------|
| Challenges/Solutions/Impacts |
|------------------------------|

7.4.2 C&A Intensive Care Programs and Services: Definitions
(Use definitions to complete questions in the following sections.)

Residential Treatment Center (RTC) is a licensed 24-hour/7-day facility which provides room and board with mental health treatment, including (but not limited to) medication management, psycho-educational counseling, case management, behavior management, individual and family counseling, group therapy, and socio-cultural peer support. In some cases, treatment is based in a charter school or academy associated with the RTC; in other cases, treatment is based in the facility and is provided before and after school programming. In some cases, treatment is provided both in school and after school. Although room and board at the RTC may be paid through child welfare or other public funds, the RTC must be licensed by ODMH to provide outpatient mental health services.

Locked facilities, such as a Juvenile Detention Center with treatment services are not included in the definition of RTC.

Intensive care implies substantial clinical contact with youth who have serious mental or emotional disabilities characterized by significantly impaired functioning and/or symptoms of significant duration to warrant a service or programmatic intensity greater than general outpatient care.

Intensive Home-Based Therapy (IHBT) provides an array of services to youth needing time-limited interventions designed to preserve their tenure in the community. IHBT includes a coordinated group of services that consolidate the following: Community Psychiatric Treatment Services, Crisis Services, Diagnostic/Assessment, Counseling/Psychotherapy, and Partial Hospitalization. Med-somatic services may be provided in addition to IHBT. Additional services which may be included are behavioral management, problem solving, social skills, communications, coping, household management, parenting skills and any other services which directly or indirectly improve the mental health of the youth. MST Therapy is considered an IHBT, and the Center for Innovative Practice provides MST consultation and training.

Partial Hospitalization (PH) Program Type I is an intensive form of medically managed outpatient treatment that is time limited (two to six weeks) and goal-oriented. PH Program Type I allows youth to return home at night and typically serves the function of step-down from inpatient and residential care or diversion from inpatient and residential care. The major goals of PH Program Type I are symptom reduction and functional improvement.

***PH Program Type II** is defined as a school-based partial hospitalization program that provides an integrated curriculum combining education, counseling, medication management, CSP, and family interventions. The over-arching goal of PH Program Type II is functional improvement and school success, and it is typically longer term, with transitions and discharge occurring on a semester basis and at the end of the school year.*

***PH Program Type III** is defined as intensive, structured outpatient treatment in a setting such as a public or private clinic or at a RTC. PH Program Type III differs from school-based PH Program Type II because it does not provide an integrated curriculum of treatment and education. In PH Program Type III, treatment activity occurs outside of or apart from educational activity. It is typically longer term, with improved social skills as the over-arching treatment goal.*

***Therapeutic Pre-School / Early Childhood Day Treatment (EC Day TX)** is partial hospitalization programming for young children up to six years old.*

***Transitional Living Program** is a comprehensive, youth-driven program that includes the following essential service elements: employment services, education support, independent living, socialization/recreation, and transition facilitation, e.g., service coordination.*

Treatment Foster Care (TFC) is a home where trained foster parents who have access to other support services provide care to a child with serious emotional disturbance. TFC parents receive a higher stipend than traditional foster parents, and they receive extensive pre-service training and in-service supervision and support. Frequent contact between case managers or care coordinators and the treatment family is expected, and additional resources and traditional mental health services may be provided as needed. The intended length of this care is usually from six to 12 months. Multidimensional and Teaching Parent are examples of evidence-based TFC. In both models, consultants provide consultation and certification training. ODMH certified foster care service does not meet criteria as TFC.

***Family Therapy** is a treatment modality with interventions aimed at increasing parental effectiveness and family cohesion. It is primarily concerned with resolving interpersonal conflict rather than teaching parents and children how to manage the impact of a psychiatric condition. It can be conducted in a clinic or as a home-based model. Treatment intensity varies from as few as eight to as many as 30 one-hour sessions over 90 days.*

Functional Family Therapy (FFT) is a proprietary, evidence-based example of Family Therapy, and FFT provides consultation and training.

Multidimensional Family Therapy (MDFT) is a proprietary, evidence-based example of Family Therapy used with delinquent and substance-abusing youth, and the Center for Treatment Research on Adolescent Drug Abuse provides technical assistance.

Intensive Community Psychiatric Support Program (CPST) is case management service with caseloads in the range of 15 consumers and service contacts of greater frequency than once per month.

Intensive Psychiatry involves med-somatic service contacts of great frequency and duration than general psychiatric care. It is characterized by smaller caseloads and/or more lengthy psychiatric contact than general med-somatic service.

7.4.2.1 Residential Treatment

7.4.2.1.1 Over a 12-month period, how many children and adolescents from the Board area were funded for mental health services while living in a residential treatment facility?

_____ C&A Consumers

7.4.2.1.2 What percentage of children and adolescents from the Board area are placed in RTCs located outside of your service area? (Numerator = All C&A consumers placed at an RTC outside the Board area; Denominator = All C&A Consumers placed in RTCs over a 12-month period.)

% _____ C&A Consumers were placed out of county in SFY 05

7.4.2.1.2.1 W _____ hat percentage of the C&A consumers identified above (question 7.4.2.1.2) involved Board participation in the placement decision?

% _____ Of all out-of-county placements involved the Board

7.4.2.1.3 From January 2004 up to the present time, how would you describe the local trend in placements at Residential Treatment Centers? (Check one.)

Demand is increasing Demand is about the same Demand is decreasing

7.4.2.1.3.1 Does the Board have an explanation for the local trend in RTC placements indicated above (question 7.4.2.1.4)?

Reasons for RTC Placement Trend

7.4.2.1.4 What barriers are you experiencing to providing intensive community-based services which could reduce high-cost placements in out-of-home settings? (Check all that apply.)

Mark Barriers
“X”

- Funding to provide intensive community based services
- Cost of implementing and sustaining best practice models
- Restrictions from funding sources (e.g., Medicaid)
- Buy-in from local mental health providers
- Buy-in from Board members/Board staff
- Buy-in from community systems (e.g., Juvenile Court, PCSA, Commissioners)
- C&A consumers placed without Board participation in decision
- Lack of qualified staff to provide intensive community based services
- Lack of technical support for planning transition from out-of-home placements to intensive community-based services

Other (Please specify):

7.4.2.1.5 Please describe any innovative practices that have reduced high-cost RTC placements:

Innovative Practices that Reduce RTC Placements

7.4.2.2 **C&A Intensive Outpatient Programs and Services**

7.4.2.2.1 *If the program or service is not available, write “NO” in the “Service Available?” column. For each of the following services that are available in the Board area, please mark (X) under the column to indicate approximately how many working days (wd.) C&A consumers typically wait for admission.*

| Service Area | Service Available? | Up to 10 wd | 11 to 15 wd | 16 to 20 wd | 21 to 30 wd | 31 to 60 wd | 61 to 90 wd | 91 wd or more |
|--|--------------------|-------------|-------------|-------------|-------------|-------------|-------------|---------------|
| IHBT / MST | | | | | | | | |
| PH Program Type I (Time limited) | | | | | | | | |
| PH Program Type II (School-based) | | | | | | | | |
| PH Program Type III | | | | | | | | |
| Transitional Living Program | | | | | | | | |
| Therapeutic Pre-School / Early Childhood Day Treatment | | | | | | | | |
| Treatment Foster Care* | | | | | | | | |
| Intensive CPST | | | | | | | | |
| Intensive Psychiatry | | | | | | | | |
| Family Therapy | | | | | | | | |
| Other (Specify): | | | | | | | | |

***ODMH certified foster care service in MACSIS claims system does not meet criteria as Treatment Foster Care**

7.4.2.2.2 **Narrative (Optional):** Which areas of intensive treatment are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

Challenges/Solutions/Impacts

7.4.3 **C&A General Care**

General Care involves service provision of low to moderate intensity. It is appropriate for the general population of C&A consumers for whom high-intensity service need has not been identified.

7.4.3.1 **Services used in General Care**

If the program or service is not available, write “NO” in the “Service Available?” column. For each of the services that are available in your area, please indicate with a mark (X) approximately how many working days (wd) C&A consumers wait for admission.

| Service Area | Service Available? | Up to 10 wd | 11 to 15 wd | 16 to 20 wd | 21 to 30 wd | 31 to 60 wd | 61 to 90 wd | 91 wd or more |
|--------------------------------------|---------------------------|--------------------|--------------------|--------------------|--------------------|--------------------|--------------------|----------------------|
| Diagnostic Assessment - Physician | | | | | | | | |
| Diagnostic Assessment – NonPhysician | | | | | | | | |
| Psychiatry (Med-Somatic) | | | | | | | | |
| Counseling/Psychotherapy | | | | | | | | |
| CPST | | | | | | | | |

7.4.3.2 **Narrative (Optional):** Which areas of general care treatment are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

Challenges/Solutions/Impacts

7.4.4 **Promising, Best and Evidence-Based Practices and Other Services: Definitions (Use definitions to complete “Other C&A Services Matrix” on following pages.)**

Early Childhood Care is defined as any service or program provided to children from birth to six years old. It can include programs like Incredible Years, Help Me Grow, play therapy, or early detection and intervention, psychiatry, psychological testing, case management, and family counseling. This measurement EXCLUDES therapeutic preschool / early childhood day treatment.

C&A Family Psycho-Education involves teaching parents and children about psychiatric disorders, their treatments, and how to work effectively with mental health and school systems. Parents also learn and practice problem-solving and communication skills for symptom

management. Children learn and practice problem-solving, anger management, and communication skills. NAMI Hand-to-Hand training is an example, but inclusion criteria are not limited to this program.

School-based Services include staff consultation and education, on-site diagnostic assessment and referral, mobile crisis response, school-wide prevention programs (i.e., bullying prevention), on-site counseling and CPST. The Center for Learning Excellence CCOE provides training and consultation.

Specialized services for C&A consumers with MR/MI involve integrated services across systems of care and clinical best practices for the service population.

Specialized services for C&A consumers with SA/MI involve integrated services across systems of care and clinical best practices for the service population.

Specialized services for C&A consumers adjudicated for sexual offending behaviors involve integrated services across systems of care and clinical best practices for the service population.

Trauma-informed Care uses staff appropriately trained to conduct trauma assessments and provide interventions/therapies to address the trauma

Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) is an evidence-based practice that addresses the needs of C&A consumers with Post Traumatic Stress Disorder (PTSD) or other problems related to traumatic life experiences, and their parents or primary caregivers. TF-CBT is a model of psychotherapy that combines trauma-sensitive interventions with cognitive behavioral therapy. Children and parents are provided knowledge and skills related to processing the trauma; managing distressing thoughts, feelings, and behaviors; and enhancing safety, parenting skills, and family communication. The National Child Traumatic Stress Network provides consultation and training.

Interpreter Services for deaf, Hispanic, or other non-English-speaking populations include competence with culturally-based definitions of health and mental illness as well as linguistic fluency.

7.4.4.1 **Other C&A Services Matrix**
(Use definitions on preceding pages to complete this matrix.)

Service Available Column: Write “NO” if the Board does not provide the service. Place a mark (X) or write “YES” if the Board provides the service.

Using Technical Support Column: Place a mark (X) or “YES” if the Board has used the relevant CCOE, Network, or other technical support for consultation, training, and assistance with implementation. Leave the box blank or write “NO” to indicate lack of technical support.

Want Technical Support Column: If the Board or a provider wants technical support for a promising, best, or evidence-based practice, but is not currently using a CCOE, Network or other technical support services, write “YES.” Leave the box blank or write “NO” to indicate lack desire for technical support services.

Number of Consumers Column: Please estimate how many consumers received this service in **SFY 2005**. If you cannot make a reasonably informed estimate, enter “N/A” into the Number of Consumers Service Column.

How the Board Estimated Column: How did the Board arrive at its estimate of number served in **SFY 2005**? E.g., “Agency report.”

SEE DEFINITIONS ON PRECEDING PAGES TO COMPLETE THIS MATRIX

| Service Area | Service Available? | Technical Support? | Want Technical Support? | Estimated Number in SFY 2005 | How the Board Estimated |
|-------------------------|--------------------|--------------------|-------------------------|------------------------------|-------------------------|
| IHBT | | | | | |
| MST | | | | | |
| Treatment Foster Care* | | | | | |
| Early Childhood Care | | | | | |
| Family Psycho-education | | | | | |
| Family Therapy | | | | | |
| School-Based Services | | | | | |
| Trauma-informed Care | | | | | |
| MR/MI Integrated Svcs. | | | | | |
| SA/MI Integrated Svcs. | | | | | |
| Sexual Offender Svcs. | | | | | |
| Trauma-focused CBT | | | | | |
| Interpreter Services | | | | | |
| Cluster-based Planning | | | | | |
| Other (Specify) | | | | | |

***ODMH certified foster care service in MACSIS claims system does not meet criteria as Treatment Foster Care.**

7.4.4.2 **Narrative (Optional):** Which areas of C&A promising, best, and evidence-based practices are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

Challenges/Solutions/Impacts

7.4.5 **School-based Services**

MH Education & Promotion programs provide students with information, skills, and/or strategies for enhancing positive mental health, getting help, and supporting others with mental health issues.

Primary Prevention programs aim to prevent the development of mental health problems. Learning to identify and modify behavioral responses to stress is an example of primary prevention.

Secondary Prevention programs target high-risk children and adolescents. Programs for youth experiencing loss or traumatic events is an example of secondary prevention.

Assessment programs involve on-site screening and diagnostic assessment.

Intervention programs include referral, counseling, crisis response, and CPST.

Mainstream Schools are defined as any public, parochial, charter, or private school that serves the mainstream population of students.

Other Schools are defined as any public, charter, or private school that primarily services children with behavioral and emotional disabilities. Other Schools include Alternative, SBH/SED, and Partial Hospital Schools.

7.4.5.1 Which of the following types of school-based mental health programs does the Board currently support? Mark (X) or write "YES" if program type is available at Mainstream Schools and/or Other Schools in the Board Area; leave blank if not available.

| Type of Program | Mainstream Schools | Other Schools |
|---------------------------------|--------------------|---------------|
| MH Education & Promotion | | |
| Primary Prevention | | |
| Secondary (Targeted) Prevention | | |
| Assessment | | |
| Intervention | | |

7.4.5.2 In the table below, please write the name of any school district in the Board area in which services are being provided by the Board in **SFY 2006**. (Add rows to the table as needed.) Across from each district where school-based services are available, indicate how many schools are receiving services.

| A. Public School District Name | Number of School Buildings |
|--------------------------------|----------------------------|
|--------------------------------|----------------------------|

B. Name of Parochial, Private, or Charter School

7.4.5.3 **Narrative (Optional)**: Which areas of school-based service provision are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array?

Challenges/Solutions/Impacts

7.5 **Other Access Issues**

7.5.1 **Telemedicine**

See OAC 5122-2-01 (B) (49) for criteria

<http://www.mh.state.oh.us/licensurecert/general/lc.community.rules.html>

7.5.1.1 Is interactive videoconferencing technology (telemedicine) available in the Board area for behavioral health counseling and/or pharmacologic management?

Yes No

7.5.1.1.1 **If YES**, please describe how telemedicine is being used in the Board area:

Telemedicine Uses

7.5.2 **Disaster/Terrorism Preparedness**

7.5.2.1 What strategies or approaches is the Board taking with regard to disaster and terrorism preparedness? What innovative solutions have the Board used? What impact has funding issues had on disaster/terrorism preparedness?

Strategies/Solutions/Impacts

7.5.3 **Prevention, Consultation & Education (PC&E) Inventory**

See OAC 5122-22-03 for definition

<http://www.mh.state.oh.us/licensurecert/general/lc.community.rules.html>

7.5.3.1 In the table below, please list the names of PC&E programs and services funded in **SFY 2006** in the community. Include all prevention programs for adults, children and families across the lifespan. Include all suicide prevention, school-based prevention, risk assessment/screening, depression awareness, training and related programs. Across from each program and service, indicate type (P=Prevention; C=Consultation; E=Education). (Add rows to the table as needed.)

PC&E Programs & Services funded in SFY 2006

P, C, E

7.5.3.2 What percent of the Board's total **SFY 2006** budget is allocated for prevention, consultation and education (PC&E) services? (Numerator = expenditures planned for PC&E programs; Denominator = all expected service expenditures)

% _____ Allocated PC&E in SFY2006

7.5.4 **Medication**

7.5.4.1 Approximately how much was disbursed on medications through each of the following funding sources? Approximately what percent of adult consumers had their medications funded primarily through one of the following sources in **SFY 2005**? (Denominator = total number of adult consumers served by provider(s); numerator = estimated number of consumers served by a funding source.) Indicate an average percentage if reporting estimates from more than one provider.

| Funding Source in SFY 2005 | \$ Amount | % Consumers |
|--|-----------|-------------|
| 419 Allocation | | |
| Local Indigent Programs | | |
| Pharmaceutical Company Assistance Programs | | |
| Pharmaceutical Company Samples | | |
| Board Funds | | |

7.5.5 **System Capacity and Stability**

7.5.5.1 During the last two years, have any significant changes occurred in the Board area regarding the number and type of ODMH-certified providers? Has the local system experienced gains or losses through closures, consolidations, or new providers? Do you anticipate any changes in the next 12 to 18 months? Please discuss the impact of any recent or pending changes in the number and type of agencies in the Board area. (If no significant changes have occurred or will soon occur, please indicate “**No significant change.**”)

Significant Changes and Impacts in Provider Capacity During the Last Two Years

7.5.5.2 **Adult Care Staff Capacity**

Adult Care Med-Somatic Practitioners include all clinical staff licensed to prescribe medications; i.e., Medical Doctors (MDs) and Osteopaths (DOs) such as gerontologists, general medicine practitioners, psychiatrists, and advanced nurse practitioners.

7.5.5.2.1 How many of the following types of **adult** med-somatic practitioners are currently under contract in the Board area?

Psychiatrist FTEs: _____ Advanced Nurse Practitioner FTEs: _____
 Gen Practice Physician FTEs: _____ Other MD or DO FTEs: _____
 Specify Other: _____

7.5.5.2.2 How many of the following adult staff positions were budgeted (047) in the Board area during **SFY 2005**?

SFY 2005 Med-Somatic Practitioner FTEs: _____
 SFY 2005 Case Manager FTEs: _____
 SFY 2005 Counselor/Therapist FTEs:* _____
 *Includes psychologists, LPC/LPCC, LSW/LISW

7.5.5.3 **C&A Care Staff Capacity**

C&A Med-Somatic Practitioners include all clinical staff licensed to prescribe medications; i.e., Medical Doctors (MDs) and Osteopaths (DOs) such as general practitioners, pediatricians, psychiatrists, and advanced nurse practitioners.

7.5.5.3.1 How many of the following types of **C&A** med-somatic practitioners are currently under contract in the Board area?

| | | | |
|------------------------|-------|-----------------------------------|-------|
| Pediatrician FTEs: | _____ | C&A. Psychiatrist FTEs: | _____ |
| Family Physician FTEs: | _____ | General Psychiatrist FTEs: | _____ |
| Other Physician FTEs: | _____ | Advanced Nurse Practitioner FTEs: | _____ |
| Specify Other: | _____ | | |

7.5.5.3.2 How many of the following child & adolescent care staff positions were budgeted (047) in the Board area during **SFY 2005**?

| | |
|---|-------|
| SFY 2005 Med-Somatic Practitioner FTEs: | _____ |
| SFY 2005 Case Manager FTEs: | _____ |
| SFY 2005 Counselors/Therapist FTEs:* | _____ |
| *Includes psychologists, LPC/LPCC, LSW/LISW | |

7.5.5.3.3 **Narrative (Optional).** Has the Board developed any successful recruitment and retention strategies with regard to med-somatic practitioners, case managers, or therapists? If so, please discuss.

C&A Staff Recruitment and Retention Strategies

7.6 **Quality Improvement**

7.6.1 **Recovery & Resiliency**

7.6.1.1 What approaches or strategies does the Board currently use or plan to use to ensure service delivery is consumer driven in its orientation to recovery?

Current or Planned Approaches or Strategies

7.6.1.2 Please describe any peer support activities or consumer operated organizations that the Board currently supports and/or funds. If funding, please indicate how much per year.

Peer Support Activities/Consumer Operated Services/Level of Funding

7.6.1.3 What approaches or strategies does the Board currently use or plan to use to ensure service delivery is family driven in its orientation to resiliency?

Current or Planned Approaches or Strategies

7.6.2 Outcomes-Based Performance Improvement

7.6.2.1 What is the Board doing in **SFY 2006** to help providers meet the 80% threshold for Outcomes record submissions required by Certification standards under Outcomes Rule 5122-28-04? What targets have been set by the Board for the number of Outcomes records submissions in **SFY 2006**?

Activities, Strategies in SFY 2006

Targets

7.6.2.2 How is the Board using Outcomes data for performance improvement? (Discuss any and all areas deemed appropriate.)

Performance Improvement Area Describe activity

Program & Policy Planning

Program & Policy Evaluation

Provider Performance

Monitoring

Other (Specify):

7.6.3 Consumer and Family Empowerment

7.6.3.1 Which areas of consumer empowerment has the Board been successful with engaging consumer and family involvement? Mark (X) for YES or NO. (Discuss all areas deemed appropriate.)

Area Consumer Family Describe activity

Involvement? Involvement?

YES NO YES NO

Program & Policy Planning

Program & Policy Evaluation

Provider

Performance

Monitoring

Other (Specify):

7.6.4 Consumer Grievances, Complaints and Other Feedback

7.6.4.1 Describe a complaint or grievance the Board has handled in the last year in terms of any of the following components.

| Component | Description |
|---|-------------|
| Resulted in an impact on the local system | |
| Resulted in policy or procedural changes | |
| Required outside consultation | |
| Was most challenging among all cases in last year | |

7.6.4.2 Please provide the name, address, phone number, and email of the Board's Client Rights Officer:

| Name | Street Address | City | Zip | Phone Number | Email |
|------|----------------|------|-----|--------------|-------|
|------|----------------|------|-----|--------------|-------|

7.6.4.3 How are you using consumer feedback such as satisfaction surveys to improve your delivery of mental health services?

Uses of Consumer Feedback

7.6.5 Cultural Competence

7.6.5.1 How does the Board evaluate an agency's ability to provide culturally competent services? Does this process include consumers and family members?

Cultural Competence Evaluation

7.6.6.2 What strategies does the Board use to reduce disparities associated with race, ethnicity, language, age, gender, sexual orientation, and/or geography in the delivery of services?

Strategies to Reduce Disparities

7.7 **Cross-System Issues**

7.7.1 **Coordination of Child Serving Systems**

7.7.1.1 **Collaboration Matrix.** Please mark (X) in the “Collaborating” column to indicate agencies the Board is most engaged with in building stronger collaborative relationships.

Narrative: Which areas of collaboration are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array? (Discuss all areas deemed appropriate.)

[**Note to multi-county Boards:** Please discuss collaboration activities only with agencies in the counties where significant activity is currently taking place or is being planned.]

| Child-Serving Agency | Collaborating | Challenges/Solutions/Impacts |
|--|---------------|------------------------------|
| <i>FCFC</i> | | |
| <i>Juvenile/Family Court</i> | | |
| <i>Law Enforcement</i> | | |
| <i>Public Child Serving Agencies (PCSAs)</i> | | |
| <i>School Boards & Schools</i> | | |
| <i>MR/DD Boards & Providers</i> | | |
| <i>Health Department</i> | | |
| <i>Primary Care Physicians</i> | | |
| <i>Other (Specify)</i> | | |

7.7.2 **Adult and Juvenile Criminal Justice: Definitions**

Criminal Justice Coordination is an active planning committee or collaborative process involving the Board, providers, law enforcement, and the adult criminal and/or juvenile justice system.

Recidivism Strategies involve services to jails, youth detention and state correctional centers, and community re-entry programs designed to decrease the number of mental health consumers who return to jail, prison, or youth correctional centers.

Diversion Strategies involve CIT, mental health courts, and court liaison/boundary-spanner services designed to decrease the number of mental health consumers incarcerated in jail, youth detention, prison, and youth correctional centers.

Court involved adult is defined as an adult adjudicated for misdemeanors and/or felonies. Court-involved adult consumers may be on parole or probation; they may also be former prisoners or forensic patients who have returned to the community and are receiving services.

Court-involved juvenile is defined as a child or adolescent adjudicated for unruly and/or delinquent behavior. The definition DOES NOT include children and adolescents involved with courts due to abuse, neglect, or dependency.

7.7.2.1 **Adult Criminal Justice**

Narrative: Which areas of **adult criminal justice** and mental health are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area? (Discuss all areas deemed appropriate.)

[Note to multi-county Boards: Please discuss cross-system issues with Criminal Justice only in those counties where significant activity is taking place or being planned.]

Adult Criminal Justice Area Challenges/Solutions/Impacts
Adult Criminal Justice Coordination
Adult Recidivism Strategies
Adult Diversion Strategies

7.7.2.2 Can the Board estimate the number of adult consumers served by contract providers who are incarcerated in a local jail over a one-year period. Consumers served by contract providers are a non-duplicated count of adults who received enough services in the public mental health system to be identified as SMD through MACSIS claims administrative criteria during any year since 2000.

Yes No

7.7.2.2.1 **If “YES” to Question 7.7.2.2:**

What is the percentage estimate of adult consumers with SMD who are incarcerated in local jails over a one-year period? Numerator = unduplicated count of consumers with SMD incarcerated over a one-year period; Denominator = total number of adult consumers with SMD served by the Board over a one-year period.

% _____ Consumers in jail

7.7.2.3 Can the Board estimate the number of persons with SMD incarcerated in your local jails over a one-year period? Persons with SMD would be a non-duplicated count of consumers who have received services in the public mental health system (existing cases) as well as individuals with SMD (new cases) who have not received public mental health services.

Yes No

7.7.2.3.1 **If “YES” to Question 7.7.2.3:**

What is the percentage estimate of persons with SMD are incarcerated in local jails over a one-year period? Numerator = one-year unduplicated count of incarcerated consumers AND incarcerated individuals with SMD who are new cases for the mental health system; Denominator = total number of individuals incarcerated over a one-year period in local jails.

% _____ Persons with SMD in jail

7.7.2.4 Does the Board collect information on number of referrals involving **court-involved adults**?

Yes No

7.7.2.4.1 **IF “YES” to Question 7.7.2.4:**
 What is the estimated number of **court-involved adults** expected to receive services in **SFY 2006**? (This estimate is presumably based on number served in SFY 2005.)

_____ Court-involved adults in SFY 2006

7.7.2.4.2 **IF “YES” to Question 7.7.2.4:**
 How did the Board estimate the number of court-involved adults expected to receive services? E.g., “BH Mod” or “Agency Report”

Estimation Method

7.7.2.5 Please provide the name, address, phone number, and email of the Board’s Forensic Monitor:

| | | | | | |
|------|----------------|------|-----|--------------|-------|
| Name | Street Address | City | Zip | Phone Number | Email |
|------|----------------|------|-----|--------------|-------|

7.7.2.6 Please provide the name, address, phone number, and email of the Board’s Community Linkage Contact:

| | | | | | |
|------|----------------|------|-----|--------------|-------|
| Name | Street Address | City | Zip | Phone Number | Email |
|------|----------------|------|-----|--------------|-------|

7.7.2.7 **Juvenile Justice**

7.7.2.7.1 **Narrative:** Which areas of **juvenile justice** and mental health are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area? (Discuss all areas deemed appropriate.)

[**Note to multi-county Boards:** Please discuss cross-system issues with Juvenile Justice only in those counties where significant activity is taking place or being planned.]

| | |
|-------------------------------|------------------------------|
| Juvenile Justice Area | Challenges/Solutions/Impacts |
| Juvenile Justice Coordination | |
| Recidivism Strategies | |
| Diversion Strategies | |

7.7.2.8 Does the Board collect information on the number of referrals involving **court-involved juveniles**?

Yes No

7.7.2.8.1 **IF “YES” to Question 7.7.2.8**
 What is the estimated number of **court-involved juveniles** expected to receive services in **SFY 2006**? (This number is presumably based on number served in SFY 2005.)

_____ **Court-involved juveniles in SFY 2006**

7.7.2.8.2 **IF “YES” to Question 7.7.2.8**

How did the Board estimate the number of court-involved juveniles expected to receive services? E.g., “BH Mod” or “Agency Report”

Estimation Method

7.7.2.9 Does the Board fund services to county juvenile detention centers?

Yes No

7.7.3 **Integrated Physical Health Care**

7.7.3.1 Please mark (X) to indicate which age groups can access the indicated area of physical health care with a mental health provider in the Board area. Which areas of general health care by mental health providers are most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area? (Discuss all areas deemed appropriate.)

| Health Care Area | 18 yrs & below | 19 to 59 yrs old | 60 & above | Challenges/Innovations/Impacts |
|--|-------------------|---------------------|---------------|--------------------------------|
| Physical Health Assessments | | | | |
| Medication Compliance & Side-Effect Monitoring | | | | |
| Physical Health Information and Referral | | | | |
| Home Visiting Services | | | | |

7.7.4 **Older Adults**

7.7.4.1 **Older Adults** are individuals aged 60 or older.

Older Adult Matrix: Please mark (X) in the “Collaborating” column to indicate agencies the Board is most engaged with in building stronger collaborative relationships.

Narrative: Which areas of collaboration are the most problematic or on which the Board is most focused? What innovative solutions have the Board used? What impact has funding issues had on this area of the service array? (Discuss all areas deemed appropriate.)

[Note to multi-county Boards: Please discuss collaboration activities only with agencies in the counties where significant activity is currently taking place or is being planned.]

Older Adult Agency
Health Department

Collaborating

Challenges/Solutions/Impacts

Council on Aging

Adult Protective Services

Courts/Judicial System

Law Enforcement

MR/DD Boards

AOD Agencies

Housing Authorities

County Senior Svcs. Agency

Other (Specify):

Name, Board, Phone Number, and Email Address of Person Who Completed this Survey:

NAME:

BOARD:

PHONE:

EMAIL:

Completed surveys MUST be emailed electronically to Area Directors' Assistants:

Lynette Cashaw
CashawL@mh.state.oh.us
(Roma Barickman)
(Robin Gilbert)

Matt Loncaric
LoncaricM@mh.state.oh.us
(Jessica Byrd)
(Bill Cramer)
(Carroll Hernandez)

Direct any questions about the survey to:

Carol Carstens, PhD, LISW
614-752-9705 (Office)
CarstensC@mh.state.oh.us