I: State Information

State Information

Plan Year

Start Year:
2012

End Year:
2013

State DUNS Number

Number
809550106

Extension

I. State Agency to be the Grantee for the Block Grant

Agency Name
Ohio Department of Mental Health

Organizational Unit
Division of Program and Policy Development

Mailing Address
30 East Broad Street, 8th floor

City
Columbus, OH

Zip Code
43085

II. Contact Person for the Grantee of the Block Grant

First Name
Liz

Last Name
Gitter

Agency Name
Ohio Department of Mental Heatlh

Mailing Address
30 East Broad St., 8th floor

City
Columbus OH

Zip Code
43085

Telephone
614-466-9963

Fax

Email Address
Liz.Gitter@mh.ohio.gov

III. State Expenditure Period (Most recent State expenditure period that is closed out)

From
7/1/2010

To
6/30/2011

IV. Date Submitted

NOTE: this field will be automatically populated when the application is submitted.

Submission Date

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Liz

Last Name

Gitter

Telephone

614-446-3077

Fax

614-466-1571

Email Address

Liz.Gitter@mh.ohio.gov

Footnotes:

I: State Information

Assurances - Non-Construction Programs

Public reporting burden for this collection of information is estimated to average 15 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the Office of Management and Budget, Paperwork Reduction Project (0348-0040), Washington, DC 20503.

PLEASE DO NOT RETURN YOUR COMPLETED FORM TO THE OFFICE OF MANAGEMENT AND BUDGET. SEND IT TO THE ADDRESS PROVIDED BY THE SPONSORING AGENCY.

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non-discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§469a-1 et seq.).

14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance.
16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
17. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
18. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

Name	Tracy J. Plouck
Title	Director
Organization	Ohio Department of Mental Health

Signature: _____ Date: _____

Footnotes:

Ohio submitted these forms via overnight UPS mail to Virginia Simmons, Grants Management Officer at SAMHSA, Division of Grants Management. Office of Financial Resources on August 30, 2011.

I: State Information

Certifications

1. Certification Regarding Debarment and Suspension

The undersigned (authorized official signing for the applicant organization) certifies to the best of his or her knowledge and belief, that the applicant, defined as the primary participant in accordance with 45 CFR Part 76, and its principals:

a. are not presently debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from covered transactions by any Federal Department or agency;
b. have not within a 3-year period preceding this proposal been convicted of or had a civil judgment rendered against them for commission of fraud or a criminal offense in connection with obtaining, attempting to obtain, or performing a public (Federal, State, or local) transaction or contract under a public transaction; violation of Federal or State antitrust statutes or commission of embezzlement, theft, forgery, bribery, falsification or destruction of records, making false statements, or receiving stolen property;
c. are not presently indicted or otherwise criminally or civilly charged by a governmental entity (Federal, State, or local) with commission of any of the offenses enumerated in paragraph (b) of this certification; and
d. have not within a 3-year period preceding this application/proposal had one or more public transactions (Federal, State, or local) terminated for cause or default.

Should the applicant not be able to provide this certification, an explanation as to why should be placed after the assurances page in the application package.

The applicant agrees by submitting this proposal that it will include, without modification, the clause titled "Certification Regarding Debarment, Suspension, Ineligibility, and Voluntary Exclusion--Lower Tier Covered Transactions" in all lower tier covered transactions (i.e., transactions with subgrantees and/or contractors) and in all solicitations for lower tier covered transactions in accordance with 45 CFR Part 76.

2. Certification Regarding Drug-Free Workplace Requirements

The undersigned (authorized official signing for the applicant organization) certifies that the applicant will, or will continue to, provide a drug -free work-place in accordance with 45 CFR Part 76 by:

a. Publishing a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the grantee's work-place and specifying the actions that will be taken against employees for violation of such prohibition;
b. Establishing an ongoing drug-free awareness program to inform employees about--
    1. The dangers of drug abuse in the workplace;
    2. The grantee's policy of maintaining a drug-free workplace;
    3. Any available drug counseling, rehabilitation, and employee assistance programs; and
    4. The penalties that may be imposed upon employees for drug abuse violations occurring in the workplace;
c. Making it a requirement that each employee to be engaged in the performance of the grant be given a copy of the statement required by paragraph (a) above;
d. Notifying the employee in the statement required by paragraph (a), above, that, as a condition of employment under the grant, the employee will--
    1. Abide by the terms of the statement; and
    2. Notify the employer in writing of his or her conviction for a violation of a criminal drug statute occurring in the workplace no later than five calendar days after such conviction;
e. Notifying the agency in writing within ten calendar days after receiving notice under paragraph (d)(2) from an employee or otherwise receiving actual notice of such conviction. Employers of convicted employees must provide notice, including position title, to every grant officer or other designee on whose grant activity the convicted employee was working, unless the Federal agency has designated a central point for the receipt of such notices. Notice shall include the identification number(s) of each affected grant;
f. Taking one of the following actions, within 30 calendar days of receiving notice under paragraph (d) (2), with respect to any employee who is so convicted?
    1. Taking appropriate personnel action against such an employee, up to and including termination, consistent with the requirements of the Rehabilitation Act of 1973, as amended; or
    2. Requiring such employee to participate satisfactorily in a drug abuse assistance or rehabilitation program approved for such purposes by a Federal, State, or local health, law enforcement, or other appropriate agency;
g. Making a good faith effort to continue to maintain a drug-free workplace through implementation of paragraphs (a), (b), ?, (d), ?, and (f).

For purposes of paragraph ? regarding agency notification of criminal drug convictions, the DHHS has designated the following central point for receipt of such notices:

Office of Grants and Acquisition Management
Office of Grants Management
Office of the Assistant Secretary for Management and Budget

Department of Health and Human Services
200 Independence Avenue, S.W., Room 517-D
Washington, D.C. 20201

3. Certifications Regarding Lobbying

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non-appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93).

The undersigned (authorized official signing for the applicant organization) certifies, to the best of his or her knowledge and belief, that:

1. No Federal appropriated funds have been paid or will be paid, by or on behalf of the undersigned to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with the awarding of any Federal contract, the making of any Federal grant, the making of any Federal loan, the entering into of any cooperative agreement, and the extension, continuation, renewal, amendment, or modification of any Federal contract, grant, loan, or cooperative agreement.
2. If any funds other than Federally appropriated funds have been paid or will be paid to any person for influencing or attempting to influence an officer or employee of any agency, a Member of Congress, an officer or employee of Congress, or an employee of a Member of Congress in connection with this Federal contract, grant, loan, or cooperative agreement, the undersigned shall complete and submit Standard Form-LLL, "Disclosure of Lobbying Activities," in accordance with its instructions. (If needed, Standard Form-LLL, "Disclosure of Lobbying Activities," its instructions, and continuation sheet are included at the end of this application form.)
3. The undersigned shall require that the language of this certification be included in the award documents for all subawards at all tiers (including subcontracts, subgrants, and contracts under grants, loans and cooperative agreements) and that all subrecipients shall certify and disclose accordingly.

This certification is a material representation of fact upon which reliance was placed when this transaction was made or entered into. Submission of this certification is a prerequisite for making or entering into this transaction imposed by Section 1352, U.S. Code. Any person who fails to file the required certification shall be subject to a civil penalty of not less than $10,000 and not more than $100,000 for each such failure.

4. Certification Regarding Program Fraud Civil Remedies Act (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Public Health Service terms and conditions of award if a grant is awarded as a result of this application.

5. Certification Regarding Environmental Tobacco Smoke

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, daycare, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

By signing the certification, the undersigned certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act.

The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

The Public Health Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the PHS mission to protect and advance the physical and mental health of the American people.

Name	Tracy J. Plouck
Title	Director
Organization	Ohio Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements/Certifications (Form 3)

Community Mental Health Services Block Grant Funding Agreements
FISCAL YEAR 2012

I hereby certify that Ohio agrees to comply with the following sections of Title V of the Public Health Service Act [42 U.S.C. 300x-1 et seq.]

I. Section 1911:

Subject to Section 1916, the State will expend the grant only for the purpose of:
i. Carrying out the plan under Section 1912(a) [State Plan for Comprehensive Community Mental Health Services] by the State for the fiscal year involved:
ii. Evaluating programs and services carried out under the plan; and
iii. Planning, administration, and educational activities related to providing services under the plan.

II. Section 1912:

(c)(1)&(2) [As a funding agreement for a grant under Section 1911 of this title] The Secretary establishes and disseminates definitions for the terms “adults with a serious mental illness” and “children with a severe emotional disturbance” and the States will utilize such methods [standardized methods, established by the Secretary] in making estimates [of the incidence and prevalence in the State of serious mental illness among adults and serious emotional disturbance among children].

III. Section 1913:

(a)(1)(C) In the case for a grant for fiscal year 2011, the State will expend for such system [of integrated services described in section 1912(b)(3)] not less than an amount equal to the amount expended by the State for the fiscal year 1994.

[A system of integrated social services, educational services, juvenile services and substance abuse services that, together with health and mental health services, will be provided in order for such children to receive care appropriate for their multiple needs (which includes services provided under the Individuals with Disabilities Education Act)].

(b)(1) The State will provide services under the plan only through appropriate, qualified community programs (which may include community mental health centers, child mental-health programs, psychosocial rehabilitation programs, mental health peer-support programs, and mental-health primary consumer-directed programs).

(b)(2) The State agrees that services under the plan will be provided through community mental health centers only if the centers meet the criteria specified in subsection (c).

(C)(1) With respect to mental health services, the centers provide services as follows:

(A) Services principally to individuals residing in a defined geographic area (referred to as a “service area”)
(B) Outpatient services, including specialized outpatient services for children, the elderly, individuals with a serious mental illness, and residents of the service areas of the centers who have been discharged from inpatient treatment at a mental health facility.
(C) 24-hour-a-day emergency care services.
(D) Day treatment or other partial hospitalization services, or psychosocial rehabilitation services.
(E) Screening for patients being considered for admissions to State mental health facilities to determine the appropriateness of such admission.

(2) The mental health services of the centers are provided, within the limits of the capacities of the centers, to any individual residing or employed in the service area of the center regardless of ability to pay for such services.

(3) The mental health services of the centers are available and accessible promptly, as appropriate and in a manner which preserves human dignity and assures continuity and high quality care.

IV. Section 1914:

The State will establish and maintain a State mental health planning council in accordance with the conditions described in this section.

(b) The duties of the Council are:
(1) to review plans provided to the Council pursuant to section 1915(a) by the State involved and to submit to the State any recommendations of the Council for modifications to the plans;
(2) to serve as an advocate for adults with a serious mental illness, children with a severe emotional disturbance, and other individuals with mental illness or emotional problems; and
(3) to monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the State.

(c)(1) A condition under subsection (a) for a Council is that the Council is to be composed of residents of the State, including representatives of:

(A) the principle State agencies with respect to:
(i) mental health, education, vocational rehabilitation, criminal justice, housing, and social services; and
(ii) the development of the plan submitted pursuant to Title XIX of the Social Security Act;
(B) public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services;
(C) adults with serious mental illnesses who are receiving (or have received) mental health services; and
(D) the families of such adults or families of children with emotional disturbance.

(2) A condition under subsection (a) for a Council is that:
(A) with respect to the membership of the Council, the ratio of parents of children with a serious emotional disturbance to other members of the Council is sufficient to provide adequate representation of such children in the deliberations of the Council; and
(B) not less than 50 percent of the members of the Council are individuals who are not State employees or providers of mental health services.

V. Section 1915:

(a)(1) State will make available to the State mental health planning council for its review under section 1914 the State plan submitted under section 1912(a) with respect to the grant and the report of the State under section 1942(a) concerning the preceding fiscal year.
(2) The State will submit to the Secretary any recommendations received by the State from the Council for modifications to the State plan submitted under section 1912(a) (without regard to whether the State has made the recommended modifications) and comments on the State plan implementation report on the preceding fiscal year under section 1942(a).

(b)(1) The State will maintain State expenditures for community mental health services at a level that is not less than the average level of such expenditures maintained by the State for the 2-year period preceding the fiscal year for which the State is applying for the grant.

VI. Section 1916:

(a) The State agrees that it will not expend the grant:

(1) to provide inpatient services;
(2) to make cash payments to intended recipients of health services;
(3) to purchase or improve land, purchase, construct, or permanently improve (other than minor remodeling) any building or other facility, or purchase major medical equipment;
(4) to satisfy any requirement for the expenditure of non-Federal funds as a condition of the receipt of Federal funds; or
(5) to provide financial assistance to any entity other than a public or nonprofit entity.

(b) The State agrees to expend not more than 5 percent of the grant for administrative expenses with respect to the grant.

VII. Section 1941:

The State will make the plan required in section 1912 as well as the State plan implementation report for the preceding fiscal year required under Section 1942(a) public within the State in such manner as to facilitate comment from any person (including any Federal or other public agency) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary.

VIII. Section 1942:

(a) The State agrees that it will submit to the Secretary a report in such form and containing such information as the Secretary determines (after consultation with the States) to be necessary for securing a record and description of:

(1) the purposes for which the grant received by the State for the preceding fiscal year under the program involved were expended and a description of the activities of the State under the program; and
(2) the recipients of amounts provided in the grant.

(b) The State will, with respect to the grant, comply with Chapter 75 of Title 31, United Stated Code. [Audit Provision]
(c) The State will:
(1) make copies of the reports and audits described in this section available for public inspection within the State; and
(2) provide copies of the report under subsection (a), upon request, to any interested person (including any public agency).

IX. Section 1943:

(1)(A) for the fiscal year for which the grant involved is provided, provide for independent peer review to assess the quality, appropriateness, and efficacy of treatment services provided in the State to individuals under the program involved; and
(B) ensure that, in the conduct of such peer review, not fewer than 5 percent of the entities providing services in the State under such program are reviewed (which 5 percent is representative of the total population of such entities);
(2) permit and cooperate with Federal investigations undertaken in accordance with section 1945 [Failure to Comply with Agreements]; and
(3) provide to the Secretary any data required by the Secretary pursuant to section 505 and will cooperate with the Secretary in the development of uniform criteria for the collection of data pursuant to such section

(b) The State has in effect a system to protect from inappropriate disclosure patient records maintained by the State in connection with an activity funded under the program involved or by any entity, which is receiving amounts from the grant.

Notice: Should the President's FY 2008 Budget be enacted, the following statement applies only to States that received the Mental Health Transformation State Infrastructure Grants:

This Agreement certifies that States that received the Mental Health Transformation State Infrastructure Grants shall not use FY 2008 Mental Health Block Grant transformation funding to supplant activities funded by the Mental Health Transformation Infrastructure Grants.

Name	Tracy J. Plouck
Title	Director
Organization	Ohio Department of Mental Health

Signature: _____ Date: _____

Footnotes:

I: State Information

Disclosure of Lobbying Activities (SF-LLL)

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Footnotes:

Ohio did not submit this form, as it was optional in the instructions.

II: Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations

Page 22 of the Application Guidance

Narrative Question:

Provide an overview of the State's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the State, intermediate and local levels differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA and other State agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic and sexual gender minorities as well as youth who are often underserved.

Footnotes:

Step 1: Assess the strengths and needs of the service system.

Overview of Ohio's Mental Health System

State Agencies - Ohio has two cabinet level behavioral health agencies (in which the director reports directly to the governor). These agencies are the Ohio Department of Mental Health (ODMH) and Ohio Department of Alcohol and Drug Abuse Services (ODADAS). ODMH and ODADAS share some data systems including a Medicaid claims data base. The two agencies have become more collaborative in recent years by implementing a common Community Plan for Boards to apply for state funding, collaborating on interagency committees to integrate health care and shared prevention planning.

ODMH oversees a county-administered community mental health system which provides Comprehensive Community Mental Health Services, operates 6 state psychiatric hospitals, licenses private psychiatric hospitals and residential services, and certifies 389 community mental health providers. Effective SFY 2012, ODMH assumed responsibility for licensing Adult Care Facilities (ACF) and administration of the Residential State Supplement (RSS) program which transferred to ODMH from the Ohio Departments of Health and Aging, respectively.

Ohio's new Governor, John Kasich, created an executive Office of Health Transformation (OHT) which is overseeing health care reform in Ohio. Other state agencies having a major role in health care in Ohio are the Ohio Departments of Job and Family Services (ODJFS - state Medicaid agency and child welfare agency), Alcohol and Drug Addiction, Health, Developmental Disabilities, Aging and Insurance (Health Insurance Exchanges). Additional state agencies which provide services and supports to persons with mental illness and emotional disturbances include the Rehabilitation Services Commission (employment) and the Ohio Departments of Education, Rehabilitation and Corrections (adult justice), Youth Services (juvenile justice), and Development (housing).

Children's System of Care - For many years, Ohio's state budget has included a line item for Ohio Family and Children First which facilitates a System of Care (SOC) for multi-system-served children and youth. County Family and Children First Councils (FCFCs) include representatives from all child serving systems in the community; mental health, child welfare, health, juvenile justice, developmental disabilities, and education, as well as family members. FCFCs streamline and coordinate existing government services for families seeking services for their children. Service Coordination is not affiliated with any single system, but the results of service coordination impact family and community outcomes across all systems through a collaborative, coordinated, cross-system approach. FCFCs also annually evaluate and prioritize

services, fill service gaps where possible, and invent new approaches to achieve better results for families and children. State agencies contribute funds to the OFCF SOC framework through three collaborative funding components: (1) Family Centered Services and Supports (FCSS) focuses on maintaining children and youth in their own homes and communities by providing non-clinical, (2) family centered services and supports (i.e. respite, transportation, advocacy); (3) Behavioral Health/ Juvenile Justice (BHJJ) funds in six urban counties serves serious juvenile offenders who have co-occurring behavioral health care needs, diverting these youth form detention centers into more comprehensive, community –based behavioral health treatment; and Early Childhood Mental Health (ECMH) funds provide ECMH Consultation to identify and address early childhood behavioral health needs in child care settings, reducing the risk of removal from an early childhood settings. Community Mental Health Boards are also encouraged to provide community treatment services to children & youth with intensive behavioral health needs and at risk of removal from their homes, schools, early care, educational settings, and communities due to behavioral health issues, through their 505 budget line allocation.

County Behavioral Health Authorities known as "Boards" - Fifty county and multi-county Alcohol Drug Abuse and Mental Health/Community Mental Health (ADAMH/CMH) Boards are by state law responsible for planning, evaluating and contracting for mental health services; 47 of these Boards are also responsible for both mental health and substance use disorder services with only 3 counties (Butler, Lorain and Mahoning) continuing to maintain separate Boards. The Boards are prohibited by state law from providing direct mental health services except under exceptional circumstances. Most of these Boards have local tax levies that fund a large portion of the behavioral health services in Ohio. In the counties without local levies or lower tax bases (mostly rural Appalachian counties), fewer services are available to consumers. To address this service gap in a system with shrinking resources, ODMH has allocated $500,000 of Block Grant funds for crisis services (the only out-patient service required by state law) for Board areas with financial need which will allow these Boards to fund other services with Mental Health Block Grant Base (formula award), Title XX Block Grant and Ohio General Revenue Funds.

Impact of Recession on Mental Health Budgets - Nationally, the Great Recession simultaneously increased demand and decreased state subsidies and local tax revenue available for public sector mental health services. As part of its efforts to address budget shortfalls, Ohio reduced state subsidies for community-based mental health by 33% between Fiscal Year (FY) 2007 and FY 2010. At the same time, overall demand for public sector community-based mental health services increased by 14%, and Medicaid-covered individuals accessing these services increased by 21%. At the onset of the recession, Medicaid-covered individuals comprised 67% of the public sector community mental health caseload, and by 2010, the share of Medicaid-covered individuals equaled 72%. Under the American Recovery and Reinvestment Act (ARRA), the federal government temporarily paid a higher share of Medicaid costs, and the

higher rate of reimbursement tempered the loss in state subsidy for community-based mental health services in Ohio. The growth in Medicaid-covered individuals provided community-based organizations with a revenue stream that helped to offset the increased demand caused by the Great Recession.

Ohio, like other states, experienced major shortfalls for the FY 2012-2013 budget. The budget shortfall was primarily caused by relatively small gains in tax revenue that did not offset the loss of ARRA funds. ARRA was meant to provide temporary aid to help states with the increased need for public sector services during the Great Recession and through the early stages of recovery. Even though ARRA has expired, the higher level of demand for public sector services continues to persist, as is evident by Medicaid caseload counts for community-based mental health services. Even though the Great Recession officially ended 24 months prior to the end of FY 2011, preliminary data for FY 2011 indicate that Medicaid caseloads for community-based mental health services have continued to remain fairly constant at recessionary levels. In order to balance the budget without raising tax rates, Ohio reduced state subsidies for public sector services, including community-based mental health programs. To moderate the effects of reduced state subsidies, policymakers enacted cost containment measures for community-based mental health services reimbursed through the Medicaid program. For each Medicaid allowable service, state-enacted cost containment measures set a limit on the number of hours that can be billed for a consumer during a fiscal year. Prior authorization is required if limits for a given service are to be exceeded. Since FY 2011 Medicaid caseloads have not declined, top managers of community-based mental health organizations are confronted with the challenge of developing organizational strategies to absorb decreases in Medicaid revenue while maintaining the appropriate level of services.

Behavioral Health Medicaid Responsibility Changes – Under the Ohio Mental Health Act of 1988, Boards have historically been responsible for providing the state/local match for Community Medicaid Services (a behavioral health services carve-out), which became financially unsustainable as health expenditures grew and tax revenues shrunk. After meetings with major stakeholders including consumers, families, providers and Boards, a plan was developed which will be phased in during the next few years which will financially stabilize Ohio's mental health system, and align it with state health care reform efforts administered by the Office of Health Transformation.

Effective SFY 2012, the state (ODMH and ODADAS) will assume fiscal responsibility for meeting state Medicaid match for FFP (Federal Participation Rate) for behavioral health services. Responsibility for processing Medicaid claims will move from ODMH and ODADAS to Ohio Department of Job and Family Services (ODJFS, state Medicaid agency) during SFY 2012.

Effective SFY 2013, ODJFS will assume fiscal responsibility for Medicaid match for behavioral health services. At that time, providers will begin receiving Medicaid reimbursement for behavioral health services from ODJFS. ODMH will continue to develop mental health policies and programs, operate state hospitals, administer state General Revenue Funds and federal grant funds for mental health, and license residential facilities and certify Community Mental Health Centers. Boards will continue to plan, evaluate and fund local mental health services with local tax levies, state General Revenue Funds, federal grants and other non-Medicaid funds.

ODMH, ODADAS and ODJFS are working towards inclusion of behavioral health in managed health care plans for Medicaid-covered individuals. ODMH is also implementing general cost control strategies in SFY 2012.

Additionally, Governor Kasich's new Office of Health Transformation (OHT is implementing the **Affordable Health Care Act** in collaboration with all health related state agencies. A major goal of OHT is to manage costs of persons with multiple chronic health conditions including, but not limited to, severe and persistent mental illness. Ohio has a Money Follows the Person grant which funds an ODMH staff position focused on moving persons with severe and persistent mental illness back into the community from nursing facilities. Also, the State Legislature increased the amount of funding available for home and community based services and set limits to contain nursing facility expenditures.

Regional Psychiatric Hospitals - ODMH operates six nationally accredited psychiatric hospitals which serve adults only; more than half of adults in these hospitals are on forensic status. During SFY 2010 ODMH's hospitals had 4,665 civil admissions with an average length of stay of 21.5 days. All children, as well as the majority of adults on civil status are served by private psychiatric hospitals. More than 40 of the Boards have contracts with private psychiatric hospitals to provide in-patient services for consumers without Medicaid.

Community and Residential Providers – ODMH certifies 389 providers including 36 consumer-operated services. Providers of Medicaid-reimbursable services are required to have national accreditation and receive deemed status for most ODMH certification rules. ODMH also licenses 106 adult residential facilities with 948 beds and 49 child and adolescent residential facilities with 1,031 beds. In addition ODMH licenses a total of 83 Private Psychiatric Inpatient Hospital/Units, which includes 2,215 adult beds, 273 Adolescent Beds and 148 Child Beds. Providers range from small consumer-operated services to large health care organizations spanning several counties, including general and children's hospitals and some for-profit providers. Effective SFY 2012, ODMH assumed responsibility for licensing 674 Adult Care Facilities and administration of the Residential Supplemental Services (RSS) program which includes 89 Adult Foster Homes. ODMH is now the regulatory body that oversees license application, inspections and renewal procedures for operators of these residential options for

adults with various disabilities. Ohio's RSS program provides a cash subsidy for room and board, and Medicaid coverage, for eligible applicants who live in these types of community homes.

How Ohio Community Providers Address Diversity – Ohio's county-administered service system requires that local ADAMH/CMHs plan to meet diversity needs in their own communities. In some ADAMH/CMH areas some mental health services targeted for specific populations including African American, Somali, Hispanic, Deaf and Hard-of-Hearing, Appalachian, LGBT, military families and Amish. Additionally, ODMH funds **Multi-ethnic Advocates for Cultural Competence (MACC)** which provides regional trainings to providers to increase cultural competence, a statewide conference, and resources written in multiple languages. These resources provide guidance on how to meet the cultural needs of specific populations when delivering mental health services.

Statewide Consumer and Family Organizations funded by MHSBG provide essential Recovery Supports and education, as well as develop leaders who participate in state policy development workgroups. These groups also support advocacy----both for the individual (called "empowerment by consumer groups) and for the group. Major consumer and family organizations which provide these services include Ohio Empowerment Coalition, NAMI- Ohio, Ohio Federation for Children's Mental Health and Multi-ethic Advocates for Cultural Competence. Consumer and family organizations provide a range of non-clinical Recovery Supports that are a major component of Ohio's mental health system. These organizations also support networking and provide both formal and informal Recovery Support including informational and referral services, host statewide conferences and provide services developed by their members to fill gaps in the traditional mental health system. They have implemented nationally recognized evidence-based practices of WRAP (Wellness Recovery Action Plan), Family-to-Family, as well as a number of additional peer-education and family-education programs. For information about individual statewide and consumer organizations and the services provided, see #4 Priority – Recovery Supports.

Coordinating Centers of Excellence (CCOEs) are non-profit organizations which receive funding from ODMH to provide technical assistance, training and data analysis for the implementation of evidence-based and promising practices in Ohio. These organizations are supported by Mental Health Block Grant (MHBG) funds and actively seek financial support from grants, corporations and foundations, and also collaborate with universities and advocacy organizations. The Center for Innovative Practices (CIP) supports a range of children's evidence based practices including Multi-systemic Therapy, Integrated Co-occurring Treatment (mental health/substance abuse), Intensive Home Based Treatment and Multi-dimensional Treatment Foster Care. CIP holds a leadership role in the development and implementation of the Ohio Resiliency Initiative in partnership with the Ohio Federation for Children's Mental Health. Additional CCOEs support the evidence-based practices and promising for Substance

Abuse/Mental Illness, Supported Employment, Crisis Intervention Training for law enforcement, Wellness Management and Recovery, and Mental Illness/Developmental Disabilities best clinical practices. The Substance Abuse/Mental Illness CCOE has been jointly funded by ODADAS and ODMH since 2000. Also, ODMH funds some technical support and training for integration of behavioral health with primary care and development of best practices in housing supports.

#1 Priority Population – Children with Serious Emotional Disturbances (SED) and their Families

(Service descriptions apply to all ages.)

Ohio's behavioral health system has a public health approach that builds upon established collaboration among the state's child-serving agencies for children's services and among adult-serving agencies for adults. The continuum of services for children with Serious Emotional Disorders (SED) or at-risk for SED is provided in a System of Care framework and the continuum of services is described throughout this section. There are services such as Early Intervention, IHBT (Intensive Home Based Treatment), Family Therapy, school psychology services and residential care that are specific solely to children within Ohio's behavioral health system. Since almost all of these services are available to adults as well, this section describes services available in Ohio's mental health system for all ages, as well as some programs and initiatives that are population-specific for children and youth.

Prevention – Ohio's mental health system addresses prevention as evidenced by $5.3 million expended by ADAMH/CMHs in SFY 2010 for prevention of which more than $3 million was from local sources. ODMH and ODADAS are collaborating on prevention through a Shared Prevention Framework, and jointly fund the Ohio Suicide Prevention Foundation. Recently ODADAS represented ODMH at a NASMHPD (National Association of Mental Health Program Directors) prevention meeting. See Community Prevention priority for additional information. Additionally, some ADAMH/CMHs fund local prevention projects with Block Grant. Prevention initiatives in Ohio specific to children and families include: the Resiliency Initiative, Maternal Depression Screening and Training, Red Flags Depression Awareness Program, Ohio Mental Health Network for School Success, Early Childhood Mental Health Consultation, and Ohio Suicide Prevention Foundation.

Childhood Trauma - ODMH has convened intersystem stakeholders for Ohio's Childhood Trauma Initiative and has been involved in helping infuse trauma-informed care principles and

practices into the children's mental health system as well as working with other child-serving systems. ODMH is collaborating with Ohio's child welfare system to infuse trauma informed care in child welfare practices and when indicated, connecting with trauma-focused mental health treatment. The correlation of child maltreatment and behavioral health is undeniable. Children in the child welfare system are more likely to struggle with substance abuse and mental health problems. Chaotic home environments, trauma related to abuse, neglect and dependency and grief associated with separation and loss exacerbate the emotional stress suffered by these children.

In 2005 ODMH convened a cross-stakeholder Childhood Trauma Task Force that developed recommendations for statewide integration of trauma informed practice across all child and family-serving systems. The Task Force published a monograph on the continuum of trauma, the impact of trauma in everyday life, and model programs in Ohio. The expertise of four Ohio based National Child Traumatic Stress Network (NCTSN) centers provides a strong knowledge base needed to transform local systems and expand evidence-based treatment practices statewide.

Fourteen counties in Ohio currently are conducting a demonstration project for early childhood mental health/child welfare collaboration, for children birth to age 6 including their families (either birth, custodial, adoptive or foster) involved with the child welfare system. The demonstration project includes cross-system training of child welfare caseworkers and ECMH professionals on screening, assessment and social and emotional development of young children and childhood trauma.

Early Intervention – ODMH funds an early intervention program for children ages 0 – 6. The Early Childhood Mental Health (ECMH) Initiative provides parents and caregivers of young children with the knowledge and skills necessary to help their children develop into mentally healthy individuals. More than 24,000 children, their families and caregivers participated in Early Childhood Mental Health Consultation in early care and education settings in SFY 2010. Examples of Early Childhood Mental Health Treatments include: Play Therapy, DINA Small Group Therapy, Filial Therapy, Trauma Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, and Therapeutic Daycare/Preschool. For more information about this program, see Ohio's Early Childhood Mental Health for ages 0-6 which is a targeted population in this Plan.

Medicaid-Eligible Services - Ohio's community mental health system provides the following intervention services to persons of all ages that are included in ODMH Certified Mental Health Service Rules which are eligible for Medicaid reimbursement through a behavioral health carve out:

- **Behavioral Health Counseling and Therapy Service** means interaction with a person served in which the focus is on treatment of the person's mental illness or

emotional disturbance. When the person served is a child or adolescent, the interaction may also be with the family members and/or parent, guardian and significant others when the intended outcome is improved functioning of the child or adolescent and when such interventions are part of the Individual Service Plan.

- **Mental Health Assessment** is a clinical evaluation provided by an eligible individual either at specified times or in response to treatment, or when significant changes occur. It is a process of gathering information to assess client needs and functioning in order to determine appropriate service/treatment based on identification of the presenting problem, evaluation of mental status, and formulation of a diagnostic impression. The outcome of mental health assessment is to determine the need for care, and recommend appropriate services/treatment and/or the need for further assessment. Results of the mental health assessment shall be shared with the client.

- **Pharmacologic Management Service** is a psychiatric/mental health/medical intervention used to reduce/stabilize and/or eliminate psychiatric symptoms with the goal of improved functioning, including management and reduction of symptoms. Pharmacologic management services should result in well-informed/educated individuals and family members and in decreased/minimized symptoms and improved/maintained functioning for individuals receiving the service.

- **Community Psychiatric Supportive Treatment (CPST)** service 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. They are directed towards adults, children, adolescents and families and will vary with respect to hours, type and intensity of services, depending on the changing needs of each individual. (This service includes, but is not limited to, case management services.)

- **Partial Hospitalization** is an intensive, structured, goal-oriented, distinct and identifiable treatment service that utilizes multiple mental health interventions that address the individualized mental health needs of the client. Partial hospitalization services are clinically indicated by assessment with clear admission and discharge criteria. The environment at this level of treatment is highly structured, and there should be an appropriate staff-to-client ratio in order to guarantee sufficient therapeutic services and professional monitoring, control, and protection.

- **Crisis Intervention** is that process of responding to emergent situations and may include: assessment, immediate stabilization, and the determination of level of care in the least restrictive environment in a manner that is timely, responsive, and therapeutic.

Major gaps in Ohio's mental health system are community-based services for children and adults with more intensive needs. To address those needs, Ohio is working on rules for Medicaid-reimbursable services of:

- **Intensive home based treatment (IHBT)** service is a comprehensive service provided to a youth and his or her family that integrates community psychiatric supportive treatment (CPST) service, mental health assessment service, crisis response, behavioral health counseling and therapy service, and social services with the goals of either preventing the out-of-home placement or facilitating a successful transition back to home. These intensive mental health services are provided in the home, school, and community settings, and should address and improve the mental health functioning of the youth in each of these domains. (Currently included in ODMH's certification rules, but not yet Medicaid reimbursable as a service although some IHBT programs bill component Medicaid-reimbursable services listed earlier.)

- **Family Therapy** is therapeutic intervention for families of children with severe emotional disturbances. **(Family therapy is not currently included as an ODMH certified service.)**

- **Assertive community treatment (ACT)** is a collaborative, multidisciplinary team approach that shall include, at a minimum, behavioral health counseling and therapy service, mental health assessment service, pharmacologic management service, community psychiatric supportive treatment (CPST) service, self-help/peer support service, mental health crisis response service, substance abuse services, and supported employment services. (This service is primarily for adults with severe and persistent mental illness, but may also include transition age youth and young adults. The service is currently included in ODMH's certification rules, but not yet Medicaid reimbursable as ACT. However, some ACT teams bill component Medicaid services described earlier.)

- **Peer Support Services** is a service provided by persons who self-identify as having experienced serious mental illness, and who have met the credentialing requirements to become Certified Peer Specialists (CPS). Peer Support Service is a set of peer-based activities that engage, educate and support an individual to successfully make changes necessary to recover from disabling mental illness and co-occurring disorders. (This is a service primarily for adults with severe mental illness, but may also include young adults in transition. A new rule is being developed.)

Additional Services (Not Medicaid-Reimbursable) - Additional ODMH certified mental health services for all ages that are not Medicaid reimbursable include forensic evaluation service (described in Priority #6), Behavioral Health Hotline Service, Referral and Information Service, Adjunctive Therapy Service, Occupational Therapy Service, Social and Recreational Service, Adult Educational Services, and School Psychology Services. (Schools, not ODMH, fund most school psychology services in Ohio.)

- **Forensic Evaluation Service** means an evaluation resulting in a written expert opinion regarding a legal issue for an individual referred by a criminal court, domestic relations

court, juvenile court, adult parole authority, or other agency of the criminal justice system or an ODMH operated regional psychiatric hospital. Forensic evaluation service includes all related case consultation and expert testimony. Forensic evaluation service also assists courts and the adult who is being evaluated for placement or services. (See Priority Population #6 for more information about this service which has a line item in ODMH's budget.)

- **Recovery Supports** are funded by most ADAMH/CMH Boards with local and state funding. Recovery supports include **consumer operated services, employment services and housing services** which are described in Priority #4. Recovery Support Services, while essential to consumers, are not eligible for Medicaid reimbursement.

Additional Services for Children that are vital components of the Children Continuum of Services which are licensed (rather than certified) by ODMH include**:**

- **Therapeutic or Treatment Foster Care**: a foster home that incorporates special rehabilitative services designed to treat the specific needs of the children received in foster home and that receives and cares for children who are emotionally or behaviorally disturbed. These children may also have a co-occurring chemical dependency or developmental disability, or other exceptional needs.

- **Residential Treatment Facility (RTF)** are publicly or privately operated homes or facilities that meet one of the following classifications: a) Type 1 provides room and board and personal care services, and mental health services to one or more children and adolescents with a serious emotional disturbance or in need of mental health services, who have been referred or are receiving mental health services from a hospital, mental health agency, or practitioner; (b) Type 2 provides only beds-treatment may be provided by an external agency. (This service is also available to adults.)

Services Required for Children's System of Care - The System of Care framework supports care coordination serving the individual across service systems, rather than within the system in which the individual is served. The collaboration across government and private agencies, providers, families and youth for the purpose of improving access and expanding the array of services is a great benefit to children, youth and families living with mental health issues. Services are community-based, culturally and linguistically competent. SAMHSA Block Grant required System of Care Services include:

- **Social Services** include Title XX (Social Services Block Grant) administered by ODJFS as well as children's protective services. The ODJFS Office of Children and Families works for children, adults and families by mutually educating and engaging communities and systems to jointly provide services to achieve safety, permanency, self-sufficiency

and well-being. This office is responsible for state level administration and oversight of programs that prevent child abuse and neglect; provide services to abused/neglected children and their families (birth, foster and adoptive); license foster homes and residential facilities; license child care homes and facilities; and investigate allegations of adult abuse, neglect and exploitations.

ODJFS is also the state agency under Ohio law responsible for the administration of Title XX Social Service program. ODMH receives 12.93% of Ohio's Title XX funds, which are distributed to the Boards for mental health services and included in Ohio's Title XX Plan with a cross-walk to ODMH Certified Mental Health Services. The purpose of the Title XX program is to provide social services directed to enable residents of Ohio to restore, maintain or improve their capabilities for self-support, self-care, independent living and for strengthening family life.

- **Educational Services -** The Ohio Department of Education (ODE) Office for Exceptional Children provides leadership assistance and oversight to school districts and other entities that provide differentiated instruction for students with disabilities and gifted students. This agency administers state and federal funds, and implements a statewide monitoring and complaint-resolution system designed to assess district/educational agency compliance with applicable federal and state laws and regulations. Additionally the ODE Office of Safe and Supportive Learning Environments works collaboratively with ODMH on a comprehensive system of learning supports to improve school climate and reduce the non-academic barriers to learning for students at risk for mental health challenges.

- **Services Provided under the Individuals with Disabilities in Education Act (IDEA)** - ODE provides technical assistance to districts and educational agencies around issues of compliance with the Individuals with Disabilities Education Improvement Act (IDEA) which has established a process for determining educational needs and getting special education services when a child's disability requires them. Part C of the IDEA provides services, education and support for children birth through 2 who have a disability or delay. The Ohio Department of Health utilizes Part C of the IDEA to fund local Help Me Grow programs to provide family supports and service coordination for families with infants and toddlers with developmental delays and disabilities.

- **Juvenile Services -** The Ohio Department of Youth Services (ODYS) is the juvenile corrections system for Ohio. County juvenile court judges commit male and female offenders, ages 10 to 18; who have been adjudicated for felony-level offenses. Committed youth may be incarcerated until age 21. ODYS operates five juvenile correctional facilities, one privately contracted facility and five regional parole offices.

ODYS administers federal and state funds to communities for projects that are consistent with federally-mandated goals and Ohio's juvenile justice needs. In addition, given that 55% of the youth committed to ODYS are placed on a mental health caseload, ODYS has collaborated with ODMH on several mental health initiatives for justice involved youth. The Behavioral Health/Juvenile Justice (BHJJ) Project funds six urban counties to assess youth for appropriateness of services in their communities versus admission to a detention facility. The goals of the project include reducing ODYS admissions, reducing recidivism, building stronger family units, and identifying and promoting community integration.

- **Substance Abuse Services** - The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) provides statewide leadership in establishing a high quality addiction prevention, treatment and recovery services system of care that is effective, accessible and valued by Ohioans. ODADAS has been a key partner with cross-system collaboration, prevention and recovery efforts, and the alignment of resources. ODADAS and ODMH jointly support the Substance Abuse/Mental Illness Coordinating Center of Excellence.

Additional services required by SAMHSA federal Block Grant statute:

- **Medical and Dental Services** are available by referral; a few community mental health centers include primary health care on site.

- **Homeless** - Services for homeless children and youth are provided by the child welfare system rather than mental health system. Residential treatment and foster care available; a few mental health providers in urban areas have programs targeted to run-away, homeless youth (e.g. Huckleberry House in Columbus). See Priority #5 for services for homeless adults.

- **Case Management** (See Community Psychiatric Supportive Treatment which includes, but is not limited to, case management.)

- **Rural Services –** see Priority #7

Management Systems (Required by Block Grant)

- **Financial Resources** – see Table 7

- **Staffing** – Boards and providers are responsible for local work force development. ODMH participates in the Health Professional Shortage Area (HPSA) program to provide forgiveness for student loans for new graduates who practice in underserved areas.

ODMH also provides limited funding for psychiatric residents. Ohio has multiple graduate schools for medicine, psychology, social work, nursing and counseling.

- **Training for Mental Health Providers to Implement State's System of Care** is provided by ODMH Divisions of Medical Director, Program and Policy Development and the Office of Medicaid. Training includes implementation of ODMH policies and programs into service delivery of clinical services (Medicaid reimbursable) and resiliency supports (e.g. Parent Advocacy Connection and Hand-to-Hand for children and youth, and peer support and peer education for adults).

- **Training of Providers of Emergency Health Service Regarding Mental Health -** Ohio's county boards contract with local providers and are responsible for ensuring training for staff delivering emergency mental health services under ordinary conditions in clinical settings and in community settings. The All Hazards Leadership Advisory committee, county behavioral health authorities, and provider agencies continue support of clinician and other responder trainings to address emergency mental health needs following disasters.

#2 Priority Population – Adults with Serious Mental Illness (SMI)

Priority Population – Adults with Serious Mental Illness (SMI) are a diverse group with complex needs and are often dually diagnosed with SMI and substance use disorders, developmental disabilities and physical health conditions. The majority of these adults face poverty, unemployment, incarceration, victimization, homelessness and lack of social support. Additionally, the severe and chronic nature of serious mental illness along with the complexity of needs and high cost of health care make this population a priority.

The public mental health system that is responsible for caring for adults with SMI consists of the state agency, 6 Regional Psychiatric Hospitals, 50 ADAMH/CMH boards and 389 community mental health providers. The 389 providers range from regional health care centers which are integrated with hospitals to small consumer operated services which provide only one service. The mental health system is in need of increased funding and a sustainable fiscal structure to restore services and expand capacity after decreased state revenues secondary to economic downturn led to deep cuts in the mental health system for the past several years. The community subsidy of state General Revenue Funds was reduced from a high of $330 million in SFY 2008 to $216 million in SFY 2010, and increased slightly to $218 in SFY 2011. To manage these cuts, Boards and community mental health centers eliminated programs and staff, but did not reduce

the number of persons served. Behavioral health services have been shrinking which has reduced access to care while need for these services have been rising due to unemployment. Furthermore, the budget cuts forced local Boards to shift state and local funds to cover match requirements for Medicaid services, leaving less funding for essential non-Medicaid services and Recovery Supports (e.g. housing, employment and peer support) to the SMI population.

On the positive side, Adults with SMI remain a high priority and services for this population are a core mission for ODMH. The administration passed a series of initiatives to reform the health care delivery system and Medicaid. In order to sustain the mental health system fiscally, the state has introduced cost containment measures in the form of reimbursement rate reductions for CPST (Community Psychiatric Supportive Treatment) services exceeding 90 minutes in one day. Additionally, ODMH implemented prior authorization requirements for CPST and partial hospitalization services exceeding annual service caps. The Ohio Office of Health Transformation has been leading and coordinating these health care reforms in the state by working with the six health and human services state agencies.

Clinical Services and Recovery Supports for Adults with SMI – Please see the description of Ohio's comprehensive mental health system under Children with SED as most services are for all ages except for Intensive Home Based Treatment.

ODMH Program Initiatives

Coordinating Centers of Excellence- ODMH continues to support Coordinating Centers of Excellence (CCOEs) as a means of promoting evidence-based practices and emerging best practices that address critical needs of adults affected by serious mental illness. CCOEs provide training, consultation, fidelity assessment and evaluation services to provider organizations implementing evidence-based and promising practices. CCOEs are composed of a unique mix of partners which include ODMH, Ohio universities, consumer or advocacy groups, local mental health boards, private research entities and provider trade associations. Their primary audience is agency-based mental health practitioners, but they also work with consumers, family members, other health practitioners, and key constituents from other local systems, such as education and criminal justice. Each CCOE promotes a specific evidence-based or emerging best practice by providing services such as education, training, consultation, and fidelity and outcomes evaluation. ODMH has been supporting evaluation and cost-effectiveness of Integrated Dual Diagnosis Treatment (IDDT) for the past several years and is in the process of launching a larger scale project through the Office of Research and Evaluation to evaluate cost-effectiveness of other EBPs in Ohio.

Wellness Management and Recovery CCOE- is a not-for profit technical assistance organization that assists providers and systems to implement and sustain Wellness Management and Recovery for adults with serious mental illness and co-occurring substance use disorders and physical health problems. The WMR curriculum promotes good physical, spiritual and emotional

health by teaching skills that empower individuals to identify and achieve personal goals; develop informed, collaborative approaches to selecting and managing treatment and recovery effectively and achieve a healthier lifestyle. The curriculum is team taught with consumer and practitioner facilitators. A total of 21 provider agencies including Consumer Operated Service Centers, have implemented WMR within 16 Counties since 2009. Over 1000 adults with SMI received WMR services. The CCOE trained 287 mental health professionals and peers in WMR.

Substance Abuse/Mental Illness (SAMI/MISA) CCOE promotes clinical quality through implementation of Integrated Dual Disorder Treatment (IDDT) in Ohio's community mental health system, and has been jointly funded by ODMH and ODADAS for more than ten years. The New Hampshire-Dartmouth Integrated Dual Disorder Treatment (IDDT) model is an evidence-based practice that improves the quality of life for people with co-occurring severe mental and substance use disorders by combining substance abuse services with mental health services. It helps people address both disorders at the same time—in the same service organization by the same team of treatment providers. This CCOE promotes IDDT with Boards and providers by providing services such as education, training, consultation, and fidelity reviews and outcomes evaluation. A total of 49 organizations implemented over 60 IDDT teams, which served about 5800 adults with SMI and serious substance use disorders. Over 5000 mental health professionals are trained in IDDT. The CCOE also promotes services to assist mental health and addiction providers to become dual diagnosis treatment capable to serve the substantial number of dual diagnosed adults that do not meet the severity criteria for IDDT. It is estimated that fifty-percent of the population served in the mental health system are dually diagnosed with mental illness and substance use disorder.

The Mental Illness/Developmental Disabilities (MI/DD) CCOE provides training, technical assistance, integration of service systems and consumer advocacy to support assessments and evidence-based treatments to meet the needs of individuals with Mental Illness and Developmental Disabilities. This CCOE also uses Block Grant funding to support a statewide conference and regional training for professionals, advocates and family that addresses the needs of consumers dually diagnosed with MI/DD. This CCOE is jointly funded by the Ohio Department of Developmental Disabilities and ODMH.

ODMH Evidence-Based Practice (EBP) Evaluation Project - One of the Block Grant proposed projects is to use data and outcomes to measure the effectiveness of EBPs currently being used and supported by ODMH. Over the past few years, the department in conjunction with the Center for Evidence Based Practices (CEBP) at Case Western Reserve University has been conducting "the IDDT Affiliation Code Project". This is a tool to help the state measure the impact of IDDT on consumers. A recent study by the SAMI CCOE evaluation team revealed that one year after being on the IDDT team, service costs were reduced by $1.4 million for a high utilizer group of 160 people. Also, a significant decrease in utilization of crisis and inpatient services was observed. The new expanded project aims to measure impact of other evidence-

based practices including Wellness Management and Recovery (WMR), Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT) and Supported Employment (SE) on recipients of these services.

Other State Initiatives

Elevate Medicaid Behavioral Health Financing to the State - Beginning in SFY 2012, the state will transition the financial responsibility for the non-federal share of Medicaid matching funds for alcohol and drug treatment and mental health carve-out benefits from community behavioral health boards to the state, with full integration occurring in SFY 2013. This move clarifies and aligns responsibility among state agencies and frees up community levy funding, allowing county behavioral health boards to focus on developing and managing non-Medicaid community services and supports.

Manage Behavioral Health service Utilization - The budget establishes much-needed utilization-management controls and cost-containment tools for community mental health Medicaid benefits. Without these strategies, which are already available for other services provided under Medicaid, funding for community mental health services will not be sustainable, and increased pressure will be placed on state and local funding structures. Controls will be put in place to ensure that individuals receive the mental health services they need.

Consolidate Housing Programs -The budget consolidates oversight of the Residential State Supplement (RSS) housing program, and regulation of Adult Care Facilities and Adult Foster Homes in ODMH, resulting in a streamlined and efficient administrative structure.

Older Adults - Healthy IDEAS (Identification, Depression, Empowering Activities for Seniors), an evidence based mental health practice for seniors, continues to be available to PASSPORT recipients through integration of limited mental health services through a Home and Community Based wavier service. Additionally, a few mental health providers, mostly in urban areas, offer targeted services to older adults. In most other areas of the state, older adults receive the same services as adults do.

Integrated Care Initiatives – see Priority #3.

#3 Priority Population – Bi-directional Integration of Behavioral Health with Primary Care

Priority Population – Bi-directional Integration of Behavioral Health and Primary Care Services - ODMH and ODADAS promote and support a broad array of initiatives in the area of

integration to address increasing co-morbid behavioral and other physical health conditions and improve health outcomes for individuals with severe and persistent mental illness. Below are brief descriptions of current efforts ODMH and ODDAS are undertaking to promote bi-directional integration of behavioral health and primary care services.

Integrated Clinical Care Director Section -ODMH created Integrated Clinical Care (ICC) Director position within Medical Director's Division for promoting, overseeing and coordinating the state-wide efforts in bi-directional integration of behavioral health and primary care. The ICC Director promotes integrated care approach by engaging in program development, technical assistance and education, formal presentations, and training. This position serves as the "content" expert on primary care and behavioral health integration and represents ODMH on state-wide committees.

Create a Single Point of Care Coordination - The budget lays the groundwork for a new Integrated Care Delivery System (ICDS) that will provide comprehensive, person-centered care that addresses the physical health, behavioral health, long-term care and social needs of seniors and people with disabilities. Ohio will submit a waiver proposal to the federal Centers for Medicare & Medicaid Services to implement the ICDS for people who are eligible for both Medicaid and Medicare ("dual eligible") and people with severe and persistent mental illness by September 2012.

Promote Health Homes -The budget invests $47.25 million over the biennium to enhance coordination of the medical and behavioral health care needs of individuals with severe and/or multiple chronic illnesses by expanding on the traditional medical home model of care. The Integrated Clinical Care Director and ODMH Medicaid Director are currently in the process of designing Behavioral Health/Primary Care Integration Innovation and HIT (Health Information Technology) Innovation Projects to accelerate adoption of integrated care programs around the state and lay the foundation for Health Homes for people with serious mental illness. ODMH has been coordinating health home design efforts for Behavioral Health populations with the Governor's Office of Health Transformation, the state Medicaid agency and Ohio Department of Alcohol and Other Drug Services.

Integrate Behavioral and Physical Health Benefits -The state budget takes several important steps to treat physical health conditions and behavioral health conditions in a comprehensive, coordinated manner. During SFY 2012-2013, Ohio will integrate the Medicaid alcohol and drug treatment and mental health carve-out benefits (currently administered by ODMH and ODADAS) into the overall Medicaid program administered by ODJFS, improving coordination of these services. Ohio will also improve care coordination for people with a severe and persistent mental illness through the creation of the ICDS (Integrated Care Delivery System) and the development of ACOs (Accountable Care Organizations) and health homes.

Pediatric Psychiatry Network (PPN) aims to help primary care physicians deliver and/or coordinate mental health care for youth within the primary care setting. This initiative integrates behavioral health specialty services into primary care. PPN is a technologically supported partnership between ODMH, several medical schools, and Ohio's children's hospitals. Primary care practices, community mental health provider organizations, and general psychiatrists, are able to call a single toll-free number and be linked within minutes to a child/adolescent psychiatrist at a children's hospital or medical school to obtain consultation about treating a child in his/her care. This preserves the medical home and improves services. Additionally, health care professionals have the ability to send a video via a secure link for more detailed diagnostic and consultative work using a state of the art web-site. The web-site provides up to date information, a set of common protocols, and live, real-time telemedicine. There are approximately 100,000 children who can benefit from these services. To this date, 162 telephone consults have been provided to primary care providers and their patients across the state since October 2010. The behavioral health consult requests have included a full range of diagnosis such as, ADHD (attention deficit, hyperactivity disorder), Anxiety/Trauma, Depression, Aggression, Bipolar, OCD (obsessive compulsive disorder), Panic Attacks, Suicidal Ideations, and Eating Disorders.

ODMH Longevity Project- The longevity project is an analysis of comorbidity and mortality rates for Ohioans who have been diagnosed as having SPMI (severe and persistent mental illness) and who receive publicly funded mental health services. This analysis 1) compares SPMI individuals' morbidity/mortality rates with the overall Ohio and U.S. rates; 2) provides information about the leading causes of death; 3) compares SPMI years of potential life lost rates by Ohio and U.S. rates, by gender and race/ethnicity; and 4) analyzes medical comorbidity conditions. Recently available results of the longevity study showed that Ohio decedents in the publicly funded MH system die 26 years earlier than an age-matched cohort of those who did not die (ODMH, 2011).

Get Connected is a program designed to meet the physical health and wellness needs of consumers of mental health. ODMH contracts with Mental Health America of Franklin County to implement this 10-week health education program. The program includes tips and tactics, and resources for overall better health.

Medication-Assisted Treatment Clinical Trials Project — The ODADAS treatment division and consulting physician Dr. Philip Prior, in conjunction with the Ohio Society of Addiction Medicine and the Cincinnati-based Clinical Trials Network are developing recommended protocols for the use of FDA-approved medication-assisted treatment. This protocol will play a critical role in the treatment of opiate addiction. ODADAS data shows that clients in treatment for opiate addiction are almost three times more likely to terminate from treatment early. National research shows that persons treated for opiate addiction relapse at a rate that ranges from 80 to 95 percent. Treatment integrated with medication has shown to dramatically improve clinical outcomes.

Recovery to Work — In February 2011, ODADAS, in partnership with the Ohio Department of Mental Health, Ohio Rehabilitation Services Commission and the Ohio Association of County Behavioral Health Authorities, began the Ohio Recovery to Work project. ODADAS, ODMH and local ADAMHS Boards provided the funding match for the opportunity to utilize $36 million in federal dollars to serve Ohioans in need of addiction and/or mental health treatment services, along with job readiness skills for re-entry into the workforce. The project includes a specific designation for Scioto County to assist in treating the opiate epidemic. Target populations for the project are people with opiate addiction or severe mental illness, veterans, offenders leaving institutions, and young adults.

Health Home for People with Opiate Addiction— ODADAS is working with the Appalachian Regional Commission (ARC) and the Ohio Association of Community Health Centers to develop a pilot health home project in southern Ohio counties, including Scioto, to connect physical and behavioral health care for residents struggling with the disease of addiction. This health center will focus on integrating both physical and behavioral health care needs.

Substance Abuse/Mental Illness Coordinating Center for Excellence has been jointly funded by ODMH and ODADAS since 2000, and is described under Priority #2.

#4 Priority Population – Recovery Supports

Recovery Supports (non-clinical services and supports) for persons with substance disorders have developed separately for consumers with mental health and drug abuse services in Ohio, and are funded by separate state agencies, ODMH and ODADAS. Recovery Supports are provided by statewide consumer and family organizations funded by **Mental Health Block Grant** and are represented on Planning Council. These organizations include:

- **Peer Recovery Support and Peer Education - <u>Ohio Empowerment Coalition (OEC)</u>** OEC is a statewide consumer organization that provides consumer representatives for state policy committees, hosts an annual statewide conference and provides supports for about 60 local consumer organizations/peer support groups of which 36 are ODMH certified providers. Additionally, OEC supports training-of-trainers for the evidenced based practice of WRAP, as well as BRIDGES (Building Individual Dreams and Goals through Education and Support) and Psychiatric Advance Directives (PAD). These peer education programs are provided through local consumer organizations which also receive technical assistance from OEC. Current new work includes developing a certified Peer Support Service standard for Medicaid-reimbursable Peer Support Services, as well as the training and certification process.

- **Family & Peer Recovery Support and Education - NAMI – Ohio** (National Alliance on Mental Illness) provides recovery supports for more than 50 local chapters which provide *Family-to-Family* education (evidence based practice) for families of adults with SMI and *NAMI – Basics* (replacing *Hand-to-Hand*) for families of children with SED. Additionally, NAMI provides *Crisis Intervention Training* for law enforcement officers, which increases their skill level to respond to consumers with mental illness and/or co-occurring substance use disorders. For children with SED, NAMI operates *Parent Advocacy Connection* (PAC) which provides "parent-navigators" to serve as mentors for families with children with SED. NAMI also recently provided training to mental health professionals to address primary care health issues in their practice that are common to consumers (e.g. constipation, metabolic disorders). NAMI-Ohio participates in NAMI-nationals' bi-annual survey to identify gaps in each state's mental health system

- **Family & Children/Youth Recovery Support & Education - Federation for Children's Mental Health facilitates networking** among children and youth with SED and their families, and represents them on state policy groups. This group has been instrumental in developing the Resiliency initiative, and an Ohio chapter of Youth MOVE for transitional age youth/young adults. The parents of children with SED continue to assist ODMH in prioritizing unmet needs in Ohio's behavioral health care system and make significant contributions to policy development.

- **Diversity Consumer and Family Recovery Supports - Multi-ethnic Advocates for Cultural Competence's (MACC)'s** purpose is to enhance the quality of care in Ohio's behavioral health system and to incorporate cultural competence into systems and organizations that provide care to Ohio's most vulnerable and at-risk populations. MACC supports networking among diversity advocates, conducts needs assessments on under-served populations (e.g. military families), and provides training to behavioral health care staff to increase their cultural competence in providing mental health services. See also Priority #8.

Additional recovery supports available in the mental health system include:

- **Housing** – See ODMH Priority #5 - Homeless Persons and Persons with Severe Mental Illness in Need of Supportive Housing.

- **Employment Services** are offered by only about 5% of Ohio's providers. ODMH does not collect data except for the 14 sites (in 2009) engaged by the Supported Employment Coordinating Center of Excellence. In those 14 sites during fiscal year 2009, 2,664 people with severe mental illness received Supported Employment services and 567 people obtained competitive employment. (Subsequently, the number of sites increased

to 20 in SFY 2010.) The Ohio Rehabilitation Services Commission (the state/federal vocational rehabilitation program) reports 1,124 persons with severe mental disabilities obtained competitive employment through working with their program in 2009.

- **Consumer Participation in Mental Health Policy Development - Consumer and Family Partnership Team (CFPT)** identifies consumers and family participants who are **not** employees of advocacy groups to participate in mental health policy groups and provides a stipend and travel expenses. CFPT provides representatives for Planning Council and Resiliency Leadership Ohio which is described in Priority #11. This program also provides technical assistance funding to local consumer groups and scholarships for consumers and family members to attend national conferences.

Ohio Department of Alcohol and Drug Addiction Services

Access to Recovery – (ATR) - The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) has had the ability to offer Recovery Support Services in a limited number of counties in northeast Ohio through federal funding outside of the SAPT Block Grant. ODADAS was awarded its first Access to Recovery (ATR) grant of $13.8 million in 2007 by the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Treatment. ATR is a federal initiative that provides vouchers to clients for the purchase of treatment and recovery support services for alcohol and other drug addiction. The goals of the program are to expand capacity, support client choice, and increase the array of faith-based and community-based providers of AoD (alcohol and other drug) treatment and recovery support services. The initial grant focused specifically on adult men and women with an AoD diagnosis who were re-entering their community — Cuyahoga, Mahoning, Stark and Summit Counties — following incarceration or other criminal justice system involvement and veterans. The Department exceeded all of its performance goals including its client intake goal (6,435 served), client outcomes follow-up (greater than 80 percent) and expenditures on clients who had used methamphetamine.

ODADAS was awarded $13.3 million over four years in October 2010. This round of ATR will provide services to more than 9,000 clients. Changes to the expanded program include: addition of Lorain County, a new target population of adolescents, and family counseling as a new service.

Recovery Support Services offered to adult criminal justice clients include: Drug Free Supportive Transitional Housing, GED Training, Substance Abuse Education, Relapse Prevention, Employment Skills Training, (Vocational, Resume, interview, coaching), Transportation, Domestic Violence Education, HIV/AIDS Education, Peer Mentoring, Parenting Classes, Spiritual Support, Daily Living Skills, Family Engagement, Recovery Coaching, Anger Management, Self Help and Support Groups (Not including 12 step).

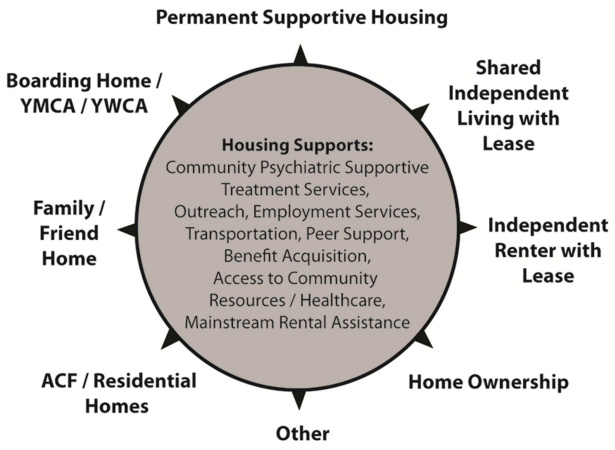
Recovery Support Services offered for adolescents include: Employment Skills Training (Resume writing, job coaching, placement), Daily Living Skills, Anger Management (Conflict Resolution, Navigating Authority), Parenting Classes, Peer Mentoring Support Groups and Spiritual Support.

ODADAS Recovery Oriented System of Care (ROSC) Training - As a result of technical assistance provided by the Great Lakes ATTC (Addiction Technology Transfer Center), ODADAS has provided a statewide ROSC Symposium and five regional introductory level training sessions on ROSC. In addition, the Department met with other stakeholders representing the Ohio Association of County Behavioral Health Authorities and the Ohio Council of Behavioral Health and Family Service Providers as well as a session at the ODADAS Spring Conference and the ODADAS Workforce Development Academy. The training sessions provided an overview of eight key performance areas in ROSC and Recovery Management, including:

- Attraction, access and early engagement
- Screening, assessment and placement
- Composition of the service team
- Service relationship
- Service dose, scope and quality
- Locus of service delivery
- Assertive linkage to communities of recovery
- Post-treatment monitoring, support and early re-intervention
- These training sessions will be of even greater value as changes are occurring with criminal sentencing reform and changes to primary health care.

#5 Priority Population – Homeless Persons and Persons with SMI in Need of Permanent Supportive Housing

Safe, decent affordable, housing that honors client choice is essential in preventing homelessness and in reducing institutional recidivism from settings such as jails, prisons, nursing homes, and psychiatric hospitals. While permanent supportive housing is the best practice model that helps to address the high priority needs of the most vulnerable households with serious and long-term disabilities, many of these projects are designed and funded solely for persons experiencing homelessness. Therefore much of the Permanent Supported Housing model only targets a sub-population of consumers served by ODMH. As such, ODMH recognizes that a continuum of community housing options ranging from adult care facilities (ACF) to supportive housing to home ownership is needed to meet the diverse needs of our client population. ODMH is currently undertaking efforts to create and preserve housing for the sub-population of Ohioans we serve.



ODMH is working more closely with Ohio Housing Finance Agency (OHFA), Federal Home Loan Bank and other funders of housing to maximize capital funds. ODMH is prioritizing its capital funds for HUD 811 projects that create new permanent supportive housing units for persons diagnosed with mental illness. In SFY 12, OHFA reserved approximately $1 million from the Housing Trust Fund specifically to assist ODMH- funded Permanent Supportive Housing projects with minor repairs and renovations through the ODMH/OHFA Permanent Supportive Housing Capital Investment Pilot Program.

ODMH will annually designate some Block Grant funds towards housing efforts targeting ODMH's client population. Some funds will be available to housing developers interested in exploring tax credits for preservation of existing housing stock and for development of new projects. Funds will also be used for mini-grants for local system planning for the hardest to know how to house individuals. ODMH will work with ODJFS, Ohio's Medicaid Agency, to assist persons with severe and persistent mental illness currently in institutions in obtaining community housing of their choice through Ohio's Money Follows the Person HOME Choice Program. ODMH will continue to direct a portion of its General Revenue Funds towards Homeless Assistance Grants in order to increase and preserve the number of existing housing units in which ODMH has been a funding participant.

#6 Priority Population – Persons Involved with Criminal Justice System

ODMH supports individuals who are sentenced to the Ohio Department of Rehabilitation and Correction (ODRC) by funding the Community Linkage Social Work Program that provides continuity of care for persons with SPMI (Severe and Persistent Mental Illness) entering and leaving prison. This program was reorganized in collaboration with other state and community agencies to provide a more holistic approach to offender reentry by linking individuals with

SPMI to community mental health agencies, housing, transportation, local reentry coalitions, benefits (SSI/Medicaid), and consumer operated services, etc. The goal is reduced recidivism.

ODMH also funds forensic evaluations and some monitoring costs associated with individuals who have been found Not Guilty by Reason of Insanity (NGRI) or Incompetent to Stand Trial (IST). In addition, Ohio received a SAMHSA grant to address trauma and mental health needs for justice involved veterans. In recent years veteran specific courts have been developed with more being considered as a result of the grant. Ohio continues to be a national leader in statewide implementation of Crisis Intervention Teams (CIT).

However, in spite of these initiatives, barriers remain including: housing restrictions and limited housing; stigma of being a mentally ill ex-offender; as well as lack of population-specific programs, timely access to mental health treatment, community supports and employment/educational opportunities. Lack of disability benefits (e.g. SSI, Medicaid) upon re-entry is a major barrier to access housing, as well as behavioral and primary health care.

#7 Priority Population – Persons of All Ages in Crisis including Veterans

Crisis and Safety Net – For SFY 2012 Ohio allocated Block Grant funds for "Crisis and Safety Net" which included $500,000 for mini-capacity grants (non-forensic) to Boards that do not have local tax levies. Ohio has 15 Boards with no local levy funds. These Boards are disproportionately in economically depressed rural and Appalachian areas of the state that have been especially impacted by state reductions in state General Revenue Funds of 20% - 30% over the past few years. The intent is to reduce the disparities between Boards in access to community services for consumers without Medicaid or other health insurance. The economic recession finds increasing community needs at the same time state General Revenue Funds for non-Medicaid mental health services were reduced.

Military Personnel and Their Families – No one who is or was involved in a war is untouched by the experience. Combat stress reactions are a normal part of the readjustment process. For most service members, combat stress reactions are not permanent and will go away on their own. However, for some, the impact of war and the separation from their families can result in long-term behavioral health effects. Unfortunately, the fear of stigma discourages many service members and their families from getting the help they may need. The casualties experienced by Ohio's service members have had a significant and long-lasting impact on the service members themselves, their families, communities and the state as a whole.

Ohio is just beginning to understand the behavioral health needs of returning service members and their families and develop the state and local service system infrastructure needed to support their needs. Ohio's strength includes the support of 50 Boards which contract with 389 certified mental health providers that have a recovery focus in providing care and treatment. Additionally, OHIOCARES provides a strong and collaborative partnership of key state agencies addressing service member needs that include Ohio Department of Mental Health, Ohio National Guard, Department of Alcohol and Drug Addiction Services, Ohio Office of Veteran Services, Veterans Administration, Rehabilitation Services, Ohio Association of County Behavioral Healthcare Authorities (Board Association), Ohio NAMI, and the Ohio Council of Behavioral Health and Family Services Providers.

#8 Priority Population – Underserved Racial and Ethnic Minorities and LGBTQ Populations

Initiatives to Serve Underserved Populations – ODMH is addressing cultural diversity needs through **Multi-ethnic Advocates for Cultural Competence (MACC)** as well as funding statewide mental health services for children and youth who are deaf and hard of hearing. The funding for youth who are deaf and hard of hearing provides specialized services that are not funded by Medicaid. Additionally, "Priority #7 – Crisis/Safety Net" funding provides funding to **rural** residents living in counties without local tax levies and "Priority #5 Homeless and In Need of Housing" addresses the needs of homeless persons. While older adults is not listed as a priority population, the completed TSIG initiative resulted in Ohio Department of Aging continuing to fund training for Healthy IDEAS, an evidence-based practice addressing depression among older adults participating in a Home and Community Based Service funded by Medicaid.

Diversity Initiative - The purpose of MACC is to enhance the quality of care in Ohio's behavioral health system and to incorporate cultural competence into systems and organizations that provide care to Ohio's most vulnerable and at-risk populations. Each year MACC hosts a statewide conference with a different population focus each year. Additionally, MACC conducts needs assessments on under-served populations (e.g. military families), and provides training to behavioral health staff to increase their cultural competence in providing mental health services. Recent new work products include "*How to Navigate Social Services in Ohio*" in Spanish and Somali. MACC also provides some resources on the LGBT community, Muslims, deaf/hard-of-hearing, Latinos, Asian Americans, immigrants with limited English proficiency and seniors. MACC is one of four statewide organizations represented on Planning Council.

MACC offers CARE (Level 1) training which "is a foundational training program that increases the knowledge and understanding about the impact of cultural practices, attitudes and beliefs on the patient/client and provider relationship, and provides tools, concepts and strategies for strengthening cross-cultural skills. Care Ohio (Level II) training **"CARE Continues"** explores the **C.A.R.E. Model - C**onsider, **A**ccept, **R**ecognize and **E**xecute in more detail. An evaluation of C.A.R.E. was published in the Journal of the National Medical Association, September, 2010[1].

#9 Priority Population – Youth/Young Adults in Transition

The transition into adulthood represents a particularly challenging period for youth and young adults with emotional/behavioral difficulties. This reality is further complicated due to the absence of services or lack of coordination among children's mental health, child welfare, education, adult mental health, juvenile justice and rehabilitation sectors. Ohio was fortunate to be awarded a Georgetown Technical Assistance Policy Academy grant which supported a Youth and Young Adults (YYAT) Policy Team to develop a shared vision, mission and action plan. Through this team and TSIG support, Ohio sponsored Transition to Independence (TIP) Model training in four regions with Boards convening local cross-systems teams. ODMH has actively participated in the Ohio Family and Children First YYAT Steering Committee, with thirteen state departments, youth and youth serving organizations, family organizations, and statewide trade associations to align and consolidate youth transition resources, policies and services across systems. The Ohio Federation for Children's Mental Health serves as the state chapter of Youth MOVE National, a youth led organization devoted to improving services and supports across mental health, child welfare, education and juvenile justice. Ohio has a pending application to SAMHSA for the System of Care Planning Grant, targeting capacity-building for transition-age youth and their families.

10 Priority Population – Early Childhood Mental Health

Early Childhood Mental Health (ECMH) consultation's primary goal is to increase knowledge, awareness, resources and skills necessary for communities to meet the behavioral health needs of all young children and their families. The program's objectives are to build

[1] Journal of the National Medical Association, September, 2010.
http://www.maccinc.net/documents/CARE_Columbus_J_Nat_Med_Assoc.pdf

protective factors in young children, increase skills of parents and promote the competencies of early childhood care providers, especially for children ages birth to six years who are at risk for abuse, neglect and poor social and emotional health. Services include consultation to child-serving organizations and families using predominantly evidence based and strengths based practices. The program provides:

- Consultation and training to early childhood providers to address the needs of children at-risk of removal due to behavioral issues.
- Consultation to families of children at-risk of removal from early childhood settings due to behavioral issues.

Consultation to organizations includes mentoring, coaching, and classroom observation as well as training. Training sessions focus on problem identification, referral processes, classroom management strategies, as well as the impact of maternal depression, substance abuse, domestic violence, and other stressors on young children. Additionally, ECMH works with families of children identified as at-risk of removal from their early childhood setting due to their behavioral issues. ECMH strives to enhance their ability to create strong, nurturing environments and relationships with their young children in partnership with their early childhood settings.

#11 Priority Population – Community Prevention

As indicated in the Overview Section, about $5.3 million was expended by Boards in SFY 2010 for prevention of which more than $3 million was from local sources. Prevention initiatives in Ohio include the Ohio Suicide Prevention Foundation, Red Flags Depression Awareness Program, the Resiliency Ohio Initiative, Maternal Depression Screening and Training, and Early Childhood Mental Health Consultation.

Ohio Suicide Prevention Foundation (OSPF) promotes suicide prevention as an Ohio public health issue and advances evidence-based awareness, intervention, and methodology strategies which support all Ohio-based suicide prevention efforts. The OSPF, launched in 2005, is a catalyst to bring about change in attitudes and perceptions regarding stigma attached to suicide, mental illness, alcohol and drug abuse and addiction. OSPF has focused on building partnerships with 78 county coalitions. OSPF just received a SAMHSA Garrett Lee Smith Youth Suicide Prevention Grant for $ 1,440,000 over 3 years, which will expand suicide prevention services for at-risk youth, military families, youth in foster care and justice systems and LGBT (lesbian, gay, bisexual and transgendered) youth. It will provide funds to:

- Mobilize 78 coalitions covering all 88 Ohio counties and target 25 at-risk counties

- Implement Kognito's At-Risk by training 20,000 gatekeepers for high school staff and military families
- Provide assessment and managing suicide risk training to 438 professionals
- Implement TeenScreen and Signs of Suicide in at risk counties--- screen 8,000 at-risk youth
- Engage and mentor local mental health service agencies in suicide prevention for at-risk youth which is expected to result in 700 youth referred for continuing mental health treatment
- Actively promote the National Suicide Prevention Lifeline

Red Flags Depression Awareness Program - This is a comprehensive mental health awareness program for middle schools, and teaches students, parents and school personnel the signs of depression and other mental illnesses, along with a process for getting help.

Resiliency Ohio Initiative - In January of 2005, ODMH empowered youth and families to take a lead role in the development and dissemination of a statewide mental health resiliency initiative that informs policy and practice across the developmental life stages from infancy to the transition to adulthood. In 2008, with additional support from Ohio's Transformation State Incentive Grant (SAMHSA), the resiliency workgroup was transformed into Resiliency Leadership Ohio. Resiliency Leadership Ohio is a youth-guided, family-driven initiative that is co-facilitated by the Center for Innovative Practices at Case Western Reserve, and the Ohio Federation for Children's Mental Health, with the support of ODMH. Resiliency Leadership Ohio's unique contribution to resiliency and children's mental health can be found throughout the ResiliencyOhio.org website.

Resiliency Leadership Ohio in collaboration with the OSPF and ODMH is preparing to disseminate a resiliency-themed video on managing thoughts of suicide and self-harm. The emphasis for this video is that resiliency supports mental wellness, even when presented with the difficult and serious challenges of coping with self-injurious thoughts and behaviors. Youth who are suicidal need a hopeful message which is best delivered by other youth who have gone through the same thoughts and feelings and made it through.

Rise Sister Rise - ODMH in partnership with Mental Health America of Summit County and Principal Investigator, Fran Frazier, completed a research study this year entitled: "Rise Sister Rise: Placing Black Girls at Promise". A total of 409 African American girls, ages 11 to 18, from 4 urban areas participated in this research study. Data findings suggest there are an impressive number and array of internal and external assets these girls possess. There were also a number of risk factors identified, such as a high exposure to violence in their lives. Additionally, more than half of the girls reported they had been emotionally abused, or

emotionally neglected. The data provides an opportunity and pose a challenge to Ohio's state and community leaders to collaborate on behalf of these girls and others who face similar risks.

Maternal Depression Screening and Training - Ohio's mental health service providers are working diligently to increase awareness of the effects of maternal depression through general training for early childcare providers and by identifying and linking services for at-risk families. For example, Ohio's Maternal Depression Program (MDP) implements screening programs through a collaborative effort involving county health departments' *Help Me Grow* programs, and alcohol, drug abuse and mental health providers. Mental health professionals in each local program have been trained in providing therapy for women with maternal depression. Therefore, they provide consultation and accept referrals for services as appropriate.
MDP objectives include:

- Increase the number of mothers screened for maternal depression
- Increase the number of mothers referred for further services to treat maternal depression
- Increase the percentage of mothers referred for further service who follow up and participate in such services

Early Childhood Mental Health Consultation (ECMHC): The primary goal of ECMHC is to increase knowledge, awareness, resources and skills necessary for communities to meet the behavioral health needs of young children and their families. For more information about this program, see Ohio's Early Childhood Mental Health for ages 0-6 which is a targeted population in this Plan.

ODMH and ODADAS Collaboration - As noted in the Overview section, ODMH and ODADAS are collaborating on prevention through a Shared Prevention Framework, and jointly fund the Ohio Suicide Prevention Foundation. Additionally, ODMH and ODADAS are beginning to develop cross systems collaboration with the Resiliency Ohio Initiative. Recently ODADAS represented ODMH at a NASMHPD prevention meeting which focused preparation for the potential opportunity in the proposed budget for Mental Health State Prevention Grants.

II: Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system

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Narrative Question:

This step should identify the data sources used to identify the needs and gaps of the populations relevant to each Block Grant within the State's behavioral health care system, especially for those required populations described in this document and other populations identified by the State as a priority.

The State's priorities and goals must be supported by a data driven process. This could include data and information that are available through the State's unique data system (including community level data) as well as SAMHSA's data set including, but not limited to, the National Survey on Drug Use and Health, the Treatment Episode Data Set, and the National Facilities Surveys on Drug Abuse and Mental Health Services. Those States that have a State Epidemiological Outcomes Workgroup (SEOW) must describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with serious mental illness and children with serious emotional disturbances that have been historically reported. States should use the prevalence estimates, epidemiological analyses and profiles to establish substance abuse prevention, mental health promotion, and substance abuse treatment goals at the State level. In addition, States should obtain and include in their data sources information from other State agencies that provide or purchase behavioral health services. This will allow States to have a more comprehensive approach to identifying the number of individuals that are receiving behavioral health services and the services they are receiving.

In addition to in-state data, SAMHSA has identified several other data sets that are available by State through various Federal agencies such as the Center for Medicaid and Medicare Services or the Agency for Health Research and Quality. States should use these data when developing their needs assessment. If the State needs assistance with data sources or other planning information, please contact planningdata@samhsa.hhs.gov.

Footnotes:

Step 2:
Identify the unmet needs and critical gaps of this population. This step should identify the data sources used to identify the data.

#1 Priority Population – Children with Serious Emotional Disturbances (SED) and their Families

Children with Serious Emotional Disturbances (SED) – Over the past four years, Ohio's publically funded community mental health system faced a continuous erosion of services, service capacity, and workforce due to increasing costs coupled with declining state revenue. [1] The recent economic recession exacerbated the chronic under-funding of the mental health system and increased demand for mental health services as more individuals and families struggled with the emotional toll of job losses, foreclosures, family instability, and lack of access to programs and services across the health and human services sector. Until sufficient federal, state and local funds are available to sustain the well-being of Ohioans, there will continue to be gaps and unmet needs in local systems of care for children, youth and their families.

Estimated Need for Services - To estimate need for services in the population for the purpose of the Block Grant Plan, Ohio, like most other states, has historically used the NASMHPD-NRI (National Association of State Mental Health Policy Directors – National Research Institute) data to estimate the prevalence of mental illness in Ohio's population. This data is from the Uniform Reporting System (URS) data tables funded by SAMHSA's Data Infrastructure Grant for the purpose of providing data for the Mental Health Block Grant.

To more accurately reflect local community-based need and available resources among local mental health boards when distributing Block Grant funds among the Boards, ODMH transitioned to a formula based on population, poverty, and prevalence of severe mental illness for individuals with incomes under 200% of the federal poverty line. This formula was developed in consultation with the Ohio State University's College of Public Health's Center for Health Outcomes and Evaluation Studies.

Estimated Need for Children's Mental Health Services - An estimated 152,058 children ages 9 – 17 in Ohio have a serious emotional disturbance (SED) using a level of functioning of 60 – lower limit according to 2009 NASMHPD-NRI data. ODMH is using the same 2009 prevalence

[1] Ohio's SFY 2008 – 2011 Block Grant Plans

data for the 2012 – 2012 Plan as well as the 2011 and 2010 Implementation Reports. Due to changes in when the NASMHPD-NRI prevalence data becomes available, NASMHPD-NRI advised states to use prevalence estimates from calendar year 2009 for the 2012 – 2013 Plan, as well as the SFY 2010 and SFY 2011 Implementation Reports. [2] For prior years, the calendar year of the prevalence data (e.g. 2008) is the year proceeding the Implementation Report year (e.g. 2009).

The NASMHPD-NRI estimate of number of children with SED in Ohio increased almost 9% from 139,689 to 152,058 between Ohio's SFY 2009 and SFY 2010 Implementation Reports. This was due to a change in Ohio's poverty level as compared to other states----moving from a "mid-level poverty" state to a "high poverty" state between 2008 and 2009. Ohio has been more severely impacted by the recession and earlier declines in the automobile industry than many other states, which resulted in Ohio's increased ranking in poverty relative to other states. Increased poverty increases the rate of serious emotional disturbances among Ohio's youth. However, the change in NASMHPD-NRI's prevalence estimate increased the denominator in the prevalence calculation so much, that most of the difference between treated prevalence between SFY 2009 and SFY 2010 is due to changes in measurement (poverty classification) rather than changes in number served which increased.

For children, ages 9 – 17, Ohio's public mental health system served 89,398 of which 58,001 children met Ohio-specific criteria for SED in SFY 2010. (SFY 2010 is the most recent year for which complete data is available since Ohio providers may submit claims up to 12 months after service date). When the total number of children ages 9 – 17 served in SFY 2010 who met Ohio's criteria for SED is compared to the NASMHPD-NRI estimate, an estimated 41.52% (58,001 of 152,058)[3] received services. When the total number of children ages 9 - 17 served for SFY 2010 is compared to the NASMHPD-NRI estimate, an estimated 58.79% (89,398 of 152,058) of the children in need of service received it. As Ohio's definition of SED is more restrictive than SAMHSA's, the 58.79% is probably the closest estimate to SAMHSA's SED criteria. While both the total number of children served as well as children with SED served increased from the previous year, by 6% and 4% respectively, the treated prevalence decreased 2% due to an increase in prevalence estimates by NASMHPD-NRI as described in the preceding paragraph. (These estimates used ODMH's service data from MACSIS and the most recent estimate of prevalence of SED for children ages 9 -17 at the lower limit of functioning for a score of 60. For more information about treated prevalence, please see Step 4, #1 Priority Population – Children with SED and their families.

[2] Data Infrastructure Grant Call - Midwest, August 2012
[3] ODMH MACSIS data used in SFY 2010 and SFY 2009 Block Grant Implementation Reports

Early Childhood Prevalence - The NASMHPD-NRI estimates do not include children ages 0 – 8 who were slightly more than 25% (31,220[4] of 120,618) of the children served by Ohio's mental health system in 2010. NASMHPD-NRI's estimates are missing this important prevalence estimate, so Ohio is not reporting treated prevalence for this population. Ohio recommends that SAMHSA consider providing prevalence estimates for this population.

The Ohio Family Health 2010 Survey[5] key findings (in a survey of the general public) indicate that while the percent of working-age Ohioans reporting a harder time securing health care than three years ago has remained statistically similar, the rate of working-age Ohioans reporting trouble paying medical bills has increased by 5.7 percentage points between 2003/04 and 2010. In 2010, uninsured children had an 11.7 times higher rate of not having a usual source of care than insured children. Lack of usual source of care decreases service coordination and quality of care.

Medicaid is a key driver in Ohio's mental health system and an important resource for Ohio's children. The Ohio Family Health 2010 Survey key findings indicate that Medicaid is the second largest source of coverage for children at 39.5%. Reports show Medicaid case loads and utilization have consistently grown, particularly for children, putting increased pressures on scarce resources and reducing funding for essential supporting services that keep children and families together in their community.

In-Patient Services -In SFY 2010, there were 5,732 psychiatric inpatient admissions to private hospitals for consumers under the age of 18 who were covered by Medicaid. This is an increase of about 7% over the number of admissions in SFY 2009 (5,378) and an increase of about 11% over the number of admissions for SFY 2008 (5,168). This steady increase in the number of admissions over the three-year period may be due to increased eligibility of Medicaid coverage.

Reduce Anti-psychotic Medication Use among Children in Foster Care - Additionally, in SFY 10, some 14, 851 children and adolescents under the age of 18 were covered as members in Medicaid's foster care eligibility programs. By contrast, there were 1,250,634 youth under 18 covered by all other Medicaid eligibility programs, such as SCHIP. (SCHIP is an Ohio Medicaid program for children and pregnant women from families at $\leq$200% of the federal poverty level.) In SFY 2010, about 1.2% of covered members under age 18 were Medicaid eligible through foster care. Among the 14,851 members in the foster care group, 57% received treatment for a psychiatric condition as the principal diagnosis during SFY 2010. By comparison, only 32% of

[4] MACSIS data; Ohio's mental health system's community mental health claims data base. Age was calculated on the last age billed during the year. http://mentalhealth.ohio.gov/what-we-do/protect-and-monitor/macsis/index.shtml

[5] http://grc.osu.edu/ofhs/ 2010 Ohio Family Health Survey, which is a large population-based survey beginning in 1998 that informs health care reform in Ohio. The survey questions include health status, health care access, utilization, insurance status, and demographics of Ohioans. Current survey sponsors include the Ohio Departments of Insurance, Job and Family Services, Health, and Mental Health and the Health Foundation of Greater Cincinnati.

the 1, 250,634 youth covered under other Medicaid programs received treatment for a psychiatric condition as the principal diagnosis. Some 2,139 foster care eligible youth received 22,260 prescriptions for antipsychotic medication. During the same period, 36,928 youth covered under all other Medicaid programs received 231,947 antipsychotic prescriptions. By percentage and ratio, some 14.4% of youth in the foster care group received an average of 10.4 antipsychotic prescriptions each compared to 3% of all other youth who received an average of 6.3 antipsychotic prescriptions each. Ohio is committed to examining the use of antipsychotic medications for the foster care population and is contracting for additional study of the issue.

Preliminary study of antipsychotic prescribing patterns among all children and adolescents covered by Medicaid indicated that about 30% of physicians who prescribed antipsychotic medications were not psychiatrists. To address Ohio's longstanding lack of access to child and adolescent psychiatrists, the Pediatric Psychiatric Network (PPN) was developed in 2010 to improve access to child psychiatrists. A partnership comprised of ODMH, many of the state's children's hospitals, and psychiatric teaching programs came together to develop a professionally staffed network of providers and a technology infrastructure that includes a single toll-free telephone number for any pediatrician or other primary care practitioner to call, enabling them to speak with a child psychiatrist 24 hours a day, seven days a week regarding patient mental health diagnosis, treatment or referral.

Reduce Out-of-Home Placements -In SFY 2010, about 8% of all children and adolescents served by Ohio's community mental health providers were in out-of-home placements at the time of receiving service. Due to a steady decrease in the number of children placed in out-of-home settings, the percent of such children receiving mental health services has declined from 9.5% in 2008 to 8% in 2010. Conversely, about 60% of all children in foster care received mental health services in 2010.

Through the utilization of Intensive Home-Based Therapy (IHBT), almost half, 43.33%, of Ohio's counties reported in FY 2010 that out-of-home placements were avoided or significantly decreased. Fifty (50) counties (56.8%), reported utilization of Children's Community Behavioral Health funds in SFY 2010 for IHBT. A workgroup consisting of ODMH, ODJFS and Case Western Reserve University's Center for Innovative Practices has been meeting in preparation to submit a request to CMS for a state Medicaid plan amendment to include IHBT as an Ohio Medicaid covered service. This will increase the number of certified IHBT providers in Ohio as well as access to children, youth and families.

Trauma-Informed Care Needed - Recent data available on Ohio youth from the National Child Abuse and Neglect Data System (NCANDS), the Adoption and Foster Care Analysis and

Reporting System (AFCARS) and state census data demonstrate the prevalence of child abuse and the need for trauma informed care and treatment[6]

In 2009, the number of substantiated cases of abuse/neglect was 34,084 (12.6 for 1000 children). 7.3% of abuse/neglect cases were a recurrence within 6 months of the original abuse/neglect victimization. The rate of entry of child victims in foster care has been slowly declining; however, there are a high number of children still in foster care (14,521 in 2009). Once children enter foster care, care tends to be longer term. The median length of stay for those in foster care was 15.8 months. Children are more likely to be removed from their homes if they are less than one year old. Black children are over-represented in the percentage of abuse/neglect victims.

Because Ohio's rates of abuse/neglect, and out-of-home placements are highest for young children, early childhood interventions and family-based, trauma-focused treatment are indicated for this target population. Cognitive-based, trauma-focused interventions are also needed for adolescents. Disproportional racial representation within the child welfare system clearly documents the need for culturally relevant interventions.

#2 Priority Population – Adults with Serious Mental Illness (SMI)

Ohio is estimated to have 476,210 adults (ages 18+) with severe mental illness (SMI) using the NASMHPD-NRI most recent prevalence estimates for SFY 2009. Ohio's public mental health system provided services to 233,552 adults in SFY 2010. Of these 233,552 adults receiving treatment, 101,398 met Ohio's Severely Mentally Disabled (SMD) criteria which is more restrictive than SAMHSA's SMI criteria, and is based on an algorithm that as calculated using diagnosis, treatment history and functioning.

Based on calculations using these numbers, an estimated 49% (233,552 of 476,210) of Ohio's adults who need mental health services are receiving them from the public mental health system. Additionally, an estimated 21% (101,398) of the persons with SMD are receiving services. As Ohio's definition for SMD is more restrictive than SAMHSA's definition of SMI, the total number of persons receiving services (49%) is probably a closer estimate to SAMHSA's SMI criteria. Ohio reports both numbers, as it measures how well Ohio's mental health system is addressing the needs of adults who are significantly disabled by mental illness as well as how well Ohio is meeting the needs of the total population that needs public mental health treatment.

[6] US Dept. of HHS, ACF, Children's Bureau, 2011

These numbers do not include the number of adults receiving psychiatric treatment from the private sector or anti-depressants from their family physicians or from Federally Qualified Health Care (FQHC) Centers.

Ohio has additional population data on prevalence of mental illness from the 2010 and 2008 Ohio Family Health Surveys. The Ohio Family Health Survey is a major population survey sponsored by the Health Foundation of Greater Cincinnati and multiple state agencies which includes prevalence rates for mental health and physical health. According to the 2008 Ohio Family Health Survey Special Populations[7] report, 5.38% of adults reported Serious Psychological Distress (SPD) which was a proxy for SMI. This prevalence estimate of 5.38% of adults among Ohio's citizen who have SPD is very close to the NASMHPD-NRI estimate of 5.4% of adults with SMI. The 2008 Ohio Family Health Survey Special Population Report indicates that 11% of persons with SPD reported that they did not receive needed mental health care, and 11% did not receive needed care for physical health conditions. Ohioans with SPD were more likely to be women (55%), minority (19%), middle-aged (40% ages 35 – 54), and have less educational attainment, live in Appalachian counties and live below the poverty line than Ohioan's without SPD. Persons with SPD cited the major reason for not receiving needed mental health care as "too expensive/can't afford" (41%) and "lack of insurance coverage" (38%). They also cited "too expensive/can't afford" (55%) and "lack of insurance" (38%) as the major reasons for not getting needed physical care. Additionally, adults with SPD reported" needing assistance coordinating care" (40%) and "needing counseling" (43%)

Finally, the quarterly reports provided by the Coordinating Centers of Excellence (CCOEs) show a drop in the number of new organizations implementing evidence-based practices (EBPs) in Ohio due to the recent budget cuts. An increasing number of agencies have downgraded to lower fidelity teams or have disbanding their teams and programs altogether. As a result of low implementation the number of new SMI adults receiving EBPs has been also declining (Substance Abuse/Mental Illness and Wellness Management and Recovery CCOE quarterly reports, SFY 2010 & 2011). Additional information on needs for this population is included in the next two sections.

[7] Carstens, Carol, Ph.D., Ohio Department of Mental Health, 2008 Ohio Family Health Survey – Special Population Report; survey by Health Policy Institute of Ohio http://mentalhealth.ohio.gov/what-we-do/promote/research-and-evaluation/index.shtml Ohio Family Health Survey – home page http://grc.osu.edu/ofhs/

#3 Priority Population – Bi-directional Integration of Behavioral Health with Primary Care - as reported jointly by ODMH and ODADAS

Need for Integrated Care - Ohioans with Serious Mental Illnesses (SMI) experience rates of somatic physical health morbidity and mortality that far exceed those of the general population. State and national research has revealed that the years of life lost attributable to this common co-morbidity are significant. Causes of high morbidity and premature mortality are often preventable and treatable medical conditions associated with modifiable risk factors include obesity, poor nutrition, lack of exercise and smoking.[8] Smoking is an addictive behavior which can be addressed through substance use disorder treatment. Integrated care could better address these risk factors for this population.

Expenditures for Co-occurring Substance Use Disorder and Mental Illness – Ohio's public mental health and alcohol and other drug treatment systems paid $147,707,809 in claims for treatment of adults with both mental health and alcohol and other drug diagnoses, and $56,966,603 for children with dual diagnoses in SFY 2010. Of those served, 14% of adults and 10% of youth received both a mental health and an alcohol and other drug (AOD) diagnosis. Only half of the adults and one-third of the youth diagnosed with co-occurring disorders received treatment for both disorders. Treatment expenditures for those with co-occurring disorders were higher than for those without co-occurring disorders. Given the high prevalence of co-occurring disorders and higher costs for treatment, clinicians should be trained to diagnose and treat co-occurring disorders.

ODADAS's SFY 2009 data indicates that 27.4% of adults receiving substance abuse treatment self-reported mental health treatment. [9] Among persons with serious mental illness, SAMHSA's 2002 National Survey on Drug Use and Health found that 17.5 million adults aged 18 or older (8%) were estimated to have a serious mental illness in the past year. About 4 million of the adults with a serious mental illness in 2002 also were dependent on or abused alcohol or an illicit drug; that is, they had a co-occurring substance abuse and mental disorder.[10] As compared to these numbers, Ohio's percentage of adults receiving dual MH/AOD (mental health/alcohol and other drug) diagnoses (14%) is lower than these prevalence estimates. This data also suggests a need for more cross training of staff and greater availability of integrated services for persons who need them.

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[8] Brown et al, The Unhealthy Lifestyle of People with Schizophrenia, Psychol. Med 29:697-701, 1999

[9] ODADAS, Special Populations: Client Profiles, June 28, 2011
[10] SAMHSA Office of Applied Studies http://oas.samhsa.gov/2k4/coOccurring/coOccurring.cfm

Behavioral Health Data for Adults - Ages 18+
Served by Ohio's Community Behavioral Health Providers in SFY 2010
MH = Mental Health; AOD = Alcohol and other Drug

Diagnosis	Treatment	Number Served	Percent Served	Claims Paid	Percent Expenses	Percent Male
MH/AOD	MH/AOD	21,211	7%	$89,817,947	16%	49%
MH/AOD	MH only	17,063	6%	$51,683,401	9%	49%
MH/AOD	AOD only	3,421	1%	$4,206,461	1%	66%
Dual Diagnosis Total		41,695	14%	$145,707,809	25%	
AOD only	AOD only	56,696	19%	$79,994,518	14%	68%
MH only	MH only	181,946	60%	$309,328,600	54%	40%
Other		21,821	7%	$42,084,621	7%	53%
Single Diagnosis Total		260,463	86%	$431,407,739	75%	
Total		302,158		$577,115,547		

Behavioral Health Data for Children and Youth - Ages 0 - 17
Served by Ohio's Community Behavioral Health Providers in SFY 2010
MH = Mental Health; AOD = Alcohol and other Drug

Diagnosis	Treatment	Number Served	Percent Served	Claims Paid	Percent Expenses	Percent Male
MH/AOD	MH/AOD	3,717	3%	$29,878,032	9%	67%
MH/AOD	MH only	8,819	7%	$26,391,564	8%	58%
MH/AOD	AOD only	423	0%	$697,007	0%	71%
Dual Diagnosis Total		12,959	10%	$56,966,603	18%	
AOD only	AOD only	3,881	3%	$7,093,209	2%	77%
MH only	MH only	102,513	83%	$236,777,897	75%	59%
Other		4,744	4%	$14,109,968	4%	55%
Single Diagnosis Total		111,138	90%	$257,981,073	82%	
Total		124,097	100%	$314,947,677	100%	

High Mortality Rates - ODMH has sponsored several studies examining mortality and medical comorbidity among patients with serious mental illness in Ohio. The first study included 20,018 patients admitted to an Ohio public mental health hospital between 1998 and 2002. The results of this study showed that heart disease (21%) was the leading cause of death and the mean age at death for ODMH decedents was 47.7 years, corresponding to an average of 32 years of potential life lost per patient (Miller et al., 2006).[11] A more recent study showed that Ohio decedents in the publicly funded mental health system die 26 years earlier than an age-matched cohort of those who did not die. [12] [13]

Co-morbid Illnesses - The Special Population Report of the 2008 Ohio Family Health Survey[14] indicated that Ohioans who reported having serious psychological distress (SPD) were significantly more likely than the general population of the state to report a diagnosis of diabetes, stroke, coronary heart disease, hypertension, congestive heart failure, and cancer. Compared to the 35% of the general Ohio population that reported having a cardio-vascular condition, 58% of individuals with serious psychological distress reported having had a diagnosis of stroke, hypertension, cardiac arrest, coronary heart disease, or congestive heart failure in the 2008 Ohio Family Survey.

A recent analysis of Medicaid data from SFY2009 by the ODMH Office of Research and Evaluation (2010) [15] showed that among Medicaid enrollees with SMI, the incidence of a treatment episode for diabetes was 2.4 times higher than that of other members, 2 times higher for ischemic heart disease, 2.1 times higher for hypertension, 1.5 times higher for cerebrovascular disease, 1.6 times higher for chronic respiratory disease, and 2.5 times higher for

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[11] Miller, B., Paschall, B., Svendsen, D. (2006). Mortality and Medical Comorbidity among Patients with Serious Mental Illness. Psychiatric Services, 57: 1482-1487.
Office of Research and Evaluation, ODMH, 2008 Ohio Family Health Survey: Special Population Report.
http://www.mh.state.oh.us/assets/tsig/ohfs-special-population-report-2008.pdf

[12] Colton CW & Manderscheid RW, (2006), Congruencies in Increased Mortality Rates, Years of Potential Life Lost, and Causes of Death Among Public Mental Health Clients in Eight States. Prevention of Chronic Disease, 3(2) Accessed on 10/21/09 at: http://www.cdc.gov/pcd/issues/2006/apr/05_0180.htm
Mauer, Barbara. (2006), Thirteenth in a Series of Technical Reports, Morbidity and Mortality in People with Serious Mental Illness, Editors: Joe Parks, MD. Dale Svendsen, MD. Patricia Singer, MD. Mary Ellen Foti, MD. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council

13 Mauer, Barbara. (2006). Thirteenth in a Series of Technical Reports Morbidity and Mortality in People with Serious Mental Illness Editors: Joe Parks, MD. Dale Svendsen, MD. Patricia Singer, MD. Mary Ellen Foti, MD. National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council

[14] Carstens, Carol, Ph.D., Ohio Department of Mental Health, unpublished 2008 Ohio Family Health Survey – Special Population Report; survey by Health Policy Institute of Ohio http://mentalhealth.ohio.gov/what-we-do/promote/research-and-evaluation/index.shtml Ohio Family Health Survey – home page http://grc.osu.edu/ofhs/

[15] Ohio Medicaid Claims Data Analyses for Articulating the Business case for Integrated Behavioral Health: Defining the problem. (2011). Available at http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=d565d_kYeBA%3d&tabid=7

arthritis. A more recent Ohio Medicaid Claims analysis[16] showed that individuals with SMI comprised of 10% of Medicaid Beneficiaries (253,977), but were responsible for 26% of Medicaid costs. This difference was due to higher rates of expensive chronic conditions, as well as emergency room utilization and hospitalizations at twice the rate of the non-SMI Medicaid Beneficiaries. Medicaid enrollees with SMI had higher prevalence of hypertension (SMI 36% vs. non-SMI 25%), diabetes (SMI 18% vs. non-SMI 13%), heart disease (SMI 21% vs. non-SMI 15%), and obesity (SMI 10% vs. non-SMI 5%). Hypertension and obesity are identified more frequently in Appalachian counties while respiratory disease and arthritis are identified more frequently in Metropolitan counties. This data is similar to national CMS data for similar populations included in presentations at the 2010 SAMHSA Block Grant Conference.

Metabolic Syndrome and Smoking - Psychotropic medication such as second generation antipsychotics (SGA) increases risk for metabolic syndrome for persons with SMI and they should be prescribed with appropriate education and monitoring. The Food and Drug Administration issued a warning to doctors in 2003 about the risk of high glucose levels and SGAs. Additionally, people living with mental illness have a very high rate of smoking due to an addiction to nicotine. A study by the Journal of the American Medical Association (2000)[17] reported that 44.3 percent of all cigarettes in America are consumed by individuals who live with mental illness and/or substance abuse disorders. Smoking is caused by an addiction to nicotine, so treatment for addiction is needed.

#4 Priority Population –Recovery Supports – as reported jointly by ODMH and ODADAS

Peer Support Services are not accessible to all consumers in Ohio who want them, and are not available in most Comprehensive Community Mental Health Centers where the majority of consumers receive public mental health services. Peer Support empowers consumers, provides hope and mentoring to consumers, and facilitates their active participation in their recovery. ODMH expects to complete development of a certified Peer Support Certification standard for inclusion in Ohio's State Medicaid Plan along with three other services to be added. While some Ohio communities offer WRAP, BRIDGES and Advance Directives, these peer education programs are not universally available---especially in some rural areas which do not have Consumer Operated Services.

[16] Ohio Government Resource Center, February, 2011

[17] Lasser K, Boyd JW, Woolhandler S, Himmelstein DU, McCormick D, Bor DH. Smoking and mental illness: a population-based prevalence study. JAMA, 2000; 284:2606-2610.

Family Supports – Families of children with SED and adults with SMI continue to need support as state budget cuts have made services less accessible and parents have lost jobs. ODMH is currently conducting focus groups regarding housing for youth and young adults (16 – 22) with SED. The results of these focus groups will inform ODMH's work. Recovery supports for families enable them to become better informed to support the recovery of their loved ones, and are provided by local chapters of statewide advocacy groups---NAMI-Ohio and the Ohio Federation for Children's Mental Health.

Diversity Recovery Supports are needed to increase access of underserved populations and increase the cultural competence of the workforce. For some examples of unmet need, see unmet needs among Priority Population #8 – Underserved Racial and Ethnic Minorities and LGBTQ Populations (all ages)

Housing – See #5 Priority Population - Homeless Persons and Persons with Severe Mental Illness in Need of Supportive Housing

Employment - Only 20.27% of adult consumers of Ohio's public mental health were employed in SFY 2009 according to National Outcome Measures (NOMs) data. This is considerably fewer than the majority of consumers who indicate that they want to work. Ohio continues to have high unemployment rates which exacerbate this problem. As state revenues decreased over the past few years, non-Medicaid mental health eligible services including employment were reduced as state General Revenue Funds and local levy funds decreased. While the Rehabilitation Services Commission funds some employment services for persons with serious mental illness, it does not fully meet the need. As a result, employment services are an unmet need in many Ohio communities.

#5 Priority Population – Homeless Persons and Persons with SMI

Unmet Need - The number of the State of Ohio Disability Vouchers from across all disability groups totaled 5,839 (from the local Metropolitan Housing Authorities).[18] In SFY 2011 there were 233,552 adults within Ohio's publically funded mental health system. Also in TAC's 2009 Report a target for the creation of 5,000 more Permanent Supportive Housing (PSH) units over 5 years was set as a reasonable goal for Ohio. Out of this report the Ohio Interagency Council on Homeless and Affordable Housing has adopted a goal of creating 6,000 new PSH units over the next five years. These units are in addition to the January 2007 number that the Corporation for

[18] Report to the Ohio Interagency Council on Homelessness and Affordable Housing (June 29, 2009)" prepared by the Technical Assistance Collaborative (TAC),

Supportive Housing estimates being somewhere between 8,000 and 8,500 of existing units of permanent supportive housing in Ohio.

Additional gaps include the number of housing vouchers, supportive services for PSH, funding for the renovation and maintenance of all existing housing stock not just limited to PSH. Also, Ohio needs to develop housing for some of the most difficult to know how to serve sub-populations of people with mental illness such as ex-offenders (especially sex offenders) who have very limited access to housing resources and public housing subsidies. It is clear that there is a shortage of safe, affordable, decent housing, which is essential for the recovery of consumers.

#6 Priority Population – Persons Involved with Criminal Justice System

ODRC currently has 50,000+ offenders with approximately 8% - 9% (4,000+) being considered SPMI[19] (*ODRC reports/website*). Of that SPMI Group 1,839 offenders with SPMI re-entering communities received CLSW (Community Linkage Social Work) services in state fiscal year 2011 (*community linkage database*) as compared to over 3,000 in SFY 2009. The decrease is due to Ohio priority setting to provide more intensive services at re-entry to offenders with SPMI rather simply providing a community mental health appointment to all offenders with any mental illness upon re-entry. CLSW services were expanded to include a wider variety of community mental health services and supports and includes facilitating application for benefits (e.g. SSI, Medicaid). In spite of this program, there remain barriers such as housing, quick access to services, supports and programs that address the multi-facet issues, and stigma.

Housing was specifically identified as a barrier during the Forensic Strategies Workgroup with a specific recommendation to "increase housing opportunities throughout the state for individuals who have received forensic services"[20] Upon release, an estimated (11%) of this population is homeless and another 15% has an "unknown" place of residence which usually also means homeless.[21] Additionally, housing is also an unmet need for Incompetent to Stand Trial and Not Guilty by Reason of Insanity clients being released from ODMH psychiatric hospitals.

In addition, most offenders released from prison did not have any benefits in place. During the reorganization, the CLSW program began applying for SSI benefits for offenders. The CLSW program reported 54 SSI approvals for SFY 2011 and expects to increase this number significantly for SFY 2012.

[19] http://www.drc.ohio.gov/
[20] *Forensic Strategies Workgroup Final Report, January 2010*
[21] *Community Linkage Database, SFY 2011 data*

#7 Priority Population – Persons of All Ages in Crisis including Veterans

Crisis and Safety Net - ODMH's Fiscal Office annually analyzes boards' budgets to determine those at financial risk. Those boards without sufficient resources to meet Medicaid match obligations are eligible for additional Safety Net funds to ensure that crises services remain in place and that Medicaid match requirements are met. For SFY 2011 seven of 50 Boards met the criteria for being at financial risk.

Military Personnel and Their Families - According to the Department of Veterans Services, Ohio has approximately 957,889 veterans including over 18,000 Ohio National Guard members deployed to Iraq or Afghanistan since September 11, 2001. Of the 18,000, 91% are male and 9% are female; 47% are single, 46% are married and 6% are divorced[22] It has been estimated that between 11% - 35% of returning veterans experience ongoing symptoms of unwanted distressing memories, images or thoughts, feelings of anxiety or panic, flashbacks and/or difficulty sleeping as well as substance abuse as a result of their combat experiences. Additional evidence of need is that the number of suicides in the National Guard and Reserve increased by 55 percent (80 in 2009; 145 in 2010) while the Army's suicide rate among active-duty soldiers dropped slightly (162 in 2009; 156 in 2010). More than half of the Army National Guard members who killed themselves in 2010 had never deployed.[23] In addition to the unmet needs specific to military families, service gaps shared by the general population (i.e. inadequate service delivery, financing and workforce), access barriers specific to this population include:

- About 50 percent of returning service members in need of treatment seek it
- Only slightly more than half of treatment-seekers receiving adequate care
- Stigma due to the tag of being fragile, vulnerable, or unable to perform under pressure
- Inadequate number of Tricare providers
- Access/eligibility to services veteran administration vs. community providers
- Little understanding of the "military culture" among community providers
- Lack of evidence-based and culturally competent services[24]

[22] Ohio National Guard, 2009
[23] Provided by the Ohio National Guard, OHIOCARES, Army Times January 2011, Veterans Administration, Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services
[24] Ohio National Guard, OHIOCARES, Army Times January 2011, Veterans Administration, Ohio Department of Mental Health and Ohio Department of Alcohol and Drug Addiction Services.

#8 Priority Population – Underserved Racial and Ethnic Minorities and LGBTQ Populations (all ages)

There are many disparities affecting minority access to mental health services. African Americans, American Indians, Asian Americans, Hispanic and Latinos, and cultures such as the Lesbian Gay Bi-sexual Transgender Questioning (LGBTQ) culture have traditionally been impacted. Overall, racial and ethnic minorities are often overrepresented in emergency and in-patient settings and underrepresented in outpatient care. However, data suggests that there are many other disparities which impact racial, ethnic, and cultural group access to quality mental health treatment. For example Hispanic and Latinos, the largest minority group in the U.S., are the largest group of uninsured in this country.[25] In addition, the lack of licensed interpreters and bilingual professionals interferes with appropriate evaluation, treatment, and emergency response to this population. American Indians have been impacted by very high poverty, more than twice the national average.[26] They have traditionally had difficulty accessing mental health services because of economic barriers, social and cultural differences, mistrust, and the lack of mental health providers.

According to the American Psychiatric Association,[27] one out of three African Americans who need mental health care receives it. Compared to the general population, African Americans are more likely to stop treatment early and are less likely to receive follow-up care. For some disorders, such as schizophrenia and mood disorders, there is a high probability of misdiagnosis because of differences in how African Americans express symptoms of emotional distress. Asian Americans are often viewed as a model community. However, despite this perception, they face many of the same mental health problems as other groups. Evidence shows high rates of addiction, gambling, and family violence among some groups of Asian Americans. In addition, many Asian Americans are at risk for post-traumatic stress disorder because of trauma suffered before immigration.

Some cultural groups are also at higher risk for mental health issues. For example, research suggests that LGBTQ community members are likely to be at higher risk for depression, anxiety, and substance use disorders.[28] One study found that members of the LGBTQ community are about two-and-one-half times more likely than heterosexual men and women to have had a mental health disorder, such as those related to mood, anxiety, or substance use, in their lifetime. In a national study comparing LGBTQ and heterosexual groups, researchers found that gay and

25 http://www.healthyminds.org/More-Info-For/HispanicsLatinos.aspx
26 http://www.healthyminds.org/More-Info-For/American-IndiansAlaskan-Natives.aspx
27 http://www.healthyminds.org/More-Info-For/African-Americans.aspx
28 http://www.nami.org/TextTemplate.cfm?Section=Fact_Sheets1&Template=/ContentManagement/ContentDisplay.cfm&ContentID=54036

bisexual men were more likely to report major depression and panic disorder in the previous twelve month period. Lesbian and bisexual women were more than three times as likely to have experienced generalized anxiety disorder.

#9 Priority Population – Youth/Young Adults in Transition (Children)

Transition-age youth face many barriers which prevent them from obtaining the mental health services and supports they need. They are caught between distinct child and adult mental health systems which are separated by different policies, funding structures and eligibility criteria. According to the 2010 Ohio Family Health Survey, an estimated 77,642 young adults age 18 to 24 (8% of the population in this age range) reported 14-plus days per month of functional impairment due to a mental health condition. Among the group with serious mental health impairment, 50% (38,906) are uninsured and 59% (45,675) live below the federal poverty line. An ODMH study (Carstens, 2009) of service patterns in the 14 to 24 age group shows that adolescents eligible for high intensity services in the children's mental health system have low service use in the adult system. Approximately 95% of adolescents in the 14-17 age range served by publically-funded mental health providers are eligible for Medicaid coverage based on family income. Of that group, 25% are treated for SED. Many of these adolescents received residential treatment, counseling and/or community psychiatric support treatment (CPST). With Ohio's application for the SAMHSA System of Care Planning Grant, there is the opportunity to promote the optimal wellness and recovery for our transition-age youth struggling with mental illness as they move towards independence and adulthood.

 # 10 Priority Population – Early Childhood Mental Health (ages 0 – 6)

More than 26,500 children, their families and caregivers participated in the early childhood mental health (ECMH) consultation program in SFY 2010. The result is that 87% of the children receiving intervention succeeded in staying in their <u>same</u> childcare or educational setting despite being at risk for removal due to behavioral issues, and only 1.5% of the children were expelled. ECMH is not available statewide due to funding constraints. Ohio published Ohio's Core Competencies for ECMH Professionals in 2009. In SFY 2012 and 2013, Ohio will develop and implement an ECMH Credentialing process which will include training on the skills and requirements of implementing service models with fidelity as well as bi-annual meetings to support these activities.

#11 Priority Population – Community Prevention

ODMH and ODADAS continue to coordinate their prevention efforts. Recently, ODADAS represented ODMH at a national prevention meeting hosted by NASMHPD (National Association of State Mental Health Policy Directors). ODMH is aligning its prevention activities with ODADAS's prevention framework. Additionally, ODMH and ODADAS are jointly funding the Ohio Suicide Prevention Foundation (OSPF) which is headed by a former ODADAS Director.

Suicide Prevention – In addition to Block Grant, OSPF received a $1.44 million Garrett Lee Smith Suicide Prevention Grant from SAMHSA for Federal Fiscal Years 2012 – 2014. This grant will target youth and other selected populations in 25 at-risk counties, as well as provide some statewide resources. In this grant application, OSPF described Ohio's needs:

> Ohio lost 1,402 of its citizens to suicide in 2008.[29] Approximately 4,643 were hospitalized for injuries related to an attempted suicide. According to the Center for Disease Control (CDC) the Ohio estimated average annual medical costs of suicide is $3,879,185 and work loss costs attributed to suicide is $921,766,767. Sadly, suicide is the 11th leading cause of death in the state. This represents over 3 suicides a day[30] and an additional 12.7 attempts per day[31] The statistics for youth are even more sobering: suicide is the 3rd leading cause of death for youth ages 15 to 24, and the 2nd leading cause of death for those 19 to 24. These figures are particularly bleak in light of the number of children and young adults they represent. According to the Ohio Department of Health, from 2002-2005 there were 57 suicides in the state annually by children ages 5-14. Additionally, between those same years there was an overwhelming 646 deaths due to suicide by young people 15-24 years of age[32] Furthermore, suicide was the second leading cause of death among 15-24 year olds and has increased 18% since 2001. Overall suicides by youths 15-24 years, accounted for 14% of all deaths in Ohio (CDC). Not surprisingly then, according to the Youth Risk Behavior Survey - 2007 (YRBS) 27% of Ohio's youth reported feeling depressed, and a frightening 18% claimed that they had seriously considered suicide.
>
> There exists a multitude of complex reasons why teens complete suicide such as feeling bullied or rejected by peers, perceived failures, disappointments, and turbulent family

[29] Ohio Department of Health Vital Statistics http://www.odh.ohio.gov/vitalstatistics/vitalstats.aspx
[30] Department of Health and Human Services
[31] National Centers for Health Statistics
[32] Ohio Department of Health http://www.odh.ohio.gov/vitalstatistics/vitalstats.aspx

situations. These are not necessarily the causes of teen suicide, but rather triggers in an individual who is suffering from mental illness, such as depression. The majority of teen suicide victims suffer from mental illness or a substance-abuse disorder, which contributes greatly to their inability to cope with stressors typical of the teen years. This added to the well-documented impulsivity of teens and young adults, puts them at greater risk of suicide.[33] Some teen populations are at a greater risk of suicide than others, perhaps because of increased stressors. For example lesbian, gay, bisexual, and transgendered youth are three times more likely to attempt suicide than their heterosexual peers (Massachusetts Youth Risk Survey, 2006 as well as American Association for Suicidology).

Additionally, Ohio has disparities between rural and urban areas in accessing mental health services, especially, in the southeastern region of Ohio and the 29 counties designated by the ARC (Appalachian Regional Council) to be Appalachian, Nineteen of the 29 Appalachian counties have an above average suicide rate, as compared with the rest of the state (2009, Ohio Department of Development). Although, the land area covered is nearly a third of the State, only 13% of Ohio's population lives in the Appalachian portion of the state, and over 25% of the population are under the age of 18.

Red Flags (Middle School) - According to NIMH, major depressive disorder is the leading disease related cause of death in the U.S. for ages 11-24. In SFY 2011, 4334 Ohio middle school students, 2025 parents and 334 school personnel participated in Red Flags, a school-based depression awareness and intervention program. As a result of the training measured by pre and post-tests, students consistently show increased recognition of depression and understanding of the importance of seeking help for themselves or a friend.

Maternal Depression Screening - Evidence suggests that maternal depression can interfere with parenting, leading to poor social development and problems with physical, psychological, behavioral, and mental health in children[34] In particular, maternal depression during infancy is a serious concern. Prenatal depression is linked to complications during pregnancy or delivery and adverse pregnancy outcomes. Just as concerning, depression is also associated with newborn crying; fussiness, and inconsolability, factors that in turn, may make it difficult for a parent to provide nurturing care.[35]

Ohio has provided 3667 maternal depression screenings from the period of FY 2006-2010. Fifteen of the mothers screened had a positive screening. 63% were referred to treatment, and 45% kept their appointment. The primary reason for refusing a referral was that the mother was either already in services or wanted to receive treatment with another agency or therapist. Beginning July, 2010, all mothers with infants involved in Ohio's *Help Me Grow* program are screened for maternal depression.

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[33] National Alliance on Mental Illness
[34] National Research Council and Institute of Medicine 2009
[35] National Research Council and Institute of Medicine 2009

Summary – Ohio has a well-documented need for mental health treatment and prevention services, as well as prevention and treatment for co-occurring conditions. As SAMHSA's message says, "Behavioral health is essential to health. Prevention works. Treatment is effective. People recover."

II: Planning Steps

Table 2 Step 3: Prioritize State Planning Activities

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Start Year:

2012

End Year:

2013

Number	State Priority Title	State Priority Detailed Description
1	Children with Serious Emotional Disturbances (SED) and their Families	Children who have received services through Ohio's public mental health system and meet Ohio-specific criteria for SED
2	Adults with Serious Mental Illness (SMI)	This population includes persons age 18 and older with Serious Mental Illness (SMI) who are served by Ohio's public mental health system.
3	Bi-directional Integration of Behavioral Health with Primary Care - Joint with Ohio Department of Alcohol and Drug Addiction Services (ODADAS)	This priority describes Ohio's work to integrate primary care into behavioral health services, as well as Ohio's efforts to integrate behavioral health into primary care.
4	Recovery Supports - Joint with ODADAS	This priority describes the non-clinical serivces and supports available to Ohio's behavioral health consumers. These services include housing and employment, peer support, educational groups, mentoring, and a number of additional services which support consumers in their recovery.
5	Homeless Persons and Persons with SMI in Need of Permanent Supportive Housing	This priority includes funding permanent supportive housing for persons with SMI, as well as related planning activities and supports, in collaboration with other state and federal agencies. Permament supportive housing includes shared independent living with lease, independent renter with lease, home ownership, adult care facility/residential homes, family or friend home, boarding home (e.g. YMCA/YWCA) or other permament housing.
		This priority provides community linkage for offenders with severe and persistent mental

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6	Persons Involved with Criminal Justice System	illness who are re-entering the community with the goal of reducing recidivism. Additionally, it includes mental health evaluations for persons referred by the courts, as well as some monitoring costs associated with persons who have been found Not Guilty by Reason of Insanity (NGRI) or Incompetent to Stand Trial (IST).
7	Persons of All Ages in Crisis including Veterans	This priority provides funds for crisis services to seven Boards which are at financial risk due to the recession, low tax base and/or lack of a local tax levy that funds mental health serivces in most Ohio communities. Additionally, this priority includes veterans and military personnel who may be experiencing unwanted distressing memories, flashbacks, ect., as well as their families.
8	Underserved Racial and Ethnic Minorities and LGBT (Lesbian, Gay, Bisexual, Transgender) Populations	This prority include underserved population groups who have access barriers or are at higher risk for specific mental health diagnoses. The mental health system is addressing these barriers and risks through some of the Block Grant funded projects.
9	Youth/Young Adults in Transition	This priority addresses the mental health needs of persons ages 14 to 24 who are transitioning from the children's service sytem to the adult service system which have different policies, funding structures and eligibility criteria. Many youth experience barriers when transitioning to the adult service system that prevent them from getting the services which they need.
10	Early Childhood Mental Health (ages 0 - 6)	This priority provides consultation services to parents, teachers and caregivers who are addressing behavioral health needs of children, ages 0 - 6. A major goal is to reduce removal from school or childcare due to behavioral health issues.
11	Community Prevention	ODMH is collaborating with ODADAS, as well as aligning with their prevention framework. The two state agencies jointly fund the Ohio Suicide Prevention Foundation that will be revising Ohio's Suicide Prevention Plan, as well as expanding youth suicide screening with a SAMHSA grant. Additional prevention programs include Red Flags (middle school depression education program) and Maternal Depression Screening.

Footnotes:

II: Planning Steps

Table 3 Step 4: Develop Objectives, Strategies and Performance Indicators

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Start Year:

2012

End Year:

2013

Priority	Goal	Strategy	Performance Indicator	Description of Collecting and Measuring Changes in Performance Indicator
		Strategies: To increase access to services for children with SED and their families, ODMH will: 1. Continue to develop and promote state interdepartmental partnerships and county/state collaborations to facilitate children, youth and family access to needed and preferred services. 2. Prioritize and increase services accessibility to young consumers and their families at risk of serious family emotional instability, loss of parental custody, child placement,		

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Children with Serious Emotional Disturbances (SED) and their Families	Goal: Access (NOM): Ohio will increase the accessibility of services for children with SED and children at-risk for SED through a system of care approach.	court involvement, and/or academic failure due to untreated mental illness. 3. Continue the Pediatric Psychiatric Network (PPN) so any Ohio pediatrician or other primary care practitioner may call, enabling them to speak with a child psychiatrist 24 hours a day, 7 days a week regarding a patient mental health diagnosis, treatment, or referral if required. 4. Continue advocacy and innovative initiatives aimed at consumer and family-guided use of federal, state and local resources in creative, efficient ways to expand the choices and array of the community systems of care options available. Description of Collecting and Measuring Changes in Performance Indicator: Data will be collected using claims for community mental health services for children ages 0 – 17 submitted through	Performance Indicator: Number of children and adolescents ages 0 – 17 who receive community mental health services in each state fiscal year.	Description of Collecting and Measuring Changes in Performance Indicator: Data will be collected using claims for community mental health services for children ages 0 – 17 submitted through MACSIS regardless of payment source. Change will be measured by comparing the number of children served each year from one state fiscal year to the next. This performance indicator includes all children ages 0 – 17 who receive out-patient services from Ohio's public mental health system of which about 25% are ages 0 – 8, which is an age group excluded from NASMHPD-NRI's prevalence estimates.

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		MACSIS regardless of payment source. Change will be measured by comparing the number of children served each year from one state fiscal year to the next. This performance indicator includes all children ages 0 – 17 who receive out-patient services from Ohio's public mental health system of which about 25% are ages 0 – 8, which is an age group excluded from NASMHPD-NRI's prevalence estimates.		
	Goal: Measure Treated Prevalence			The numerator will be collected using claims for community mental health services for children ages 9-17 submitted through MACSIS regardless of payment source. (Data is accessed directly from MACSIS rather than using MACSIS Data Mart as the age ranges are not available in Data Mart. The denominator will be measured using NASMHPD-NRI estimates for prevalence. (Note: Due to availability of data, the NASMHPD-NRI estimate is for the calendar year proceeding the years prior to the state fiscal year data reported. For example, for SFY2010, the service data is for

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Children with Serious Emotional Disturbances (SED) and their Families	of Children with SED. Ohio will increase the accessibility of services for children with SED through a system of care, and strive to increase the percentage of children estimated to need services who actually receive them	See strategies for Priority Area #1- Increase accessibility of services.	Numerator in Table A: Number of children and adolescents ages 9 – 17 who receive community mental health services in each state fiscal year using Ohio's restrictive definition of SED which Ohio uses in setting priorities.	SFY 2010 and the prevalence estimate is for calendar 2009. NASMHPD-NRI prevalence data for SFY 2009 will be used for service data for SFY 2010 and 2011 due to changes in availability of data. Additionally, Ohio's poverty level increased from "mid-level" to "high-level", so Ohio's estimated prevalence of SED increased between SFY 2008 and SFY 2009 (which is applied to estimate treated prevalence for SFY2009 and SFY 2010 making the calculated "treated prevalence" difficult to compare for those years. The decrease in treated prevalence between SFY 2009 and SFY 2010 was due to NASMHPD-NRI's prevalence estimate which applied to children, but not adults. Change will be measured by comparing the number of children served each year from one state fiscal year to the next. This performance indicator includes all children ages 0 – 17 who receive out -patient services from Ohio's public mental health system of which about 25% are ages 0 – 8 (and not included in NASMHPD-NRI's prevalence estimates.)
		To decrease number of children and adolescents in out of home placements, ODMH will: 1. Increase the statewide capacity of Intensive Home-Based Treatment (IHBT) which is a mental health service designed to meet the needs of		

Children with Serious Emotional Disturbances (SED) and their Families	There will be a decrease in the number of all children and adolescents served by Ohio's community mental health providers in out-of-home placements at the time of service receipt.	youth with serious emotional disturbances who are at risk of out-of -home placement or who are returning home from placement. 2 .Continue IHBT trainings and provider consultation available through the Center for Innovative Practices at Case Western Reserve University. 3. Continue preparation to submit a request to CMS for a state Medicaid Plan amendment to include IHBT as an Ohio Medicaid covered service.	There will be a decrease in the number of children and adolescents ages 0 – 17 served by Ohio's community mental health providers who are in out-of-home placements at the time of service receipt.	Data is derived from a match of Child Welfare SACWIS and ODMH MACSIS Databases. Change will be measured by comparing the number of children served in out-of –home placements each year from one state fiscal year to the next.
		1. ODMH will continue to fund existing (PPN) and new innovative projects (Behavioral Health/Physical Health (BH/PH) Integration Innovation, Health Information Technology (HIT) Innovation) to accelerate adoption of bi-directional integration of behavioral health and primary care services. 2. ODMH will coordinate		

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Adults with Serious Mental Illness (SMI)	ODMH will strive to develop a truly integrated care system that treats both physical, and mental health conditions in a comprehensive, coordinated way, where all of the individual's health care providers work together and regularly communicate.	elevation of carve-out behavioral health Medicaid benefit to the state for fiscal integration and better coordination of services 3. ODMH will coordinate establishment of Medicaid Health Homes for Behavioral Health population with OHT, ODJFS/Medicaid and ODADAS. 4. ODMH will coordinate the creation of the ICDS (Integrated Care Delivery System) for improved care coordination for people with a severe and persistent mental illness 5. ODMH will participate in Ohio Patient-Centered Primary Care Collaborative and other Primary Care/Mental Health efforts to integrate behavioral health and primary care services.	Number of people with Serious Mental Illness receiving Health Home Services	Data will be collected using JFS/Medicaid Health Home Enrollment Records for number of SMI individuals. Change will be measured by comparing the number of SMI adults receiving Health Home services each year from one state fiscal year to the next.
		To sustain access for adults with mental health treatment needs, ODMH will: 1.		

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Adults with Serious Mental Illness (SMI)	ODMH will strive to maintain the accessibility to public mental health services for adults with SMI despite the recession which resulted in reduced funding to serve this population.	Continue to develop and promote state interdepartmental partnerships and county/state collaborations to facilitate consumer access to needed and preferred services. 2. Prioritize and increase services accessibility to adults who are leaving institutions (psychiatric hospitals, prisons, nursing facilities) as well as persons who are homeless and/or veterans. 3. Monitor and develop tools that address accessibility from the perspectives of service quality, quantity, satisfaction and outcome achievement. 4. Promote development of nationally recognized evidence based practices and supports to address consumer needs and preferences as reflected in individualized plans of care. 5. Continue advocacy and innovative	The numerator is the number of adults ages 18 and over who receive community mental health services in each state fiscal year as taken directly from ODMH's MACSIS data base (not Data Mart). The numerator matches the year that the service was provided.	Data will be collected using MACSIS data for community mental health services for adults regardless of payment source. Change will be measured by comparing the number of adults served each year from one state fiscal year to the next. (Note: Ohio's data system is in the process of changing from MACSIS (owned by ODMH) to MITTS (owned by ODJFS, state Medicaid agency) so this is the final year of consistent data until Ohio has a few years of MITTS data.)

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		initiatives aimed at consumer-guided use of federal, state and local resources in creative, efficient ways to expand the choices and array of care options available.		
Bi-directional Integration of Behavioral Health with Primary Care - Joint with Ohio Department of Alcohol and Drug Addiction Services (ODADAS)	ODMH will strive to develop a truly integrated care system that treats both physical, and mental health conditions in a comprehensive, coordinated way, where all of the individual's health care providers work together and regularly	1. ODMH will continue to fund existing (PPN) and new innovative projects (Behavioral Health/Physical Health (BH/PH) Integration Innovation, Health Information Technology (HIT) Innovation) to accelerate adoption of bi-directional integration of behavioral health and primary care services. 2. ODMH will coordinate elevation of carve-out behavioral health Medicaid benefit to the state for fiscal integration and better coordination of services 3. ODMH will coordinate establishment of Medicaid Health Homes for Behavioral Health population with OHT, ODJFS/Medicaid	Number of people with Serious Mental Illness receiving Health Home Services	Data will be collected using JFS/Medicaid Health Home Enrollment Records for number of SMI individuals. Change will be measured by comparing the number of SMI adults receiving Health Home services each year from one state fiscal year to the next.

	communicate.	and ODADAS. 4. ODMH will coordinate the creation of the ICDS (Integrated Care Delivery System) for improved care coordination for people with a severe and persistent mental illness 5. ODMH will participate in Ohio Patient-Centered Primary Care Collaborative and other Primary Care/Mental Health efforts to integrate behavioral health and primary care services.		
		1. Complete development of Peer Support Service rule for services by Certified Peer Specialists, and complete the Ohio legislative rules process to incorporate the rule into the ODMH Certification Standards for Ohio's community mental health and consumer operated service providers. 2. Develop Recovery Support Services; Consumer Operated Services rule to provide non		

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Recovery Supports - Joint with ODADAS	Increase the availability of Peer Support Services by Certified Peer Specialists in Ohio.	-Medicaid reimbursable services by Certified Peer Specialists. Rule will be developed to be consistent with one of SAMHSA's new service descriptions. Reimbursement will be from local levy funds, Block Grant and other non-Medicaid funds. 3. Complete development of certification process and training curriculum for Certified Peer Support Specialists. 4. Train and certify Peer Support Specialists. 5. Develop an experienced workforce through hiring Certified Peer Support Specialists for Recovery Support Services – Consumer Operated Services during the year that ODMH will be working to complete a State Plan Amendment to incorporate Peer Support Services into Ohio's State Medicaid Plan.	Number of certified Peer Support Specialists	ODMH will measure the number of certified Peer Support Specialists in Ohio. As this is a new measure, we will collect baseline data.
		1. Provide peer-to-		

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Recovery Supports - Joint with ODADAS	Provide Recovery Support to adults with SMI, children with SED and their families available through statewide groups	peer and family-to-family education through statewide consumer and family organizations funded by Block Grant. 2. Promote cultural competence and develop diversity resources to increase access to underserved groups through Multi-ethnic Advocates for Cultural Competence. 3. Increase professionals' understanding of consumer and family perspectives in the recovery process to enhance their clinical skills and cultural competence.	Number of persons receiving Recovery Supports, peer and family education and training through Ohio's statewide consumer and family mental health organizations.	ODMH will collect the number of persons receiving peer, family and professional education through Ohio's statewide consumer and family organizations funded by Block Grant. Additionally, ODMH is piloting a pre-test and post-test with all trainings to evaluate their impact on the trainee. As this is a new measure, we will collect base line data.
		1. Increase and preserve the number of existing Permanent Supportive Housing units in which ODMH has been a funding participant. 2. Leverage housing dollars from sources outside of	Number of new people	

Homeless Persons and Persons with SMI in Need of Permanent Supportive Housing	Increase and preserve safe, decent, and affordable housing to persons with severe and persistent mental illness	ODMH 3. Work cooperatively with Ohio's Medicaid agency on the Money Follows the Person (MFP) grant to assist persons with severe mental illness currently in institutions in obtaining housing. Award 15 mini-grants around Ohio as pilot projects to provide additional resources to existing housing programs serving persons exiting institutions.	with SPMI (Severe and Persistent Mental Illness) assisted through ODMH's Money Follows the Person (MFP) Home Choice Program designed to assist persons with SPMI who choose to move from nursing facilities to community housing.	ODMH MFP Program: PASSAR database.
		1. Increase and preserve the number of existing Permanent Supportive Housing units in which ODMH has been a funding participant. 2. Through ODMH Homeless Assistance Grant, leverage housing dollars from Ohio		

Homeless Persons and Persons with SMI in Need of Permanent Supportive Housing	Increase and preserve safe, decent, and affordable housing to persons with severe and persistent mental illness.	Department of Development for ODMH housing projects to serve persons with SMI. 3. Work cooperatively with Ohio's Medicaid agency, ODJFS, on the Money Follows the Person (MFP) grant to assist persons with severe mental illness residing in nursing facilities in obtaining housing. Award 15 mini-grants around Ohio as pilot projects to provide additional resources to existing housing programs serving persons exiting institutions.	Number of existing units that will be repaired and/or renovated to preserve longevity. The Ohio Housing Finance Agency (OHFA) utilizes state housing trust fund dollars for both development and preservation. ODMH and OHFA are partnering to provide approxi	ODMH has a Capital Data Base that tracks projects from application to completion which will be used to collect this data.
		1. Increase and preserve the number of exiting Permanent Supportive Housing units in which ODMH has been a funding participant. 2. Through ODMH Homeless Assistance Grant, leverage housing dollars from sources outside of ODMH (through Ohio Department		ODMH will use Capital Data Base that tracks projects from application to completion. The target values for new units depend upon

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Homeless Persons and Persons with SMI in Need of Permanent Supportive Housing	Increase safe, decent, and affordable housing to persons with severe and persistent mental illness	of Development) for ODMH housing projects to serve persons with SMI. 3. Work cooperatively with Ohio's Medicaid agency on the Money Follows the Persons (MFP) grant to assist persons with severe mental illness currently in institutions in obtaining housing. Award 15 mini-grants around Ohio as pilot projects to provide additional resources to existing housing programs serving persons exiting institutions.	Number of new units built.	receiving Capital funds from the Ohio Legislature as a result of bond dollars. Capital budgets are on the opposite biennium from the state's operating budget biennium. SFY 2011 numbers are high because they are finishing development from SFY 2010. SFY 2012 targets are lower than previous years as no funds were awarded in Capital Budgets for SFY 2011 – 2012. Target numbers for SFY 2012 and SFY 2013 are projects using funds left over from the previous biennium.
	Increase over the next 3 years, the number of released	1. CLSW will develop a procedure in conjunction with ODRC for staff to apply for SSI benefits for offenders with mental health issues 2. Offenders that meet policy criteria will be assisted with benefit application 3. CLSW program staff will have access to ODRC Medicaid database and assist		

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Persons Involved with Criminal Justice System	offenders with severe mental health issues who are released from prison with an application for benefits completed and submitted to the SSA/BDD offices.	offenders with reinstatement of Medicaid benefits as appropriate 4. CLSW program will work with ODJFS to identify a process for presumptive Medicaid approval for offenders whose SSI (Supplemental Security Income) has been approved 5. CLSW program will work closely with the Social Security Administration and Bureau of Disability Determination offices to assure program integrity, as well as continuous quality improvement (CQI).	The number of benefit applications submitted to SSA/BDD offices for offenders diagnosed with SPMI being released from prison.	The number of offenders who have a benefit application submitted will increase. Change will be measured by comparing the numbers across state fiscal years.
		1. Market the Community Linkage Social Work (CLSW) program and its benefits to offenders, Ohio Department of Rehabilitation and Corrections (ODRC) staff, and other stakeholders 2. Provide necessary tools and skills to		Data from the CLSW data based will include (1)

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Persons Involved with Criminal Justice System	Increase the percentage of offenders with SPMI agreeing to participate in the community linkage program during discharge planning.	CLSW staff inclusive of motivational interviewing techniques (from Substance Abuse/Mental Illness evidence based practices). 3. Plan, implement and monitor the CLSW program so that it is able to provide adequate coverage for all ODRC prisons 4. Work cooperatively with community stakeholders to assure quick access to mental health appointments and other supports needed	Percentage of offenders linked with mental health appointments and/or other supports (housing, employment agencies, reentry coalitions, consumer operated services, etc.)	the number of offenders served by the CLSW program (numerator) divided by (2) the number of offenders who were eligible to be served by the CLSW program (denominator). These numbers will be used to calculate the percentage of eligible offenders who agreed to be served by the CLSW program. Change will be measured by the difference in the percentage of offenders who agreed to participate in the program in each year as compared to previous years.
		1. Develop and issue 16 mini grants through a Request for Proposal (RFP) process that focuses on increasing the capacity to serve the forensic population being released from prison. Goals of the		

Persons Involved with Criminal Justice System	Increased Community capacity to serve the forensic population being released from prison.	RFP e.g. decrease wait time to access ongoing medication, increase the number of offenders served, increase the services provided to offenders, increase in-reach efforts to the SPMI offenders population. 2. Develop appropriate evaluation strategies for each grant. 3. Develop sustainability plan for leveraging additional dollars and/or capacity beyond the life of the grant.	To be determined by the grant proposals. Examples include: 1) number of individuals receiving medication within 14 days 2) average wait time to receive an appointment 3) total number of services received/connected to 4) number of in-reach appointments.	To be developed based on the goals of the projects submitted.
Persons of All Ages in Crisis including Veterans	Develop An Interagency Memorandum of Understanding (MOU) for State Agency partners in addressing veteran and service member behavioral health and related needs.	• In coordination with OHIOCARE and state agency directors collaborate and meet to identify and define various agency roles in support of veterans and service member behavioral healthcare needs. • Agency Partners will be asked to sign to agreement and commit to roles as identified.	Number of agencies signing MOU	The number of agencies signing the MOU will be measured each year.
		Conduct cultural competence training to provider		

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Underserved Racial and Ethnic Minorities and LGBT (Lesbian, Gay, Bisexual, Transgender) Populations	Enhance mental health workforce skills through cultural competence training.	staff, consumers, family members and community members on the elimination of disparities, and access to culturally appropriate services, as well as other topics.	Number of persons receiving cultural competence training.	Multi-ethnic Advocates for Cultural Competence (MACC) will count the number of persons trained. Additionally, MACC will collect training evaluations.
Youth/Young Adults in Transition	Goal: Develop youth and young adult leadership to participate in decision making processes regarding mental health policy, services and supports for transition-age youth.	To increase Youth/Young Adults in Transition (YYAT) voices in policy and program development, ODMH will: Convene youth/young adult leadership training with the SAMHSA System of Care and Transition to Independence Program (TIP) communities.	Number of YYAT trained in youth/young adult leadership	The measure is the number of youth and young adults who complete the leadership training. The project will collect baseline data for this new project.
	Early mental health	1. Provide consultation and training to staff of child-care providers and pre-schools to address the needs of children at-risk of removal due to behavior. 2. Provide consultation to families of children at-risk of removal from childcare settings and pre-schools due to behavior. 3.	The percentage of children ages 0 - 6 that are at risk of removal from a child	

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Early Childhood Mental Health (ages 0 - 6)	screening, assessment, and referral to services are common practice.	Establish an ECMH Professional Credential 4. Data reporting is yielding findings about the impact of these services and will continue to be analyzed. 5. ODMH will provide five professional development opportunities for ECMH professionals statewide in SFY 2012. This trend is expected to continue in SFY 2013.	care setting due to behavioral issues that are maintained in an early childhood setting with ECMH Consultation services will increase by 2 per year.	The measure is the number of children, ages 0-6, at risk of removal who receives mental health consultation services.
Community Prevention	ODMH and ODADAS will collaborate with community prevention efforts.	ODMH and ODADAS will continue to: • Jointly fund the Ohio Suicide Prevention Foundation. • Develop cross systems collaboration with the Resiliency Ohio Initiative. • Hold information sharing meetings regarding prevention initiatives and trends on the state level as well as national front. Ohio Suicide Prevention Foundation (OSPF) will increase the number of youth	Number of teens who are screened.	OSPF staff will track collaborative projects/ activities.

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		receiving suicide prevention screening with the evidence-based practices of TeenScreen and Signs of Suicide.		
Community Prevention	Ohio schools and organizations will continue to implement Red Flags, school-based depression awareness and intervention program.	1. Develop and promote collaboration between Red Flags /Mental Health America of Summit County (MHASC), Ohio Suicide Prevention Foundation (OSPF), and county suicide coalitions to expand suicide prevention services to at-risk youth. 2. Ohio's suicide coalitions in Ohio will help market and promote Red Flags, school-based depression awareness and intervention program. 3. With decreased funding, the Red Flags Program will strive to sustain provision of identification, prevention and early intervention for middle school children and school personnel and parents with the collaborative efforts noted in Strategy #1.	The measure will be the number of Ohio middle school students, school personnel and parents participating with Red Flags.	Data will be collected from OSPF and MHASC reporting on prevention services to at-risk youth.

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Community Prevention	The Resiliency Ohio Initiative will increase education and awareness capacity through regional training opportunities.	Resiliency Leadership Ohio will facilitate regional trainings in collaboration with local systems such as the County Family and Children First Councils, and ADAMH Boards to 1. Recruit new youth and family Resiliency Initiative Trainers in Ohio, 2. Increase knowledge of resiliency and principals, 3. Increase cross system collaborations, and 4. Increase the Resiliency Initiative's capacity for increasing awareness and providing education to Ohioans.	Number of regional trainings in resiliency leadership.	Data provided by Center for Innovative Practices/ Case Western Reserve University and Ohio Federation for Children's Mental Health.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 Services Purchased Using Reimbursement Strategy

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Start Year:
2012

End Year:
2013

Reimbursement Strategy	Services Purchased Using the Strategy
Grant/contract reimbursement	All of Ohio's Block Grant is awarded using a grant/contract reimbursement strategy.

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5 Projected Expenditures for Treatment and Recovery Supports

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Start Year: 2012

End Year: 2013

Category	Service/Activity Example	Estimated Percent of Funds Distributed
Healthcare Home/Physical Health	• General and specialized outpatient medical services • Acute Primary Care • General Health Screens, Tests and Immunization • Comprehensive Care Management • Care coordination and health promotion • Comprehensive transitional care • Individual and Family Support • Referral to Community Services	<10% 6
Engagement Services	• Assessment • Specialized Evaluation (Psychological and neurological) • Services planning (includes crisis planning) • Consumer/Family Education • Outreach	<10% 6
Outpatient Services	• Individual evidence-based therapies • Group therapy • Family therapy • Multi-family therapy • Consultation to Caregivers	10-25% 6
Medication Services	• Medication management • Pharmacotherapy (including MAT) • Laboratory services	<10% 6
Community Support (Rehabilitative)	• Parent/Caregiver Support • Skill building (social, daily living, cognitive) • Case management • Behavior management • Supported employment • Permanent supported housing • Recovery housing • Therapeutic mentoring • Traditional healing services	26-50% 6
Recovery Supports	• Peer Support • Recovery Support Coaching • Recovery Support Center Services • Supports for Self Directed Care	<10% 6
Other Supports (Habilitative)	• Personal care • Homemaker • Respite • Supported Education • Transportation • Assisted living services	<10% 6

	• Recreational services • Interactive Communication Technology Devices • Trained behavioral health interpreters	
Intensive Support Services	• Substance abuse intensive outpatient services • Partial hospitalization • Assertive community treatment • Intensive home based treatment • Multi-systemic therapy • Intensive case management	<10% 6
Out-of-Home Residential Services	• Crisis residential/stabilization • Clinically Managed 24-Hour Care • Clinically Managed Medium Intensity Care • Adult Mental Health Residential • Adult Substance Abuse Residential • Children's Mental Health Residential Services • Youth Substance Abuse Residential Services • Therapeutic Foster Care	10-25% 6
Acute Intensive Services	• Mobile crisis services • Medically Monitored Intensive Inpatient • Peer based crisis services • Urgent care services • 23 hour crisis stabilization services • 24/7 crisis hotline services	<10% 6
Prevention (Including Promotion)	• Screening, Brief Intervention and Referral to Treatment • Brief Motivational Interviews • Screening and Brief Intervention for Tobacco Cessation • Parent Training • Facilitated Referrals • Relapse Prevention /Wellness Recovery Support • Warm line	<10% 6
System improvement activities		10-25% 6
Other		<10% 6

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6 Primary Prevention Planned Expenditures Checklist

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Start Year: 2012

End Year: 2013

Strategy	IOM Target	Block Grant FY 2012	Other Federal	State	Local	Other
Information Dissemination	Universal	$	$	$	$	$
Information Dissemination	Selective	$	$	$	$	$
Information Dissemination	Indicated	$	$	$	$	$
Information Dissemination	Unspecified	$	$	$	$	$
Information Dissemination	Total	$	$	$	$	$
Education	Universal	$	$	$	$	$
Education	Selective	$	$	$	$	$
Education	Indicated	$	$	$	$	$
Education	Unspecified	$	$	$	$	$
Education	Total	$	$	$	$	$
Alternatives	Universal	$	$	$	$	$
Alternatives	Selective	$	$	$	$	$
Alternatives	Indicated	$	$	$	$	$
Alternatives	Unspecified	$	$	$	$	$
Alternatives	Total	$	$	$	$	$
Problem Identification and Referral	Universal	$	$	$	$	$
Problem Identification and Referral	Selective	$	$	$	$	$
Problem Identification and Referral	Indicated	$	$	$	$	$
Problem Identification and Referral	Unspecified	$	$	$	$	$
Problem Identification and Referral	Total	$	$	$	$	$

Community-Based Process	Universal	$	$	$	$	$
Community-Based Process	Selective	$	$	$	$	$
Community-Based Process	Indicated	$	$	$	$	$
Community-Based Process	Unspecified	$	$	$	$	$
Community-Based Process	Total	$	$	$	$	$
Environmental	Universal	$	$	$	$	$
Environmental	Selective	$	$	$	$	$
Environmental	Indicated	$	$	$	$	$
Environmental	Unspecified	$	$	$	$	$
Environmental	Total	$	$	$	$	$
Section 1926 Tobacco	Universal	$	$	$	$	$
Section 1926 Tobacco	Selective	$	$	$	$	$
Section 1926 Tobacco	Indicated	$	$	$	$	$
Section 1926 Tobacco	Unspecified	$	$	$	$	$
Section 1926 Tobacco	Total	$	$	$	$	$
Other	Universal	$150,000	$	$	$	$
Other	Selective	$	$	$	$	$
Other	Indicated	$200,000	$	$	$	$
Other	Unspecified	$1,634,626	$1,405,249	$1,963,496	$6,809,155	$
Other	Total	$1,984,626	$1,405,249	$1,963,496	$6,809,155	$

Footnotes:

Ohio's Mental Health Block Grant funds the following activities defined by SAMHSA as prevention in Table 5. These include:
$892,626 Local mental health prevention, consultation and education activities reported by Boards - extrapolated from SFY 2010 expenditures (unspecified)
$150,000 Statewide promotion of middle school program of depression education (univeral)
$200,000 Early childhood consultation for parents, teachers and caregivers of children ages 0 - 6 with behavioral problems (indicated)
$550,000 Ohio Suicide Prevention Foundation (also funded by ODADAS) (unspecified)
$ 70,000 Warm line at ODMH staffed by consumers for consumers and families (unspecified)

Additional amounts from Other Federal Grants were extrapolated from SFY 2010 Board expenditure reports of Prevention and Other.
(1) Other federal sources include the Child Care Quality Grant CFDA 93.596.
(2) State funds include funds directed for early childhood consutation and forensic monitoring as well as state General Revenue Funds for which the Board has discretion to spend for any mental health purpose, and chooses to allocate to prevention.
(3) Local funds are from local tax levies organized by Ohio's 50 Boards, of which 47 are combined mental health and substance abuse boards.

III: Use of Block Grant Dollars for Block Grant Activities

Table 7 Projected State Agency Expenditure Report

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Start Year: 2012

End Year: 2013

Date of State Expenditure Period From: 10/01/2011 Date of State Expenditure Period To: 09/30/2013

Activity	A. Block Grant	B. Medicaid (Federal, State, and Local)	C. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	D. State Funds	E. Local Funds (excluding local Medicaid)	F. Other
1. Substance Abuse Prevention and Treatment	$	$	$	$	$	$
2. Primary Prevention	$1,864,625	$	$	$5,949,972	$7,415,186	$
3. Tuberculosis Services	$	$	$	$	$	$
4. HIV Early Intervention Services	$	$	$	$	$	$
5. State Hospital		$949,241	$27,878,006	$418,194,928	$	$
6. Other 24 Hour Care	$3,720,560	$	$	$7,566,542	$57,314,150	$
7. Ambulatory/Community Non-24 Hour Care	$21,131,813	$581,700,470	$	$331,909,090	$372,585,516	$
8. Administration (Excluding Program and Provider Level)	$1,369,524	$5,574,397	$	$33,406,511	$70,117,022	$
9. Subtotal (Rows 1, 2, 3, 4, and 8)	$3,234,149	$5,574,397	$	$39,356,483	$77,532,208	$
10. Subtotal (Rows 5, 6, 7, and 8)	$26,221,897	$588,224,108	$27,878,006	$791,077,071	$500,016,688	$
11. Total	$28,086,522	$588,224,108	$27,878,006	$797,027,043	$507,431,874	$

Footnotes:

1. Extrapolated from Block Grant as reported by CMH Boards on SFY 2010 expenditure report. Multiplied by 2 for estimating 2 years and the SFY 2012 Block Grant Expenditure Budget for allocations to specific projects ("directs").
System Improvement activities are included in ambulatory care which they are improving.
2. Medicaid: State Hospital is FY 10 & 11 revenue earned from Medicaid (IMD) (Fund 3240)(revenue = expenditures for this) 3. Medicare : State Hospital is FY 10 & 11 Fund 3240 expenditures.
4. State Funds: Primary Prevention, Other 24 Hr Care, and Non-24 Hr Care all from FY 10 board expenditure report (multiplied by 2), State Hospital is FY 10 annual report net operating (multiplied by 2)
5. Local Funds: FY 10 Board expenditure report (multiplied by 2)
a. Admin: Medicaid is from State Fund (3B10) FY 10 & 11 expended for payroll, State Fund (GRF, 333321) is total Admin expenditures (FY 10 & 11)

III: Use of Block Grant Dollars for Block Grant Activities

Table 8 Resource Development Planned Expenditures Checklist

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Start Year: 2012

End Year: 2013

Activity	A. Prevention-MH	B. Prevention-SA	C. Treatment-MH	D. Treatment-SA	E. Combined	F. Total
1. Planning, Coordination and Needs Assessment	$		$			$
2. Quality Assurance	$		$			$
3. Training (Post-Employment)	$		$			$
4. Education (Pre-Employment)	$		$			$
5. Program Development	$		$			$
6. Research and Evaluation	$		$			$
7. Information Systems	$		$			$
8. Total	$	$	$	$	$	$

Footnotes:

As this table is optional, ODMH chose not to complete it. ODMH does not break out its Block Grant funded preject budgets in this way.

Ohio uses about half of its Block Grant for these kinds of Resource Development activities, which are often blended around a specific program area. For example, Center for Innovative Practices does "Planning, Coordination and Needs Assessment" for "innovative practices" for children and youth with behavioral health needs, provides "Training" to providers of children's mental heatlh practices, and maintains an "Information System" used for "Quality Improvement" of MST (Multi-systemic Therapy), which is an evidence-based practice. Ohio makes a number of project awards that blend these system's development activities into a single project budget.

IV: Narrative Plan

D. Activities that Support Individuals in Directing the Services

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Narrative Question:

SAMHSA firmly believes in the importance of individuals with mental and substance use disorders participating in choosing the services and supports they receive. To achieve this goal, individuals and their support systems must be able to access and direct their services and supports. Participant direction, often referred to as consumer direction or self direction, is a delivery mode through which a range of services and supports are planned, budgeted and directly controlled by an individual (with the help of representatives, if desired) based on the individual's needs and preferences that maximize independence and the ability to live in the setting of his/her choice. Participant-directed services should include a wide range of high-quality, culturally competent services based on acuity, disability, engagement levels and individual preferences. The range of services must be designed to incorporate the concepts of community integration and social inclusion. People with mental and substance use disorders should have ready access to information regarding available services, including the quality of the programs that offer these services. An individual and their supports must be afforded the choice to receive services and should have sufficient opportunities to select the individuals and agencies from which they receive these services. Person centered planning is the foundation of self-direction and must be made available to everyone. The principles of person centered planning are included at www.samhsa.gov/blockgrantapplication. Individuals must have opportunities for control over a flexible individual budget and authority to directly employ support workers, or to direct the worker through a shared employment model through an agency. People must have the supports necessary to be successful in self direction including financial management services and supports brokerage. In addition, individuals and families must have a primary decision-making role in planning and service delivery decisions. Caregivers can play an important role in the planning, monitoring and delivery of services and should be supported in these roles. In the section below, please address the following:

- Either summarize your State's policies on participant-directed services or attach a copy to the Block Grant application(s).
- What services for individuals and their support systems are self-directed?
- What participant-directed options do you have in your State?
- What percentage of individuals funded through the SMHA or SSA self direct their care?
- What supports does your State offer to assist individuals to self direct their care?

Footnotes:

D. Activities that Support Individuals in Directing the Services

Self-Directed Care for Substance Use Disorders - Persons with co-occurring substance abuse disorders who live in northeastern Ohio have access to Access to Recovery (ATR), which provides self-directed care. Access to Recovery is funded by a $13.3 million grant from SAMHSA to ODADAS. With this grant, consumers are able to direct their care through managing a budget that offers them the opportunity to choose non-traditional services, as well as traditional clinical services. Examples of non-traditional services include a YMCA membership to exercise or the services of a recovery coach. The service plan and its budget are reviewed by professional staff in a meeting with the client who is self-directing his/her care.

Self- Directed Care Policy – In an environment of shrinking funding during the recession for mental health services or a federal grant, ODMH has not developed a policy or prioritized self-directed care. However, ODMH has a long tradition of supporting consumer participation in their care through peer-to-peer education program, consumer operated services and peer support groups. Additionally, ODMH includes consumer participation in the development of the "individual service plan" as a core value in training mental health professionals on documentation of services.

Consumer Education on Participant Directed Care - ODMH funds Ohio Empowerment Coalition (OEC), a statewide consumer operated service, which coordinates train-the-trainer for peer-to-peer education programs that provide opportunities for consumers to develop the self-advocacy skills to participate in directing their services. These programs include Wellness Recovery Action Plan (WRAP), BRIDGES (Building Recovery through Individual Dreams and Goals through Education and Support, and Psychiatric Advance Directives (PAD).[1] OEC hosted a consumer conference on August 12 and 13 attended by about 190 persons, which included a presentation by ODMH's director and many peers. The conference, *Peer Support – Transforming Ohio's Mental Health System* – was planned and implemented entirely by consumers who built on a consumer advocacy movement that hosted its first Ohio conference in 1984. The Directors of ODMH and OEC provided the keynote address. Almost all of the workshops were led by consumer speakers with expertise in providing peer support and/or peer education. A few traditional providers and ODMH staff were invited to present on peer support activities. The conference included an evaluation that was carefully worded for consumers by consumers.

Most of the peer education and peer support in Ohio is provided by 36 consumer operated services which are certified by ODMH as providers, and as well as an additional 20 – 25 local peer support groups which provide nationally recognized peer education programs to consumers including WRAP, BRIDGES and PAD. Through these peer education programs, Ohio consumers become advocates for themselves and their peers, which empowers them to actively

[1] http://www.ohioempowerment.org/programs.htm

participate in their individual service plans and WRAP plans. While peer support is not "self-directed care," it is expected to empower consumers to more effectively participate in developing their service plans and in directing their own recovery. Additionally, ODMH is in the process of developing a rule that will allow Medicaid-reimbursement for peer support services which is expected to expand the availability of peer support statewide. Peer support staff will provide education to consumers on how to collaborate with providers in developing their service plans.

Resiliency Training for Children, Youth and Their Families - Resiliency training is available that provides tools for self-directed and family-directed care. *"Resiliency is an inner capacity that when nurtured, facilitated, and supported by others empowers children, youth and families to successfully meet life's challenges with a sense of self-determination, mastery, hope and well-being."*[2] Resiliency concepts were developed jointly by youth with SED, their families, Center for Innovative Practices, and the Ohio Federation for Children's Mental Health. For children and youth, parents or guardians have the legal responsibility for making decisions about care. Parents and guardians make the choices about how much of this responsibility may be shared with youth, so must be involved in the process in a different way than families are in the service planning for adults.

Additionally, NAMI-Ohio provides Parent Advocacy Connection (PAC) in which parents of children with SED who receive services from multiple systems can be assigned another parent with similar experiences. The PAC mentor may attend service planning meetings with parents.

[2] http://www.resiliencyohio.org/OH_res/prod/

IV: Narrative Plan

E. Data and Information Technology

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Narrative Question:

Regardless of financing or reimbursement strategy used, unique client-level encounter data should be collected and reported for specific services that are purchased with Block Grant funds. Such service tracking and reporting is required by SAMHSA to be reported in the aggregate. Universal prevention and other non-service-based activities (e.g. education/training) must be able to be reported describing the numbers and types of individuals impacted by the described activities. States should to complete the service utilization Table 5 in the Reporting Section of the Application. States should provide information on the number of unduplicated individuals by each service purchased with Block Grant Funds rather than to provide information on specific individuals served with Block Grant funds. In addition, States should provide expenditures for each service identified in the matrix. If the State is currently unable to provide unique client-level data for any part of its behavioral health system, SAMHSA is requesting the State to describe in the space below its plan, process, resources needed and timeline for developing such capacity. States should respond to the following:

- List and briefly describe all unique IT systems maintained and/or utilized by the State agency that provide information on one or more of the following:
  - Provider characteristics
  - Client enrollment, demographics, and characteristics
  - Admission, assessment, and discharge
  - Services provided, including type, amount, and individual service provider
  - Prescription drug utilization
- As applicable, for each of these systems, please answer the following:
  - For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?
  - Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?
  - Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?
  - Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider?
  - Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?
- As applicable, please answer the following:
  - Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?
  - Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?
  - Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?
  - Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?
  - Is your State Medicaid agency engaging in or planning to improve its IT system? If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

Footnotes:

E. Data and Information Technology – ODMH has unique IT systems maintained and/or utilized by the State agency that provide information on provider characteristics; client enrollment, demographics and characteristics; admission, assessment and discharge; services provided, including type, amount and individual service provider, and prescription drug utilization.

- **MACSIS** – This application is used for Community Mental Health Services. It includes client eligibility, client information, service claims that includes type, amount and service provider. Its primary purpose is to pay Medicaid claims. Boards have discretion regarding what non-Medicaid services are reported in this system. This system will be replaced by **MITTS** operated by ODJFS, the state Medicaid agency within the next year as ODJFS will be assuming responsibility for behavioral health Medicaid claims in SFY 2013.
- **PCS** – This application is used for patient services provided by the six regional psychiatric hospitals operated by ODMH. It includes client eligibility, client information, admission, assessment, discharge, services provided and drug utilization for patients served by Regional Psychiatric Hospitals. This application is in the process of retirement and is being replaced by Avatar.
- **Avatar** - This application is used for clinical and in-patient services for the six regional psychiatric hospitals operated by ODMH. It includes client eligibility, client information, admission, assessment, discharge, services provided and drug utilization. This application is in development and starting implementation.
- **OH-BH** – This application is under development to report Community Mental Health demographic data, admission and enrollment data, as well as consumer outcomes for housing, criminal justice and education/employment as required by the Data Infrastructure Grant. This data system will add the Global Assessment of Functioning (GAF) Axis V to Ohio's community mental health data base, which will enable ODMH to use new criteria to identify children with SED and adults with SMI, as well as provide client level data to SAMHSA.

Ohio's responses are in bold to SAMHSA's questions in italics.

- *For provider information, are providers required to obtain national provider identifiers, and does the system collect and record these identifiers?* - **Yes**
- *Does the system employ any other method of unique provider identification that provides the ability to aggregate service or other information by provider?* **Yes**
- *Does the system use a unique client identifier that allows for unduplicated counts of clients and the ability to aggregate services by client?* **Yes**
- *Are client-level data in the form of encounters or claims that include information on individual date of service, type of service, service quantity, and identity of individual provider*? **Yes**

- *Does the system comply with Federal data standards in the following areas (use of ICD-10 or CPT/HCPCS codes)?* **Yes, CPT/HCPCS. ICD-10 is under development.**

Additional applicable responses are:

- *Do provider and client identifiers in the behavioral health IT system allow for linkage with Medicaid provider identifiers that provides the ability to aggregate Medicaid and non-Medicaid provider information?* **Yes**
- *Are Medicaid data or linked Medicaid-behavioral health data used to routinely produce reports?* **Yes**
- *Does your State's IT division participate in regular meetings with Medicaid and other agencies to address mutual issues concerning system interoperability, electronic health records, Federal IT requirements or similar issues?* **Yes**
- *Does your State have a grant to create a statewide health information exchange and does your agency participate in the development of the exchange and in issues concerning MH/SA data?* **Yes**
- *Is your State Medicaid agency engaging in or planning to improve its IT system?* **Yes**
- *If so, is your agency included in such efforts for the purposes of addressing issues related to data interoperability, behavioral health IT system reform, and meeting Federal IT data standards?* **Yes**

In addition to the questions above, please provide any information regarding your State's current efforts to assist providers with developing and using Electronic Health Records.

ODMH is in the process of developing Avatar to provide Electronic Health Care capabilities for the Regional Psychiatric Hospitals operated by ODMH.

IV: Narrative Plan

F. Quality Improvement Reporting

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Narrative Question:

SAMHSA expects States to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures that will describe the health of the mental health and addiction systems. These measures should be based on valid and reliable data. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, reflect their evidence of effectiveness. The State's CQI process should also track programmatic improvements; and garner and use stakeholder input, including individuals in recovery and their families. In addition, the CQI plan should include a description of the process for responding to critical incidents, complaints and grievances. In an attachment, please submit your State's current CQI plan.

Footnotes:

F. Quality Improvement Reporting – ODMH has quality improvement reporting, but does not have a quality improvement plan. ODMH will develop a Quality Improvement Plan for submission with its next Block Grant Application.

ODMH monitors and prepares reports on critical incidents, complaints, and grievances. The reduction of seclusion and restraint by providers, including hospitals and residential facilities, is a major focus of quality improvement. Each of the Regional Psychiatric Hospitals has a Quality Improvement Director, who develops plans to improve outcomes. Twin Valley in Columbus has implemented trauma-informed care to improve the quality of its services.

Quality Improvement at ODMH is in a state of transition. ODMH is in the process of hiring a new Director of Quality Improvement. Additionally, the Office of Research and Evaluation (ORE) is beginning to develop a new dashboard to replace the Flexible Performance Agreement used by the previous administration that was included in Ohio's last three Block Grant Plans. ORE staff is working with program staff to develop new performance indicators for this Plan. Additionally, ORE staff is also working with ODADAS to develop the OH-BH which will report client level data for the access, criminal justice, housing, and education/employment National Outcome Measures. ODMH will develop a new Quality Improvement Plan after the new dashboard is developed, and will submit it with its next Block Grant Plan.

IV: Narrative Plan

G. Consultation With Tribes

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Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it is to engage in regular and meaningful consultation and collaboration with tribal officials in the development of Federal policies that have Tribal implications.

Consultation is an enhanced form of communication, which emphasizes trust, respect and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process, which results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues. For the context of the Block Grants, SAMHSA views consultation as a government to government interaction and should be distinguished from input provided by individual Tribal members or services provided for Tribal members whether on or off Tribal lands. Therefore, the interaction should include elected officials of the Tribe or their designee. SAMHSA is requesting that States provide a description of how they consulted with Tribes in their State. This description should indicate how concerns of the Tribes were addressed in the State Block Grant plan(s). States shall not require any Tribe to waive its sovereign immunity in order to receive funds or in order for services to be provided for Tribal members on Tribal lands.

Footnotes:

G. Consultation with Tribes – Ohio has no federally recognized tribes.

IV: Narrative Plan

H. Service Management Strategies

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Narrative Question:

SAMHSA, similar to other public and private payers of behavioral health services, seeks to ensure that services purchased under the Block Grants are provided to individuals in the right scope, amount and duration. These payers have employed a variety of methods to assure appropriate utilization of services. These strategies include using data to identify trends in over and underutilization that would benefit from service management strategies. These strategies also include using empirically based clinical criteria and staff for admission, continuing stay and discharge decisions for certain services. While some Block Grant funded services and activities are not amenable (e.g. prevention activities or crisis services), many direct services are managed by other purchasers.

In the space below, please describe:

1. The processes that your State will employ over the next planning period to identify trends in over/underutilization of SABG or MHBG funded services
2. The strategies that your State will deploy to address these utilization issues
3. The intended results of your State's utilization management strategies
4. The resources needed to implement utilization management strategies
5. The proposed timeframes for implementing these strategies

Footnotes:

H. Service Management Strategies – ODMH does not have the data to analyze over/underutilization of Mental Health Block Grant. This is the first year that Ohio has employed cost control measures and required pre-authorization for Medicaid services that exceed a cap. ODMH has limited experience in implementing utilization review.

ODMH historically has awarded about half of its Mental Health Block Grant by formula grants to the 50 ADAMH/CMH Boards which plan, evaluate and funds mental health services in Ohio. Boards have not been required to report client level data on non-Medicaid services, including Block Grant. Boards sometimes report expenditures more than six months after the end of the fiscal year without major consequences. To address this, ODMH will need to set new expectations with Boards for fiscal reporting of Block Grant funds.

ODMH's first task will be for the Block Grant Planner to schedule an internal meeting with ODMH Office of Fiscal Services, and the Office of information Services to discuss what information is needed, and what is required for Boards to report this information.
While ODMH Fiscal Office believes that they can add the needed reports, and make the reporting dates earlier, it will take some work with the Boards to get the reports in time to compile them for the Implementation Report. Some Boards may not have adequate accounting systems to support this level of reporting, so it may take a year or two to achieve quality fiscal reporting of Block Grant formula funds.

For ODMH to be able to efficiently analyze service utilization would require that Boards report service data for Block Grant in a data base. Developing a data base for implementation with Boards is an expensive multiple year process that involves Fiscal, Information Technology and Program, and Research and Evaluation. Implementing a Block Grant data base is a lower priority than implementing the major changes in Medicaid which is required to stabilize Ohio's mental health system. ODMH does not have enough information to be specific about what strategies Ohio would use to address utilization of Block Grant for clinical services, or to describe the resources needed, and the proposed time frame. Ohio will need at least a couple years to come into compliance with this new requirement.

IV: Narrative Plan

I. State Dashboards (Table 10)

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Narrative Question:

An important change to the administration of the MHBG and SABG is the creation of State dashboards on key performance indicators. SAMHSA is considering developing an incentive program for States/Territories based on a set of state-specific and national dashboard indicators. National dashboard indicators will be based on outcome and performance measures that will be developed by SAMHSA in FY 2011. For FY 2012, States should identify a set of state-specific performance measures for this incentive program. These state-specific performance indicators proposed by a State for their dashboard must be from the planning section on page 26. These performance indicators were developed by the State to determine if the goals for each priority area. For instance, a state may propose to increase the number of youth that receive addiction treatment in 2013 by X%. The state could use this indicator for their dashboard.

In addition, SAMHSA will identify several national indicators to supplement the state specific measures for the incentive program. The State, in consultation with SAMHSA, will establish a baseline in the first year of the planning cycle and identify the thresholds for performance in the subsequent year. The State will also propose the instrument used to measure the change in performance for the subsequent year. The State dashboards will be used to determine if States receive an incentive based on performance. SAMHSA is considering a variety of incentive options for this dashboard program.

Plan Year:

Priority	Performance Indicator	Selected
Children with Serious Emotional Disturbances (SED) and their Families	Performance Indicator: Number of children and adolescents ages 0 – 17 who receive community mental health services in each state fiscal year.	é
Children with Serious Emotional Disturbances (SED) and their Families	Numerator in Table A: Number of children and adolescents ages 9 – 17 who receive community mental health services in each state fiscal year using Ohio's restrictive definition of SED which Ohio uses in setting priorities.	é
Children with Serious Emotional Disturbances (SED) and their Families	There will be a decrease in the number of children and adolescents ages 0 – 17 served by Ohio's community mental health providers who are in out-of-home placements at the time of service receipt.	é
Adults with Serious Mental Illness (SMI)	Number of people with Serious Mental Illness receiving Health Home Services	é
Adults with Serious Mental Illness (SMI)	The numerator is the number of adults ages 18 and over who receive community mental health services in each state fiscal year as taken directly from ODMH's MACSIS data base (not Data Mart). The numerator matches the year that the service was provided.	é
Bi-directional Integration of Behavioral Health with Primary Care - Joint with Ohio Department of Alcohol and Drug Addiction Services (ODADAS)	:Number of people with Serious Mental Illness receiving Health Home Services	é
Recovery Supports - Joint with ODADAS	Number of certified Peer Support Specialists	é
Recovery Supports - Joint with ODADAS	Number of persons receiving Recovery Supports, peer and family education and training through Ohio's statewide consumer and family mental health organizations.	é
Homeless Persons and Persons with SMI in Need of Permanent Supportive Housing	Number of new people with SPMI (Severe and Persistent Mental Illness) assisted through ODMH's Money Follows the Person (MFP) Home Choice Program designed to assist persons with SPMI who choose to move from nursing facilities to community housing.	é
Homeless Persons and Persons with SMI in Need of Permanent Supportive Housing	Number of existing units that will be repaired and/or renovated to preserve longevity. The Ohio Housing Finance Agency (OHFA) utilizes state housing trust fund dollars for both development and preservation. ODMH and OHFA are partnering to provide approxi	é

Homeless Persons and Persons with SMI in Need of Permanent Supportive Housing	Number of new units built.	
Persons Involved with Criminal Justice System	The number of benefit applications submitted to SSA/BDD offices for offenders diagnosed with SPMI being released from prison.	
Persons Involved with Criminal Justice System	: Percentage of offenders linked with mental health appointments and/or other supports (housing, employment agencies, reentry coalitions, consumer operated services, etc.)	
Persons Involved with Criminal Justice System	To be determined by the grant proposals. Examples include: 1) number of individuals receiving medication within 14 days 2) average wait time to receive an appointment 3) total number of services received/connected to 4) number of in-reach appointments.	
Persons of All Ages in Crisis including Veterans	Number of agencies signing MOU	
Underserved Racial and Ethnic Minorities and LGBT (Lesbian, Gay, Bisexual, Transgender) Populations	Number of persons receiving cultural competence training.	
Youth/Young Adults in Transition	Number of YYAT trained in youth/young adult leadership	
Early Childhood Mental Health (ages 0 - 6)	The percentage of children ages 0 - 6 that are at risk of removal from a child care setting due to behavioral issues that are maintained in an early childhood setting with ECMH Consultation services will increase by 2 per year.	
Community Prevention	Number of teens who are screened.	
Community Prevention	The measure will be the number of Ohio middle school students, school personnel and parents participating with Red Flags.	
Community Prevention	Number of regional trainings in resiliency leadership.	

Footnotes:

ODMH will develop a state dashboard in SFY 2012 and SFY 2013.

IV: Narrative Plan

J. Suicide Prevention

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Narrative Question:

In September of 2010, U.S. Health and Human Services Secretary Kathleen Sebelius and Defense Secretary Robert Gates launched the National Action Alliance for Suicide Prevention. Among the initial priority considerations for the newly formed Action Alliance is updating and advancing the National Strategy for Suicide Prevention, developing approaches to constructively engage and educate the public, and examining ways to target high-risk populations. SAMHSA is encouraged by the number of States that have developed and implemented plans and strategies that address suicide. However, many States have either not developed this plan or have not updated their plan to reflect populations that may be most at risk of suicide including America?s service men and women -- Active Duty, National Guard, Reserve, Veterans -- and their families. As an attachment to the Block Grant application(s), please provide the most recent copy of your State's suicide prevention plan. If your State does not have a suicide prevention plan or if it has not been updated in the past three years please describe when your State will create or update your plan.

Footnotes:

The Ohio Suicide Prevention Foundation will update ODMH's Suicide Prevention Plan during SFY 2012.

saving

lives

Ohio's Suicide Prevention Plan

one

person

Prepared by the Ohio Department of Mental Health
in collaboration with the Ohio Coalition for Suicide Prevention

at a

time

May 2002

"Still the effort seems unhurried. Every seventeen minutes in America someone commits suicide. Where is the public concern and outrage?"

Kay Redfield Jamison,
Author of *Night Falls Fast: Understanding Suicide*

For additional copies of this Plan, or for information about suicide prevention programs, please contact:

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30 E Broad Street, 8th Floor
Columbus OH 43215-3430
614-466-1984
www.mh.state.oh.us

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Columbus OH 43215
614-228-0402

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Dedication

Ohio's Suicide Prevention Plan is dedicated to Kirk "Crunch" Knick, son of Linda Whittle of Sidney, Ohio, an organizer of the Suicide Prevention Advocacy Network (SPAN), and to all other Ohioans touched by suicide.

Kirk "Crunch" Knick
November 29, 1979 - March 27, 1995

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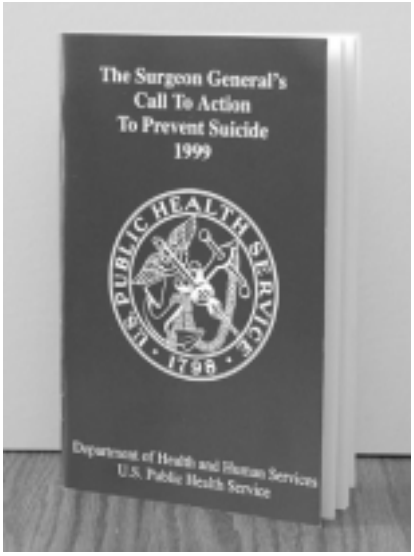
Introduction



More than 1,200 Ohioans die by their own hand every year. The impact of suicide does not stop with the lost lives. For every suicide death, it is estimated that six individuals will be profoundly affected for the rest of their lives. These deaths and their effects are even more tragic as suicide is largely preventable.

As the ninth leading cause of death in Ohio, suicide remains an ongoing challenge for healthcare policymakers, providers of care, schools, faith communities and law enforcement. Ohio statistics continue to mirror national trends where suicide rates are increasing among particular areas of the population. Adolescents, young adults, men 25 to 44 years of age and the elderly are among those at the highest risk in Ohio. Economic downturns and the inability to effectively problem solve and cope with challenges increase the risk for these priority groups, making the development of suicide prevention policies even more essential.

In October 1998, at the request of the U.S. Surgeon General and in collaboration with the Suicide Prevention Advocacy Network (SPAN), the Substance Abuse and Mental Health Services Administration (SAMHSA) convened a national suicide prevention conference. The Ohio Department of Mental Health (ODMH) appointed an eight-member team to attend the conference and assist in drafting the Surgeon General's *Call to Action to Prevent Suicide*, which was released in 1999.

ODMH Director Michael F. Hogan, Ph.D., was appointed to a national committee that assisted in the development of the National Goals and Objectives for Suicide Prevention 2000-2005. These National Goals serve as the framework for Ohio's state plan that utilizes Awareness, Intervention and Methodology, or AIM strategy to reduce the prevalence of suicide.

In January 2001, the Report of Ohio's Mental Health Commission, *Changing Lives, Ohio's Action Agenda for Mental Health*, included a recommendation that Ohio should build an initiative to reduce suicides. Ohio's Suicide Prevention Plan is the next step in saving lives and reducing suicidal behaviors by developing a comprehensive strategy in response to a very complex set of issues.

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To develop a statewide plan, the Ohio Department of Mental Health established a partnership with the Ohio Coalition for Suicide Prevention, a grassroots organization of medical, mental health, and public health professionals, faith-community members and advocates who are dedicated to preventing suicide by raising awareness and promoting well-being.

In addition to the Ohio Coalition for Suicide Prevention, a number of various constituencies assisted in developing a coordinated statewide strategy and commitment. The following organizations were represented: SPAN; American Foundation for Suicide Prevention - Northeast Ohio Chapter; People of Color Suicide Support Group; Ohio General Assembly; Ohio Departments of Aging, Alcohol and Drug Addiction Services, Education, Health, Job and Family Services; The Ohio State University; the Ohio Public Health Association; local public health agencies; local crisis centers and suicide prevention hotline services; local mental health boards; medical and mental health professionals in public health, adolescent medicine, psychiatry, psychology and geriatrics; the Catholic Diocese of Columbus; the United Presbyterian Church; the West Ohio Conference of the United Methodist Church; and the Ohio Federation of Community Planning.

On July 28, 2001, the Ohio Coalition for Suicide Prevention hosted a daylong strategic planning session with 40 participants representing a broad range of stakeholders. This group developed a list of preliminary recommendations and made plans to obtain further input in the formulation of a statewide plan.

The Department, along with the Ohio Coalition for Suicide Prevention, launched the plan of action for suicide prevention during a Statehouse press conference on October 10, 2001. Director Hogan released the Executive Summary that included the preliminary recommendations. A symposium, *A Call to Action: A Suicide Prevention Strategy for Ohio*, convened later that day for policy makers, providers, advocates, and survivors of suicide. Dr. David Litts, USAF, Special Advisor on Suicide Prevention to the U.S. Surgeon General, and Lucy Davidson, M.D., Clinical Associate Professor of Psychiatry at Emory University, addressed the participants on the opportunity for Ohioans to take action in preventing suicide.

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In the fall of 2001, the Ohio Coalition conducted a series of six regional forums across Ohio to identify and convene local leadership in the public health, mental health, academic, faith, and survivor communities. The following organizations sponsored the regional forums:

- The University of Toledo
- The Health Improvement Collaborative of Greater Cincinnati
- The Mahoning County District Board of Health (Held at the Ursuline Center in Canfield)
- Children's Hospital, Columbus
- The Ohio Federation for Community Planning (Held at the Visiting Nurses Association in Cleveland)
- The Southern Consortium for Children (Held in Athens)

More than 300 participants at these forums provided invaluable input in culling the best recommendations, developing goals, and recommending strategies to be used over the next three to five years. Their work has formed the framework for this state plan. These important partners will also be leaders in the implementation of the plan.

Recognizing that suicide is a public health problem that requires an evidence-based approach to prevention, the regional forum participants outlined the following characteristics of an effective statewide suicide prevention strategy. Ohio's strategy must be:

- Prevention-focused
- Culturally competent
- Focused on adolescents and young adults first, then on other priority groups (middle-aged white males and the elderly)
- Public health focused
- Appropriate for a community-based mental health system
- Built on data, research and best practices
- Able to address statewide needs

The plan's goals and objectives account for three levels of prevention strategies: universal, selective and indicated. Research supports the recognition that, as vulnerability and suicide potential increase, so does the need for stronger prevention interventions.

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Universal prevention is focused on providing needed interventions to keep communities healthy. These programs benefit everyone in a community universally by providing general awareness information and education.

Selective prevention is dedicated to prevent the onset of suicidal behavior in priority risk groups. These strategies may include screening and assessment, training of natural community "gatekeepers," and community-based mental health treatment.

Indicated prevention strategies identify priority groups known to be at high-risk for suicide. This may be done through skill building and services and treatment that reinforce protective factors.

To determine the best approach for creating a blueprint for Ohio's suicide prevention plan, the following assumptions were used to guide the process and planning:

- The final action planning and execution must occur at the local level.
- All tools and protocols will be appropriate for the local community and its diverse members.
- There will be uniform messages and language across all activities, across all locations, and across all priority groups.
- Gatekeepers are anyone who has contact with individuals in need of help.
- The list of key gatekeepers will vary by local area.
- All interventions will be delivered in appropriate ways given the community and its diversity.
- Development of the capacity to achieve plan goals will be community-based.

In addition to being tailored to the needs and resources available within Ohio, strategies to prevent suicide must be part of strong collaborative and creative partnerships at all levels. By working together to raise awareness, reduce stigma and encourage Ohio's citizens to seek help, we can save many lives that would otherwise be lost to suicide.

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Priority Groups

- More teens and young adults die from suicide than from cancer, heart disease, AIDS, birth defects, stroke, pneumonia, influenza, and chronic lung disease combined.

- Between 1952 and 1995, the incidence of suicide among adolescents and young adults nearly tripled.

Source: The Surgeon General's Call to Action to Prevent Suicide

The Young

The 1999 Ohio Youth Risk Behavior Survey shows that nearly 20 percent of all high school students in Ohio seriously contemplated suicide during the 12 months preceding the survey. Significantly more females (25 percent) than males (16 percent) seriously considered suicide.

Young women are more likely to attempt suicide than young males by about 6 to 1, but completed suicide is more common in adolescent males than in females by about 3 to 1. While some clinicians believe that psychiatric illness, such as clinical depression, underlies all suicide among the young, some think it is more complex than that, pointing to developmental factors that influence behavior. Certainly, all agree that substance and/or alcohol abuse significantly increases the risk of suicide in young people, as does anxiety or impulsivity, sexual identity issues – including being gay, lesbian or bisexual – and sexual abuse.

Middle-aged Men

At particular risk of suicide are Ohio men, 25 to 44 years of age. According to the Ohio Department of Health, white men between the ages of 25 to 34 have the highest rate of this group. From 1996 to 1998, men between the ages of 25 and 34 had a suicide death rate of 23.7 per 100,000 and men between the ages of 35 to 44 had a suicide death rate of 23.0 per 100,000.

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Men are generally more successful at completing suicide than women because they choose violent, more lethal means. However, the impulse to take one's own life is rooted in problems far more complex than the actual vehicle for death. Men who are 25 to 44 years of age are under enormous stress to perform, achieve, and provide. This oftentimes overwhelming stress coupled with a tendency to not seek help in times of need may actually describe why men of this age are at higher risk for suicide.

The Elderly

While the young are at particular risk for suicide, the group at greatest risk for suicide is the elderly. The suicide risk for Ohioans above the age of 80 is three to four times higher than for the average Ohioan.

Some of the factors that make the elderly more vulnerable to suicide are social isolation, significant losses (death of spouse, loss of home, family, and friends) illness, disability, chronic pain, depression, and oftentimes, hidden alcoholism. While many of these factors may be unique to the aging process, their presence and influence should not be fatal.

- Males are four times more likely to die from suicide than females.
- White males account for more than 75 percent of Ohio's suicides.
- In the month prior to their suicide, 75 percent of elderly suicide victims had visited a physician.

Sources: The Surgeon General's Call to Action to Prevent Suicide; Ohio Department of Health, Center for Public Health Data and Statistics

Goals and Objectives

Awareness

AIM

Appropriately broaden the public's awareness of suicide and its risk factors.

The Ohio Department of Mental Health, the Ohio Department of Health and the Ohio Coalition for Suicide Prevention believe that the number of Ohioans dying from suicide can be reduced through implementation of prevention strategies. The *Surgeon General's Call to Action to Prevent Suicide* introduced an initial blueprint for addressing suicide prevention. Goal areas for Ohio's prevention strategy are categorized as Awareness, Intervention and Methodology, or AIM, as were set forth in the Surgeon General's report.

Awareness Goal:

Increase awareness that suicide is a public health and mental health problem in order to reduce stigma and increase people's ability to seek help.

Awareness Objective 1:

Develop local, broad based support for suicide prevention.

Create or enhance a suicide prevention coalition in each Ohio county to develop a prevention plan based upon local needs and resources available. Coalition partners should include, but not be limited to, representatives of the Child Fatality Review Board, school districts, health department, crisis response teams, Area Agency on Aging, local news media, hospitals, human services providers, faith-based organizations, health care professional organizations, local service organizations (Kiwanis, Sertoma, Lions, Jaycees, Grange, etc.), mental health and addiction services boards, survivor groups, and human resources offices or employee assistance programs from local employers.

Awareness Objective 2:

Partner with Ohio's media to advance effective prevention efforts.

Educate the broadcast and print media (including but not limited to the entertainment industry) about the powerful role suicide-related coverage can play in future suicide prevention. Provide information about suicide, its warning signs, depression and other mental illnesses and substance abuse. Collaborate with media partners to ensure responsible media policies and practices are utilized in coverage related to suicide and suicide prevention.

Awareness Objective 3:

Increase awareness of policy makers.

In collaboration with public and private organizations, increase education and awareness of state and county policy makers about suicide and its warning signs. Educate officials on the impact that suicide, depression and other mental illnesses, and substance abuse have on other policy areas such as criminal justice, law enforcement and health care.

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Awareness Objective 4:

Develop and implement a public awareness campaign.

Create a statewide media campaign to increase public awareness of available resources. Partnerships should be engaged to produce public service announcements, news articles, billboards, public speaking opportunities and other ventures that will reduce the stigma surrounding suicide and increase Ohioans' willingness to seek help.

Awareness Objective 5:

Encourage effective use of evidence-based prevention and awareness programs in educational settings.

Direct students, faculty and staff of Ohio's colleges and universities to available resources to encourage help-seeking behavior. One fourth of all persons age 18 to 24 in the United States are full or part-time college students, suggesting that a large proportion of young adults could be reached through college-based suicide prevention efforts.

Educate staff in Ohio school districts on the warning signs for suicidal youth and encourage schools to develop a plan of action for helping at-risk students. Researchers have found that suicidal youth are not likely to self-refer or seek help from school staff, so teaching youth to identify the warning signs of suicide may not be effective. However, researchers have also found that enhancing problem-solving and coping skills reduces suicidal ideation among young people who are facing difficult problems or life situations, so targeting risk and protective factors that occur earlier in the pathways to suicide is a necessary component of school-based efforts.

Intervention Goal:

Reduce factors that increase the risk of suicide.

Intervention Objective 1:

Strengthen crisis response and build community capacity to serve persons at risk and in need of treatment.

Identify gaps in available resources and services that create a barrier to suicide prevention. Encourage collaborations of community stakeholders to create a "safety net" by enhancing existing service delivery systems.

Intervention

AIM

Enhance services and programs, both population-based and clinical care.

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Intervention

AIM

Enhance services and programs, both population-based and clinical care.

According to the National Strategy for Suicide Prevention, in the month prior to their suicide, 75 percent of elderly persons had visited a physician. With increased training in identifying risk factors in patients, fewer suicidal patients will go unrecognized.

Intervention Objective 2:

Through education and promotion, increase the number and quality of key gatekeepers in Ohio.

Gatekeepers are primarily individuals in the community who can effectively recognize life-threatening distress in individuals or families. Equipped with the appropriate knowledge and resources, these individuals can intervene when early signs of risk appear. Gatekeepers may include teachers and other school staff, school health personnel, clergy, police officers, correctional personnel, coaches, supervisors in the work environment, primary healthcare providers, hospice and nursing home providers and volunteers, mental health care and substance abuse treatment providers and emergency health care personnel, among many others.

Intervention Objective 3:

Increase the ability of healthcare professionals to intervene.

Identify or develop training curricula for physicians, psychologists, social workers, counselors, nurses and physician assistants to increase the ability of these individuals to effectively intervene. Identify health professional training programs that include assessment and management of suicide risk and identification and promotion of protective factors.

Intervention Objective 4:

Increase the ability of clergy to intervene.

Identify or develop resources to increase the proportion of clergy who have been trained to recognize signs of suicide risk and behaviors. Clergy often provide counseling and interventions for those in distress, and for some, may be the only individuals in a position to provide emotional support. Clergy and clinicians should work collaboratively to enhance treatment options for people in need of services.

Intervention Objective 5:

Promote and support the presence of protective factors.

Change policies and procedures and enhance risk-assessment tools in settings such as hospital emergency rooms, community mental health centralized access points and primary care offices where persons at risk of suicide often come for help.

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Methodology Goal:

Gather more data about suicide attempts and evaluate the effectiveness of programs designed to prevent suicide.

Methodology Objective 1:

Develop a state and county surveillance system.

Developing a comprehensive suicide surveillance system to collect and link information related to suicide attempts and gestures would significantly enhance each county's efforts to prevent suicide. Improved surveillance, data collection and dissemination are essential for the development of effective suicide prevention efforts.

Methodology Objective 2:

Increase scientific knowledge.

Advancing research, outcome evaluations and knowledge transfer can increase the awareness of evidence-based programs which would work for the priority groups in Ohio.

Methodology Objective 3:

Promote a research agenda.

Establish partnerships and assist in securing funding, especially with colleges and universities, to increase the amount of research being done in Ohio related to risk and protective factors and effective prevention programs and treatments.

AIM

Methodology

Advance the science of suicide prevention.

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Special thanks to the more than 300 Ohioans who provided input into this plan by attending the regional forums and conferences and completing the questionnaire related to suicide prevention needs in Ohio.

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Fact Sheet

Common Warning Signs

Giving away favorite possessions

A marked or noticeable change in an individual's behavior

Previous suicide attempts and statements revealing a desire to die

Depression (crying, insomnia, inability to think or function, excessive sleep or appetite loss)

Inappropriate "good-byes"

Verbal behavior that is ambiguous or indirect: "I'm going away on a real long trip. You won't have to worry about me anymore. I want to go to sleep and never wake up."

Purchase of a gun or pills

Alcohol or drug abuse

Sudden happiness after long depression

Obsession about death and talk about suicide

Decline in performance of work, school, or other activities

Deteriorating physical appearance, or reckless actions

High Risk Life Events Associated With Suicide

Death or terminal illness of a loved one

Divorce, separation, or broken relationship

Loss of health (real or imaginary)

Loss of job, home, money, self-esteem, personal security

Anniversaries

Difficulties with school, family, the law

Early stages of recovery from depression

What To Do

Take suicide threats seriously, be direct, open and honest in communications.

Listen, allow the individual to express their feelings and express your concerns in a non-judgmental way.

Say things like, "I'm here for you. Let's talk. I'm here to help."

Ask, "Are you having suicidal thoughts?" A detailed plan indicates greater risk.

Take action sooner rather than later.

Get the individual who is at risk connected with professional help.

Dispose of pills, drugs and guns.

Don't worry about being disloyal to the individual; contact a reliable family member or close friend of the person.

What Not To Do

Do not leave the person alone if you feel the risk to their safety is immediate.

Do not treat the threat lightly even if the person begins to joke about it.

Do not act shocked or condemn. There may not be another cry for help.

Do not point out to them how much better off they are than others. This increases feelings of guilt and worthlessness.

Do not swear yourself to secrecy.

Do not offer simple solutions.

Do not suggest drugs or alcohol as a solution.

Do not judge the person.

Do not argue with the person.

Do not try to counsel the person yourself, GET PROFESSIONAL HELP!

Where to get help: Contact your local Mental Health or ADAMH Board, or call a Crisis Hotline (look in the yellow pages under "Mental Health" or "Crisis Intervention") or call 1-800-SUICIDE.

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Ohio Department of Mental Health

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IV: Narrative Plan

K. Technical Assistance Needs

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Narrative Question:

Please describe the data and technical assistance needs identified by the State during the process of developing this plan that will be needed or helpful to implement the proposed plan. The technical assistance needs identified may include the needs of State, providers, other systems, persons receiving services, persons in recovery, or their families. The State should indicate what efforts have been or are being undertaken to address or find resources to address these needs, and what data or technical assistance needs will remain unaddressed without additional action steps or resources.

Footnotes:

K. **Technical Assistance Needs –** To assist states in implementing amendments to their State Medicaid Plans or 1915i waivers, SAMHSA could promote consistency with their federal partners and advocate with the fiscal staffs of CMS. Additionally, Ohio would welcome more opportunities to share program ideas with other states through conference calls or meetings on topics of common interest.

IV: Narrative Plan

L. Involvement of Individuals and Families

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Narrative Question:

The State must support and help strengthen existing consumer and family networks, recovery organizations and community peer advocacy organizations in expanding self advocacy, self-help programs, support networks, and recovery-oriented services. There are many activities that State SMHAs and SSAs can undertake to engage these individuals and families. In the space below, States should describe their efforts to actively engage individuals and families in developing, implementing and monitoring the State mental health and substance abuse treatment system. In completing this response, State should consider the following questions:

- •How are individuals in recovery and family members utilized in the development and implementation of recovery oriented services (including therapeutic mentors, recovery coachers and or peer specialists)?
- •Does the State conduct ongoing training and technical assistance for child, adult and family mentors; ensure that curricula are culturally competent and sensitive to the needs of individuals in recovery and their families; and help develop the skills necessary to match goals with services and to advocate for individual and family needs?
- •Does the State sponsor meetings that specifically identify individual and family members? issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
- •How are individuals and family members presented with opportunities to proactively engage and participate in treatment planning, shared decision making, and the behavioral health service delivery system?
- • How does the State support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Footnotes:

L. Involvement of Individuals and Their Families

Block Grant Funding of Statewide Consumer and Family Advocacy Groups – ODMH has funded statewide consumer and family advocacy organizations to provide resources for their local counterparts with Mental Health Block Grant since the 1980's. These organizations conduct the training and technical assistance for their members and local-affiliate organizations, as well as annual meetings. The result is that ODMH funds consumers and family organizations to provide the activities that SAMHSA is asking states to provide in this question.

Block Grant currently funds the Ohio Empowerment Coalition (primarily adult consumers), Ohio Federation for Children's Mental Health (families of children with SED), NAMI-Ohio (families of adults and children, as well as some adult consumers), and Multi-ethnic Advocates for Cultural Competence (MACC), as well as statewide projects operated by Mental Health of America in Franklin and Summit Counties. Please see Priority Populations #4 (Recovery Supports) and #7 (Underserved Populations) of this Application for information about the peer education and peer support provided.

Promotion of Recovery Oriented Policies - Consumer and Family Partnership Team (recruits and reimburses consumers and families for participation in state mental health policy development) - During the years of the Transformation State Incentive Grant (TSIG), Ohio added consumers and/or family members to all of its major policy groups and work groups. ODMH expanded its Consumer and Family Partnership Team (CFPT) so that consumers and family members who were not employed by an organization funded by ODMH received stipends and travel expenditures to participate. Participation grew rapidly with reimbursement with many consumers participating effectively in one or two workgroups. However, a few consumers attended many groups for the purpose of gaining income, and ODMH has a few initiatives, in which a large number of consumers attended without much orientation or planning. As a result, ODMH staff learned how to more effectively work with consumer representatives and developed policies to provide orientation and mentoring.

When TSIG funding ended during a time of budget cuts, ODMH limited CFPT reimbursement to two work group members per meeting with the exception of Planning Council (required by this grant) and the Resiliency Workgroup (youth with SED and their parents). When this change was announced at the Ohio Empowerment Coalition Conference in August 2011, consumers expressed anger and disappointment. OEC is responding by organizing a meeting to maximize representation by ensuring that each Ohio work group has two effective CFPT representatives, and that the opportunity for reimbursement is disbursed among the maximum number of consumers and family members. In doing this, consumers are demonstrating leadership in organizing their own representation.

Toll Free Bridge Line – ODMH has a consumer-staffed 1-800 line to provide responses to consumers and family members who ask for information or call with a concern. The consumer

staff is supervised by the state Clients Rights Officer who responds to officially filed grievances and complaints. This line was created as a result of Planning Council's efforts a number of years ago.

IV: Narrative Plan

M. Use of Technology

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Narrative Question:

Interactive Communication Technologies (ICTs) are being more frequently used to deliver various health care services. ICTs are also being used by individuals to report health information and outcomes. ICT include but are not limited to: text messaging, etherapy, remote monitoring of location, outreach, recovery tools, emotional support, prompts, case manager support and guidance, telemedicine. In the space below, please describe:

a. What strategies has the State deployed to support recovery in ways that leverage Interactive Communication Technology?
b. What specific applications of ICTs does the State plan to promote over the next two years?
c. What incentives is the State planning to put in place to encourage their use?
d. What support systems does the State plan to provide to encourage their use?
e. Are there barriers to implementing these strategies? Are there barriers to wide-scale adoption of these technologies and how does the State plan to address them?
f. How does the State plan to work with organizations such as FQHCs, hospitals, community-based organizations and other local service providers to identify ways ICTs can support the integration of mental health services and addiction treatment with primary care and emergency medicine?
g. Will the State use ICTs for collecting data for program evaluation at both the client and provider levels?
h. What measures and data collection will the State promote for promoting and judging use and effectiveness of such ICTs?

Footnotes:

M. Use of Technology - While Ohio's mental health system has implemented telemedicine to provide psychiatric consultation in rural areas, implementation of interactive communication technology has been slow. Implementation of video conferencing for clinical services in remote locations is delayed due to a law suit.

However, video conferencing is routinely used by ODMH's Regional Psychiatric Hospitals and Central Office for staff meetings and continuing education. ODMH and ODADAS also use webinars to communicate with Boards regarding the Community Plan, and to listen to national webinars. ODMH staffs are using web-provided continuing education programs.

In working with youth and young adults with SED, lack of resources to monitor content on a web page has delayed use of Interactive Communication Technology (ICT) to facilitate communication among youth and young adults in Youth MOVE. ODMH Children's staff is considering what can be done to address this barrier. Additionally, ODMH asked the Ohio Suicide Prevention Foundation to use ICT in its Garrett Lee Smith grant targeting youth and young adults to use ICT in reaching out to youth and young adults.

ODMH Central Office policies prohibit use of Facebook and texting using ODMH computers with the intent of preventing misuse of state time and equipment for personal use. Unfortunately, this also prevents ODMH program staff from using ICT effectively to communicate with consumers, families, Boards, behavioral health providers, primary care providers, FQHCs and other stakeholders. While individual ODMH staff is able to get some of these barriers removed, ODMH management needs to revisit these policies to determine if they pose an unneeded barrier to reaching out to younger consumers and communicating with other state and federal agencies.

IV: Narrative Plan

N. Support of State Partners

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Narrative Question:

The success of a State's MHBG and SABG will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, education and other State and local governmental entities. States should identify these partners in the space below and describe the roles they will play in assisting the State to implement the priorities identified in the plan. In addition, the State should provide a letter of support indicating agreement with the description of their role and collaboration with the SSA and/or SMHA, including the State education authority(ies); the State Medicaid agency; the State entity(ies) responsible for health insurance and health information exchanges (if applicable); the State adult and juvenile correctional authority(ies); the State public health authority, (including the maternal and child health agency); and the State child welfare agency. SAMHSA will provide technical assistance and support for SMHAs and SSAs in their efforts to obtain this collaboration. These letters should provide specific activities that the partner will undertake to assist the SMHA or SSA with implanting its plan. This could include, but is not limited to:

- The State Medicaid Agency agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to the expanded Medicaid population.
- The State Department of Justice that will work with the State and local judicial system to develop policies and programs that address the needs of individuals with mental and substance use disorders that come into contact with the criminal and juvenile justice systems; promote strategies for appropriate diversion and alternatives to incarceration; provide screening and treatment; and implement transition services for those individuals reentering the community.
- The State Education Agency examining current regulations, policies, programs, and key data-points in local school districts to ensure that children are safe; supported in their social-emotional development; exposed to initiatives that target risk and protective actors for mental and substance use disorders; and, for those youth with or at-risk of emotional behavioral and substance use disorders, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements.
- The State Child Welfare/Human Services Department, in response to State Child and Family Services Reviews, working with local child welfare agencies to address the trauma, and mental and substance use disorders in these families that often put their children at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system.

Footnotes:

N. Support of State Partners – ODMH elected not to request letters of support since it was recommended, but not required for this Application. ODMH has a long history of collaborating with other state agencies on projects. Major projects continuing through SFY 2012 – 2013 which address SAMHSA's questions are:

- **Development of health care homes** by the Ohio Office of Health Transformation (OHT) in collaboration with the state Medicaid agency (ODJFS), as well as other state agencies overseeing portions of Ohio's Medicaid policy including Health, Aging, and Developmental Disabilities as well as behavioral health (ODMH and ODADAS).
- **Collaboration with primary Care –** Four Ohio mental health providers are implementing SAMHSA grants to integrate behavioral health care with primary health care. One of these, Southeast Mental Health Center in Columbus, recently became an FQHC. The other three providers are in Cleveland, Cincinnati and Shawnee Hills, a rural provider. Additionally, ODMH partnered with NAMI-Ohio to pilot a training of CPST and behavioral health counseling staff in using treatment protocols to address bowel and metabolic functioning of consumers in their treatment. ODMH is also partnering with the Ohio Office of Health Transformation as well as other state agencies in the development of Health Care Homes in primary care and behavioral health settings.
- **Collaboration with Ohio Department of Rehabilitation and Corrections** in providing transition services for offenders with SPMI who are leaving prison which is described in Priority #6 of this application. Additional collaboration with the Ohio Supreme Court has promoted the expansion of mental health and drug courts, as well as the development of county I-Teams (interdisciplinary teams) to address the needs of persons coming before courts with guardianship questions due to severe mental illness.
- **Behavioral Health/ Juvenile Justice (BHJJ)** -In partnership with the Ohio Department of Youth Services (ODYS) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS), ODMH funded six urban counties to assess youth for appropriateness of services in their community versus admission to a detention facility. Each community project is a partnership that includes the community mental health board, the juvenile court, community providers, the school system, and various ancillary services and supports. The projects provide evidence based services targeting the youth and their families. The goals of the projects include reducing ODYS admissions, reducing recidivism, building stronger family units, and identifying and promoting community integration.
- **Partnering with ODJFS-State Child Welfare Office** on a pending grant application to address the trauma of children served by the child welfare system. As a result ODMH submitted a grant application with ODJFS- Child Welfare as a partner, to implement trauma informed care evidence-based practices for children in the child welfare system. If funded, both departments would staff this grant. Additionally, our two departments collaborated on a System of Care expansion grant for youth and young adults in transition which will be staffed by both agencies, if funded.

IV: Narrative Plan

O. State Behavioral Health Advisory Council

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Narrative Question:

Each State is required to establish and maintain a State advisory council for services for individuals with a mental disorder. SAMHSA strongly encourages States to expand and use the same council to advise and consult regarding issues and services for persons with or at risk of substance abuse and substance use disorders as well. In addition to the duties specified under the MHBG, a primary duty of this newly formed behavioral health advisory council would be to advise, consult with and make recommendations to SMHAs and SSAs regarding their activities. The council must participate in the development of the Mental Health Block Grant State plan and is encouraged to participate in monitoring, reviewing and evaluating the adequacy of services for individuals with substance abuse disorders as well as individuals with mental disorders within the State.

Please complete the following forms regarding the membership of your State's advisory council. The first form is a list of the Advisory Council for your State. The second form is a description of each member of the behavioral health advisory council.

Footnotes:

O. State Mental Health Advisory Council – ODMH maintains a Planning Council to advise the Department on the Mental Health Services Block Grant (MHSBG). ODADAS maintains a separate advisory council to inform the development of the SAPT Block Grant. The staffs of the MHSBG and the SAPT collaborate on a common Community Plan for the Boards to complete, and used the relationship developed to collaborate on joint sections for this Application. Preparation of the two joint sections went smoothly.

ODMH and ODADAS would like to maintain their separate advisory organizations. However, ODMH's Planning Council is considering inviting ODADAS to send a representative to Planning Council to increase the communication between the advisory groups.

ODMH's Planning Council participated in the development of the SFY 2012 – 2013 Mental Health Block Grant Plan, and will be participating in the SFY 2011 Implementation Report. Planning Council evaluated about 25 individual projects funded by the grant, and distributed their recommendations in a report to staff. Additionally, the Council made recommendations to the director on their priorities for funding. They also serve as an advisory group to the Data Infrastructure Grant which provides data for Block Grant.

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Table 11 List of Advisory Council Members

Pages 51 and 52 of the Application Guidance

Start Year: 2012

End Year: 2013

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Elaine Early-Hall	State Employees		Ohio Dept. of Job & Family Services - Social Services Block Grant, 50 West Town St., 6th floor Columbus, OH 43215 PH: 614-995-5727	elaine.early-hall@jfs.ohio.gov
Vicki Grosh	State Employees		Ohio Dept. of Education , 25 S. Front Street Columbus, OH 43235 PH: 614-438-1200	Vicki.grosh@ode.state.oh.us
Sue Williams	State Employees		Ohio Dept. of Job & Family Services - Medicaid, 50 West Town St., 6th floor Columbus , OH 43215 PH: 614-752-1119	susan.williams@jfs.ohio.gov
Sharon Hanger	State Employees		Ohio Dept. of Rehabilitation and Corrections , 770 N. Broad Street Columbus, OH 43215 PH: 614-728-1188	sharon.hanger@odrc.state.oh.us
Susan Pugh	State Employees		Rehabilitation Services Commission - employment, 400 E. Campus View Blvd. WA2 Columbus, OH 43235 PH: 614-438-1200	susan.pugh@rsc.state.oh.us

William Graves	State Employees	Department of Development - housing, 77 S. High Street Columbus, OH 43216 PH: 614-466-3144	wgraves@odod.state.oh.us
Marcus Molea	State Employees	Ohio Dept. of Aging, 50 West Broad Street Columbus, OH 43215 PH: 614-752-9167	mmolea@age.state.oh.us
Esther Branscome	Individuals in Recovery (from Mental Illness and Addictions)	1663 East Main Street Lancaster, OH 43130	mrsbranscome@gmail.com
Steve Copper	Individuals in Recovery (from Mental Illness and Addictions)	935 Kieser Road Waverly , OH 45690	stillmeadowfarms@yahoo.com
Lynda Cassidy	Individuals in Recovery (from Mental Illness and Addictions)	PO Box 67194 Cuyahoga Falls, OH	hopalong67194@yahoo.com
Pat Risser	Individuals in Recovery (from Mental Illness and Addictions)	154 Ronald Ave. Ashland, OH 44805	parisser@att.net
Cassandra Rufat	Individuals in Recovery (from Mental Illness and Addictions)	189 M.E. Street Nelsonville, OH 45764	rufat@att.net
Secquora Showers	Individuals in Recovery (from Mental Illness and Addictions)	PH: 330-569-4376	slittlebird22@aol.com
Jeannie Copper	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	935 Kiesser Road Waverly , OH 43590	stillmeadowfarms@yahoo.com
Yvetta Collins	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	2751 Arbor Avenue #5 Cincinnati , OH 45219	Yvetta.Collins@gmail.com
Marjorie Cook	Family Members of Individuals in Recovery (from Mental Illness and	1254 Winhurst Drive Akron, OH 44313	maccook@netzero.net

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	Addictions)		
Paul Dorn	Others (Not State employees or providers)	311 Heron Point #301 Columbus, OH 43231 PH: 614-843-1332	Paul.Dorn@natinowidechildrens.org
Gloria Walker	Family Members of Individuals in Recovery (from Mental Illness and Addictions)	1556 Blair Ave. #2 Cincinnati , OH 45207	gwconsultingandeducation@earthlink.net
Victoria Webb	Individuals in Recovery (from Mental Illness and Addictions)	8034 Hill Ave. - represents Ohio Empowerment Coalition Mentor, OH	webvj3@hotmail.com
Wayne Lindstrom	Providers	Crossroads, 8445 Munson Road Columbus, OH 44060	wlindstrom@crossroads-lake.org
Jennifer Moses	Providers	Zeph , 6605 West Central Avenue Toledo, OH 43617	jmoses@zepfcom.com
M. Vanessa Eubanks	Individuals in Recovery (from Mental Illness and Addictions)	PAIMI, 3062 Southfield Drive Columbus, OH 43207	ohwellnessnetwork@gmail.com
Renuka Punjabi	Others (Not State employees or providers)	Ohio Assoc. of County Behavioral Health Authorities (Board Assoc.), 33 N. High St., Suite 500 Columbus, OH 43215	rpunjabi@oacbha.org

Footnotes:

State Organizational memberships include:
Social Service - Elaine Early Hall
Education - Vicki Groce
Medicaid - Sue Willams
Criminal Justice - Sharon Hangar
Employment - Susan Pugh
Housing - William Graves
Aging - Marc Molea

Other organizational memberships include:

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NAMI - Ohio - Gloria Walker
Ohio Empowerment Coalition (consumers) - Victoria Webb
PAIMI - M. Vanessa Eubanks
Multi-ethnic Advocates for Cultural Competence - Paul Dorn
Ohio Association for County Behavioral Health Authorities - Renuka Punjabi
Ohio Assocation of Behavioral Health and Family Service Providers - Wayne Lindstrom and Jennifer Moses

IV: Narrative Plan

Table 12 Behavioral Health Advisory Council Composition by Type of Member

Pages 52 and 52 of the Application Guidance

Start Year: 2012

End Year: 2013

Type of Membership	Number	Percentage
Total Membership	26	
Individuals in Recovery (from Mental Illness and Addictions)	8	
Family Members of Individuals in Recovery (from Mental Illness and Addictions)	4	
Vacancies (Individuals and Family Members)	2	
Others (Not State employees or providers)	2	
Total Individuals in Recovery, Family Members & Others	16	61.54%
State Employees	7	
Providers	2	
Leading State Experts	0	
Federally Recognized Tribe Representatives	0	
Vacancies	1	
Total State Employees & Providers	10	38.46%

Footnotes:

IV: Narrative Plan

P. Comment On The State Plan

Page 50 of the Application Guidance

Narrative Question:

SAMHSA statute requires that, as a condition of the funding agreement for the grant, States will provide opportunity for the public to comment on the State plan. States should make the plan public in such a manner as to facilitate comment from any person (including Federal or other public agencies) during the development of the plan (including any revisions) and after the submission of the plan to the Secretary. In the section below, States should describe their efforts and procedures to obtain public comment on the plan in this section.

Footnotes:

P. Public Comment on the State Plan - ODMH will post the 2012 – 2013 Block Grant Plan to its web page and will invite statewide consumer and family organizations to add a link to their websites. These organizations include NAMI-Ohio, the Ohio Federation for Children's Mental Health, Ohio Empowerment Coalition and Multi-ethnic Advocates for Cultural Competence (MACC). ODMH will also invite the statewide board and provider associations to add a link on their websites. These organizations include the Ohio Association of County Behavioral Health Authorities (OACBHA), Ohio Council of Behavioral Health and Family Service Providers, and the Ohio Association of Child Caring Agencies (OACCA). ODMH will ask these organizations to encourage their members to submit comments on Ohio's Mental Health Services Block Grant application by email, U.S. mail or telephone. Consumers and family member organizations will receive a toll free telephone number for comments. Any revisions made based on these comments will be included with the 2011 Implementation Report due December 1, 2011.

2012 - 2013 Performance Targets for Ohio's Metnal Health Block Grant

9/1/2011

Priority Population #1 - Children with SED

Performance Target - Access to Services for Children (NOM)
Children with SED and at-risk for SED Receiving Public Mental Health Services

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	114,273	121,432	114,001	114,002	114,003		
Numerator							
Denominator							

Performance Target -Table A - Treated Prevalence of Children ages 9 - 17 with SED
Using Ohio's restrictive definition of SED
Numerator - Children with SED ages 9 – 17 who receive mental health services in Ohio setting
Denominator - Children with SED estimated by NASMHPD-NRI's prevalence estimate

Note: The prevalence estimate changes markedly from SFY 2009 to SFY 2010 due to Ohio's poverty level being changed from mid-level to high-level despite an increasing number served.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	35.99%	39.76%	38.14%	38.14%	38.14%		
Numerator	50,273	55,547	58,001	58,001	58,001		
Denominator	139,689	152,058	152,058	152,058	152,058		
Excluded: Ages 0 - 8	14,833	15,830	17,494	9,773			

Priority Population #2 - Adults with Serious Mental Illness - SMI

Performance Target -Table B - Treated Prevalence of All Children ages 9 - 17

Includes all children served, which is more comparable to SAMHSA's SED definition than Ohio's more restrictive definition of SED.

Numerator - Children ages 9 – 17 who receive mental health services in Ohio setting.

Denominator - Children with SED estimated by NASMHPD-NRI's prevalence estimate.

Note: The prevalence estimate changes markedly from SFY 2009 to SFY 2010 due to Ohio's poverty level being changed from mid-level to high-level despite an increasing number served.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	60.23%	58.79%	60.11%	60.11%	60.11%		
Numerator	84,138	89,398	91,406	91,406	91,406		
Denominator	139,689	152,058	152,058	152,058	152,058		
Excluded: Ages 0 - 18	29,145	31,220	32,235	32,235	32,235		

Performance Target - Percentage of Children and Adolsecents in Out-of-Home Placements

Includes all children served by Ohio's mental health system

Note: The number served is about 1% less than in the previous tables due to this data being produced earlier. in the year when claims were not complete. ODMH's goal is to reduce these numbers.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	9.78%	8.80%	7.91%	7.09%	6.35%		
Numerator	11,066	10,609	10,152	9,695	9,238		
Denominator	113,186	120,555	128,355	136,660	145,501		

Performance Target - Access to Services for Adults (NOM)
Adults with SMI and at-risk for SMI Receiving Public Mental Health Services
Includes all adults served by public mental health system

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	224,351	233,552	208,535	208,536	208,537		
Numerator							
Denominator							

Performance Target -Table A - Treated Prevalence of Adults with SMD
Using Ohio's restrictive definition of SMD (Severely Mentally Disabled - more restrictive definition than SAMHSA's "SMI" definition)
Numerator - Adults with SMD who receive mental health services in Ohio setting
Denominator - Adults with SMI by NASMHPD-NRI's prevalence estimate

Note: NASMHPD-NRI did not adjust the poverty level for adults as they did for children.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	20.95%	21.29%	21.29%	21.29%	21.29%		
Numerator	98,962	101,398	101,398	101,398	101,398		
Denominator	472,306	476,210	476,210	476,210	476,210		

Performance Target -Table B - Treated Prevalence of All Adults

Includes all adults served, which is more comparable to SAMHSA's SMI definition than Ohio's more restrictive definition of SMD.

Numerator -Adults who receive mental health services in Ohio setting.

Denominator - Adults with SMI estimated by NASMHPD-NRI's prevalence estimate.

Note: NASMHPD-NRI did not adjust the poverty level for adults as they did for children.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage SFY 2012
Performance Indicator	47.50%	49.04%	49.04%	49.04%	49.04%		
Numerator	224,351	233,552	233,552	233,552	233,552		
Denominator	472,306	476,210	476,210	476,210	476,210		

Priority Population # 3 Bi-directional Integration of Behavioral Health - Joint with ODAD

Performance Target - Number of Adults with SMI who Receive Health Care Homes

Ohio will collect baseline data on this new program which is part of state and federal health care reform.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	0	0	0				
Numerator							
Denominator							

Priority Population #4 - Recovery Supports - Joint with ODADAS

Performance Target - Number of Certified Peer Support Specialists in Ohio

Ohio will collect baseline data on this new program.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator							
Numerator							
Denominator							

Performance Target - Number of Persons Receiving Training from Statewide Consumer-and-Family Organizations Funded by Block Grant

Includes Ohio Empowerment Coalition, NAMI-Ohio and Ohio Federation for Children's Mental Health

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator				1,000			
Numerator							
Denominator							

Priority Population #5 Homeless Persons and Persons with SMI in Need of Housing

Performance Target - Number of New Housing Units Built for Adults with SMI							
	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	68	100	103	26	49		
Numerator							
Denominator							

Performance Target - Number of Existing Housing Units to be Repaired or Renovated for Adults with SMI							
	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	NA	NA	NA	20	25		
Numerator							
Denominator							

Priority Population #6 - Persons Involved with the Criminal Justice System

Performance Target - Number of New People with SPMI (Severe and Persistent Mental Illness) Assisted by Money Follows the Person program

Note: This program supports persons with SPMI living in nursing facilities to move to the community.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	0	0	26	33	36		
Numerator							
Denominator							

Performance Target - Percentage of Offenders with SMI Leaving Prison Eligible for Community Linkage Social Work Service who are Successfully Linked with Community Services

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	64.00%	82.00%	90.00%	91.00%	92.00%		
Numerator							
Denominator							

Performance Target - Number of Offenders with SMI Leaving Prison who Submit Benefit Application (e.g. Supplemental Security Income (SSI), Social Security Disability (SSDI), Medicaid)

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	NA	NA	200	225	250		
Numerator							
Denominator							

Performance Target - Measure Outcome of 16 Mini-Grants for the Purpose of Increasing Capacity in the Community to Serve Adults with SMI Involved with the Criminal Justice System - outcome measurement to be determined

Examples include (1) number of individuals receiving medication within 14 days, (2) average wait time to receive an appointment, (3) total number of services received/connected (4) number of in-reach appointments.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator							
Numerator							
Denominator							

Priority Population #7 - Persons of All Ages in Crisis including Veterans

Performance Target - Number of State Agencies Signing Memorandum of Understanding to Address Veteran and Service Behavioral Health Needs

NA = Not Applicable

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	NA	NA	NA	4	4		
Numerator							
Denominator							

Priority Population #8 - Underserved Racial and Ethnic Minorities and LGBT

Performance Target - Number of Persons Receiving Cultural Competence Training through Multi-ethnic Advocates for Cultural Competence

Ohio will collect baseline data on this program.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator				400			
Numerator							
Denominator							

Priority Population # 9 Youth/Young Adults in Transition

Performance Target - Number of Youth/Young Adults in Transition (Y/YAT) Trained in Leadership of Y/YAT Activities which Support Mental Health

Ohio will collect baseline data on this program.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator							
Numerator							
Denominator							

Priority Population #10 Early Childhood Mental Health (ages 0 - 6)

Performance Target - Number of Young Children (ages 0 -6) Who are At-risk of Removal from School or Childcare who Receive Mental Health Consultation

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator	3,252	2,302	2,300	2,300	2,300		
Numerator							
Denominator							

Priority Population #11 - Community Prevention

Performance Target - Number of Participants in Red Flags - Middle School Depression Education Program							
Performance Indicator	**SFY 2009 Actual**	**SFY 2010 Actual**	**SFY 2011 Projected**	**SFY 2012 Target**	**SFY 2013 Target**	**Implementation Report Actual SFY 2012**	**Implementation Report Percentage Attained SFY 2012**
Middle School Students	NA	4,553	4,334	4,434	4,334		
Parents	NA	1,684	2,025	2,025	2,025		
School Personnel	NA	301	334	334	334		

Performance Target - Number of Persons Trained in Resiliency This is an educational program to promote resiliency for children with SED and their families. http://www-dev.rags.kent.edu/CIP_web/resiliency.html							
	SFY 2009 Actual	**SFY 2010 Actual**	**SFY 2011 Projected**	**SFY 2012 Target**	**SFY 2013 Target**	**Implementation Report Actual SFY 2012**	**Implementation Report Percentage Attained SFY 2012**
Performance Indicator							
Numerator							
Denominator							

Performance Target - Number of Youth Receiving Suicide Prevention Screening

Number of youth receiving TeenScreen or Signs of Suicide Screening in 25 at-risk counties

Baseline data will be collected.

	SFY 2009 Actual	SFY 2010 Actual	SFY 2011 Projected	SFY 2012 Target	SFY 2013 Target	Implementation Report Actual SFY 2012	Implementation Report Percentage Attained SFY 2012
Performance Indicator							
Numerator							
Denominator							