

I: State Information

State Information

Plan Year

Start Year:

2014

End Year:

2015

State SAPT DUNS Number

Number

808847669

Expiration Date

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

Agency Name

Ohio Mental Health and Addiction Services

Organizational Unit

Office of Quality, Planning and Research

Mailing Address

30 East Broad Street, 8th floor

City

Columbus

Zip Code

43215

II. Contact Person for the SAPT Grantee of the Block Grant

First Name

Sanford

Last Name

Starr

Agency Name

Ohio Mental Health and Addiction Services

Mailing Address

30 East Broad Street, 8th floor

City

Columbus

Zip Code

43215

Telephone

614-644-8316

Fax

614-644-5331

Email Address

Sanford.Starr@mha.ohio.gov

State CMHS DUNS Number

Number

808847669

Expiration Date

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

Agency Name

Ohio Mental Health and Addiction Services

Organizational Unit

Office of Quality, Planning and Research

Mailing Address

30 East Broad Street, 8th floor

City

Columbus

Zip Code

43215

II. Contact Person for the CMHS Grantee of the Block Grant

First Name

Liz

Last Name

Gitter

Agency Name

Ohio Department of Mental Health and Addiction Services

Mailing Address

30 East Broad Street, 8th floor

City

Columbus

Zip Code

43215

Telephone

614-466-9963

Fax

614-644-5331

Email Address

Liz.Gitter@mha.ohio.gov

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

From

To

IV. Date Submitted

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

Submission Date

9/3/2013 4:46:23 PM

Revision Date

V. Contact Person Responsible for Application Submission

First Name

Sanford

Last Name

Starr

Telephone

614-644-8316

Fax

Email Address

Sanford.Starr@mha.ohio.gov

Footnotes:

Alternate Contacts Responsible for Submission:
For SAPT: Karin.Carlson@mha.ohio.gov 614-752-8330
For MHBG: Liz.Gitter@mha.ohio.gov 614-466-9963

Please see Attachment Section of WebBGAS for signed assurances, certifications and funding agreements.

I: State Information

Assurance - 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 Coastal 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

Title

Organization

Signature: _____ Date: _____

Footnotes:



JOHN R. KASICH
GOVERNOR
STATE OF OHIO

August 28, 2013

Virginia Simmons
Division of Grants Management
Office of Financial Resources, SAMHSA
1 Choke Cherry Road
Room 7-1109
Rockville, MD 29857

Dear Ms. Simmons:

With this letter, I delegate to the Director of the Ohio Department of Mental Health and Addiction Services the authority to apply for the Community Mental Health Services, Projects for Assistance in Transition from Homelessness, and Substance Abuse Prevention and Treatment grants. I also grant the authority to make the certifications, assurances, agreements and any proper waiver requests required. The authority will remain in effect for the duration of my administration as the Governor of Ohio.

Sincerely,

John R. Kasich
Governor

I: State Information

Assurance - Non-Construction Programs

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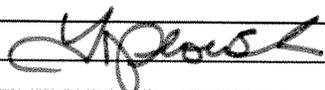
Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

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.
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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 Coastal 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).
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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
Title
Organization

Signature:  Date: 8/28/13

Footnotes:

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), (c), (d), (e), and (f).

For purposes of paragraph (f) 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

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.

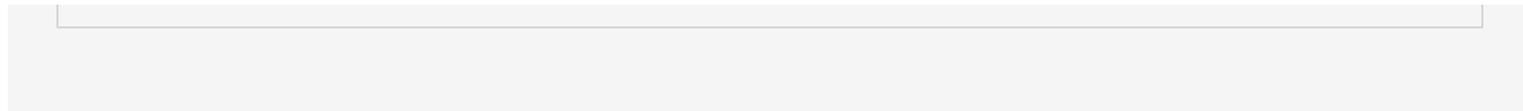
The applicant organization agrees that it will require that the language of this certification be included in any subawards which contain provisions for children's services and that all subrecipients shall certify accordingly.

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	<input type="text" value="Tracy J. Plouck"/>
Title	<input type="text" value="Director"/>
Organization	<input type="text" value="Ohio Department of Mental Health and Addiction Services"/>

Signature: _____ Date: _____

Footnotes:



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

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- 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), (c), (d), (e), and (f).

For purposes of paragraph (f) 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

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 and Addiction Services

Signature: 

Date: 8-29-13

Footnotes:

I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Title 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act

Section	Title	Chapter
Section 1921	Formula Grants to States	42 USC § 300x-21
Section 1922	Certain Allocations	42 USC § 300x-22
Section 1923	Intravenous Substance Abuse	42 USC § 300x-23
Section 1924	Requirements Regarding Tuberculosis and Human Immunodeficiency Virus	42 USC § 300x-24
Section 1925	Group Homes for Recovering Substance Abusers	42 USC § 300x-25
Section 1926	State Law Regarding the Sale of Tobacco Products to Individuals Under Age 18	42 USC § 300x-26
Section 1927	Treatment Services for Pregnant Women	42 USC § 300x-27
Section 1928	Additional Agreements	42 USC § 300x-28
Section 1929	Submission to Secretary of Statewide Assessment of Needs	42 USC § 300x-29
Section 1930	Maintenance of Effort Regarding State Expenditures	42 USC § 300x-30
Section 1931	Restrictions on Expenditure of Grant	42 USC § 300x-31
Section 1932	Application for Grant; Approval of State Plan	42 USC § 300x-32

Title XIX, Part B, Subpart III of the Public Health Service Act

Section 1941	Opportunity for Public Comment on State Plans	42 USC § 300x-51
Section 1942	Requirement of Reports and Audits by States	42 USC § 300x-52
Section 1943	Additional Requirements	42 USC § 300x-53

Section 1946	Prohibition Regarding Receipt of Funds	42 USC § 300x-56
Section 1947	Nondiscrimination	42 USC § 300x-57
Section 1953	Continuation of Certain Programs	42 USC § 300x-63
Section 1955	Services Provided by Nongovernmental Organizations	42 USC § 300x-65
Section 1956	Services for Individuals with Co-Occurring Disorders	42 USC § 300x-66

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

Name of Chief Executive Officer (CEO) or Designee
 Title

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

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Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [SA]

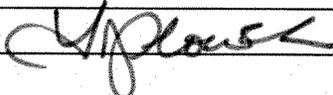
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Name of Chief Executive Officer (CEO) or Designee:
 Title:

Signature of CEO or Designee¹:  Date: 8/29/13

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I: State Information

Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

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Title XIX, Part B, Subpart I of the Public Health Service Act

Section	Title	Chapter
Section 1911	Formula Grants to States	42 USC § 300x
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	42 USC § 300x-1
Section 1913	Certain Agreements	42 USC § 300x-2
Section 1914	State Mental Health Planning Council	42 USC § 300x-3
Section 1915	Additional Provisions	42 USC § 300x-4
Section 1916	Restrictions on Use of Payments	42 USC § 300x-5
Section 1917	Application for Grant	42 USC § 300x-6

Title XIX, Part B, Subpart III of the Public Health Service Act

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Name of Chief Executive Officer (CEO) or Designee

Tracy J. Plouck

Title

Director, Ohio Dept. of Mental Health & Addiction Services

Signature of CEO or Designee¹: _____ Date: _____

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

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Chief Executive Officer's Funding Agreements (Form 3) - Fiscal Year 2014 [MH]

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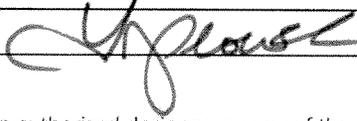
Name of Chief Executive Officer (CEO) or Designee

Tracy J. Plouck

Title

Director, Ohio Dept. of Mental Health & Addiction Services

Signature of CEO or Designee¹:



Date:

8/29/13

¹ If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

I: State Information

Disclosure of Lobbying Activities

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

[Standard Form LLL \(click here\)](#)

Name

Title

Organization

Signature: _____ Date: _____

Footnotes:

Not applicable. The State of Ohio does not lobby.

II: Planning Steps

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

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 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, tribal, 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.

Footnotes:

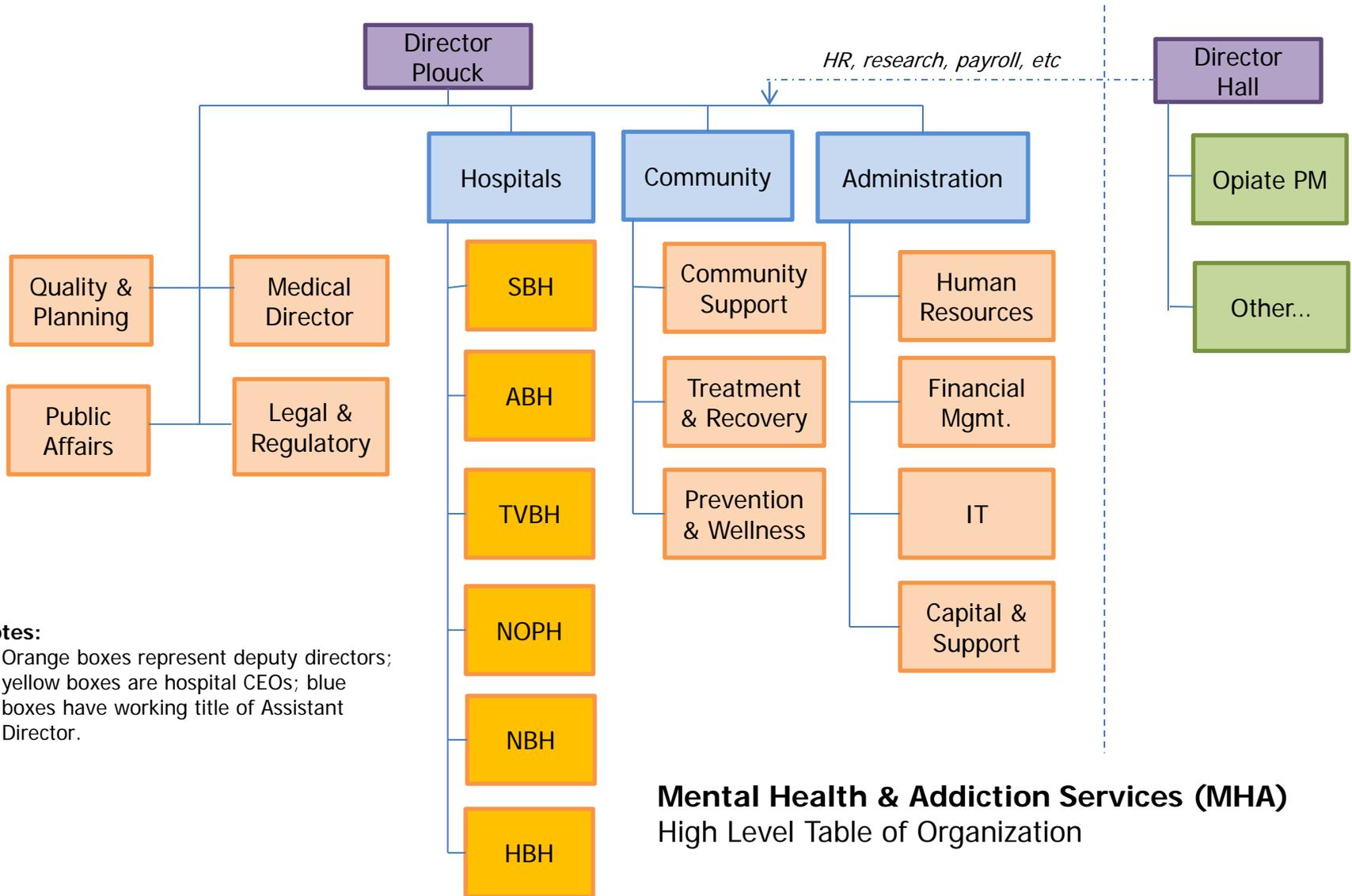
Step 1: Assess the strengths and needs of the service system.

Overview of Ohio's Mental Health and Addiction Services System

State Substance Abuse & Mental Health Agencies Consolidate - Effective July 1, 2013 the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services consolidated into a single cabinet level department – the Ohio Department of Mental Health and Addiction Services (OhioMHAS). The new Ohio Department of Mental Health and Addiction Services (OhioMHAS) aligns state-level service delivery with the local system, in which 47 of the 50 county board systems operate both mental health and addiction services while 3 counties continue to have separate Boards for addiction services and mental health services. OhioMHAS will oversee a statewide service network that includes 379 alcohol, drug and gambling addiction prevention and treatment providers and 400 community mental health agencies. Additionally, OhioMHAS will continue to operate the six regional psychiatric hospitals. The blended department has a staff of approximately 2,400 (including 300 central office staff) and a budget of approximately \$698 in fiscal year 2014 and \$687 million in fiscal year 2015.

Mission - The mission of the Ohio Department of Mental Health and Addiction Services (OhioMHAS) is “to provide statewide leadership in supporting a high quality mental health and addiction prevention, treatment and recovery system that is effective, accessible and valued by all Ohioans.”

Consolidation Process - The two departments began by consolidating fiscal, legislation, communications, information technology, legal and Medicaid policy operations. The consolidation of back office functions reduced the number of staff through attrition in central office which will result in a modest reduction in state administrative expenditures in central office. Community program offices were consolidated to include Treatment & Recovery, Prevention & Wellness, and Community Support under a single Assistant Director. Each community program area includes staff with expertise in addiction, as well as mental health services. Additionally, the Medical Director's responsibilities were expanded to include additional services and require specialization in addiction, as well as psychiatry. The planning and research functions of both departments were also consolidated into a single Office of Quality, Planning and Research, and will manage epidemiological, research and evaluation, outcomes, performance improvement and local planning activities in addition to coordinating SAPT and MH block grant applications. Please see the new table of organization on next page.



Notes:

- Orange boxes represent deputy directors; yellow boxes are hospital CEOs; blue boxes have working title of Assistant Director.

Mental Health & Addiction Services (MHA)
High Level Table of Organization

Impact of Consolidation - More than 1000 local providers of prevention, treatment, hospital and/or residential services licensed and/or certified by the state will be impacted by changes in licensing and certification anticipated as a result of consolidation. Planned changes to licensing and certification processes are expected to reduce provider, board and state administrative costs for these services and to increase the efficiency and effectiveness of treatment for persons with co-occurring mental illness and addiction. As a result, some funding previously used for administration may be re-purposed to provide clinical and non-medical recovery supports (e.g. housing). Providing housing for persons who are homeless due to mental illness and/or addiction may further reduce high cost, inefficient use of hospital emergency departments.

Ohio is a home rule state, and as such, OhioMHAS provides state oversight for a county-administered behavioral health care prevention and treatment system. The goal is to have a single system of care with no wrong doors, shared resources and combined expertise. Expertise in prevention of alcohol and other drug addiction will be expanded to include mental health prevention and wellness, across the lifespan with an emphasis on children. Expertise in community linkage of persons with serious mental illness involved with the criminal justice system will better address the community linkage needs of persons with co-occurring mental illness and substance abuse.

The new state agency combines the resources of the two departments to integrate care and reduce state bureaucracy. In partnership with local providers and recovery boards, the new agency will touch the lives of more than 3.5 million Ohioans. This plan is written as the program areas are in the process of consolidating. The information below is from a consolidated agency budget presentation to the legislature:

Ohio Mental Health and Addiction Services & Number Served	
Service/Support	Number of Clients (FY 2012)¹
Substance use prevention activities	2.2 million
Community substance use treatment	98,900 persons
Community mental health treatment	233,700 adults and 124,000 children/youth
Six state psychiatric hospitals	7,700 admissions
Workforce development	1,100 providers trained
Therapeutic Community - Pickway Correctional Institution	250 residents
Pharmacy services	65 health departments, free clinics or recovery centers; 36 correctional facilities; 9 developmental centers; other inpatient and outpatient facilities and several state agencies

¹ Director Tracy J. Plouck; Testimony before the House Health and Human Services Subcommittee of Finance on the Ohio Department of Mental Health and Addiction Services

Other State Health and Human Service Agencies - Ohio's Governor, John Kasich, created an executive Office of Health Transformation (OHT) which is overseeing health care reform in Ohio. The state Medicaid agency changed its place in Ohio's state government structure from a unit within the Ohio Department of Job and Family Services (ODFJS), known as the Office of Medical Assistance (OMA) to a full separate cabinet level agency, the Ohio Department of Medicaid, effective July 1, 2013.

OHT develops and implements state health care policies with other state agencies that have a major role in health care. These agencies include the Ohio Departments of Job and Family Services (ODJFS - state child welfare agency and employment services), Health, Developmental Disabilities, Aging and Insurance (health insurance exchanges). Additional state agencies which provide services and supports to persons with mental illness and/or addiction include the Rehabilitation Services Commission (employment) and the Ohio Departments of Education, Rehabilitation and Corrections (adult justice), Youth Services (juvenile justice), Public Safety (SYNAR) and Development (housing).

Ohio's Community System – State and Local Partnership

Local Boards Administer Ohio's System of Care – Publicly funded behavioral healthcare in Ohio is a state-supervised, county-administered system of care. OhioMHAS has formed a productive partnership with the Alcohol, Drug Addiction and Mental Health Services/Alcohol and Drug Addiction Services, and Community Mental Health Boards (ADAMHS/ADAS/CMH) Boards in administering Ohio's alcohol and other drug system of care. OhioMHAS allocates funds to each of the 47 ADAMHS, 3 ADAS and 3 CMH Boards which, in turn contract with and offer support to the alcohol and other drug and mental illness prevention and treatment programs in their counties. ADAMHS/ADAS/CMH Boards are responsible by state statute for planning, evaluating and contracting for substance abuse services for their counties. In addition to federal and state funds allocated to the Boards by OhioMHAS, many Boards have local levies that also support behavioral healthcare.

State Licensure and Certification of Providers – While the Boards fund the services, OhioMHAS licenses or certifies individual provider organizations with deeming used for organizations with national accreditation (e.g. JCHAO, CARF, and COA). OhioMHAS is in the early stages of developing a single accreditation process which will require CMS approval of a State Medicaid Plan Amendment. Below is a table summarizing the number and types of providers licensed or certified by the Ohio Department of Mental Health and Addiction Services at the time of consolidation.

Ohio Mental Health and Addiction Services (OhioMHAS) Licenses or Certifies			
	Addiction Services	Mental Health Services	Addiction & Mental Health Services
Prevention providers	155	unknown	
Driver intervention programs	96		
Therapeutic community	1		
Community treatment providers	166	273	133
Consumer operated services		35	
Private psychiatric hospital units		81	
State psychiatric hospitals		6	
Adult care facilities- family		550	
Adult care facilities - group		262	
Adult foster homes		93	

Integration of Primary Care and Behavioral Health – Governor Kasich's Jobs Budget (HB 153) authorized Ohio Medicaid to design a person-centered system of care, called a health home, to improve care coordination for high-risk beneficiaries. Ohio Medicaid teamed up with ODMH and ODADAS to focus first on creating health homes for Medicaid beneficiaries with SPMI (Serious and Persistent Mental Illness of children and adults as Ohio defines). Care managers will be embedded in Patient-Centered Medical Homes (PCMH) to provide intensive care coordination and develop an individualized care plan for each consumer to address both medical and non-medical needs. Ohio Medicaid received federal approval and in October 2012 began claiming enhanced federal match to pay for care coordination in SPMI-focused health homes.² The October 2012 implementation included five counties. The remaining 83 counties will begin implementation in October 2013 with additional new providers expected in 2014. Extensive information is available on the department's website.

Children's System of Care – Ohio's state budget has included a line item since 1993 for Ohio Family and Children First which facilitates a state and county 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 coordinate government services for families seeking services for their children. Service Coordination is not affiliated with any single system, but the results of service coordination 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

² <http://www.healthtransformation.ohio.gov/CurrentInitiatives/CreateHealthHomes.aspx>

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 from 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.

Recovery Oriented System of Care

Recovery Oriented System of Care (aka Community Support) – Many adults and adolescents also require recovery support services in addition to clinical and medical services in order to recover. These services are not eligible for insurance (e.g. Medicaid) reimbursement, and are funded through a variety of sources including federal Block Grant, state General Revenue Funds and local mental health and addiction tax levies, as well as churches and other private sources including self-pay. Recovery support services include housing, spiritual support, employment skills training, daily living skills, relapse prevention, anger management, transportation, GED support, substance abuse and/or mental health education, recovery coaching/peer support, parenting, peer mentoring, self-help and support groups.

Statewide Consumer and Family Organizations

Statewide Consumer and Family Organizations provide essential recovery supports in a Recovery Oriented System of Care (ROSC), as well as develop leaders who participate in state policy development workgroups. These groups also support advocacy for individuals as well as for the group. Statewide mental health consumer and family advocacy organizations which provide these services include Ohio Empowerment Coalition (OEC), NAMI- Ohio, Ohio Federation for Children’s Mental Health, Ohio Suicide Prevention Foundation and Multi-ethnic Advocates for Cultural Competence. (In 2013 Ohio Federation for Children’s Mental Health developed a management agreement with NAMI-Ohio which is their agent with OhioMHAS. Statewide advocacy organizations for addiction services include SOLACE and Ohio Citizen Advocates for Chemical Dependency Prevention and Treatment. Many of these advocacy groups participate in implementing prevention activities, have local chapters, and are described in more detail in the prevention section.

Consumer and family advocacy organizations provide a range of non-clinical Recovery Supports that are a major component of Ohio's mental health and addiction system. These groups organize communities to promote environmental changes that reduce addiction and mental illness, as well as provide non-clinical recovery supports. These organizations provide services developed by their members to fill gaps in the traditional mental health and addiction system. They provide informational and referral services, support groups, educational classes and statewide conferences. 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, and prevention strategies such as the National Strategy for Suicide Prevention.

Planned Expansion of Peer Support Workforce

Peer Support/Peer Recovery Coaching – During SFY 2013 Ohio's statewide mental health consumer organization, Ohio Empowerment Coalition (OEC), and Ohio Citizen Advocates (OCA) for Chemical Dependency Prevention and Treatment collaborated with state substance abuse and mental health agencies in a BRSS TACS (Bringing Recovery Supports to Scale – Technical Assistance Center Strategies) to expand recovery support services provided by peers. Ohio's BRSS TACS project developed the *Ohio Peer Supporter Training Manual*, a five-day core-competency of "skill training" for persons in recovery from mental illness and/or addiction to alcohol and other drugs. Additionally, webinars will provide 16 hours of "knowledge-based" training on addiction, and 16 hours of "knowledge-based" training on mental illness. During SFY 2014 OEC & OCA will collaborate to field test the training and refine the training manual. A certification process for peer supporters was established, and will be used in a proposed State Medicaid Plan Amendment to add peer support to the list of services eligible for Medicaid reimbursement in Ohio. Additionally, it will increase the training available for peer staff who is eligible to provide some of the educational and support services included in Ohio Medicaid Health Home Services for Individuals with Serious and Persistent Mental Illness which is being phased in during SFY 2013 – 2014.

Additional Workforce Development

Workforce development will be improved through building on the strengths of two agency's workforce development resources. During planning for consolidating, the two departments formed teams addressing major issues. One of the teams was the "Workforce Development Consolidation Team." This team addressed documenting the current state of workforce initiatives, identified critical issues and challenges and presented recommendations to address the issues with the goal of establishing a well-trained workforce with access to competency and skill building opportunities. A Workforce Strategic Plan was developed that addresses retention and recruitment, rural counties, competency building of OhioMHAS staff, leadership training, cross-training of state and provider staff, increasing mental health and addiction practitioners, outreach to colleges and universities, and use of existing web-based training capacities.

Additionally, OhioMHAS' Medical Director has identified a shortage of psychiatrists and other licensed professionals as a major issue, and is collaborating with the Department of Health, the Governor's Office and the Office of Health Transformation to address shortages of mental health and addiction professionals. As a specialist in addiction psychiatry who has previously served as an administrator in The Ohio State University's Medical School, Dr. Hurst is well qualified to promote collaboration with Ohio's graduate and professional schools which promote integration of behavioral health and primary care.

Ohio is using a federal loan repayment program for psychiatrists and other professionals in underserved areas. Additionally, Ohio is enhancing the expertise of primary care providers in behavioral health through conferences, trainings and a Pediatric Psychiatric Network in which psychiatrists at major children's hospitals provide consultation to primary practitioners. Also, the new Department will continue to build on relationships with graduate and professional schools in place for many years to promote education of new behavioral health professionals as well as continuing education for those currently employed. Examples of these relationships include:

- Providing small grant awards to residency training programs and graduate schools
- Funding Coordinating Centers of Excellence affiliated with major universities that provide technical assistance and training to implement specific evidence-based practices including Integrated Dual Diagnosis Treatment for persons with serious co-occurring substance abuse and mental illness
- Joint sponsorship of conferences and trainings with major universities and medical schools including Ohio State University, Case Western Reserve University, and Northeast Ohio Medical University.

OhioMHAS' major workforce training for SFY 2014 will be to prepare providers for Ohio Medicaid Health Homes for Persons with Serious and Persistent Mental Illness, as well as to expand training required for certification for Certified Peer Specialists and Peer Recovery Coaches. Trainers have included staff from the National Council of Community Behavioral Healthcare Providers as well as staff from the Ohio Empowerment Coalition, NAMI-Ohio, and the Substance Abuse/Mental Illness Coordinating Center of Excellence.

Additionally, the Ohio Association of County Behavioral Health Authorities hosted a conference, *Turning the Tide Together – 2013 Opiate Conference* in collaboration with ODADAS that was attended by more than 800 persons. An additional conference “*2013 Mental Health and Addictions Conference – Coming Together for a Healthy Ohio*” is scheduled in December 2013.

Key Factors Shaping Prevention and Treatment Service Delivery in Ohio

Economic Environment – During the SFY 2012 – 2013 biennium, Ohio’s state budget recovered from the recession which had resulted in significant budget reductions to the state’s allocations for prevention and treatment of mental illness, gambling and substance abuse. However, Ohio has five counties³ which continue to have unemployment rates of at least 12.0% of which two are in a Board area experiencing high rates of opiate addiction. However, OhioMHAS’ budget is still less than the combined budgets of the two previous agencies at one time. Economic and budgetary conditions had resulted in continual reduction over the past ten years in both state and federal funding for ODADAS. ODMH experienced funding reductions from SFY 2007 – SFY 2011. Beginning in SFY 2009, ODADAS and ODMH undertook the spending reductions and cost containment strategies of hiring freezes, laying off of staff, reduction in services, and travel restrictions. Funding for mental health and addiction, staffing levels and travel has stabilized at a lower level than in SFY 2008.

Sequestration - The Federal Fiscal Year (FFY) 2013 sequestration resulted in reduction of federal funds by 5.1% which disproportionately impacts alcohol and other drug (AoD) service funding which has significantly more federal grant funding. OhioMHAS has passed these state budget cuts on to the county ADAMH/ADAS/CMH Boards, providers and other organizations who receive these funds directly from OhioMHAS.

³ <http://ohiolmi.com/laus/ColorRateMap.pdf>

Prevention Services Overview

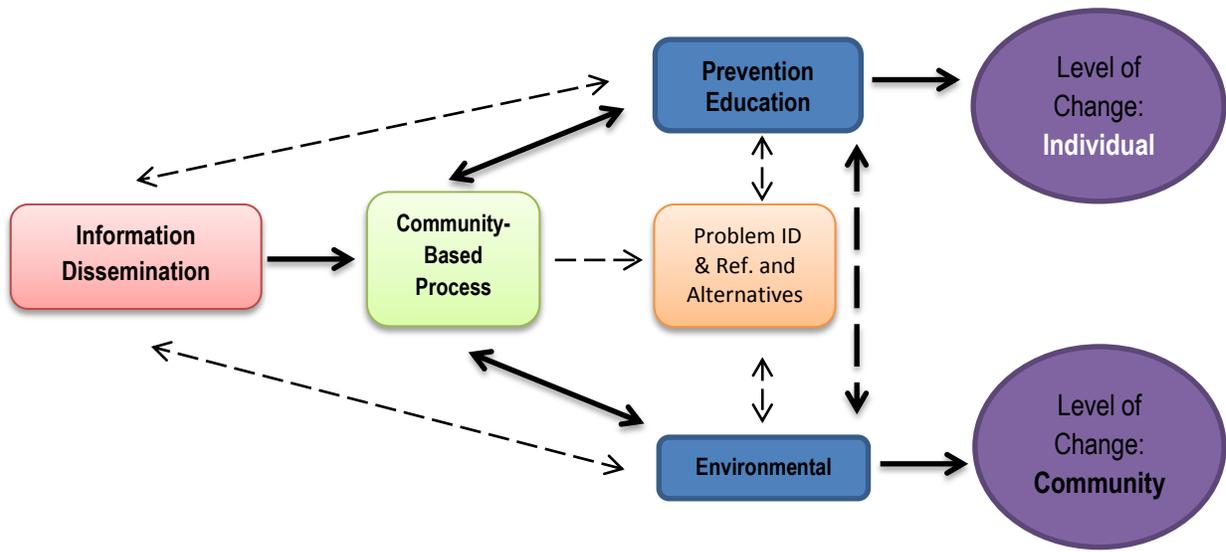
Ohio prevention focuses on reducing the likelihood of or delaying the onset of behavioral health problems (i.e. substance abuse, mental illness, suicide and problem gambling). Prevention services are a planned sequence of culturally appropriate, science-driven strategies intended to facilitate attitude and behavior change for individuals and communities.

Funding of the prevention service delivery system is primarily through allocations to Boards although a small amount of funds are spent to support state-wide initiatives. The updated Prevention Continuum of Care Taxonomy provides the guidelines for the delivery of this service array. Strategies implemented are based on the assessment of needs, resources and readiness conducted as part of the community planning process to ensure funded prevention interventions will address community risk and protective factors that either complicate or mitigate substance use and other risk behaviors. These community prevention efforts benefit all Ohioans through a number of programs at the local and state levels.

Ohio has updated its Prevention Continuum of Care Taxonomy based on a re-conceptualized the model for how CSAP's six prevention strategies are to be implemented for the greatest impact in Ohio communities. The goal of prevention services in Ohio is to facilitate change in individuals and/or communities. The following graphic provides a visual representation of how the six CSAP Strategies contribute to individual and community-level change. This new model provides a foundation for how substance abuse prevention funded through CSAP intersects with other prevention efforts funded through other federal and state funding streams. The focus on intended level of change and a further definition of strategies allows for the strategies of multiple systems to be integrated into one conceptual model. This will be the focus of one of the projects in the SPE Interagency Strategic Plan.

Prevention education and *environmental* strategies are seen as the main prevention strategies and have the strength to influence attitude, behavior and status on their own. The other four strategies support the implementation of these two main strategies. All six strategies in appropriate proportions are needed as part of a comprehensive prevention approach. *Information dissemination* creates awareness and builds knowledge which provides a foundation for *community-based process* to engage and mobilize communities into action.

Although *prevention education* interventions can be implemented without the foundational of *information dissemination* and *community-based process*, these interventions tend to lack the benefits resulting from broad-based community support and opportunities for expansion and quality improvement. *Community-based process* activities are essential to effectively implementing an *environmental* strategy. The *problem identification and referral* strategy is implemented as an adjunct when an individual enrolled in a direct service is identified as possibly needing or being able to benefit from services that exceed the scope of prevention. *Alternative activities* are implemented as a celebration of individual or community success and must be an activity that will, through evidence, also contribute to addressing risk/protective factors and/or intervening variables identified in initial program development.



Requested Bureau of Prevention Functions - During planning for department consolidation, stakeholder and subject matter experts were engagement from various aspects of the field. The new Office of Prevention & Wellness will focus on providing the following four requested functions as consolidation progresses. These requested functions have shaped the priorities set forth in this plan.

1. Facilitate on-going and shared learning regarding promotion/prevention science and associated technologies
2. Strategically coordinate messaging/branding to ensure consistent evidence-based practice
3. Engage stakeholders (Sustain processes for stakeholders to provide input and feedback & Sustain processes for valuing consumers and families)
4. Provide leadership in evidence-based policy, programming and practice

Through various planning processes in SFY 2013, Ohio developed a logic model to organize and target the approach to prevention and to identify outcomes that will contribute to the national outcome measures (NOMs). The following table provides a summary of the priorities and programmatic resources that Ohio is planning for SYF 2015.

Adopt a public health approach (SPF) into all levels of the prevention infrastructure	Strategic Prevention Framework
	Ohio Center for Coalition Excellence & Statewide Prevention Coalition Association
	Statewide Youth Survey
	Workforce Development
	Infusion of prevention in other systems (i.e. law enforcement, justice, faith, child welfare, education, suicide, etc.)
	Compliance with Synar Legislation
Ensure prevention services are available across the lifespan with a focus on families with children/adolescents	Families
	Youth Initiatives (Good Behavior Game/PBS, School-Based Prevention Education, Ohio Youth-Led Network)
	Marijuana & Underage Drinking Initiatives (Higher Ed Network, College Initiative, Parents Who Host, Trace Back)
	Family Engagement
	UMADAOP Prevention
	Military Initiative
Empower pregnant women and women of child-bearing age to engage in healthy choices	Women & Babies
	FASD
	Neonatal Abstinence Syndrome
	Women's Prevention
Promote wellness in Ohio's workforce	Workplace
	Partnership with Bureau of Worker's Compensation Behavioral Health Wellness

Priority 1: Adopt a public health approach into all levels of the prevention infrastructure

Integrated Planning Infrastructure - The Interagency Prevention Consortium and various stakeholders input workgroups will serve as a structure for linking statewide policy and program development. The SPE Consortium will focus on interagency alignment of prevention-related policies and practices. The Prevention and Wellness Roundtable was created in 2012 to assist in addressing concerns of the prevention field related to the future of prevention in light of healthcare reform. This group is a solution-oriented, policy think-tank that discusses and analyzes how state and federal prevention-related matters impact the prevention field. It consists of 16 of the most highly educated, trained and experienced prevention specialists in Ohio. The Behavioral Health Leadership group consists of numerous stakeholder representatives and meets quarterly to provide feedback on various departmental behavioral health issues.

This structure provides a mechanism for multi-directional information flow (bottom-up, top-down and outside-in) for all key stakeholder groups. It also provides a forum for the improvement of prevention policy, data and practice by providing a single entry point for input and feedback from all key areas of the field. Other workgroups will also inform policy and practice. For example, the Ohio Youth-Led Prevention Network Adult and Youth Advisory Councils, SEOW, Synar Advisory Committee, SPF Advisory Committee, Evidence-Based Practice Workgroup, Workforce Development Workgroup, Data Workgroup, Prevention Rules Workgroup, Coalition Excellence Workgroup and other ad hoc workgroups. More than 100 individuals serve on these various workgroups.

Alignment of Ohio's Substance Abuse Prevention Service System with Other Systems

SPE Consortium Overview - The Ohio Department of Alcohol and Drug Addiction Services (OhioMHAS) sought out federal grant funding to strengthen and enhance the state's prevention infrastructure to support more strategic, comprehensive systems of community-oriented care. Ohio received a \$600,000 Strategic Prevention Enhancement (SPE) grant September, 2011 from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to strengthen and extend the national implementation of the Strategic Prevention Framework (SPF). The SPF process is an integral part of SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities.

The State of Ohio has built a solid foundation, upon which to establish the ideal prevention infrastructure. The SPE Interagency Prevention Consortium was formed in December 2011, to provide oversight to the grant and to participate in the development of Ohio's comprehensive five-year Strategic Plan. Ohio has worked across divisions and departments to ensure a representation from state agencies, foundations, universities, prevention providers and other community members that are involved in the prevention of substance use and associated problems.

The Ohio SPE Consortium is comprised of the following entities: the Ohio Departments of Alcohol and Drug Addiction Services, Health, Mental Health, Education and Youth Services, the Ohio National Guard, the University of Cincinnati, the Ohio Suicide Prevention Foundation, the Urban Minority Alcohol and Drug Abuse Outreach Program (UMADAOP) Federation, juvenile court and the Ohio Children's Trust Fund for child abuse prevention.

OhioMHAS contracted with the Invitation Institute, the Ohio University and the Pacific Institute of Research and Evaluation (PIRE) to support various components of the work of the Consortium. Having the variety of disciplines at the table enhanced the creation of the comprehensive plan aimed at closing service system gaps, building capacity and enhancing and aligning policy and process across systems. Names of current SPE Policy Consortium members are provided below.

- Mindy Vance, Ohio Department of Mental Health
- Jill Jackson, Ohio Department of Education
- Judi Moseley, Ohio Department of Health
- Laura Rooney, Ohio Department of Health
- Cheryl Holton, Ohio Suicide Prevention Foundation
- Keith King, Ph.D. University of Cincinnati
- CPT. Matt Toomey, Ohio National Guard
- Craig Comedy, Franklin County UMADAOP
- Kristi Oden, Ohio Department of Youth Services
- David Edelblute, President, Ohio Urban Juvenile Court Administrators Association
- Kristen Rost, Executive Director, Ohio Children's Trust Fund

Strategic Planning - Under the facilitation of the Invitation Health Institute (formerly the Minnesota Institute of Public Health), the group explored system collaboration needs and was able to formulate the foundation for the plan, including a vision and mission, strategic priorities and action steps. The work of the group also included examining how these efforts could be implemented and sustained across systems. Strengthening interagency and intersystem working partnerships has allowed the Consortium members to explore the opportunity to: a) embed substance abuse prevention within their infrastructure at both the state and community levels, b) share resources and cross train staff; and c) explore cost saving opportunities as Ohio prepares for the behavioral health role in the evolving health care delivery system. Through these efforts there will be increased substance abuse prevention system capacity and support for effective prevention services.

Invitation Health Institute and Steven Dent, Principal of Partnering Intelligence, facilitated and recorded the process of engaging key stakeholders in the strategic planning process. The Ohio SPE Consortium strategic planning process included four, face-to-face meetings, teleconferences and email communications between meetings. A structured open-ended participatory evaluation process was used throughout the process asking participants to identify aspects of the process that they liked (pluses) and aspects of the meeting that they might like to change in future meetings (deltas).

This cross-system consortium of key stakeholders worked to develop this five-year strategic plan to foster more responsive, interactive State and local systems to better address and adjust to the complexities of evolving health care initiatives. The vision of the Consortium is: All Ohioans are able to live in a state of physical, social, and emotional wellness. The mission: The SPE consortium promotes and advances prevention capacity and alignment of state and local agencies to afford Ohioans increased wellness and productivity.

The plan prioritizes putting systemic processes in place that will serve as the foundation of interagency work on behavioral health under a public health framework. The four Interagency Plan Goals are consistent with adoption of the Strategic Prevention Framework (SPF) or the public health approach. The strategic priorities and strategies adopted include the following. Action steps were developed for each project under the four strategic priority areas. Lead stakeholders and a timeline were identified for each project.

1. Broad recognition of prevention as effective and cost saving.
 - Champion prevention because the healthy mental, emotional and behavioral development of young people is a public health priority
2. To ensure consistently effective outcomes and streamline operations.
 - Promote evidence-based, culturally competent policies and practices that support and integrate prevention at multiple levels across systems.
3. Working together to ensure the best use of resources to meet identified needs.
 - Promote and support formalized collaboration and systems integration at the community and state level for the sharing of resources and program implementation

4. Programs, practices, and strategies are data-driven and effective.
 - o Use relevant data to assess community strengths to select programs, practices and strategies and evaluate their effectiveness

The Consortium also aligned its Strategic Priorities and projects with the 10 Essential Public Health Services (EPHS) to promote the integration of substance abuse prevention with public health in Ohio and the EPHS Model Standards to facilitate future evaluation. The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

One of the projects in Ohio's Strategic Prevention Enhancement 2012 Action Plan was to develop a data-driven funding method related to high need communities (i.e., equity, highest contributor, highest rate and hybrid models). One of the top priorities for consolidation work in SFY 15 is to develop a method for granting prevention service funds that will provide the most value for our citizens. As a first step in this process, Ohio brought in a national speaker on the Ethics of Allocation in an Environment of Scarcity in July 2012 to provide information to the behavioral health leadership at the state and board levels. Dr. Michael Gillette provided an introduction to some of the most interesting and difficult ethical issues in the provision of behavioral health services in an environment of scarce financial resources. He demonstrated a practical approach to ethical reasoning that can be applied to a variety of sub-topics including prioritization and micro-allocation, macro-allocation and budgeting across service areas, along with an overview of a draft budgeting algorithm. This information will be foundational as we select an updated method for funding behavioral health services in Ohio.

Feedback from the Prevention Field on Strategic Priorities -The Ohio SPE Evaluation Team (Ohio University and PIRE staff) developed a short survey to collect feedback on the goals and strategic priorities and to solicit ideas for the associated action steps. To facilitate the deployment of the web survey, OhioMHAS provided a list of individuals registered for the alcohol and other drug prevention and treatment portion of the OhioMHAS Spring Conference. As such, e-mail invitations were sent to 277 preregistered conference attendees asking for their participation in the web survey. The personalized e-mail described the purpose of the survey and included a link to the web-based survey. The survey was also deployed via a posting on the OhioMHAS Prevention List-serv. Because the survey link was not unique to the individual respondents and the fact the survey was deployed using a Listserv, it is not possible to calculate a response rate because the total number of individuals exposed to the survey is unknown. By the closing of the survey on May 14, 2012, 156 respondents had completed the survey.

The SPE Evaluation Team prepared an Executive Summary and detailed report of findings. The findings affirmed the importance of the goals and provided concrete action steps for consideration in the final stage of developing the Strategic Plan. Survey participants were asked to list up to five action steps for each of the four goals and their associated strategic priority. Results by goal area follow.

Goal 1 – Broad recognition of prevention as effective and cost saving.

Strategic Priority 1 – Champion Prevention

- When asked to rate the importance of Goal 1, 86.4 percent of survey respondents indicated that it was *very important*, and 9.7 percent indicated that it was *somewhat important*.
- When asked to rate the importance of Strategic Priority 1, 75.7 percent of survey respondents indicated that it was *very important*, and 15.1 percent indicated that it was *somewhat important*.
- The top three themes for the Strategic Priority 1 action steps are as follows:
 - Make more ATOD prevention information available to public / stakeholders including through media / media campaigns
 - Strategic Planning and Related Topics
 - Increase Capacity / Collaboration / Advocacy / Community Involvement

Goal 2 – To ensure consistently effective outcomes and streamline operations.

Strategic Priority 2 – Develop and promote evidence-based, culturally competent policies and practices that support and integrate prevention at multiple levels across systems.

- When asked to rate the importance of Goal 2, 60 percent of survey respondents indicated that it was *very important*, and 30.7 percent indicated that it was *somewhat important*.
- When asked to rate the importance of Strategic Priority 2, 60.9 percent of survey respondents indicated that it was *very important*, and 25.8 percent indicated that it was *somewhat important*.
- The top three themes for the Strategic Priority 2 action steps are as follows:
 - Provide Training and Technical Assistance for the Prevention Workforce
 - Develop a Multi-disciplinary Approach to Prevention
 - Create a Resource Library of EBP and Culturally Competent Practices

Goal 3 – Working together to ensure the best use of resources to meet identified needs.

Strategic Priority 3 – Promote and support formalized collaboration and systems integration at the local and state level for the sharing of resources and program implementation.

- When asked to rate the importance of Goal 3, 72.3 percent of survey respondents indicated that it was *very important*, and 18.2 percent indicated that it was *somewhat important*.
- When asked to rate the importance of Strategic Priority 3, 69.1 percent of survey respondents indicated that it was *very important*, and 16.8 percent indicated that it was *somewhat important*.
- The top three themes for Strategic Priority 3 action steps are as follows:
 - enhance and improve opportunities and support for collaboration at state and local levels
 - Enhance the frequency and effectiveness of communication about prevention at the state and local levels
 - Use Media to Implement Strategic Priority and to Enhance Prevention

Goal 4 – Programs, practices, and strategies are data-driven and effective.

Strategic Priority 4 – Use relevant data to assess community strengths to select programs, practices, and strategies and help evaluate their effectiveness.

- When asked to rate the importance of Goal 4, 57.9 percent of survey respondents indicated that it was *very important*, and 34.5 percent indicated that it was *somewhat important*.
- When asked to rate the importance of Strategic Priority 4, 57.5 percent of survey respondents indicated that it was *very important*, and 30.8 percent indicated that it was *somewhat important*.
- The top three themes for Strategic Priority 4 action steps are as follows:
 - Collection of substance use-related data
 - Data access and sharing
 - Technical Assistance and/or Training

Infusion of Prevention into Other Systems -The consolidation of ODADAS and ODMH will support the infusion of prevention into other systems to better Champion Prevention. The new Office of Prevention and Wellness at OhioMHAS is comprised of individuals from five different disciplines: children and families mental health, substance abuse prevention, criminal justice, communications and substance abuse treatment. This combination encapsulates not only a wealth of skills and knowledge, but also the connections with other state partners and communities to assist in the infusing prevention into other systems. Three groups have been the priority to engage in this effort in SFY 2013. They included community coalitions, other state agencies and higher education. These efforts are summarized below. Work is just starting on adding the medical community as a priority for engagement in infusing prevention into their service system. This area will be the focus of work in SYF 2014.

The Department was moving forward with this initiative prior to the consolidation working with the coalitions in the state. Coalitions are a prime target for infusion of the SPF across the state due to their engagement of multiple community sectors. Training and technical assistance provided a well-rounded view regarding the importance of representation of all community sectors on coalitions. The role that they all can play and in concert the positive impacts that can be made in the community. This was well received at the community level and we have mirrored this at the state level. We have worked diligently with the Office of the Attorney General and have provided general education that has significantly increased their knowledge and awareness of what does and does not work in prevention. They have become an active partner in our work and we have had discussions regarding the increased participation of law enforcement in our efforts.

The Consortium has been instrumental in our efforts to infuse prevention into other systems. We have ensured that individuals from other systems such as: youth services, education, faith-based organizations, child welfare, juvenile court, law enforcement and public health are represented on the SPF Advisory Committee, the EBP workgroup and the SPE/Interagency Policy Consortium. This provides opportunities for discussion, education and planning as to how prevention resources can be coordinated to better enhance everyone's services.

The Department has been working with four colleges/universities to infuse prevention into their curriculum. Wright State University, Ohio University, Miami University and the University of Cincinnati currently working on the development of a bachelor's level degree, a thematic sequence and/or master's level leadership degree.

Capacity Building

Ohio needs a modern infrastructure to increase capacity to implement and improve an integrated, comprehensive, evidence-based behavioral health care system of services for youth.

Although prevention and early intervention science have made great strides in the last few decades, it is clear from Ohio's behavioral health problem indicator and consequence data that more detailed multi-level models of what works and what does not work for preventing and treating youth internalizing and externalizing disorders need to be embraced by Ohio communities.

Over the last year, Ohio has engaged in an extensive behavioral health systems assessment process prompted by the upcoming integration of the Ohio Departments of Alcohol and Drug Addiction Services and Mental Health into the newly formed Department of Mental Health and Addiction Services (MHA) on July 1, 2013. This presents the perfect opportunity to conduct comprehensive planning around addressing the needs identified in the assessment, and then the resources to document the success of various community-based models of integrated community/school/justice service systems for Ohio's youth. In tandem with assessment efforts regarding Department consolidation, Ohio utilized the Strategic Prevention Enhancement (SPE) grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) to strengthen and enhance the state's prevention infrastructure to support more a strategic, comprehensive system of community-oriented care in 2011 and 2012.

The economic crisis greatly impacted the availability of funding for social services in Ohio. Currently, the only funds available for substance abuse prevention through our Department are federal, and these have been cut every year the past few years. The opiate crisis in rural and Appalachian areas of Ohio has created a demand for more effective behavioral health care models for youth, and we know from the 2009 Institute of Medicine Report (IOM) that such addictions have very early, preventable antecedents. Five Ohioans lose their life every day as a result of drug overdose. This has created an unprecedented readiness for change in Ohio communities. Prior to the last year, Ohio was pushing as many dollars as possible out to the communities and therefore cutting much of the state's prevention infrastructure for statewide training, technical assistance and systems reform. The SPE helped Ohio leap forward in modernizing our prevention system, and we expect this grant would produce similar results for our early intervention system for youth.

During our assessment over the last year, four statewide infrastructure issues were discovered that may be contributing to increases in youth behavioral health problems.

The first is that a large gap exists between prevention and early intervention science and practice among preventionists, clinicians and other stakeholders in the community. One barrier that creates this gap between science and practice includes different theoretical

orientations of the various backgrounds of the professionals involved and the lack of training in child and adolescent development and risk behavior theory (Wandersman, 2003). Ohio rule currently recognizes 19 credentials that allow individuals to provide prevention services with only minimal requirements for training in prevention science. Ohio has endeavored to address this issue by conducting a workforce development assessment and strategic plan to address the issues discovered. In our effort to modernize our prevention system, Ohio embraced the findings and recommendations in the 2009 Institute of Medicine (IOM) report on “Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.” The first step in diffusing these innovations in Ohio was to make our system aware of the new science and recommendations of the IOM report. Ohio utilized SPF-SIG carry over dollars to fund capacity development in of-the-art prevention science practice. The following paragraphs provide a summary of some of these efforts.

The Ohio Prevention and Wellness Roundtable hosted a Prevention Policy Summit October 10, 2012. The Summit focused on building awareness of more than 300 people from the prevention field about IOM report recommendations and how to implement environmental strategies and population-based interventions. Anthony Biglan, Ph.D. and Dennis Embry, Ph.D. providing the training along with local community groups that have successfully implemented IOM recommendations. The Alcohol and Drug Abuse Prevention Association of Ohio (ADAPAO) and the Drug-Free Action Alliance (Ohio’s Center for Coalition Excellence) conducted a Bridging the GAP (Grief, Advocacy, Prevention) conference on September 21-22, 2012. The first day focused on how prevention professionals can better work on engaging communities in prevention for the implementation of environmental strategies and population-based prevention interventions. The second day provided basic training on evidence-based prevention for family and community groups who have not previously been engaged in prevention but have been mobilizing due to the opiate addiction and overdose epidemic in Ohio. ADAPAO also hosted two, one-day events for members this past year, one focusing on Prevention Consultancy and another on Prevention’s Future in Healthcare Reform. Both were attended by more than 130 preventionists.

The Department and the Department of Education jointly hosted the annual Ohio Prevention Education Conference, “Prevention without Boundaries” December 4-6, 2012, with a focus on population-based strategies and community engagement in prevention for more than 300 practitioners. Another effort was the Strategic Prevention Framework (SPF) three-day Boot C.A.M.P. held in May 2013 which provided our 13 SPF sub-recipient communities intensive training in environment strategies in preparation for their upcoming implementation year in SFY 14. However, providing the knowledge is only the first step in diffusion of innovation (Rogers 1995). Ohio took the next by the Wellness & Prevention Roundtable and ADAPAO hosting Ohio’s first Prevention Academy in June 2013. Roundtable members served as faculty for the advanced track, three-day residential Academy that offered courses on interpreting and implementing prevention science with a focus on the IOM report recommendations. In one working session, Ohio preventionists, clinicians and professors examined ten IOM recommendations discussing barriers to implementation in their communities and brainstorming ways to overcome the barriers. This information is being compiled by the faculty member and will be reported to Dr. Biglan as an IOM report author for future consultation with Ohio.

Another problem is the difficulty in replicating expensive model programs (Nation et al., 2003) which in many Ohio communities has resulted in practitioners creating or adapting their own programs with marginal effects. Only 27.3% of all prevention funded by the Department was reported as evidence-based in 2011. In Ohio, it is not so much that theory-driven, scientific-based interventions are not available, it is often that communities and practitioners do not have adequate resources to implement them with fidelity for a sustained enough period to see results. Ohio's experience of receiving large reductions in federal and state funding as a result of economic problems has exacerbated this problem. New approaches must be identified that take advantage of resources already available within communities or evidence-based strategies that are easier to use, more cost efficient, and easier to maintain like the PAX Good Behavior Game that have shown tremendous positive results in Licking, Knox, Greene, Madison, Clark, Putnam and Wood Counties. Without infrastructure development that changes service systems, resources will continue to be wasted on the punishment and treatment end of the service continuum while precious opportunities are lost to assist high-risk youth in living healthy and productive lives.

The third gap in Ohio's infrastructure is that **most evidence-base interventions are targeted at changing the behavior of the child without enhancing the child's primary environment of influence, the family** (Nation et al., 2003). Romer stated in the introduction to his edited volume on "Reducing Adolescent Risk: Toward an Integrated Approach" that more comprehensive interventions cannot be developed until better theory and measurement of causal pathways underlying multiple risk behavior are developed. Strategies that impact the youth's environment must be provided to achieve population-levels improvements in the behavioral health of Ohio's youth. There is a dearth in the literature regarding the comparative effectiveness of comprehensive, integrated approaches compared to single strategy interventions.

A final infrastructure gap is that ***Ohio communities lack resources and guidance to conduct comprehensive planning for integrated service approaches.*** Behavioral health problems are complex and therefore cannot be adequately addressed without involving multiple service systems that address and risk and protective factors. Risk factors are neurobiological facts, stressful events or psychosocial factors that increase an adolescent's vulnerability to poor outcomes (Gullotta & Adams, 2005). Protective factors help safeguard youth from poor outcomes. This bio-ecological risk and protective factors framework of Hawkins and Catalano was based on Bronfenbrenner's Bioecological Systems Theory that suggests outcomes grow out of the complex web of interactions of various domains including: genetic/individual, family, peers, school, community and society. These factors must be interwoven with the development process in which certain factors may be more influential at key developmental points and often operate differentially according to gender, race, ethnicity and culture. Communities need formal assistance in sorting through these complexities to identify and address the intervening variables that are operating to elevate risk levels among their various populations.

Another infrastructure need is that ***Ohio's multi-faceted diversity presents challenges for service delivery.*** Ohio is comprised of 88 diverse counties, is largely rural with an agricultural economic base, but also encompasses 15 metropolitan areas. The majority of residents live in these metropolitan areas which exhibit familiar urban problems, such as substance abuse, poverty, low educational attainment, health disparities, and violence. Ohio's minority populations reside

primarily in urban areas. The western portion of the state hosts significant numbers of migrant Latino farm workers and their families. Northeastern and central regions are home to one of the largest Amish communities. Almost a quarter (23%), of the population lives in rural areas. The Appalachian Regional Commission characterizes 32 contiguous counties located in the southeastern part of Ohio, as Appalachian. Ohio's Appalachian population reflects unique socio-cultural characteristics that uniquely influence community readiness for change, attitudes toward accessing behavioral health services and assistance from cultural outsiders.

Along with cultural and geographic diversity, Ohio is also becoming increasingly racial diverse. About one in six Ohioans is a member of a racial minority or is Hispanic. According to the US Census Bureau (2010), Ohio's population was 11,536,504 making it the 11th most populous state in the nation. Of these, 82.7% are White, 12.2% Black or African American, 1.7% Asian, 1.1% Some Other Race, and 2.1% Two or More Races. These figures include 1.9% Hispanic or Latino (a) individuals who may be of any race. Ohio experienced an increase in population of 1.6% between 2000 and 2010 with all racial groups other than white increasing.

The effect of poverty on behavioral health outcomes is well established. Low-income individuals/ families have reduced access to all health services including behavioral health care due to a lack of insurance coverage. In addition, poverty has been correlated with several negative effects, including increased risks for mental health issues, violent behaviors, crime and suicide (Evans & Adams, 2009). Barriers to health services include: transportation, childcare, mistrust of the medical profession and underestimation of behavioral and primary conditions/illnesses/diseases. All children, particularly those living in poverty, are more vulnerable to related negative effects than adults as they lack the ability to control their own circumstances and are dependent upon others to intervene and provide the services they need.

Unfortunately, the economic outlook within Ohio declined significantly in past years. The unemployment rate within Ohio was 8.6% in 2011 dropping just slightly below the national average for the first time since 2002. However, the State is still recovering from the recession. Ohio's unemployment rate in 2011 remained 3% higher than the rate in 2007. Not surprisingly, similar results have presented at the state level in the areas of poverty and childhood poverty. This increase in personal poverty coupled with large cuts over the past few years in federal and state grant funds available to communities for prevention and early intervention services resulted in unprecedented service gaps for Ohio children and adolescents particularly in rural areas.

Ohio's Strategic Prevention Framework State Incentive Grant (SPF-SIG) - Ohio was awarded the competitive five-year, Strategic Prevention Framework State Incentive Grant (SPF-SIG) totaling more than \$10 million, funded by the Substance Abuse and Mental Health Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) in July 2009. The SPF- SIG Initiative is enhancing the capacity of the state and counties to build a sustainable, culturally competent infrastructure focusing on delaying the onset of alcohol and other drug use and reducing substance-related problems.

To develop capacity at the community level, Ohio is utilizing training, technical assistance and coaching to provide intense, ongoing support to the 13 SPF SIG sub-recipient communities. This work is helping to lay a solid foundation for the sub-recipient communities, to mobilize, promote, evaluate and/or enhance existing locally driven drug-free community coalitions to

address community substance abuse prevention needs. The 13 SPF SIG sub-recipient communities have been thoroughly trained in implementation of the SPF, and 35 of 37 other community Boards have participated in training to become familiar with the framework. An additional eight board areas have requested intensive technical assistance in the SPF which will be provided in SFY 2014 to assist them in redesigning their prevention systems in their catchment areas.

Evidence-Based Practice Workgroup - The Evidence-Based Practice (EBP) Workgroup, consisting of key state partners, has been integral in the facilitation of the SPF process. The Department and SPF EBP Workgroup will ensure all sub-recipient comprehensive strategic plans are based on a data driven process and include goals, objectives and measures reflecting the cultural values, linguistic characteristics and socio-economic factors of each community, prior to implementation. The SPF EBP Workgroup provides guidance on the implementation of effective, evidence-based policies, programs and practices. This work continues to assist the state in moving toward a more cohesive and collaborative system that coordinates and maximizes resources to support the sustainability of the statewide infrastructure.

During the initial phases of the SPF SIG grant, the development of capacity at the state level involved training on the SPF-SIG process provided by CSAP's Central Regional Expert Team to all stakeholders involved in the initiative. This training has been the foundation the SPF SIG the SPF SIG training team and the Regional Prevention Coordinators have utilized to strengthen existing stakeholder relationships and support the system. The Central RET serves as a resource for the state and provides technical assistance as needed. The utilization of the SPF process has increased system capacity by ensuring state and local resources are targeted to AOD prevention services that have been demonstrated to be effective.

To develop capacity at the community level, Ohio has utilized training, technical assistance and coaching to provide intense ongoing support to the sub-recipient communities. This work has helped to lay a solid foundation for the sub-recipient communities, to mobilize, promote and/or enhance existing locally driven drug-free community coalitions to address community AOD needs. Ohio's prevention infrastructure supports a broad view of AOD prevention by focusing on both risk and protective factors and developmental assets related to substance abuse prevention. Through the development of community strategic plans, communities identify target priority areas, intervening variables and contributing factors to address. Sub-recipient communities have used the information gathered in their needs assessment to focus on environmental strategies as they develop their implementation plan.

In addition to the training resources identified above we have utilized our partnership with Central RET to build a cadre of Substance Abuse Prevention Specialist Training (SAPST) trainers and have utilized these trainers to provide training to the communities. Many of the community members have also had the opportunity to participate in the SAPST Training of Trainers which further strengthens the training and technical assistance capacity across the state. Existing community level capacity building activities include; ongoing training and technical assistance for the sub-recipients, coalition members and other community stakeholders, development of a community planning team, strengthening of relationships across systems at the local level and ongoing effective communication.

Communities who did not receive a SPF SIG sub-recipient grant have been provided the opportunity to develop capacity through needs assessment and training and technical assistance as part of the state wide system development.

Prevention staff has extensive experience providing technical assistance and fostering relationships with ADAMHS/ADAS Boards and prevention providers throughout the state of Ohio. They work intensively with sub-recipients in the field and assist with training sub-recipients as well as conduct site visits with the Boards and Providers in their regions.

Global Insight, the contracted training team for the SPF SIG project, has been in the training and professional speaking industry for close to 20 years. They have over 100 years of combined team experience with an extensive background in online training, coaching, consulting, assessment and evaluations. They have training and technical assistance experience in a variety of areas including; drug and alcohol, leadership, cultural competency, team building, empowerment, professional/personal development, community outreach and collaboration, quality assurance process improvement, marketing, project management, community needs assessments, capacity building, focus groups and strategic planning. They also are SAPST trainers and have additional experience in research and the implementation of evidence based prevention strategies.

Statewide Prevention Coalition Association (SPCA) - Ohio has found that community coalitions are the single most effective means of promoting grassroots alcohol, tobacco and other drug prevention across disciplines at the local level. Drug Free Community Coalition funding helps communities to address local alcohol and other drug abuse needs and mobilize and promote healthy youth development and healthy communities. Coalitions assist county alcohol and drug boards in determining prevention needs and in developing strategic prevention plans. The Department currently funds 18 coalitions in 16 counties in addition to the 13 SPF SIG sub-recipient coalitions. The Department also supports the Statewide Prevention Coalition Association (SPCA) and The Ohio Center for Coalition Excellence (OCCE) working with coalitions in over 100 communities. Both SPCA and OCCE provide training, technical assistance and support to communities in their efforts to impact community norms; access and availability of alcohol, tobacco and other drugs; media messages; and policy enforcement issues on the local level. The Department also funds 80 Suicide Prevention Coalitions through a grant to the Ohio Suicide Prevention Foundation.

Ohio has a rich history of coalition development. The following maps illustrate a snapshot of Ohio's prevention coalitions. They have various funding sources which include: 18 coalitions funded through the Department; 17 Higher Education Coalitions, 8 of which are funded through the Department; 29 Drug Free Community Coalitions and 1 Weed and Seed coalition. In addition, some of Ohio's AOD coalitions also receive funding from their local ADAMHS/ADAS Boards. Ohio's community coalitions serve a number of geographically and culturally diverse populations; however, it appears that there are gaps in that service. As the map illustrates, there are a number of both counties and board areas that have very few, if any, community coalitions while others have a plethora. A few of the 29 federally funded Drug Free Community Coalitions

have also received funding for the Sober Truth on Preventing Underage Drinking. The picture below shows all of Ohio's coalitions.

In 1995 the *Statewide Prevention Coalition Association (SPCA)* was formed with funding from the Center for Substance Abuse Prevention to provide a state infrastructure for substance abuse prevention coalitions and other groups to advocate for policies related to substance abuse prevention, build and enhance their local collaborative capacity, and to plan, implement, evaluate and sustain prevention strategies within communities.

SPCA members have an opportunity to network with many other coalitions at unique stages of growth and development. They share knowledge and resources to help them strengthen and sustain their infrastructure. Members also receive practical information about effective strategies and initiatives, which engage the community and create environmental change.

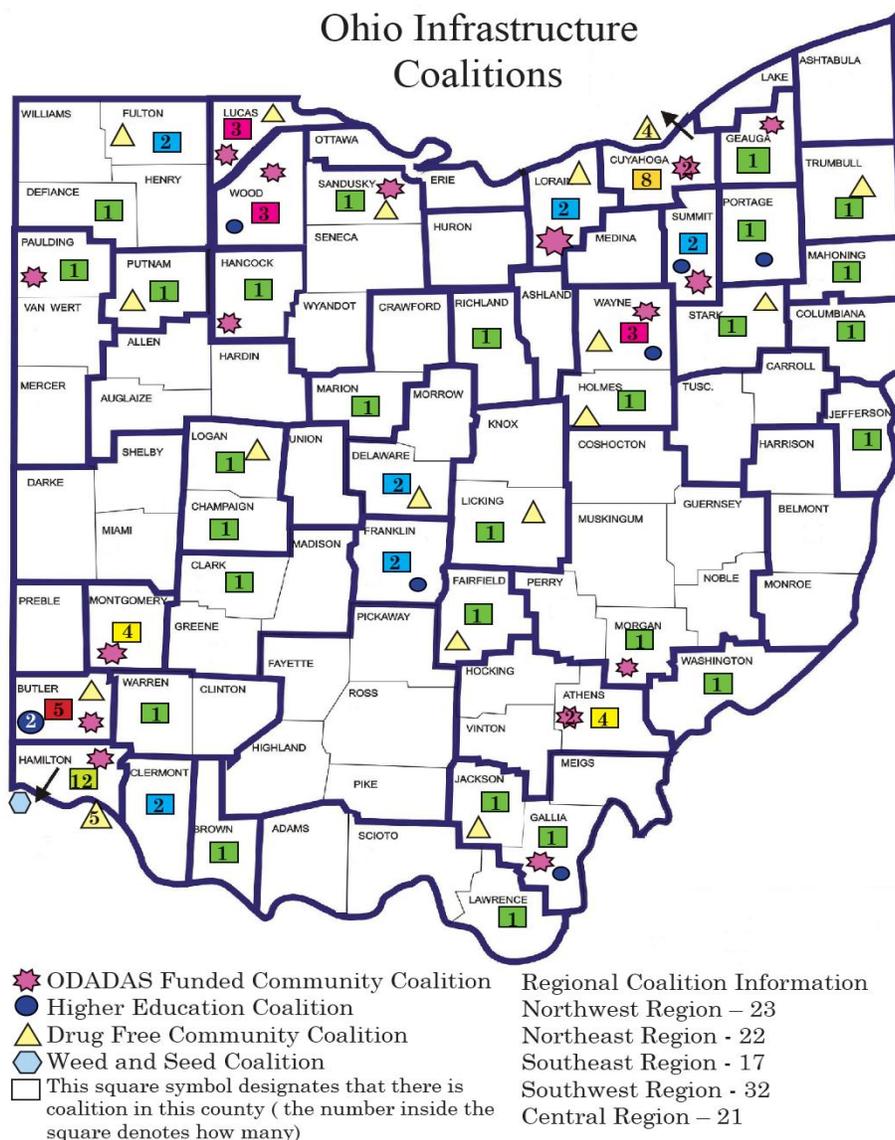
The mission of the *Statewide Prevention Coalition Association* is to unite organizations through collaboration and sharing of resources to promote prevention for a safe, healthy and drug-free Ohio. The Association's goal is to: "Build Collaborative Capacity through Community-Based Processes". The Statewide Prevention Coalition Association assists its Associate Members in their pursuit of successful advocacy for ATOD prevention, building and/or enhancing their collaborative capacity and implementing effective prevention strategies within their communities.

SPCA Associate Member Organizations advocate for National/State/Local policies related to ATOD prevention, build/enhance their local collaborative capacity, implement effective prevention strategies within their communities and utilize the information learned through SPCA to address their local prevention issues.

The Association includes geographically and culturally diverse substance abuse and violence prevention organizations that are active in providing prevention services to their community and are interested in learning and receiving training on the latest practices and important information of the prevention field. Representatives include: Funded Drug-Free Community Coalition members, federally funded Drug-Free Community Coalitions in Ohio, Ohio CADCA members, substance abuse and violence prevention organizations, drug-free schools, agencies, coalitions, state departments, Ohio universities and more.

In the summer of 2000, the SPCA became the state association for CADCA (Community Anti-Drug Coalitions of America) members. Through this association, Ohio CADCA members have a venue to collaborate and receive the benefits of the Statewide Prevention Coalition Association. SPCA is governed by an Advisory Council of representative prevention organizations and coalitions. The Advisory Council meets three times a year.

Ohio Infrastructure Coalitions



The SPCA meetings include legislative updates, information/trainings on Hot Topics in prevention, updates from state partners, member-sharing/networking opportunities and focuses on successful ways to involve and engage different sectors of the community in local prevention efforts. In addition, each meeting provides coalition leaders an opportunity to gain a statewide and national perspective on prevention practice and learn and reaffirm best practices for planning and implementing environmental prevention strategies. All meetings will be held in Columbus, Ohio.

SPCA also offers coalitions the opportunity to stay involved and informed on statewide and national advocacy activities through weekly emailed legislative updates, monthly advocacy webinars, and annual legislative education events in Columbus, Ohio and Washington DC. This network of coalitions allows for a natural environment for mentor/mentee relationships among new/developing coalitions and older/experienced coalitions to be formed.

The *Statewide Prevention Coalition Association* is unique in that it is the only statewide association for prevention organizations in Ohio. The statewide perspective enhances and broadens the local and regional perspectives that the associate members already have. The Statewide Prevention Coalition Association received the Outstanding State Association Award from Community Anti-Drug Coalitions of America in 2002.

SPCA provides a state infrastructure for substance abuse prevention coalitions and other groups to advocate for policies related to substance abuse prevention. Both SPCA and the Ohio Center for Coalition Excellence assist in working with coalitions in over 90 communities to build and enhance their local collaborative capacity to plan, implement, evaluate and sustain prevention strategies. The focus of these groups is to help local communities increase capacity, increase use of environmental prevention strategies on a local level and foster drug free lifestyles. The Ohio College Initiative brings together more than 45 colleges and universities that focus on forming campus and community coalitions that work to change the alcohol-related culture surrounding college students. These three initiatives provide training, technical assistance and support to communities in their efforts to impact community norms; access and availability of alcohol, tobacco and other drugs; media messages; and policy enforcement issues on the local levels.

The Ohio Center for Coalition Excellence - Born out of the Statewide Prevention Coalition Association in 2006, The *Ohio Center for Coalition Excellence* was conceptualized to further assist communities to mobilize substance abuse prevention efforts. Ohio Center for Coalition Excellence, housed at the Drug-Free Action Alliance, assists community groups to build and enhance their local collaborative capacity, to plan, implement, evaluate and sustain prevention strategies within communities in an effort to increase capacity, change their community environments and foster drug free lifestyles. The Center works with the Underage Enforcement Training Center, Community Anti-Drug Coalitions of American and national and state experts to provide trainings that assist coalitions strengthen their coalition's development and increase their impact within their community. Training topics have included Media Advocacy, the Business of Coalitions, Working with Local Law Enforcement, New and Emerging Drug Trends and Understanding Responsible Beverage Service Programs & Community Organizing for Policy Change. Technical assistance is provided to coalitions through site visits and through webinar and conference call. This allows coalitions the opportunity to solve problems unique to their situation. Coalitions also have the opportunity to take advantage of CADCA membership benefits as the Center offers discounted CADCA membership through funding from the Ohio Department of Alcohol and Drug Addiction Services. Once a year, the Center convenes coalition evaluators to engage in conversations about the issues and opportunities involved in meaningful coalition evaluation and exploring state-of-the-art coalition evaluation, including defining it and discussing how to advance it in the state of Ohio.

Ohio is undertaking a new initiative in SFY 2014 to develop a set of criteria for a designation of an "Ohio Coalition of Excellence." SPCA members will be assisting in this endeavor and the national guardsman imbedded in the Office of Prevention & Wellness will lead this initiative for the Department to bring to bear the resources of the National Guard's association with CADCA.

Suicide Prevention - Approximately 1,300 Ohioans die by suicide each year. Ohio experiences two suicides for every homicide. Males account for about 80% of Ohio's suicides and females 20%. Firearms are used in over 55% of completed suicides. Roughly 90% of individuals who complete suicide experience a mental health and/or substance use disorder which is untreated or undertreated at the time of their death. It is estimated that over 70% of youth who attempt or complete suicide have alcohol or illicit drugs in their systems. Suicide is the #2 cause of death for youth ages 19 to 24.

Because substance abuse and use is a key risk factor in suicide deaths and attempts, OhioMHAS provides ongoing support to the Ohio Suicide Prevention Foundation (OSPF) in implementing its mission to promote suicide prevention as a public health issue and advance evidence-based awareness, intervention and methodology strategies which will support all Ohio-based suicide prevention efforts, with the ultimate goal of saving the lives of hundreds of Ohioans. The audience for the primary prevention efforts of the foundation is essentially the entire population of the state, while specific at-risk audiences such as substance abusing populations may be the target of specific preventative programs. We anticipate that more than 5,000 people will benefit from these prevention efforts each year.

In the fall of 2008 the U. S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration published the white paper "Substance Abuse and Suicide Prevention: Evidence and Implications". This paper describes a Public Health Approach to suicide/substance abuse prevention. The OSPF is using this approach and has partnered with community coalitions to provide the opportunity and structure for allied groups to pursue coordinated strategies to educate and increase public awareness that suicide is a public health problem. Coalitions are committed to reducing stigma, which helps increase people's ability to seek help and ultimately prevent the loss of life.

The coalitions provide training/education on suicide risk factors, warning signs (especially when combined with AOD use/abuse) and prevention strategies. Community Collaboratives apply for mini-grants to develop and execute combined suicide/AOD prevention strategies in their community. The strategies developed are culturally relevant to the intended audiences and inclusive of local resources. The combined forces of the suicide prevention and AOD prevention coalitions and/or UMADAOPs create a synergy of culturally relevant information and awareness that will reach a much larger percentage of the population. Through public awareness campaigns, education and training Ohioans will recognize the increased risk for suicide associated with AOD use/addiction and increase help seeking behavior, thus helping to reduce the number of suicide attempts and deaths in Ohio.

OSPF received a Substance Abuse and Mental Health Services Administration (SAMHSA) Garrett Lee Smith Youth Suicide Prevention Grant in 2011. The application titled, *Ohio's Campaign for Hope-Youth Suicide Prevention* is for \$1,440,000 over 3 years, and is working to expand suicide prevention services for at-risk youth, military families, LGBT youth, youth in foster care and youth in the justice systems. The project objectives are as follows:

- Targets and provides funding for suicide prevention activities for 25 at-risk counties that have higher than national and state youth suicide

- Mobilize 78 suicide prevention coalitions to help promote and implement
- Kognito’s “At-Risk” online Gate Keeper training by training 20,000 high school staff, military families and professionals working with youth in foster care, LGBT youth and youth involved with the justice system.
- Provide Assessing & Managing Suicide risk training to over 400 professionals
- Implement TeenScreen & Signs of Suicide in at--risk counties- screen 8,000 at--risk youth
- Engage local MH service providers as mentor programs for the 25 at--risk Counties to help establish suicide prevention programming for at--risk youth which is expected to result in 700 youth referred for continuing MH treatment
- Actively promote the National Suicide Prevention Lifeline Program through websites, literature promotion and webinars

Workforce Development - Workforce development is a challenge for prevention in Ohio. Recruitment is a significant problem for the substance abuse prevention profession because of a lack of standardized education pathways. Retention is also a concern because of the rate of turnover for substance abuse prevention professionals. Due to the economic times and limited dollars available for training and continuing education our workforce does not always have the opportunity to access resources to remain current in substance abuse prevention practices. This coupled with the aging workforce in substance abuse prevention provides unique circumstances when looking at workforce development issues.

In summary, while Ohio is fortunate to have a fairly strong infrastructure supporting the substance abuse prevention system at the state and local levels, a number of factors affect advancement of this system. These include a current state budget crisis that may result in a reduction in the amount of per capita allocations going to county boards to support prevention services and a reduction in the amount of competitive funding awarded by the Department. Other factors include the underrepresentation of Appalachian counties in county-level consumption data, a lack of science-based prevention programs in place across Ohio, particularly in rural areas, and a lack of population-specific suicide prevalence data needed to serve our LGBTQ and military families who are at an increased risk for suicide.

In our effort to modernize our prevention system, Ohio embraced the findings and recommendations in the 2009 Institute of Medicine (IOM) report on “Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.” The first step in diffusing these innovations in Ohio was to make our system aware of the new science and recommendations of the IOM report. Ohio utilized SPF-SIG carry over dollars to fund capacity development in of-the-art prevention science practice. The following paragraphs provide a summary of some of these efforts.

The Ohio Prevention and Wellness Roundtable hosted a Prevention Policy Summit October 10, 2012. The Summit focused on building awareness of more than 300 people from the prevention field about IOM report recommendations and how to implement environmental strategies and population-based interventions. Anthony Biglan, Ph.D. and Dennis Embry, Ph.D. providing the training along with local community groups that have successfully implemented IOM recommendations. The Alcohol and Drug Abuse Prevention Association of Ohio (ADAPAO)

and the Drug-Free Action Alliance (Ohio's Center for Coalition Excellence) conducted a Bridging the GAP (Grief, Advocacy, Prevention) conference on September 21-22, 2012. The first day focused on how prevention professionals can better work on engaging communities in prevention for the implementation of environmental strategies and population-based prevention interventions. The second day provided basic training on evidence-based prevention for family and community groups who have not previously been engaged in prevention but have been mobilizing due to the opiate addiction and overdose epidemic in Ohio. ADAPAO also hosted two, one-day events for members this past year, one focusing on Prevention Consultancy and another on Prevention's Future in Healthcare Reform. Both were attended by more than 130 preventionists.

ODADAS and the Department of Education jointly hosted the annual Ohio Prevention Education Conference, "Prevention without Boundaries" December 4-6, 2012, with a focus on population-based strategies and community engagement in prevention for more than 300 practitioners. Another effort was the Strategic Prevention Framework (SPF) three-day Boot C.A.M.P. held in May 2013 which provided our 13 SPF sub-recipient communities intensive training in environment strategies in preparation for their upcoming implementation year in SFY 14. However, providing the knowledge is only the first step in diffusion of innovation (Rogers 1995). Ohio took the next by the Wellness & Prevention Roundtable and ADAPAO hosting Ohio's first Prevention Academy in June 2013. Roundtable members served as faculty for the advanced track, three-day residential Academy that offered courses on interpreting and implementing prevention science with a focus on the IOM report recommendations. In one working session, Ohio preventionists, clinicians and professors examined ten IOM recommendations discussing barriers to implementation in their communities and brainstorming ways to overcome the barriers. This information is being compiled by the faculty member and will be reported to Dr. Biglan as an IOM report author for future consultation with Ohio.

Training/Technical Assistance -To develop capacity at the state level all stakeholders involved in the initiative, OhioMHAS staff, SPF-SIG Committee, EBP, SPE Policy Consortium, etc. have received or will receive training on the SPF-SIG process. This has been the foundation utilized to strengthen existing stakeholder relationships and support the system as we move forward. The utilization of the SPF process has also been instrumental in increasing system capacity by helping to ensure state and local resources are targeted to AOD prevention services that have been demonstrated to be effective.

To continue to develop capacity at the community level, Ohio will utilize training, technical assistance and coaching to provide intense ongoing support to communities. This will support a solid foundation for communities, to mobilize, promote and/or enhance existing local activities to address community AOD needs. Ohio's supports a broad view of AOD prevention by focusing on both risk and protective factors and developmental assets related to substance abuse prevention. Through the development of community strategic plans, communities identify target priority areas, intervening variables and contributing factors to address.

All OhioMHAS and state contractors for training and technical assistance have extensive experience providing technical assistance and fostering relationships with ADAMHS/ADAS Boards and prevention providers throughout the state of Ohio. OhioMHAS' regional structure

has enabled the field to receive more coordinated and effective technical assistance from the Department.

The Central RET has served as a resource for the state and we will continue to utilize them as needed for training and technical assistance at all levels. We have worked extensively with them to bring the SAPST training to Ohio, and we have built a cadre of Substance Abuse Prevention Specialist Training (SAPST) trainers and have utilized these trainers to provide training to the communities. With the unveiling of the new SAPST curriculum, we have worked with Central RET to engage in a TOT in Ohio. This opportunity is critical to our field as we move forward with OhioMHAS consolidation with the Department of Mental Health.

The Department utilizes two other entities as a part of our training arm to strengthen capacity at the community level through ongoing training and technical assistance for coalition members and other community stakeholders, development of a community planning team, strengthening of relationships across systems at the local level and ongoing effective communication to maintain support for prevention.

Global Insight has been in the training and professional speaking industry for close to 20 years. They have over 100 years of combined team experience with an extensive background in online training, coaching, consulting, assessment and evaluations. They have training and technical assistance experience in a variety of areas including; drug and alcohol, leadership, cultural competency, team building, empowerment, professional/personal development, community outreach and collaboration, quality assurance process improvement, marketing, project management, community needs assessments, capacity building, focus groups and strategic planning. They also have additional experience in research and the implementation of evidence based prevention strategies. James White Sr. is a senior, Master Training Management Consultant and Executive Coach. With more than 25 years of corporate, education, and government experience, White is committed to the training and development of individuals and organizations.

OhioMHAS also works closely with the Drug-Free Action Alliance. They provide training, technical assistance and support to communities in their efforts to impact community norms; access and availability of alcohol, tobacco and other drugs; media messages; and policy enforcement issues on the local level. The education, coaching and technical assistance occurs most frequently through the work of the Statewide Prevention Coalition Association (SPCA), the Ohio Center for Coalition Excellence and the Ohio College Initiative to Reduce High Risk Drinking, all supported by OhioMHAS. SPCA provides a venue for substance abuse prevention coalitions and other groups to advocate for policies related to substance abuse prevention. Both SPCA and the Ohio Center for Coalition Excellence assist in working with coalitions in over 90 communities to build and enhance their local collaborative capacity to plan, implement, evaluate and sustain prevention strategies. These groups will continue to assist local communities increase their capacity and to increase use of environmental prevention strategies to foster drug free lifestyles.

Workforce Development Workgroup - To address these issues a workforce development committee (WFD) has been convened, comprised of seasoned and credentialed prevention

professionals from across the state. The work of the WFD committee is in part based upon the work of the Ohio SPF SPE Evaluation Team. The Workgroup review the following historic information to begin their planning.

- Ohio Prevention Training Needs Assessment (2002) by ADAPAO
- Enhancing the Prevention Workforce in Ohio (2006) by the ODADAS WFD taskforce
- Assuring Public Safety in the Delivery of Substance Abuse Prevention Service (2009), an ICRC Position Paper
- Prevention Certification Restructuring Survey (2010) by the OCDP Board
- Credentialing of Prevention Professional is a Critical Component to Implementing National Health Care Reform (2010) by the ICRC

During the SPE grant period, they created a web survey to help the Department understand workforce development needs in Ohio. This survey was fielded in July and August 2012 with individuals holding a current prevention or treatment credential. There were two key objectives to the survey:

- To provide data to profile the prevention workforce in Ohio and to inform workforce development efforts with Ohio's prevention workforce, and
- To understand how Ohio's prevention workforce views the importance of the Essential Public Health Services.

Ohio Workforce Development Survey -The changes in the behavioral healthcare field due to the Affordable Care Act implementation and a new understanding of the science behind behavioral health will require a whole new set of competencies for the prevention in Ohio. Role delineation and minimum standards for various Certified Prevention Specialist levels will be a focus of Ohio's revitalized Workforce Development Workgroup. To inform these efforts, OhioMHAS staff will look at how other states are changing their services systems and OhioMHAS has contracted with the SPF SPE Evaluation Team to create a web survey to help understand workforce development needs in Ohio. This survey will be fielded in late July and August 2012 with individuals holding a current prevention or treatment credential. The survey will close mid-August in order to meet reporting requirements. The two key objectives to the survey are the following:

1. To provide data to profile the prevention workforce in Ohio and to inform workforce development efforts with Ohio's prevention workforce, and
2. To understand how Ohio's prevention workforce views the importance of the Essential Public Health Services.

Instrumentation - The 2012 Workforce Development Survey included two modules of questions. Module 1 (Appendix C) focuses on training and workforce development needs and was administered with all sampled individuals. Module 2 (Appendix C) focuses on the perceived importance of the Essential Public Health Services (EPHS) to prevention in Ohio and was administered with individuals holding an OCPS II credential. The SPE evaluation team used an iterative approach to design the questionnaire used for the 2012 Workforce Development Survey.

The first module on workforce development is designed to provide Ohio with a data-informed profile of the prevention workforce and to inform planning for future workforce development and training efforts. The questions in this module were adapted from a 2008 survey fielded with

prevention professionals in Maine by the Edmund Muskie School of Public Service at the University of Southern Maine (Hartley, et al., 2008). Draft versions of the survey were reviewed by the SPE Evaluation Team, prevention services staff at OhioMHAS, and by Ohio's Prevention and Wellness Roundtable. This review process provided extensive feedback that resulted in a survey instrument that better fit the context of Ohio and the upcoming challenges and changes to the prevention system.

The second module on perceived importance of the ten Essential Public Health Services (EPHSs) was adapted from the State Public Health System Performance Assessment Instrument that was created as part of the National Public Health Performance Standards Program (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007). The ten Essential Public Health Services represent the spectrum of public health services that should be provided by states and local communities. The SPE evaluation team used the State Public Health System Performance Assessment Instrument to develop 44 questions measuring the perceived importance of Essential Public Health Services 1 to 5 and 8 to 10. EPHSs 6 and 7 were omitted from the instrument because they do not directly relate to the focus of the SPF-SPE grant. As with the first module, the SPE evaluation team used an iterative process to review and refine the questions and used feedback and suggestions from SPE evaluation team members and OhioMHAS staff to improve the questions and to tailor them to prevention in Ohio. This second module of questions on the EPHS was administered only to respondents who indicated that they held an OCPS II credential. As described below, in order to minimize survey burden, OCPS II respondents were randomly assigned to receive questions on only two of the eight EPHSs included in module 2 of the survey.

Sampling - The target population for the 2012 Workforce Development Survey is prevention practitioners and workers in the state of Ohio who held one of 19 different prevention or treatment credentials or who were Registered Applicants (and working to obtain a prevention credential). Under Ohio Revised Code, the Ohio Chemical Dependency Professionals Board (OCDPB) is required to maintain a database containing the names and contact information of all Registered Applicants and credentialed prevention and treatment professionals. The sampling frame for this survey was drawn from the 6,347 individuals listed in the OCDPB database who either had an active prevention or treatment credential or who were considered active Registered Applicants. Prior to beginning fieldwork for the survey, Evaluation Team members reviewed the information in the sampling frame. In a few cases, there were minor errors in either individual's names or contact information. Evaluation Team members made these minor corrections prior to the start of fieldwork to maximize the accuracy and efficiency of the sampling frame. As noted above, the first module of questions on training and workforce development will be administered to all 6,347 individuals listed in the OCDPB. Module 2, which focuses on the EPHS, will be administered to at least 135 individuals who currently held an OCPS II certification.

Next Steps - Fieldwork for the 2012 Workforce Development Survey will begin in late July 2012 and will be completed in mid-August 2012. The survey will be fielded using Qualtrics and is designed so that personalized survey invitation emails will be sent to each sampled respondent. The personalized e-mail describes the purpose of the survey and includes a link to the web-based survey. In keeping with best practices, we will deploy three reminder emails for the survey.

For the OCPSII module (which was fielded with the Workforce Development Survey) we randomly assigned OCPSIIs to receive only items related to 2 of the 8 EPHS included in order to decrease survey burden. A total of 36 OCPSII completed this module of questions (approximately 15 OCPSIIs per EPHS) for a response rate of 27% (computed by comparing the 36 completed OCPSII modules to the 135 OCPSIIs included in the sample).

Key data provided as part of the 2012 Workforce Development Survey include:

- Profile of Ohio’s Prevention Workforce
- Credentials
- Currently providing services
- Years in prevention
- Most Important Type of Prevention
- Familiarity with Key Prevention Concepts and Constructs
- Training Needs and Preferred Modalities

Key data provided as part of the OCPSII module focused on the perceived importance of the ten Essential Public Health Services (EPHSs). Ratings were made using a five point “importance scale” that included the following response categories:

- Not at all important
- Not very important
- Unsure
- Somewhat important
- Very Important

All mean scores were greater than 4.13, between “somewhat important” and “very important.”

Utilizing the results from these surveys as well as some historical documentation from past surveys the WFD committee identified an overall committee goal and three goals for the plan itself. Each of these goals has a state level and local level components. The draft is included below.

Current Draft of Workforce Development Plan

Goal: Create a sufficient, prepared, positioned, marketable, competent and diverse behavioral health prevention workforce through a structured two year plan for Ohio which will integrate behavioral health prevention with public health, educate the field on behavioral health prevention/promotion and population based strategies and define promote common language across systems.

Objectives for the WFD plan:

- Define and promote a common language for prevention across systems.
- Continue to educate field on behavioral health, prevention/promotion and population-based strategies.
- Integrating behavioral health in and with Public Health.

Each of these goals contains a state level and regional/community level component.

Goal #1 - The WFD Workgroup, the Interagency Prevention Consortium and the Ohio Chemical Dependency Professionals Board will provide the state level work. They will create a crosswalk

between substance abuse, mental health and public health prevention utilizing the current MHAS Prevention and Wellness Taxonomy and the Guiding Prevention Science documents as foundation. This work will be executed through statewide conferences (i.e.: OPEC, ADAPAO, Prevention Academy and UMADAOP) collaborative work on statewide committees, e-based Academy and the Departments website. Regional and community level work will focus on promoting the state plan through local educational opportunities.

Goal #2 - The state level work will be done through many of the training/conferences listed under Goal #1, as well as technical assistance provided by the Prevention Program Specialists, the Prevention Fellowship program started by the members of the Prevention and Wellness Roundtable and continued collaborative efforts on statewide committees and task forces. The WFD Workgroup would also like to see the utilization of a Statewide WFD Coordinator to guide these efforts. On the regional/community level the WFD committee will work to establish a regional workforce development consortium that will look at regional and local needs to ensure they are met and to ensure they are addressed in the state agenda. They could also provide regional and local learning collaborative(s) for sharing lessons learned, networking and establishing common outcomes. It is anticipated that the ADAMHS/ADAS Boards will also play in integral role in this work through funding and support to build capacity in their areas.

Goal #3 will require the same collaboration and coordination at the state level as Goals #1 & #2. The Department's Prevention & Wellness Specialists will take the lead in ensuring that behavioral health is being integrated into public health through their work on statewide committees, conference planning and the development of marketing strategies. They will work with the members of the Prevention and Wellness Roundtable and the Interagency Prevention Consortium to create elevator speeches, crosswalks, white papers and position papers that will frame our work in ways that others can understand and see the benefits of the integration. Most of this work will be done initially at the state level, though community and local partners will be utilized to identify and engage other fields and systems.

Other pieces of the WFD plan will include the updating and revision of the e-based academy to include the integration of behavioral health in the selection of educational sessions, continue to produce resources such as the Guiding Prevention/Promotion Science documents, distance learning and ensuring a connection with the OCDPB credentials/domains. It is the expectation that there will be a Substance Abuse Specialist Skills Training in each region annually and one statewide opportunity along with opportunities for test/prep study groups for the IC & RC exam.

Ohio possesses both individual and agency certifications for Prevention. Agency certification is provided by OhioMHAS and has minimum requirements and criteria agencies must show to be a prevention certified agency. Agencies must complete an application and an agency site review is conducted to ensure application is accurate. The agency must show policies and procedures that meet the requirements as well as show evidence of culturally appropriate interventions and qualified personnel that are implementing the interventions. Agencies are certified for three year time periods after which they can participate in a renewal process. (The complete rules document can be found at www.mha.ohio.gov in certification).

Individuals are certified through the Ohio Chemical Dependency Professionals Board. Prior to SFY 13 there were three options for an individual to choose from: Registered Applicant (RA), Ohio Certified Prevention Specialist I (OCPSI) and Ohio Certified Prevention Specialist II (OCPSII). The purpose of an RA was to get enable an individual to begin the process of prevention certification while working in the field. They must be supervised by and OCPS I or II and initially could stay at this level for an unlimited time period. The requirements for an OCPS I & II vary in that the different levels require different educational criteria and work experience hours.

The OCDPB realized that there were many individuals “parked” in the RA level and they were not advancing forward to the credential which was the intent. So in working with the OCDPB Prevention Committee, it was decided that maybe the creation of an Ohio Certified Prevention Specialist Assistant (OCPSA) would help individuals who may not have the required educational hours or work experience to move forward and provide an opportunity for them to complete their credential. The committee developed educational criteria and scope for the OCPSA and put a 2 year limit on the RA level.

It is anticipate that the addition of the OCPSA will increase the capacity of the prevention field in Ohio significantly. It is the thought that the RA level was so stagnant because many individuals wanted to move forward but due to educational and work experience requirements, and unemployment issues due to the economic downturn they could not.

Cultural Competency - OhioMHAS, ADAMHS/ADAS boards and providers face challenges in addressing the prevention needs of new, emerging and under-represented populations in culturally competent and relevant ways. Ohio has significant African American, Somali, Latino, Asian, Appalachian and Amish population groups, and new immigrant and refugee populations from Asia and Northern Africa are increasing the number of languages and dialects spoken, stretching current capacity and dramatically boosting the demand for English as a Second Language services. In addition, the demographics of persons currently served by Ohio’s AOD system do not necessarily reflect those of persons in need of services and strategies, but rather persons who are comfortable accessing services. Most professional conference and training events try to incorporate cultural competency components into all elements of planning and implementation. As Ohio’s increasingly diverse population grows, the ongoing need for AOD providers to be adequately trained remains to be a priority for the state.

OhioMHAS recognizes the need to be more inclusive in engaging Ohio’s culturally diverse populations in prevention planning, coalition participation, and access to services; however, there is no formal or comprehensive approach to ensure that all components and levels of the Ohio prevention system are providing culturally appropriate prevention services, ensuring that prevention protocols and administration is culturally relevant and optimizing inclusion of these disparate populations in the system. OhioMHAS has requested CSAP technical assistance to develop a draft Cultural Competence State Plan with its partners to be implemented in the prevention system at the State (OhioMHAS) and sub-state levels (county boards, coalitions, and funded prevention providers). OhioMHAS has also inquired about other States and what has been done to implement cultural competency in their prevention systems at the State and sub-state levels. OhioMHAS has requested examples of agency cultural competence organizational

assessments, and recommendations on how coalitions can attract community representatives from currently underrepresented diverse populations.

In many of Ohio's communities with high poverty rates and large minority populations there is a huge saturation of access points leading to increased vulnerability of minority youth. It is imperative that communities understand the risk this places on these youth and how to address the issue to decrease the risk.

The Urban Minority Alcohol and Other Drug Addiction Outreach Programs (UMADAOPs) play a significant role with Ohio's SPF SIG project as subject matter experts in the area of cultural competence. The culturally relevant evidence based and promising practices programming they provide in African-American and Latino communities will be integral resources for communities. **As sub-recipient communities work to infuse cultural competence throughout the implementation of the SPF process these partners will also provide resources through education, training and technical assistance that will strengthen communities and help to ensure sustainability after funding has ended.**

In September 2010, The Multiethnic Advocates for Cultural Competence, Inc. (MACC) unveiled a State of Ohio Cultural Competence Definition that was developed by various state departments including OhioMHAS. In Ohio, cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities, and traditions of all Ohioans in order to develop policies to promote effective programs and services. This definition will begin to lay a foundation for building cultural competence not only for Ohio's SPF SIG project but in the state of Ohio as a whole. OhioMHAS understands that cultural and linguistic competence is fundamental to evidence-based prevention and is critical to meeting the diverse needs of all Ohioans.

Implementation of the final Cultural Competency plan and its recommendations to enhance cultural competency within the prevention system will result in increased prevention workforce capacity in cultural competence and increased participation of underrepresented and underserved populations within the AOD prevention system (including community coalitions).

A literature review was also undertaken to address specific Ohio concerns. Examples of the materials reviewed are "Substance Abuse Prevention Dollars and Cents: A Cost-Benefit Analysis," "Identifying and Selecting Evidence-Based Interventions," "Primary Prevention of Substance Abuse: A Workbook for Project Operators," and "Cancer Prevention in Underserved African American Communities: Barriers and Effective Strategies—A Review of the Literature." OHIOMHAS requested that the consultant prepare a report (rather than a plan) that addressed cultural competency in three SPF areas: needs assessment, capacity development, and evaluation.

2010 Cultural Competence in Substance Abuse Prevention Services Report - This report is submitted as requested, by Edwin J. Nichols, Ph.D., Consultant in compliance with the Cultural Competence State Plan Organizing Framework, utilizing three steps of the Strategic Prevention Framework (SPF); 1) Needs Assessment, 2) Capacity Development and 3) Evaluation.

NEEDS ASSESSMENT is a systematic exploration of present functions in an organization versus the desired functions.

Strengths - The desired functions of AOD are subsumed in the Ohio Cultural Competence definition:

“Cultural Competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, language and traditions of all Ohioans in order to provide effective programs and services.”

- The Annual Report of 2007 and the combined Annual Report of 2008 and 2009 mention cultural competence as a desired goal.
- The Office of Workforce Development and Cultural Competency has had training and conference workshops on cultural competence. Within the last year, Dr. James White conducted cultural competence training for all prevention staff. In March 2010, Dr. Edwin Nichols presented the *Philosophical Aspects of Cultural Difference* as an elaboration of cultural competence, specific to substance abuse prevention services.

Gaps -A benchmark for the state of the art in cultural competence substance abuse prevention services is needed.

Problem 1: There is no established baseline from which to measure program progress or the lack of it. A state curriculum for training in cultural competence for substance abuse prevention services is needed. Without the uniformity of a statewide curriculum on cultural competence, there will be no standard from which to measure accountability. A cost-effective dissemination process for training courses in cultural competence prevention throughout the State is needed.

Problem 2: There is no standardization of materials to be learned by which to measure accountability, because all state agencies do not have had an equal access to training. An action plan is needed to address the following: who has responsibility for tasks, what tasks will be performed and within what time frame to implement the cultural competence prevention goals and objectives of the Strategic Prevention Framework to assure sustainability.

Problem 3: Without an action plan, programs fail to come to fruition and previous efforts are lost and/or become obsolete. There is no sustainability when programs are lost.

Recommendations:

1. Arrange assessment and evaluation structures and instrumentation for implementation.
2. Utilize graduate students; e.g., from the Ohio State University, College of Public Health and the Division of Epidemiology by offering internships. In collaboration with university faculty, permit interns to utilize the studies and research work for their master's thesis or doctoral dissertation. A bonus is to have the research supervised by university faculty.

CAPACITY is the ability of a staff to problem-solve and meet the Department's mission, goals and objectives.

Strengths - The Ohio Office of Workforce Development and Cultural Competence staff has the ability to conceptualize programmatic constructs (process) to create a culturally competent state substance abuse prevention agenda. This agenda would reference the reality of Ohio's resources, policy development capability and gauge the capacity to impact state boards and providers through outreach.

The staff has the analytic ability to development content measurement and instrumentation for an assessment and evaluation of current efforts toward cultural competence in the state. This would establish a benchmark from which to reference progress. A simple questionnaire asking:

- a. How does your agency determine the needs of the community?
- b. What practices are in place to bridge the gap between the board, providers and the community in the decision making process?
- c. Does your board membership reflect the community that you serve? (Ethnic, racial, linguistic, deaf, GLBT community)
- d. How does your board reach the underrepresented and underserved of your community?

The staff has interagency contact with other departments to secure technical assistance for distance learning projects; e.g., televised course offerings on cultural competence specific to substance abuse prevention and distance learning for certification and continuing education credits.

Gaps - With the myriad of daily ongoing tasks, there would not be enough time to undertake a statewide agenda for cultural competence in substance abuse prevention.

Resolution 1: There needs to be a re-prioritization of tasks. A lack of knowledge of substance abuse prevention regarding cultural competence intervention models is not acceptable.

Resolution 2: Provide a trainer of trainers' sessions. Develop a research evaluation design including multivariate statistical analysis. Quantification is necessary for program evaluation.

Resolution 3: Recruit an Ohio State Epidemiology intern to assist with these efforts. The Office of Workforce Development and Cultural Competency staff members could have opportunities to make site visits throughout the State to determine a Best Practices policy specific to Ohio. Ohio State Interns from Public Health and Epidemiology would be most helpful.

EVALUATION is the ability to measure and quantify an output.

The Latin word *prevention* means to anticipate and hinder.

In substance abuse parlance, Prevention is a holistic and proactive approach to developing supportive communities through a series of strategies to empower individuals and systems to make healthy life choices across the life span. The State of Ohio TSIG Workgroup's definition for Cultural Competency is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, language and traditions of all Ohioans in order to provide effective programs and services. With these two definitions how did OHIOMHAS staff and Board personnel/ Providers propose addressing Cultural Competence in Substance Abuse Prevention Services?

Strengths - The staff, board personnel and providers have recognized that community needs be understood and solicited in agenda development and have understood the difference between cost-effective and cost-benefit in development and/or reduction of programs. For example, it may be cost-effective to eliminate the position of a bilingual staffer. What effect does this action have upon her/his community and its relationship to the center? Was this action cost-beneficial?

It is recognized that no single state agency represents the true benchmark for cultural competence in prevention. However, a collective/composite of an idealized State agency can be deduced and serve as a benchmark. It is also recognized that cultural competence in substance abuse prevention services cannot be accomplished without changes in policy and procedures at all levels. To that end the terms policy and procedure have been defined: Policy is a deliberate plan of action to direct decisions and achieve rational outcomes, which are culturally competent for substance abuse prevention services. Procedure is a series of culturally competent actions or operations that when implemented produce the desired policy outcomes for substance abuse prevention services. Ohio must acknowledge that without agency changes in policy and procedures, little progress can be made.

For example, the underserved are clients excluded from and/or with limited access to services. Culturally competent outreach procedures would help close that service gap. The underrepresented are communities that are excluded from the process of governance. Culturally competent board policy would address having on the Board representatives of diverse populations. Without such representation, there will be limited cultural competence in the functions of the agency.

There is demonstrated a vast reservoir of knowledge for problem solving in Ohio.

Gaps - There are three sets that must be addressed to assure accountability:

1. Training: If agencies are to demonstrate Culturally Competent Substance Abuse Prevention skills in a comprehensive manner, then staff must be trained to meet that expectation. Certification assures a collective of skilled individuals functioning from the same knowledge base.
2. Sustainability: Once trained and certified, skills must be kept current. Continuing Education Credits afford that opportunity.
3. Departmental accountability must be demonstrated through measurement; e.g., a benchmark, a baseline, a before and after.

Recommendation 1: Establish a baseline of knowledge about cultural competence in substance abuse prevention services from agencies, boards and providers by:

- Conducting Focus Groups
- Developing a questionnaire and test piloting it
- Conducting an online survey across the state
- Making a statistical evaluation – multivariate
- Using the executive summary to develop an action plan
- Developing a cultural competence curriculum for substance abuse prevention services
- Conducting statewide training and certification through distance learning.

Recommendation 2: Try to incorporate cultural competence skills into 3793:5-1-01 Prevention Standards – Certification Process. If certification for the state is not possible, consider it for provider agencies.

Evaluation - Ohio has developed a new, web-based system, Proving Ohio’s Prevention Success (POPS), to manage all prevention programmatic, budgeting, performance management and reporting requirements. The new system will fulfill all Block Grant Reporting requirements and will allow for performance management at both the outcome and process level. A Workgroup of users developed the system. The objectives of the new system are to provide the following.

- Establish a secure and centralized online grant and allocation application functionality for prevention that can be utilized by both authorized internal staff and community stakeholders.
- Automate funding to streamline the grant and allocation process and improve efficiency, accountability and service delivery.
- Promote prevention and stakeholder ability to monitor progress and performance.
- Support prevention compliance with state and federal reporting requirements.
- Position OHIO MHAS Division of Prevention Services for emerging health system transformation by adopting a continuous quality improvement grants management partnership that leverages our collective resources and extends our collective capacity.

The new system has each step of the SPF imbedded in various components. A logic model approach taking into account the link between need, target population, intervening variables, strategy selection and prevention intervention selection is being used to gather outcomes. Data will be synthesized using Dr. David Julian’s results continuum for categorizing and aggregating varied programmatic outcomes. Dr. Julian is Director of Community Planning and Evaluation at The Ohio State University Center for Special Populations.

The Niatx process improvement model will be used the process evaluation component of the system. OhioMHAS staffs have worked with Niatx staff over the last two years to modify the process for prevention as well as treatment services. A module of the new system will allow reporting of Niatx project results and learnings.

Priority 2: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents

The Department provides funding of the prevention service delivery system primarily through allocations to Boards and funding state-wide initiatives. The funding provided to prevention agencies through allocations to Boards supports the development and implementation of a comprehensive array of primary of prevention interventions programs to meet the needs of their communities. The Ohio Prevention Continuum of Care Taxonomy provides the guidelines for the delivery of this service array. Strategies implemented are based on the assessment of needs, resources and readiness conducted as part of the community planning process to ensure funded prevention interventions will address community risk and protective factors that either complicate or mitigate substance use and other risk behaviors.

In addition to board prevention allocations, OhioMHAS has a variety of initiatives which form the foundation of the state-level prevention infrastructure and support prevention across the lifespan. Summaries of these initiatives are provided in this section.

Youth Initiatives

Good Behavior Game - Ohio is supporting the Good Behavior Game (GBG) because it is unique in that it has shown both proximal and distal outcomes regarding student behavior and mental illness and substance abuse. The research suggests that durable results lasting well into young adulthood can be achieved with only one year of exposure to the GBG in first-grade. The GBG was invented by a 4th grade teacher, Muriel Saunders, from Baldwin, KS in 1967, and the first publication of impact on student behavior appeared in 1969 by researchers Harriet Barrish, Muriel Saunders and Montrose Wolf from the University of Kansas.

GBG has been broadly embraced by teachers in Ohio due to more and more children coming to school with problem behaviors and difficulty with self-regulation. Self-regulation of attention is a predictive meta-skill that predicts standardized achievement test scores and school success. GBG used during normal instruction gives teachers a tool to cultivate this essential skill. Ohio communities are using GBG both with and without coaching. The training, coaching and materials cover all sorts strategies to make the Game create more effective, how to increase PAX when not playing the Game, and what to do with children who are not responsive or have special needs. The "kernels" introduced to participants have been used with a wide range of ethnic groups and diverse populations. The brain science behind the success of the "kernels" is universally applicable. The Game can be easily combined with other curricula, other prevention strategies and initiatives such as Positive Behavioral Support (PBS or PBIS), Response to Intervention (RTI), PeaceBuilders, PATHS, or Second Step to name a few.

The Department supports the implementation of this program and has worked closely with Dr. Dennis Embry to provide opportunities for schools, community members, prevention providers and other stakeholders to learn about GBG. The Mental Health and Recovery Board of Clark/Greene/Madison county has embraced Dr. Embry's work and they have worked extensively with Wright State University to provide training and technical assistance to teachers who are implementing or interested in implementing the program and with local juvenile justice

and court systems to implement evidence-based kernels into the practice of their systems. The Mental Health and Recovery Boards of Clark/Greene/Madison; Licking/Knox Counties; Allen, Auglaize & Hardin Counties; Montgomery, Putnam County; Wood County; and Cuyahoga County are also implementing GBG in several of the schools in their districts.

School-Based Prevention Education - The Department will continue to support evidence-based prevention education targeted to selective and indicated populations through community prevention allocation funds which local Boards administer through the Ohio MHAS Community Plan process.

During the 2012 National Substance Abuse Prevention Month, Ohio's authorities on healthy, drug free lifestyles created and released to the web a toolkit titled, *Prevention Works! A Guide for Red Ribbon throughout the Year*, that is full of practical and easy-to-use messages and tools to help teachers deliver prevention-focused information to their students. The annual Red Ribbon Week, Oct. 23-31, 2012, is a great time for educators and school administrators to talk to young people about the risks of underage drinking, illicit drug use and prescription drug abuse, and to emphasize the importance of making healthy decisions.

The Department partnered with the Ohio Department of Education (ODE) and Drug Free Action Alliance to develop this toolkit and activity guide (<https://www.drugfreeactionalliance.org/red-ribbon-history>.) to bring drug free messages into the classroom. The theme for Red Ribbon Week 2012 was "We are the Majority," which drives home the fact with students that a majority of their peers are alcohol and drug free. A Red Ribbon Week video featuring Ohio Governor John Kasich, Director Orman Hall, and Ohio National Guard Sargent James Phipps, was distributed along with the toolkit promoting "We Are the MAJORITY!" "We Are the MAJORITY" PSAs were also launched as part of National Substance Abuse Prevention Month. The Department plans to continue and expand these efforts in 2014.

Ohio Youth-Led Prevention Network (OYLPN) - Promoting meaningful youth involvement in community prevention efforts is a sound investment in wellness for Ohio. Ohio has a proud history as the birthplace of two of the country's longest-standing and most-widespread youth-led prevention program: Teen Institute and Youth to Youth. These programs led to the development of the OYLPN. Youth-Led Prevention is based on the prevention theories of Social Emotional Learning, Resiliency, and Developmental Assets. These theories, in addition to evidence-based prevention strategies including education, alternative activities, environmental and community-based process, provide a strong foundation toward supporting Youth Led Prevention.

The Ohio Youth-Led Prevention Network (OYLPN) consists of youth-led prevention providers and youth throughout the state who are committed to the cornerstones of youth-led prevention which are peer prevention, positive youth development and community service. The OYLPN fosters partnerships and collaborations among these youth-led prevention programs throughout Ohio. The OYLPN consists of an Adult Advisory Council and a Youth Council, which is the driving force behind the prevention initiatives and efforts set by the network to enhance youth-led prevention in Ohio. Funds provided to Boards foster partnerships that empower youth to participate in community-based processes promoting the health and safety of individuals and

communities. Funds are provided to the Drug-Free Action Alliance to conduct statewide initiatives and coordinate the network of local Youth-Led Prevention groups.

Through a strategic planning process in 2012, the Youth Council (YC) developed a statewide social norming campaign *We Are the Drug-Free MAJORITY* that kicked off with a rally at the Ohio Statehouse in May 2012 where more than 600 youth came together to spark a drug-free youth movement to maximize the power of positive peer influence. The rally was to kickoff Ohio's Substance Abuse Awareness Month, as well as the statewide social norming campaign. The YC sees the rally as an annual event that will be a celebration of the successes throughout the year. The second annual event was held on May 2, 2013, and participation more than doubled to over 1,000 youth at the statehouse with a satellite event held in northeast Ohio with more than 600 youth participating. The OYLPN YC is looking forward to continuing to expand the participation in this celebration event and have more satellite events across the state next year.

The YC also wanted to encourage, inspire, and promote this healthy lifestyle choice for all teens as the various youth-led groups took the message back to their home communities. Over the years, the majority of teens who are drug-free have become a silent majority, allowing the minority to set the "norm." Social norms are people's beliefs about the attitudes and behaviors that are normal, acceptable or expected in a particular social context. Building awareness that most youth do not use substances, communicates healthy expectations about alcohol and other drug-related behaviors. According to the 2011 Youth Risk Behavior Survey, the majority of Ohio adolescents do not use alcohol and other drugs. For example, 62% of teens did not drink alcohol and 76.4% did not use marijuana in the 30 days prior to the survey.

In order to take youth led prevention to the next level in Ohio, the decision was made to assist the AC in developing a Youth-Led Prevention Theory of Change. A theory of change is a helpful tool for developing solutions to complex social problems and would explain how a group of early and intermediate accomplishments sets the stage for producing long-range results. By developing this theory of change, it became apparent that OYLPN impacted more than just substance abuse. These programs were also implementing mental health promotion and wellness strategies. It was clear to those involved that youth-led prevention takes a behavioral health approach to building resiliency and increasing protective factors in the youth and young adults of Ohio. Having a broad focus for interventions that aim to prevent substance abuse and/or other problem behaviors has been found to be more effective than short-term educational strategies. Youth-led prevention programs take a more contextual approach and focus on truly building overall social competence which leads to greater success.

Youth-Led Prevention gives youth and young adults significant opportunities to develop and practice appropriate social emotional skills and serve as bases from which to promote and reinforce social emotional learning. By taking a broad contextual approach and truly focusing on building adolescents overall social competence leads to the empowerment of youth and young adults allowing them to become compassionate, productive, nonviolent, ethical and contributing members of society. When youth and young adults are empowered to take action to improve their own contexts, this also improves the contexts for their peers. Youth-led prevention programs must integrate service, leadership and engagement into all types of programs and settings. This youth engagement and leaderships should become normalized to the youth and not

occasional add-on, recognizing that the cumulative impact of these programs overtime and cross contexts of effective youth engagement.

Along with the completion of the theory of change, OYLPN is working with Ohio University School of Public Health to develop an evaluation tool for the field to utilize so that short-term program outcomes can be measured and collected. Training and technical assistance will be provided to the field once the theory of change and evaluation tools are finalized to ensure that all youth-led prevention providers are providing effective prevention services that not only impact the youth involved but also their communities. As part of the year two strategic planning, workforce development has been identified as a need for Ohio's youth led prevention service providers. The YC and AC developed and implemented five regional trainings around the state targeting providers as well as youth. The trainings, focused on the foundation and theories of youth led prevention and the theory of change were very well received in the communities.

To further promote the message, "*We Are the MAJORITY!*" and encompass prevention and mental health promotion, the OYLPN launched *Actively Caring for People* developed by Virginia Tech and coined by Dr. E. Scott Geller. It refers to any behavior going above and beyond the call of duty for others. Actively Caring for People embodies a large-scale movement that aims to establish a more compassionate, interdependent, and empathic culture within schools, businesses, organizations, and throughout entire communities. By encouraging people to actively care, individuals are inspired to perform intentional acts of kindness as part of their daily routine. The positive exchanges between people, resulting from actively-caring behaviors and its supportive recognition has a mutually reinforcing effect and leads to an actively-caring culture.

Marijuana Initiative - With marijuana legalization occurring across the country, Ohio plans to target many of its prevention initiatives in the coming two years on youth at risk for using or abuse. Marijuana is the most frequently abused drug among Ohio's adolescents. Within Ohio, the marijuana consumption rates among young adults between the ages of 18 and 25 remained above that of other ages groups. Marijuana use has been on the rise in 18 to 25 year olds since 2007-2008, and current marijuana use is more prevalent than with young adolescents or adults. Between state fiscal years 2008 and 2011, almost 21,000 adolescents (73% of all adolescents receiving publically funded treatment services) reported marijuana as a primary, secondary, tertiary or quaternary drug of choice. Over half of all admissions to publically funded treatment were associated with marijuana, and the percentage of adolescents reporting this substance as a drug of choice rose from 70 percent in 2008 to 77 percent in 2011. Research shows that the initiation of marijuana use at young ages, especially in pre-adolescence, has been linked to more intense and problematic levels of use of marijuana in adolescent and in adulthood, this also includes physical health problems.

With the limited amount of available treatment resources, there is a need in Ohio for increased prevention efforts among youth and young adults addressing marijuana use. To kick-start this effort, a series of three Regional Summit professional learning experiences sponsored by Drug Free Action Alliance, the Butler County Coalition for Healthy, Safe and Drug-Free Communities, the Community Awareness and Prevention Association (CAPA), and the Alcohol and Drug Abuse Prevention Association of Ohio (ADAPAO) were provided in 2013 and others are being planned for 2014. Featured speakers were Dr. Kevin Sabet, Director of Drug Policy

Institute and Assistant Professor, University of Florida College of Medicine, Division of Addiction Medicine, Department of Psychiatry and Sue Thau, Public Policy Consultant, from Community Anti-Drug Coalitions of America (CADCA). Dr. Sabet was President Obama's Senior Drug Policy Advisor. Dr. Sabet's areas of specialization include evidence-based drug prevention, treatment, and law enforcement (both domestic and international), as well as the impacts of drug legalization and "medical" marijuana. Topics addressed at the summits were 1) Marijuana and the Workplace, 2) Law Enforcement and Medicinal Marijuana; and 3) Organizational Collaboration: Creating a Unified Message.

Underage Drinking Initiatives - "Parents Who Host, Lose The Most: Don't be a party to teenage drinking" - Another initiative through Drug-Free Action Alliance that supports the commitment to the reduction of childhood/underage drinking is the public awareness campaign, "Parents Who Host, Lose The Most: Don't be a Party to Teenage Drinking." This program was launched in the spring of 2000. The campaign objectives are to educate parents about the health and safety risks of serving alcohol at teen house parties and to increase awareness of and compliance with the Ohio Underage Drinking Laws. The campaign is an environmental strategy to change parents' perceptions that drinking alcohol is a "rite of passage." The campaign takes place on a local and a statewide level and runs April through early June during prom and graduation season. Since the campaign began, it has been requested for replication in 50 states, Puerto Rico, the Virgin Islands, Guam and Canada. To facilitate local support for the campaign, public awareness kits are disseminated throughout Ohio to local communities. The kits contain a poster, fact sheet, fact card, parent tips, sample press materials, and other information. The intent of the kits is to provide communities with tools that are factual, reproducible, and free.

Trace Back Program - An ongoing program, called the Trace Back Program, is designed to deter drivers before they become intoxicated. The program has been in use for some time, but now, authorities can immediately request help from the Ohio Investigative Unit. "Our resources are brought in to basically help trace the source of that alcohol," said Eric Wolf of the Ohio Investigative Unit. "The effort will not only help reduce that number but also will hold the permit holders accountable for their actions." Beginning in 2013, state patrol officials will be able to immediately request assistance from the Ohio Investigative Unit to find where a suspected drunken-driver consumed the alcohol and potentially file charges against a bar or liquor establishment.

Ohio College Initiative - OHIOMHAS supports The Ohio College Initiative to Reduce High Risk Drinking which began in 1996, and brings together more than 45 college and universities in the effort. OHIOMHAS provides funding to Drug-Free Action Alliance, a private, non-profit agency committed to the reduction of underage drinking, to coordinate this state-wide initiative. From its beginning, the focus of the Ohio College Initiative has been on forming campus and community coalitions that work to change the alcohol-related culture surrounding college students. To achieve cultural change, campuses initiate a coordinated effort to alter the physical, social, economic and legal environment (including that dimension governed by informal rules in the form of customs, traditions and norms) to influence the decisions that students make about alcohol use. There are currently 45 member campuses.

OHIOMHAS provides additional funds to ten colleges and universities to implement a prevention and early intervention program to students under the age of 21, with special emphasis on addressing underage access and increasing awareness of the problem of high risk drinking.

Higher Education Network - Colleges and universities receive funding to implement prevention and early intervention programs to college students under the age of 21, with special emphasis on addressing underage access and increasing awareness of the problem of high risk drinking. Higher Education funds also provide an opportunity for universities to form coalitions that work to change the alcohol-related culture surrounding college students and benefit the campus and surrounding community residents. The Department also provides funding to Drug Free Action Alliance to support The Ohio College Initiative to Reduce High Risk Drinking which began in 1996. Training and technical assistance is also provided to colleges and universities to address issues of high risk drinking that focus on utilizing environmental strategies.

Drug Free Action Alliance has developed a program to help colleges educate their students on the responsibilities of social hosting. Based on the nationally-recognized, evidence based program, Parents Who Host, Lose the Most: Don't be a party to teenage drinking, BUZZKILL: Serve Under 21 and the Party's Over is an eye-catching social host campaign that gives colleges the tools to let students understand the consequences when hosting parties with alcohol and underage people attend. A universal prevention program kit is available to provide information to assist communities with implementation planning, ready-to-use reproducible materials, print-ready artwork and materials that can easily be customized.

Initiatives for Families and At-Risk Populations

Family Engagement - Ohio is in the midst of a public health crisis due to the dramatic increase in availability of opiate-based prescription painkiller medications and the abuse of these drugs for nonmedical purposes. A dramatic increase in prescribing over the past decade has brought these dangerous medications into the homes of the majority of Ohioans, averaging 67 pills for every man, woman, and child in the state. As a result, addiction to prescription pain medications and their chemical lookalike, heroin, is on the rise. Drug overdoses are also at an all-time high, averaging four deaths a day in Ohio with nearly 45 percent of them attributable to prescription drugs. Prescription opioids (pain medications) are the drugs most often responsible for the rise in fatal overdoses in Ohio. Admissions for non-heroin opioid substance abuse treatment are on the rise. In the past decade, admissions have increased more than 300 percent in Ohio.

These overdoses have devastated Ohio families. Many family members personally impacted by the consequences of substance abuse have found a collective voice to issue a public outcry and gain solace from grief in their community. The Family Engagement initiative supports individuals and families affected by addiction through building the capacity of local family engagement groups to bridge the GAP for their families and communities.

- Grief: Aid in the development of family support groups for individuals and families grieving a loved one who died as a result of addiction.

- **Advocacy:** Provide training and technical assistance to build community capacity for participating in community-based processes to mobilize their communities to implement policy changes that can change environmental conditions that encourage drug use.
- **Prevention:** Provide training and connection to local resources to promote community prevention services, especially to children and adolescents.

The Department, the Drug Free Action Alliance, the Ohio Attorney General's Office, the Ohio Association of County Behavioral Health Authorities and the Ohio Department of Health teamed up to bring together experts in all areas of Bridging the G.A.P. (moving from Grief to taking Action for Prevention) regarding prescription opiate abuse for a night of celebration followed by a day of education in fall of 2012. The two-day event began with an evening tribute concert by singer/songwriter Edwina Hayes, where people from all over Ohio gathered to honor loved ones lost to prescription drug abuse, remember those currently struggling with addiction, and celebrate the great strides being made in Ohio communities to combat the issue. The Bridging the G.A.P. conference that took place the following day was designed to equip Family Engagement groups with effective strategies for bridging the G.A.P. between Grief and taking Action for Prevention, as well as bridging the G.A.P. between the prevention field and those affected by substance abuse. The workshops addressed the many unique needs and dynamics of family engagement advocacy groups. Workshops included topics such as prevention 101, building community buy-in, building financial support, engaging youth in prevention, loss and grief that are complicated by addiction, and environmental prevention strategies. Many of these families have become powerful voices for prevention by turning their pain into positive action for community change.

DFAA will continue to build capacity of the more than 40 family engagement groups that are part of the GAP Network in SFY 2014. The Department supports DFAA's plan to formalize training in the three focus areas to further assist family members in mobilizing their communities for change.

Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOPs)

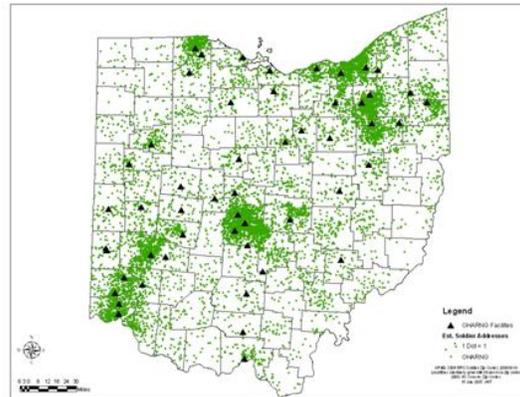
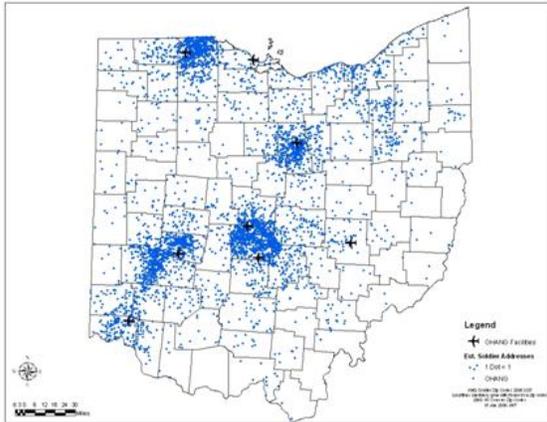
Prevention - The primary purpose of the UMADAOP is to provide culturally appropriate prevention services to African-American and Hispanic/Latino American communities in Ohio. All programming activities are structured to provide a foundation to build and rebuild positive, violence and substance free lifestyles, families and communities. This is achieved by increasing protective factors within the community and family domains. UMADAOP provides programming with the belief that substance abuse is best prevented and treated when the cultural dynamics of a group are addressed and included in the process of prevention, treatment recovery and education. Chemical dependency is viewed as an illness of the total person, which has physiological, psychological, social-cultural, and spiritual components that require a holistic approach.

The UMADAOPs are located in Akron, Cincinnati, Cleveland, Cleveland Hispanic, Columbus, Dayton, Lima, Lorain, Mansfield, Toledo, Warren, and Youngstown. Since their inception they have been a vital force in meeting the substance abuse education, prevention and treatment needs of African and Hispanic/Latino Americans throughout the state of Ohio.

Military -The Department has a long history of working with the Ohio National Guard (ONG). ONG embeds counter-drug personnel with the Bureau of Prevention to support strong collaborative efforts.

The focus of this work the past year and upcoming year will be to build capacity building and sustainability in community coalitions by hosting National Guard Kaizen Events and to lead the Department's efforts in developing criteria and a process for designating coalitions as "Ohio Coalitions of Excellence." The Kaizen Event is designed to assist community-based coalitions in understanding how well they are adhering to the principles of the Strategic Prevention Framework through a series of questions, facilitated by a National Guardsman. With the Kaizen Event comes the opportunity for coaching and mentoring to help improve overall processes that will lead to coalition excellence.

Also, in SFY 2014, to further our partnership with the ONG we will work with the Ohio 4-H Operation Military Kids (OMK) project to support resiliency in military families and children in Ohio. OMK is a national initiative involving 49 states and the District of Columbia with high levels of National Guard and Reserve deployment. OMK is a partnership of Army Child & Youth Services, the USDA, National and Ohio 4-H educators. Programs are designed for military youth to help them find positive ways to cope with the stress of their parents' deployment. These efforts align with the Ohio Youth Led Prevention Network initiative, and plans are to facilitate the development of youth-led prevention groups specifically for OMK youth. National Guard and Reserve service members live throughout Ohio with some counties having a higher concentration of families than others. Because these families are spread throughout the state, they do not have the support systems that are typically available to active duty military families who live on or near military installations. From the most recent numbers provided by the Defense Manpower Data Center (2009), the total number of military youth in Ohio from all branches and components is at 34,060. The maps below show the location of Army and Air National Guard and Army Reserve service members in Ohio. Map 1 combines Army National Guard (OHARNG), Ohio Air National Guard (OHANG) and Army Reserves (USAR). Map 2 is the Army National Guard and Map 3 is the Air National Guard. Note that the scale of the first map (1 dot = 5 service members) is different from the other two (where 1 dot = 1 service member). In all, there are approximately 18,000 National Guard (Army and Air) and 4,500 Army Reserve service members in Ohio. This is not the entire picture of military families, however, because it does not account for all the branches of the service. The dots on the map represent the service member, some of whom are single, some of whom are married but do not have children, and some of whom have children. All of them, however, are part of families and extended families. The Department will use this data to target areas for youth-led network group expansion.



Source: Department of Defense, August 2009

Priority 3: Empower pregnant women and women of child-bearing age to engage in healthy life choices

Fetal Alcohol Spectrum Disorders (FASD) Initiative - Since 2004, OhioMHAS has served as the key coordinating agency for Ohio's FASD Statewide Committee, a partnership that also includes eight other state agencies, three universities, providers and parents. The Committee has worked to develop an integrated system for addressing the prevention and identification of fetal alcohol spectrum disorders (FASD). The strategic plan, developed and implemented by the committee members, addresses the use of existing systems to educate the public and enhance the identification and support of individuals and families dealing with FASD. Ohio's focus maximizes and augments the many resources available in state agencies, genetics centers, local health departments and professional associations including those that influence the practice of obstetrics-gynecology, pediatrics and general practice physicians.

The initiative's primary goals include: reducing alcohol-exposed pregnancies, increasing awareness of and access to services for those affected by FASD, forging lasting state/national partnerships and improving diagnostic and screening services. The Committee made significant strides toward the latter goal by providing a series of regional, skill-building Screening and Diagnostic trainings. In total, more than 100 Ohio physicians, nurses, behavioral health clinicians and other allied health professionals learned how to accurately screen and/ or diagnose on the FASD spectrum, which will dramatically improve outcomes for Ohioans affected by FASD.

The project implemented an Alcohol Screening Brief Intervention (ASBI) process in Ohio WIC. This initiative will allow for the screening of all WIC pregnant women for alcohol use, provide brief interventions to all who screen positive, follow those receiving brief interventions during pregnancy and refer them to treatment services. The goal is to educate pregnant women about the dangers of drinking alcohol while pregnant and in turn positively influence their decision about reducing or completely ceasing drinking. Since September 2008, Ohio Montgomery County WIC program has practiced the ASBI process. Results indicate that of the five percent of the

pregnant women who screened positive, 97% abstain from further alcohol use after an initial brief intervention and 99% after two brief interventions.

Ohio WIC is planning to print 3,500 ASBI workbooks and 600 counselor guides. The workbooks will be used by participants and counselors during brief interventions to discuss the participants' alcohol use. It is estimated that 3,500 workbooks will cover the projected 5% of Ohio WIC pregnant women who need a brief intervention. The counselor guides will help prepare the WIC health professionals to deliver a brief alcohol intervention using the workbook. Furthermore, Ohio WIC plans to design and develop an ASBI training video to train approximately 600 WIC health professionals statewide. Ohio also plans to make 59,500 copies of the ASBI screening form and 3,500 copies of the ASBI follow-up form and process sheet to screen and record the alcohol use patterns, progress, outcomes and demographics of WIC pregnant women over a 12 month period.

Neonatal Abstinence Syndrome Initiative - Drug abuse during pregnancy is occurring at an alarming rate. Nationally, an estimated 109,000 pregnant women (4.4%) between the ages of 15 and 44 used illicit drugs in 2009-2010⁴, resulting in devastating consequences to the health and wellness of infants. An estimated 60 percent of infants exposed to drugs in utero are diagnosed with Neonatal Withdrawal Syndrome (NWS⁵). Symptoms typically present themselves within 48-96 hours of birth, but may occur up to two weeks later. Manifestations of NWS vary depending on the specific drug(s) used by the mother, frequency of use, dosage and the infant's ability to metabolize and excrete the drug(s)⁶. Infants born with NWS are at risk for a variety of conditions, including pre-term birth, low birth weight, tremors, irritability, seizures, vomiting and fever or unstable temperature.⁷ Data from the Ohio Hospital Association (OHA)⁸ can speak to the impact of NWS on Ohio's health system. From 2007 to 2011, hospital visits for infants diagnosed with NWS rose every year from 443 to 1,649.

In 2011, the average length of stay for infants with NWS was 13.0 days compared to 3.2 days for all infants resulting in substantially higher hospital costs for infants with NWS. Neonatal withdrawal syndrome cannot be broken down by individual drug; however, other ICD-9 codes may prove useful when examining drug-specific trends. Diagnostic codes in the 760.7 series point toward specific noxious influences affecting the fetus or infant via placenta or breast milk⁹. Chart 2 compares two different diagnoses for fetuses and infants, including 760.72 (narcotics affecting fetuses or infants) and 760.75 (cocaine affecting fetuses or infants). From 2007 to 2010, the diagnosis associated with cocaine decreased (-60.26%) while the diagnosis associated with narcotics increased (62.42%).

⁴ Substance Abuse and Mental Health Services Administration (2012). *Results from the 2010 National Survey on Drug Use and Health: Mental Health Findings*, NSDUH Series H-42, HHS Publication No. (SMA) 11-4667. Rockville, MD: Substance Abuse and Mental Health Services Administration.

⁵ Also known as Neonatal Abstinence Syndrome (ICD-9 779.5); Infants diagnosed with Fetal Alcohol Spectrum Disorder (ICD-9 760.71) are excluded from this diagnosis.

⁶ Hamdan, A.H., MacGilvray, S.S., Windle, M.L., Carter, Wagner, C.L. & Rosenkrantz, T. (April, 2012). Neonatal Abstinence Syndrome. Retrieved from <http://emedicine.medscape.com/article/978763-overview#a0104>

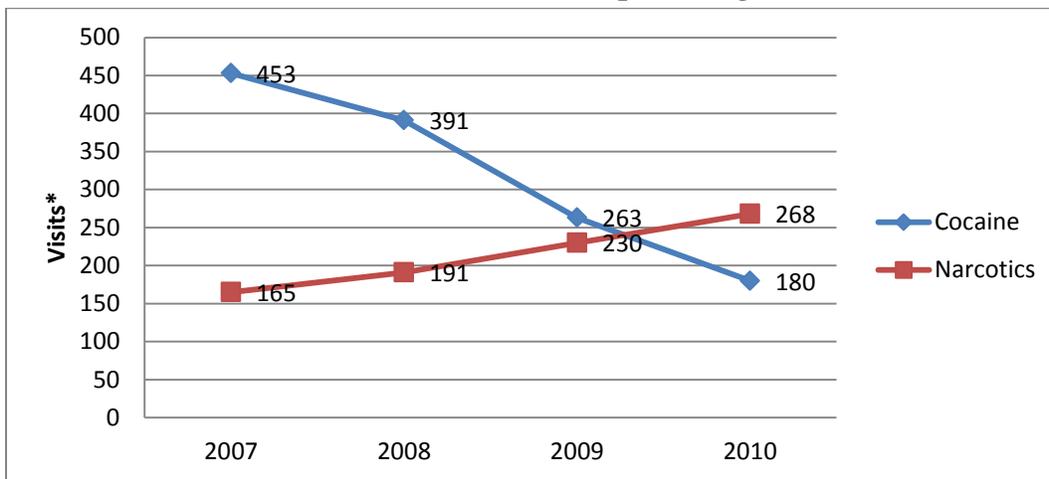
⁷ Substance Abuse and Mental Health Services Administration (2012). Glossary. Retrieved from <http://www.fasdcenter.samhsa.gov/educationTraining/courses/FASDTheCourse/misc/glossary.cfm#N>

⁸ Data comes from the OHA Statewide Clinical and Financial Database. OHA is a voluntary organization made up of 165 hospitals and 16 health systems in Ohio.

⁹ Physicians and other practitioners may or may not use this code with 779.5, so this group of codes as well as others only captures some of the fetuses and infants adversely impacted by chemicals.

The Ohio Substance Abuse Monitoring (OSAM) Network has reported on NWS information through its eight regional reports. Between 2007 and 2010, the Columbus region was impacted the most by infants with these diagnoses (639 cases), followed by the Cleveland (468 cases) and Cincinnati (453 cases) regions. The most prevalent diagnosis during this period was cocaine-related (1,287 cases), but the narcotics-related diagnosis was not far behind (854 cases). The most prevalent diagnosis across all regions was for the cocaine-related diagnosis, except for the Athens and Cincinnati regions, where the narcotics-related diagnosis was more prevalent. The number of infants affected by narcotics in their system stays relatively even for most OSAM regions between 2007 and 2010. However, marked increases occur in the Cleveland (205.56%), Cincinnati (148.28%) and Columbus (56.52%) regions. In contrast, infants diagnosed affected by cocaine in their system decrease for every region. The most prominent decreases were for the Athens (-70.00), Columbus (-67.39%) and Cleveland (-65.42%) regions.

Chart 1: Number of infants with cocaine or opiate diagnoses¹⁰



*Does not represent unique individuals

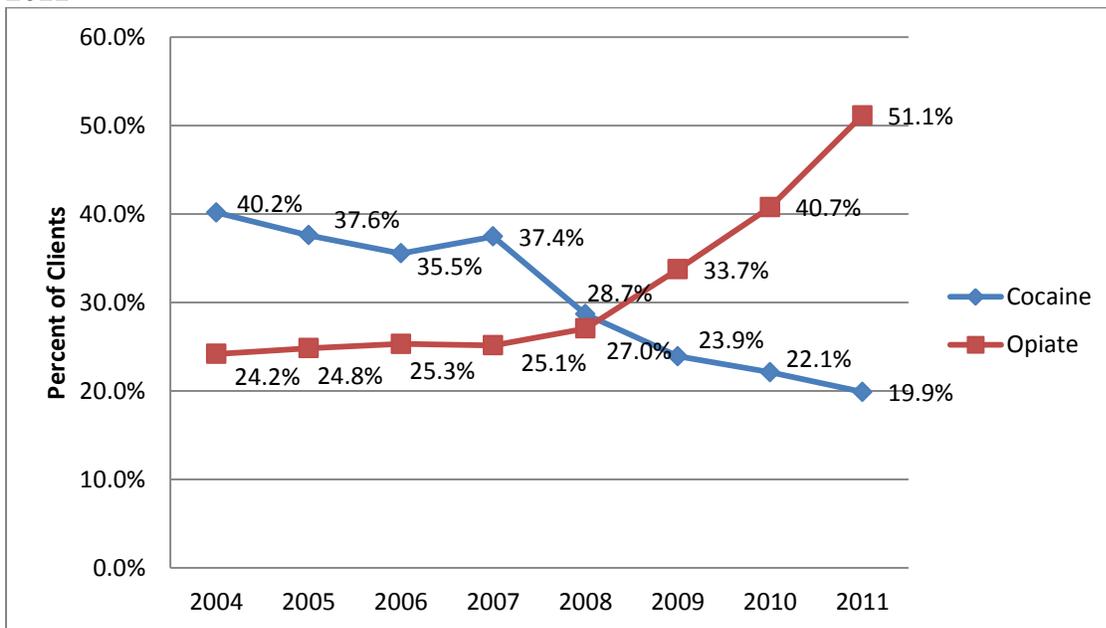
Data from the Multi-Agency Community Services Information System (MACSIS) show the increasing prevalence of alcohol and drug use among pregnant women. From 2004 to 2011, the number of pregnant women with a primary, secondary or tertiary diagnosis of opiate rose from 513 to 845, representing a 67.72 percent increase. Opiate abuse has increased dramatically among pregnant women compared to other drugs classes, rising from 24.2 percent of diagnoses in 2004 to 51.5 percent of diagnoses in 2011 (Chart 2). At the same time opiate use dramatically increased among pregnant women, cocaine use dramatically decreased. From 2004 to 2011, primary, secondary, or tertiary cocaine diagnoses among pregnant women decreased, falling from 40.2 percent to 19.9 percent. The trend in cocaine and opiate diagnoses for pregnant mothers mirrors the trend for these diagnoses in children in Chart 1. However, the shift from cocaine to opiates as the most common diagnosis among NWS infants occurred in 2009, nearly a year after the shift among pregnant women. One reason for this lag time may be due to the typical length of gestation (being around nine months) resulting in the number of infants born coming roughly a year after the shift in drug use among pregnant women.

¹⁰ Data is from OHA; cases are from fetuses and infants with primary or secondary diagnosis and do not represent unique individuals

The Department is committed to tackling alcohol and drug abuse among pregnant women. Pregnant women entering into treatment in a publicly funded treatment facility are given priority for care due to SAMHSA Block Grant requirements and ODADAS rules. To help ensure priority treatment, Ohio has numerous grant-funded programs comprising a network of gender specific services for women including 45 intensive outpatient programs, 26 outpatient programs and 34 residential programs with 803 beds for women. All grant funded women’s programs are required to provide or collaborate to obtain a developmental assessment of the child entering the program with their mothers and receive appropriate therapeutic interventions. By treating the mother and child, Ohio can benefit in terms of cost reductions that result from reducing reliance on foster care and other related public services.

Also, the Governor’s Cabinet Opiate Action Team is prioritizing prevention of Neonatal Abstinence Syndrome in SFY 2014 with the infusion of the evidence-based Family Check-up program into healthcare training and practices.

Chart 2: Percent of pregnant clients with cocaine or opiate diagnoses, SFY 2004 to SFY 2011



Women’s Prevention - The Department supports eight prevention programs to specifically address the needs of women with a focus on women with children and their families. Prevention staff worked last year to create a learning community with these eight grantees so that information could be shared among funded programs and also throughout the state. Quarterly meetings bring the programs together to help close the gap between the number of women in need of prevention services and the availability of services designed to address the complex needs of women. Additional activities are planned for SFY 2014 to create statewide interest in the learning community.

Priority 4: Promote Wellness in Ohio's Workforce

Because addressing behavioral health concerns in the workplace provides an opportunity for producing significant health improvement for employees and measureable cost savings for employers, the Bureau of Worker's Compensation and the Departments of Mental Health and Alcohol and Drug Addiction Services are partnering to propose the following three-phase plan to prevent and address behavioral health challenges in Ohio's workforce.

The workforce is a prime but underserved arena for the prevention and identification of behavioral health concerns as most adults are in the workforce. According to the National Bureau of Labor Statistics, 62% of 25 to 65 year olds are in the workforce. Although half (50%) of 18 to 25 year olds have some college experience, 68% are employed, 37% full-time. Although individuals who are employed have lower rates of substance abuse, there is still a significant percentage of workers who have unaddressed behavioral health needs (SAMSHA, 2011).

Workplace injury is a traumatic event which initiates a cycle of physiological symptoms that increase the likelihood of mental health and addiction issues and may exacerbate and prolong recovery. Early intervention may decrease the development of complications associated with prolonged absence from work and increased costs.

BWC has a well-developed educational program available to employers to identify and address substance use and mental health issues. Many employers have health insurance to provide treatment for individuals with diagnosable behavioral health conditions. However, there is a lack of coordination of available community resources to promote overall workforce wellness and minimize time away from work.

A comprehensive approach which provides services from the entire continuum of care is valued by both the employer and employee. It is a balance between policy and the perception of workers. Employees with a problem are encouraged to get help and are provided the necessary resources, so the workplace environment continues to be supportive and productive.

- Mental health concerns are likely to result in higher loss of work productivity and absences than physical issues (NBGH, 2007 & SAMHSA, 2009)
- Research identified that at least 64% of individuals with physical concerns are likely to experience mental health concerns (Buist-Bouwman, deGraaf, Vollebergh & Ormel 2005, Gatchel, Polatin, & Mayer, 2002)
- CDC reports in a 3-month period, patients with depression miss an average of 4.8 workdays and suffer 11.5 days of reduced productivity

The goal of the initiative is to maintain an educated, innovative and reliable workforce.

The target audience includes the following.

- Employers participating in BWC
- Agencies providing services and supports to employers and employees
- Employees within the State of Ohio under BWC and military/veterans eligible to file worker compensation claims
- Managed Care Organizations, Third Party Administrators and Health Care Providers

The objective of the Wellness Phase is to invest in health and wellness to reduce absenteeism and injuries due to unaddressed behavioral health issues. A comprehensive workplace-based prevention plan can change the culture of a workplace, reduce risk, improve the overall health of employees and their families, help employees identify issues to reduce injury and loss of productivity all of which will have a ripple effect within the entire community. Three projects are planned for this phase:

Project 1: Integrate behavioral health into existing wellness screens and align resources to provide a comprehensive approach for employees

- Screening (Universal Population - No Risk)
 - Assess instruments and procedures
 - Adapt or develop instrument
 - BWC Wellness grantees and Drug-Free Safety Program administer to 80,000 employees
- Prevention Education (Selective Population - Low Risk)
 - On-line modules and other information
- Outreach (Indicated - Moderate Risk)
 - 2 outreach calls per individual by Master's-level licensed provider
- Brief Treatment (Intervention - High Risk)
 - Full Assessment and 3 Counseling Sessions
 - Referral for additional services if necessary

Project 2: Provide resources for employer education regarding behavioral health and community resources with a focus on military/veterans

- On-line modules (Mental Health/Addiction First Aid, Military/Veterans & Families, Traumatic Brain Injury, Community Resources/Support Services, etc.)
- Continued collaboration with Safety Congress
- Training of Trainers (80 Safety Councils)
- Tool Kit on access and utilization of resources

Project 3: Explore creating or increasing incentives for employers to adopt the behavioral health wellness approach

- Review policies
- Conduct cost analysis

The objective of the **Intervention Phase** is to reduce the risk for worker's compensation claims by early identification of sub-diagnostic conditions which create the potential for injury (e.g. distractions due to personal issues, depressed mood without major depression, substance use that does not meet the criteria for dependence, etc.). An effective workplace intervention model will work to identify and screen for behavioral health problems, provide brief intervention and institute procedures for assessment when indicated.

Project 1: Identify and share referral path for Drug-Free Workplace Program pre-employment positive screens

Project 2: Research and develop a right-size, affordable Employee Assistance Program (EAP) with capacity to assess potential behavioral health issues and provide trauma related interventions

Project 3: Integrate Behavioral Health Providers into the BWC network to better serve employers regarding case management, service scheduling and return to work plans

Treatment Services

OhioMHAS consolidated its priority populations for treatment services, and asked Boards to respond to them in the next Community Plans due in December 2013. These treatment priority populations are organized with the SAMHSA mandated populations first and the state selected priorities next. OhioMHAS has not yet ranked the state selected priorities as a new department. However, for priority populations receiving substance abuse treatment and mental health services, staff with expertise in both types of services drafted the material included in this Plan.

Treatment Priority Populations

SAPT Block Grant mandated populations are:

1. Persons who are intravenous/injection drug users (IDU)
2. Women who are pregnant and have a substance use disorder
3. Parents with substance abuse disorders who have dependent children
4. Individuals with tuberculosis and other communicable diseases

MH Block Grant mandated populations are:

5. Children with Serious Emotional Disturbances (SED)*
 6. Adults with Serious Mental Illness (SMI)*
- *Federal definitions broadly include almost all people in need of treatment.

SAPT and MH Block Grants mandated populations are:

7. Integration of behavioral health and primary care services
8. Recovery support services for individuals with mental or substance use disorders

Ohio's state-selected populations are:

9. Veterans
10. Individuals with disabilities

11. Individuals involved with the criminal justice system
12. The growing number of opiate addicted individuals in the state including illicit drugs such as heroin and non-medical use of prescription drugs
13. Homeless Persons and Persons with Mental Illness and/or Addiction in Need of Permanent Supportive Housing
14. Underserved Racial and Ethnic Minorities and LGBTQ Populations
15. Youth/Young Adults in Transition/Adolescents and Young Adults
16. Early childhood mental health (ages 0 – 6)

#1 Priority Population - Persons Who are Intravenous/Injection Drug Users (IDU)

The rise in heroin use and subsequent rise in injection drug use is a byproduct of the prescription drug epidemic that Ohio is experiencing. The January 2011 the Ohio Substance Abuse Monitoring (OSAM) Network report referred to prescription Opioids as “the gateway drug to heroin.” OSAM reports have consistently shown a link between prescription drug use and the user’s migration to heroin, which is less expensive than prescription narcotics, and is of high quality and readily available.

Opiate users and professionals report an alarming increase in Opiate use among young people (teens through early 20’s). The most common routes of administration are oral consumption and intranasal inhalation, with notable increases in intravenous injection recorded.” OhioMHAS works closely with the Ohio Department of Health to raise awareness through education and tracks trends through regional networks of epidemiologists. The departments have successfully worked with Ohio Governor John R. Kasich and the legislature to close “Pill Mills through the enactment of House Bill 93.” In Ohio, there were 327 fatal unintentional drug overdoses in 1999 growing to 1,765 annual deaths in 2011 of which a significant portion were related to prescription opiates and heroin. The Departments have also teamed up to disseminate Opiate prescribing guidelines for hospital emergency departments and acute care facilities. These actions are driving a decrease in the number of prescriptions written for Opiates. Another tool in the fight against overdose deaths is Project DAWN (Deaths Avoided with Naloxone). More Ohio programs are using Naloxone and Naltrexone to reduce deaths.

Ohio has 14 certified methadone programs and is working to expand the availability of medication assisted therapy, especially Suboxone. In conjunction with the federal government and with a grant from SAMHSA Ohio funded a pilot project to open a federally certified Opioid Treatment Program in Jackson County, the epicenter of Ohio’s Opiate epidemic. MHAS expects that by addressing Ohio’s opiate epidemic, the number of injection drug users will decrease in the state.

#2 Priority Population - Women Who are Pregnant and Have a Substance Use Disorder

In SFY 2013 the Department awarded and allocated \$10,950,895 in SAPT Block Grant funds and \$2,047,903 in state funds to support 77 programs that provide alcohol and other drug abuse treatment services to women of child bearing age, pregnant women, women with dependent

children, mature women, and women working toward family reunification. For SFY 2011, the Department allocated and awarded a total of \$11,724,691 in SAPT Block Grant funds and \$2,051,394 in state funds to support 83 programs for treatment and prevention/early intervention services to women throughout Ohio.

Certified treatment providers receiving funds will be required through SAPT Block Grant Assurances to provide and/or refer pregnant clients to prenatal care as well as offer childcare. Alcohol and other drug treatment services to women of childbearing age, pregnant women, women with dependent children, mature women, and young women continue to be provided as an SAPT Block Grant priority population.

Treatment and prevention services are available to all women in Ohio through a comprehensive statewide network of providers. Gender specific, culturally competent alcohol and other drug residential, outpatient and prevention programs are funded through this initiative. Funding for the gender specific programs meet federal Maintenance of Effort requirements. The intent of the network is to assist in responding to existing or emerging needs of alcohol and other drug addicted pregnant women and women with dependent children. The women's network provides a variety of programs to serve women as young as 14 and as mature as 70, insuring all women have access to programming that will address the disease and encourage recovery. The new Department along with the local Alcohol and Drug Addiction and Alcohol, Drug Addiction and Mental Health (ADAS/ADAMHS) Services Boards are working to close the gap between the number of women in need of services and the availability of services designed to address the complex needs of women. Although programming for pregnant women and women with dependent children is priority, Ohio developed this network to serve women across the life span.

**#3 Priority Population - Parents with Substance Use Disorders
Who Have Dependent Children**

Ohio Mental Health and Addiction Services (OhioMHAS), in cooperation with the Ohio Department of Job and Family Services (ODJFS) is required by the Family Reunification and Stabilization (FRS) legislation to develop a statewide plan to prioritize substance abuse services for families involved in the child welfare system. Family Reunification and Stabilization (FRS) is Ohio's response to the federal Adoption and Safe Families Act. The bill exceeded the federal standards by specifying that child abuse or neglect associated with parental substance abuse could be grounds for termination of custodial rights. FRS also emphasized the need to provide timely and appropriate treatment necessary to facilitate family reunification. Additionally, FRS included tasks such as improving accessibility and timeliness of alcohol and other drug services for the FRS populations. Realizing that substance abuse recovery is vital to family reunification and preservation, ODJFS and the former ODADAS have been working together to meet the multiple needs of children and families. In fact, ODADAS was nationally recognized by the Child Welfare League of America for progressively working to address the challenges of substance abuse problems among clients in the child welfare system.

#4 Priority Population - Individuals with Tuberculosis (TB) and Other Communicable Diseases

Ohio Department of Health data on tuberculosis (TB) cases in Ohio reveals that the disease occurs most in Metropolitan Counties. Data for 2012 reported 149 cases, which translated to 1.3 cases per 100,000 population. 61% of these TB cases occurred within Cuyahoga, Franklin, Hamilton, and Montgomery Counties. This represents a decrease from 2010 when 190 cases were reported.

Reducing the risk for communicable diseases including HIV/AIDS and TB for persons who have mental health or addiction is a particular challenge. Outreach to these individuals includes early intervention, prevention, treatment and recovery support services. HIV/AIDS Surveillance Program data for Ohio reveal a growing trend in persons living with HIV/AIDS. The rate per 100,000 population rose from 128.1 in 2006 to 155.4 by June 30, 2012. This poses additional challenge since behaviors associated with substance abuse, including intravenous drug use and increased sexual contact are among the significant factors in the spread of HIV infection. **Ohio is not a HIV designated state**; hence block grant dollars do not support HIV early intervention programs.

Despite the increase in IVDU the rate of Hepatitis C is decreasing. In 2003, the rate of reported Hepatitis C cases (past or present, non-acute) per 100,000 population rose from 39.5 cases per 100,000 to 91.4 in 2009. The rate then began an annual decline. As of 2012, the Hepatitis C rate had fallen to 32.19 cases per 100,000 population.

MHAS requires that all local funding and auditing Board's require written Assurances that agencies receiving SAPT Block Grant funds for operating a program of substance abuse treatment (A) *will, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services to each individual receiving treatment for such abuse; and (B) in the case of an individual in need of such treatment who is denied admission to a program on the basis of lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services* [Sec. 1924(a)(1)].

All certified addiction providers are required to have policies and procedures in place for referring or providing counseling and/or client education on exposure to, and the transmission of, tuberculosis, Hepatitis type B and C, and HIV disease for each client admitted to the program. On July 1, 2013 the two previously separate Department of Mental Health and Department of Alcohol and Drug Addiction consolidated into one department. The Administrative Codes of each department are being collapsed into one set of rules to simplify regulatory requirements.

Methadone maintenance programs are required to conduct TB screening and MHAS checks client files on-site annually to verify this activity is being conducted. If the TB test shows a positive result, MHAS verifies that a referral was made for medical treatment. MHAS also requires "counseling on preventing exposure to tuberculosis, hepatitis type B and C, and the transmission of human immunodeficiency virus (HIV) disease." Documentation indicating compliance for this requirement is also reviewed in the client chart.

MHAS requires that all outpatient clients receive education on exposure to, and the transmission of, tuberculosis, hepatitis type B and C, and HIV disease for each client admitted to the program. Programs may refer clients out to receive this from other expert sources and are required to maintain written evidence of compliance. MHAS provides training to providers on client record documentation and each provider is offered individual technical assistance as needed in order to demonstrate compliance with the rule. MHAS assists county Boards and provider agencies with technical assistance for referrals for or counseling for TB testing.

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

Ohio’s System of Care for Children and Youth - Ohio’s behavioral health system has a public health approach that builds upon established collaboration of state agencies and county ADAMH/CMH/ADAS Boards across the life span.

- At the state level, the newly formed Prevention and Wellness Office will provide leadership for mental health and addiction prevention and treatment services for children and youth with serious emotional disturbances. The Deputy Director of Prevention and Wellness also leads the prevention activities described earlier in this plan which are applicable to both mental health and addiction populations. This will provide additional opportunities and resources to plan prevention, early intervention and treatment services for children and youth.
- Statewide interagency coordination is led by Ohio Office of Health Transformation which coordinates the activities of the health and human services agencies, most of which serve children, youth and young adults in transition as well as adults. Ohio’s child serving health and human service agencies include: Aging (disabilities), OhioMHAS, Developmental Disabilities, Education, Health, Job and Family Services (child welfare, social services), Rehabilitation and Corrections, Youth Services, and Rehabilitation Services Commission.
- At the community level Boards plan, evaluate and fund local mental health and addiction services for children and youth in 50 local communities with state oversight from OhioMHAS. Boards contract with providers which provide mental health and/or addiction services, and coordinate services from other systems for individuals through Community Psychiatric Supportive Treatment (CPST) or Health Homes. Additionally, Boards collaborate with local child-serving systems through local Ohio Family and Children First (OFCF) organizations which coordinate services for multi-need children.

SAMSHA Required Elements of System of Care	
Services	Provided by:
Community mental health services	Local providers, ADAMHS/CMH Boards, OhioMHAS
Substance Abuse	Local providers, ADAMHS/ADAS Boards, OhioMHAS
Social Services & Employment Services	County Job & Family Services: Ohio Dept. of Job & Family Services; also Ohio Rehabilitation Services Commission
Education	Schools with oversight from Ohio Department of Education
Disabilities in Education Act (IDEA)	Local schools with technical assistance from Ohio Dept. of Education,
Juvenile Justice	County Juvenile Courts, Dept. of Youth Services
Medical & Dental	By referral for most children; for eligible Health Home enrollees – see Priority Population #7 - Integrated Care
Homeless	Ohio Dept. of Job & Family Services; County Job & Family Services
MH Crisis Services	State law requires Boards to assure local availability of providers
MH Crisis Provider Training	Providers and boards
Case Management	Providers certified by OhioMHAS to provide CPST (Community Psychiatric Supported Treatment) OR Health Home services
Community Mental Health Provider Training	Providers, Boards, OhioMHAS
Health Homes for SPMI	OhioMHAS, providers
Rural Providers	Providers, Boards, OhioMHAS

System of Care for Transition Age Youth – Project ENGAGE – OhioMHAS received a grant funded by SAMHSA from July 2013 – June 2017. ENGAGE will develop a system of care for Ohio’s transition-age-youth and young adults. The project will build on the partnerships of Ohio’s children’s system of care to address some of the policy and operational barriers to accessing services for youth with SED transitioning to the adult service system.

Continuum of Care for Children with SED - A continuum of care is provided for children with Serious Emotional Disorders (SED) or at-risk for SED is provided in a System of Care framework. Services include mental health assessment, crisis intervention, behavioral health counseling and therapy service, pharmacological management services, Community Psychiatric Supportive Treatment (CPST), or Partial Hospitalization. Residential services and foster care is available, and funded through County Job & Family Services. Intensive Home Based Treatment (team-based, time limited) home intervention is available in some areas. Services and their funding sources are included in the next four paragraphs.

Community Mental Health Services for All Ages - Eligible for Ohio Medicaid Reimbursement - 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:

- Mental Health Assessment
- Crisis Intervention
- Behavioral Health Counseling and Therapy Service
- Pharmacologic Management Service
- Community Psychiatric Supportive Treatment (CPST)
- Partial Hospitalization
- (NEW) Health Home Services for Persons with Serious and Persistent Mental Illness (includes children and adults) (Replaces CPST/case management services for some persons; see #7 Priority Population for more information.)

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 with CMS and Ohio Department of Medicaid on rules and/or state Medicaid plan amendments to allow Medicaid reimbursement for these services:

- Intensive Home based treatment (for children and youth)
- Family Therapy (for children and youth)
- Assertive Community Treatment (for transition-age youth/young adults and adults)
- Peer Support Services (for young adults and adults)

Additional Community Services and Supports (Not Medicaid-Reimbursable) - Additional OhioMHAS certified community mental health treatment services for all ages that are not eligible for Medicaid reimbursement which are funded by local Board tax levy, state or federal grant funds include:

- Housing
- Consumer operated services
- Self-help/Peer Support Service
- Forensic evaluation services
- Employment/vocational services
- Referral and information Service
- Intensive Home Based Services (for children and youth)
- Assertive Community Treatment
- Adult Education Service*
- Social and Recreational Service*
- Adjunctive Therapy Service*
- Occupational Therapy Service
- School Psychology Service
- Other Mental Health Services (locally designed housing and crisis services)

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
- Residential Treatment Facility (RTF)

Initiatives to Improve Care

Major initiatives to improve clinical care and recovery supports include Strong Families, Safe Communities, “Hot Spots” (regional board collaboratives), telepsychiatry, Pediatric Psychiatry Network and Early Childhood Mental Health, Childhood Trauma and Center for Innovative Practices. These initiatives described in this section address safe communities, psychiatry shortages (telepsychiatry and Pediatric Psychiatry Network) trauma, early intervention for children under 6, and implementation of evidence based practices. Additionally, “Hot Spots” described in Priority Population #6 for all ages includes some children’s priorities which are starred.

Strong Families, Safe Communities - On July 2, 2013 the Ohio Departments of Developmental Disabilities (DODD) and Mental Health & Addiction Services (OhioMHAS) announced awards of nearly \$3 million out of a \$5 million grant to seven community partnerships to implement the Strong Families, Safe Communities project and to provide care coordination and crisis intervention services for youth at risk of harming themselves or others due to a mental illness or developmental disability. The seven partnerships involve Boards and providers in 20 different counties. In addition to the grant awards, the project will also provide statewide training on crisis intervention for mental health and developmental disabilities services professionals. Strong Families Safe Communities is funded by Governor Kasich’s initiative to commit money from Ohio’s Children’s Health Insurance Program Reauthorization Act (CHIPRA) awards to develop targeted strategies to stabilize youth in crisis, ages 8-24, and develop long-term treatment plans that help children and their families live happy and healthy lives.

Telepsychiatry - Additionally, ODMH has partnered with Ohio Medicaid to pilot telepsychiatry services to children and youth in rural areas of Ohio. Through PPN several other programs have developed to provide pediatric practitioners with targeted training initiatives to increase their awareness and competency in early identification and age appropriate therapies for behavioral health conditions in children. This project also includes screening for maternal depression and substance use issues. There are approximately 100,000 children who can benefit from these services. To this date, 644 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.

Pediatric Psychiatry Network (PPN) aims to help pediatric and primary care providers deliver and/or coordinate behavioral health care for children and 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. Pediatric and 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 diagnosing and treating a child in his/her care. This preserves the medical home and improves services. The PPN web-site provides up to date parent, consumer and clinical information, such as common protocols, other educational information and resource information.

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 2012, ODMH joined forces with a broad base of child and adult service stakeholders to further Ohio's focus on trauma informed care. This group is currently developing a trauma screening tool that could be implemented at any entry point to child serving and/or mental health systems to identify individuals who might benefit from a more in depth trauma focused assessment. 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 Childhood Mental Health Program – 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.

Center for Innovative Practices (CIP) is a **Coordinating Center of Excellence** that provides technical assistance and training to implement evidence-based practices for children and youth. CIP is affiliated with Case Western Reserve University and funded by MH Block Grant. Current projects support Integrated Co-occurring Treatment, Multi-systemic therapy, Intensive Home Treatment, Youth/Young Adults in Transition, Resiliency, and Multidimensional Treatment Foster Care.

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

Adults with serious mental illness are a diverse group with complex needs. They are often dually diagnosed with SMI and co-occurring 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.

Community Mental Health Services for Adults with SMI – Please see the list of Ohio’s comprehensive mental health system under Children with SED as most services are for all ages except for Intensive Home Based Treatment. For a description of Ohio’s Health Homes for Medicaid recipients with SPMI (Serious and Persistent Mental Illness, please see #7 Priority Population.

Program Initiatives to Improve Services

Major initiatives to improve adult mental health services include Medicaid Health Home Implementation, Hot Spot Collaborative Projects, and Coordinating Centers of Excellence. Additionally, the Department has additional new initiatives described under Ohio selected priority populations for recovery supports, housing and forensic services.

Health Homes for SPMI - Implementation of Medicaid Health Homes to provide integrated behavioral health and primary care to adults and children with SPMI (serious and persistent mental illness) is a major focus of the Department. The Department has provided seed money for Health Innovation Min-Grants, as well as offered extensive training opportunities to providers. Trainings have featured national consultants, Ohio providers, NAMI-Ohio, Ohio Empowerment Coalitions and included both face-to-face trainings and webinars. Extensive information is available on the website. These efforts are detailed under Priority #7, Integrated Care.

Mental Health Hot Spot Collaborative Projects Encouraged to Add Substance Abuse Projects - In SFY13 Director Plouck allocated \$10.6 million in funds from the state legislature to promote regional planning and collaboration to address “Hot Spots”, which were defined as:

1. Specialized services for difficult to-serve-populations – high utilizers of service who do not achieve desired clinical outcomes;
2. Services for those with the greatest unmet needs – may be defined as highest cost clients; most clinically impaired clients; or a sub-set of clients who need services and a gap in the continuum of care exists;
3. Services that divert people from more restrictive and typically higher-cost settings (e.g., hospitals, jails/prisons, out-of-home placement for children, nursing facilities, etc.); and
4. Incentives to engage clients who are difficult to engage in behavioral health services and likely are costly to other systems.

Boards were organized into six regions based on their state hospital catchment areas. Collaborative areas worked together to determine their local needs, submitted project proposals, and supplemented projects with an additional \$7.7 million local dollars. In SFY14 the Department is continuing the \$10.6 million regional allocation and adding an additional \$2.5 million, that Collaboratives are encouraged to use to include substance abuse projects. Projects for SFY14 are in the submission process.

Projects by region during SFY13 are:

Regional Mental Health System Improvement Projects SFY 2013 Invited to Add Substance Abuse Projects in SFY 2014	
Northeast	<ul style="list-style-type: none"> • Mental health treatment to consumers with SPMI and without Medicaid • Reentry Community • Forensic Assertive Community Treatment • Housing improvement – assessment referral and support for housing
Northwest	<ul style="list-style-type: none"> • Juvenile crisis/respice* • Telemedicine • Increase access to community mental health assessment
Heartland	<ul style="list-style-type: none"> • Core service improvement • Transition age youth/young adult* • Telemedicine • Integrated Healthcare Training & hired Healthcare Navigators
Central Ohio	<ul style="list-style-type: none"> • Youth crisis stabilization* • Tele-psychiatry for children* • Residential access for adults • Common IT Data Platform
Southeast	<ul style="list-style-type: none"> • Regional crisis stabilization
Southwest	<ul style="list-style-type: none"> • Intensive care coordination • Intensive home-based treatment* • Regional crisis stabilization • Transitional youth housing*

* Children and youth focused projects

Coordinating Centers of Excellence- ODMHAS 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 ODMHAS, 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.

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.

The **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.

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

OhioMHAS Office of Health Integration - ODMHAS created a designated office, Office of Health Integration within Administrative Services Division to lead and coordinate the department's diverse health integration efforts including implementation of community behavioral health center health homes for individuals with Serious and Persistent Mental Illness. The Office of Health Integration promotes, administers and coordinates the state wide policy and program development efforts in bi-directional integration of behavioral health and primary care to prevent and reduce co-morbidity and early loss of life of persons with mental illness.

Medicaid Health Homes - The Ohio Department of Mental Health and Office of Medical Assistance (Ohio Medicaid) have jointly developed the health home proposal for individuals with Serious and Persistent Mental Illness (SPMI) through a stakeholder process that began November 3, 2011. Implementation began October 1, 2012 in five Phase I Counties; Adams, Butler, Lawrence, Lucas and Scioto. The remaining 83 Counties are scheduled for implementation on October 1, 2013. Ohio Medicaid health homes for individuals with serious and persistent mental illness are designed to: Improve care coordination, Improve integration of physical and behavioral health care, Improve health outcomes, Lower rates of hospital emergency department use, Reduce hospital admissions and readmissions, Decrease reliance on long term care facilities, Improve the experience of care and consumer quality of life, and Reduce healthcare costs. Adults and children who have Medicaid benefits and meet the State of Ohio definition of SPMI -- which includes adults with serious mental illness and children with serious emotional disturbance are eligible for health home services in community behavioral health centers.

Health Home / Health Integration Technical Assistance and Training Initiatives- The Ohio Department of Mental Health (ODMH) launched Technical Assistance and Training Initiatives to promote and support adoption of integrated health care and health home service delivery models for individuals with serious and persistent mental illness. In this endeavor, ODMH is focused on assembling a cadre of nationally recognized experts, consultants and trainers to deliver Technical Assistance and Training to community behavioral health centers who are interested in transforming their organizations through implementation of the integrated health care and health home service models.

Health Home Consumer Education Initiative - The purpose of the health home consumer education initiative is to raise consumer awareness of the new health home service for individuals with serious and persistent mental illness. OhioMHAS is committed to inclusion and education of consumers in the implementation of the health home initiative. The development and implementation of educational strategies and materials about the health home service will enable and empower consumers to make informed decisions and maximize their participation in this new initiative.

Health Home Family Education Initiative - The purpose of the health home consumer education initiative is to raise family and public awareness of the new health home service for individuals with Serious and Persistent Mental Illness. OhioMHAS is committed to inclusion and education of families and the public in the implementation of the health home initiative as their family members and friends with SPMI are potential participants in and recipients of the health home service. The development and implementation of educational strategies and materials about the health home service enables and empowers families and guardians to make informed decisions, better support and advocate on behalf of their family members with SPMI and maximize their participation in this new initiative.

Health Home/Health Integration Technical Assistance (TA) Resource Center Initiative -

The primary goal of the health home/health integration technical assistance (TA) resource center is to assist community behavioral health centers with the implementation of health home service for individuals with SPMI, and support the behavioral health care system's efforts toward the bi-directional integration of Primary and Behavioral Health Care. This TA Resource Center is responsible for the provision of consultation, technical assistance and training to assure the successful implementation and operation of CBHC health homes and integrated care programs. The TA Resource Center will include the following components:

- A. **Technical Assistance and Training for Health Homes** will focus on program planning, development, implementation, and sustainability.
- B. **Technical Assistance and Training for Health Integration** will focus on program planning, development, implementation and sustainability.
- C. **Standardized Health Home Training Curriculum for CBHC Health Homes** will be developed to educate clinical staff, support staff and leadership on key health home concepts.
- D. **Health Integration/Health Home Readiness Assessment Tool(s)** will be developed to determine the needs, assess the readiness and monitor the adherence of CBHCs to the health integration and health home program models.

Health Home Health Navigator Training Initiative - The primary goal of this initiative is to support the implementation of CBHC health homes and train health home teams on the key issues of health navigation for individuals with SPMI. This training will also introduce health home teams to using Motivational Interviewing, and Stages of Change, which are prerequisites for effective health promotion and wellness programming.

Select Evidence-Based Practices Training for Health Homes Initiative - The primary goal of this initiative is to support the implementation of CBHC health homes and train health home teams on select evidence-based practices to enhance the provision of the health home service to individuals with SPMI. This program will help develop and improve core competencies and skills of the health home teams in Motivational Interviewing, Stages of Change, and Tobacco Cessation to activate behavioral change and provide effective health promotion services to individuals with SPMI.

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).

Protocol for the use of Buprenorphine and Suboxone®– The ODADAS treatment division and consulting physician, in conjunction with the Ohio Society of Addiction Medicine and the Cincinnati based Clinical Trials Network, have developed protocols for the use of FDA-approved medication assisted therapy. 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. The Department will also be developing similar protocols for Naltrexone-based medications and methadone.

The 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. 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.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) -The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has been awarded a 5-year, \$10 million (\$2 million per year) cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a statewide Screening, Brief Intervention and Referral for Treatment (SBIRT) initiative. The federally-funded program is designed to reduce morbidity and mortality of alcohol and drug use through early intervention methodologies that rely on the integration of medical and behavioral health approaches. The ultimate goal of Ohio SBIRT is to reduce the morbidity and mortality caused by alcohol and illicit or prescription drug use through an integration of SBIRT approaches into medical and behavioral health approaches.

The expected outcomes include: Ohio's use of SBIRT services is expanded in community and primary care settings; Current technological strategies to imbed SBIRT as a clinical and business practice are expanded and enhanced; The potential misuse of prescription drugs is reduced

through the expanded use of the Ohio Automated Rx Reporting System in conjunction with SBIRT; Clinically appropriate services for people at risk for or diagnosed with a substance use disorder are supported; and System and policy changes to increase access to treatment in generalist and specialist settings are identified and implemented.

The population of focus is universal adults who receive medical services in primary care and other community settings, (which includes health centers, hospitals and emergency departments). The subpopulations to be served are the elderly, pregnant women, service members/veterans and minority populations, namely African Americans and Hispanics/Latinos, as these groups have been determined to experience health disparities. Ohio SBIRT will serve approximately 25,345 patients in year 1 and 27,000 patients each in years 2 through 5 for a total of 133,245 patients over the project lifetime. It is expected that of those patients identified as needing referral to specialty treatment, 90% will receive outpatient services and 10% will need to be placed in a residential setting.

Ohio SBIRT will employ various strategies to achieve its stated goal that include: 1. Training for screening, Motivational Interviewing and cultural competency; 2. Using health information technology to improve the continuity of care with the assistance of the Care Coordination and Technology Workgroup; 3. Using performance assessments to examine SBIRT processes, make course corrections and ensure optimum replication for future Ohio SBIRT sites; 4. Employing a Health Navigator to assist with linkage to specialty treatment and to facilitate integrated medical and behavioral health; 5. Using GPRA outcome data to support decisions regarding new strategies; and 6. Developing a diverse composition on the Ohio SBIRT Policy Steering Committee to provide oversight for the program and assistance in policy and system changes such as developing a public/private partnership to achieve a cost effective, sustainable integrated care system that contributes to a healthy Ohio populace.

8 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. OhioMHAS is in the process of determining how to best work with recovery supports to maximize access to all person with mental health and addiction needs.

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.

Housing – Historically, housing for adults with SPMI has been the largest non-Medicaid expense of the mental health system. These efforts are detailed under Priority # 13.

Peer Recovery Support and Peer Education - Ohio Empowerment Coalition (OEC), a statewide mental health consumer organization:

- Provides training for peer support/peer recovery coaching with assistance from Ohio Citizen Advocates (OCA) for Chemical Dependency Prevention and Treatment
- Will field test Ohio Peer Supporter Training Manual developed with SAMHSA BRSS TACS (Bringing Recovery Support Services to Scale – Technical Assistance Collaborative Strategies funded by SAMHSA contractor)
- Operates Young Adult Certified Peer Support Training Program
- Provides consumer education to peers (e.g. about new Medicaid Health Homes)
- Educates Ohio Medicaid Health Homes on how inclusion of peer support staff can improve consumer outcomes
- Statewide Consumer Network (funded by competitive SAMHSA grant)
- Provides consumer representatives for state policy committees
- Hosts an annual statewide conference or regional conferences for consumers
- Provides supports for about 60 local consumer organizations/peer support groups of which 38 are ODMH certified providers.

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. NAMI-Ohio also has a management contract with Ohio Federation for Children’s Mental Health.

Ohio 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 includes the Multi-ethnic Advocates for Cultural Competence's (MACC)'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. Additionally, OhioMHAS has a Cultural Competence Lead who organizes bi-monthly trainings and related activities for OhioMHAS staff, See also Priority #14 for additional information.

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 stipends and travel reimbursement for eligible consumer and family members of Planning Council. The Council is being expanded effective July 2013 to include persons in recovery from substance abuse and their families. This program also provides technical assistance funding to local consumer groups and educational activities within Ohio.

Employment Services are offered by only about 5% of Ohio's mental health providers because the evidence-based practice of Supported Employment requires a significant amount of non-Medicaid funding which was reduced in recent years. The Ohio Rehabilitation Services Commission (the state/federal vocational rehabilitation program) provides services to persons with severe mental illness. OhioMHAS also funds a Coordinating Center of Excellence to provide technical assistance and training to implement the evidence-based practice of Supported Employment.

#9 Veterans with Substance Use Disorders and/or Mental Illness

Ohio participates in OHIOCARES which is a collaboration of the Ohio Adjutant General, the OhioMHAS, Veterans Administration, community behavioral health boards and other key stakeholders and provider organizations. These partners work to improve access to timely and appropriate community services to veterans, service members and their families. A key purpose of OHIOCARES is to enhance the "safety net" of community behavioral health services available for military personnel and their families through linkage to community providers and Boards to complement the services available through the Department of Veterans Affairs and Vet Centers. The structure of OHIOCARES functions through a subcommittee facilitated by the Director of Psychological Health representing the Ohio National Guard. Workgroups such as Traumatic Brain Injury, Alcohol Reduction, Sustainability and Suicide Prevention have all been

a part of the work in creating partnerships and developing resources to address issues that impact service members, veterans and their families.

OHIOCARES developed its goals and infrastructure through the support and technical assistance of the Substance Abuse Mental Health Administration and follow-up site visits. In 2010 OHIOCARES representatives from ODADAS, ODMH, the Department of Veteran Affairs, the Ohio National Guard and The Department of Job and Family Services participated in the Returning Service Members Veterans and their Families, Policy Academy. The OHIOCARES team representatives drafted gaps and outlined the goals for the State of Ohio. Representatives from SAMSHA have made follow-up visits as well as hosting the Chief of New Hampshire's, Bureau of Alcohol and Drug Addiction Services, to the State of Ohio. OHIOCARES has begun to develop its infrastructure and has organized various workgroups named in the previous paragraph. The Ohio National Guard has placed a staff Captain within OhioMHAS, who has been involved in SAMSHA's Strategic Prevention Framework training as well as a liaison to Ohio National Guard. He has provided soldier referrals to behavioral health providers. Currently, there are efforts to increase Tricare providers serving service members and their families. In addition, OHIOCARES works with the Inter-Service Family Assistance Committees (ISFAC), to provide opportunity for military and civilian partners to share legislative updates, community resources and other information. There are continued efforts to share provider directory information as well as address the need for technology support from various partners. The goal would be to ensure the development of a website that is user friendly to service members, veterans and their families as well as to providers and collaborative partners.

The Veteran's Treatment Court Project - The Veteran's Treatment Court Project is a study that examines the effectiveness of using a Veteran's Treatment Court as a method to improve access to evidence-based treatment for those involved in the criminal justice system with a history of PTSD and military service. Sixty-one veterans with a history of trauma completed one year in a treatment-focused jail diversion program, which offered a variety of recovery services designed to meet the needs of a veteran population. Based on individual need, veterans were offered services such as; a Veteran's Treatment Court-a hybrid drug and mental health court created specifically for veterans, peer mentorships, trauma specific treatment, case management, and mental health and substance abuse treatment, among others. Veterans were evaluated at three distinct points during their time in the program, at enrollment, six months, and 12 months. This study seeks to examine the effects of participation in a large, Midwestern, urban jail diversion program and the differing outcomes veterans may have experienced based on services they received. Analyses (paired sample T-Tests) indicated that veterans experienced statistically significant improvement in nearly every outcome measured in the interviews; including decreased PTSD symptoms, decreased substance abuse, increased functioning and social connectedness, increased sleep, decreased depression symptoms, and improved family relationships.

#10 Individuals with Disabilities (in particular those who may be deaf or hard of hearing)

In 2010 OhioMHAS (formerly separate departments) was awarded a Technology Assisted Care grant from SAMHSA/CSAT. The grant provided mental health and addiction e-Therapy treatment to deliver services to underserved populations including persons with physical, intellectual and mobility disabilities who had difficulty accessing care. Much outreach was done with military and veteran organizations and veteran courts to recruit that population. Deaf education and legal responsibilities training was provided to community organizations, mental health and addiction treatment providers and Boards. OhioMHAS program staff attended many deaf community fairs and events to educate deaf and hard of hearing individuals and their families about mental health and addiction as brain diseases. A project coordinator was hired for the grant from Wright State University, a nationally renowned authority on best practices for people with disabilities.

#11 Individuals Involved with the Criminal Justice System

The new Ohio Department of Mental Health and Addiction Services provides funding for offender programming for adults and juveniles with mental health and/or substance use disorders who are under the supervision of courts, are incarcerated in county jails/detention facilities and state correctional facilities, and those in need of reentry services. Funding for these programs flows through county ADAMH/ADAS/CMH Boards to local behavioral health service providers. Ancillary services such as housing, transportation and other recovery supports are also provided by other local organizations which may not be affiliated with the ADAMH/ADAS/CMH Boards. Rather, they may be affiliated with other government entities, faith-based organizations and/or self-help groups (e.g. Alcoholics Anonymous).

Criminal Justice Population Addressed by OhioMHAS – Ohio Department of Rehabilitation and Corrections currently has approximately 50,000 offenders with 13,064 (26%) participating in alcohol and other drug programming offered in Ohio’s prisons, and approximately 9% (4,500) being considered SPMI^[1] (ODRC reports/website). The majority of persons with SPMI have co-occurring substance use disorders. Addressing addiction to alcohol and other drugs upon release is critical to both populations, as well as to provide a range of recovery supports known as “Recovery Oriented System of Care” within the AoD world, and “Community Support System” within the mental health world.

^[1] <http://www.drc.ohio.gov/>

Therapeutic Community - Since 1992, ODADAS (now OhioMHAS) has supported the Therapeutic Community (TC) treatment model for a subpopulation of incarcerated adult offenders and has provided some support for post-release *TC* programming. The emphasis of this intervention is based on self-responsibility, abstinence, and community.

Drug Courts - ODADAS began its involvement with drug courts in 1994 by providing drug court planning and training to ten of Ohio's metro counties. Ohio's first drug court was established in the Hamilton County Court of Common Pleas in 1995 with financial support from the Department. OhioMHAS now provides funding to 24 of Ohio's 95 drug courts.

A drug court is a specialized docket that serves offenders with substance use disorders by providing weekly group court sessions, judicial oversight, immediate access to treatment, drug and alcohol testing, case management and surveillance. Drug courts sanctions and incentives, as well as accountability to achieve program compliance. Most Ohio drug courts serve adult and juvenile offenders who have been charged with, and convicted of, a variety of crimes; others serve targeted populations such as those convicted of prostitution or drunk driving. Family drug courts serve parents who have been charged with abuse/neglect/dependency involving their minor children.

Drug court programs create teams that are made up of: probation officers, prosecutors, defense counsel, substance abuse treatment personnel, TASC (Treatment Alternatives to Street Crime) personnel, schools, children services personnel and other ancillary service providers. These teams meet with the judge to staff cases, provide updates and make recommendations based on participant performance and adjustment to treatment.

Treatment Alternatives to Street Crime (TASC) - ODADAS implemented Ohio's first TASC program in 1991 and now funds 14 TASC programs that serve adults and/or juveniles in 17 Ohio counties. TASC's mission is to build a bridge between the criminal justice and treatment systems which have differing philosophies and objectives and to enhance existing correctional supervision programs. The model targets nonviolent felons and misdemeanants with substance use disorders. TASC identifies chemically dependent offenders, provides assessments and makes referrals for the most appropriate drug treatment. Other key functions include case management services and drug testing. TASC case managers work closely with judges, probation officers, jail administrators and treatment providers to provide effective and comprehensive programming.

Youth Reentry – In 2000, ODADAS and DYS initiated an intensive reentry program for offenders being released from the state's juvenile prison system. These services include: assessment and case management provided by TASC programs, substance abuse treatment on demand, drug and alcohol testing and other ancillary services. These projects are administered locally by ADAS/ADAMHS Boards-and are operational in Athens/Hocking/Vinton, Cuyahoga, Hamilton, Lucas, Mahoning, Stark and Summit Counties.

Ohio's Driver Intervention Program (DIP) is an alternative to the mandatory three-day jail term that first time offenders convicted of operating a vehicle under the influence of alcohol or

other drugs may attend at the court's discretion (as proscribed by Sections 1547.99 and 4511.19 of the Ohio Revised Code). Each DIP includes traffic safety education on alcohol and other drug abuse and addiction, and small group discussions. In addition to the education component, some DIPs offer screening for substance use disorders and referral for a complete alcohol and other drug assessment.

Access to Recovery (ATR) - ODADAS was awarded an Access to Recovery grant in October of 2007 by the Substance Abuse and Mental Health Services Administration (SAMHSA). This grant provides adult clients in northeastern Ohio territory with a wide range of addiction treatment and recovery support services, such as temporary housing, job training, healthcare/childcare services and transportation assistance. With this grant, clients are able to choose among a variety of standard, faith-based and community-based recovery services providers, some of which had not been available to this population. ATR has served Cuyahoga, Summit, and Stark Counties since its inception. The project subsequently began serving Mahoning County. ODADAS received a second ATR award to serve adolescents, continue services in the aforementioned counties and expand the service area to include Lorain County. The ATR grant will end in 2014.

Community Linkage for Persons with Serious and Persistent Mental Illness - Historically, ODMH provided Community Linkage Social Work (CLSW) services for persons re-entering communities from prison. The CLSW program served 1,620¹¹ offenders with SPMI (serious and persistent mental illness) in SFY 2012. This program provides continuity of care for persons with SPMI (Severe and Persistent Mental Illness) entering and leaving prison and youth facilities; most of this population also has co-occurring substance use disorders. 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 and increased public safety.

CLSW services have expanded to include a wider variety of community mental health services and supports and includes facilitating application for benefits (e.g. SSI, Medicaid). 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 89 SSI approvals for SFY 2012 which is a 39% increase from SFY 2011. 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"[2] Upon release, an estimated (11%) of this population is

¹¹ OhioMHAS Community Linkage Database

¹² *Forensic Strategies Workgroup Final Report, January 2010*

homeless and another 15% has an “unknown” place of residence which usually also means homeless.[3] Additionally, housing is also an unmet need for Incompetent to Stand Trial and Not Guilty by Reason of Insanity clients being released from OhioMHAS psychiatric hospitals.

Forensic Evaluation and Monitoring - OhioMHAS 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.

#12 The Growing Number of Opiate Addicted Individuals in the State including Illicit Drugs such as Heroin and Non-Medical use of Prescription Drugs

Protocol for the Use of Buprenorphine and Suboxone - Ohio’s opiate epidemic is a crisis of unparalleled proportions with devastating, often deadly, consequences. The most culpable substances are the opiate family, which includes heroin and prescription pain reliever medications. In fact, these substances accounted for nearly 40 percent of the state’s 1,373 overdose deaths in 2009. In addition to the human toll, Ohio’s opiate and prescription drug epidemic has severely strained law enforcement, criminal justice and health care resources and stretched the capacity of Ohio’s publicly-funded alcohol and other drug addiction treatment services system. Evidence increasingly points to opiate addiction as a major driver of increasing health care costs as well. A study in the *Journal of Managed Care Pharmacy* estimates that the medical expenses of a person who is abusing opioids are *eight times* those of a non-addict. Meanwhile, CareSource, a leading managed care provider in Ohio, has reported that *one in four* Aged, Blind and Disabled (ABD) Medicaid recipients enrolled in its program, are using opiate painkillers.

Southern Ohio, has been particularly hard-hit by this crisis, and is widely considered “a window on the world” in terms of the wreckage caused when prescription drug abuse and addiction becomes entrenched in a community. The Ohio State Board of Pharmacy reported 9.7 million doses were legally dispensed to Scioto County residents in 2010. This is more than twice the per capita rate dispensed in Cuyahoga County (Greater Cleveland.) Scioto County, which has 78,820 residents, has the third highest overdose death rate of all 88 counties in Ohio.

[3] *Community Linkage Database, SFY 2011 data*

Developing and implementing cost-effective policies and strategies to resolve the crisis is a collective responsibility. From generating greater public awareness around the issue to toughening state laws and regulations around how controlled substances are prescribed, and embracing evidence-based treatment technologies such as Medication-Assisted Treatment (MAT) Ohio must act swiftly and decisively to formulate a coordinated response to rein in spiraling health care costs and prevent more tragic deaths.

- 2011 figures show that 8.7 million doses were dispensed in Scioto County, equivalent to 103.58 for every man woman and child (*Source: Ohio Board of Pharmacy, 2011*)
- Since 2007, unintentional drug overdoses have been the leading cause of accidental death in Ohio. Fatal and nonfatal poisonings cost Ohioans \$3.6 billion annually. (*Source: Ohio Department of Health, "Burden of Poisoning in Ohio, 1999-2008"*)
- Prescription painkillers accounted for nearly 37 percent of unintentional overdose deaths in 2008. (*Source: Ohio Department of Health*)
- The Ohio Substance Abuse Monitoring (OSAM) Network reports a move from prescription painkillers to heroin among opiate abusers. Heroin is highly available in all regions of the state. (*Source: ODADAS, OSAM Network, 2011*)
- 85 percent of substance abuse treatment requests at The Scioto County Counseling Center are now for opiate addiction, marking a 300 percent increase in just the past three years. (*Source: Scioto County Rx Drug Action Team*)

ODADAS has undertaken a series of projects to address this issue:

Medication-Assisted Therapy Clinical Trials Project – The ODADAS treatment division and consulting physician, 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 therapy. This protocol will play a critical role in the treatment of opiate addiction. Treatment integrated with medication has shown to dramatically improve clinical outcomes. This protocol will be subjected to rigorous evaluation conducted by the Clinical Trials Network and will be revised and refined based on clinical trial data. State and Community Partners in this effort include the Ohio Department of Mental Health, Ohio Society of Addiction Medicine, NIDA Clinical Trials Network, Ohio addiction treatment providers, Office of Criminal Justice Services, Ohio Department of Health and the Ohio Association of County Behavioral Health Authorities

Southern Ohio Treatment Center for Opiate-Addicted Individuals – In partnership with the Ohio Association of Community Health Centers and the Ohio Development Services Agency, ODADAS has established a regional Medication Assisted Treatment program that will provide best practice medication for opiate-addicted individuals. . The

center is located in Jackson, Ohio and will serve clients from a 10-county region in the southern region of the state.

Statewide Solace Group Expansion – ODADAS, SOLACE (Surviving Our Loss and Continuing Everyday) of Portsmouth, and the Drug Free Action Alliance have partnered to develop a work plan for statewide opiate education, prevention, and family support organization with local chapters based on the model developed in Scioto County.

Community Opiate Task Forces – ODADAS is working with Cardinal Health and the Ohio Association of County Behavioral Health Authorities to deploy County Opiate Task Forces in 10 ADAMHS/ADAS Board areas covering 23 counties with the most extreme opiate addiction problems. These task forces are focusing on: 1) community education and prevention, 2) practitioner education, 3) integration of treatment and criminal justice. Community activity has been ongoing from local task force efforts.

Statewide Media Campaign – ODADAS is working with the Ohio Association of County Behavioral Health Authorities, Cardinal Health, and Fahlgren Mortine advertising agency to create a statewide advertising campaign focused on prevention and education regarding opiate addiction. Members of the Opiate Task Forces are assisting in message development and will be part of implementation.

Medicaid Opiate Impact Study – ODADAS is partnering with CareSource, Ohio's largest Medicaid managed care company, to study the impact of opiate addiction on the Medicaid population. Preliminary data analysis shows that 45% of adult Medicaid recipients received opiate medications in 2010, and the overall cost of treating those clients who received opiates for more than a three month period was 700% higher than the cost of treating adult Medicaid recipients not prescribed opiates. The next phase will be to conduct a client utilization review to determine if inappropriate prescribing of opiate narcotics affected the overall cost of medical care.

Inter-State Opiate Task Force – ODADAS and the Office of the Governor are coordinating a series of meetings with representatives of state government from West Virginia, Kentucky and Tennessee to discuss how the three states can better address the issues of opiate interdiction, pharmaceutical monitoring, community education, and treatment. The Health Foundation of Greater Cincinnati has agreed to help facilitate some of the shared learning.

Criminal Justice Initiative – Under the organization of ODADAS, State Government funders of re-entry programs, drug courts, and other criminal justice diversion programs are meeting to determine whether common practices for intervention with criminal offenders who are addicted and/or mentally ill can be developed and issued. The intent is to improve the efficacy of court and treatment-based programs for the criminal justice population with alcohol or drug addiction, especially opiate addiction. It is hoped that this cross-systems initiative will result in reduced incarceration, improved accountability,

and reinforce beset practice standards. The group submitted its recommendations in a white paper.

#13 Homeless Persons and Persons with SMI and Substance Use Disorders in Need of Permanent Supportive Housing

Projects for Assistance in Transition from Homelessness (PATH) is a federally funded program that provides financial assistances through a formula grant process to States and Territories to help end homelessness among those living with mental illness and co-occurring substance use disorders. PATH is a homeless outreach program that seeks to locate consumers who have a mental illness, not connected with community mental health services, living on the streets, in vehicles and other places that are not designed for human habitation and to link them to supportive services and housing. As a current grantee, the Department of Mental Health provides programmatic oversight for twelve (12) projects around the state of Ohio. For additional information, please visit the website at <http://pathprogram.samhsa.gov/>

Housing is a priority for the Mental Health and Addiction Services. Ensuring 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. 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. The Department continues to partner with local mental health systems and state agencies to promote housing that provides least restrictive environment that honors client choice. The Department has four housing goals that we continue to focus attention and resources. 1. Increase the number of new permanent supportive housing. 2. Preserve existing housing stock available for persons with severe and persistent mental illness, 3. Improve the operating efficiency of the housing stock and 4. Improve the quality of housing services.



Development of new Housing Units - In the SY 13-14 capital biennium, the Department was awarded \$10 million in capital funds that will be prioritized for the creation of permanent supportive housing that leverages other state funds. ODMH is working with local ADAMH Boards /mental health systems to leverage funds to develop approximately 150 new units of permanent supportive housing in Ohio. Local systems have approximately 230 units in the pipeline for development.

Preservation of existing housing - 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. In the SFY 13, ODMH will be reserving one million dollars of capital to leverage an additional three million from OHFA for a more comprehensive rehabilitation of capital funded permanent supportive housing units.

Also in FY 12, OHFA reserved 1 million from the Housing Trust Fund to assist with critical repairs for the Licensed Adult Care Facilities. ODMH has assisted approximately 150 Adult Care facilities with life safety and critical repairs that will maintain the ability of the homes to be used for housing for those who need more support.

The Residential State Supplement (RSS) Program is Ohio's Optional State Supplementation Program and currently serves approximately 1,250 residents by providing financial assistance to adults with low incomes who have a disability and/or are over age 60, but who no longer require care at a nursing facility. The goal of RSS is to help individuals reside in the least restrictive environment with community-based services who would otherwise require institutional care. Consumers use the supplement, along with their Social Security, SSI, or SSDI income, to pay for eligible living arrangements. Eligible residences include Adult Care Facilities (ACF's) licensed by ODMH and Residential Care Facilities/Assisted Living licensed by the Ohio Department of Health. These organizations provide accommodations, supervision, and personal care services to consumers. As of January 31, 2013, approximately 89% of consumers currently enrolled in RSS have at least one mental health diagnosis, 77% have at least one physical health diagnosis, 0.7% are diagnosed with an intellectual disability, and 23% are older adults (age 60 and above).

The MFP (Money Follows the Person) program provides individuals with SMPI the ability to transition back into a community living environment from an institutional setting when otherwise it may not have been previously possible. This is first achieved through an analytical approach of utilizing MDS (Minimum Data Set) data elements collected through on-sight demographic and diagnostic reporting teamed with admissions examination data through ODMH PASRR. This newly developed, every expanding, technique allows for identifying where early intervention can occur and is proactive in addressing unnecessary long-term, or even permanent, institutional placements.

Second, MFP provides an expanding array of out-patient services above and beyond what current Medicaid State Plan offers. The services are meant to decrease the likelihood of institutional readmission. These services are available for 365 non-consecutive days after discharge from the facility and are the core of the federal demonstration project. The ultimate goal is to determine if these services promote continued stay in the community for an individual with a disability and therefore show cost/quality of life benefit to be added to the Medicaid State Plan after the federal demonstration concludes. With the potential impact of the Recovery Requires a Community Project, born out of Ohio's HOME Choice Program (MFP), the long-term care rebalancing efforts in the state could significantly impact, for the positive, funding towards out-patient SPMI resources. This would be a noteworthy funding trend change as compared to the last twenty years which trended towards increased inpatient spending, even though it was not intended.

Since February 2011, 734 primary mental health MFP participants have transitioned from an institutional setting into the community. The three years prior only 36 primary mental health transitioned occurred, with the vast majority being individuals under the age of 18. As of 2/19/13 77% of all successful transitions were with individuals 18 years and older moving out of nursing facilities. This progress is inclusive of the programmatic advancement of the entire HOME Choice (MFP) Program that has become one of the top-tier state offices administering the federal demonstration grant.

Recent data analysis completed by the Office of Medicaid, Office of Medical Assistance, and the Ohio Department of Mental Health and Addiction Services has demonstrated a significant system-wide cost avoidance of \$32,250 per individual year over year when an individual transitions from an institutional to a community setting. This is money that can be funneled back into the community through the Recovery Require a Community Project that will not allow the individual transitioned to maintain in the community, but also be invested into proactive programs to divert others not yet in a long-term care setting from every entering one.

#14 Underserved Racial and Ethnic Minorities and LGBTQ Populations

Ohio's State Plan to Eliminate Behavioral Health Disparities – OhioMHAS, is sponsoring development of a state behavioral health plan to eliminate disparities. This effort is being led by the Multiethnic Advocates for Cultural Competence (MACC). Other participating stakeholders include the Ohio County Behavioral Health Authorities; Ohio Department of Health and Job and Family Services; Ohio Asian American Health Coalition; Children's Defense Fund; Ohio Commission on Minority Health and Latino/Hispanic Affairs; and the Red Bird Center. The focus of this dynamic group will be to promote system integration of mental health and alcohol and drug addiction services.

The project builds on the behavioral health transformation work that led to the Ohio cultural competence definition. Greg Moody, Director of the Office Health Transformation, met with the advisory committee to discuss the vision of Ohio health transformation, and talked about how cultural

competence can be included in the vision. The primary goal of the plan is to provide behavioral health system stakeholders with key strategies to reduce disparities. The plan will provide OhioMHAS, system Boards and providers with the tools to:

- Increase awareness of the significance of behavioral health disparities, their impact on communities, and the actions necessary to improve behavioral health outcomes;
- Strengthen and broaden leadership for addressing behavioral health disparities;
- Improve cultural and linguistic competency of the workforce; and
- Improve the coordination, utilization, and diffusion of research and evaluation outcomes.

Ohio aims to align its plan with the vision of SAMHSA, who received a new charge last year to address behavioral health disparities nationally. In accordance with this charge, SAMHSA created the Office of Behavioral Health Equity (OBHE) to coordinate its efforts to reduce behavioral health disparities for America's diverse communities. Stakeholders involved in developing Ohio's plan will base their strategies on the *National Stakeholder Strategy for Achieving Health Equity*, a key policy driver for the OBHE. The strategies are a culmination of local conversations held across the U.S. to develop a blueprint to address elimination of health disparities.

Circle for Recovery – The former ODADAS (now OhioMHAS) partners with the Ohio Department of Rehabilitation and Correction, therapeutic community, Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOPs) and others to improve the service delivery system for African-Americans and non-dominant cultural groups who have been incarcerated upon re-entry. Circle for Recovery programs provide culturally relevant relapse prevention, re-entry and recovery support services. The services provided include employment, education, family re-unification and social reintegration services, peer support, health education including violence prevention services and crisis intervention services.

#15 Youth/Young Adults in Transition/Adolescents and Young Adults

Substance Use Challenges - Ohio's State Epidemiological Outcomes Workgroup data is indicative of the growing problem of increasing lifetime use illegal injection use among high school students. After hovering around 2.5% between 1997 and 2004, injection use among high school students declined to 1.9% in 2005 and increased to 3.2% in 2011. OhioMHAS is engaged in a collaborative Youth Re-Entry project in partnership with the ADAMHS/ADAS Boards and the Ohio Department of Youth Services. This project provides assessments, case management services, drug and alcohol testing, and life skills for offenders who are released from the state's juvenile prison system. DYS reentry projects are operating in Athens, Hocking, Vinton, Cuyahoga, Hamilton, Mahoning, Summit, Stark and Lucas Counties. In addition, this project provides funding for Smith House, a Therapeutic Community for youth transitioning from DYS institutions back to their communities. In 2010, ODADAS was awarded a \$13 million SAMHSA grant to sustain and expand its Access to Recovery program for another 4 years covering additional 9,200 clients including 600 adolescents.

Young adults aged 18 to 25 have the highest prevalence rates of drug use as can be seen in the needs assessment data below. For this reason, the ODADAS SPF-SIG committee has identified young adults as a priority prevention population.

Mental Health Challenges - The transition into adulthood also 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, and 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. OhioMHAS continues to build on a Strategic Prevention Framework - State Incentive Grant empowering transition age youth to develop evidenced based practice models to address identified issues with alcohol and other drugs. Additionally, OhioMHAS just learned that it received a Children's System of Care grant to fund Project ENGAGE from SAMHSA a year after the application was submitted. Projects ENGAGE will fund further development of a System of Care for transitional age youth and young adults.

In FY2012, ODMH provided specific funding in our Heartland Area for the TIP Program (Transition to Independence) implementation. . This resulted in 180 youth and young adult receiving TIP and over 200 stakeholders and community mental health workers receiving TIP training.

In FY2012, ODMH sponsored a special project for four counties in Northwest, Ohio to provide Crisis Beds (up to 4 days), Transitional Services (Up to 7 days) and Extended Stay (up to 30 days) for youth and youth in transition to adulthood. This project provided respite care and transitional services to assist youth in transition to adulthood to avoid homelessness and to link these youth with needed supports and services.

IN FY 2012, ODMH allocated additional funds to develop a transitional housing for youth from Montgomery and Butler who were homeless or at risk for homelessness. Initial reports indicate that 100% of those admitted were connected to community services, 88% are employed, 25%

have HS diplomas and 67% of those without diplomas are attending school, and 88% have refrained from criminal behavior.

#16 Early Childhood Mental Health (ages 0 – 6)

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 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.

II: Planning Steps

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

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: Assessment of Need

Assessment of Need Section

In this section, OhioMHAS identifies the unmet needs and critical gaps of several populations using data. The order these populations are described is substance abuse, mental health, integrated care and recovery supports in a recovery-oriented system of care.

Sources of Information and Data

The primary sources of information and data that OhioMHAS relies upon in determining need and gaps are Board community plans, the Ohio Substance Abuse Monitoring Network, State Epidemiological Outcome Workgroup indicator data, and client service and demographic data contained in the MACSIS client information system.

Board Community Plans

One important source of information used by OhioMHAS in determining needs is data included in the Board Community Plans, based on guidelines established by the Department. Boards are asked in the Community Plan Guidelines to respond to treatment, prevention and infrastructure needs and priorities. The process by which Boards determine local needs and priorities is not dictated in the guidelines, but Boards are asked to describe how needs are assessed and how (i.e., by what criteria) priorities are determined. Some Boards utilize expertise of external consultants. Formal needs assessment may be conducted, or there may be a reliance on existing information from multiple sources. For example, Boards may assess need utilizing the following sources:

1. Provider assurance and evaluation criteria reports
2. Information provided by the Board Advisory Committee
3. Utilization management reports
4. MACSIS data
5. Board continuous quality improvement plan
6. Input from the quality improvement committee
7. Satisfaction surveys, grievance procedures, peer review and waiting lists
8. Outcome and performance management data
9. State Epidemiological Outcome data

Board Community Plans demonstrate the range of unique issues and needs throughout Ohio in providing alcohol and other drug prevention and treatment services.

Ohio Substance Abuse Monitoring (OSAM) Network and State Epidemiological Outcomes Workgroup (SEOW)

The Department continues to collect drug trend data through the Ohio Substance Abuse Monitoring (OSAM) Network and through the epidemiological profiles developed through the State Epidemiological Outcome Workgroup (SEOW). OSAM and SEOW provide monitoring and surveillance functions to assist OhioMHAS in identifying drug use trends emerging issues as well as indicators of consumption and consequences of use. OSAM and SEOW reports are placed on the OhioMHAS website and summary information is distributed to Boards and providers to use in local planning. It should be noted that during SFY 2010, OSAM reports were not available. During this fiscal year, the Department took steps to in-source this work previously completed under contract to Wright State University with the participation of Akron University and Kent State University. The move to in-source this important needs assessment tool was undertaken in response to budgetary constraints. OSAM Network reports recommended in SFY 2011.

The OSAM Network uses a qualitative epidemiological approach to identifying new and emerging trends through focus groups and interviews with front line professionals as well as users. Modeled after NIDA's Epidemiological Workgroup, the OSAM Network produced twice annual reports. In addition it can undertake 6-month targeted response initiatives to address a specific issue of concern. One-page summaries of key findings known as OSAM-O-GRAMS are also produced.

Ohio's SEOW maintains the current state and county-level Epidemiological Profiles that summarize alcohol and other drug consumption patterns and associated consequences. The OhioMHAS website (<http://www.odadas.ohio.gov/SEOW/>) houses the epidemiological profiles which are available for anyone to use. Initially funded through a federal discretionary award, the SEOW is now an integral component of the ODADAS Prevention Strategic Planning Framework – State Incentive Grant. SEOW relies on secondary data sources to produce profiles. It has become a one-stop shop for easily accessible key data that includes information from the U.S. Census, National Survey on Drug Use and Health, Youth Risk Behavior Survey, BRFSS, Vital Statistics, and other data sets provided by the Ohio Departments of Health, Public Safety, Job and Family Services and other state agencies.

Data Limitations of SEOW

NSDUH Data: State-level estimates for most states are based on relatively small samples. Although augmented by model-based estimation procedures, estimates for specific age groups have relatively low precision (i.e., large confidence intervals). The estimates are provided directly by SAMHSA and raw data that could be used for alternative calculations (e.g., demographic subgroups) are not available. The estimates are subject to bias due to self-report and non-response (refusal/no answer).

BRFSS Data: BRFSS is a telephone survey subject to potential bias due to self-report, non-coverage (households without phones), and non-response (refusal/no answer). Estimates for subgroups may have relatively low precision (i.e., large confidence intervals), due to small sample size.

YRBSS Data: As of 2005, weighted representative samples were available for only 40 states. Not all states participate, and some participating states do not provide representative samples. YRBSS is a school-based survey, so students who have dropped out of school are not represented. It is also subject to bias due to self-report, non-coverage (refusal by selected schools to participate), and non-response (refusal/no answer). Estimates for subgroups may have relatively low precision (i.e., large confidence intervals). The Youth Risk Behavior Surveillance System (YRBSS) and Youth Tobacco Survey (YTS) were primary sources for data regarding consumption rates and related consequences among school age children and adolescents within Ohio and the US. The substantial sample sizes for these studies allowed SEOW to include comparisons across gender, race, and grade level. SEOW reviewed the data, and did see some trends related to race. SEOW then presented this data to the SPF-SIG committee, which reviewed all YRBSS and YTS-related graphs. After a close evaluation of the data at the federal and state levels, the SPF-SIG committee suggested that due to the youth sample, the trends related to these indicators could not be tied to a particular drug across the lifespan. As this is a primary goal of the SPF, the YRBSS and YTS data were no longer viewed as secondary to NSDUH and ODH data, which included all age groups.

ODH Mortality/Morbidity Data: Because data collection and analysis at the county and state levels generally require 1 to 2 years, there may be a lag of several years between changes in behavior and population mortality. The stability of this indicator is directly related to the size of the population in which these deaths occur. Therefore, this indicator may be unstable for less populated states and counties that have low numbers of annual deaths, especially when used for demographic subgroups. There also is variability in the procedures used within and across each state to determine cause of death. In addition, trend data regarding alcohol and drug-related mortality and morbidity were gathered from the Ohio Department of Health (ODH), analyzed, and presented to the SPF-SIG committee. After a close evaluation of data at the state and county levels, the SPF-SIG committee determined that the trends related to these indicators could not be tied to a particular drug at the regional or state levels.

Uniform Crime Reports: Violent crimes are reported under the total number of actual violent crimes. No information on the perpetrator is available to determine if they have been drinking or to disaggregate these data by demographic subgroups. Estimates of the percentage of crimes attributable to alcohol are derived primarily from self-reports of incarcerated perpetrators of the crimes. The percentage actually attributable to alcohol may vary across geographic units. Although most police departments do report UCR data, there are a few jurisdictions each year for which data are not provided. The data regarding ATOD-related crime, mortality, and morbidity indicators were analyzed and graphed by members of SEOW. Specifically, the uniform crime reports were grouped according to violent and property crimes and trend data were presented according to crime rate per 100,000 population.

OhioMHAS MACSIS Client Information System

The Multi-Agency Community Services Information System is client information. Service contact data is collected for all clients paid in whole or in part with public dollars. A component of the information system, OHBH, is an admission/discharge data set that contains client

demographic and disposition data necessary for reporting TEDS and treatment NOMS to SAMHSA.

State Demographics

According to the US Census Bureau (2010), Ohio's population is currently 11,536,504. Of these, 82.7% are White, 12.2% Black or African American, 1.7% Asian, 1.1% Some Other Race, and 2.1% Two or More Races. About one in six Ohioans is a member of a racial minority or is Hispanic. These figures include 1.9 percent Hispanic or Latino (a) individuals who may be of any race. The number of people, who identified themselves as "White Alone," decreased by approximately 1% between 2000 and 2010. All other racial groups demonstrated an increase during this period. Ohio experienced an increase in population of 1.6% between 2000 and 2010. Ohio is comprised of 88 counties, is largely rural with an agricultural economic base, but also encompasses 15 metropolitan areas. The majority of the state's residents live in these metropolitan areas which exhibit familiar urban problems such as: substance abuse, poverty, health disparities, low educational attainment and violence. Ohio's minority populations reside primarily in urban areas. The western portion of the state hosts significant numbers of migrant, Latino, farm workers and their families. Northeastern and central regions are home to one of the largest Amish communities. Twenty-three (23) percent of the population lives in rural areas. The Appalachian Regional Commission characterizes contiguous counties in Ohio, located in the southeastern part of the state, as Appalachian. Ohio's Appalachian population reflects unique sociocultural characteristics such as: a strong work ethic, suspicion of strangers (based on past exploitation), independence, modesty and a strong sense of solidarity and patriotism.

Previous research has linked unemployment with increased prevalence of alcohol and substance abuse (Mossakowski, 2008). Overall, poverty and unemployment have been conceptualized as both potential causal factors and consequences of substance abuse (Mossakowski, 2008; Khan, Murray & Barnes, 2002). The current economic climate, with increases in poverty and unemployment, suggests that Ohio is at greater risk for increased prevalence of alcohol and substance abuse.

The economic outlook within Ohio has declined significantly in the recent past. However, there are some signs of an economic recovery at the state level. In 2011, the median household income among Ohio residents was approximately \$45,803. The US Census Bureau's estimates suggest an average increase of approximately \$650 per household between 2010 and 2011 (Small Area Income and Poverty Estimates, at <http://www.census.gov//did/www/saipe/>). Unemployment within Ohio decreased 2.5% between 2010 and 2011. This improvement is the first since 2006, with the largest single year increase of 3.6% between 2008 and 2009. In 2011, Ohio's unemployment rate dropped below the national average for the first time since 2003 (See Figure 1). The most recent unemployment data from the U.S Department of Labor Bureau of Labor Statistics places Ohio's seasonally adjusted preliminary July 2013 unemployment rate at 7.2%. In contrast, both poverty and childhood poverty levels within the state have been increasing steadily since 2008 (See Figures 2 and 3).

Mossakowski, K. N. (2008). Is the duration of poverty and unemployment a risk factor for heavy drinking? *Social Science and Medicine*, 67, 947-955.

Khan, S., Murray, R. P., & Barnes, G. E. (2002). A structural equation model of the effect of poverty and unemployment on alcohol abuse. *Addictive Behaviors*, 27, 405-423.

Figure 1: Annual Unemployment Rate, 2001-2011 Ohio vs. US

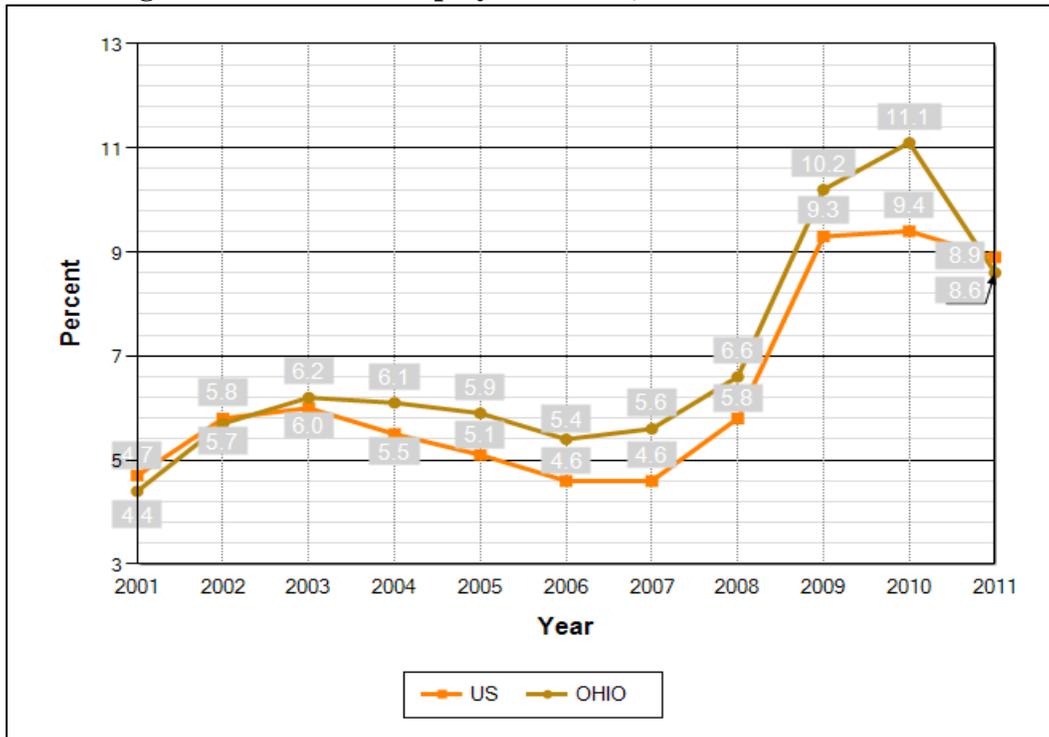


Figure 2: Poverty Rate within Ohio, 2001 to 2011

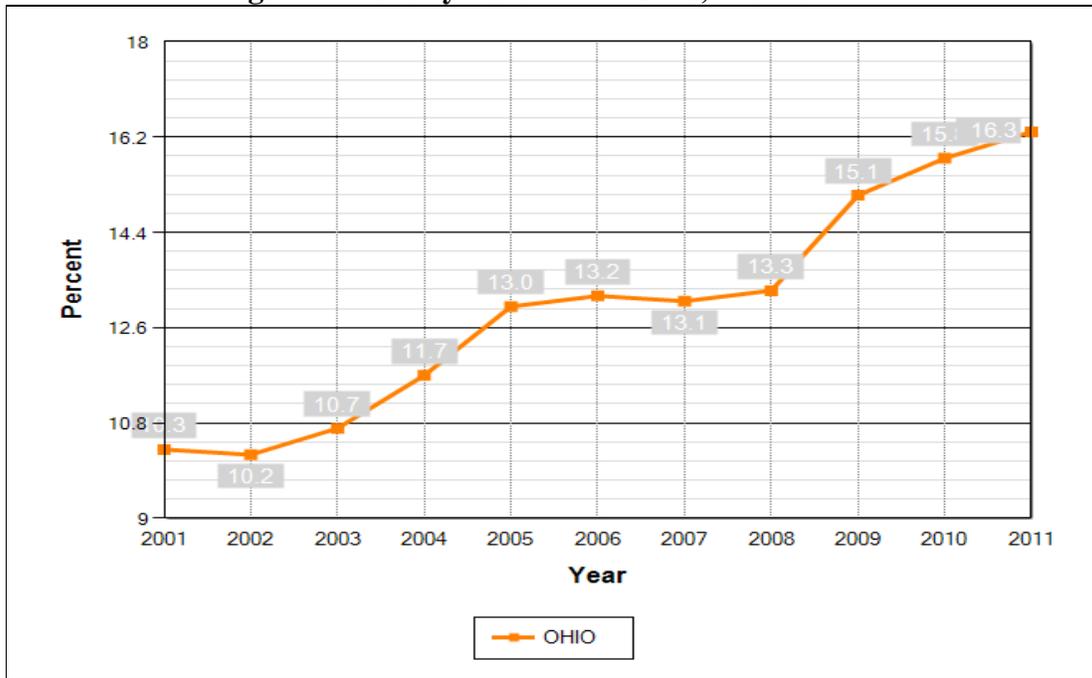
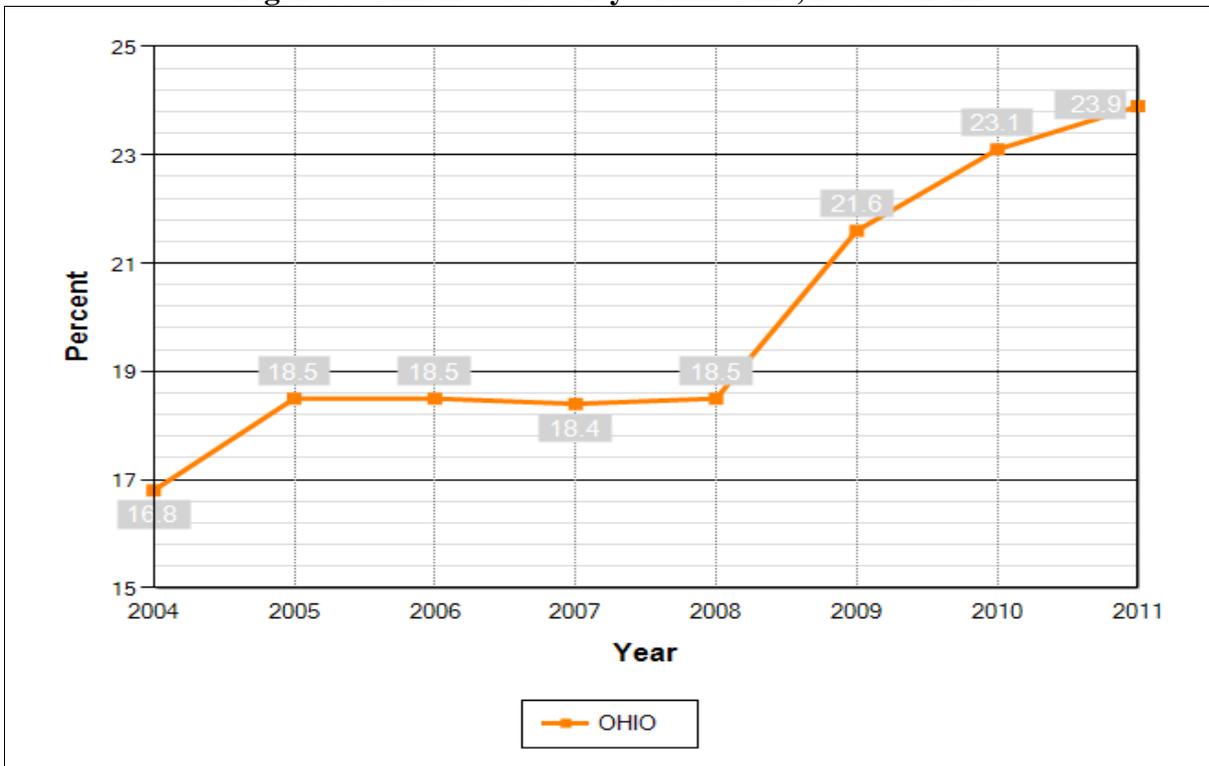


Figure 3: Childhood Poverty within Ohio, 2004 to 2011



New and Emerging Drug Trends: Ohio Substance Abuse Monitoring Network

The Ohio Substance Abuse Monitoring (OSAM) Network consists of eight regional epidemiologists (REPIs) located in Akron-Canton, Athens, Cincinnati, Cleveland, Columbus, Dayton, Toledo and Youngstown. The OSAM Network conducts focus groups and individual qualitative interviews with treatments providers, active and recovering drug users, and law enforcement officials among others to produce epidemiological descriptions of local substance abuse trends. Qualitative findings are supplemented with available statistical data such as coroner's reports and crime laboratory data. Mass media sources such as local newspapers are also monitored for information related to substance abuse trends. Once integrated, these valuable sources provide OhioMHAS with a real-time method of providing accurate epidemiologic descriptions that policymakers need to plan appropriate prevention and intervention strategies.

This Executive Summary presents findings from the OSAM core scientific meeting held in Columbus, Ohio, on February 1, 2013. It is based upon qualitative data collected by six REPIs from July 2012 through January 2013 via focus group interviews (Note: two REPIs covered two regions each). Participants were 365 active and recovering drug users recruited from alcohol and other drug treatment programs in each of OSAM's eight regions. Data triangulation was achieved through comparison of participant data to qualitative data collected from 101 community professionals via individual and focus group interviews, as well as to data surveyed from coroner's offices, family and juvenile courts, common pleas and drug courts, the Ohio Bureau of Criminal Investigation (BCI), police and county crime labs. In addition to these data sources, media outlets in each region were queried for information regarding regional drug abuse for July 2012 through January 2013. OSAM quality and planning researchers in the Office of Quality, Planning and Research prepared regional reports and compiled this summary of major findings. Please refer to regional reports for more in-depth information about the drugs reported on in this section.

In addition to its primary responsibility for the prevention and treatment of substance use disorders, OhioMHAS is also responsible for the prevention and treatment of problem and pathological gambling. For this reason, the OSAM Network amended its protocol in June 2011 to include collection of data related to problem and pathological gambling. The OSAM Network now collects data related to problem and pathological gambling, publishing its findings every six months in conjunction with its drug trend reports. A summary of gambling data is included in this executive summary. For previous gambling reports, please refer to Targeted Response Initiative (TRI) reports for January 2012 and June 2012 available for download via OSAM homepage on the OhioMHAS website: <http://www.odadas.state.oh.us/public/OsamHome.aspx>.

Powdered Cocaine

Powdered cocaine remains moderately to highly available in all regions; availability is currently high in Athens, Cleveland, Columbus and Youngstown and moderate in Akron-Canton, Cincinnati, Dayton and Toledo. Likely decreases in availability during the past six months exist for Akron-Canton, Athens, Cleveland and Dayton. Participants and community professionals in regions where availability has likely decreased attributed the following reasons for less powdered cocaine today: dealers not releasing powdered cocaine, but rather using it to manufacture crack cocaine to maximize profits; recent large scale police busts in the region involving the drug; large shipments being intercepted coming into the country; drug wars in Mexico impeding the flow of the drug across the border; and increased availability and popularity of other substances, such as heroin, decreasing the demand for cocaine. While participants noted a connection between heroin and powdered cocaine, discussing how many drug dealers now carry heroin and powdered cocaine for heroin users who like to use the two drugs together (aka “speedball”), treatment providers continued to note that powdered cocaine is not a primary drug of choice among clients entering treatment. Participant quality scores for powdered cocaine varied throughout regions from ‘0’ to ‘8,’ with the most common score being between ‘4’ and ‘6’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). Participants continued to report that the quality of powdered cocaine varies depending on dealer of purchase. Regional crime labs reported the following substances as used to cut (adulterate) powdered cocaine: boric acid, caffeine, diltiazem (high-blood pressure medication), inositol (B vitamin), levamisole (livestock dewormer), local anesthetics (benzocaine, lidocaine and procaine) and a variety of sugars. Current street jargon includes many names for powdered cocaine, with the most common names remaining “blow,” “girl,” “powder,” “soft,” “snow,” “white” and “white girl.” Depending on desired quality and from whom one buys, a gram of powdered cocaine currently sells for between \$40-100 throughout regions. Participants reported that the most common route of administration for powdered cocaine is snorting, followed by intravenous injection. However, participants in Cleveland reported that the most common way to use powdered cocaine is to smoke it as “rocked up” crack cocaine. Most participants agreed that intravenous injection of powdered cocaine is most common among individuals who also use heroin. Participants and community professionals generally described typical users of powdered cocaine as being of higher socio-economic status, often professionals and often White. Also, participants noted that powdered cocaine use is popular among drug dealers, and use is common in bars and clubs, with several participants noting common use in gay bars and clubs in particular. Additionally, participants continued to note that the drug is appealing to those who work long hours, and some treatment providers in Cincinnati reported more African-American males recently coming into treatment who have had experience with powdered cocaine than previously. Reportedly, other substances used in combination with powdered cocaine include alcohol, Ecstasy, LSD (lysergic acid diethylamide), heroin, marijuana, methamphetamine, prescription opioids, prescription stimulants, sedative-hypnotics and tobacco. Many participants reported that drugs often used in combination with powdered cocaine are used to “come down” from the stimulating effect of powdered cocaine. Participants and community professionals reported that it is common to pair

powdered cocaine use with alcohol to allow a user to drink more alcohol and use more drugs. Common practices among users include lacing marijuana (aka “primo”) or lacing cigarettes with powdered cocaine. Mixing powdered cocaine with heroin, either together in the same syringe or in sequence, is called a “speedball.” A Toledo participant commented that crushing an Ecstasy pill and mixing it with cocaine is called a, “*pixie stick*.”

Crack Cocaine

Crack cocaine remains highly available in all regions. Participants in every region continued to most often report the drug’s current availability as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Many participants noted an increase in the demand for crack cocaine during the past six months, explaining that more people are using crack cocaine because it remains a cheap drug. Additionally, participants commonly noted that crack cocaine remains highly profitable to sell; participants in Cleveland and Columbus reported walk-up or door service as common in the urban areas within certain neighborhoods, whereas a phone call is required in suburban or rural areas; participants in Dayton reported distribution of free samples of crack cocaine (aka “testers”); and while some participants and community professionals commented that even though crack cocaine is still widely available, it is now being outpaced by heroin. The most common participant quality score for crack cocaine varied throughout regions from ‘0’ to ‘7,’ with the most common score being ‘5’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). There was consensus across participant groups that quality of crack cocaine continues to be dependent upon from whom and where (regionally) the drug is purchased. Moreover, several participants noted that when availability of powdered cocaine becomes scarce, buyers are more likely to get low-concentration crack cocaine or “fake crack” (product devoid of any cocaine). Participants in Akron-Canton referred to poor quality crack cocaine, containing very little cocaine and mostly baking soda, as “soda balls.” Regional crime labs reported the following substances as used to cut crack cocaine: levamisole (livestock dewormer), local anesthetics (lidocaine and procaine) and sodium bicarbonate (baking soda). Current street jargon includes many names for crack cocaine, with the most common names being “butter,” “crack,” “hard,” “rock” and “work.” Throughout regions, a gram of crack cocaine sells for between \$40-100, depending on quality. However, many participants continued to report buying crack cocaine in dollar increments instead of measured amounts. Most participants reported buying crack cocaine in \$10 or \$20 amounts, with nearly all participants reporting that crack cocaine is typically purchased by the amount of money a user has available. Many users in Cleveland noted that the decreasing quality of crack cocaine compels them to buy larger sizes which can be cooked down; particularly popular is the “\$50 block,” which reportedly is about the size of a quarter. The most common route of administration for crack cocaine throughout regions remains smoking. Participants continued to note that a minority of users intravenously inject the drug; reportedly, those who inject are those who inject heroin. While there was no consensus throughout regions as to a

profile of a typical crack cocaine user, several common themes emerged. Many respondents described typical users as of lower socio-economic status, African American, often homeless, often unemployed, residing in an urban or inner city location and often involved in prostitution. Reportedly, other substances used in combination with crack cocaine include alcohol, Ecstasy, heroin, marijuana, prescription opioids and sedative-hypnotics. As is the case with powdered cocaine, typically, these other drugs are used with crack cocaine to help bring a user “down” from the intense high associated with cocaine.

Heroin

Heroin remains highly available in all regions. There was almost unanimous agreement among participant groups throughout regions that current availability of heroin is ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). During the past six months, heroin availability increased in Akron-Canton, and it likely increased in Athens, Cleveland, Columbus and Toledo. Many respondents continued to identify heroin as the primary drug problem and labeled its current status as “epidemic.” Participants in Cincinnati reported that heroin is as easy to find as crack cocaine, which has consistently been among the easiest drugs to find in Cincinnati. In Cleveland, participants continued to cite many crack cocaine dealers as switching inventory to accommodate increasing demand for heroin.

Today, street-level dealers actively seek new clientele and encourage their existing clients to switch to heroin. Treatment providers in Athens, Cleveland and Toledo reported an increase in the number of users entering treatment who identify heroin as their primary drug of choice. Participants in Akron-Canton continued to note increased heroin availability and use in more rural areas. Participants in Columbus explained that heroin is easily obtained by calling a dealer and arranging to meet in a parking lot. Participants continued to note that changes to the formulation of some prescription opioids, aimed at making them more difficult to abuse, has caused users to switch to heroin. Treatment providers posited that the fact that heroin is cheaper than other opiates is the reason for the increase in popularity and availability of heroin. Many participants with experience using heroin reported using prescription opioids first which seemingly led to heroin use; treatment providers also mentioned the glut of prescription opioids and the pill progression from prescription opioids to heroin users often undergo. While many types of heroin are currently available throughout regions, participants continued to report brown powdered heroin as most available in Akron-Canton, Cincinnati, Cleveland, Dayton and Youngstown; black tar heroin remains most available in Athens and Columbus; white powdered heroin is currently most available in Toledo. The most common participant quality score for heroin varied throughout regions from ‘3’ to ‘10,’ with the most common score being ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). While participants generally reported that the quality of heroin has either remained the same or has varied during the past six months, some participants noted an increase in quality, particularly some participants in Athens who reported increased quality for the drug’s “raw” form (aka “chunks” before it is broken up into “stamp bags” for sale, as it is at this point that heroin is often

adulterated with other substances). Participants in Athens, Cincinnati, Cleveland, Columbus and Toledo believed heroin to occasionally or frequently be cut with fentanyl. Some participants in Toledo were convinced that in some cases “china white” heroin is dried and crushed fentanyl being sold as heroin. However, regional crime labs reported the following substances as used to cut heroin: caffeine, diphenhydramine (antihistamine), lidocaine (local anesthetic), noscapine (cough suppressant) and quinine (antimalarial). Current street jargon includes many names for heroin. The most commonly cited names were “boy,” “dog,” “dog food,” “dope,” “H” and “smack.” Participants continued to report that it is most common to purchase a single heroin “bag,” “balloon,” “berry,” “fold” or “stamp” (1/10 gram), and then, once used to purchase another: 1/10 gram sells for between \$5-25; a gram sells for between \$100-200, depending on location and quality of heroin. Participants in Dayton reported that brown and white powder heroin is primarily available in “caps” (capsules filled with approximately 1/10 gram of heroin); a cap typically sells for \$10. Many participants in Athens commented that there is a significant difference in price, depending if one traveled to a large city, such as Columbus, or if one bought locally. Throughout regions, the most common route of administration for heroin remains intravenous injection, followed by snorting. Participants continued to note a progression of use with heroin; typically first-time users snort heroin before progressing onto intravenous injection. Participants and community professionals most often described the typical heroin user as White and under 30 years of age. Reportedly, other substances used in combination with heroin include alcohol, bath salts, crack cocaine, Ecstasy, marijuana, methamphetamine, powdered cocaine, prescription opioids, prescription stimulants and sedative-hypnotics. Heroin is used with other drugs to help balance or intensify the effects of heroin, although many participants reported that it is common not to use other substances with heroin.

Prescription Opioids

Prescription opioids remain highly available in all regions. Participants and community professionals listed the following prescription opioids as most popular in terms of illicit use: Dilaudid®, fentanyl, Opana®, OxyContin®, Percocet®, Roxicet®, Roxicodone®, Ultram® and Vicodin®. High availability of prescription opioids has generally remained unchanged during the past six months throughout regions. However, there were more mentions of Dilaudid® availability and popularity than previously, particularly in Athens and Cleveland. Despite the perceptions of many treatment providers, participants reported that users are not as likely to use the new abuse resistant formulations of OxyContin® and Opana®, and the old formulations of these drugs can no longer be found on the streets of most regions. Many prescription opioids have been “proofed,” or made resistant to crushing, putting other non-proofed opioids at a premium. This has reportedly impacted availability and given momentum to the pill-to-heroin progression. However, participants continued to report that many prescription opioids remain readily available through prescription and street purchase, although a number of respondents in Athens, Cleveland and Dayton reported that physicians are now more cautious about their

prescribing. While there were a few reported ways of consuming prescription opioids, and variations in methods of use were noted among types of prescription opioids, generally, the overall most common route of administration remains snorting, followed by intravenous injection and oral consumption (swallowing and chewing). In addition to obtaining prescription opioids on the street from dealers, participants continued to list the following other sources for prescription opioids: doctors, emergency rooms, family, friends and other people with prescriptions and pain clinics. Participants noted that prescription opioids are commonly traded through friends and family. A profile of a typical illicit user of prescription opioids did not emerge from the data. However, participants and community professionals continued to note growing popularity of prescription opioids abuse among younger people. Participants in Akron-Canton spoke about “pharm parties” as popular with adolescents (partygoers bring pills, put them into a bowl and swallow pills randomly). Additionally, there was almost universal agreement among respondents that illicit prescription opioids users are most often White. Reportedly, other substances used in combination with prescription opioids include alcohol, crack cocaine, heroin, marijuana, methamphetamine, powdered cocaine and sedative-hypnotics. Participants reported that the combination of prescription opioids with the aforementioned drugs increases the intensity, euphoria and length of their “buzz” (high). Many participants reported that it is more common to use prescriptions opioids in combination with other substances than to abuse the drugs alone.

Suboxone®

Suboxone® is highly available in all regions with the exception of Dayton where current street availability remains moderate. Changes in availability during the past six months include increased availability for Akron-Canton and Toledo, likely increased availability for Columbus and likely decreased availability for Dayton. Participants continued to report the drug to be easily available by prescription, through treatment centers, the Internet, or from dealers and friends who use heroin. Many participant groups reported that it is a common practice to sell one’s prescriptions. According to several participants, the film/strip form of Suboxone® is typically taken as part of a treatment program or obtained by heroin users as a last resort when heroin cannot be found, and Subutex® or Suboxone® tablets are the more desirable form among illicit users because they can be crushed, snorted or injected. Participants posited that as opiate use continues to increase, so too does the street availability of Suboxone®. Participants also reported that in some counties there are now more Suboxone® programs. Treatment providers reported that there seems to be a demand for Suboxone®, noting billboards advertising, “Free Suboxone®,” and individuals prescribed Suboxone® commonly sharing it with friends. In Athens, while treatment providers noted that there are few doctors in the region who prescribe Suboxone®, they reported that there is enough available Suboxone® that if a user were in withdrawal, he/she could find the drug with little effort. In addition to those who self-medicate with it, treatment providers also reported knowledge of users who get high off Suboxone®.

Participants reported that users are switching from methadone to Suboxone®, and they reported an increase in use at treatment centers. In Dayton, current prescribing patterns are attributed to the decrease in the region, as community professionals reported doctors trying to limit diversion. Collaborating data also indicated the high presence of Suboxone® throughout regions; for instance, the Mahoning County Coroner’s Office reported buprenorphine as present in 16 percent of all drug-related deaths during the past six months. Current street jargon includes few names for Suboxone®, including “oranges,” “strips” and “subs.” Participants reported that an 8 mg tablet or strip of Suboxone® sells for between \$5-25, with tablets generally selling for more as they can be crushed for snorting or injecting. The vast majority of participants continued to report most often taking Suboxone® sublingually (dissolving it under the tongue); however, in terms of illicit use, participants reported dissolving strips in water and injecting, and crushing tablets and snorting, as common. Suboxone® continues to be primarily acquired from doctors, friends and occasionally dealers who keep them to attract users to other inventory. Participants and community professionals who had knowledge of illicit use of Suboxone® continued to describe heroin and prescription opioids addicts as those who typically abuse Suboxone® when they can’t get what they want. Reportedly, other substances used in combination with Suboxone® include alcohol, crack cocaine, marijuana, methamphetamine, powdered cocaine and sedative-hypnotics. However, many participants reported that it is not too common to use other substances with Suboxone®.

Sedative-Hypnotics

Sedative-hypnotics (benzodiazepines, barbiturates and muscle relaxants) remain highly available in all regions. Changes in availability during the past six months include likely increased availability for Akron-Canton and Toledo and likely decreased availability for Dayton. Participants throughout regions most often reported the current availability of these drugs as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Many participants in Akron-Canton agreed that it is easy to find a physician who will prescribe benzodiazepines and easy to find these medications on the street; in addition, a number of participant groups in the region knew of availability of these medications on the Internet. Treatment providers in Toledo reported that the availability of sedative-hypnotics has increased during the past six months, especially for Xanax®; both reporting crime labs in the Toledo region also reported increases in the number of Xanax® cases they process. Participants in Dayton suggested that the perceived decline in availability of sedative-hypnotics is due to fewer prescription holders selling their drugs. Participants and community professionals reported Klonopin® and Xanax® as the most popular sedative-hypnotics in terms of illicit use, followed by Ambien®, Soma® and Valium®. Participants continued to report most often obtaining these drugs from individuals with existing prescriptions, or by feigning symptoms of anxiety and getting prescriptions from doctors. Participants reported that dealers often do not carry sedative-hypnotics, possibly due to their availability through other sources and their lower profitability; most of these drugs sell for no more than a few dollars per pill. While there were a few reported

ways of consuming sedative-hypnotics, the most common routes of administration remain oral consumption and snorting, with some mention of intravenous injection and smoking. A few participants reported lacing marijuana with crushed sedative-hypnotics pills for smoking. Participants and community professionals generally described the typical illicit user of sedative-hypnotics as adolescent to “young” adult, White and female. The use of sedative-hypnotics with other drugs is common. Reportedly, other substances used in combination with sedative-hypnotics include alcohol, crack cocaine, heroin, marijuana, powdered cocaine and prescription opioids. Sedative-hypnotics are often used as a way of stabilizing from a high provided by stimulants such as cocaine. When used in combination with alcohol, participants in the Columbus region reported dissolving the drugs into beer and drinking.

Marijuana

Marijuana remains highly available throughout all regions. Participants from every region most often reported the overall availability of marijuana as ‘10’ on a scale of ‘0’ (not available, impossible to get) to ‘10’ (highly available, extremely easy to get). Community professionals commonly reported that many users do not consider marijuana a drug; many community professionals also noted that marijuana currently available is far more potent and fast acting than in the past. In addition, treatment providers noted that for many young people, marijuana is easier to obtain than alcohol. Treatment providers in Athens reported that 90 percent of adolescents entering treatment report marijuana as their drug of choice. Law enforcement reported that marijuana is both grown locally and imported. In Cleveland, and in most regions, marijuana remains, by far, the most easily-obtained illegal drug, available to every socioeconomic group, rural and suburban. The bifurcation of the drug into two distinct categories continues to deepen: commercial-grade (low- to mid-grade marijuana) or hydroponically grown (high-grade) marijuana. Community professionals were in agreement with participants in reporting that commercial-grade marijuana is available “everywhere,” while purchase of hydroponic marijuana requires knowing whom to call and where to go to obtain it. In addition, several participants discussed either growing or having access to hydroponically grown marijuana; and participants in Toledo and Youngstown discussed having access to medical marijuana. Collaborating data also indicated that marijuana is readily available throughout regions. For instance in Dayton, the Montgomery County Juvenile Court reported that of the juveniles it drug tested during the past six months, 68.3 percent tested positive for the presence of an illicit drug; and of those positive, 71.7 percent were positive for the presence of marijuana. Every grade of marijuana is available throughout regions, and participants continued to explain that the quality of marijuana depends on whether the user buys commercial-grade or hydroponically grown marijuana. Participants commonly rated the quality of commercial-grade marijuana as between ‘2’ and ‘7,’ while they rated the quality of high-grade marijuana most often as ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality). A Toledo participant commented on an increase in the quality of marijuana in that region since Michigan voted to legalize the use of medical marijuana. Current street jargon includes countless names for

marijuana. The most commonly cited names for marijuana generally were “green,” “pot,” “trees” and “weed.” Prices for marijuana continue to depend upon the quantity and quality desired: for commercial-grade marijuana, a “blunt” (cigar) or two “joints” (cigarettes) sells for between \$5-10; an ounce sells for between \$50-120. Higher quality (hydroponically grown) marijuana sells for significantly more: a blunt or two joints sells for between \$10-30; an ounce sells for between \$150-400. The most common route of administration for marijuana remains smoking; however, participants again noted that marijuana can also be consumed in baked goods and by making tea. A profile for a typical marijuana user did not emerge from the data. Participants and community professionals continued to report that marijuana use is widespread across all population strata. Reportedly, other substances used in combination with marijuana include alcohol, crack cocaine, heroin, methamphetamine, PCP (phencyclidine), powdered cocaine, prescription opioids, sedative-hypnotics and Suboxone[®]. Participants reported that marijuana intensifies the high of other substances. A participant group in Akron-Canton reported knowledge of using marijuana with embalming fluid or PCP, describing marijuana with either of the aforementioned as causing one to hallucinate. Participants did not agree on whether it is more common to use marijuana by itself or to use it with other substances; some participants posited that marijuana goes with everything.

Methamphetamine

Methamphetamine availability remains high for Akron-Canton and Cleveland and variable for Cincinnati, Columbus and Youngstown; availability is also variable for Dayton, low to moderate for Toledo, and moderate to high for Athens. Changes in availability during the past six months include increased availability for Athens and likely increased availability for Akron-Canton, Cleveland, Columbus and Youngstown. In regions where availability of methamphetamine is variable, generally lower availability exists for urban areas and higher availability exists for rural areas. However, Dayton participants reported high availability for the drug within the city and much lower availability in outlying areas. Participants throughout regions reported on the production of “one-pot” or “shake-and-bake” methamphetamine, which means users are producing the drug in a single sealed container, such as a two-liter soda bottle. By using common household chemicals along with ammonium nitrate found in cold packs and pseudoephedrine, typically found in some allergy medications, drug manufacturers (aka “cooks”) can produce methamphetamine in approximately 30 minutes at nearly any location. Participants throughout regions reported “shake-and-bake” methamphetamine as the most prevalent form of available methamphetamine. Participants reported that higher quality methamphetamine, commonly referred to as “ice,” is very rare; additionally, participants named the more traditional form of locally produced “red phosphorous” methamphetamine, which large amounts were manufactured previously for sale on the streets, as also rather rare. In Athens, some participants believed that some methamphetamine is being moved into the region from southern states, and law enforcement reported that the availability of methamphetamine coming from Mexico (aka

“Mexican ice”) has decreased since users can now make their own methamphetamine. Participants generally noted that methamphetamine is cheaper and easier to make than previously. However, treatment providers have not experienced an uptick in methamphetamine abuse among their clientele. The overall quality of methamphetamine continues to range from ‘5’ to ‘10’ on a scale of ‘0’ (poor quality, “garbage”) to ‘10’ (high quality), with crystal methamphetamine being at the higher end of the scale. Participants in Columbus reported that the quality of methamphetamine has decreased during the past six months; they reported methamphetamine to be cut with baby laxative, MSM (methylsulfonylmethane – a dietary supplement), a mixture of over-the-counter chemicals, as well as salt. A participant group in Athens reported that methamphetamine is being mixed with cocaine and that some users are unaware that their cocaine contains the drug. Current street jargon includes a few names for methamphetamine. The most commonly cited names were “crank,” “crystal,” “glass,” “ice,” “meth,” “speed” and “tweak.” Prices for methamphetamine continue to depend on the quantity and quality of the drug: a gram sells for between \$50-150. However, participants in Akron-Canton and Athens reported buying small bags of methamphetamine (1/10-2/10 gram) for between \$20-30. Participants in Akron-Canton and Youngstown reported that methamphetamine is often traded for precursor ingredients, such as Sudafed®; many participants in the Youngstown region also discussed purchasing Sudafed® in exchange for other drugs, particularly heroin. While there were several reported ways of using methamphetamine, the most common route of administration remains smoking, followed by intravenous injection. There was universal agreement among all respondent groups that typical methamphetamine users are almost exclusively White. In addition, participants noted the following groups of Whites as those most likely to use: “younger,” rural, gay males, motorcycle gang members and truck drivers. Reportedly, other substances used in combination with methamphetamine include alcohol, crack cocaine, heroin, marijuana, powdered cocaine, prescription opioids, prescription stimulants and sedative-hypnotics. Alcohol, marijuana and sedative-hypnotics assist the user in coming down from the extreme stimulant high produced by methamphetamine. Heroin is used in combination with methamphetamine for the “speedball” effect. The majority of participants noted that it is more common to use methamphetamine by itself, and if used with any other substance, it is used most often with alcohol.

Prescription Stimulants

Prescription stimulants are moderately to highly available in all regions; availability remains high in Athens, Cleveland, Columbus and Youngstown and moderate to high in Cincinnati; current availability is high in Akron-Canton and moderate to high in Dayton and Toledo. Participants explained that if prescription stimulants are desired, they can easily be found. A participant group in Akron-Canton described extreme ease in being able to obtain prescription stimulants; they reported that a lot of school-aged children are prescribed Adderall® or Ritalin® and that many sell their medication. Participants reported that illicit users of prescription stimulants are not likely to obtain the drugs from a drug dealer. Many participants with use

experience reported that the most convenient way to obtain prescription stimulants is by getting them from someone who is prescribed them; participants reported getting the drugs often from family members (younger siblings) who are being treated with the medication. Reportedly, Adderall® is the most popular prescription stimulant throughout regions in terms of illicit use, followed by Concerta®, Ritalin® and Vyvanse®. Community professionals reported that they do not typically see or deal with prescription stimulants abuse; however, many treatment providers reported that some individuals currently in treatment report past use of prescription stimulants. Current street jargon includes a few names for prescription stimulants. The most commonly cited names were “addies” for Adderall®, as well as “kiddie coke,” “meth in a pill,” “poor man’s coke,” “speed” and “uppers” for prescription opioids generally. Participants reported that Adderall® 30 mg sells for between \$3-10, depending on location. While there were several reported ways of using prescription stimulants, the most common route of administration for abuse remains oral consumption (swallowing and eating) and snorting. Participants also reported knowing of some intravenous injection of prescription stimulants, but this was said to be rare. Participants described typical illicit users of prescription stimulants as high school and college aged. Community professionals also described typical illicit users as between 18-25 years of age, most often enrolled in college who take the drugs during exam time. A couple of treatment provider groups noted that abuse of prescription stimulants is higher among women; providers in Akron-Canton reported that many women use the drugs for weight control. Reportedly, other substances used in combination with prescription stimulants include alcohol, cocaine, marijuana, prescription opioids and tobacco. Prescription stimulants are used in combination with alcohol and marijuana when the user wants to “party” longer and continue to consume alcohol and/or use marijuana; they are used in combination with prescription opioids to enhance the high of prescription opioids.

Bath Salts

Bath salts (synthetic compounds containing methylone, mephedrone, MDPV or other chemical analogues) remain available throughout regions despite legislation that banned its sale and use in October 2011. Current availability remains high in Akron-Canton and Columbus and moderate in Cleveland, Dayton, Toledo and Youngstown; availability is moderate to high in Cincinnati and appears to be low in Athens. Packaged products of bath salts continue to be available from some of the same convenience stores, beverage drive-thrus, head shops, gas stations and smoke shops that sold bath salts previously. They are now “behind the counter” and available only to known users. In addition, participants noted that bath salts can still be found on the streets, but a user would have to know someone who deals in the drug. No matter what the perceived level of availability, all participant groups agreed that availability was higher before bath salts were banned. Also, respondents universally noted that legislative action has had an effect on availability. However, a DEA agent in Cincinnati stated that while there may have been a decline in the use of bath salts, the drug remains obtainable to those who desire it. Participants in Athens

noted that bath salts are still readily available in West Virginia, and hence, users go across the state line to purchase the drug. In addition, participants commented that users can still purchase bath salts over the Internet. Canton-Stark County Crime Lab reported that other substances similar to bath salts have been seen in the lab during the past six months; some of these substances are controlled (4-Fluoroamphetamine and 4-Fluoromethamphetamine) while others are uncontrolled chemical analogues. Most participants expressed an aversion for bath salts and did not report attempting to purchase them; many participants were repulsed by media stories of the negative consequences of bath salts use. New labels for bath salts are emerging to help circumvent the laws; participants said bath salts are currently sold under labels like, “hookah cleaner,” “incense,” “pixie dust,” “plant food,” “salt” and “zombie salts.” Prices for bath salts varied substantially between regions. A participant with experience purchasing the drug reported that the price of bath salts has recently increased. Participants reported that bath salts sell for between \$20-60 per gram within Akron-Canton, Cincinnati and Columbus regions. In contrast, participants in Athens reported bath salts selling for between \$40-180 per gram; participants within the remaining regions reported current pricing as unknown to them. The most common routes of administration for bath salts are snorting and intravenous injection. Participants and community professionals described typical bath salts users most often as younger than 30 years of age and likely on probation, monitored through urine drug screens. Reportedly, other substances used in combination with bath salts include alcohol, cocaine, heroin and marijuana. There was no consensus among participants as to whether regular bath salts users combined bath salts use with other substances. However, participants who had experimented with the drug reported using it with alcohol and marijuana.

Synthetic Marijuana

Synthetic marijuana (synthetic cannabinoids, aka “K2” and “Spice”) remains available throughout regions despite legislation that banned its sale and use in October 2011. Current availability remains high in Akron-Canton, Cleveland and Toledo; availability is moderate in Dayton and Youngstown; participants in Athens, Cincinnati and Columbus thought availability to be high, while community professionals in those regions viewed current availability as low to moderate. Likely increases in availability exist for Toledo and Youngstown. As with bath salts, participants throughout regions reported that synthetic marijuana continues to be available on the street from dealers as well as from many convenience stores and head shops. However, participants and law enforcement reported that recent legislation has caused the drug to be far less available at retail outlets than previously, and those which continue to sell synthetic marijuana are much more discreet about it. The general consensus among participants who have used synthetic marijuana was that the drug is not very desirable, as most users do not like the “high” produced from the drug, and thus most prefer to smoke marijuana. Law enforcement in Toledo and Youngstown regions believed that availability has slightly increased during the past six months. They cited that young people who use synthetic marijuana believe they will receive

less of a penalty than being caught with marijuana. Additionally, some users reportedly smoke synthetic marijuana because they continue to believe that it will not show up on any drug screen. New labels and names for synthetic marijuana are emerging to help circumvent the laws; however, the most commonly cited names continue to be “K2,” “K3” and “Spice.” Within most regions, a gram of synthetic marijuana currently sells for between \$20-25. The only route of administration for synthetic marijuana remains smoking. Participants and community professionals described typical users of synthetic marijuana as “young” and without connections or resources to obtain real marijuana, or users who wish to avoid the negative sanctions of a positive marijuana test, such as probationers. Participants reported that generally, synthetic marijuana is not often used in combination with other drugs besides use with alcohol and/or marijuana.

Ecstasy

Ecstasy (methylenedioxymethamphetamine: MDMA, or other derivatives containing BZP, MDA, and/or TFMPP) availability remains variable throughout regions. Current availability remains high in Cincinnati and Cleveland and moderate in Columbus and Youngstown; availability is moderate to high in Toledo, variable in Athens and appears to be low in Akron-Canton and Dayton. Changes in availability during the past six months include decreased availability for Akron-Canton and likely decreased availability for Cincinnati. Participants generally reported regular use of Ecstasy to be uncommon, explaining that if there were a music festival in the area, one would hear about Ecstasy. Law enforcement in the Athens region reported on an annual festival where Ecstasy use is thought to be prevalent. A few participants with first-hand experience reported that if you know who deals Ecstasy, you can get it. Community professionals reported that Ecstasy use seems to be more uncommon than previously. Treatment providers noted that Ecstasy is sometimes heard about but mostly in the context of experimental use among high school and college students. Participants in Cincinnati reported that Ecstasy remains popular in the city but that a user would need a connection to buy the drug; Ecstasy is not a drug obtained on the street. However, participants in Cleveland thought dealers to carry Ecstasy as many dealers are believed to personally use the drug. Several participants in Youngstown noted an increase in pure MDMA, or “Molly,” during the past six months. Current street jargon includes a few names for Ecstasy. The most commonly cited names were “beans,” “E,” “Scooby snacks,” “Skittles®” and “X.” Participants reported that a “single stack” (low dose) Ecstasy tablet sells for between \$2-10; a “double-stack” (high dose) tablet sells for between \$10-20; a “triple stack” (highest dose) tablet sells for between \$10-25; 1/10 gram of “Molly” sells for \$15; a gram sells for between \$60-100. These drugs are obtained from friends and dealers, often via a phone call or at nightclubs. Higher pricing can be expected at events or at nightclubs. While there are few reported ways of using Ecstasy, the most common route of administration remains oral consumption. In addition, a few participants discussed “plugging” Ecstasy (insertion of the drug rectally); MDMA is most often snorted. Participants

described typical users of Ecstasy as African Americans, club goers, hippies, urban youth and “younger” people. Participants and treatment providers alike continued to identify Ecstasy as a “rave” (underground dance party) drug, popular with college students. Participants explained that users of Ecstasy like to use it to enhance the night club experience or to enhance a sexual experience. Reportedly, other substances used in combination with Ecstasy include alcohol, cocaine, hallucinogens, heroin and marijuana.

Other Drugs

OSAM Network participants listed a variety of other drugs as available in Ohio, but these drugs were not reported in all regions. Participants in Dayton continued to mention anabolic steroids as available at some fitness centers in the region. Hallucinogens [lysergic acid diethylamide (LSD), phencyclidine (PCP) and psilocybin mushrooms] remain available in many regions. In addition, BCI London Crime Lab reported an increase in the number of cases involving 2C-E, 2C-I and 25I-NBOMe (psychedelic phenethylamines). LSD is rarely to moderately available in most regions, with the exception of Akron-Canton where it is highly available, and Cincinnati, where the drug is moderately to highly available. Many participants indicated that LSD is considered a seasonal drug, with availability increasing in the spring and summer months, or at particular rock concerts. Current street jargon includes a few names for LSD. The most commonly cited names were “acid,” “blotter” and “blotter acid.” Reportedly, LSD sells for between \$5-10 per “hit” (dose). The most common route of administration for LSD is oral consumption, followed by lacing a cigarette with the drug and smoking. While a typical user profile did not emerge in every region, respondents frequently reported LSD users as mostly White, hippies, teenagers and “young” adults. Reportedly, PCP remains highly available in one area of the City of Cleveland, often referred to as “water world.” Treatment providers in Cleveland reported an increase in the number of cases involving PCP during the past six months. Participants with experience purchasing the drug reported that one dip of a cigarette into liquid PCP sells for between \$10-20. The most common route of administration for PCP remains smoking. Outside of Cleveland, no other region reported on PCP use. Psilocybin mushrooms are moderately to highly available in most regions. Like other hallucinogens, participants said psilocybin mushrooms are seasonally available, found most often in the spring and summer months. Current street jargon includes a few names for psilocybin mushrooms. The most commonly cited names were “blue caps,” “caps,” “gold caps,” “magic,” “mushies” and “shrooms.” Participants reported that psilocybin mushrooms are available for \$8 per vial; 1/8 ounce of dried psilocybin mushroom material sells for between \$20-30; 1/4 ounce sells for between \$50-55; an ounce sells for between \$120-200. The most common route of administration for psilocybin mushrooms remains oral consumption, but participants also continued to report smoking and making tea with them. Participants reported getting psilocybin mushrooms from dealers, chemists, chemical engineers and professors. Participants reported typical users as “young” adults and college students. Reportedly, other substances used in combination with hallucinogens include alcohol, cocaine,

Ecstasy, inhalants and marijuana. Inhalants are highly available throughout most regions, but these substances are not preferred by most drug users. Inhalants are breathed into the lungs, or “huffed.” Participants and community professionals identified the most commonly abused inhalants as computer duster (aka “duster”) and Freon. Typically, inhalants users are junior- and high-school aged adolescents who have little access to other drugs. Reportedly, other substances used in combination with inhalants include alcohol and LSD. Over-the-counter (OTC) and prescription cough and cold medications remain highly available throughout most regions. Participants mentioned using these medications, especially Coricidin®, to get high. Typically, users combine these medications with soda. Like inhalants, participants identified OTC and prescription cough and cold medicines as substances that individuals in middle and high school are more likely to abuse than others.

Gambling

Several themes regarding the popularity of particular gambling types are common to all OSAM regions. Lottery and scratch-offs are the most common forms of gambling within each region. Internet cafes also continue to grow throughout the state, and may be directly related to drug use in some areas. A Cleveland participant reported that drug dealers frequent Internet cafes and drugs are often obtained at these businesses. Participants in every region reported participation in casino gambling during the past six months, with 20 percent of Columbus participants reporting casino gambling. Casino gambling may be more prevalent in regions closer to existing casinos in Indiana, Pennsylvania and West Virginia. Dice, poker and other street games are popular in the Cincinnati, Columbus, Dayton, Toledo and Youngstown regions. Bingo is also common, particularly in the Akron-Canton, Athens, Columbus, Dayton and Youngstown. Finally, while not as prevalent as other forms of gambling, sports gambling is available throughout regions. There was no consensus among participants as to a relationship between alcohol and other drug (AOD) use and gambling. Participants in Athens, Cleveland and Dayton gave mixed reports on the topic. However, some patterns did emerge from the data. Participants in Columbus generally agreed that AOD use and gambling are in some way related to one another. Most Columbus respondents who shared this viewpoint referred to alcohol use as very common among gamblers. Although participants in the Akron-Canton region were split as to whether or not a relationship between alcohol and gambling exists, some participants suggested that there is a significant relationship. The connection between alcohol use and gambling was also supported by participant reports in Athens, Toledo and Youngstown. Similarly, Cleveland participants suggested that both marijuana and alcohol use are prevalent among gamblers. Several participants reported that there may be an indirect relationship between drugs and gambling. Specifically, the tendency to gamble in order to buy drugs was mentioned by several participants within Athens, Columbus and Youngstown especially. In addition, some participants in Athens, Columbus and Toledo reported gambling more when they used drugs. However, Cincinnati participants reported gambling as secondary to drug use, suggesting that they would only gamble

with additional funds after obtaining their drug of choice. Reports suggest that most participants believed that gambling is potentially addictive. In addition, some participants suggested that personality influences one's susceptibility to gambling addiction. However, very few participants reported struggling with problem or pathological gambling. No participants in Cincinnati or Columbus regions reported experiencing any problems with gambling. Most descriptions of problem and pathological gambling were made in reference to family members or friends. However, some participants reported borrowing money from others to cover gambling debts. In addition, two participants in Toledo reported seeking help for an addiction to gambling, with one receiving treatment.

Assessing Substance Use and Related Consequences in Ohio: State Epidemiological Outcomes Workgroup

OhioMHAS has identified several indicators of substance use (consumption) and consequences resulting from substance use in its epidemiological data profiles. Consumption indicators include age of initiation, lifetime use, current use, and high-risk use. Consequences of use include mortality and morbidity data, measures of abuse and addictive disorders, and crime related indicators.

Several measures of mortality and morbidity which demonstrate ties to substance use are currently of concern within Ohio. In 2011, Syphilis and Chlamydia rates in Ohio declined for both adolescents and adults for the first time since 2006. Similarly, the HIV incidence within Ohio increased between 2006 and 2011 by 27.3 cases per 100,000 population. While stable, the infant mortality rate within Ohio remained above the US average every year between 2003 and 2009. Finally, Ohio's poverty rate has been rising steadily since 2001.

Some direct consequences of alcohol, tobacco and other drugs (ATOD) consumption are of concern for Ohio residents. Approximately 4 to 5% of the motor vehicle crashes within Ohio between 2001 and 2011 were alcohol related. During this time period, alcohol accounted for 5,159 deaths on Ohio's roadways. According to the NSDUH, Ohio's alcohol abuse or dependence rate has remained above the national average since 2005-2006. Ohio's illicit drug abuse or dependence rate has remained above the US average since 2005-2006, with the exception of a rate decrease in 2009. Ohio's rate of unintentional drug deaths has also been rising since 2004.

In addition, mental health issues also remain of concern for Ohio residents. The National Survey on Drug Use and Health (NSDUH) reports that Ohio has remained above the national average for major depression among individuals aged 12+ since 2004-2005. While several external factors can influence the prevalence of mental health conditions, a decrease in ATOD use could significantly reduce such problems for Ohio residents.

Contextual indicators from the Research Triangle Institute study that measure community instability and family-related factors (e.g., teen-birth rate, divorce, and child-abuse or neglect) comprised another set of measures used for the Ohio epidemiological profile. While the

relationship between such indicators and ATOD consumption is at times inconsistent, Sanchez, Dunteman, Kuo, Yu, and Bray (2001) suggested that the above demographic and contextual measures should be monitored closely in an effort to evaluate the impact of ATOD use on Ohio's population.

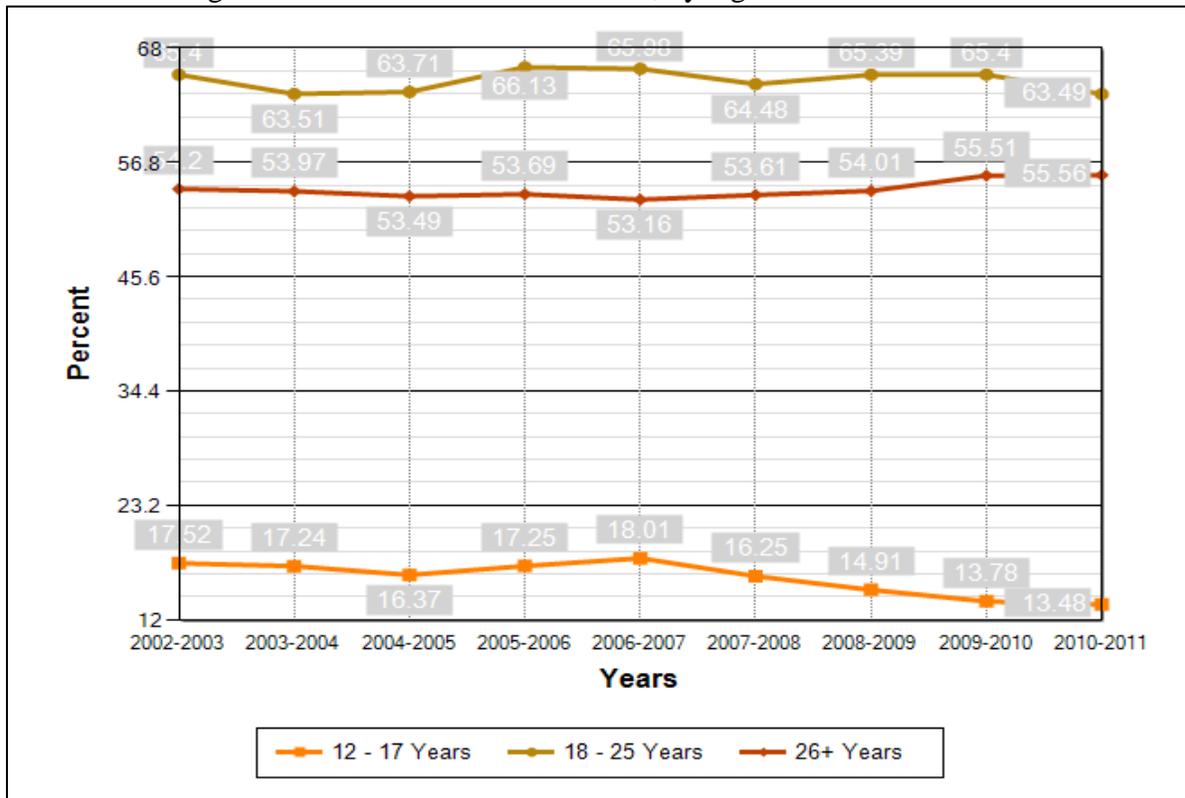
The following is a detailed description of the alcohol, tobacco and other drug consumption and related problems within Ohio. Throughout the data collection and analysis process, US Census data was used as a standard for establishing rates and comparing groups of interest.

SEOW data demonstrated the need for a focus upon the state's young adult population. Individuals aged 18 to 25 within Ohio are consistently showing higher rates of use when compared with other age groups. While other demographic categories, such as race/ethnicity, school type and gender, do demonstrate between-group differences, the consumption data shown here are the only available state-level data which are relevant to ATOD use across the lifespan. It should be noted that the finding of particularly high prevalence rates for the 18 to 25 year olds in Ohio informed the OHIO SPF-SIG Committee on the need to make this a priority population for the SPF-SIG.

Alcohol Consumption

Alcohol is the most commonly abused substance in both Ohio and the US. According to the National Survey on Drug Use and Health (NSDUH), current alcohol use is most common among young adults between the ages of 18 and 25. Within Ohio, young adults between the ages of 18 and 25 ranked above all other age groups for alcohol use in past month (Figure 4), binge alcohol use (Figures 5 and 5a), heavy drinking among adults (Figure 3), and alcohol abuse or dependence. In addition, when compared to other age groups, young adults in Ohio presented a high rate of alcohol abuse or dependence (Figure 6). Finally, Ohio was above the national average in alcohol use in past month, binge alcohol use, and heavy drinking among adults. Therefore, the data suggests that a focus upon alcohol consumption by young adults between the ages of 18 and 25 could potentially reduce alcohol consumption and, in turn, alcohol-related consequences within this age group. If successful, the prevention efforts applied to young adults could sequentially reduce AOD consumption by members of older age groups.

Figure 4: Alcohol Use in Past Month, by Age in Ohio: 2002-2011



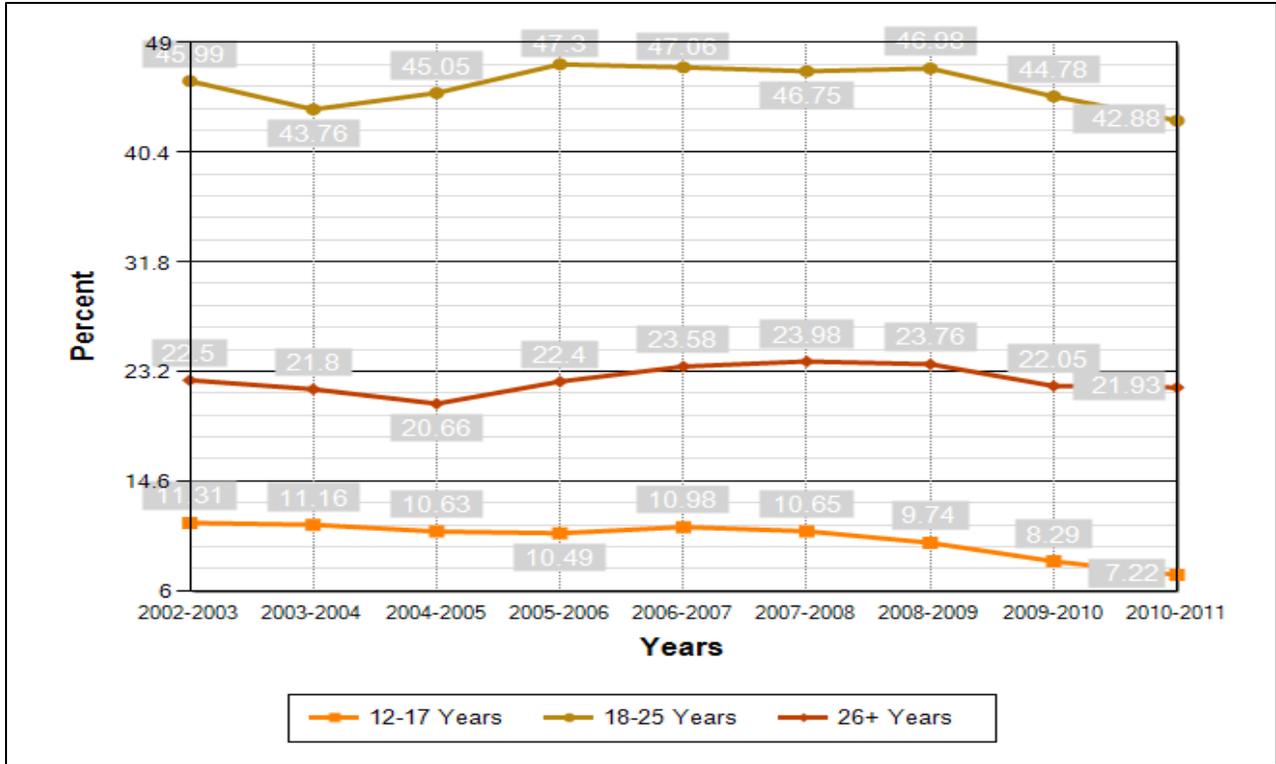
Within developed countries, alcohol use accounts for approximately 9% of years of life lost worldwide. Approximately 100,000 deaths each year in the U.S. are attributed to alcohol misuse. Among Ohio residents aged 12+, members of the 18 to 25 age group remained above other groups in current alcohol use across all years examined here. In 2005-2006, close to 2/3 of Ohio residents between the ages of 18 and 25 had used alcohol within the past month.

Variable Definition Figure 4: Percent of persons aged 12 and older reporting any use of alcohol within the past 30 days.

Data Sources: National Survey on Drug Use and Health (NSDUH).

Thomson, S. J., Westlake, S., Rahman, T. M., Cowan, M. L., Majeed, A., Maxwell, J. D., & Kang, J. Y. (2008). Chronic liver disease-An increasing problem: A study of hospital admission and mortality rates in England, 1979-2005, with particular reference to alcoholic liver disease. *Alcohol & Alcoholism*, 43(4), 416-42

Figure 5: Binge Alcohol Use in Past Month, by Age in Ohio: 2002-2011

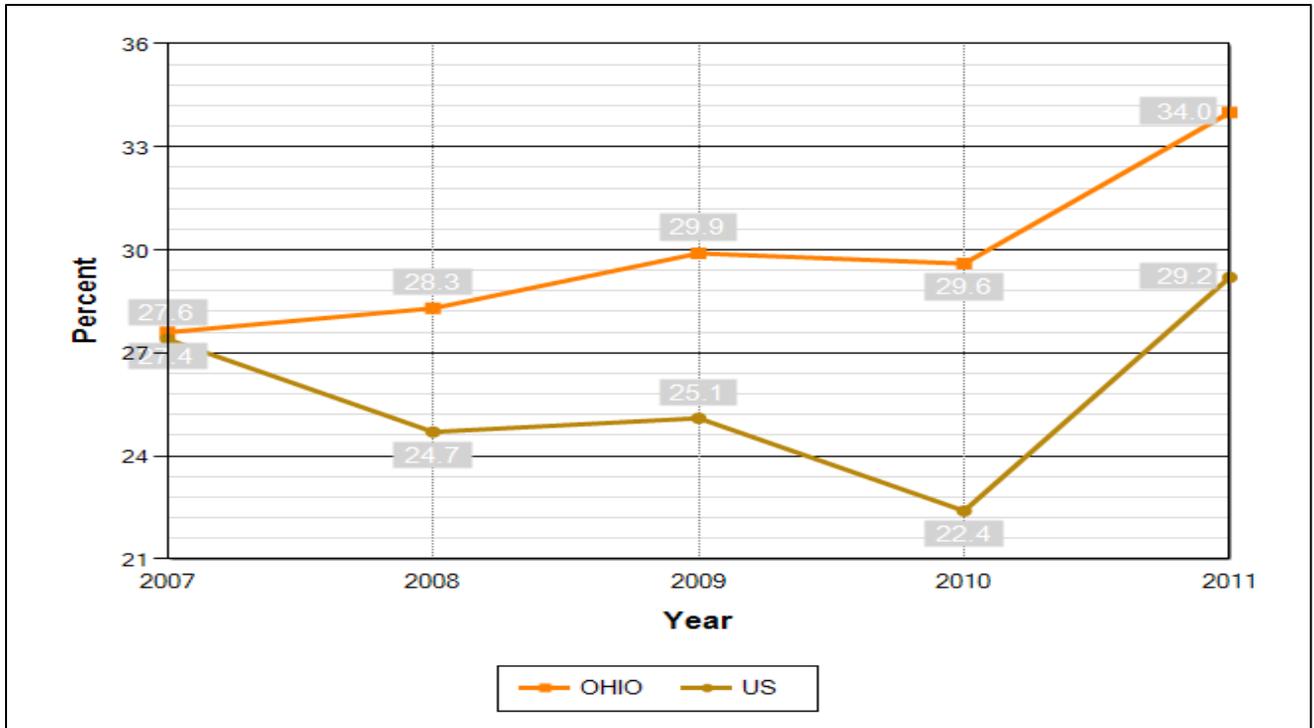


Binge drinking, as indicated by consumption of five drinks or more within a short time span, is often related to injuries, motor vehicle crashes, violence, fetal alcohol syndrome, chronic liver disease, and a number of other chronic and acute conditions. Men are more likely than women to participate in binge drinking, and the prevalence of binge drinking has been shown to decline with age.

Variable Definition Figure 5: Percent of persons aged 12 and older reporting having five or more drinks on at least one occasion within the past 30 days.

Data Sources: National Survey on Drug Use and Health (NSDUH) Morbidity and Mortality Weekly Report (MMWR), 2008; 57(49); 1333. Quickstats: Percentage of adults aged =18 years who consumed five or more alcoholic drinks in 1 day at least once in the preceding year, by sex and age group--National Health Interview Survey, United States, 2007. From <http://www.cdc.gov/mmWR/preview/mmwrhtml/mm5749a6.htm>.

Figure 5a: Binge Drinking Among Persons Aged 18 to 24: Ohio vs. US

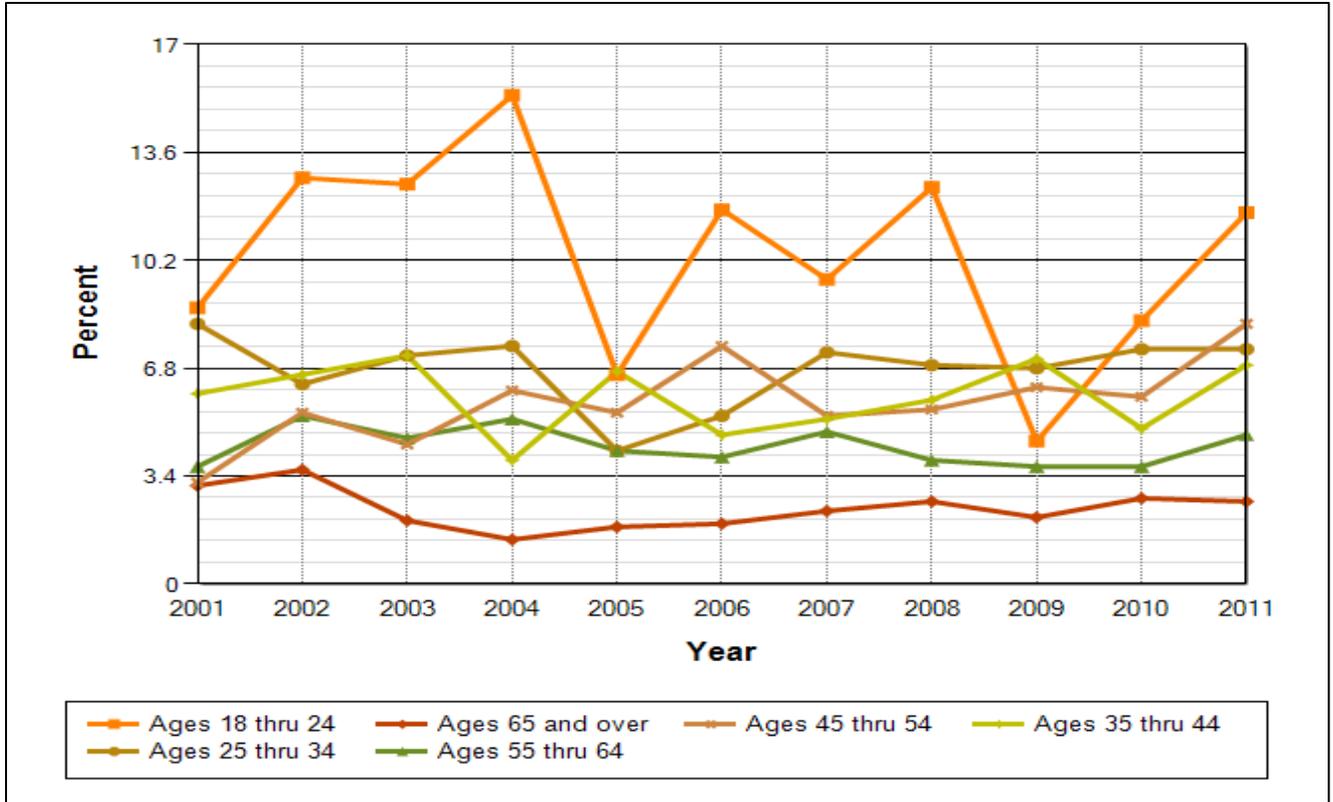


Variable Definition Figure 5a: Percent of persons aged 18 and older reporting having five or more drinks on at least one occasion within the past 30 days.

Data Sources: Behavioral Risk Factor Surveillance System

Morbidity and Mortality Weekly Report (MMWR), 2008; 57(49); 1333. Quickstats: Percentage of adults aged =18 years who consumed five or more alcoholic drinks in 1 day at least once in the preceding year, by sex and age group--National Health Interview Survey, United States, 2007. From <http://www.cdc.gov/mmWR/preview/mmwrhtml/mm5749a6.htm>.

Figure 6: Heavy Drinking among Adults, by Age in Ohio



Heavy use of alcohol pertains to a pattern of regular use at levels that exceed U.S. Dietary Guidelines. It is associated with heightened levels of mortality. Heavy drinkers are at increased risk for a variety of adverse health outcomes, including alcohol abuse and dependence. Within Ohio, the rate of heavy drinking among 18 to 25 year old residents remained at or above other age groups throughout all years examined here.

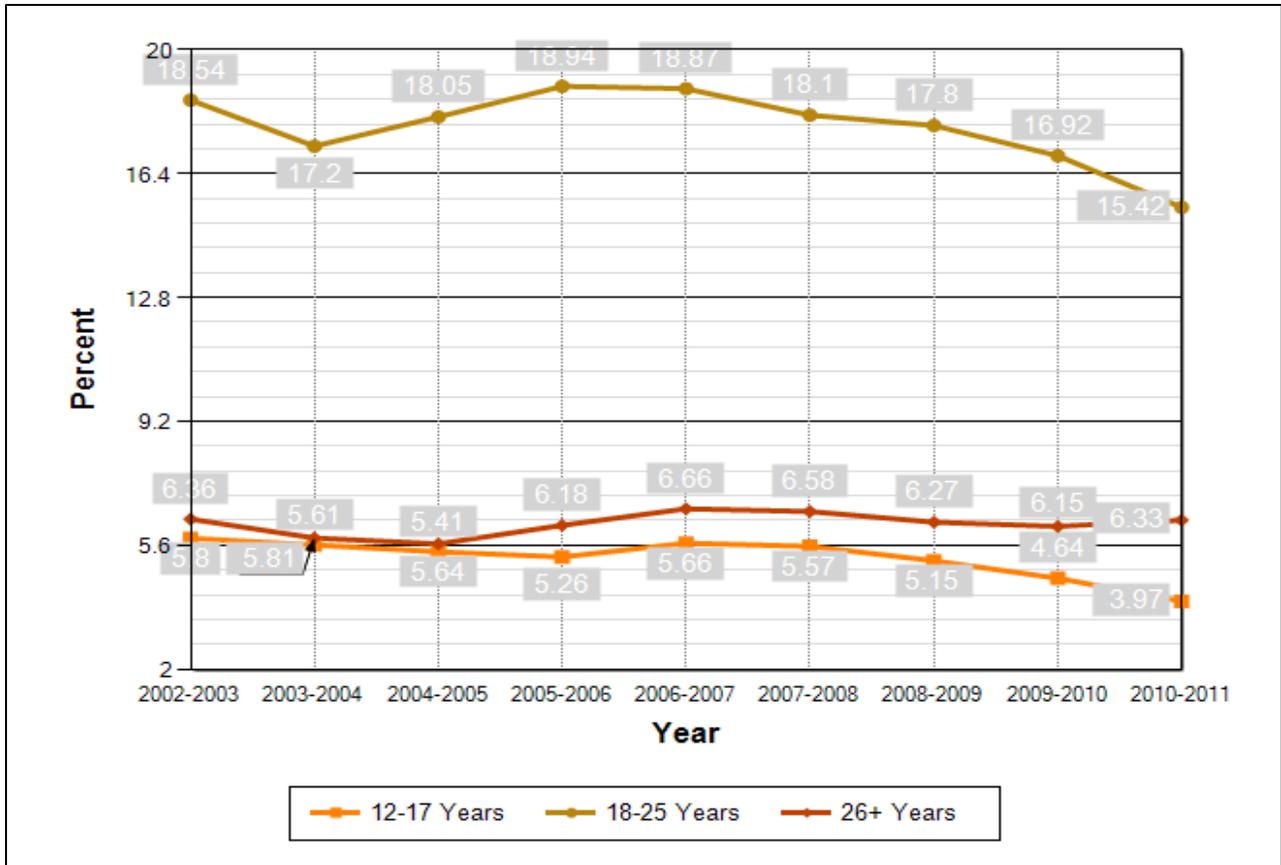
Variable Definition Figure 6: Percent of women aged 18 and older reporting average daily alcohol consumption greater than one drink per day Percent of men aged 18 and older reporting average daily alcohol consumption greater than two drinks per day.

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC)

Alcohol Consequences

As demonstrated below, young adults in Ohio are consistently presenting high rates of alcohol abuse and dependence (Figure 7). Ohio also presented a high national ranking in alcohol abuse or dependence. Combined with the apparent gap in services within this age group (See Figures 5 and 5a), it is evident that this population deserves significant attention.

Figure 7: Alcohol Abuse or Dependence in Past Year among Persons Aged 12+ By Age in Ohio



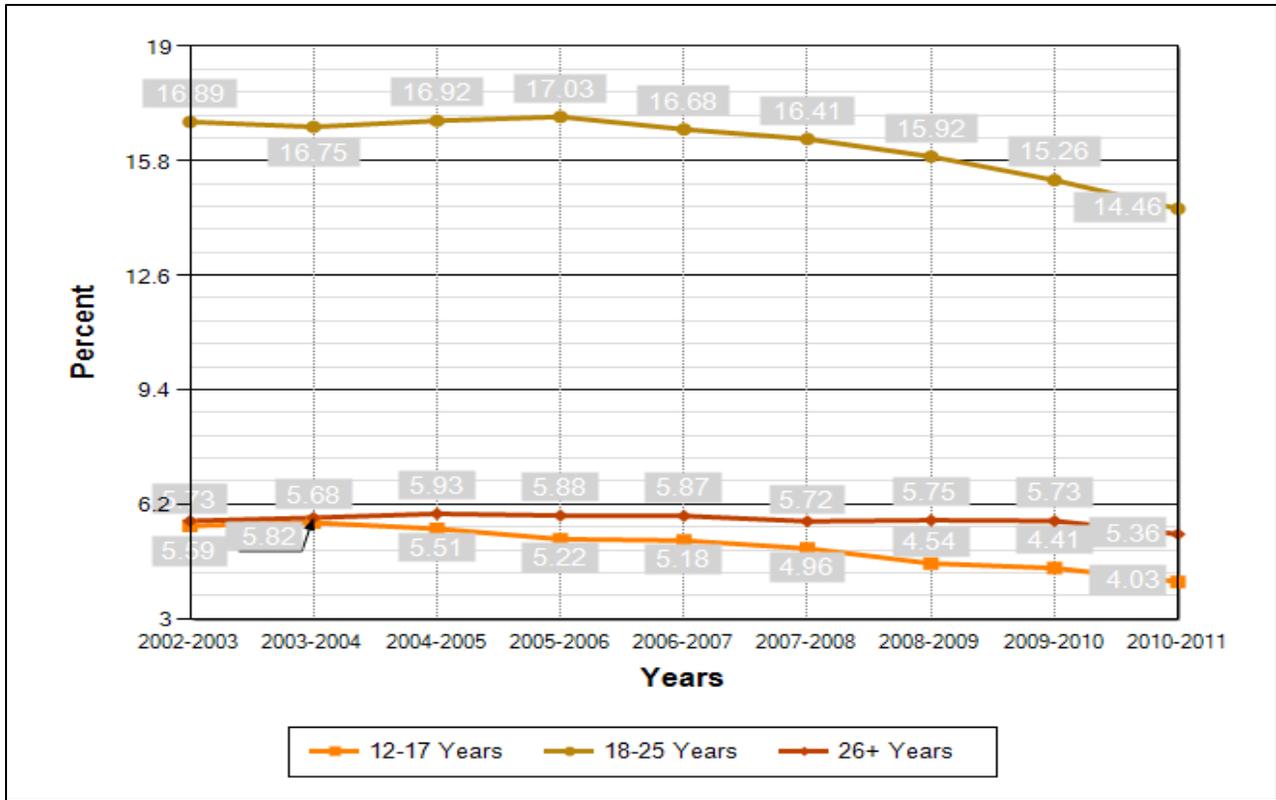
Abuse and dependence are clinical terms used to characterize patterns of alcohol use associated with significant social, psychological, and physical problems for the user and/or others that may be negatively impacted by the user.

Variable Definition Figure 7: Percent of persons aged 12 and older meeting DSM-IV criteria for alcohol abuse or dependence

Data Sources: National Survey on Drug Use and Health (NSDUH)

American Psychiatric Association. (2000). Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. Washington, DC: American Psychiatric Association.

Figure 8: Needing but Not Receiving Treatment for Alcohol Use, by Age in US

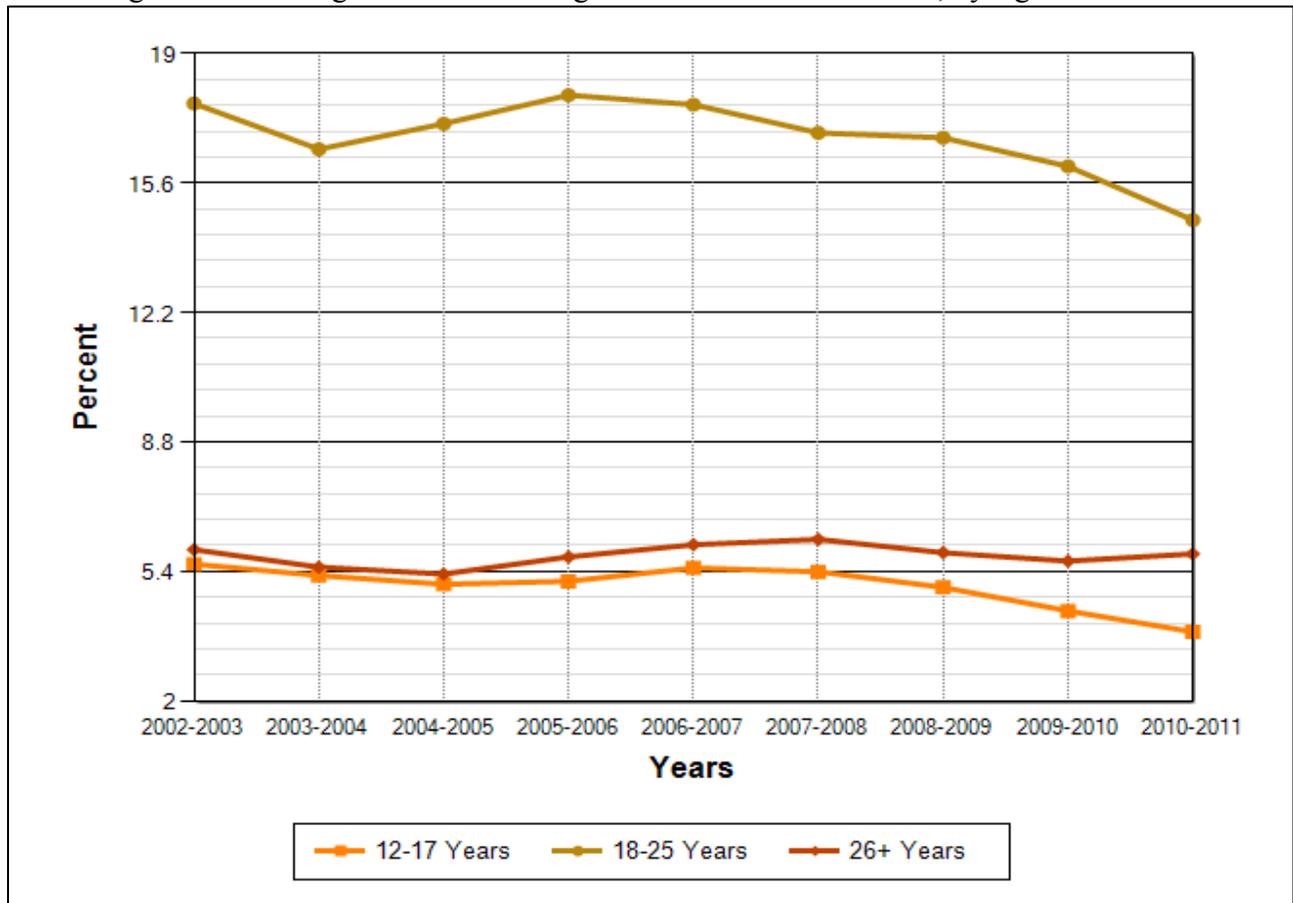


As can be seen in Figure 8, the nationwide treatment gap for alcoholism is more prevalent among individuals between the ages of 18 and 25, and remains relatively stable over time. Given that Ohio’s rate of alcohol abuse or dependence has remained above the national average for the past six years, with a slight decline in 2003-2004; the treatment gap for alcoholism among members of the 18 to 25 year old age group is viewed as a high priority within the state.

Variable Definition Figure 8: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

Data Source: National Survey on Drug Use and Health (NSDUH)

Figure 8a: Needing but Not Receiving Treatment for Alcohol Use, by Age in Ohio



As can be seen in Figure 8a, the treatment gap for alcoholism within Ohio is more prevalent among individuals between the ages of 18 and 25, and remains relatively stable over time. In addition, Ohio’s rate of alcohol abuse or dependence within this age group has remained above the national average for the past six years, with a slight decline in 2003-2004. Therefore, the treatment gap for alcoholism among members of the 18 to 25 year old age group is viewed as a high priority within the state.

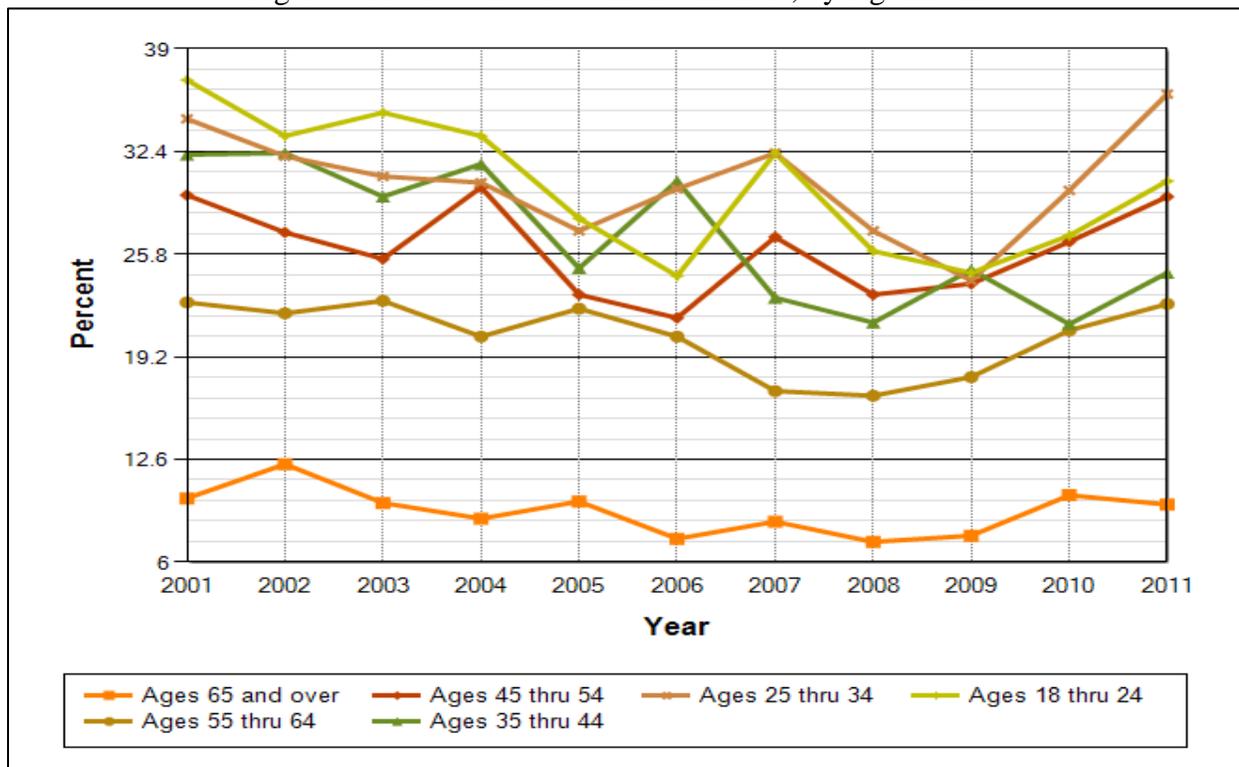
Variable Definition Figure 8a: Needing But Not Receiving Treatment refers to respondents classified as needing treatment for alcohol, but not receiving treatment for an alcohol problem at a specialty facility (i.e., drug and alcohol rehabilitation facilities [inpatient or outpatient], hospitals [inpatient only], and mental health centers).

Data Source: National Survey on Drug Use and Health (NSDUH)

Tobacco Consumption

More than 400,000 deaths each year are attributed to cigarette smoking, making it the leading preventable cause of death in the United States. Despite recent efforts to reduce tobacco sales through increased taxes and statewide media campaigns, tobacco consumption continues to be of concern within the state of Ohio. While Ohio's cigarette sales rate has declined significantly since 2001, cigarette consumption rates remain above the national average. Young adults within Ohio report high rates of current cigarette (See Figure 9) and current smokeless tobacco consumption. In addition, the percent of high school students who reported smoking a whole cigarette before age 13 remained at or above the national average between 1999 and 2007. Current smokers are highly prevalent among young adults (Figure 10).

Figure 9: Adults who are Current Smokers, by Age in Ohio

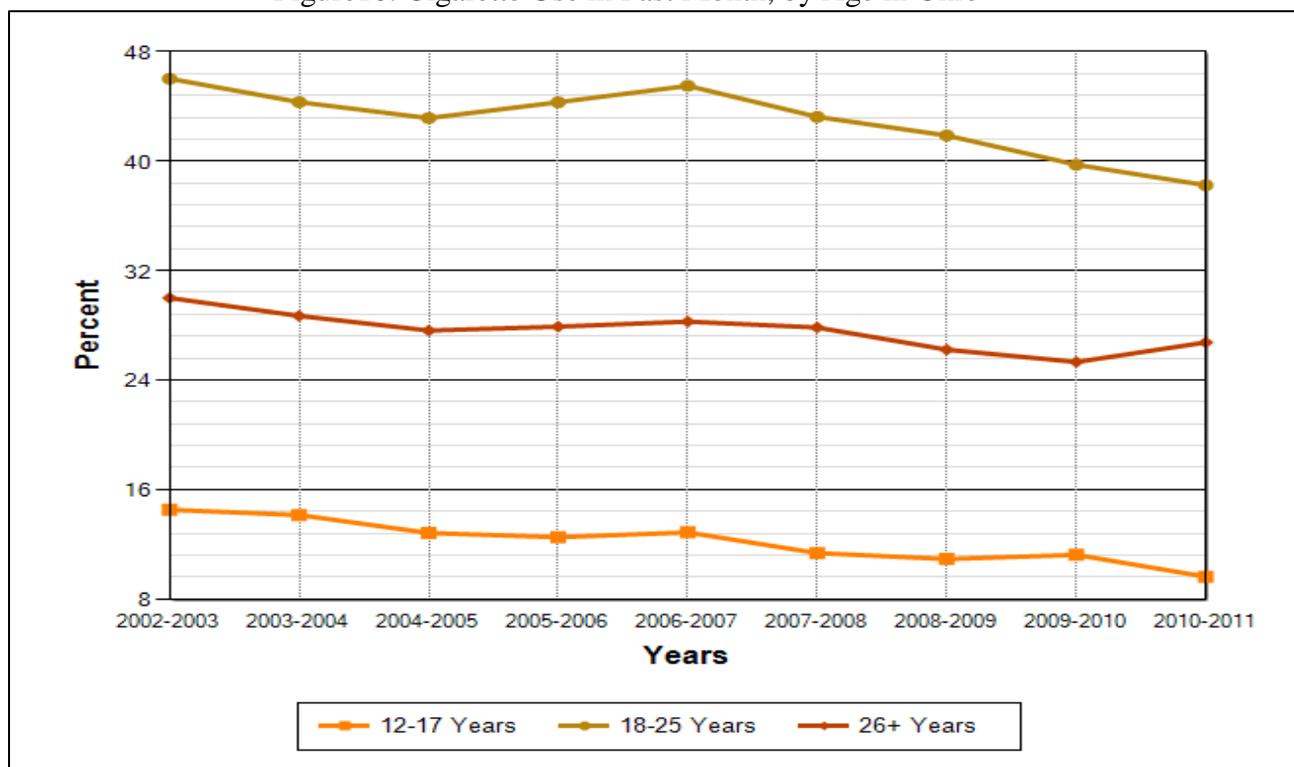


Within Ohio, current smoking is highly prevalent among individuals between the ages of 18 and 34. This trend continued despite a decline among 18 to 24 year olds since 2001. Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. The decrease in daily use of cigarettes during the early 2000's has slowed, and figures have remained relatively stable since 2004. Several age groups have shown an increase in use since 2009 (See Figure 9).

Variable Definition Figure 9: Percent of adults aged 18 and older who report smoking 100 or more cigarettes in their lifetime and also now smoke cigarettes every day or on "some days".

Data Sources: Behavioral Risk Factor Surveillance System (BRFSS), Centers for Disease Control and Prevention (CDC) at <http://www.thecommunityguide.org/tobacco/index.html>.

Figure10: Cigarette Use in Past Month, by Age in Ohio



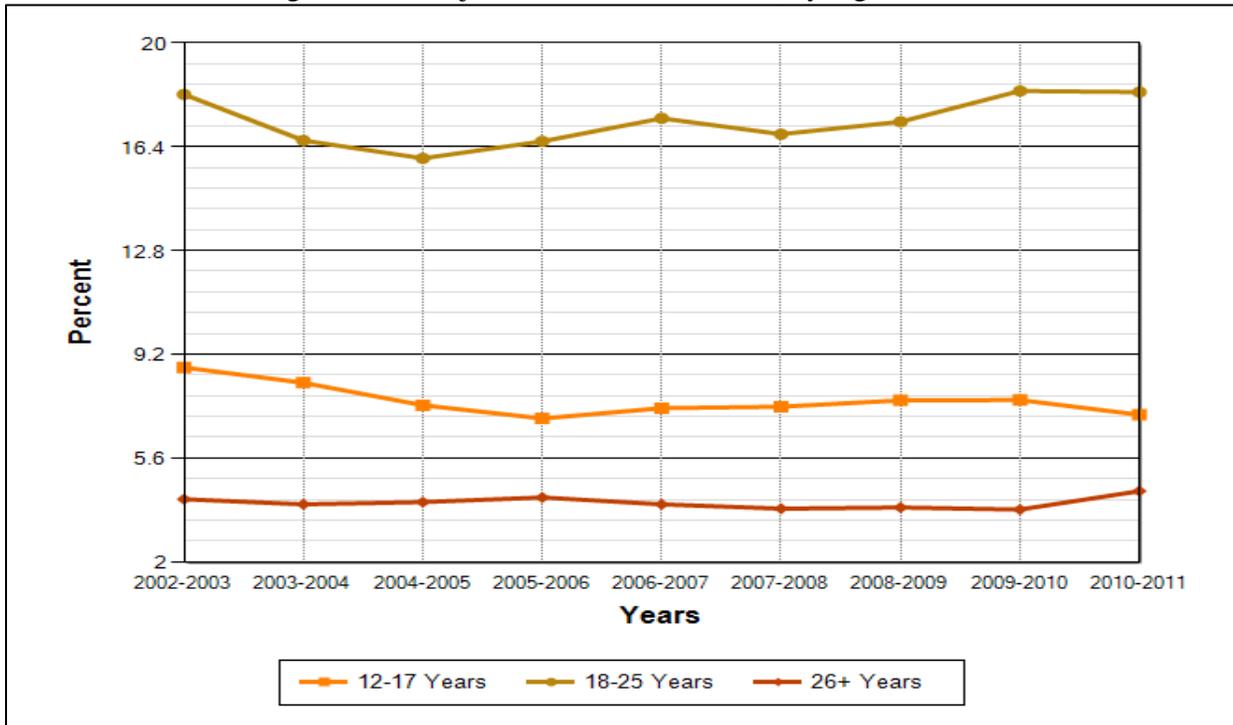
Smoking increases the risk of heart disease, cancer, stroke, and chronic lung disease. More than 400,000 deaths each year are attributed to cigarette smoking, making it the leading preventable cause of death in the United States. Within Ohio, current smoking is highly prevalent among individuals between the ages of 18 and 25, with Ohio numbers remaining approximately 5% above the US average. According to NSDUH, this trend has remained relatively stable since 2002-2003.

Variable Definition Figure 10: Percent of persons aged 12 and older reporting smoking a cigarette on one or more days within the past 30 days
 Data Source: National Survey on Drug Use and Health (NSDUH)

Illicit Drug Consumption

Within Ohio, the illicit drug data were similar to those related to alcohol consumption and related consequences. Specifically, the marijuana (See Figure 11) and cocaine (Figure 12) consumption rates among young adults between the ages of 18 and 25 remained above other age groups. In addition, young adults demonstrated high rates of non-medical use of pain relievers (See Figure 13). Therefore, the limited amount of available data on this topic does demonstrate a need for increased prevention efforts among young adults in Ohio.

Figure 11: Marijuana Use in Past Month, by Age in Ohio

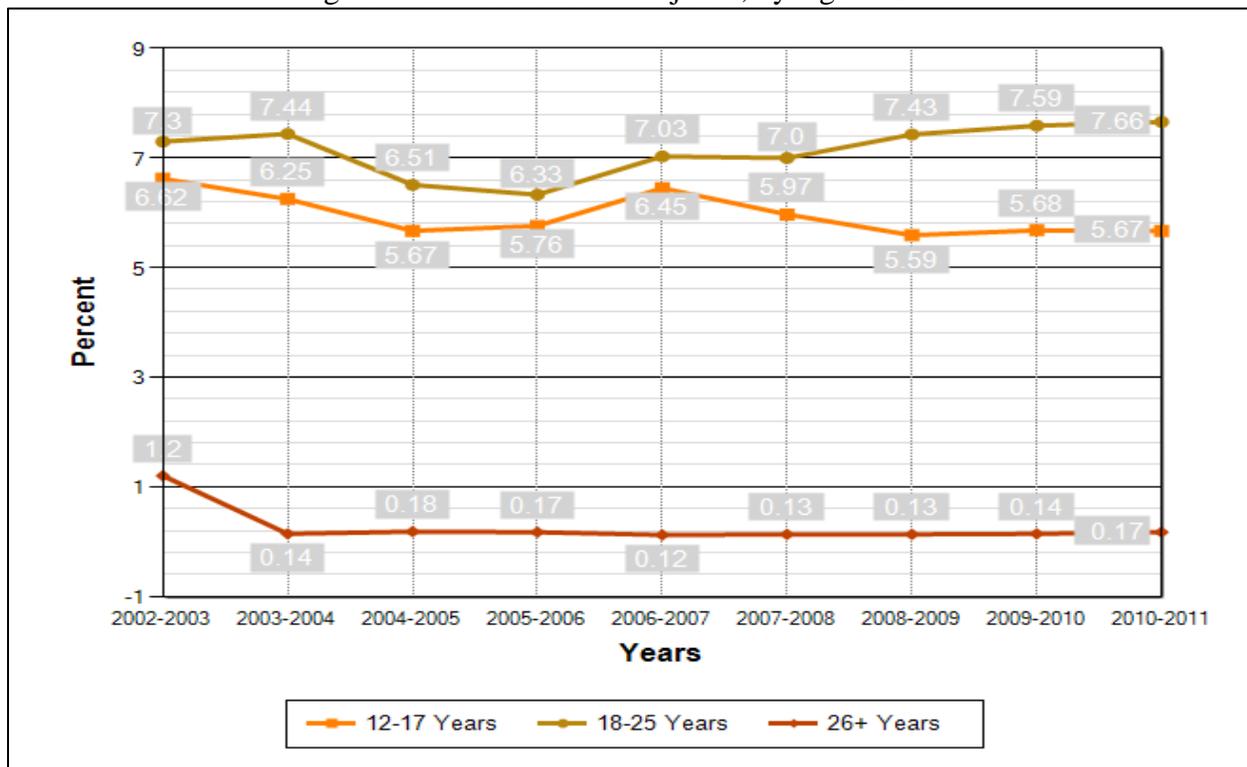


The use of marijuana can produce adverse physical, mental, emotional, and behavioral changes, and can be addictive. Health risks include respiratory illnesses, memory impairment, and weakening of the immune system. SAMHSA (2011) reported that, at the national level, marijuana had the highest rate of past year dependence of any illicit drug in 2011. Marijuana use among 18 to 25 year olds within Ohio has been on the rise since 2007-2008, and current marijuana use is more prevalent within this age group than young adolescents or adults.

Variable Definition Figure 11: Percent of persons aged 12 and older reporting any use of marijuana within the past 30 days.

Data Sources: National Survey on Drug Use and Health (NSDUH)
<http://oas.samhsa.gov/nsduh/2k7nsduh/2k7results.cfm#Ch>

Figure 11a: First Use of Marijuana, by Age in Ohio

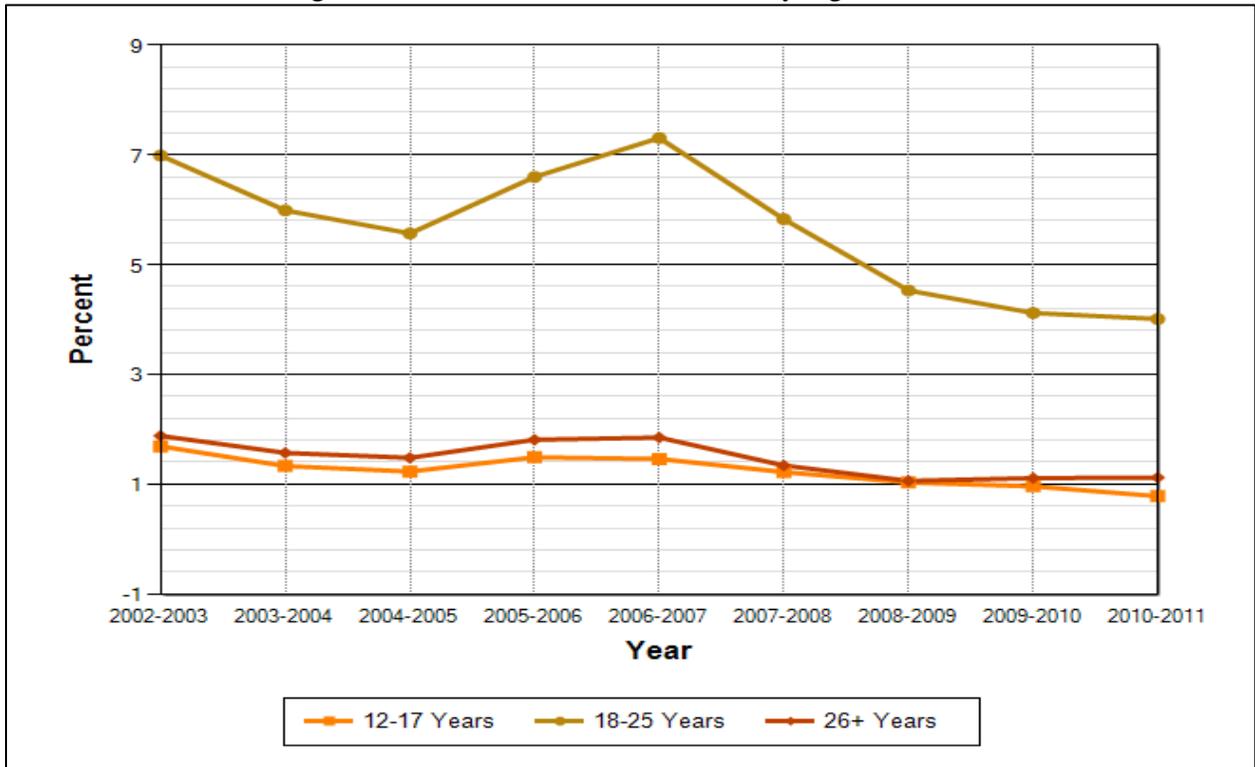


Initiation of marijuana use at young ages, especially in pre-adolescence, has been linked to more intense and problematic levels of use of marijuana and other illicit drugs in adolescence and adulthood. Early initiation of use may also present a direct, negative effect upon physical health in adulthood.

Variable Definition Figure 11a: $Average\ annual\ rate = 100 * \{ [X_1 \div (0.5 * X_1 + X_2)] \div 2 \}$, where X_1 is the number of marijuana initiates in past 24 months and X_2 is the number of persons who never used marijuana. Both of the computation components, X_1 and X_2 , are based on a survey-weighted hierarchical Bayes estimation approach. Note that the age group is based on a respondent's age at the time of the interview, not his or her age at first use.

Data Sources: National Survey on Drug Use and Health (NSDUH)
 Ellickson, P. L., D'Amico, E. J., Collins, R. L., & Klein, D. J. (2005). Marijuana use and later problems: When frequency of recent use explains age of initiation effects (and when it does not). *Substance Use & Misuse*, 40, 343-359.

Figure 12: Cocaine Use in Past Year, by Age in Ohio



Cocaine use can result in serious negative health consequences and the substance is highly addictive. Physical symptoms may include chest pain, nausea, blurred vision, fever, muscle spasms, convulsions, coma and death. Within Ohio, cocaine use in the past year has declined among 18 to 25 year olds, who remain above other age groups for all years examined here.

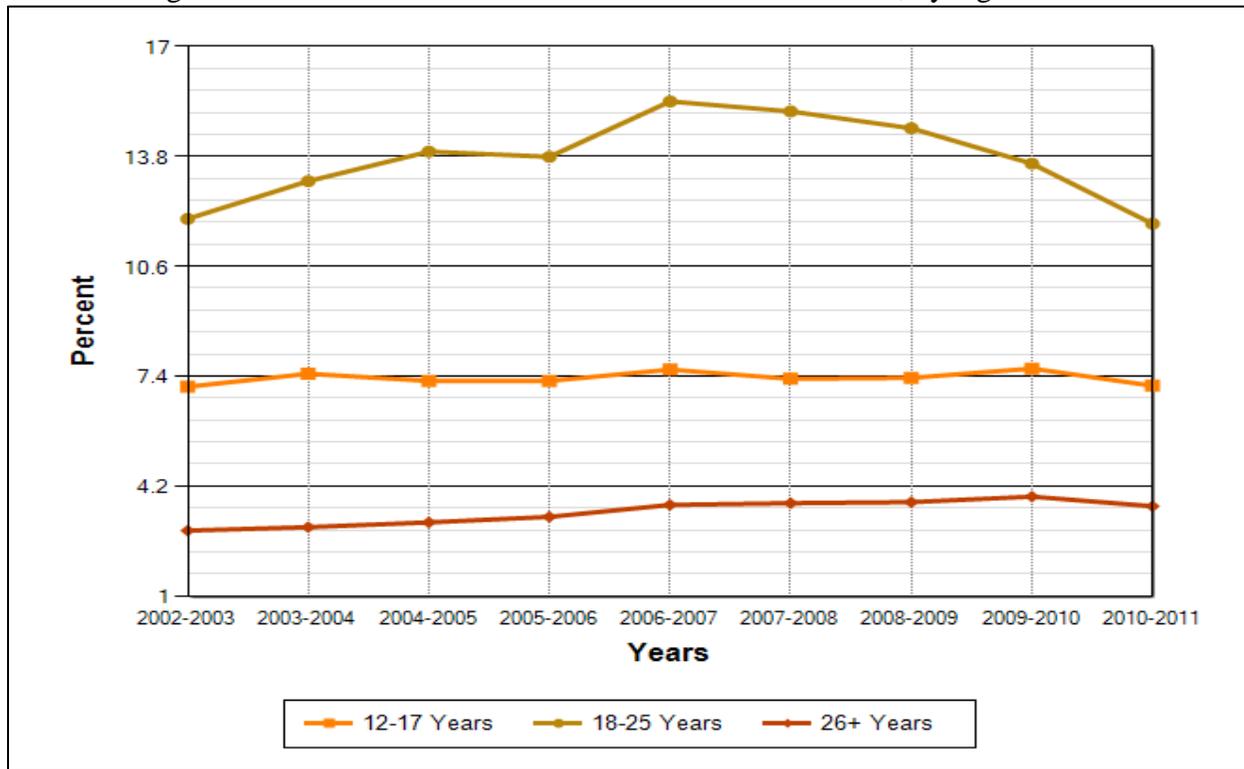
Variable Definition Figure 12: Percentage of respondents who reported using cocaine within the past year.

Data Sources: National Survey on Drug Use and Health (NSDUH)

U.S. Drug Enforcement Administration (2009). Cocaine. Retrieved 10/28/09 from <http://www.justice.gov/dea/concern/meth.html>.

Drug Enforcement Administration, U. S. Department of Justice. (2005). Drugs of Abuse. Retrieved 10/28/09 from www.dea.gov.

Figure 13: Non-Medical Use of Pain Relievers in Past Year, by Age in Ohio



The abuse of several classes of prescription drugs, including pain relievers, depressants and stimulants, is currently on the rise both within Ohio and nationwide. Within Ohio, the non-medical use of pain relievers among 18 to 25 year olds has maintained a steady climb since 2002, and remained above other age groups for all years examined here. The long-term use or abuse of prescription drugs is more common among individuals with a history of alcoholism, and carries threats of addiction, dependence and withdrawal. Without proper treatment and observation, withdrawal from depressants and opioids can be fatal.

Variable Definition Figure 13: Abusable legal products include prescription drugs (pain relievers, tranquilizers, stimulants, and sedatives) and inhalants (amyl nitrate, cleaning fluids, gasoline, paint, and glue).

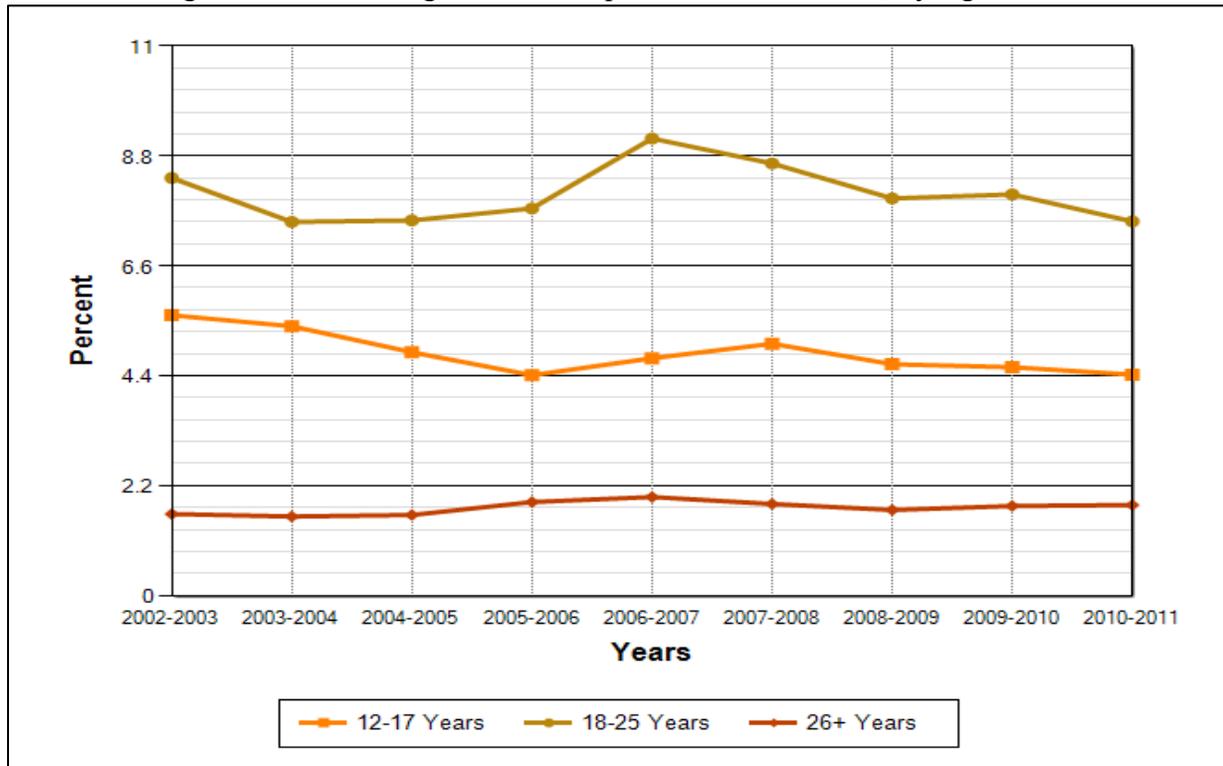
Data Sources: National Survey on Drug Use and Health (NSDUH)

McCabe, S. E., Cranford, J. A., & Boyd, C. J. (2006). The relationship between past-year drinking behaviors and nonmedical use of prescription drugs: Prevalence of co-occurrence in a national sample. *Drug and Alcohol Dependence*, 84, 281-288.

McCabe, S. E., West, B. T., Morales, M., Cranford, J. A., & Boyd, C. J. (2007). Does early onset of non-medical use of prescription drugs predict subsequent prescription drug abuse and dependence? Results from a national study. *Addiction*, 102, 1920-1930.

Illicit Drug Use Consequences

Figure 14: Illicit Drug Abuse or Dependence in Past Year, by Age in Ohio



Abuse and dependence are clinical terms used to characterize patterns of drug use associated with significant social, psychological, and physical problems for the user and/or others who may be negatively impacted by the user. When compared with other age groups, individuals between the ages of 18 and 25 demonstrate the highest drug abuse and dependence rates within Ohio. With the exception of a slight decrease between 2002 and 2007 for individuals aged 12-17, the rates of abuse and dependence have not changed significantly in recent years.

Variable Definition Figure 14: Percent of persons aged 12 and older meeting DSM-IV criteria for drug abuse or dependence

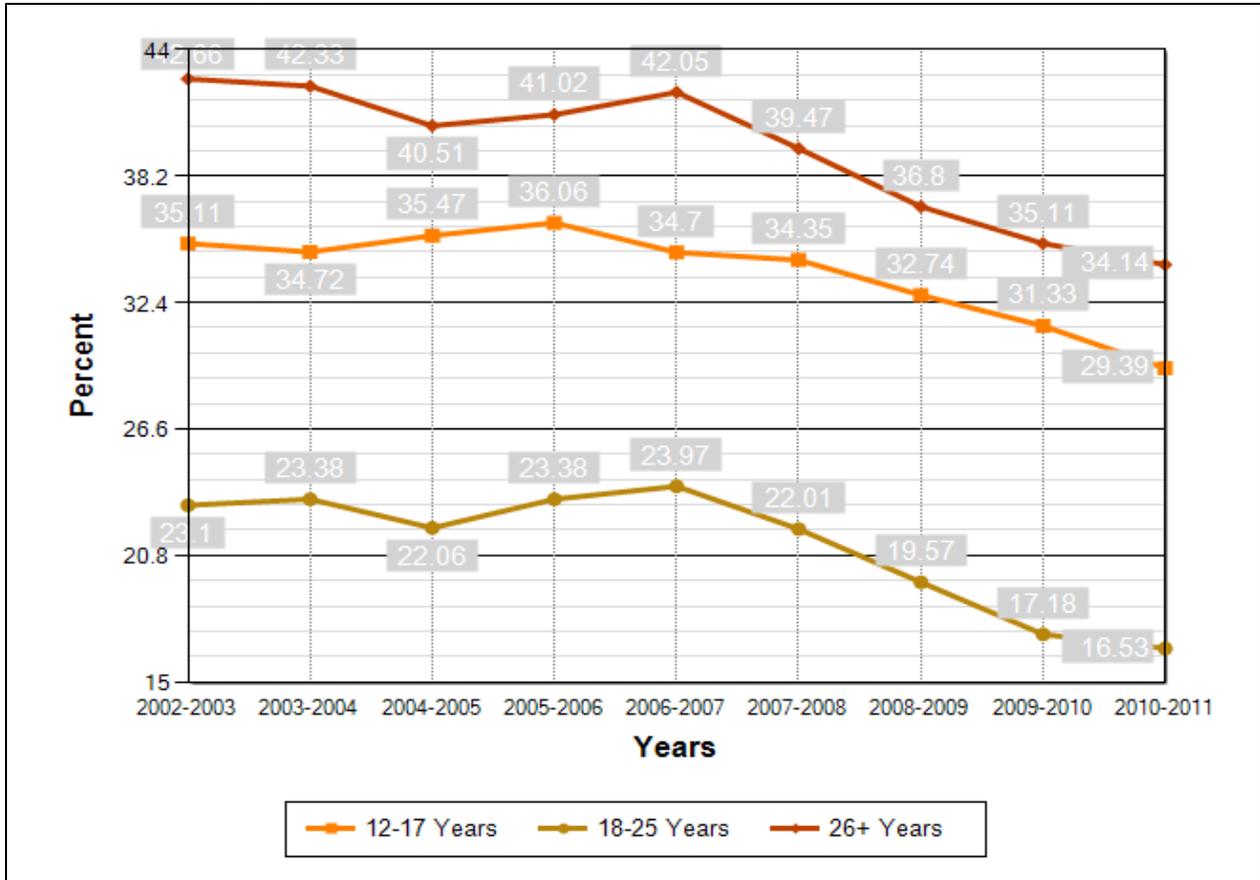
Data Sources: National Survey on Drug Use and Health (NSDUH): <http://oas.samhsa.gov/nsduh/2k7nsduh/2k7results.cfm#Ch7>

Causal Factors

Alter, Lohrmann and Greene (2006) recently reported that past month marijuana use is negatively correlated with perceived harm from marijuana use, particularly among young adults. Therefore, as perceived risk of marijuana use (See Figure 12) increases, the likelihood of use and

first use decreases. Similar results have been found in relation to cigarette use (Halpern-Felsher, et al., 2004, See Figure 13) and binge drinking (See Figure 14).

Figure 15: Perception of Great Risk of Smoking Marijuana Once a Month, by Age in Ohio

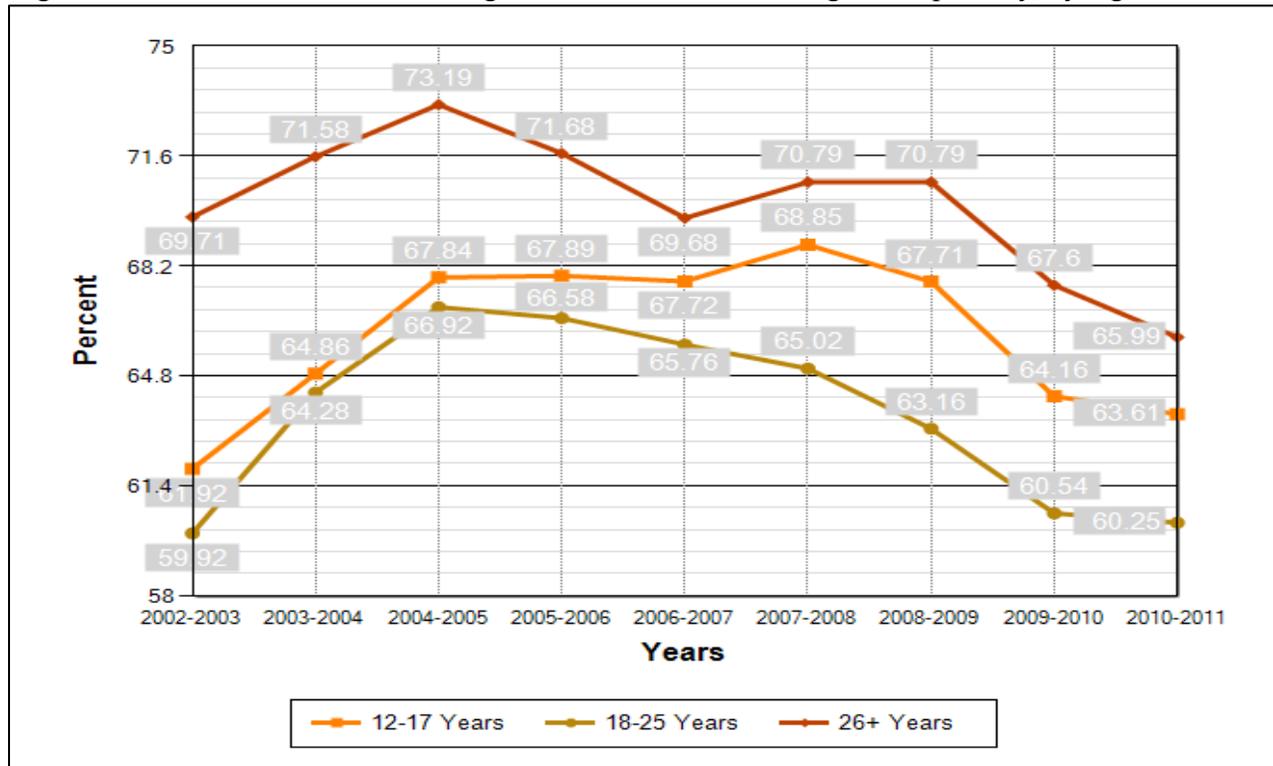


Variable Definition Figure 15: Response categories for the Perception of Risk questions include "No risk," "Slight risk," "Moderate risk," and "Great risk." The estimates in this table correspond to persons reporting "Great risk." Respondents with unknown Perception of Risk data were excluded.

Data Sources: National Survey on Drug Use and Health (NSDUH)

Alter, R. J., Lohrmann, D. K., & Greene, R. (2006). Substitution of marijuana for alcohol: The role of perceived access and harm. *Journal of Drug Education*, 36(4), 335-355.

Figure 16: Perceived Risk of Smoking One or More Packs of Cigarettes per Day, by Age in Ohio



Halpern-Felsher, et al. (2004) suggested that adolescents' beliefs regarding their risk of developing an illness related to smoking had a direct impact upon their intentions to smoke or avoid smoking in the future. Similarly, Weinstein, Marcus, and Moser (2005) found that current smokers tended to underestimate their likelihood of developing a chronic illness as a result of smoking.

Variable Definition Figure 16: Response categories for the Perception of Risk questions include "No risk," "Slight risk," "Moderate risk," and "Great risk." The estimates in this table correspond to persons reporting "Great risk." Respondents with unknown Perception of Risk data were excluded.

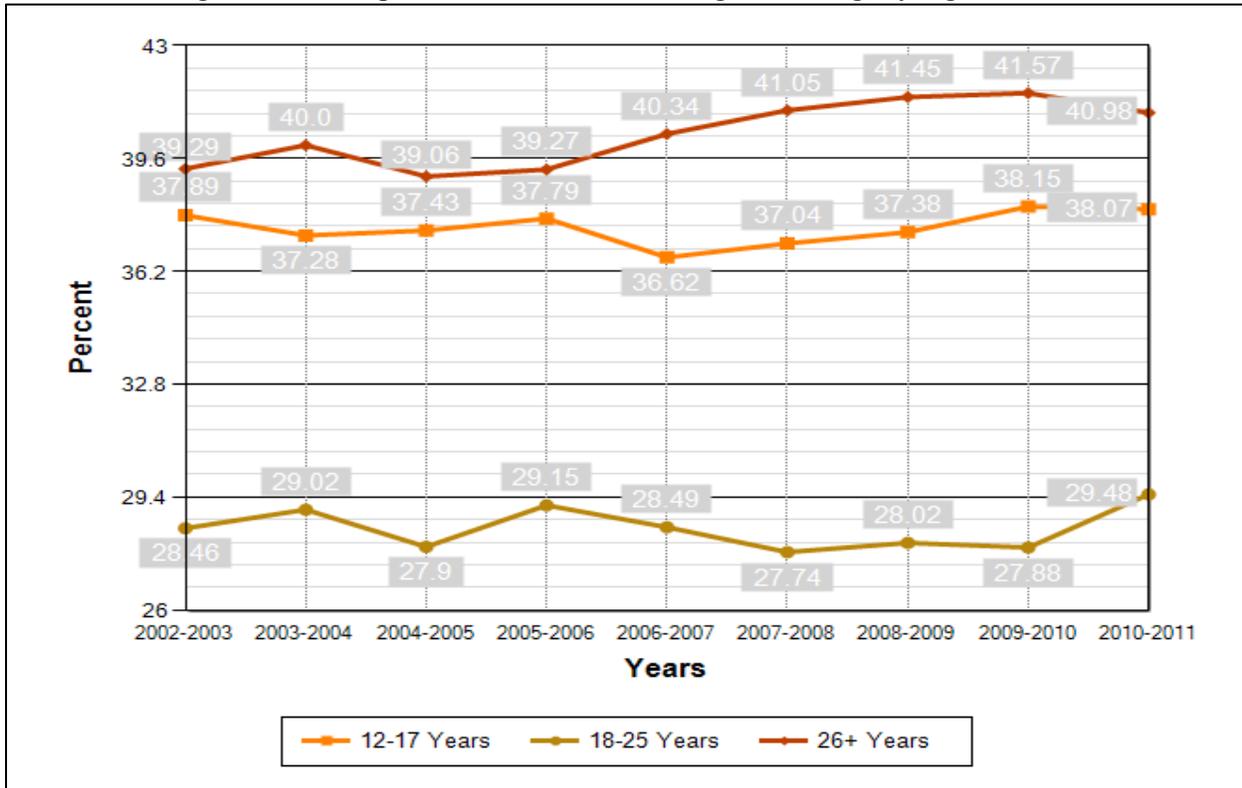
Data Sources:

National Survey on Drug Use and Health (NSDUH)

Halpern-Felsher, B. L., Biehl, M., Kropp, R. Y., & Rubinstein, M. L. (2004). Perceived risks and benefits of smoking: Differences among adolescents with different smoking experiences and intentions. *Preventative Medicine*, 39, 559-567.

Weinstein, N. D., Marcus, S. E., & Moser, R. P. (2005). Smokers' unrealistic optimism about their risk. *Tobacco Control*, 14, 55-59.

Figure 17: Perception of Great Risk of Binge Drinking, by Age in Ohio



Binge drinking, as indicated by consumption of five drinks or more within a short time span, is strongly associated with injuries, motor vehicle crashes, violence, fetal alcohol syndrome, chronic liver disease, and a number of other chronic and acute conditions. Men are more likely than women to participate in binge drinking, and the prevalence of binge drinking declines with age.

Variable Definition Figure 17: A higher perceived risk is associated with a lower prevalence in binge drinking.

Data Sources: National Survey on Drug Use and Health (NSDUH)

Morbidity and Mortality Weekly Report (MMWR), 2008; 57(49); 1333. Quickstats: Percentage of adults aged =18 years who consumed five or more alcoholic drinks in 1 day at least once in the preceding year, by sex and age group--National Health Interview Survey, United States, 2007. From <http://www.cdc.gov/mmWR/preview/mmwrhtml/mm5749a6.htm>.

The Treatment Gap in Ohio

Past Year Alcohol and Illicit Drug Abuse and Dependence: According to the latest state-level NSDUH data for Ohio (2011), the estimated number of persons 12 years or older with past year alcohol dependence or abuse was 865,000 (70,000 aged 12-17, 261,000 aged 18-25, 535,000 aged 26 and older). The number of persons with past year illicit drug dependence or abuse was 267,000 (44,000 aged 12-17, 96,000 aged 18-25, 127,000 aged 26 and older).

Needing but Not Receiving Treatment: The estimated number of individuals needing but not receiving treatment for alcohol use was 687,000 (47,000 ages 12-17, 204,000 aged 18-25 and 436,000 aged 26 and older). The estimated number of Ohioans needing but not receiving treatment for an illicit drug problem in the past year was 247,000 (41,000 ages 12-17; 92,000 ages 18-25 and 114,000 age 26 or older).

Unique Client Admissions for Addictions: Ohio's publicly-funded treatment system saw 98,902 unique admissions in SFY 2011, down from 100,490 clients in SFY 2010. The publicly funded system provided services to roughly 1 in 10 Ohioans in need of services.

Needs and Gaps in Services for Priority Populations

Service Gaps for Persons Who are Intravenous/Injection Drug Users (IDU)

ODADAS' Ohio Substance Abuse Monitoring Network (OSAM) recent reports (July 2012 to January 2013) on eight sub-state regions revealed prevalence of white powdered heroin and injection use to be common across all regions, with Appalachian regions indicating prevalence of brown powdered heroin and injection use (Youngstown) and black tar heroin and injection use (Athens).

The rise in heroin use and subsequent rise in injection drug use is in large part due to the prescription drug epidemic that Ohio is experiencing. The January 2011 OSAM report indicates that treatment providers refer to prescription opioids as, "the gateway drug to heroin." Users and professionals note an alarming increase in use among young people (teens through early 20's). The most common routes of administration are oral consumption and intranasal inhalation, with notable increases in intravenous injection recorded."

OSAM reports have consistently shown a link between prescription drug use and migration to heroin, which is less expensive than prescription narcotics, of high quality and readily available.

An ODADAS prescription drug/opioid survey conducted in September 2010 describes issues with access. Per the report executive summary:

The proportion of clients accessing services across Ohio with an opioid abuse/dependence diagnosis has dramatically increased over the past 12 months. With nearly 80 percent participation of provider agencies statewide, the Prescription Drug/Opioid Abuse Survey was successful in generating needed data to allow the Department to assess the capacity of the State's treatment system to address the needs of opioid abusing and dependent clients. Over the past 24 months, nearly 95 percent of participating provider agencies reported providing services to clients who had a diagnosis of opioid abuse or dependence, with just over 58 percent of these providers indicating that the proportion of clients receiving treatment at their agency for opioid abuse/dependence has increased over the past 12 months. In fact, proportional increases were found in each of the State's five ODADAS regions, with the highest proportional increase reported in the Southwest region where more than 70 percent of participating

providers reported an increase in clients seeking treatment services for opioid abuse/dependence. Moreover, almost a third of all providers reported that opioid abusing/dependent clients now make up more than a quarter of all clients served. White males remained the largest group identified for opioid abuse/dependence statewide; however, providers continue to see an increase of opioid abuse/dependence among females, and are now seeing an increase among young people.

A majority of providers (55%) reported using one or more evidenced-based programs or practices in serving opioid abusing/dependent clients, including Medication Assisted Treatment (MAT). Of providers citing MAT, most indicated Suboxone®. Most providers (79%) indicated that they knew of area physicians licensed to induce/manage Suboxone®, although only 43 percent reported making referrals to these physicians for Suboxone®. Practically half of referring providers indicated difficulty in getting clients into a physician's office for Suboxone®. Cited barriers to clients receiving Suboxone® primarily consisted of financial issues (i.e., client lack of insurance and cost of physician visit and medication) and access issues (i.e., lack of licensed physicians and travel distance to/location of licensed physicians). While most providers know of area physicians licensed to induce/manage Suboxone®, a majority of providers are not referring to these physicians.

Ten of Ohio's methadone programs responded to the Prescription Drug/Opioid Abuse Survey. On average, these programs reported having received 343 referrals over the past 12 months. Almost 38 percent of non-methadone treatment providers reported making referrals to methadone clinics; and of these providers, the majority indicated that it was difficult to get clients into methadone programs. Cited barriers to clients receiving methadone primarily consisted of capacity issues (i.e., no openings/methadone programs not accepting new clients) and financial issues (i.e., client lack of insurance and cost of clinic visit and methadone). With capacity issues noted as the greatest barriers to clients receiving methadone, and client placement into methadone programs most often described as difficult, the capacity of methadone programming should be considered for expansion.

The State's current treatment system is challenged in addressing the needs of Ohio's rapidly increasing number of opioid abusing/dependent clients. With wait times for opioid abusing/dependent clients currently reported for assessment services by nearly 80 percent of providers who offer assessment services and wait times of several weeks reported for residential treatment, and with difficulty in MAT placement reported extensively, it is evident that the State's already challenged public treatment system has been further strained by a new crisis: Ohio's emergent prescription drug abuse epidemic.

Access to Medication Assisted Treatment (MAT)

Most injection drug users seeking treatment in Ohio identify heroin or other opiates (89.1%) as their drug of choice (MACSIS, 2010). OhioMHAS has taken steps to increase access to medication assisted treatment throughout the state; however this access to medication assisted treatment remains a significant concern.

Based upon data from MACSIS client information system, the treatment system has seen an increase in injection drug-using clients from SFY 2005 to SFY 2010. IDU clients comprised 6.6% of admissions (unduplicated client count) in 2005 and 13.5% of admissions in SFY 2012. An increasing percent of IDU clients are women (39.2% in SFY 2005 to 50.0% in SFY 2012). During this same time frame the percent of IDU clients who identified themselves as African-American/Black decreased from 15.6% to 6.9% while Caucasian/White clients increased from 79.8% to 90.1%. A shift in ethnicity of clients is also noted, with 0.6 of clients identifying themselves as Hispanic/Latino in SFY 2005 and 2.6% so identified in SFY 2012. The shift in race and ethnicity corresponds to the greater geographic dispersion of IDU clients through the state. While predominately an issue in the urban areas, IDU clients are much more likely to live in suburban, rural and Appalachian counties today. In SFY 2005, urban/metropolitan counties accounted for 70.4% of IDU admissions. In SFY 2012, these admissions fell to 59.5%. At the same time, suburban counties saw slight a slight decrease in admissions (17.1% to 16.7%), rural counties saw and increase from 5.5% to 9.3%, and Appalachian counties saw a 2-fold increase – from 7.0% to 14.5 %.

An Executive Order signed by Governor John Kasich in February 2011 expanded the availability of MAT by allowing the state's local treatment partners to use medications other than methadone approved by the federal government to assist with opiate addiction therapies.

Ohio MHAS has intensified efforts to improve access to and retention in effective treatment for opioid addiction, using medication-assisted (MAT) treatments such as methadone and buprenorphine. In fall 2012 OhioMHAS began recruiting Boards to become a part of the five years NIATx Buprenorphine Implementation Study. This study is a randomized controlled trial to test ways to increase MAT with buprenorphine in Ohio. Fifteen Ohio Alcohol, Drug Addiction, and Mental Health Services Boards (the county-level entities responsible for planning, funding and monitoring public mental health and alcohol and other drug addiction services) signed up to participate in the study. The 15 Boards, which represent 23 Ohio counties, recruited a total of 50 treatment sites to participate. The Boards and their provider organizations have been randomized into two study groups or "arms." The control group will use the NIATx model alone, which makes changes at the provider level, to increase use of buprenorphine. The intervention group will use the NIATx model plus the Advanced Recovery framework, which also makes changes at the payer level.

Women who are pregnant and have a substance use disorder

Drug using women are more likely to be single, separated or divorced, have less than a high school education, use alcohol and tobacco in addition to illicit drugs, have fewer sources of social support, are significantly influenced by their male partners, have histories of childhood physical and sexual abuse, are exposed to stigmatization from the public and peers, experience a wide range of health problems and engage in other risk behaviors. Data analysis of currently pregnant women sample in Ohio Family Health Survey 2008 (N=49,796) reveal worrisome findings especially in the context of risk to the unborn babies. Of those women who reported being currently pregnant (n=281), 17.4% were current smokers. As concerns past alcohol use, 10% (n=28) of the currently pregnant women reported drinking alcohol beverages at least 1 day

in past 30 days. Of these 28 currently pregnant women with alcohol use disorder, close to 18% had 4 or more drinks (binge) on at least one day in the past 30 days. Close to 7% (n=19) of the 281 reporting being currently pregnant when asked if she feels need or get treatment or counseling for any kind of mental health, substance abuse or emotional problem. Specific data regarding alcohol and tobacco consumption among pregnant women is also available through the Centers for Disease Control and Prevention's Pregnancy Risk Assessment and Monitoring System (PRAMS) dataset. Ohio's PRAMS dataset suggests that women aged 35+ are more likely to drink during their last trimester than younger women.

Data from the OhioMHAS client information system shows that women with children and/or pregnant at admission accounted for 14.3% in SFY 2005, rising to 20.9% of all admissions in SFY 2012. These women show a trend during this same time frame to being increasingly white (68.1% - 79.5%) compared to African American women whose admissions fell from 29.2% to 17.5%. Drug trends (drug of choice) for these women demonstrate that between 2005 and 2012, heroin rose from 6.3% to 14.8%, other opiates rose from 5.9% to 19.7%, and marijuana rose from 22.7% to 24.3%. Alcohol, cocaine, and other drugs as a drug of choice all decreased in this time frame.

With an increasing number of women presenting for treatment for opiate addiction, access to medication assisted treatment is becoming a growing issue. Likewise, reports of increased births of opiate-addicted babies are also surfacing. Although Ohio has a well-established network of women's programs for substance abuse treatment, program capacity can be an issue, especially for residential services.

Parents with substance use disorders who have dependent children

The 2010 Implementation Report on Amended Substitute H.B. 484 by the Ohio Department of Job and Family Services and the Ohio Department of Alcohol and Drug Addiction Services summarizes the needs of parents/caregivers with substance use disorders involved with the child welfare system:

Given the multiple demands for effective client care, ODADAS and ODJFS continue to identify treatment needs, gaps in services, and opportunities for joint programming to address them. Data for the current 484 needs assessment have been derived from a variety of sources including: the Alcohol, Drug Addiction and Mental Health Services/Alcohol and Drug Addiction Services (ADAMHS/ADAS) Boards, Public Children's Services Agencies (PCSAs), ODADAS Community Plan Updates, ODADAS research project findings, ODADAS' and ODJFS' information systems, the Public Children's Services Association of Ohio (PCSAO), *System of Care* project analyses, Ohio's Strategic Plan to address Fetal Alcohol Spectrum Disorders (FASD), the federal Child and Family Services Review, the Ohio Department of Health (ODH), and reports from the Supreme Court of Ohio's Specialized Docket Programs.

Gap and Needs Assessment Findings of the Joint Report:

- Ohio continues to face challenges associated with being a state supervised, county administered system in implementing H.B. 484. Issues such as defining treatment failure or “best interest of the child” vary among jurisdictions depending on local values and available resources.
- Each system has its unique culture complete with language differences, diverse client expectations and goals, as well as often conflicting regulations. There is strong consensus that comprehensive, collaborative models must be developed among the disciplines which share these priority clients.
- Financial support among counties is disparate and categorical earmarking of funds can create barriers to use.
- Because families in the child welfare system who struggle with substance abuse are often involved with other systems, efforts to maximize available funding streams (e.g., TANF, Medicaid, grants) must be maintained to more effectively meet the multiple needs of these clients.
- While an array of substance abuse services is provided in each county, many areas are unable to maintain the full spectrum of care (i.e., prevention, education, early intervention, outreach, residential treatment, and detoxification). Where there is a shortage of local services, decreased accessibility and limited funding may restrict the ability of family members to participate in therapy; thereby potentially compromising treatment effectiveness. In addition, the ability to make custody determinations based on a parent’s failed treatment is compromised if s/he has not been enrolled in the appropriate level of care.
- The lack of substance abuse services has been found to be a contributing factor in the number of children coming into care, and to longer lengths of stay in out-of-home placements.
- Holistic, family-based intervention and treatment services, as well as specialized programming for children who have been affected by parental substance abuse need to be expanded.
- Approximately one of every 100 babies born in Ohio has been prenatally exposed to alcohol. ODH has estimated that Ohio spends approximately \$300 Million per year providing services to these children with multiple needs.
- Many professionals who provide services to children and families are ill-prepared to effectively address Fetal Alcohol Spectrum Disorders (FASD) resulting from prenatal exposure. Discipline-specific and cross-systems training are needed to increase workers’ knowledge about the impact of prenatal substance exposure, diagnostic indicators, and effective interventions/treatments. In addition, programming provided to this population is often fragmented; enhanced service coordination is recommended.

- With the exception of a few areas in the state, services available to individuals affected by FASD are inadequate. Service needs for this population include:
 - o Screening and assessment;
 - o School-based interventions;
 - o Wrap-around interventions;
 - o Vocational training and employment assistance;
 - o Housing; and
 - o Assistance with development of daily living skills.

- There are limited services available for parents, foster parents, and other caregivers who play key roles in promoting the welfare of children affected by FASD. Needed programming includes:
 - o Support groups;
 - o Respite care;
 - o Parent/caregiver training;
 - o Treatment advocacy; and
 - o Assistance with estate planning.

- Children whose care givers use methamphetamine are susceptible to child abuse and neglect as well as physical problems associated with toxic exposure. As a result, these children often have intensive and costly treatment needs when they enter PCSA custody.

- Local child welfare personnel have identified the following programming needs for families affected by Methamphetamine abuse:
 - o Comprehensive medical testing;
 - o Housing;
 - o Substance abuse, mental health, and medical services--including inpatient treatment;
 - o Supportive services to family care givers;
 - o Employment assistance;
 - o Child and adolescent prevention, education and early intervention services; and
 - o Specialized services for pregnant addicts.

- While the national death rates from unintentional drug poisonings doubled between 1999 and 2006, Ohio's rate more than tripled. ODH reports that in 2007 and 2008, "unintentional drug poisoning" became the leading cause of injury death in Ohio. Between 2003 and 2006, 96% of all unintentional poisoning deaths in Ohio were due to medications, primarily prescription pain killers: Fentanyl, OxyContin®, Vicodin®, and methadone. Statistics also show there is a greater death rate in southern Ohio.

- The Pacific Institute for Research and Evaluation has estimated the annual fatal costs (e.g., work loss, and quality-of life) of unintentional drug overdose in Ohio were \$3.5 Billion, and annual hospital admission costs were \$31.9 Million.

Veterans with substance use disorders

According to OhioMHAS client information system data, clients with military service accounted for 2.2% of admissions in 2012, up from 1.8% in 2005. Over 88.2% of veterans seeking services for substance abuse treatment are male. With regard to age, 43.1% are between the ages of 25 and 44 years while close to half (46.9%) are aged 45 to 64 years. Veterans tend to be unemployed (44.7%), with only 20.2% employed full-time. An increasing number of veterans are being referred by the criminal justice system (up from 39.9% in 2005 to 40.6% in 2012). Drug of choice tends to be alcohol, or alcohol in combination with other drugs. While identification of other opiates was not as predominate as alcohol and alcohol in combination, it is worthy to note that opiates other than heroin saw the largest increase from 2005 to 2012 compared to other drug categories (2.5% to 11.2%).

Individuals with disabilities (in particular those who may be deaf or hard of hearing)

Despite the introduction of DODA and the TAC program client information system data shows that the percentage of clients who are deaf and hard of hearing have remained stable since 2005. Also unchanged during this time period, approximately 2/3 of these clients are male, 80% are white, and approximately 80% are between the ages of 25 and 64 years of age. Between 2005 and 2010, the proportion of unemployed clients ranged from a low of 42.6% (in 2010) and a high of 48%, (in 2009). As with other client groups, while alcohol and alcohol in combination with other drugs are the most commonly identified drugs of choice (49.8 in SFY2010), heroin and opiates other than heroin were the only two categories that exhibited an increase (from 3.3% to 8.4% and 3.4% to 7.9% respectively). The TAC program ends September 30, 2013.

Individuals with Tuberculosis and Other Communicable Diseases

As was discussed earlier, Available data on tuberculosis (TB) cases in Ohio reveal that the disease appears to occur more within Metropolitan Counties. Most recent TB data for 2012 reveal 149 cases which translates to 1.3 per 100,000 populations. About 61.1% of these TB cases occurred within Cuyahoga, Franklin, Hamilton, and Montgomery Counties.

As concerns persons with or at risk for other communicable diseases like HIV/AIDS and who are in need of mental health or substance abuse early intervention, treatment or prevention services, it is a growing challenge. For instance, HIV/AIDS Surveillance Program data for Ohio reveal a growing trend in persons living with HIV/AIDS. Rate per 100,000 population rose from 128.1 in 2006 to 155.2 in 2011. This poses additional challenge since behaviors associated with substance abuse, including intravenous drug use and increased sexual contact are among the significant factors in the spread of HIV infection. Ohio is not a HIV designated state; hence block grant dollars do not support HIV early intervention programs. Clients admitted for treatment who indicated that they were HIV/AIDS positive accounted for less than 0.5% of admissions.

Despite the increase in IVDU the rate of Hepatitis C is decreasing. In 2003, the rate of reported Hepatitis C cases (past or present, non-acute) per 100,000 population rose from 39.5 cases per 100,000 to 91.4 in 2009. The rate then began an annual decline. As of 2012, the Hepatitis C rate had fallen to 32.19 cases per 100,000 population.

Individuals involved with the criminal justice system

A 2010 report prepared for Ohio by the Council of State Governments Justice Center highlighted the capacity issues that the behavioral health system faced in serving the criminal justice-involved population. The lack of treatment options and quick access to services has been a barrier to criminal justice involved clients.

MACSIS client information system data indicates that in SFY 2012, 66.6% of clients were criminal justice (CJ) involved. Almost three quarters of admissions were male (67.5%) with 74.6% White and 22.6% African-American. 33% had less than a high school education and 40.0% were unemployed.

In addition to addressing treatment capacity, this data suggests that education and job training need to be emphasized.

Prevention Infrastructure Assessment Efforts

OhioMHAS has a historic process for community and statewide assessment and planning guided by state and federal law and regulation. The first part of this section provides information on the current community and state level assessment and planning processes. In addition to current efforts, the Ohio SPF-SPE Evaluation Team conducted a variety of assessments and inventories to inform the work of the SPE Consortium specifically around data collection. The second section provides a summary for each of the three main projects.

Community Assessment and Planning

OhioMHAS allocates funds to each of the 50 ADAMHS and ADAS Boards who, in turn contract with and offer support to the alcohol and other drug prevention and treatment programs in their counties. ADAMHS and ADAS Boards are required by Ohio law to prepare and submit to OhioMHAS a plan for the provision of alcohol, drug addiction and mental health services in the board service area. The community plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by OhioMHAS.

OhioMHAS develops guidelines for boards in their development of their community plans. The most recent community plan guidelines were developed jointly with the Ohio Department of Mental Health which has similar statutory authority in order to streamline reporting requirements and eliminate duplication of efforts for county boards who must submit plans to both departments.

The OhioMHAS Planning Committee of the Governor's Shareholders Group produced a final report June 17, 2003 that continues to provide guidance to the development of the community plan guidelines. The report identified seven priority issues related to community planning which were expanded upon to address both the AOD and mental health system in light of this first ODMH/OHIOMHAS combined community plan guidelines effort for the plan submission for SFY 2010-2011.

- The community plan should be a living, useful document with widespread applicability and awareness. The community plan should be viewed as a management tool for the Board. In this regard the plan is best used for marketing, resource development, service identification and delivery and evaluation.
- Service planning needs to be purposefully connected with other related planning processes in the community. The plan should address shared community priorities where possible. It should promote solutions for priorities established by other entities within the service area.
- “Best practices” of community planning should be identified and shared with all counties.
- It is important to identify tangible benefits for local communities that come from doing quality planning.
- There must be a better connection between local community plans and departmental funding priorities and decisions. This allows local planners to support departments’ initiatives and allow the departments to promote local initiatives. An improved connection between state and local planning places the field in a position to better advocate for and develop the system. Community plans and department priorities should jointly be the basis for the development of state plans.
- Identify and eliminate activities that are non-productive to the planning process.
- Recognize that local political process and activity influences community planning.

National Outcome Measures & Alignment of Federal, State & Community Planning

Central to OhioMHAS’ planning framework is the alignment of federal, state and community planning requirements as reflected in the federal Substance Abuse/Mental Health (SAMH) Block Grant, the comprehensive state plan, and board community plans. The connecting thread of these plans is the National Outcome Measures. The graphic below provides a visual of this alignment. The Government Performance Results and Accountability Act of 1993 requires federal agencies to develop strategic plans with measurable outcomes. The Substance Abuse Mental Health and Services Administration (SAMHSA) operationalized this requirement with National Outcome Measures (NOMS) reported annually in the SAMHSA Block Grant. SAMHSA’s NOMS cover ten domains with associated outcomes and measures for substance abuse treatment and prevention.

Planning Alignment

Level	Entity	Focus	Framework	Reporting Requirements
Federal	CSAT/CSAP/MHSA (SAMHSA)	Sets national menu of outcomes	National Outcome Measures	SAPT/MH Block Grant
State	OhioMHAS	Establishes statewide targets that meet NOMS and respond to state needs and priorities. Incorporates Governor's priorities and community issues and priorities identified by county boards	Outcome reporting integrated into Community Plan Guidelines and Department Grant Program	Certification standards/rule** Community plan guidelines Grant applications Assurances
County	County Boards	Establishes county treatment, prevention and capacity targets that meet Community Plan Guideline requirements and respond to local needs and priorities	Local discretion with required targets and roll up in Community Plan	Board-Provider Contracts or related mechanism Assurances
Community	Providers	Propose goals and objectives that contribute directly to OhioMHAS priorities and County requirements	Outcomes and objectives consistent with NOMS as required element in Department Grant Program and board contracts	Interim and year end reports for grant program and board reporting requirements to meet contract specifications

State Epidemiological Outcomes Workgroup (SEOW)

Ohio has a sound, functioning and well-organized community prevention infrastructure that is supported by the Ohio Epidemiological Outcomes Workgroup (SEOW). Since 2006, the SEOW has had the responsibility for the collection, analysis, and reporting of substance use incidence, prevalence and related data and National Outcome Measures (NOMs). The NOMs are a set of domains and measures which SAMHSA uses to meet reporting requirements. Substance abuse NOMs are drawn from many types of data including: substance use incidence and prevalence, related consequence data, and program process and output data.

The SEOW has developed state and county level profiles that are utilized by OhioMHAS, various state agencies and ADAMHS/ADAS Boards for state and community need assessment. The profiles incorporate all substance abuse related components and indicators, including evidence of associated problems (e.g., school dropouts, delinquency, depression, suicide, and violence). Indicators that met the SEOW inclusion criteria were categorized broadly by ATOD consumption and the consequences associated with alcohol, tobacco, or illicit drug use. Consumption indicators include age of initiation, lifetime use, current use, and high-risk use. Consequences of use include mortality and morbidity data, measures of abuse and addictive disorders, and crime related indicators. Contextual indicators from the RTI study that measure community instability and family-related factors (e.g., teen-birth rate, divorce, and child-abuse or neglect) comprised another set of measures used for the Ohio epidemiological profile. While the relationship between such indicators and ATOD consumption is at times inconsistent, Sanchez, Dunteman, Kuo, Yu, and Bray (2001) suggested that the above demographic and contextual measures should be monitored closely in an effort to evaluate the impact of ATOD use on Ohio's population.

Information from the epidemiological profiles enhances data-driven decision making at both the state and community levels driving the implementation of evidence-based programs, policies and strategies. The utilization of logic models at both the state and community level has supported cross system planning and monitoring efforts as well as producing systematic analytical thinking related to the causes and effects of substance use.

The SEOW has enabled the SPF-SIG Advisory Committee to make data-driven decisions during the identification of Ohio's SPF-SIG priorities. The SEOW currently provides data at the national, state, regional and county levels and will continue to update data relevant to alcohol, tobacco, and other drug consumption and consequences. The SEOW has worked in conjunction with SPF-SIG Evaluation Team to develop valid and reliable instruments for measuring consumption among 18 to 25 year old residents. Each instrument is being designed to meet the substance-specific needs and aims of the community in which it will be used.

While the members of the SPF-SIG Advisory Committee and the SEOW will continue to work to identify reliable and valid sources of secondary data, it is expected that the majority of consumption data at the state and national levels will be provided by national surveys, such as the National Survey on Drug Use and Health (NSDUH), Behavioral Risk Surveillance System (BRFSS), and the Youth Risk Behavior Surveillance System (YRBSS). While the Center for Disease Control surveys have been primary to the SEOW dataset, survey data and administrative data from OhioMHAS sister agencies have also served as data sources for the state and county-level mortality and morbidity indicators. Memorandums of Understanding were developed with administrative data source organizations to facilitate annual updates of the compendium. This process allowed the state and county profiles to be updated annually where data was available.

OhioMHAS, ADAMHS/ADAS Boards and Providers are also working to address the prevention needs of existing, new, emerging and hard to reach populations in culturally competent and relevant ways. Ohio has significant African American, Somali, Latino, Asian, Appalachian and Amish population groups. In an effort to assess the needs of Ohio's large cultural population groups, the SEOW has gathered mortality and morbidity data available.

In addition, OhioMHAS is working to develop relationships with other data collection entities at the regional and county level as well as, Memorandums of Understanding (MOU's) with the Ohio Department of Health, Ohio Department of Job and Family Services, and the Ohio Department of Development regarding specific data needs. Such efforts will assist in providing the SEOW with age-specific consequence and other types of population-specific data at both the state and county level. The SEOW is also exploring prescription drug abuse data in partnership with West Virginia and Kentucky to address the increase in prescription drug use across the Appalachian region. As new data becomes available, it will be analyzed, graphed, and placed upon the SEOW website at <http://www.ada.ohio.gov/seow/>

In conjunction with the Interagency Prevention Consortium and the Evidence-Based Practice (EBP) Workgroup, the SEOW will identify local data sources to provide population-level measures of local initiative success.

Ohio Substance Abuse Monitoring Network (OSAM)

The Ohio Substance Abuse Monitoring (OSAM) Network is a collaborative effort funded by OhioMHAS in association with key stakeholders in the substance abuse community throughout Ohio. The OSAM Network first began monitoring drug trends in 1999 and has the capacity to respond rapidly to investigate new drugs being used on the streets as well as to monitor drug and alcohol abuse and changes in drug abuse or drug-using populations. The primary mission of OSAM is to provide a dynamic picture of substance abuse trends and newly emerging problems within Ohio's communities every six months. The OSAM Network has grown significantly over the years, through the establishment of working relationships with community professionals and agencies that provide rich and diverse sources of drug trend data. This expansion has allowed the Network to provide coverage in most of the major urban and some rural areas of Ohio.

The OSAM Network collects and analyzes both qualitative (focus groups and individual interviews) and quantitative (statistical) data. This data provides substance abuse professionals and policy makers with the information necessary to plan for alcohol and drug addiction prevention, treatment and recovery services.

A diverse sample of individuals is recruited to participate in focus groups and individual interviews for the purpose of collecting qualitative data. These participants have an intimate knowledge of drug abuse trends in their communities and include:

- Treatment professionals
- People actively engaged in drug use or recovery
- Law enforcement officers
- Adult and juvenile probation officers
- School counselors
- Crime lab professionals

The Network's findings are disseminated through a variety of publications. Drug trend reports that provide general epidemiological descriptions of substance abuse trends across the state, focusing on drug availability, prices, quality, and abuse patterns are one example. Reports

are published on a biannual basis shortly after OSAM researchers meet as a group in January and June of each year. Critical findings are also disseminated through “OSAM-O-GRAMS,” one-page summary reports that briefly and graphically represent significant substance abuse trends. Targeted Response Initiatives (TRI’s) represent another publication that typically focus on specific substance abuse-related issues that OhioMHAS has determined need further investigation. This targeted response capability provides OhioMHAS with a necessary tool to collect information in order to respond to substance abuse issues in a timely and effective manner.

The OSAM Network has been integral in OhioMHAS’ ability to respond to media inquiries, aid local Alcohol and Drug Addiction Services (ADAS)/Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards and agencies in grant-writing efforts, to address and respond to important needs of the Ohio Legislature and to assist OhioMHAS in planning and prioritizing resources based on emerging drug trends.

Resource Assessment Projects Funded by SPE Grant

National Resource Assessment: Statewide Student AOD Surveys in SAMHSA’s Central CAPT Region

The Ohio SPF SPE Evaluation Team conducted a web search to determine what states in SAMHSA’s Central CAPT Region (i.e., Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Pennsylvania, West Virginia, and Wisconsin) regularly conduct student surveys that provide either county-level or regional estimates of substance use. For most of these states, information was found on the website of the lead substance abuse agency for the state. The purpose was to obtain information about how common it is for states surrounding Ohio to have student surveys that can provide sub-state estimates of substance use, and to learn more about the implementation of such surveys.

The Evaluation Team also developed a set of additional questions to be used to both verify the information we located through the Internet search, and to address other key points related to implementing statewide student surveys. Although we did not contact officials (such as the NPNs) in these states to ask them these questions, the questions themselves are listed in Appendix C. OhioMHAS and the Evaluation Team are working with Ms. Kate Buchanan, an AOD Research Analyst at the National Association of State Alcohol/Drug Abuse Directors, to field a survey (Appendix C) with the membership of NPN. The survey was deployed to all NPNs in the United States in late July.

The following shows summary results by state. It should be noted that this information was gathered solely from the links noted; information was not verified by representatives of the states.

- **Illinois** conducts the Illinois Youth Survey (grades 6, 8, 10 and 12) every two years (e.g., 2010 and 2012) which is available to all eligible public and private schools. The goals are to provide local data and to provide state estimates through a random sample to represent students in these grades in Illinois public schools. In 2010, 188,882 youth in 1,104 schools participated in the survey. Source: <http://iys.cprd.illinois.edu/>
- **Indiana** conducts the Survey of Alcohol, Tobacco and Other Drug Use by Indiana Children and Adolescents (or Indiana Survey) annually in grades 6 through 12. In 2011, the survey was administered to 152,678 students in 478 schools throughout the state. The

strength of the survey is to describe reported ATOD use at the local level. Source: http://www.drugs.indiana.edu/publications/survey/indianaSurvey_2011.pdf

- **Iowa** conducts the Iowa Youth Survey with students in the 6th, 8th and 11th grades “across the state of Iowa”; surveys were implemented in 1999, 2002, 2005, 2008, and 2010, and will be administered in 2012. The website for the survey included 2010 trend reports at the county level for all 99 counties. Source: <http://www.iowayouthsurvey.org/>
- **Kentucky** conducts the KIP Student Survey with students in grades 6, 8, 10 and 12 in even-numbered years. A total of 8 of 120 counties (and 21 of 176 school districts in the Commonwealth) had no participants in the survey in 2010. Source: <http://www.reachoflouisville.com/kip/index.htm>
- **Michigan** conducts the Michigan Profile for Health Youth (MiPHY) every other year as an online student health survey with students in grades 7, 9, and 11. In 2010, 63 counties had surveys implemented in at least two districts, yielding a county level report. There are a total of 83 counties in Michigan. Source: http://www.michigan.gov/mde/0,1607,7-140-28753_38684_29233_44681---,00.html
- **Minnesota** conducts the Minnesota Student Survey (MSS) as a statewide student survey every three years with students in grades 6, 9 and 12. All public school districts are invited to participate. In 2010, 295 of the 335 school districts (88%) agreed to participate. Source: <https://edocs.dhs.state.mn.us/lfsrserver/Public/DHS-6380A-ENG>
- **Pennsylvania** conducts the Pennsylvania Youth Survey (PAYS) every three years (most recently in 2011). All schools are encouraged to participate and a random sample of schools is selected through which state level estimates are produced (the schools selected participate at no cost). Source: http://www.portal.state.pa.us/portal/server.pt/community/pennsylvania_youth_survey/5396/2011/775032
- **West Virginia** conducts the YRBS and CDC Tobacco Survey, but does not otherwise conduct a statewide survey. Sources: <http://wvde.state.wv.us/healthyschools/YRBS.htm> and <http://www.wvdhhr.org/bph/hsc/statserv/yts.asp>
- **Wisconsin**: No student surveys (except BRFS, YRBS, and NSDUH) were reported in a 2010 state epidemiological profile on alcohol and other drug use, and we did not locate any estimates from survey data at the county level in that profile. Source: <http://www.dhs.wisconsin.gov/publications/P4/P45718.pdf>

Statewide Youth Survey Initiative

The initial discussion related to the development and administration of a statewide youth survey occurred during the implementation of Ohio’s Prevention State Incentive Grant in 2004. At that time, the Interagency Prevention Partnership (IPP), consisting of the Office of the Governor, the Ohio Attorney General, Ohio Family and Children First (OFCF), and the Ohio Departments of Education, Alcohol and Drug Addiction Services, Health, Mental Health, Mental Retardation and Developmental Disabilities, Job and Family Services, Youth Services and Public Safety was given two Cabinet Council approved tasks during the Fall of 2004. The first task was to develop a shared state agency prevention framework (completed and published 1/2006) and the second task was to initiate a process to examine the feasibility of developing and implementing a multi- agency supported youth survey that would meet agency data needs that could only come from surveying youth and would also provide county level data.

With regard to the second task, although much work was completed, a single statewide survey was never adopted. Ohio learned from this first attempt and is attempting to revitalize efforts for a single statewide survey.

In 2004, the IPP elicited the expertise of its advisory arm, the Expert Prevention Panel (EPP) made up of experts and epidemiologists from seven Ohio universities, the Ohio Department of Health with facilitation from the Center for Substance Abuse Prevention (CSAP) Central Center for the Application of Prevention Technologies (CCAPT). The EPP provided technical oversight and expertise regarding assessment, research and evaluation. The OYS Pilot Project was implemented through county partnerships between the Local ADAMH/ADAS Boards, the Family and Children First Councils and the Schools. The survey was web based and was conducted through SmartTrack™, an Internet-based data collection, needs assessment, and evaluation tool. The ten original counties solicited for participation were determined based on regional representation, demographic diversities and service board and county system service support. Those counties included: Butler, Clinton, Crawford, Cuyahoga, Lake, Marion, Montgomery, Stark, Summit and Washington. Delaware, Fairfield and Franklin were then invited to participate due to several counties opting out of the survey. In addition to the 3 new counties, Ohio's largest online school serving over 10,000 students surveyed their 6-12th graders. The most common feedback provided for non-participation discussed school disinterest or the county partner's inability to convince them to participate. Other reasons stated that the schools were "already participating in several different types of surveys", or "just bad timing and they couldn't meet the survey deadline", (although it was extended numerous times) and lastly, they "just hadn't heard enough about it and didn't want to commit to something for one year when they might not be able to administer it again". Results were available to county partners during data demonstration sessions. The OYS provided important information about Ohio's young people and the communities in which they live. Schools and county partners were able to use this information for immediate planning, reporting and guiding policies and programs that serve youth. SmartTrack and OSU-CLEX staff attended and provided training during "data reveal" sessions also observing the county partner's reaction to obtaining student survey results through a live web based tool.

In 2012, during SPE planning, the Prevention Policy Consortium identified through the strategic planning process that data collection was a priority and the idea of a statewide youth survey needed to be revisited and included as one of their goals. The Ohio University, Ohio SPF/SPE Evaluation Team (OSET) developed several surveys related to youth data collection to identify what currently occurring across the state. Once the SPE plan was complete, the group advocated for the pursuit of a statewide youth survey.

A committee of state partners was convened to establish the commitment and desire of the agencies to pursue this endeavor once again. The state partners showed a much higher level of readiness and have been actively involved in the process thus far. The group is being facilitated by the OSET so all state partners are equal owners of the process and the survey.

The initial meeting was spent reviewing the previous process including the developed survey, administration process, constructs and the diverse needs of each state partner. The group decided the first step was to update the data requirement needs for each agency since it was initially completed years ago. This information was forwarded to OSET and presented back to the group. Much of the data requirements have remained unchanged but there were some updates that needed to be made.

OSET also took the list of constructs and provided an updated comparison of all the current surveys being implemented in the state showing duplicative and complimentary items. They then conducted several resource assessments to ascertain what was already being done across the state.

Community Coalition Data Resource Assessment

The first resource assessment conducted by OSET was with the Drug Free Community Coalitions around data collection. The OSET created a web-based form to gather information about local-level surveys collecting substance use data in Ohio. This resource assessment was conducted between April and August 2012 with DFC-funded coalitions and ADAMHS/ADAS Boards.

The resource assessment sought to collect information on youth or adult surveys being conducted at the local-level throughout Ohio. A web-based instrument was developed to collect the following information about local-level surveys and if possible, to obtain an electronic copy of the survey instrument.

- Survey population
- Administration schedule
- Year of most recent administration
- Geographic area covered by survey
- Cost for most recent survey administration
- Inclusion of National Outcome Measures (NOMs)

The Evaluation Team began the resource assessment process by contacting DFC program directors, as these grantees are required to field a youth survey to collect core measures for the program. This ensured that the potential respondents would have at least one survey to enter into the resource assessment. A list of DFC grantees funded for fiscal year 2011 was downloaded from the Office of National Drug Control Policy (ONDCP) website. This list included the contact information for 27 DFC-funded grantees in Ohio. Before deploying to all DFC-funded grantees in Ohio, the resource assessment was pilot tested by two DFC program directors. Minor changes were made to incorporate their feedback into the final instrument. On June 1, 2012, an email was sent to remaining 25 DFC program directors requesting their participation in the resource assessment. Periodic email reminders were sent to non-respondents and follow-up requests were made by the Ohio Prevention Program Specialists from ODADAS. The DFC portion of the resource assessment concluded on July 6, 2012 with 16 of the 27 DFC program directors submitting information on local-level surveys.

- Almost all of the DFC coalitions (15 of 16) reported contracting with an outside organization for some part of the survey process for their core measures survey.
- Three of the DFC coalitions reported conducting the required DFC core measures survey every year with middle school and high school surveys implemented in alternating years (e.g., middle school in even years and high school in odd years). The majority reported conducting their survey every other year while one conducted their survey every three years.
- DFC coalitions were asked to upload an electronic version of local-level surveys collecting substance use data in their areas. A total of 17 surveys were provided by respondents. Among these are 12 youth surveys used to collect the required DFC core measures and five other youth or adult surveys conducted in their area.

To collect information on areas not covered by the DFC-funded coalitions a plan was developed to expand the resource assessment to ADAMHS and ADAS Boards. Due to time constraints, this portion of the resources assessment was conducted by telephone. Initial emails were sent to the executive directors of ADAMHS and ADAS Boards requesting their participation in the resource assessment. This email described the project and asked for the individual with the most knowledge of local-levels surveys to contact the SPF SPE evaluation team about a brief telephone interview. Follow-up calls were conducted with boards not responding to the initial request. OSET was able to contact 33 of the 50 (66%) current ADAS/ADAMHS Boards and were able to locate local survey information for 35 of the 50 (70%) Boards. They found that many of the Boards contacted had some sort of youth survey and many were collecting data from adult populations (18 or older) in their communities. This suggests that many Ohio's local communities have developed infrastructure for collecting youth and/or adult data.

This original data is currently being supplemented by the OSET team and Consortium partners from the Ohio Department of Health to inventory all assessment conducted by local health departments and medical centers.

Higher Education Data Resource Assessment

The second resource assessment was done with Institutions of Higher Education around their current prevention data collection strategies. The OSET collected and compiled data and information on which Ohio institutions of higher education implement student surveys that include measures of alcohol and other drug (AOD) use. The purpose was to obtain information on the availability of data as well as on the overlap between the measures used and the National Outcome Measures (NOMs).

First, the OSET developed a listing of colleges and universities in Ohio, which included the 24 largest universities by enrollment, as well as 25 two-year community and technical colleges in the state. The smallest enrollment four-year university on the list had an estimated enrollment of just over 3,000 students. Next, they searched the websites of the institutions to determine who to contact that would be familiar with AOD surveys implemented by the institution. Third, they developed a script to be used to ask the contacts about any surveys their institution regularly conducts that asks students about AOD use. Fourth, calls were conducted starting in mid-June 2012 to collect and compile the information. An Excel spreadsheet was used to track contacts, and a separate Excel spreadsheet to compile the final information. We also attempted to obtain copies of all surveys implemented.

The OSET also gathered from the website of the Higher Education Research Institute at UCLA information on what Ohio colleges and universities implemented two surveys (College Senior Survey, and Your First College Year Survey), as well as in what years since 2008 they implemented these surveys. Finally, they developed a table of the measures in the main surveys (College Senior Survey, Your First College Year Survey, NCHA, and Core) to allow comparison with National Outcome Measures (NOMs).

Information was collected via telephone interviews (or in a few cases, via emails from key informants) from 30 of 49 institutions of higher education (IHEs). The response rate was 61.2%. The response rate for four-year institutions (22 of 25, or 88%) was much higher than the response rate for community colleges (8 of 24, or 33%).

Key findings from the information gathering include: Of the 30 IHEs that responded to the interview with information about surveys conducted in their institutions, a total of 16 IHEs

(53%) reported implementing ATOD surveys on a regular basis (one university implemented two different surveys). Of these:

- Seven IHEs (41%) reported using the American College Health Association's National College Health Assessment (NCHA).
- Five IHEs (29%) reported using the Core Institute's Core Alcohol and Drug Survey.
- Five IHEs (29%) reported implementing surveys developed by their own faculty.
- Information from the Higher Education Research Institute website also showed that 10 IHEs implemented either the College Senior Survey or Your First College Year Survey since 2008.
- Of the 16 IHEs that responded to the survey and reported having used these surveys, all reported having collected data in 2010 or more recently (with the exception of one, which reported last implementing a survey in 2009).
- Of the 8 community colleges for which we interviewed key informants, none reported implementing surveys to collect prevention data on a regular basis.

Most key informants reported that surveys to collect prevention data were implemented either every two years or every three years. Surveys to collect prevention data seem to be implemented most commonly as web surveys, and somewhat less commonly, as paper and pencil surveys with students in a random sample of classrooms. Over three fourths of the surveys were implemented via the web.

To inform future planning, we compiled all ATOD measures from the following surveys: (1) College Senior Survey, (2) Your First College Year Survey, (3) National College Health Assessment, and (4) Core Alcohol and Drug Survey (long form).

Need for Prevention & Early Intervention Services Assessment

Promoting Early Childhood Social and Emotional Learning and Development

In 2010, nearly 18% of Ohio's children had special health care needs, which higher than the national average (Data Resource Center for Child and Adolescent Health). Clearly, one of the most vulnerable sub-population is children ages zero to five years of age with nearly 3% of Ohio children in this age group having a special health care need, and also having an emotional, behavioral or developmental problem which requires treatment or counseling. This is 56% higher than the national average and also represents a large increase over the previous five years. With needs this high, pre-school aged children must be a focus to prepare for a smooth and successful transition to school. Training and skill development for teaching staff and parents in social emotional development is needed to promote positive development and to increase the early identification and intervention with children with exhibiting behavior indicative of risk.

Promoting Mental, Emotional and Behavioral Health

The integration of the Departments is aimed at providing a more integrated care system for individuals struggling with separate and co-occurring conditions. These issues are particularly evident within Ohio schools. Ohio's adolescents are in particular need of assistance for depression and anxiety, which substantially predict suicidal attempts and other co-morbidities. The Ohio Family Health Survey (2008) reported that, "For children, being ages 13-17 years old, male and African-American or multi-racial backgrounds were all associated with having more emotional, developmental or behavioral problems" (p.5). National Survey on Drug Use and Health (NSDUH) data show the rate of major depression among youth between 12 and 17 years of age has recently increased, and was above the national average in 2009-2010. This

trend suggests that depression among school-aged children must be a focus of prevention and treatment within Ohio schools.

Preventing Behavioral Health Problems

Ohio has identified several troubling indicators of rising behavioral health problems in children and adolescents. Contextual indicators that measure community instability and family-related factors are closely related to the emotional and social well-being of pre-school and school-aged children. As previously mentioned, unemployment rates have increased dramatically during recent years within Ohio's communities. According to a recent Department study on Medicaid usage for mental health services, needs have risen significantly in conjunction with unemployment. The National Survey on Drug Use and Health (NSDUH) reports that Ohio has remained above the national average for major depression among individuals aged 12+ every year between 2007 and 2010 making it a particular concern for Ohio youth.

According to the National Survey on Drug Use and Health (NSDUH), Ohio was also above the national average in binge alcohol use in past month in 2010 and 2011 and in alcohol abuse or dependence since 2005-2006. Similarly, the illicit drug abuse or dependence rate has remained above the US average since 2005-2006. These figures are of particular concern for the younger age group. NSDUH reports that in 2010-2011, binge drinking in the past month, youth between 12 and 17 finally dropped below the national average for the first time in more than ten years. In addition, NSDUH found limited perception of risk among 12 to 17 year olds in regards to binge drinking. Per capita liquor sales within Ohio have increased steadily since 2005. Williams County found that 18% of their students between grades 6 and 12 had at least one drink in the past 30 days. Of these, 55% reported binge drinking at least once within the past month. Smoking and drinking were also closely related, with almost 2/3 of current youth smokers in Williams County identifying as current drinkers.

Approximately four to five percent of Ohio motor vehicle crashes between 2001 and 2011 were alcohol related. Ohio's rate of unintentional drug deaths has also been rising since 2004. The Ohio Department of Health (ODH) reports the infant mortality rate has remained well above the national average since 2003 (ODH Information Warehouse), and it is estimated that substance abuse is a contributing factor in up to 80% of parents with children in foster care (PCSAO, 2007).

As a result of increases of illicit drug use within recent years, dependence and abuse are issues of great concern for Ohio residents. Although several substance abuse problems exist within our population, heroin and prescription drug abuse are among the most prevalent within Ohio. According to the Ohio Substance Abuse Monitoring Network (2012), heroin is easily accessible within all regions of the state, particularly within suburban and rural areas. Heroin was also reportedly increasing among school-aged and young adults within Ohio. The YRBSS reported that heroin use among high school students in Ohio has remained above the national average since 2007. The rate of heroin-related overdose deaths across the State nearly tripled between 2006 and 2010 (Ohio Department of Health, 2012). In a recent qualitative report, the Ohio Substance Abuse Monitoring (OSAM) Network (2013) suggested that prescription opioid use may be increasing among younger populations, including school-aged children and adolescents. OSAM also reported that prescription opioid users often quickly move to heroin, which is cheaper and easier to access than prescription opioids. Similar reports were seen in Williams County, where 8% of students in grades 6-12 abused prescription medications at least once in their lifetime. Marijuana use in past year within Ohio remained above the national average every year between 2002 and 2010 (NSDUH, 2012). In addition, Ohio's rate for early initiation of marijuana use has

remained above the national average since 2003 (YRBSS, 2011). Similar results are seen at the state level for lifetime heroin use among high school students (YRBSS, 2011). Ohio's rates for illicit drug abuse and dependence were above the national average between 2006-2007 and 2009-2010 (NSDUH, 2012).

The cost of unaddressed behavioral health problems in Ohio's children and adolescents are paid for in increased costs in primary and emergency health care, juvenile/criminal justice and child welfare. A large portion of Ohio's annual public expenditure for children's services is driven by substance abuse. Approximately 72% of youth served within Ohio's Department of Youth Services have a diagnosed severe substance abuse disorder (most likely would qualify for residential treatment).

The treatment gap among both alcohol and illicit drug users within Ohio is of grave concern. The population who need but do not receive treatment for both alcohol and illicit drug abuse has been increasing since 2005-2006. This trend is of particular concern for providers in the face of state and federal budget cuts. The number of school-age children struggling with alcohol and other drugs within Ohio continues to grow. The treatment gap for adolescents within our State is of great concern. According to SAMHSA (2012), an estimated 7.92% of persons aged 12 to 17 did not receive needed treatment for an alcohol or illicit drug addiction problem in the past year. The National Survey of Substance Abuse Treatment Services (2010) indicated that on March 31, 2010, only approximately 38% of Ohio's treatment centers included programs designed for adolescents. In addition, only 80.7% of children receiving treatment for alcohol and other drug treatment centers were placed in an age-specific treatment center. At the state level, policies are needed to increase the ability of teachers and schools to assess and refer students with alcohol and other drug or mental health issues. Similarly, Belmont County reports a need to increase the percentage of mental health referrals for students grades K-12, implement programs and activities that enhance protective factors of the student, and improve family-child relationships and other protective factors that precede or and reduce substance use.

How Many Ohioan's have Mental Illness (Prevalence)? What Percentage Receive Treatment (Treated Prevalence)?

Ohio Estimates Prevalence of Mental Illness – Ohio has a statewide health survey which estimates the presence of mental illness among its citizens. This survey, formerly known as the Ohio Family Health Survey, was renamed the Ohio Medicaid Assessment Survey (OMAS) in 2012.¹ This study measures severe (SPD) psychological distress among the general population which approximates serious and persistent mental illness and serious emotional disturbances among the population under treatment. It also addresses the prevalence of mental illness among persons who are uninsured.

Key findings indicate that 6.6% of Ohioans report experiencing 14 or more days of functional impairment due to mental health distress in the past 30 days. Within that group, 4.1% report a score greater than 12 on the Kessler-6, a measure of severe psychological distress (SPD).

¹ <http://grc.osu.edu/omas/> This 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. Summary by Carol Carstens, Ph.D., OhioMHAS Office of Quality and Planning.

Among all Ohioans, 9% of Ohioans are covered only by Medicaid, but among that 9%, nearly a quarter (23.7%) is individuals with SPD who report 14+ days of functional impairment due to a mental health condition. While 14.2% of all Ohioans are uninsured, nearly one-third (29.3%) of the uninsured are persons with SPD and 14+ days of functional impairment. The number of uninsured persons with SPD is expected to decrease if the Ohio General Assembly passes the Governor's proposal to expand Medicaid coverage to 138% of FPL.

The OMAS 2012 key findings also indicate that Medicaid is the second largest source of coverage for children at 39.8%. Among children 0 to 4 years old, 40% are recipients in the Women, Infants, and Children (WIC) program. Reports show Medicaid case loads and utilization for children grew 7% between 2010 and 2012.²

National Estimates of Prevalence and Treated Prevalence for Ohio

Estimated Need for Services by SAMHSA Contractor - 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.

Estimated Need for Children's Mental Health Services - An estimated 139,483³ children ages 9 – 17 in Ohio have a serious emotional disturbance (SED) according to 2011 NASMHPD-NRI data using a level of functioning of "60 – lower limit." There is an 8% decrease from 152,058 to 139,483 children with serious emotional disturbances between SFY 2008/2009 and SFY 2011. The majority of this 8% decrease is attributable to Ohio returning from its status as a "high-tier poverty" state to a "mid-tier poverty state as it recovered from a recession which impacted Ohio more than other states. This recession increased the number of children with serious emotional disturbances while decreasing the number of resources to serve them.

Treated Prevalence - In SFY 2012, Ohio's public mental health system served a total of 130,304 children ages 0 – 17 which included 94,349 children ages 9- 17. For children ages 9 – 17, the ages matching NRI's prevalence data, 94,349 (67.64%) of the 139,483 children estimated to need treatment were served. Using more restrictive criteria for Ohio's definition of SED, 63,608 (45.60%) of the 139,483 children ages 9 – 17 were served.⁴

Ohio and Federal Definitions of SED Differ - SAMHSA's definition is closer to the total number of children served in Ohio than OhioMHAS' historic definition. Historically, Ohio has used a narrow definition for SED to allocate high intensity services to those who need them the

² Ibid

³ 2011 SMI and SED Prevalence Estimates for Table 1; http://www.nri-inc.org/projects/SDICC/urs_forms.cfm

⁴ Ohio SFY 2012 Mental Health Block Grant Report, December 1, 2012

most, while SAMHSA has used a broad definition to advocate for all children who need services. As a result of different uses for the definition of SED, Ohio's and SAMHSA's definitions are not likely to match. The same is true for adult definitions for mental illness.

Early Childhood Prevalence - The NASMHPD-NRI estimates do not include children ages 0 – 8 who were 26% (34,374⁵ of 130,304) of the children served by Ohio's mental health system in 2012. 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.

Estimated Prevalence for Adults with SMI - Ohio is estimated to have 477,496 adults (ages 18+) with severe mental illness (SMI) using the NASMHPD-NRI most recent prevalence estimates for SFY 2011. Ohio's public mental health system provided services to 234,880 adults in SFY 2012. Of these 234,880 adults receiving treatment, 105,288 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.

Treated Prevalence - Based on calculations using these numbers, 52.6% (234,880 of 446,496) of Ohio's adults who need mental health services are receiving them from the public mental health system. Additionally, an estimated 23.6% (105,288 of 446,496) 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 (52%) is 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. These numbers do not include the number of adults receiving psychiatric treatment from the private sector, anti-depressants from their family physicians, or services from Federally Qualified Health Care (FQHC) Centers.

In-Patient Services - In SFY 2012, 4,878 Medicaid-covered hospital admissions for patients under age 18 represented a 1.6% decrease under the previous year's 5,959 admissions. This decrease was preceded in the previous four fiscal years (FY08-FY11) by an average annual increase of 4.7%. This steady growth in the number of admissions over the four year period may be associated with increased Medicaid eligibility. This increased eligibility, in turn, was likely influenced by the economic downturn the state experienced in FY09 which continued to impact hospitalization for several years.⁶

⁵ 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>

⁶ Special Report, Carol Carstens, Ph.D, OhioMHAS Office of Quality and Planning, using Ohio Medicaid claims data.

Mental Health and Addiction Services Related Needs Identified by Ohio Office of Health Transformation

Ohio's Office of Health Transformation (OHT) - Identifies Unmet Needs and Critical Gaps in Health Care – Governor Kasich established OHT to reform health care. OhioMHAS' Director Tracy Plouck, a former state Medicaid Director, is leading the reforms in mental health and addiction services. Selected OHT initiatives that have a behavioral health component are bolded in the following list of Ohio's health initiatives:

- Modernize Medicaid
 - **Extend Medicaid coverage to more low income Ohioans**
 - Reform nursing facility reimbursement
 - **Integrate Medicare and Medicaid benefits**
 - **Prioritize health and community based services**
 - **Create health homes for people with mental illness**

Rebuild community behavioral health capacity

- Enhance community developmental disabilities services
- Improve Medicaid managed care plan performance
- Streamline Health and Human Services
 - Implement a new Medicaid claims payment system
 - Create a cabinet-level Medicaid department
 - **Consolidate mental health and addiction services**
 - Simplify and integrate eligibility determination
 - **Coordinate programs for children**
 - **Share services across local jurisdictions**
- Improve Overall Health System Performance
 - Pay for health care based on value instead of volume
 - Provide access to medical homes
 - Coordinate health information technology infrastructure
 - **Coordinate health sector workforce programs**
 - Federal Health Insurance Exchange
 - Support regional payment reform

For each of the items listed in bold as important to behavioral health, the following section identifies a need and the data to support that need as identified by the Ohio Office of Health Transformation.⁷

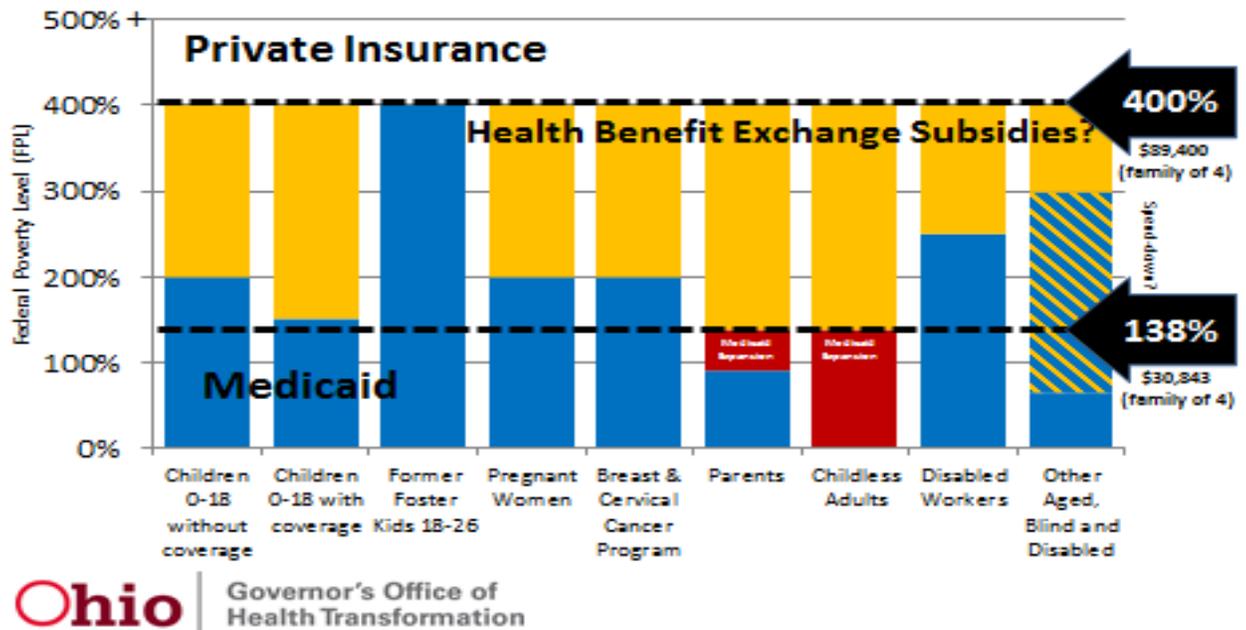
Need - Many Ohioans lack health care coverage including persons with mental illness and addictions

Data: Current Medicaid eligibility policies leave gaps in coverage. An estimated 1.5 million Ohioans do not have health insurance, most of them from working families, and some

⁷ Ohio Office Of Health Transformation, website home page <http://www.healthtransformation.ohio.gov/>

of them very.⁸ Medicaid plays a critical role in protecting the health of low-income Ohioans, but it leaves out many people as demonstrated in the graph below this paragraph. Like many states, Ohio does not extend Medicaid coverage to adults unless they have children or are disabled. Beginning in January 2014, the federal government will establish a Health Insurance Exchange to offer tax credits for insurance premiums to Ohioans with incomes between 100 percent and 400 percent FPL, but no credits will be provided below 100 percent FPL. As a result, parents between 90 percent and 100 percent FPL and childless adults with income below 100 percent FPL will be caught in a “coverage gap” without access to Medicaid or tax credits on the Exchange⁹ as indicated in red in the graph below. For the Community Mental Health consumers who received one of the Medicaid reimbursable services, approximately 30% of those between the ages of 18 and 64 are not covered by Medicaid; under the age 18, approximately 10% are not covered by Medicaid.¹⁰ For a combined mental health and addiction services population in SFY 2012 services, the numbers of persons not covered by Medicaid were 15.9% of children (under age 18), 53.1% of adults (age 18 – under 65), and 62.7% of adults (age 65 and older).¹¹

Eligibility Modernization: New Federal Income Eligibility Levels in 2014



⁸ US Census Bureau, *Health Insurance Coverage Status by State for All People* (2011).

⁹ Ohio Office Of Health Transformation, website home page <http://www.healthtransformation.ohio.gov/>; Extend Medicaid Coverage and Automate Enrollment

¹⁰ OhioMHAS Office of Quality and Planning, Ohio Medicaid claims data, special report, July 2013

¹¹ OhioMHAS Office of Quality and Planning, Ohio Medicaid claims data, special report, January 2012¹² MyCare Ohio: Connecting Medicare+Medicaid, Ohio's Integrated Care Delivery System (ICDS)

Need – Medicare and Medicaid benefits are poorly coordinated.

Data - A number of persons with serious mental illness have dual eligibility for Medicaid and Medicare, and need a coordinated team approach to care. While Ohio’s response to this issue is driven by the OHT and the Ohio Department of Medicaid, it impacts a sizable group of persons served by community mental health centers. OHT explained the need for “Why Must We Act” by stating,

“The Medicaid and Medicare programs have almost no connection to each other. No one entity is accountable for the care of the whole person. The current system is confusing and difficult for individuals to navigate. Benefits for individuals eligible for both programs, such as long-term care services and supports, behavioral health services, and physical health services, are fragmented and poorly coordinated.”¹²

Need - Prioritize health and community based services, including those for persons with serious mental illness in nursing facilities

Data from the Ohio Office of Health Transformation - *On average, Ohio Medicaid spends \$102,500 per year for Medicaid services in a nursing home for an individual under age 60 who is reasonably physically healthy but has a diagnosis related to severe and persistent mental illness. Many of these individuals could be served in less restrictive, clinically appropriate settings at lower taxpayer expense. Based on an analysis of more than four hundred successful HOME Choice placements in 2011, Ohio Medicaid and the Ohio Department of Mental Health estimate the average cost avoided by moving one of these individuals into a community based setting was approximately \$35,250 per year.¹³ By proactively shifting funds to community based services, the state can achieve significant long-term savings to get more people out of nursing homes and into the settings they prefer.*

Data from Adult Care Facilities - The rate for Adult Care Facilities (for which more than 50% are SMI) remained \$16 per day for many years until SFY 2014 – 2015 when they were raised to \$28 per day.¹⁴

Need: Medical Homes for Persons with Serious and Persistent Mental Illness are needed due to lack of coordination between primary care and behavioral health care for persons with serious mental illness. Many also have co-occurring substance use disorders.

¹² MyCare Ohio: Connecting Medicare+Medicaid, Ohio’s Integrated Care Delivery System (ICDS)
<http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=ogpyaFUvTFc%3d&tabid=105>

¹³ Helping Ohioans Move Expands Choice (HOME Choice) is a Medicaid program that provides a \$2,000 one-time stipend to assist seniors and people with disabilities move from nursing homes and other long-term care facilities into their own homes or community-based settings. The stipend can be used to cover the first month’s rent, previous bills, transportation and other expenses associated with reestablishing a person in the community.

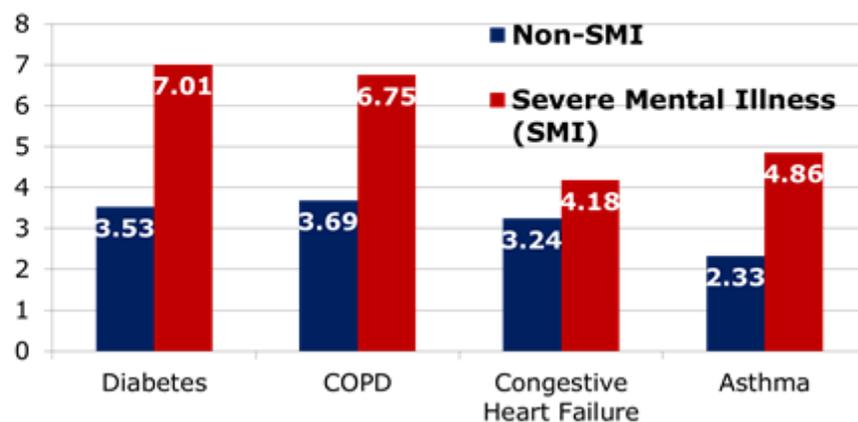
¹⁴ Rebuild Community Behavioral Health Capacity, Ohio Office of Health Transformation
<http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=X8HY4spx0QA%3d&tabid=125>

Data: To make the case for Medicaid Health Care Homes to improve coordination of care for adults and children with serious mental illness. Tracy Plouck, Director of OhioMHAS, provided data available through Ohio Health Transformation's website from a variety of sources. She identified the following points in her June 8, 2012 presentation on *Medicaid Health Homes in Context of Other Progress*:

- Ohioans spend more per person on health care than residents in all but 17 states¹⁵
- 36 states have a healthier workforce than Ohio¹⁶
- Ohioans had 35% more (general) hospital emergency room visits than the US in 2010¹⁷
- Nursing home care per capita spending is 36.5% higher, and hospital care is 16.4% higher in Ohio than in the U.S.¹⁸
- One percent of the U.S. population consumes 23% of total health spending¹⁹
- Adults with serious mental illness are 10% of Ohio's Medicaid population, and expend 26% of the resources.²⁰
- Avoidable hospitalizations in Ohio per 1000 persons for ambulatory care sensitive conditions (avoidable with proper treatment) are significantly higher for adults with serious mental illness on Medicaid as compared to adults without serious mental illness. Please see the graph below.

**Medicaid Hot Spot:
Hospital Admissions for People with Severe Mental Illness**

Avoidable hospitalizations per 1000 persons for ambulatory care sensitive conditions (avoidable with proper treatment)



Governor's Office of Health Transformation

Source: Ohio Colleges of Medicine Government Resource Center and Health Management Associates, Ohio Medicaid Claims Analysis (February 2013)

¹⁵ Kaiser Family Foundation State Health Facts (December 2011)

¹⁶ Commonwealth Fund 2011 State Scorecard on Health System Performance

¹⁷ Source: Providers and Service Use, Emergency Department Use at www.statehealthfacts.org

¹⁸ Source: 2009 Health Expenditure Data, Health Expenditures by State of Residence, Centers for Medicare and Medicaid Services, Office of the Actuary, National Health Statistics Group, released December 2011; available at <http://www.cms.gov/NationalHealthExpendData/downloads/resident-state-estimates.zip>

¹⁹ Source: Kaiser Family Foundation calculations using data from AHRQ Medical Expenditure Panel Survey (MEPS), 2007

²⁰ Presentation; *Medicaid Health Homes in Context of Other Progress*, Tracy Plouck, Director of ODMH, June 8, 2012

Need - Rebuild behavioral health capacity

Service Gap and Data as Identified by Office of Health Transformation²¹ - The Ohio state government and 53 local Boards partner to fund the safety net system for addiction and mental health services. This safety net exists for a wide variety of Ohioans, including but not limited to: childless adults who are struggling with substance use challenges that complicate their ability to work; people who have experienced significant trauma in childhood but, as adults, lack health care coverage necessary to access treatment; parents in families between 90 percent and 138 percent of the federal poverty level; and adults or children of any age who live with mental illness and/or addiction and lack access to treatment. Today, services for these individuals are funded 100 percent by state and local resources *to the extent that resources are available*. In many Ohio communities, basic behavioral health needs are unaddressed because there is a lack of funding and system capacity. Waiting lists are commonly weeks or months long, leading to crisis situations for individuals and families that could otherwise be avoided. People in rural areas may have to travel hours in order to access basic services. This safety net is fragile at best, and the need for a sustainability plan has never been greater.

Need - Consolidate mental health and addiction services to streamline government and better support the coordination and integration of treatment services.

Data - *Administration of behavioral health services largely is integrated at the local level in that 47 of the 53 county boards now administer both mental health and alcohol and drug addiction services. Many providers are certified for both types of services, and data from various sources indicate that a significant percentage of consumers interact with providers in both systems. As such, a state-level administrative consolidation will help to support local government partners, providers and clients who are involved in the two treatment systems.*²²

Need – Coordinate programs for children

Data - *Approximately 1.3 million of Ohio's 2.8 million children are in health and early childhood development programs. Ohio's programs for children cut across multiple health and human services departments. These state agencies work together and with other child-caring stakeholders to ensure that children are born healthy, succeed in school, and transition into healthy and productive adults.*²³

Need - Share services across local jurisdictions

²¹ *Rebuild Community Behavioral Health Capacity*, Ohio Office of Health Transformation, updated January 31, 2013 <http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=X8HY4spx0QA%3d&tabid=122>

²² Establishing a New Cabinet-Level Agency for Behavioral Health, John Kasich, Governor, Orman Hall, Director, ODADAS, Tracy J. Plouck, Director, ODMH
http://www.adamh.ohio.gov/Portals/0/pdf/Summary%20on%20consolidation_2.pdf

²³ Ohio Office of Health Transformation
<http://www.healthtransformation.ohio.gov/CurrentInitiatives/ProvideAccountableCareforChildren.aspx>

Data – Some non-urban Boards do not have the resources to independently provide 24/7 crisis services and/or permanent supported housing as indicated in Community Plans.

Need – The behavioral health workforce doesn't meet the current need, especially for child psychiatrists.

Data – OhioMHAS Medical Director, Mark Hurst, MD, provided the following data in his June 21, 2013 presentation to Planning Council:

Workforce issues

- *Demand already outstrips supply and the problem is getting worse*
- *<5% of medical school graduates seek psychiatry residency*
- *15% decrease in psychiatry residency slots*
- *Among active psychiatrists, more than 55% are 55 or older²⁴*

Data - The Child Access to Psychiatry Project led by OhioMHAS Office of Quality and Evaluation systematically examined how long an adolescent waits for a new patient appointment with a psychiatrist for routine medication management. Using a mystery shopper methodology, researchers posing as parents telephoned randomly selected offices in 9 geographical regions during spring and summer 2012, seeking care for a 14-year-old. The scenario was varied to measure how access differed by problem (anxiety vs. depression) and insurance type (Medicaid vs. a private insurer), in addition to season and region. Overall, the study generated 498 wait times at 140 unique offices. Overall, the typical wait time for an appointment was 6 ½ weeks (geometric mean=46.2 days, s.d. =2.4). In the spring, teens covered by Medicaid waited longer than those covered by a private insurer (50.9 vs. 41.9 days). During the summer, however, there was no such difference. Wait times also varied by region. In Cuyahoga County, mean wait time was 27.1 days (s.d. =2.6), compared to 69.6 days (s.d. =3.1) in Franklin County. Around each core metropolitan county, adjacent counties reported similar wait times. Presenting problem was not associated with wait times.²⁵

**Additional Needs
Identified by OhioMHAS Draft Strategic Plan
July 2013**

OhioMHAS recently completed a first draft of a strategic plan in July 2013, and has sent it out for stakeholder comment. One of the stakeholder groups invited to comment is Planning

²⁴ Medical Director Initiatives for the Ohio Department of Mental Health and Addiction Services, June 21, 2013, Presentation to Ohio Community Support Planning Council.

²⁵ OhioMHAS, Office of Quality and Planning, July 2013

Council. The following additional needs were identified which are relevant to the SAPT and MH Block Grants, and are not included in Office of Health Transformation's Initiatives.

Need – Trauma informed care is not universally available in Ohio's mental health and addiction services system.

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 treatment²⁶

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.

Need – Increase access to permanent community housing for persons with addiction and mental illness by creating new and strengthening established partnerships, expanding community funding opportunities and increasing the quality of housing options.

Data to Estimate Ohio Need for Adults with Serious Mental Illness:

Nursing Facility Residents Who Choose to Move Back to Community- Money Follows the Person (Ohio Home Choice) successfully transferred 734 persons under age 60 with serious mental illness back to the community from nursing facilities in its first two years.²⁷

Homelessness Who Need Mental Health Services - Ohio's PATH (Projects for Assistance in Transition from Homelessness) program for persons with mental

²⁶ US Dept. of HHS, ACF, Children's Bureau, 2011

²⁷ OhioMHAS Money Follows the Person data

illness (funded by SAMHSA formula grant) indicates that of 5,642 homeless persons were served by PATH. Of this group, 3,196 were determined to be eligible for services, and 2253 (64%) of the eligible persons received community mental health services. The major principal diagnoses of the persons served were affective disorders (57%) and schizophrenia (23%). However, 59% of the PATH clients also had co-occurring substance abuse disorders.²⁸

Permanent Supportive Housing - Community Plans and Community Capital Assistance Project Applications submitted to OhioMHAS identify a need for permanent housing for persons with mental illness and/or addictions.²⁹

The Buckeye Sheriff's Association identified their top need as housing for offenders with mental illness and addiction who are being released.³⁰

Adult Care Facilities – Ohio has approximately 400 adult care facilities housing approximately 5000 citizens, primarily persons with serious mental illness often with co-occurring addiction and/or developmental disabilities.³¹

Need – Reduce unnecessary regulations and administrative barriers to promote access to treatment while maintaining safety standards.

Data – Ohio has 133 providers certified for both mental health and addiction services which are required to meet two separate sets of standards for licensure or certification. With consolidation, the new department will have a single application for certification.³²

Need - Promote the health and safety of individuals and communities by modernizing and integrating Ohio's behavioral health prevention and early intervention system.

- **Need – Promote mental health and addiction prevention and treatment services to youth and young adults, the ages of onset for most substance abuse and mental illness.**

Data – The onset of 75% percent of mental health and substance use disorders occurs by 24.³³

²⁸ Ohio's 2012 PATH Report

<http://pathprogram.samhsa.gov/Path/Reports09/ViewReports.aspx?slid=st1039&rYear=2012&rpts=StateProfile>

²⁹ OhioMHAS CommunityPlans

³⁰ ³⁰ Medical Director Initiatives for the Ohio Department of Mental Health and Addiction Services, June 21, 2013, Presentation to Ohio Community Support Planning Council.

³¹ Ohio Adult Care Facilities Association <http://ohioadultcarefacilitiesassociation.org/publications.html>

³² OhioMHAS Bureau of Licensure and Certification

³³ *Lifetime Prevalence and Age-of-Onset Distributions of DSM IV Disorders in the National Comorbidity Study*, JAMA Psychiatry, Ronald Kessler, Ph.D., Patricia Burchard, MBA, Olga Demier, MA, MS, Robert Jin, MA,

- **Need – Reduce addiction to alcohol and other drugs by strengthening community prevention coalitions by developing and vetting criteria meeting standards set by Community Anti-Drug Coalitions of America.**

Data - According to data collected by the National Survey on Drug Use and Health³⁴ (NSDUH), 8.5% of Ohioans age 12 and older have used illicit drugs in the past month (2010, 2011 NSDUH), 52.5% have used alcohol in the past month, including 23.6% who engaged in binge drinking. NSUDH data indicates dependence or abuse of alcohol of 7.3% for alcohol and 2.8% for illicit drugs.

- **Need – Promote healthy choices among young adults for responsible gambling.**

While limited research is available about what protects youth from engaging in problem gambling behaviors, the Search Institute has studied factors called the “40 Developmental Assets” that help young people grow into healthy, responsible adults while helping buffer against problem behavior. Some gambling prevention experts believe that youth are more likely protected from problem gambling if they have certain assets. Communities and families can play a critical role in promoting healthy choices around gambling by providing these assets³⁵ They include: support (from family, community and school); positive outlook; realistic boundaries and expectations; internal control; constructive use of time/contributing; high self-esteem; and good problem solving skills.

- **Need – Develop criminal justice partnerships and community innovations.**

Data – Ohio Department of Rehabilitation and Corrections currently has 50,000+ offenders with approximately 8% - 9% (4,000+) being considered SPMI³⁶ (*ODRC reports/website*). Approximately 300 youth offenders and 1600 offenders with serious mental illness being released from prisons and juvenile facilities and are in need of community linkage in 2014.³⁷

Kathleen R. Menikangas, Ph.D., Ellen Walters, MS

<http://archpsyc.jamanetwork.com/article.aspx?articleid=208678#yoa40305t3>

³⁴ <http://www.samhsa.gov/data/NSDUH.aspx> National Survey on Drug Use and Health, 2010 - 2011 (NSDUH)

³⁵ <http://heapro.oxfordjournals.org/content/20/1/69.full>, Carmen Messerlian, Jeffrey Derevensky and Rina Gupta, Health Promotional International, volume 20, issue 1, January 2005

³⁶ <http://www.drc.ohio.gov/> Ohio Department of Rehabilitation and Corrections

³⁷ OhioMHAS Strategic Plan Draft---July 2013

- **Need – Promote the development and expansion of a system of care for youth and young adults ages 14 – 21 with serious emotional disorders or serious mental illness and/or co-occurring disorders.**

*Data - Ohio's YYAT population totals 1,287,162, with more than 90,000 having SED or SMI. Yet, adolescents eligible for high intensity services in the children's mental health system demonstrate low service use in the adult system. Less than half of Ohio's young adults who need individual counseling after age 18 receive it, and by age 21, only about one third of young adults receive this service. Even when youth have sufficient health care coverage and life skills to access adult mental health services, they may refuse to engage in services that are perceived as unresponsive to their individual needs and life goals.*³⁸

Need – Enhance the availability and quality of services to meet the needs of individuals with addiction and mental illness throughout the life span.

Data to estimate the need for services:

- **Peer support and recovery coaching which** is a priority for Ohio Empowerment Coalition and Ohio Citizen Advocates for Prevention and Treatment of Chemical Dependency which represent Ohio citizens in recovery. Peer support reduced hospital admissions by 42% and decreased substance abuse and depression.³⁹
- **Alcohol and other drugs residential treatment model** – OhioMHAS employees identified this as a need during a strategic planning process.⁴⁰
- **Employment** – Sixteen percent of Ohioans receiving mental health services are employed. Only 25.2% of adults receiving mental health services in Ohio were in the labor force as compared to 33.6% in the United States.⁴¹
- **Health Disparities** – OhioMHAS does not have standard language regarding cultural competency in its contracts with Boards, providers and non-profits.⁴²

Cultural Competency and Perception of Outpatient Services and Hospital Use; OhioMHAS Office of Quality, Planning and Research -
This cross-sectional study examined the relationship between patient-reported perception of outpatient services and hospital use. A survey was

³⁸ Ohio ENGAGE Implementation Grant Abstract, ODMH, submitted 6/19/2012 to SAMHSA, awarded July 2013

³⁹ Larry Davidson, Ph.D., Professor of Psychiatry, Yale University School of Medicine, presentation , The Pillars of Peer Support Services Summit IV Establishing Standards for Excellence, Sept. 24 – 25, 2012; also additional academic publications with similar data

⁴⁰ OhioMHAS Strategic Plan Draft – July 2013

⁴¹ Ohio 2012 Mental Health National Outcome Measures (NOMS): Community Mental Health Services (CMHS) Uniform National Reporting System

⁴² OhioMHAS Strategic Plan Draft – July 2013

sent to 373 consumers about cultural competence. Forms were matched with administrative data on hospitalization during the study period. After controlling for subject-related factors, consumer perception of cultural competence was significantly related to likelihood of hospitalization. Results suggest that cultural competence is a specific approach to patient centered care that can improve community tenure and reduce the likelihood of hospitalization.

- **Assertive Community Treatment, Intensive Home Based Services and Peer Support/Recovery Coaching** – OhioMHAS needs to develop a project plan and a proposed submission date, and estimated implementation date for State Medicaid Plan Amendments to add these services.⁴³

•
Need – Provide necessary support for the statewide opiate initiative to be successful. More specifically, OhioMHAS and its partners need to:⁴⁴

Data - According to NSDUH,⁴⁵ 5% of Ohioans have engaged in non-medical use of pain relievers in the last year.

OMHAS MACSIS (public behavioral health service) data indicate that 26.4% of clients are admitted with a diagnosis of an opiate-related disorder. Ohio's opiate epidemic has not been uniform across the state. Some counties have opiate-related admissions in the single digits. Other counties, especially those in Southeast Ohio, have opiate-related admission rates of half to two-thirds of their admissions.

- Evaluate OhioMHAS' buphenorphine protocol
- Develop evidence-based prescribing standards for naltrexone and methadone
- Improve accessibility and acceptability of medication assisted treatment
- Assist pregnant and addicted mothers and babies born addicted to opioids
- Support development of network of family support for opioid addiction

⁴³ OhioMHAS Strategic Plan Draft – July 2013

⁴⁴ OhioMHAS Strategic Plan Draft – July 2013

⁴⁵ <http://www.samhsa.gov/data/NSDUH.aspx> National Survey on Drug Use and Health, 2010 - 2011 (NSDUH)

Integration of Care

Need: Treatment for Persons with Co-occurring Substance Use Disorders and Mental Illness

Expenditures for Co-occurring Substance Use Disorder and Mental Illness – Ohio’s public mental health and alcohol and other drug treatment systems paid in \$160,851,914 in claims for treatment of adults with both mental health and alcohol and other drug diagnoses, and \$24,891,096 for children with dual diagnoses in SFY 2012. Of those served, 13.1% of adults and 2.8% of youth received both a mental health and an alcohol and other drug (AOD) diagnosis. While adults with co-occurring disorders make up 13.1% of the treatment population, they account for 26.6% of the expenditures. For children the difference is even greater with 2.8% of the children served having co-occurring diagnoses, and accounting for 8.4% of the expenditures. About 63% of the adults and 85% of the youth diagnosed with co-occurring disorders received treatment for both disorders which is an increase in the percentage from two years ago. 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, more clinicians should be trained to diagnose and treat co-occurring disorders.

Behavioral Health Data for Adults – Ages 18 + Served by Ohio’s Community Behavioral Health Providers in SFY 2012						
MH – Mental Health AOD = Alcohol and other Drug						
Diagnosis	Treatment	Number Served	Percent Served	Claims Paid	Percent Expenses	Percent Male
MH/AOD	MH/AOD	25,611	8.3%	\$ 119,196,847	19.7%	48.8%
MH/AOD	MH only	13,291	4.3%	\$ 38,651,137	6.4%	55.8%
MH/AOD	AOD only	1,503	0.5%	\$ 3,003,930	0.5%	50.6%
Dual Diagnosis Total		40,405	13.1%	\$ 160,851,914	26.6%	
AOD only	AOD only	58,243	18.8%	\$ 95,073,868	15.7%	66.4%
MH only	MH only	200,456	64.8%	\$ 341,355,135	56.5%	39.2%
Other		10,350	3.3%	\$ 7,408,433	1.2%	58.6%
Single Diagnosis Total		269,049	86.9%	\$ 443,837,436	73.4%	
Total		309,454	100%	\$ 604,689,350	100%	

**Behavioral Health Data for Juveniles – Ages 0 – 17
Served by Ohio’s Community Behavioral Health Providers in SFY 2012**

MH=Mental Health, AOD=Alcohol and Other Drug

Diagnosis	Treatment	Number Served	Percent Served	Claims Paid	Percent Expenses	Percent Male
MH/AOD	MH/AOD	2,884	2.4%	\$ 23,358,778	7.9%	70.6%
MH/AOD	MH only	367	0.3%	\$ 1,211,149	0.4%	64.6%
MH/AOD	AOD only	77	0.1%	\$ 321,169	0.1%	71.4%
Dual Diagnosis Total		3,328	2.8%	\$ 24,891,096	8.4%	
AOD only	AOD only	2,124	1.8%	\$ 4,570,072	1.5%	77.7%
MH only	MH only	109,040	90.6%	\$ 253,241,725	85.3%	58.7%
Other		5,857	4.9%	\$ 14,079,467	4.7%	65.4%
Single Diagnosis Total		117,021	97.2%	\$ 271,891,264	91.6%	
Total		120,349	100%	\$ 296,782,361	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).⁴⁶ 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.^{47 48}

Co-morbid Illnesses - The Special Population Report of the 2008 Ohio Family Health Survey⁴⁹ indicated that Ohioans who reported having serious psychological distress (SPD) were

⁴⁶ 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>

⁴⁷ 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

⁴⁸ 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

⁴⁹ 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/>

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)⁵⁰ 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 arthritis. A more recent Ohio Medicaid Claims analysis⁵¹ 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)⁵² 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.

⁵⁰ 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

⁵¹ Ohio Government Resource Center, February, 2011

⁵² 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.

Need for Recovery Supports in Recovery Oriented System of Care

Gaps in Recovery Support Services - 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. OhioMHAS expects to complete development of a certified Peer Support Service 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.

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 conducted focus groups regarding housing for youth and young adults (16 – 22) with SED. The results of these focus groups will inform OhioMHAS' 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 #13 Priority Populations - Homeless Persons and Persons with Severe Mental Illness in Need of Supportive Housing

Employment - Only 25.2%% of adult consumers of Ohio's public mental health were employed in SFY 2012 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.

II: Planning Steps

Table 1 Step 3,4: -Priority Area and Annual Performance Indicators

Priority #:	1
Priority Area:	1 Persons who are intravenous/injection drug users (IDU)
Priority Type:	SAT
Population (s):	IVDUs
Goal of the priority area:	
Increase availability of medication assisted treatment	
Strategies to attain the goal:	
Expand board and treatment program authority to utilize FDA-approved medications in addition to methadone. Encourage creation of OTCs	
Annual Performance Indicators to measure goal success	
Indicator #:	1
Indicator:	Number and percent of injection drug users who receive medication assisted treatment (MAT)
Baseline Measurement:	SFY 2009 - 3,581 persons; SFY 2010 - 4,597 persons; Target SFY 2013 - 6,000
First-year target/outcome measurement:	SFY 2011-4635
Second-year target/outcome measurement:	SFY 2012-4964
Data Source:	
MACSIS/OHBH systems. MACSIS is a claims based data system. OHBH collects client demographics, admission and discharge information and NOMS (National Outcome Measures).	
Description of Data:	

Utilize MACSIS/OHBH client information to track the number of injecting drug users who receive medication assisted treatment. SFY 2010 and SFY 2011 serve as a baseline.

Data issues/caveats that affect outcome measures::

MACSIS is no longer being used to report Medicaid-claims for behavioral health carve-out services after SFY 2012, but will continue to be used to collect data on non-Medicaid services. Starting in SFY 2013 MITTS data from Ohio's Medicaid claims payment system will be used. As a result, the data reported may or may not be comparable between years prior to SFY 2013, and SFY 2013 and subsequent years.

Priority #: 2

Priority Area: 2 Women who are pregnant and have a substance use disorder

Priority Type: SAT

Population PWWDC
(s):

Goal of the priority area:

Increase in percent of pregnant women who complete treatment with all goals met (Successful disposition at discharge

Strategies to attain the goal:

Provision of culturally competent, gender specific treatment.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percent of pregnant women enrolled in treatment who have a disposition code signifying successful completion
Baseline Measurement:	SFY 2009 -31.6%; SFY 2010 - 29.7%; Target SFY 2013 35.5%
First-year target/outcome measurement:	SFY 2011-23.8%
Second-year target/outcome	SFY 2012--22.1%

measurement:

Data Source:

MACSIS/OHBH data systems. MACSIS is a claims-based data system. OHBH collects client demographics, admission and discharge information and NOMS.

Description of Data:

MACSIS/OHBH client information system contains disposition data that allows for quantifying the number of women who 1) received assessment only, 2) had a "neutral" disposition (e.g., transferred to other services), 3) negative outcome (e.g., dropped out of treatment) and 4) successful outcome (e.g., completed treatment, all goals met).

Data issues/caveats that affect outcome measures::

Please see data issues under priority area 1, indicator 1.

Indicator #:	2
Indicator:	Percent of drug-free births
Baseline Measurement:	SFY 2009 - 27/28 = 96.5% Drug Free; SFY 2010 73/85 = 85.8% Drug Free; SFY 2013 Projection 93%
First-year target/outcome measurement:	SFY 2011 --78.0%
Second-year target/outcome measurement:	SFY 2012--91.7%

Data Source:

MACSIS/OHBH data systems

Description of Data:

Utilize MACSIS/OHBH client information system to capture birth outcomes of pregnant women who give birth prior to discharge.

Data issues/caveats that affect outcome measures::

Please see data issues under priority area 1, indicator 1.

Priority #: 3

Priority Area: 3 - Parents with substance use disorders who have dependent children

Priority Type: SAT

Population PWWDC

(s):

Goal of the priority area:

Increase family reunification for parents/caregivers involved in child welfare system (prevent loss of custody)

Strategies to attain the goal:

Provide culturally competent treatment to parents/caregivers of children involved with the child welfare system. Work with ODJFS to develop data matching strategy that complies with HIPAA and 42 CFR

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Percent of families that remain intact or are re-unified vs. percent of families in which child custody is lost

Baseline Measurement:

Not yet developed

First-year target/outcome measurement:

?

Second-year target/outcome measurement:

?

Data Source:

This indicator requires matching data from SACWIS (Ohio's child welfare system) and MACSIS/OHBH Ohio's substance abuse client data base.

Description of Data:

This requires matching data from the ODJFS child welfare data base with records from the substance abuse treatment information system to identify clients receiving services in both systems and to determine treatment and custody outcomes. The integration of these data sets for the purposes of this analysis will be explored. Because this methodology will be established no concurrent baseline data exists.

Data issues/caveats that affect outcome measures::

Indicator #:

2

Indicator:

Percent of individuals receiving treatment who report having at least one child living at home and who are discharged as successful per disposition code

Baseline Measurement:

SFY 2009 - 32.2%; SFY 2010 29.3%; SFY 2013 Projection 34%

First-year target/outcome measurement:

SFY 2011--35.7%

Second-year target/outcome measurement:

SFY 2012--39.0%

Data Source:

MACSIS is a claims-based data system. OHBH collects client demographics, admission and discharge data and NOMS.

Description of Data:

Using MACSIS/OHBH admission and discharge data, identify individuals who report children living in the home and identify disposition at discharge (discharged with all goals met).

Data issues/caveats that affect outcome measures::

Please see data issues under priority 1, indicator 1.

Priority #: 4

Priority Area: 4. Individuals with tuberculosis and other communicable diseases

Priority Type: SAT

Population TB

(s):

Goal of the priority area:

100% of clients found to have tuberculosis receive medical care.

Strategies to attain the goal:

Enforcement of Board Assurances and agency treatment standards.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Annual report received from ADAMH/ADAS Boards indicating number of individuals enrolled in treatment services who were positive for TB and required medical treatment and number who received medical attention.

Baseline Measurement: Will be collected

First-year target/outcome measurement: ?

Second-year target/outcome measurement: ?

Data Source:

Report from ADAMH/ADAS Boards

Description of Data:

Compilation of Board reports identifying number of clients in need of medical treatment for TB. This data is not currently sent to the Department from Boards. Boards will be asked to submit data for measurement.

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: 5 Children with Serious Emotional Disturbances (SED)

Priority Type: MHS

Population SED

(s):

Goal of the priority area:

Increase accessibility of services for children with SED and children at-risk for SED through a system of care approach.

Strategies to attain the goal:

Strategies: To increase access to services for children with SED and their families, OhioMHAS 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, 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. Expand system of care for youth/young adults with aid of SAMHSA System of Care Grant awarded summer 2013.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Children Served by Ohio's mental health system (all children treated, regardless of Ohio-SED status)

Baseline Measurement: SFY 2010 - 121,432; SFY 2011 - 123,496; SFY 2012 - 130,304

First-year target/outcome measurement: SFY 2014 - 131,000

Second-year target/outcome measurement: SFY 2015 - 132,000

Data Source:

MACSIS/OHBH and MITTS

Description of Data:

MACSIS/OHBH and MITTS are client information systems that provide data on the number of persons served, admission and discharge, and some of the National Outcomes Measures.

Data issues/caveats that affect outcome measures::

SED in Ohio is not comparable to SAMHSA's SED definition. Rather, SED is more restrictively defined in Ohio to prioritize children in need of more intensive services. Also, MACSIS is no longer being used to report Medicaid-claims for behavioral health carve-out services after SFY 2012, but will continue to be used to collect data on non-Medicaid services. Beginning SFY 2013, MITTS will be used to report Medicaid claims data. As a result, the data reported may or may not be comparable between years prior to SFY 2013, and SFY 2013 and subsequent years.

Ohio uses a state-specific definition of SED which is more restrictive than SAMHSA's SED definition. Therefore, the number treated reported for this indicator is a closer approximation for SED than the number of Ohio children with SED treated.

Indicator #: 2

Indicator: Number of Children served with SED as defined by Ohio more restrictively than SAMHSA to identify children most in need of intensive services

Baseline Measurement: SFY 2011; 43,815; SFY 2012 - 63,608

First-year target/outcome measurement: SFY 2014 - 64,000

Second-year target/outcome measurement: SFY 2015 - 65,000

Data Source:

MACSIS/OHBH data system and MITTS data system

Description of Data:

MACSIS/OHBH is a client information system that provides data on the number of persons served, admission and discharge, and some of the National Outcomes Measures.

Data issues/caveats that affect outcome measures::

MACSIS is no longer being used to report Medicaid-claims for behavioral health carve-out services after SFY 2012, but will continue to be used to collect data on non-Medicaid services. MITTS data base will be used. As a result, the data reported may or may not be comparable between years prior to SFY 2013, and SFY 2013 and subsequent years.

Ohio uses a state-specific definition of SED which is more restrictive than SAMHSA's SED definition. Therefore, the number treated reported for this indicator is a closer approximation for SED than the number of Ohio children with SED treated.

Indicator #: 3

Indicator: Treated Prevalence of Children Ages 9 - 17 Using Ohio's Restrictive Definition of SED

Baseline Measurement: SFY 2011 - 28.81%; SFY 2012 - 45.60%

First-year target/outcome measurement: SFY 2014 - 45.8%

measurement:

Second-year target/outcome SFY 2015 - 46%

measurement:

Data Source:

MACSIS/OHBH and MITTS

Description of Data:

The numerator is the number of children served ages 9 -17 using Ohio's restrictive definition of SED. The denominator is the number of children in the "lower limit--level of functioning 60" estimated in the URS Table 1 Number of Children with SED Ages 9 - 17 produced by NASMHPD-NRI which has been used by most states to estimate prevalence for MH Block Grant.

Data issues/caveats that affect outcome measures::

NASMHPD-NRI (SAMHSA contractor) estimate of Ohio's prevalence changed markedly due to changes in Ohio's "state tier for % in poverty" which has historically been "mid", but changed to "high" for SFY 2010 - 2012 service data due to the economic recession hitting Ohio harder than most states. Also, About 1/4 of Ohio children served are ages 0 - 8 which are excluded by SAMHSA's prevalence data. Additionally, for info about data bases, see priority 1, indicator 1.

Indicator #: 4

Indicator: Treated Prevalence Including All Children Ages 9 - 17 Served by Ohio's Mental Health System
(Note: This number is a closer approximation of treated prevalence than the number in indicator #3.)

Baseline Measurement: SFY 2011 - 60.08%; SFY 2012 - 67.64%

First-year target/outcome SFY 2014 - 67.8%
measurement:

Second-year target/outcome SFY 2015 - 67.9%
measurement:

Data Source:

Same as previous indicator (priority 5, indicator #4)

Description of Data:

Same as previous indicator except includes all children ages 9 - 17 served by Ohio's mental health system. This number is

probably closer to the number Ohio would have if using SAMHSA's definition of SED rather than Ohio's more restrictive definition of SED.

Data issues/caveats that affect outcome measures::

Same as previous indicator (priority 5, indicator #4

Priority #: 6

Priority Area: 6 Adults with Serious Mental Illness

Priority Type: MHS

Population SMI

(s):

Goal of the priority area:

Maintain and expand accessibility to public mental health services for adults with SMI

Strategies to attain the goal:

To sustain access for adults with mental health treatment needs, OhioMHAS will:

1. 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 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 including the expansion of Health Homes for Adults with SPMI (serious and persistent mental illness).

Annual Performance Indicators to measure goal success

Indicator #: 0

Indicator: Adults receiving services in Ohio's mental health system

Baseline Measurement: SFY 2011 - 208,535; SFY 2012 - 234,880

First-year target/outcome measurement: SFY 2014 - 234,890

Second-year target/outcome measurement: SFY 2015 - 234,900

Data Source:

MITTS/OHBH/MACSYS

Description of Data:

Number of adults who receive public mental health services each fiscal year

Data issues/caveats that affect outcome measures::

Indicator #: 1

Indicator: Adults with SPMI receiving public mental health services (using Ohio's restrictive definition of SPMI)

Baseline Measurement: SFY 2011 - 101,398; SFY 2012 105,288

First-year target/outcome measurement: SFY 2014 - 105,400

Second-year target/outcome measurement: SFY 2015 - 105,500

Data Source:

Same as priority 5, indicator 1

Description of Data:

Data issues/caveats that affect outcome measures::

Ohio's definition of SPMI is more restrictive than SAMHSA's definiton of SMI. Ohio uses SPMI criteria to determine which adults and children are eligible for Ohio Medicaid Health Homes which provide intensive care coordination. See other caveats with priority 5, indicator 1.

Indicator #: 2
Indicator: Treated Prevalence of Adults with SPMI (using criteria more restrictive than SAMHSA's SMI definition)
Baseline Measurement: SFY 2011 - 21.29%; SFY 2012 - 22.05%
First-year target/outcome measurement: SFY 2014 - 22.2%
Second-year target/outcome measurement: SFY 2015 - 22.3%
Data Source:

Same as priority 5, indicator 1.

Description of Data:

The numerator is the number of adults with SPMI treated. The denominator is the number of persons estimated to have SMI by NASMHPD NRI.

Data issues/caveats that affect outcome measures::

Ohio is expanding Ohio Health Homes from 5 counties to all 88 counties effective October 1, 2013.

Indicator #: 3
Indicator: Treated Prevalence of All Adults (which is closer approximation of SAMHSA's SMI definition than Ohio's SPMI definition)
Baseline Measurement: SFY 2011 - 49.46%; SFY 2012 - 49.19%
First-year target/outcome measurement: SFY 2014 - 49.3%
Second-year target/outcome measurement: SFY 2015 - 49.4%
Data Source:

See priority 5, indicator 1.

Description of Data:

The numerator is the number of adults served in Ohio's public mental health system. The denominator is the number of adults estimated to have SMI by NASMHPD-NRI for SAMHSA.

Data issues/caveats that affect outcome measures::

As Ohio uses a very restrictive definition for SPMI for eligibility for Ohio Medicaid Health Homes, this number is closer to SAMHSA's broad definition of SMI.

Priority #: 7

Priority Area: 7 Integration of behavior health and primary care

Priority Type: SAT, MHS

Population SMI, SED, PWWDC, IVDUs, HIV EIS, TB

(s):

Goal of the priority area:

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.

Strategies to attain the goal:

OhioMHAS will:

1. 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. coordinate elevation of carve-out behavioral health Medicaid benefit to the state for fiscal integration and better coordination of services
3. coordinate establishment of Medicaid Health Homes for Behavioral Health population with Office of Health Transformation and Ohio Department of Medicaid.
4. coordinate the creation of the ICDS (Integrated Care Delivery System) for improved care coordination for people with a severe and persistent mental illness
5. participate in Ohio Patient-Centered Primary Care Collaborative and other Primary Care/Mental Health efforts to integrate behavioral health and primary care services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults with SPMI who receive Ohio Medicaid Health Home Services

Baseline Measurement: SFY 2011 & SFY 2012 - 0 persons (new service)

First-year target/outcome measurement: SFY 2014 - collect baseline data

Second-year target/outcome measurement: SFY 2015 - collect baseline data

Data Source:

MACSIS/OHBH and MITTS

Description of Data:

See priority 5, indicator 1.

Data issues/caveats that affect outcome measures::

Ohio piloted Ohio Medicaid Health Homes in 5 counties starting in October 2012 and will offer the service statewide in 88 counties starting in October 2013.

Priority #: 8

Priority Area: 8 Recovery Supports

Priority Type: SAT, MHS

Population SMI, SED, PWWDC, IVDUs, HIV EIS, TB

(s):

Goal of the priority area:

Increase the availability of Certified Peer Supporters in Ohio among persons in recovery from mental illness and/or addictions.

Strategies to attain the goal:

1. Complete development of Peer Support Service rule for services by Certified Peer Supporters (staff in recovery from mental illness and/or addiction) , and complete the Ohio legislative rules process to incorporate the rule into the Certification Standards for Ohio's community mental health and addiction services.
2. Complete development of certification process and training curriculum for Certified Peer Supporters which includes recovery coaches as well as certified peer support.
3. Train and certify Peer Supporters.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of peer supporter certified each year
Baseline Measurement: SFY 2011 & SFY 2012 - None
First-year target/outcome measurement: SFY 2014 - 50
Second-year target/outcome measurement: SFY 2015 - 50

Data Source:

Ohio Empowerment Coalition data

Description of Data:

Number of persons in recovery from mental illness and/or addiction who are newly certified as peer supporters during each fiscal year

Data issues/caveats that affect outcome measures::

Ohio is piloting a curriculum for peers in recovery from mental illness and/or addiction developed with a SFY 2012 BRSS TACS award. Peer services are not eligible for Medicaid reimbursement as "peer services" at this date, so certification is not required. The numbers for this performance indicator will be impacted by progress (or lack of progress) in securing a State Medicaid Plan Amendment to add peer support services to Ohio's Medicaid reimbursable services. Services provided by peers who are not required to be certified may be included at the individual provider's option in Ohio's Health Homes, which may also impact the need for certified peer supporters in Ohio.

Priority #: 9
Priority Area: 9 Veterans
Priority Type: SAT, MHS
Population (s): SMI, PWWDC, IVDUs, HIV EIS, TB, Other (Military Families)
Goal of the priority area:

Increase the number of veterans receiving services

Strategies to attain the goal:

1. Participate in OHIOCARES to engage veterans and their families.
2. Ask Boards to respond to veterans as a potential priority population in Community Plans.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Veterans receiving treatment

Baseline Measurement: Substance abuse treatment only - SFY 2009 - 1171; SFY 2010 - 1468; SFY 2011-2365; SFY 2012-2092

First-year target/outcome measurement: SFY 2014 - baseline for all persons receiving mental health and/or addiction services in Ohio's public system

Second-year target/outcome measurement: SFY 2015 - baseline for all persons receiving mental health and/or addiction services in Ohio's public system

Data Source:

MACSIS/OHBH and MITTS

Description of Data:

See priority 1, indicator 1

Data issues/caveats that affect outcome measures::

See priority 1, indicator 1.

Priority #: 10

Priority Area: 10 Individuals with disabilities

Priority Type: SAT

Population (s): PWWDC, Other (Persons with Disabilities)

Goal of the priority area:

Number of deaf and hard of hearing who access services through telehealth

Strategies to attain the goal:

Expand telehealth

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Number of deaf and hard-of-hearing clients who receive services through telehealth.

Baseline Measurement:

Use 2012 data for baseline for comparison for 2013

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

MACIS/OHBH

Description of Data:

Enrollment of deaf and hard of hearing clients and their use of telehealth.

Data issues/caveats that affect outcome measures::

Data is being collected, but not yet available for analysis.

Priority #: 11

Priority Area: 11 Individuals involved with criminal justice system

Priority Type: SAT, MHS

Population SMI, PWWDC, Other (Criminal/Juvenile Justice)
(s):

Goal of the priority area:

For SAT, increase percent of criminal-justice involved clients who are successfully discharged from treatment.

For SMI, Increase the percentage of offenders with SPMI (seriously and persistently mentally ill) agreeing to participate in the community linkage program during discharge planning. Many of these offenders have co-occurring substance abuse issues.

Strategies to attain the goal:

For SAT, support evidence-based and promising practices; maintain collaborative partnership with criminal justice system.

For SMI, 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 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

Annual Performance Indicators to measure goal success

Indicator #:

1

Indicator:

Percent of criminal justice-involved clients who are discharged as successful per disposition

Baseline Measurement:

Successful Disposition: SFY 2009 = 39.1%; SFY 2010 = 37.3%; SFY 2013 Projected = 42%

First-year target/outcome measurement:

SFY 2011--31.7%

Second-year target/outcome measurement:

SFY 2012--33.9%

Data Source:

OHBH

Description of Data:

Utilize dispositional data of OHBH closure records to determine percent of criminal justice-involved clients wh were discharged with all goals met (successful).

Data issues/caveats that affect outcome measures::

Indicator #: 1
Indicator: Percentage of Offenders with SMI Leaving Prison Eligible for Community Linkage Social Work Service who are Successfully Linked with Community Services
Baseline Measurement: SFY 11 - 81.96%; SFY 12 - 93.17%
First-year target/outcome measurement: SFY 13 - 93.3%
Second-year target/outcome measurement: SFY 14 - 93.5%
Data Source:

Community Linkage Pogram data

Description of Data:

Data collected by Community Linkage social workers. Most of the offenders served have co-occurring substance use disorders.

Data issues/caveats that affect outcome measures::

Priority #: 12

Priority Area: The growing number of opiate addicted inviduals in the state including illicit drugs such as heroin and non-medical use of prescription drugs

Priority Type: SAT

Population PWWDC, IVDUs
(s):

Goal of the priority area:

Increase percentage of opiate addicted inviduals who have successful disposition at discharge (all goals met)

Strategies to attain the goal:

Provision of culturally competent treatment utilizaing best practices including MAT (medication assisted treatment).

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Peercent of individuals diagnosed with opiate abuse/addiction who are discharged from treatment with all goals met

Baseline Measurement: Successful disposition of opiate users: SFY 2009 = 18.9%, SFY 2010 = 20.1%: SFY 2013 Projected = 25%

First-year target/outcome measurement: SFY 2011--22.3%

Second-year target/outcome measurement: SFY 2012--23.3%

Data Source:

OHBH

Description of Data:

Utilize dispositional data of OHBH closer records to determin number of opiate addicted individuals who were discharged with all goals met (successful).

Data issues/caveats that affect outcome measures::

Priority #: 13

Priority Area: 13 Homeless persons and persons with mental illness and/or addiction in need of permanent supported housing

Priority Type: SAT, MHS

Population (s): SMI, PWWDC, Other (Homeless, persons with SMI in nursing facilities who wish to return to community living)

Goal of the priority area:

Increase and preserve safe, decent, and affordable housing to persons with severe and persistent mental illness including persons with co-occurring substance use disorders.

Strategies to attain the goal:

1. Increase and preserve the number of existing Permanent Supportive Housing units in which OhioMHAS has been a funding participant, and

include persons with substance use disorders.

2. Through Homeless Assistance Grant, leverage housing dollars from Ohio Department of Development for OhioMHAS housing projects to serve persons with SMI.

3. Work cooperatively with Ohio's Medicaid agency on the Money Follows the Person (MFP) grant to assist persons with severe mental illness residing in nursing facilities in obtaining housing.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of new people with SPMI assisted by Ohio's Money Follows the Person Program (nationally known as Home Choice Program) designed to assist person with SPMI under age 60 to move from nursing facilities to community housing---if that is their choice.

Baseline Measurement: SFY 2011 = 38; SFY 2012 = 286

First-year target/outcome measurement:

Second-year target/outcome measurement:

Data Source:

OhioMHAS Money Follows the Person Program data; PASSR data base

Description of Data:

Program data collected by Money Follows the Person and PASRR data based

Data issues/caveats that affect outcome measures::

Priority #: 14

Priority Area: 14 Underserved Racial and Ethnic Minorities and LGBTQ Populations

Priority Type: SAP, SAT, MHP, MHS

Population Other (LGBTQ, Underserved Racial and Ethnic Minorities)
(s):

Goal of the priority area:

Enhance mental health and addiction workforce skills through cultural competence training.

Strategies to attain the goal:

Conduct cultural competence training to provider staff, consumers, family members and community members on the elimination of disparities, and access to culturally appropriate services, as well as other topics.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Number of persons receiving cultural competence training
Baseline Measurement: SFY 2011 = not available; SFY 2012 = 521
First-year target/outcome measurement: SFY = 525
Second-year target/outcome measurement: SFY = 530
Data Source:

Multi-ethnic Advocates for Cultural Competence project reports

Description of Data:

Multi-ethnic Advocates for Cultural Competence (MACC) will count the number of persons trained. Additionally, MACC will collect training evaluations.

Data issues/caveats that affect outcome measures::

Priority #: 15
Priority Area: 15 Youth/Young Adults in Transition/ Adolescents and Young Adults
Priority Type: SAT
Population (s): PWWDC, IVDUs
Goal of the priority area:

Increase positive treatment outcomes for adolescents

Strategies to attain the goal:

Provide culturally competent treatment services. Enhance use of social media and telehealth to attract and retain adolescents in treatment.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Percent of adolescents with disposition code indicating successful treatment
Baseline Measurement: Successful disposition of adolescents SFY 2009 = 33.9%; SFY 2010 = 34%; SFY 2013 Projection = 36%
First-year target/outcome measurement: SFY 2011----35.7%
Second-year target/outcome measurement: SFY 2012---39.1%
Data Source:

OHBH

Description of Data:

Utilize OHBH data disposition data.

Data issues/caveats that affect outcome measures::

Priority #: 16

Priority Area: 16 Early childhood mental health (ages 0 - 6)

Priority Type: MHP, MHS

Population SED, Other (ages 0 - 6)
(s):

Goal of the priority area:

Goal: Early mental health screening, assessment, and referral to services are common practice.

Objective: OhioMHAS will continue to evaluate the Early Childhood Mental Health Consultation program in Ohio including professional development for ECMH professionals.

Strategies to attain the goal:

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.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children ages 0 -6 who are at risk for removal from school/childcare due to BH issues who are not removed

Baseline Measurement: SFY 2012 = 1272

First-year target/outcome measurement: SFY 2013 = 1280

Second-year target/outcome measurement: SFY = 2014 = 1290

Data Source:

OhioMHAS early childhood program

Description of Data:

The measure is the number of children, ages 0-6, at risk of removal who receives mental health consultation services.

Data issues/caveats that affect outcome measures::

Our child welfare partners drastically reduced funding for this program when their federal funds were reduced. Continuation of sequestration will add to funding reductions.

Priority #: 17

Priority Area: Public health approach using strategic prevention framework

Priority Type: SAP

Population

(s):

Goal of the priority area:

Adopt a public health approach (SPF) into all levels of the prevention infrastructure.

Strategies to attain the goal:

Ohio will:

- 1) Champion prevention with broad recognition of prevention as effective and cost saving.
- 2) To develop and promote evidence-based and culturally competent policies and practices that support and integrate prevention at multiple levels across systems.
- 3) Promote and support formalized collaborations and systems integration at the local and state levels for the sharing of resources and program implementations.
- 4) Use relevant data to assess community strengths in other systems.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of persons reached and trained in other systems
Baseline Measurement:	New - collect base-line data
First-year target/outcome measurement:	report baseline data
Second-year target/outcome measurement:	report baseline data
Data Source:	<input type="text"/>
Description of Data:	<input type="text"/>
Data issues/caveats that affect outcome measures::	<input type="text"/>

Priority #: 18

Priority Area: Families - Ensure prevention services are available across the lifespan with a focus on families with children and/adolescents

Priority Type: SAP

Population Other (Children/Youth at Risk for BH Disorder, Parents of children/adolescents)
(s):

Goal of the priority area:

Increase family communication around drug use

Strategies to attain the goal:

Ohio will:

- 1) support youth initiatives (Good Behavior Game, PBS, School-Based Prevention Education, Ohio Youth-led Network)
- 2) promote marijuana and underage drinking initiatives (Higher Ed Network, College Initiative, Parents Who Host, Trace Back)
- 3) promote family engagement
- 4) fund UMADOP prevention to reach minority communities
- 5) support Military Initiative

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Family Communications around Drug Use - NSDUH Survey Item (Youth)

Baseline Measurement: Ages 12 - 17 - CY 2009 - 2010 - 561

First-year target/outcome measurement: 565

Second-year target/outcome measurement: 570

Data Source:

NSDUH Questionnaire; prevention NOMS data

Description of Data:

Source Survey Item: NSDUH Questionnaire: "Now think about the past 12 months, that is, from [DATEFILL] through today. During the past 12 months, have you talked with at least one of your parents about the dangers of tobacco, alcohol, or drug use? By parents, we mean either your biological parents, adoptive parents, stepparents, or adult guardians, whether or not they

live with you?[Response options: Yes, No]

Outcome Reported: Percent reporting having talked with a parent.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Family Communication around Drug Use - Adults Ages 18+ (Parents)

Baseline Measurement: Age 18+ - CY 2009 - 2010 - 890

First-year target/outcome measurement: 900

Second-year target/outcome measurement: 910

Data Source:

NSDUH Questionn

Description of Data:

Source Survey Item: NSDUH Questionnaire: "During the past 12 months, how many times have you talked with your child about the dangers or problems associated with the use of tobacco, alcohol, or other drugs?[1][Response options: 0 times, 1 to 2 times, a few times, many times]

Outcome Reported: Percent of parents reporting that they have talked to their child.

Data issues/caveats that affect outcome measures::

Priority #: 19

Priority Area: Empower pregnant women to make health choices

Priority Type: SAP

Population PWWDC

(s):

Goal of the priority area:

Increase in the percentage of women who discuss with doctor how to prepare for health pregnancy as measured by PRAMS

Strategies to attain the goal:

Discuss with doctor how to prepare for healthy pregnancy.

Annual Performance Indicators to measure goal success

Indicator #: 1
Indicator: Discussed with doctor how to prepare for healthy pregnancy
Baseline Measurement: SFY 2008 - 26.0 (23.1 - 29.0) SFY 2009 - 27.8 (24.8 - 31.0); SFY 2010 - 31.8 (28.5 - 35.2)
First-year target/outcome measurement: SFY 2011 - 31.9
Second-year target/outcome measurement: SFY 2012 - 32.0
Data Source:

PRAMS data

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 20

Priority Area: Wellness in the workforce

Priority Type: SAP

Population Other (Workforce)
(s):

Goal of the priority area:

Increase the number of employers providing prevention training

Strategies to attain the goal:

Partnership with Bureau of Worker's Compensation Behavioral Health Wellness

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of Bureau of Worker's Compensation employers providing prevention information

Baseline Measurement: SFY 2013 - 80

First-year target/outcome measurement: SFY - 2014 - 82

Second-year target/outcome measurement: SFY - 2015 - 84

Data Source:

BWC data

Description of Data:

Data issues/caveats that affect outcome measures:

Footnotes:

Data Bases Used for Most of Ohio's Performance Indicators – Ohio takes performance indicators from four databases. The first of these is OHBH data system which has demographic data, admission and discharge data, and the National Outcome Measures (NOMS). OHBH includes data elements some of which are specific to mental health and some of which are specific to addiction treatment. The second database is MACSIS which provides data for services reimbursed by public, non-Medicaid sources and Medicaid reimbursed behavioral health services provided prior to SFY 2013. Additionally, the third database is MITS. MITS provides claims data for Medicaid-reimbursed behavioral health services starting in SFY 2013. Finally, a fourth data base, Ohio MHSIP and YSS-F Client Satisfaction Survey data are used for some mental health NOMS.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [SA]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention and Treatment	\$93,971,808		\$156,300,966	\$6,961,564	\$128,071,300	\$	\$
a. Pregnant Women and Women with Dependent Children*	\$21,903,420		\$	\$	\$	\$	\$
b. All Other	\$72,068,388		\$156,300,966	\$6,961,564	\$128,071,300	\$	\$
2. Substance Abuse Primary Prevention	\$25,059,150		\$	\$38,944,448	\$6,015,180	\$	\$
3. Tuberculosis Services	\$		\$	\$	\$	\$	\$
4. HIV Early Intervention Services	\$		\$	\$	\$	\$	\$
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention							
9. Mental Health Evidenced-based Prevention and Treatment (5% of total award)							
10. Administration (Excluding Program and Provider Level)	\$6,264,788		\$	\$7,875,148	\$11,401,334	\$	\$
11. Total	\$125,295,746	\$	\$156,300,966	\$53,781,160	\$145,487,814	\$	\$

* Prevention other than primary prevention

Footnotes:

A. Substance Abuse Block Grant - Planning figures are based upon the SAPT13 Federal Award of \$62,647,873.
 C. Medicaid - Planning figures based upon FY13 data.

III: Use of Block Grant Dollars for Block Grant Activities

Table 2 State Agency Planned Expenditures [MH]

Planning Period - From 07/01/2013 to 06/30/2015

Activity (See instructions for using Row 1.)	A. Substance Abuse Block Grant	B. Mental Health Block Grant	C. Medicaid (Federal, State, and Local)	D. Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E. State Funds	F. Local Funds (excluding local Medicaid)	G. Other
1. Substance Abuse Prevention* and Treatment							
a. Pregnant Women and Women with Dependent Children*							
b. All Other							
2. Substance Abuse Primary Prevention							
3. Tuberculosis Services							
4. HIV Early Intervention Services							
5. State Hospital			\$ 300,000	\$ 31,742,253	\$ 383,461,000	\$	\$
6. Other 24 Hour Care		\$ 4,077,981	\$	\$ 3,396,518	\$ 24,918,425	\$ 122,564,610	\$
7. Ambulatory/Community Non -24 Hour Care		\$ 18,795,097	\$ 918,014,900	\$ 14,490,447	\$ 105,785,080	\$ 271,347,870	\$
8. Mental Health Primary Prevention		\$ 611,656	\$	\$	\$ 5,153,932	\$ 14,608,320	\$
9. Mental Health Evidenced- based Prevention and Treatment (5% of total award)		\$ 3,974,232	\$	\$	\$	\$	\$
10. Administration (Excluding Program and Provider Level)		\$ 1,305,126	\$ 3,000,000	\$ 10,000,000	\$ 69,800,000	\$ 77,016,734	\$
11. Total	\$	\$ 28,764,092	\$ 921,314,900	\$ 59,629,218	\$ 589,118,442	\$ 485,537,547	\$

* Prevention other than primary prevention

Footnotes:

Based on SFY 2012 Accruals multiplied by 2. Block Grant Budget based on SFY 2012 Block Grant Expenditure Report numbers multiplied by 2.

III: Use of Block Grant Dollars for Block Grant Activities

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period - From 07/01/2013 to SFY 06/30/2015

Service	Unduplicated Individuals	Units	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health			\$	\$
Specialized Outpatient Medical Services			\$	\$
Acute Primary Care			\$	\$
General Health Screens, Tests and Immunizations			\$	\$
Comprehensive Care Management			\$	\$
Care coordination and Health Promotion			\$	\$
Comprehensive Transitional Care			\$	\$
Individual and Family Support			\$	\$
Referral to Community Services Dissemination			\$	\$
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			\$	\$
Substance Abuse (Primary Prevention)			\$	\$
Classroom and/or small group sessions (Education)			\$	\$
Media campaigns (Information Dissemination)			\$	\$
Systematic Planning/Coalition and Community Team Building(Community Based Process)			\$	\$
Parenting and family management (Education)			\$	\$
Education programs for youth groups (Education)			\$	\$
Community Service Activities (Alternatives)			\$	\$
Student Assistance Programs (Problem Identification and Referral)			\$	\$
Employee Assistance programs (Problem Identification and Referral)			\$	\$

Community Team Building (Community Based Process)			\$	\$
Promoting the establishment or review of alcohol, tobacco, and drug use policies (Environmental)			\$	\$
Engagement Services			\$	\$
Assessment			\$	\$
Specialized Evaluations (Psychological and Neurological)			\$	\$
Service Planning (including crisis planning)			\$	\$
Consumer/Family Education			\$	\$
Outreach			\$	\$
Outpatient Services			\$	\$
Evidenced-based Therapies			\$	\$
Group Therapy			\$	\$
Family Therapy			\$	\$
Multi-family Therapy			\$	\$
Consultation to Caregivers			\$	\$
Medication Services			\$	\$

Medication Management			\$	\$
Pharmacotherapy (including MAT)			\$	\$
Laboratory services			\$	\$
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			\$	\$
Recovery Supports			\$	\$
Peer Support			\$	\$
Recovery Support Coaching			\$	\$

Recovery Support Center Services			\$	\$
Supports for Self-directed Care			\$	\$
Other Supports (Habilitative)			\$	\$
Personal Care			\$	\$
Homemaker			\$	\$
Respite			\$	\$
Supported Education			\$	\$
Transportation			\$	\$
Assisted Living Services			\$	\$
Recreational Services			\$	\$
Trained Behavioral Health Interpreters			\$	\$
Interactive Communication Technology Devices			\$	\$
Intensive Support Services			\$	\$
Substance Abuse Intensive Outpatient (IOP)			\$	\$
Partial Hospital			\$	\$

Assertive Community Treatment			\$	\$
Intensive Home-based Services			\$	\$
Multi-systemic Therapy			\$	\$
Intensive Case Management			\$	\$
Out-of-Home Residential Services			\$	\$
Children's Mental Health Residential Services			\$	\$
Crisis Residential/Stabilization			\$	\$
Clinically Managed 24 Hour Care (SA)			\$	\$
Clinically Managed Medium Intensity Care (SA)			\$	\$
Adult Mental Health Residential			\$	\$
Youth Substance Abuse Residential Services			\$	\$
Therapeutic Foster Care			\$	\$
Acute Intensive Services			\$	\$
Mobile Crisis			\$	\$
Peer-based Crisis Services			\$	\$

Urgent Care			\$	\$
23-hour Observation Bed			\$	\$
Medically Monitored Intensive Inpatient (SA)			\$	\$
24/7 Crisis Hotline Services			\$	\$
Other (please list)			\$	\$

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 4 SABG Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Expenditure Category	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	\$46,985,905	
2 . Substance Abuse Primary Prevention	\$12,529,574	
3 . Tuberculosis Services		
4 . HIV Early Intervention Services**		
5 . Administration (SSA Level Only)	\$3,132,394	
6. Total	\$62,647,873	

* Prevention other than primary prevention

** HIV Early Intervention Services

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Strategy	IOM Target	FY 2014	FY 2015
		SA Block Grant Award	SA Block Grant Award
Information Dissemination	Universal		
	Selective		
	Indicated		
	Unspecified	\$1,264,234	
	Total	\$1,264,234	
Education	Universal		
	Selective		
	Indicated		
	Unspecified	\$6,078,097	
	Total	\$6,078,097	
Alternatives	Universal		
	Selective		
	Indicated		
	Unspecified	\$2,067,380	
	Total	\$2,067,380	
Problem Identification and Referral	Universal		
	Selective		
	Indicated		
	Unspecified	\$915,912	
	Total	\$915,912	

	Total	\$915,912	
Community-Based Process	Universal		
	Selective		
	Indicated		
	Unspecified	\$1,855,630	
	Total	\$1,855,630	
Environmental	Universal		
	Selective		
	Indicated		
	Unspecified	\$348,322	
	Total	\$348,322	
Section 1926 Tobacco	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Other	Universal		
	Selective		
	Indicated		
	Unspecified		
	Total		
Total Prevention Expenditures		\$12,529,575	
Total SABG Award*		\$62,647,873	
Planned Primary Prevention Percentage		20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5b SABG Primary Prevention Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award	FY 2015 SA Block Grant Award
Universal Direct	\$2,505,915	
Universal Indirect	\$5,011,830	
Selective	\$3,132,394	
Indicated	\$1,879,435	
Column Total	\$12,529,574	
Total SABG Award*	\$62,647,873	
Planned Primary Prevention Percentage	20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 5c SABG Planned Primary Prevention Targeted Priorities

Targeted Substances	
Alcohol	☐
Tobacco	☐
Marijuana	☐
Prescription Drugs	☐
Cocaine	☐
Heroin	☐
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☐
Military Families	☐
LGBTQ	☐
American Indians/Alaska Natives	☐
African American	☐
Hispanic	☐
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☐
Underserved Racial and Ethnic Minorities	☐

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period - From 10/01/2013 to 09/30/2015

Activity	FY 2014 SA Block Grant Award				FY 2015 SA Block Grant Award			
	Prevention	Treatment	Combined	Total	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	\$103,887	\$415,549		\$519,436				
2. Quality Assurance	\$197,657	\$790,628		\$988,285				
3. Training (Post-Employment)								
4. Education (Pre-Employment)								
5. Program Development								
6. Research and Evaluation								
7. Information Systems	\$38,767	\$155,068		\$193,835				
8. Enrollment and Provider Business Practices (3 percent of BG award)								
9. Total	\$340,311	\$1,361,245		\$1,701,556				

Footnotes:

III: Use of Block Grant Dollars for Block Grant Activities

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period - From 07/01/2013 to 06/30/2014

Service	Block Grant
MHA Technical Assistance Activities	\$ 2,038,558
MHA Planning Council Activities	\$ 3,616
MHA Administration	\$ 652,563
MHA Data Collection/Reporting	\$ 78,787
Enrollment and Provider Business Practices (3 percent of total award)	\$
MHA Activities Other Than Those Above	\$ 4,108,523
Total Non-Direct Services	\$6882047
Comments on Data: Planned Expenditures are from ODMH SFY 2012 MH Block Grant Expenditures Report. Planning Council numbers are from SFY 2012 CFPT Report.	

Footnotes:

IV: Narrative Plan

C. Coverage M/SUD Services

Narrative Question:

Beginning in 2014, Block Grant dollars should be used to pay for (1) people who are uninsured and (2) services that are not covered by insurance and Medicaid. Presumably, there will be similar concerns at the state-level that state dollars are being used for people and/or services not otherwise covered. States (or the Federal Marketplace) are currently making plans to implement the benchmark plan chosen for QHPs and their expanded Medicaid programs (if they choose to do so). States should begin to develop strategies that will monitor the implementation of the Affordable Care Act in their states. States should begin to identify whether people have better access to mental and substance use disorder services. In particular, states will need to determine if QHPs and Medicaid are offering mental health and substance abuse services and whether services are offered consistent with the provisions of MHPAEA.

Please answer the following questions:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs on January 1, 2014?
2. Do you have a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who in your state is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe their monitoring process.
4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?

Footnotes:

C. Coverage M/SUD Services

Ohio's Medicaid program currently offers a fairly comprehensive behavioral health benefit consisting of ten community based services available for persons identified with substance use disorders and seven community based services available for persons identified with mental health conditions, including the new health home service for persons with SPMI (serious and persistent mental illness). Individuals identified with both conditions would have all 17 services available to them. Additionally, in instances where an Ohioan enrolled in an Ohio Medicaid managed care plan is unable to access any or all of these 17 services, the managed care plan is responsible for making alternative services available.

Ohio operates a community services network which is planned, managed and funded through fifty three (53) local behavioral health authorities, commonly referred to as Boards. The Boards are responsible for conducting a biannual planning process that identifies service needs of their local populations. Through this planning process and financing decisions, the Boards will likely identify and monitor the effects of QHPs (Qualified Health Plans) operating in their areas.

IV: Narrative Plan

D. Health Insurance Marketplaces

Narrative Question:

Health Insurance Marketplaces (Marketplaces) will be responsible for performing a variety of critical functions to ensure access to desperately needed behavioral health services. Outreach and education regarding enrollment in QHPs or expanded Medicaid will be critical. SMHAs and SSAs should understand their state's new eligibility determination and enrollment system, as well as how insurers (commercial, Medicaid, and Medicare plans) will be making decisions regarding their provider networks. States should consider developing benchmarks regarding the expected number of individuals in their publicly-funded behavioral health system that should be insured by the end of FY 2015. In addition, states should set similar benchmarks for the number of providers who will be participating in insurers' networks that are currently not billing third party insurance.

QHPs must maintain a network of providers that is sufficient in the number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay. Mental health and substance abuse providers were specifically highlighted in the rule to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities.

Please answer the following questions:

1. How will the state evaluate the impact that its outreach, eligibility determination, enrollment, and re-enrollment systems will have on eligible individuals with behavioral health conditions?
2. How will the state work with its partners to ensure that the Navigator program is responsive to the unique needs of individuals with behavioral health conditions and the challenges to getting and keeping the individuals enrolled?
3. How will the state ensure that providers are screening for eligibility, assisting with enrollment, and billing Medicaid, CHIP, QHPs, or other insurance prior to drawing down Block Grant dollars for individuals and/or services?
4. How will the state ensure that there is adequate community behavioral health provider participation in the networks of the QHPs, and how will the state assist its providers in enrolling in the networks?
5. Please provide an estimate of the number of individuals served under the MHBG and SABG who are uninsured in CY 2013. Please provide the assumptions and methodology used to develop the estimate.
6. Please provide an estimate of the number of individuals served under the MHBG and SABG who will remain uninsured in CY 2014 and CY 2015. Please provide the assumptions and methodology used to develop the estimate.
7. For the providers identified in Table 8 -Statewide Entity Inventory of the FY 2013 MHBG and SABG Reporting Section, please provide an estimate of the number of these providers that are currently enrolled in your state's Medicaid program. Please provide the assumptions and methodology used to develop the estimate.
8. Please provide an estimate of the number of providers estimated in Question 7 that will be enrolled in Medicaid or participating in a QHP. Provide this estimate for FY 2014 and a separate estimate for FY 2015, including the assumptions and methodology used to develop the estimate.

Footnotes:

D. Health Insurance Marketplaces

Ohio operates a community services network which is planned, managed and funded through fifty three (53) local behavioral health authorities, commonly referred to as Boards. The Boards are responsible for conducting an annual planning process that identifies service needs of their local populations. Through this planning process and financing decisions, the Boards will likely be informed of the extent to which local behavioral health providers are “in network” with QHPs (Qualified Health Plans). Based upon this, the Boards will be able to adjust their financing, including MHBG and SABG funds, accordingly. The Ohio legislature has not enacted Medicaid expansion as of this block grant plan submission.

To estimate the shift of funding with Medicaid expansion for the Mental Health Block Grant, OhioMHAS’ economist used data to estimate the shifts by service below using Board budgets for SFY 2012. She used the estimate that 50% of the cost of clinical services eligible for Medicaid reimbursement that are currently funded out of Mental Health Block formula allocations to the Boards would be funded by Medicaid under Medicaid expansion.

Estimated Block Grant Expenditures					
Non-Medicaid Mental Health Consumers, Ages 18 to 64					
FY 2012					
Services	Block Grant Expenditures	Ratio	Estimated Expenditures Non Medicaid Ages 18 to 64	Average Service Cost Non Medicaid Ages 18 to 64	Estimated Non Medicaid Consumers Ages 18 to 64
BH Counseling Individual	\$ 480,238.0	0.870	\$ 417,807	\$ 495	844
BH Counseling Group	44,613	0.751	33,504	\$ 482	70
CPST Group	133,773	0.562	75,180	\$ 484	155
CPST Individual	1,891,695	0.829	1,568,215	\$ 832	1,885
Crisis Intervention	961,423	0.893	858,551	\$ 395	2,174
Partial Hospitalization	99,873	0.562	56,129	\$ 1,827	31
Pharm. Management	768,180	0.928	712,871	\$ 540	1,320
Diagnostic Assesment--Doctor	36,067	0.922	33,254	\$ 222	150
Diagnostic Assesment--Non	197,898	0.836	165,443	\$ 197	840
Total	\$ 4,613,760		\$ 3,920,954		
Take Up Rate @50%			\$ 1,960,477		
Block Grant Expenditures: Source Fiscal Report 040 for FY 2012					
Ratio: Non LOB Expenditures for Ages 18 to 64 divided by Total Non LOB Expenditures; Source MACSIS Data Mart for FY 2012					
Estimated Expenditures Non Medicaid Ages 18 to 64: Block Grant Expenditures *Ratio					
Average Service Cost: Non LOB Expenditures for Ages 18 to 64 divided by Non LOB Cliets Ages 18 to 64					
Estimated Non Medicaid Consumers Ages 18 to 64: Estimated Expenditures Non Medicaid Ages 18 to 64 divided by					
Average Service Cost Ages 18 to 64					

IV: Narrative Plan

E. Program Integrity

Narrative Question:

The Affordable Care Act directs the Secretary of HHS to define EHBs. Non-grandfathered plans in the individual and small group markets both inside and outside of the Marketplaces, Medicaid benchmark and benchmark-equivalent plans, and basic health programs must cover these EHBs beginning in 2014. On December 16, 2011, HHS released a bulletin indicating the Secretary's intent to propose that EHBs be defined by benchmarks selected by each state. The selected benchmark plan would serve as a reference plan, reflecting both the scope of services and any limits offered by a "typical employer plan" in that state as required by the Affordable Care Act.

SMHAs and SSAs should now be focused on two main areas related to EHBs: monitoring what is covered and aligning Block Grant and state funds to compensate for what is not covered. There are various activities that will ensure that mental and substance use disorder services are covered. These include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including EHBs as per the state benchmark; (2) ensuring that individuals are aware of the covered mental health and substance abuse benefits; (3) ensuring that consumers of substance abuse and mental health services have full confidence in the confidentiality of their medical information; and (4) monitoring utilization of behavioral health benefits in light of utilization review, medical necessity, etc.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the SABG and MHBG. State systems for procurement, contract management, financial reporting, and audit vary significantly. SAMHSA expects states to implement policies and procedures that are designed to ensure that Block Grant funds are used in accordance with the four priority categories identified above. Consequently, states may have to reevaluate their current management and oversight strategies to accommodate the new priorities. They may also be required to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment. States should describe their efforts to ensure that Block Grant funds are expended efficiently and effectively in accordance with program goals. In particular, states should address how they will accomplish the following:

1. Does the state have a program integrity plan regarding the SABG and MHBG?
2. Does the state have a specific staff person that is responsible for the state agency's program integrity activities?
3. What program integrity activities does the state specifically have for monitoring the appropriate use of Block Grant funds? Please indicate if the state utilizes any of the following monitoring and oversight practices:
 - a. Budget review;
 - b. Claims/payment adjudication;
 - c. Expenditure report analysis;
 - d. Compliance reviews;
 - e. Encounter/utilization/performance analysis; and
 - f. Audits.
4. How does the state ensure that the payment methodologies used to disburse funds are reasonable and appropriate for the type and quantity of services delivered?
5. How does the state assist providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How will the state ensure that Block Grant funds and state dollars are used to pay for individuals who are uninsured and services that are not covered by private insurance and/or Medicaid?

SAMHSA will review this information to assess the progress that states have made in addressing program integrity issues and determine if additional guidance and/or technical assistance is appropriate.

Footnotes:

E. Program Integrity – The Affordable Care Act

On July 1, 2013, the Ohio Department of Mental Health and Addiction Services, a consolidation of ODADAS and ODMH, will be the state agency responsible for both the MHBG and SABG funds. Through the consolidation process, ODADAS and ODMH have merged our monitoring processes for the MHBG and SABG funds which is used to assure that the funds we provide the community, including MHBG and SABG funds, are properly expended. Adjustments to our monitoring activities can and will be made and/or supplemented accordingly.

IV: Narrative Plan

F. Use of Evidence in Purchasing Decisions

Narrative Question:

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers decisions regarding mental health and substance abuse services. SAMHSA is requesting that states respond to the following questions:

- 1) Does your state have specific staff that are responsible for tracking and disseminating information regarding evidence-based or promising practices?
- 2) Did you use information regarding evidence-based or promising practices in your purchasing or policy decisions?
 - a) What information did you use?
 - b) What information was most useful?
- 3) How have you used information regarding evidence-based practices?
 - a) Educating State Medicaid agencies and other purchasers regarding this information?
 - b) Making decisions about what you buy with funds that are under your control?

Footnotes:

F. Use of Evidence in Purchasing Decisions

OhioMHAS continues to use Mental Health Block Grant funding to fund some Coordinating Centers of Excellence to provide technical assistance and training on specific evidence-based practices, and report to a project manager on OhioMHAS program staff. ODADAS program staff trained community providers on the implementation of some evidence-based practices and will continue to do so as OhioMHAS staff.

The Ohio Department of Mental Health and Addiction Services has staff who, while not specifically tasked with information dissemination on EBPs (evidence based practices) or promising practices, are resources for our community partners on EBPs and promising practices. This is important since many funding and purchasing decisions are made by Boards rather than directly by the Department. The Department also is consulted by Ohio's Medicaid program to make recommendations and suggestions on covered services and coverage policies. OhioMHAS staff take into account EBPs and promising practices when making our recommendations.

IV: Narrative Plan

G. Quality

Narrative Question:

Up to 25 data elements, including those listed in the table below, will be available through the Behavioral Health Barometer which SAMHSA will prepare annually to share with states for purposes of informing the planning process. The intention of the Barometer is to provide information to states to improve their planning process, not for evaluative purposes. Using this information, states will select specific priority areas and develop milestones and plans for addressing each of their priority areas. States will receive feedback on an annual basis in terms of national, regional, and state performance and will be expected to provide information on the additional measures they have identified outside of the core measures and state barometer. Reports on progress will serve to highlight the impact of the Block Grant-funded services and thus allow SAMHSA to collaborate with the states and other HHS Operating Divisions in providing technical assistance to improve behavioral health and related outcomes.

	Prevention	Substance Abuse Treatment	Mental Health Services
Health	Youth and Adult Heavy Alcohol Use - Past 30 Day	Reduction/No Change in substance use past 30 days	Level of Functioning
Home	Parental Disapproval Of Drug Use	Stability in Housing	Stability in Housing
Community	Environmental Risks/Exposure to prevention Messages and/or Friends Disapproval	Involvement in Self-Help	Improvement/Increase in quality/number of supportive relationships among SMI population
Purpose	Pro-Social Connections Community Connections	Percent in TX employed, in school, etc - TEDS	Clients w/ SMI or SED who are employed, or in school

- 1) What additional measures will your state focus on in developing your State BG Plan (up to three)?
- 2) Please provide information on any additional measures identified outside of the core measures and state barometer.
- 3) What are your states specific priority areas to address the issues identified by the data?
- 4) What are the milestones and plans for addressing each of your priority areas?

Footnotes:

G. Quality

With the merger of the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) effective July 1, 2013, the new Ohio Department of Mental Health and Addiction Services (ODMHAS) will be conducting a Kaizen process to determine which Outcomes are of greatest priority to the new agency. ODMHAS will submit a revised Quality measures to SAMHSA as soon as the priorities and measures are established. The Quality Monitoring and Improvement Plans included in Section R supply additional information about potential available measures.

Currently for mental health, the following quality measures will be reported for SAMHSA for their use in the Behavioral Health Barometer:

- **Health:**
 - Percent of consumers reporting positive Functioning (general coping skills). (Source: MHSIP)
 - Percent of consumers that indicate increase in Outcomes (quality of life). (Source: MHSIP)
 - Percent of parents of youth that indicate increase in Outcomes (quality of life). (Source: YSS-F)
- **Home:**
 - Percent of consumers who move from homelessness to housed. (Source: OH-BH)
- **Community:**
 - Percent of consumers indicating positive Social Connectedness (availability of social support and community resources). (Source: MHSIP)
 - Percent of parents of youth reporting positive Social Connectedness (perception of the family's support system). (Source: YSS-F)
- **Purpose:**
 - Percent of consumers who are employed. (Source: OH-BH)
 - Percent of parents of youth reporting increased School Attendance. (Source: YSS-F)

Source information:

- The Ohio Behavioral Health (OH-BH) is a web application tool for providers to enter client-level data at intake, yearly update and discharge.
- The Mental Health Statistics Improvement Program (MHSIP) and Youth Services Survey for Families (YSS-F) are distributed to a stratified random sample of people who receive or have received public mental health system services within the last year.

1) Additional measures: The new Ohio Department of Mental Health and Addiction Services (ODMHAS) will be conducting a Kaizen process to determine which Outcomes are of

greatest priority to the new agency. However there are several likely indicators that will be included:

- The Department launched the Health Home initiative to integrate physical and behavioral health care by offering and facilitating access to medical, behavioral and social services that are timely, of high quality and coordinated by an individualized care team. Initial implementation began in five regions in October 2012, with the balance of homes scheduled for implementation beginning October 2013.
 - Number and percent of Medicaid consumers enrolled in Behavioral Health Homes. (Source: Health Home database)
 - Percent of consumers enrolled in Behavioral Health Homes that received cholesterol screening, blood pressure measurement, assessment of Glycemic Control and Lipids, or comprehensive Diabetes care. (Source: Health Home database)
- Housing is an area of interest to the department, potential measures include:
 - Number of new housing units built and/or existing units repaired/renovated for adults with SMI (Source: Capital project database)
 - Number of persons receiving recovery supports for community living from the Residential State Supplement (RSS) program (Source: RSS program data)
- The Department also seeks to help adults upon release from prison, and youth upon release from juvenile detention, achieve successful reentry in the community. The Department links SMI adults and SED youth to community mental health services.
 - Number and percent of adults/youth exiting the Ohio Department of Rehabilitation and Correction (ODRC)/Ohio Department of Youth Services (ODYS) with SPMI/SED who are linked with mental health services upon release. (Source: Community Linkage database)

2) Information on additional measures: see above

3) Specific priority areas/populations:

- Adults with SMI needing physical health coordination
- Adults with SMI needing housing resources
- Adults with SMI and youth with SED exiting prisons and juvenile detention facilities

4) Milestones and plans for addressing priority areas:

Once ODMHAS has determined the priority areas and measures through the Kaizen process, baseline measures will be established and the Department will determine appropriate milestones.

IV: Narrative Plan

H. Trauma

Narrative Question:

In order to better meet the needs of those they serve, states should take an active approach to addressing trauma. Trauma screening matched with trauma-specific therapies, such as exposure therapy or trauma-focused cognitive behavioral approaches, should be used to ensure that treatments meet the needs of those being served. States should also consider adopting a trauma-informed care approach consistent with SAMHSA's trauma-informed care definition and principles. This means providing care based on an understanding of the vulnerabilities or triggers of trauma survivors that traditional service delivery approaches may exacerbate so that these services and programs can be more supportive and avoid being traumatized again.

Please answer the following questions:

1. Does your state have any policies directing providers to screen clients for a personal history of trauma?
2. Does the state have policies designed to connect individuals with trauma histories to trauma-focused therapy?
3. Does your state have any policies that promote the provision of trauma-informed care?
4. What types of evidence-based trauma-specific interventions does your state offer across the life-span?
5. What types of trainings do you provide to increase capacity of providers to deliver trauma-specific interventions?

Footnotes:

H. Trauma

The OhioMHAS supports the concept that trauma informed assessment and treatment be available throughout the behavioral health system in Ohio. The community mental health centers, private psychiatric facilities/units and state operated facilities, which have a direct relationship with the department, are encouraged to be accredited by a National Accreditation organization. State rules and requirements are built on these national standards. These entities meet the requirement of assessment and specialized treatment requirements of these organizations.

OhioMHAS rules and policies do not include a requirement for assessment of trauma, nor require that individuals be referred and/or treated in a specific intervention. Many organizations have staff specifically trained in trauma informed assessment and treatment, but not all areas of Ohio offer the same access to services or access to trained providers. Many community providers and hospital staff are trained in the use of comfort rooms, debriefing, and development of safety plans and these options are referenced in Ohio.

OhioMHAS, through our hospital system, invited SAMHSA's National Center for Trauma Informed Care (NCTIC) staff to Ohio in June. NCTIC staff provided training to hospital leaders and central office staff about Trauma Informed Systems of Care. Our next phase of this work is to continue to partner with NCTIC and various system partners to implement trauma informed practices throughout Ohio. Additional training and ongoing technical assistance are part of the components of this plan.

IV: Narrative Plan

I. Justice

Narrative Question:

The SABG and MHBG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

Communities across the United States have instituted problem-solving courts, including those for defendants with mental and substance abuse disorders. These courts seek to prevent incarceration and facilitate community-based treatment for offenders, while at the same time protecting public safety. There are two types of problem-solving courts related to behavioral health: drug courts and mental health courts. In addition to these behavioral health problem-solving courts, some jurisdictions operate courts specifically for DWI/DUI, veterans, families, and reentry, as well as courts for gambling, domestic violence, truancy, and other subject-specific areas.^{42,43} Rottman described the therapeutic value of problem-solving courts: Specialized courts provide a forum in which the adversarial process can be relaxed and problem solving and treatment processes emphasized. Specialized courts can be structured to retain jurisdiction over defendants, promoting the continuity of supervision and accountability of defendants for their behavior in treatment programs. Youths in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient utilization of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; and therefore, risk factors remain unaddressed.⁴⁴

A true diversion program takes youth who would ordinarily be processed within the juvenile justice system and places them instead into an alternative program. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with mental and/or substance use disorders from correctional settings. States should also examine specific barriers such as lack of identification needed for enrollment; loss of eligibility resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention

Please answer the following questions:

1. Does your state have plans to enroll individuals involved in the criminal and juvenile justice systems in Medicaid as a part of coverage expansions?
2. What screening and services are provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Are your SMHA and SSA coordinating with the criminal and juvenile justice systems with respect to diversion of individuals with mental and/or substance use disorders, behavioral health services provided in correctional facilities, and the reentry process for those individuals?
4. Do efforts around enrollment and care coordination address specific issues faced by individuals involved in the criminal and juvenile justice systems?
5. What cross-trainings do you provide for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system?

42 The American Prospect: In the history of American mental hospitals and prisons, The Rehabilitation of the Asylum. David Rottman, 2000.

43 A report prepared by the Council of State Governments. Justice Center. Criminal Justice/Mental Health Consensus Project. New York, New York for the Bureau of Justice Assistance Office of Justice Programs U.S. Department of Justice, Renee L. Bender, 2001.

44 Journal of Research in Crime and Delinquency: Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice. Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. OJJDP Model Programs Guide.

Footnotes:

I. Justice

1. Yes. Ohio employees Community Linkage Social Workers that apply for Medicaid benefits for eligible offenders with an SMI in both the adult and juvenile corrections systems. Most of these offenders also have co-occurring substance use disorders.
2. Each jail operates independently, but, it is standard for each jail to screen individuals for mental health history and/or indicators of mental illness.
3. The Ohio Department of Mental Health and Addiction Services coordinates with the criminal and juvenile justice systems on diversion and reentry services. The Department funds a Criminal Justice Coordinating Center of Excellence to promote CIT trainings and encourage communities to forge collaborative relationships between the behavioral health and criminal justice systems. OhioMHAS also awards communities Community Innovation Grants that link criminal justice and behavioral health. Additionally, OhioMHAS funds Therapeutic Communities inside the prisons that provide drug and alcohol treatment services. In addition, we have nine Community Linkage Social Workers working in all the Ohio prisons and youth facilities to provide behavioral health community linkage prior to the offender or youth's release.
4. Individuals with SMI leaving jails and prisons often need assistance with care coordination. Community Linkage Social Workers assist with the coordination of housing, transportation, medical treatment, and reentry coalitions.
5. OhioMHAS provides Crisis Intervention trainings, regional forensic trainings, an annual forensic conference, as well as training on specific treatment models working with SMI individuals.

I. Justice

1. Yes. Ohio employees Community Linkage Social Workers that apply for Medicaid benefits for eligible offenders with an SMI in both the adult and juvenile corrections systems. Most of these offenders also have co-occurring substance use disorders.

2. Each jail operates independently, but, it is standard for each jail to screen individuals for mental health history and/or indicators of mental illness.

Additionally, the Treatment Alternatives to Street Crime (TASC) programs that are operational in 15 Ohio counties provide screening and assessment for substance use disorders and report their findings to inform the court of jurisdiction prior to sentencing.

3. The Ohio Department of Mental Health and Addiction Services coordinates with the criminal and juvenile justice systems on diversion and reentry services. The Department funds a Criminal Justice Coordinating Center of Excellence to promote CIT trainings and encourage communities to forge collaborative relationships between the behavioral health and criminal justice systems. OhioMHAS also awards communities Community Innovation Grants that link criminal justice and behavioral health. Additionally, OhioMHAS funds Therapeutic Communities inside the prisons that provide drug and alcohol treatment services. In addition, we have nine Community Linkage Social Workers working in all the Ohio prisons and youth facilities to provide behavioral health community linkage prior to the offender or youth's release.

The TASC programs are involved with the adult reentry coalitions and provide reentry treatment services. There are six TASC programs providing reentry treatment services to juvenile offenders who are released from the state juvenile prison system and returning to six metropolitan counties and three rural counties.⁴ Individuals with SMI leaving jails and prisons often need assistance with care coordination. Community Linkage Social Workers assist with the coordination of housing, transportation, medical treatment, and reentry coalitions.

5. OhioMHAS provides Crisis Intervention trainings, regional forensic trainings, an annual forensic conference, as well as training on specific treatment models working with SMI individuals.

IV: Narrative Plan

J. Parity Education

Narrative Question:

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action states can develop communication plans to provide and address key issues. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position.

Please answer the following questions:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness about parity?
2. How will or can states coordinate across public and private sector entities to increase awareness and understanding about benefits (e.g., service benefits, cost benefits, etc.?)
3. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that are directly impacted by parity?

Footnotes:

J. Parity Education

The state has not focused on parity education.

IV: Narrative Plan

K. Primary and Behavioral Health Care Integration Activities

Narrative Question:

Numerous provisions in the Affordable Care Act and other statutes improve the coordination of care for patients through the creation of health homes, where teams of health care professionals will be rewarded to coordinate care for patients with chronic conditions. States that have approved Medicaid State Plan Amendments (SPAs) will receive 90 percent Federal Medical Assistance Percentage (FMAP) for health home services for eight quarters. At this critical juncture, some states are ending their two years of enhanced FMAP and returning to their regular state FMAP for health home services. In addition, many states may be a year into the implementation of their dual eligible demonstration projects.

Please answer the following questions:

1. Describe your involvement in the various coordinated care initiatives that your state is pursuing?
2. Are there other coordinated care initiatives being developed or implemented in addition to opportunities afforded under the Affordable Care Act?
3. Are you working with your state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHC), other primary care practices and the publicly funded behavioral health providers?
4. Describe how your behavioral health facilities are moving towards addressing nicotine dependence on par with other substance use disorders.
5. Describe how your agency/system regularly screens, assesses, and addresses smoking amongst your clients. Include tools and supports (e.g. regular screening with a carbon monoxide (CO) monitor) that support your efforts to address smoking.
6. Describe how your behavioral health providers are screening and referring for:
 - a. heart disease,
 - b. hypertension,
 - c. high cholesterol, and/or
 - d. diabetes.

Footnotes:

K. Primary and Behavioral Health Care Integration Activities

Question 1 - Medicaid Health Homes for individuals with Serious and Persistent Mental Illness (SPMI) - The SFY2012/2013 budget invested \$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. Ohio Medicaid teamed up with the Ohio Department of Mental Health to prioritize and focus on creating health homes for individuals on Medicaid who have serious and persistent mental illness (SPMI) through a stakeholder process that began November 3, 2011. Ohio has chosen a phase-in approach to implementing health homes and submitted its State Plan Amendment to CMS on June 29, 2012 for Phase I Implementation of Medicaid health homes for October 1, 2012 in five Counties; Adams, Butler, Lawrence, Lucas and Scioto. The remaining 83 Counties are scheduled for implementation under Phase II on October 1, 2013. A cornerstone of the Health Home service is to improve care coordination.

Integrated Care Delivery System (ICDS) for Medicare-Medicaid enrollees - Governor Kasich's first Jobs Budget authorized Ohio Medicaid to seek approval through CMMI to design and implement a Medicare-Medicaid Integrated Care Delivery System (ICDS). The goal of ICDS is to manage the full continuum of Medicare and Medicaid benefits for Medicare-Medicaid Enrollees, including long-term care. The Integrated Care Delivery System (ICDS) is a system of managed care plans selected to coordinate the physical, behavioral, and long-term care services for individuals over the age of 18 who are eligible for both Medicaid and Medicare. This includes people with disabilities, older adults and individuals who receive behavioral health services. Ohio's ICDS is called "MyCare Ohio." Enrollment into MyCare Ohio will be in phases, by region, over several months beginning in September of 2013.

Question 2: ENGAGE Systems of Care Initiative - The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has been awarded a \$4 million "System of Care Expansion Implementation" grant from the federal Substance Abuse and Mental Health Services Administration to improve care coordination, and strengthen supports for youth and young adults. The Department is partnering with the Governor's Office of Health Transformation and Ohio Family and Children First to oversee the development of Systems of Care throughout Ohio. Dubbed ENGAGE (Engaging the New Generation to Achieve their Goals through Empowerment), the Ohio project will serve 2,000 youth from all 88 counties over the next four years. The effort builds upon the success of an earlier strategic planning grant and will help guide effective youth-driven and family-guided local systems of care that promote optimal wellness and recovery for youth as they move toward independence and adulthood. Collaboration among government and private agencies, providers, families and youth will strengthen coordination of community-based services and promote improved outcomes.

Screening, Brief Intervention, and Referral to Treatment (SBIRT) -The Ohio Department of Mental Health and Addiction Services (OhioMHAS) has been awarded a 5-year, \$10 million (\$2

million per year) cooperative agreement from the Substance Abuse and Mental Health Services Administration (SAMHSA) for a statewide Screening, Brief Intervention and Referral for Treatment (SBIRT) initiative. The federally-funded program is designed to reduce morbidity and mortality of alcohol and drug use through early intervention methodologies that rely on the integration of medical and behavioral health approaches. Among the strategies employed in meeting the program goal are: 1) training of physicians and other medical personnel in substance abuse screening, motivational interviewing and cultural competency, 2) using health information technology to improve the continuity of care, and 3) employing health navigators to assist with linkage to specialty treatment and to facilitate integrated medical and behavioral healthcare.

Question #3 - Primary Care Partners - OhioMHAS program staff work with primary care organizations and FQHCs through the initiatives listed above. Ohio Association of Community Health Centers had opportunity to participate in the planning and design of the Medicaid health homes through the multi-stakeholder input process. Community behavioral health centers are strongly encouraged to partner with community health centers and pursue different models of coordination and integration. Pediatric Psychiatry Network aims to help primary care physicians deliver and/or coordinate mental health care for youth within the primary care setting by providing consultation. This initiative integrates behavioral health specialty services into primary care.

Question #4 – Addressing Nicotine Dependence -The Ohio Department of Mental Health and Addiction Services has a long working relationship with Case Western Reserve University’s Center for Evidence Based Practices to provide training, consultation and fidelity monitoring for evidence based and emerging best practices including: Tobacco: Recovery Across the Continuum (TRAC). TRAC is an emerging best practice that incorporates the Treating Tobacco Use and Dependence Clinical Practice Guidelines; Integrated Dual Disorders Treatment; Motivational Interviewing; and Cognitive Behavioral Therapy evidence-based practices - adapted to include specific focus on the unique interplay between tobacco, smoking, and behavioral health conditions and related treatments. Case Western Reserve University in partnership with OhioMHAS has been awarded a \$100,000 grant by Pfizer to train healthcare professionals in Ohio to deliver smoking cessation services to people with behavioral health conditions. The overall aim for this initiative is to make evidence-based smoking cessation services available to Ohioans with behavioral health conditions (BH – including serious and persistent mental illness (SPMI) and/or substance use disorders (SUD)) to reduce death and disability from smoking related chronic disease. Additionally, the health home providers are strongly encouraged to provide tobacco cessation services as part of the health promotion activity covered by the monthly case rate payment. The health home providers are accountable for addressing tobacco use through the State selected quality measures associated with tobacco cessation.

Question #5 – Screening Smoking - The Ohio Department of Mental Health and Addiction Services has a long working relationship with Case Western Reserve University’s Center for

Evidence Based Practices to provide training, consultation and fidelity monitoring for evidence based and emerging best practices including: Tobacco: Recovery Across the Continuum (TRAC). TRAC is an emerging best practice that incorporates the Treating Tobacco Use and Dependence Clinical Practice Guidelines; Integrated Dual Disorders Treatment; Motivational Interviewing; and Cognitive Behavioral Therapy evidence-based practices - adapted to include specific focus on the unique interplay between tobacco, smoking, and behavioral health conditions and related treatments. Case Western Reserve University in partnership with OhioMHAS has been awarded a \$100,000 grant by Pfizer to train healthcare professionals in Ohio to deliver smoking cessation services to people with behavioral health conditions. The overall aim for this initiative is to make evidence-based smoking cessation services available to Ohioans with behavioral health conditions (BH – including serious and persistent mental illness (SPMI) and/or substance use disorders (SUD)) to reduce death and disability from smoking related chronic disease. The health home providers are strongly encouraged to provide tobacco cessation services as part of the health promotion activity covered by the monthly case rate payment. The health home providers are accountable for addressing tobacco use through the State selected quality measures associated with tobacco cessation. The CEBP has conducted a series of regional trainings throughout Ohio on the proper assessment, pharmacological, and psychosocial interventions for people who use tobacco. These trainings were followed by opportunities for direct consultation on the information and implementation of these interventions. The state also proposes to use the mandatory Medicaid Health Home Learning Communities to introduce and implement educational and quality improvement activities specific to the integration of tobacco treatment education and intervention within the community behavioral health clinics (CBHCs).

Question #6 – Screening for Cardio-vascular and Metabolic Diseases - The Medicaid health home initiative is designed to improve health outcomes for individuals with Serious and Persistent Mental Illness which began implementation on October 1, 2012 within Phase 1 Counties. The State Plan Amendment contains specific goals and mandatory outcomes measures for improving cardiovascular and diabetes care. The health home providers are required to collect and submit data for metabolic syndrome screening, BMI, controlling high blood pressure, cholesterol management for Patient with Cardiovascular condition, HbA1c levels and LDL-C screening. As a condition of health home certification and Medicaid reimbursement for health home services, the health homes are also expected to provide or arrange comprehensive, timely, and quality services through integration of primary care, medical specialists, network of diverse providers and collaboration with Managed Care Plans.

IV: Narrative Plan

L. Health Disparities

Narrative Question:

In the Block Grant application, states are routinely asked to define the population they intend to serve (e.g., adults with SMI at risk for chronic health conditions, young adults engaged in underage drinking, populations living with or at risk for contracting HIV/AIDS). Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, Latino adults with SMI may be at heightened risk for metabolic disorder due to lack of appropriate in-language primary care services, American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community, and African American women may be at greater risk for contracting HIV/AIDS due to lack of access to education on risky sexual behaviors in urban low-income communities.

While these factors might not be pervasive among the general population served by the Block Grant, they may be predominant among subpopulations or groups vulnerable to disparities. To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is being served or not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. In order for states to address the potentially disparate impact of their Block Grant funded efforts, they will be asked to address access, use, and outcomes for subpopulations, which can be defined by the following factors: race, ethnicity, language, gender (including transgender), tribal connection, and sexual orientation (i.e., lesbian, gay, bisexual).

In the space below please answer the following questions:

1. How will you track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBTQ, and age?
2. How will you identify, address and track the language needs of disparity-vulnerable subpopulations?
3. How will you develop plans to address and eventually reduce disparities in access, service use, and outcomes for the above disparity-vulnerable subpopulations?
4. How will you use Block Grant funds to measure, track and respond to these disparities?

Footnotes:

L. Health Disparities

Ohio State Plan to Eliminate Behavioral Health Disparities

The Ohio Department of Mental Health and Addiction Services is sponsoring development of a state behavioral health plan to eliminate disparities. This effort is being led by the Multiethnic Advocates for Cultural Competence (MACC). Other participating stakeholders include the Ohio County Behavioral Health Authorities; Ohio Department of Health and Job and Family Services; Ohio Asian American Health Coalition; Children's Defense Fund; Ohio Commission on Minority Health and Latino/Hispanic Affairs; and the Red Bird Center. The focus of this dynamic group will be to promote system integration of mental health and alcohol and drug addiction services.

The project builds on the behavioral health transformation work that led to the Ohio cultural competence definition. Greg Moody, Director of the Office Health Transformation, met with the advisory committee to discuss the vision of Ohio health transformation, and talked about how cultural competence can be included in the vision. The primary goal of the plan is to provide behavioral health system stakeholders with key strategies to reduce disparities. The plan will provide OhioMHAS, system Boards and providers with the tools to:

- Increase awareness of the significance of behavioral health disparities, their impact on communities, and the actions necessary to improve behavioral health outcomes;
- Strengthen and broaden leadership for addressing behavioral health disparities;
- Improve cultural and linguistic competency of the workforce; and
- Improve the coordination, utilization, and diffusion of research and evaluation outcomes.

Ohio aims to align its plan with the vision of the [Substance Abuse and Mental Health Services Administration \(SAMHSA\)](#), who received a new charge last year to address behavioral health disparities nationally. In accordance with this charge, SAMHSA created the [Office of Behavioral Health Equity \(OBHE\)](#) to coordinate its efforts to reduce behavioral health disparities for America's diverse communities. Stakeholders involved in developing Ohio's plan will base their strategies on the [National Stakeholder Strategy for Achieving Health Equity](#), a key policy driver for the OBHE. The strategies are a culmination of local conversations held across the U.S. to develop a blueprint to address elimination of health disparities.

IV: Narrative Plan

M. Recovery

Narrative Question:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

1. Has the state has developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?
2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?
3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?
4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).
5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?
6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?
7. Does the state have an accreditation program, certification program, or standards for peer-run services?
8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Involvement of Individuals and Families

Recovery is based on the involvement of consumers/peers and their family members. States must work to support and help strengthen existing consumer, family, and youth networks; recovery organizations; and community peer support and advocacy organizations in expanding self-advocacy, self-help programs, support networks, and recovery support services. There are many activities that 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:

1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?
2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?
3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?
4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?

Housing

1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?
2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a

supportive community?

Footnotes:

M. Recovery

- Questions:

SAMHSA encourages states to take proactive steps to implement recovery support services. SAMHSA is in a unique position to provide content expertise to assist states, and is asking for input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports, SAMHSA has launched Bringing Recovery Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.

Indicators/Measures

Please answer yes or no to the following questions:

- **1. Has the state developed or adopted (or is the state in the process of developing and/or adopting) a definition of recovery and set of recovery values and/or principles that have been vetted with key stakeholders including people in recovery?**
 - Yes, persons in recovery developed new definition of recovery using 2013 BRSS TACS funds.
- **2. Has the state documented evidence of hiring people in recovery in leadership roles (e.g., in the state Office of Consumer Affairs) within the state behavioral health system?**
 - Yes. We do not maintain a master list of people in recovery. There are probably at least two dozen employees in mental health or addiction recovery in central office. That does not include people in the state hospitals. These staff range from consumers who work on the OhioMHAS Help Line to senior staff at central office and in our six regional psychiatric hospitals. The regional psychiatric hospitals have peer support staff who include former patients. Staff in recovery includes the consumer services administrator.
- **3. Does the state's plan include strategies that involve the use of person-centered planning and self-direction and participant-directed care?**
 - Yes, strategies for person-centered planning has been included in Ohio's systems for care for more than a decade. Workforce development for health homes includes training provided by NAMI-Ohio and Ohio Empowerment Coalition which received competitive mini-grants to provide this training. The Access to Recovery grant funds self-directed care for a limited population of persons in recovery involved with the criminal justice system in northeastern Ohio.
- **4. Does the state's plan indicate that a variety of recovery supports and services that meets the holistic needs of those seeking or in recovery are (or will be) available and accessible? Recovery supports and services include a mix of services outlined in The Good and Modern Continuum of Care Service Definitions, including peer support, recovery support coaching, recovery support center services, supports for self-directed care, peer navigators, and other recovery supports and services (e.g., warm lines, recovery housing, consumer/family education, supported employment, supported employments, peer-based crisis services, and respite care).**
 - Yes.

- **5. Does the state's plan include peer-delivered services designed to meet the needs of specific populations, such as veterans and military families, people with a history of trauma, members of racial/ethnic groups, LGBT populations, and families/significant others?**
 - Yes. OhioMHAS has long funded a network of 14 Urban Minority Alcohol and Drug Abuse Outreach Projects that target services to African American and Hispanic citizens. These UMADAOPs provide an array of supports and services to consumers and their families and children that include: re-entry; education; treatment; housing linkage and supports. Ohio MHAS collaborates with the Ohio National Guard, Department of Veteran Affairs, and veteran advocacy groups on an array of behavioral and primary care issues of mutual concern. Trauma screening and treatment is being infused throughout the service system. Our Children's office is very active at finding evidence-based trauma treatments and providing and/or supporting training on them. Trauma treatment is also very big on our network of funded women's gender specific outpatient and residential treatment programs. Many of these residential women's programs allow the children of consumers to live with mother while she is being treated.
- **6. Does the state provide or support training for the professional workforce on recovery principles and recovery-oriented practice and systems, including the role of peer providers in the continuum of services?**
 - Yes, In the past 5 years OhioMHAS has been very active in providing training by staff who are persons in recovery for both mental health peer support and recovery oriented systems of care and recovery coach training. Dozens, perhaps hundreds of trainings have been provided regionally and throughout Ohio over and over to progressively build skill development and passion within our network of care for these services.

7. Does the state have an accreditation program, certification program, or standards for peer-run services?

OhioMHAS certifies about 35 Consumer Operated Services. The service standard for consumer operated services requires that 50% or more of board and staff are peers.

8. Describe your state's exemplary activities or initiatives related to recovery support services that go beyond what is required by the Block Grant application and that advance the state-of-the-art in recovery-oriented practice, services, and systems. Examples include: efforts to conduct empirical research on recovery supports/services, identification and dissemination of best practices in recovery supports/services, other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system.

Ohio recently completed the development of a 40 hour joint peer support/recovery coach training using BRSS TACS funds. The initial training with this curriculum of peer support and recovery coaches was very successful.

Involvement of Individuals and Families

- **1. How are individuals in recovery and family members utilized in the planning, delivery, and evaluation of behavioral health services?**
 - Ohio appoints a mental health consumer and family member and a person in addiction recovery and a family member on each local funding and auditing Board. These Boards plan, evaluate and make funding decisions for local mental health and addiction systems. Twenty three seats on the Ohio Community Recovery Supports Planning Council are filled with persons in mental health and addiction recovery and their family members. The Council also has representation from prevention professionals.
 - Family members are active in the OhioMHAS funded Ohio Federation for Children's Mental Health and NAMI-Ohio, and staff NAMI-Basics and Family-to-Family groups across Ohio.
 - Persons in recovery and family members are active in OhioMHAS funded Ohio Citizen Advocates for Chemical Dependency Prevention and Treatment, and OhioMHAS funded Ohio Suicide Prevention Foundation local coalitions.
 - Persons in recovery and family developed a new definition of recovery for OhioMHAS.
 - Persons in recovery created Ohio's new peer support/recovery coaching curriculum and provided the training.
 - Family members and persons in recovery lead many of the substance abuse prevention, treatment and peer/recovery support activities.
 - Peer supporters and recovery coaches (persons in recovery) work in many local mental health and addiction service boards and providers.
 - OhioMHAS certified 35 consumer operated services that are operated by persons in recovery and are required to have consumers as 50% or more of their Board.
 - Participation on many policy and workgroups is facilitated by Consumer/Family Partnership funds which reimburse travel and provide stipends.
 - Planning Council evaluates the performance of Mental Health Block Grant funded projects and reviews the Mental Health and Substance Abuse Prevention and Treatment Block Grant Plan.
 - A Toll Free Bridge information and referral line operated by OhioMHAS is staffed by persons in recovery.
 - Consumers and family members evaluate the mental health services through response to the MHSIP and YSS-F surveys. As members of the local funding and auditing boards and the Planning Council consumers and family evaluate service delivery. OhioMHAS prevention office provides many opportunities for recipients of prevention services to evaluate prevention, treatment and recovery support services
- **2. Does the state sponsor meetings or other opportunities that specifically identify individuals' and family members' issues and needs regarding the behavioral health service system and develop a process for addressing these concerns?**
 - State funding to NAMI-Ohio and Ohio Empowerment Coalition provides bi-annual conferences and local community groups in which to address their concerns.
 - Additionally, OhioMHAS employs a client rights officer, and requires Boards and providers to each hire client rights officers. The client rights officer is available to address individual concerns of people receiving services, and/or their families.

- **3. How are individuals and family members presented with opportunities to proactively engage the behavioral health service delivery system; participate in treatment and recovery planning, shared decision making; and direct their ongoing care and support?**
 - OhioMHAS periodically provides training to providers and Boards that incorporates information about inclusion of persons in recovery in planning and decision making. Additionally, OhioMHAS funds Ohio Citizen Advocates for Chemical Dependency Prevention & Treatment, Ohio Empowerment Coalition and NAMI-Ohio which provide information and education to engage persons in recovery and family members as advocates, planners and decision makers.
- **4. How does the state support and help strengthen and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?**
 - OhioMHAS funds Ohio Empowerment Coalition, Ohio Citizens for Chemical Dependency Prevention and Treatment, NAMI-Ohio and Ohio Federation for Children's Mental Health. Additionally, many of these organizations have a representative at the table in meetings such as Behavioral Health Leadership when key policy decisions are discussed.

Housing

- **1. What are your state's plans to address housing needs of persons served so that they are not served in settings more restrictive than necessary?**
 - Ohio is using Money Follows the Person (nationally known as Home Choice) to support persons with serious mental illness to voluntarily move out of nursing facilities to less restrictive housing. Additionally, OhioMHAS uses capital funds and partners with housing funders and Boards to expand permanent supportive housing. With consolidation, these opportunities will be expanded to include persons in recovery from addiction. For more detail, please see Step 1, Priority Population, #13 Homeless Persons and Persons with SMI and Substance Use Disorders in Need of Permanent Supportive Housing
- **2. What are your state's plans to address housing needs of persons served so that they are more appropriately incorporated into a supportive community?**
 - OhioMHAS has worked with housing providers including Adult Care Facilities to encourage connection with community organizations (e.g. churches, twelve step groups, YMCA,) available to the general public. Additionally, OhioMHAS has supported consumer operated services, as well as training for peer support and recovery coach staff which may lead to connections with other community members. The Access to Recovery grant has encouraged services by small community organizations which often have strong ties to local communities.

IV: Narrative Plan

N.1. Evidence Based Prevention and Treatment Approaches for the SABG

Narrative Question:

As specified in 45 C.F.R. §96.125(b), states shall use a variety of evidence-based programs, policies, and practices to develop prevention, including primary prevention strategies (45 CFR §96.125). Strategies should be consistent with the IOM Report on Preventing Mental Emotional and Behavioral Disorders, the Surgeon General's Call to Action to Prevent and Reduce Underage Drinking, the NREPP or other materials documenting their effectiveness. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance abuse prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health.

The SABG statute directs states to implement strategies including : (1) information dissemination: providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities; (2) education aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities; (3) alternative programs that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use; (4) problem identification and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use; (5) community-based processes that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and (6) environmental strategies that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population. In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

States should provide responses to the following questions:

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

Footnotes:

N. 1. Evidence Based Prevention and Treatment Approaches for SABG

1. How did the state use data on substance use consumption patterns, consequences of use, and risk and protective factors to identify the types of primary prevention services that are needed (e.g., education programs to address low perceived risk of harm from marijuana use, technical assistance to communities to maximize and increase enforcement of alcohol access laws to address easy access to alcohol through retail sources)?
2. What specific primary prevention programs, practices, and strategies does the state intend to fund with SABG prevention set-aside dollars, and why were these services selected? What methods were used to ensure that SABG dollars are used to purchase primary substance abuse prevention services not funded through other means?
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. What outcome data does the state intend to collect on its funded prevention strategies and how will these data be used to evaluate the state's prevention system?
5. How is the state's budget supportive of implementing the Strategic Prevention Framework?
6. How much of the SABG prevention set-aside goes to the state, versus community organizations? (A community is a group of individuals who share common characteristics and/or interests.)
7. How much of the prevention set-aside goes to evidence-based practices and environmental strategies? List each program.

1-Use of Data for Assessment

OHIOMHAS has a historic process for community and statewide assessment and planning guided by state and federal law and regulation. The first part of this section provides information on the current community and state level assessment and planning processes. In addition to current efforts, the Ohio SPF-SPE Evaluation Team conducted a variety of assessments and inventories to inform the work of the SPE Consortium specifically around data collection. The second section provides a summary for each of the three main projects.

Central to OHIOMHAS' planning framework is the alignment of federal, state and community planning requirements as reflected in the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, the comprehensive state plan, and board community plans. The connecting thread of these plans is the National Outcome Measures.

State Epidemiological Outcomes Workgroup (SEOW)

Ohio has a sound, functioning and well-organized community prevention infrastructure that is supported by the Ohio Epidemiological Outcomes Workgroup (SEOW). Since 2006, the SEOW has had the responsibility for the collection, analysis, and reporting of substance use incidence, prevalence and related data and National Outcome Measures (NOMs). The NOMs are a set of domains and measures which SAMHSA uses to meet reporting requirements. Substance abuse NOMs are drawn from many types of data including: substance use incidence and prevalence, related consequence data, and program process and output data.

The SEOW has developed state and county level profiles that are utilized by OHIOMHAS, various state agencies and ADAMHS/ADAS Boards for state and community need assessment. The profiles incorporate all substance abuse related components and indicators, including evidence of associated problems (e.g., school dropouts, delinquency,

depression, suicide, and violence). Indicators that met the SEOW inclusion criteria were categorized broadly by ATOD consumption and the consequences associated with alcohol, tobacco, or illicit drug use. Consumption indicators include age of initiation, lifetime use, current use, and high-risk use. Consequences of use include mortality and morbidity data, measures of abuse and addictive disorders, and crime related indicators. Contextual indicators from the RTI study that measure community instability and family-related factors (e.g., teen-birth rate, divorce, and child-abuse or neglect) comprised another set of measures used for the Ohio epidemiological profile. While the relationship between such indicators and ATOD consumption is at times inconsistent, Sanchez, Dunteman, Kuo, Yu, and Bray (2001) suggested that the above demographic and contextual measures should be monitored closely in an effort to evaluate the impact of ATOD use on Ohio's population.

Information from the epidemiological profiles enhances data-driven decision making at both the state and community levels driving the implementation of evidence-based programs, policies and strategies. The utilization of logic models at both the state and community level has supported cross system planning and monitoring efforts as well as producing systematic analytical thinking related to the causes and effects of substance use.

The SEOW has enabled the SPF-SIG Advisory Committee to make data-driven decisions during the identification of Ohio's SPF-SIG priorities. The SEOW currently provides data at the national, state, regional and county levels and will continue to update data relevant to alcohol, tobacco, and other drug consumption and consequences. The SEOW has worked in conjunction with SPF-SIG Evaluation Team to develop valid and reliable instruments for measuring consumption among 18 to 25 year old residents. Each instrument is being designed to meet the substance-specific needs and aims of the community in which it will be used.

While the members of the SPF-SIG Advisory Committee and the SEOW will continue to work to identify reliable and valid sources of secondary data, it is expected that the majority of consumption data at the state and national levels will be provided by national surveys, such as the National Survey on Drug Use and Health (NSDUH), Behavioral Risk Surveillance System (BRFSS), and the Youth Risk Behavior Surveillance System (YRBSS). While the Center for Disease Control surveys have been primary to the SEOW dataset, survey data and administrative data from OHIOMHAS sister agencies have also served as data sources for the state and county-level mortality and morbidity indicators. Memorandums of Understanding were developed with administrative data source organizations to facilitate annual updates of the compendium. This process allowed the state and county profiles to be updated annually where data was available. OHIOMHAS, ADAMHS/ADAS Boards and Providers are also working to address the prevention needs of existing, new, emerging and hard to reach populations in culturally competent and relevant ways. Ohio has significant African American, Somali, Latino, Asian, Appalachian and Amish population groups. In an effort to assess the needs of Ohio's large cultural population groups, the SEOW has gathered mortality and morbidity data available.

In addition, OHIOMHAS is working to develop relationships with other data collection entities at the regional and county level as well as, Memorandums of Understanding (MOU's) with the Ohio Department of Health, Ohio Department of Job and Family Services, and the Ohio Department of Development regarding specific data needs. Such efforts will assist in providing the SEOW with age-specific consequence and other types of population-specific data at both the state and county level. The SEOW is also exploring prescription drug abuse data in partnership with West Virginia and Kentucky to address the increase in prescription drug use across the

Appalachian region. As new data becomes available, it will be analyzed, graphed, and placed upon the SEOW website at <http://www.ada.ohio.gov/seow/>

In conjunction with the Interagency Prevention Consortium and the Evidence-Based Practice (EBP) Workgroup, the SEOW will identify local data sources to provide population-level measures of local initiative success.

Ohio Substance Abuse Monitoring Network (OSAM)

The Ohio Substance Abuse Monitoring (OSAM) Network is a collaborative effort funded by OHIOMHAS in association with key stakeholders in the substance abuse community throughout Ohio. The OSAM Network first began monitoring drug trends in 1999 and has the capacity to respond rapidly to investigate new drugs being used on the streets as well as to monitor drug and alcohol abuse and changes in drug abuse or drug-using populations. The primary mission of OSAM is to provide a dynamic picture of substance abuse trends and newly emerging problems within Ohio's communities every six months. The OSAM Network has grown significantly over the years, through the establishment of working relationships with community professionals and agencies that provide rich and diverse sources of drug trend data. This expansion has allowed the Network to provide coverage in most of the major urban and some rural areas of Ohio.

The OSAM Network collects and analyzes both qualitative (focus groups and individual interviews) and quantitative (statistical) data. This data provides substance abuse professionals and policy makers with the information necessary to plan for alcohol and drug addiction prevention, treatment and recovery services.

A diverse sample of individuals is recruited to participate in focus groups and individual interviews for the purpose of collecting qualitative data. These participants have an intimate knowledge of drug abuse trends in their communities and include:

- Treatment professionals
- People actively engaged in drug use or recovery
- Law enforcement officers
- Adult and juvenile probation officers
- School counselors
- Crime lab professionals

The Network's findings are disseminated through a variety of publications. Drug trend reports that provide general epidemiological descriptions of substance abuse trends across the state, focusing on drug availability, prices, quality, and abuse patterns are one example. Reports are published on a biannual basis shortly after OSAM researchers meet as a group in January and June of each year. Critical findings are also disseminated through "OSAM-O-GRAMS," one-page summary reports that briefly and graphically represent significant substance abuse trends. Targeted Response Initiatives (TRI's) represent another publication that typically focus on specific substance abuse-related issues that OHIOMHAS has determined need further investigation. This targeted response capability provides OHIOMHAS with a necessary tool to collect information in order to respond to substance abuse issues in a timely and effective manner.

The OSAM Network has been integral in OHIOMHAS' ability to respond to media inquiries, aid local Alcohol and Drug Addiction Services (ADAS)/Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards and agencies in grant-writing efforts, to address and

respond to important needs of the Ohio Legislature and to assist OHIOMHAS in planning and prioritizing resources based on emerging drug trends.

2-Prevention Services Overview

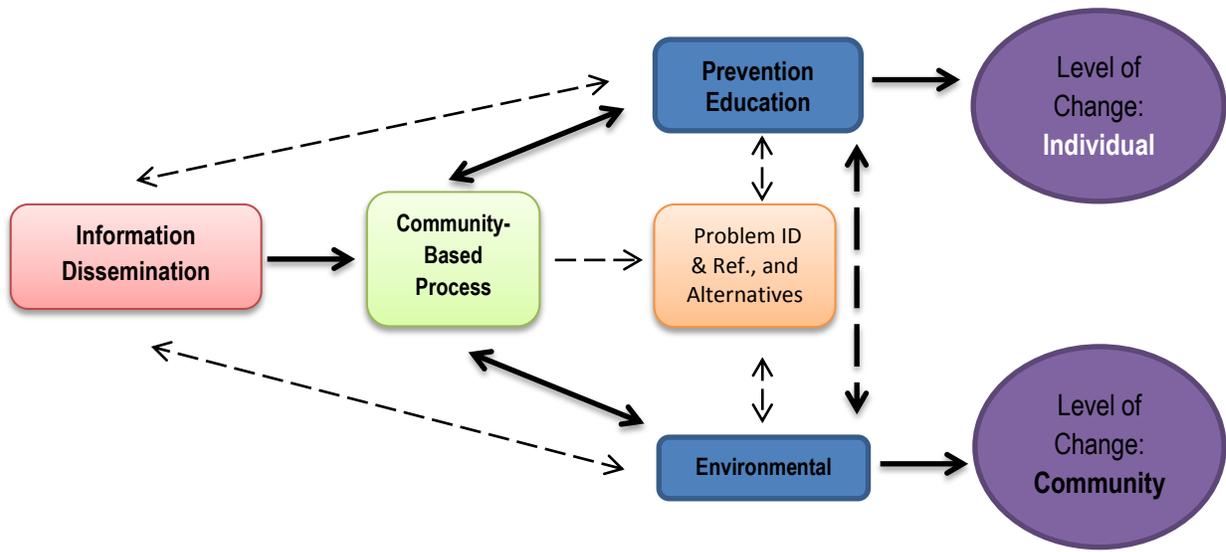
Ohio prevention focuses on reducing the likelihood of or delaying the onset of behavioral health problems (i.e. substance abuse, mental illness, suicide and problem gambling). Prevention services are a planned sequence of culturally appropriate, science-driven strategies intended to facilitate attitude and behavior change for individuals and communities.

Funding of the prevention service delivery system is primarily through allocations to Boards although a small amount of funds are spent to support state-wide initiatives. The updated Prevention Continuum of Care Taxonomy provides the guidelines for the delivery of this service array. Strategies implemented are based on the assessment of needs, resources and readiness conducted as part of the community planning process to ensure funded prevention interventions will address community risk and protective factors that either complicate or mitigate substance use and other risk behaviors. These community prevention efforts benefit all Ohioans through a number of programs at the local and state levels.

Ohio has updated its Prevention Continuum of Care Taxonomy based on a re-conceptualized the model for how CSAP's six prevention strategies are to be implemented for the greatest impact in Ohio communities. The goal of prevention services in Ohio is to facilitate change in individuals and/or communities. The following graphic provides a visual representation of how the six CSAP Strategies contribute to individual and community-level change. This new model provides a foundation for how substance abuse prevention funded through CSAP intersects with other prevention efforts funded through other federal and state funding streams. The focus on intended level of change and a further definition of strategies allows for the strategies of multiple systems to be integrated into one conceptual model. This will be the focus of one of the projects in the SPE Interagency Strategic Plan.

Prevention education and *environmental* strategies are seen as the main prevention strategies and have the strength to influence attitude, behavior and status on their own. The other four strategies support the implementation of these two main strategies. All six strategies in appropriate proportions are needed as part of a comprehensive prevention approach. *Information dissemination* creates awareness and builds knowledge which provides a foundation for *community-based process* to engage and mobilize communities into action.

Although *prevention education* interventions can be implemented without the foundational of *information dissemination* and *community-based process*, these interventions tend to lack the benefits resulting from broad-based community support and opportunities for expansion and quality improvement. *Community-based process* activities are essential to effectively implementing an *environmental* strategy. The *problem identification and referral* strategy is implemented as an adjunct when an individual enrolled in a direct service is identified as possibly needing or being able to benefit from services that exceed the scope of prevention. *Alternative activities* are implemented as a celebration of individual or community success and must be an activity that will, through evidence, also contribute to addressing risk/protective factors and/or intervening variables identified in initial program development.



Requested Bureau of Prevention Functions

During planning for Department consolidation, stakeholder and subject matter experts were engagement from various aspects of the field as well as from our Interagency Prevention Consortium. The new Office of Prevention & Wellness will focus on providing the following four requested functions as consolidation progresses. These requested functions have shaped the priorities set forth in our plan.

1. Facilitate on-going and shared learning regarding promotion/prevention science and associated technologies
2. Strategically coordinate messaging/branding to ensure consistent evidence-based practice
3. Engage stakeholders (Sustain processes for stakeholders to provide input and feedback & Sustain processes for valuing consumers and families)
4. Provide leadership in evidence-based policy, programming and practice

Through various planning processes in SFY 2013, Ohio developed a logic model to organize and target the approach to prevention and to identify outcomes that will contribute to the national outcome measures (NOMs). The following table provides a summary of the priorities and programmatic resources that Ohio is planning for SYF 2015. For detailed information on these program areas see Step 1.

Adopt a public health approach (SPF) into all levels of the prevention infrastructure	Strategic Prevention Framework
	Ohio Center for Coalition Excellence & Statewide Prevention Coalition Association
	Statewide Youth Survey
	Workforce Development
	Infusion of prevention in other systems (i.e. law enforcement, justice, faith, child welfare, education, suicide, etc.)
	Compliance with Synar Legislation
Ensure prevention services are available across the lifespan with a focus on families with children/adolescents	Families
	Youth Initiatives (Good Behavior Game/PBS, School-Based Prevention Education, Ohio Youth-Led Network)
	Marijuana & Underage Drinking Initiatives (Higher Ed Network, College

	Initiative, Parents Who Host, Trace Back)
	Prescription Drug (Family Engagement)
	UMADAOP Prevention
	Military Initiative
Empower pregnant women and women of child-bearing age to engage in healthy choices	Women & Babies
	FASD
	Neonatal Abstinence Syndrome
	Women's Prevention
Promote wellness in Ohio's workforce	Workplace
	Partnership with Bureau of Worker's Compensation Behavioral Health Wellness

3. Workforce Development

Workforce development is a challenge for prevention in Ohio. Recruitment is a significant problem for the substance abuse prevention profession because of a lack of standardized education pathways. Retention is also a concern because of the rate of turnover for substance abuse prevention professionals. Due to the economic times and limited dollars available for training and continuing education our workforce does not always have the opportunity to access resources to remain current in substance abuse prevention practices. This coupled with the aging workforce in substance abuse prevention provides unique circumstances when looking at workforce development issues.

In summary, while Ohio is fortunate to have a fairly strong infrastructure supporting the substance abuse prevention system at the state and local levels, a number of factors affect advancement of this system. These include a current state budget crisis that may result in a reduction in the amount of per capita allocations going to county boards to support prevention services and a reduction in the amount of competitive funding awarded by the Department. Other factors include the underrepresentation of Appalachian counties in county-level consumption data, a lack of science-based prevention programs in place across Ohio, particularly in rural areas, and a lack of population-specific suicide prevalence data needed to serve our LGBTQ and military families who are at an increased risk for suicide.

In our effort to modernize our prevention system, Ohio embraced the findings and recommendations in the 2009 Institute of Medicine (IOM) report on “Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities.” The first step in diffusing these innovations in Ohio was to make our system aware of the new science and recommendations of the IOM report. Ohio utilized SPF-SIG carry over dollars to fund capacity development in of-the-art prevention science practice. The following paragraphs provide a summary of some of these efforts.

The Ohio Prevention and Wellness Roundtable hosted a Prevention Policy Summit October 10, 2012. The Summit focused on building awareness of more than 300 people from the prevention field about IOM report recommendations and how to implement environmental strategies and population-based interventions. Anthony Biglan, Ph.D. and Dennis Embry, Ph.D. providing the training along with local community groups that have successfully implemented IOM recommendations. The Alcohol and Drug Abuse Prevention Association of Ohio (ADAPAO) and the Drug-Free Action Alliance (Ohio's Center for Coalition Excellence) conducted a Bridging the GAP (Grief, Advocacy, Prevention) conference on September 21-22, 2012. The first day focused on how prevention professionals can better work on engaging

communities in prevention for the implementation of environmental strategies and population-based prevention interventions. The second day provided basic training on evidence-based prevention for family and community groups who have not previously been engaged in prevention but have been mobilizing due to the opiate addiction and overdose epidemic in Ohio. ADAPAO also hosted two, one-day events for members this past year, one focusing on Prevention Consultancy and another on Prevention's Future in Healthcare Reform. Both were attended by more than 130 preventionists.

ODADAS and the Department of Education jointly hosted the annual Ohio Prevention Education Conference, "Prevention Without Boundaries" December 4-6, 2012, with a focus on population-based strategies and community engagement in prevention for more than 300 practitioners. Another effort was the Strategic Prevention Framework (SPF) three-day Boot C.A.M.P. held in May 2013 which provided our 13 SPF sub-recipient communities intensive training in environment strategies in preparation for their upcoming implementation year in SFY 14. However, providing the knowledge is only the first step in diffusion of innovation (Rogers 1995). Ohio took the next by the Wellness & Prevention Roundtable and ADAPAO hosting Ohio's first Prevention Academy in June 2013. Roundtable members served as faculty for the advanced track, three-day residential Academy that offered courses on interpreting and implementing prevention science with a focus on the IOM report recommendations. In one working session, Ohio preventionists, clinicians and professors examined ten IOM recommendations discussing barriers to implementation in their communities and brainstorming ways to overcome the barriers. This information is being compiled by the faculty member and will be reported to Dr. Biglan as an IOM report author for future consultation with Ohio.

Training/Technical Assistance

To develop capacity at the state level all stakeholders involved in the initiative, OHIOMHAS staff, SPF-SIG Committee, EBP, SPE Policy Consortium, etc. have received or will receive training on the SPF-SIG process. This has been the foundation utilized to strengthen existing stakeholder relationships and support the system as we move forward. The utilization of the SPF process has also been instrumental in increasing system capacity by helping to ensure state and local resources are targeted to AOD prevention services that have been demonstrated to be effective.

To continue to develop capacity at the community level, Ohio will utilize training, technical assistance and coaching to provide intense ongoing support to communities. This will support a solid foundation for communities, to mobilize, promote and/or enhance existing local activities to address community AOD needs. Ohio's supports a broad view of AOD prevention by focusing on both risk and protective factors and developmental assets related to substance abuse prevention. Through the development of community strategic plans, communities identify target priority areas, intervening variables and contributing factors to address.

All OHIOMHAS and state contractors for training and technical assistance have extensive experience providing technical assistance and fostering relationships with ADAMHS/ADAS Boards and prevention providers throughout the state of Ohio. OHIOMHAS' regional structure has enabled the field to receive more coordinated and effective technical assistance from the Department.

The Central RET has served as a resource for the state and we will continue to utilize them as needed for training and technical assistance at all levels. We have worked extensively with them to bring the SAPST training to Ohio, and we have built a cadre of Substance Abuse Prevention Specialist Training (SAPST) trainers and have utilized these trainers to provide

training to the communities. With the unveiling of the new SAPST curriculum, we have worked with Central RET to engage in a TOT in Ohio. This opportunity is critical to our field as we move forward with OHIOMHAS consolidation with the Department of Mental Health.

The Department utilizes two other entities as a part of our training arm to strengthen capacity at the community level through ongoing training and technical assistance for coalition members and other community stakeholders, development of a community planning team, strengthening of relationships across systems at the local level and ongoing effective communication to maintain support for prevention.

Global Insight has been in the training and professional speaking industry for close to 20 years. They have over 100 years of combined team experience with an extensive background in online training, coaching, consulting, assessment and evaluations. They have training and technical assistance experience in a variety of areas including; drug and alcohol, leadership, cultural competency, team building, empowerment, professional/personal development, community outreach and collaboration, quality assurance process improvement, marketing, project management, community needs assessments, capacity building, focus groups and strategic planning. They also have additional experience in research and the implementation of evidence based prevention strategies. James White Sr. is a senior, Master Training Management Consultant and Executive Coach. With more than 25 years of corporate, education, and government experience, White is committed to the training and development of individuals and organizations.

OHIOMHAS also works closely with the Drug-Free Action Alliance. They provide training, technical assistance and support to communities in their efforts to impact community norms; access and availability of alcohol, tobacco and other drugs; media messages; and policy enforcement issues on the local level. The education, coaching and technical assistance occurs most frequently through the work of the Statewide Prevention Coalition Association (SPCA), the Ohio Center for Coalition Excellence and the Ohio College Initiative to Reduce High Risk Drinking, all supported by OHIOMHAS. SPCA provides a venue for substance abuse prevention coalitions and other groups to advocate for policies related to substance abuse prevention. Both SPCA and the Ohio Center for Coalition Excellence assist in working with coalitions in over 90 communities to build and enhance their local collaborative capacity to plan, implement, evaluate and sustain prevention strategies. These groups will continue to assist local communities increase their capacity and to increase use of environmental prevention strategies to foster drug free lifestyles.

Workforce Development Workgroup

To address these issues a workforce development committee (WFD) has been convened, comprised of seasoned and credentialed prevention professionals from across the state. The work of the WFD committee is in part based upon the work of the Ohio SPF SPE Evaluation Team. The Workgroup review the following historic information to begin their planning.

- Ohio Prevention Training Needs Assessment (2002) by ADAPAO
- Enhancing the Prevention Workforce in Ohio (2006) by the ODADAS WFD taskforce
- Assuring Public Safety in the Delivery of Substance Abuse Prevention Service (2009), an ICRC Position Paper
- Prevention Certification Restructuring Survey (2010) by the OCDP Board
- Credentialing of Prevention Professional is a Critical Component to Implementing National Health Care Reform (2010) by the ICRC

During the SPE grant period, they created a web survey to help the Department understand workforce development needs in Ohio. This survey was fielded in July and August 2012 with individuals holding a current prevention or treatment credential. There were two key objectives to the survey:

- To provide data to profile the prevention workforce in Ohio and to inform workforce development efforts with Ohio's prevention workforce, and
- To understand how Ohio's prevention workforce views the importance of the Essential Public Health Services.

Ohio Workforce Development Survey

The changes in the behavioral healthcare field due to the Affordable Care Act implementation and a new understanding of the science behind behavioral health will require a whole new set of competencies for the prevention in Ohio. Role delineation and minimum standards for various Certified Prevention Specialist levels will be a focus of Ohio's revitalized Workforce Development Workgroup. To inform these efforts, OHIOMHAS staff will look at how other states are changing their services systems and OHIOMHAS has contracted with the SPF SPE Evaluation Team to create a web survey to help understand workforce development needs in Ohio. This survey will be fielded in late July and August 2012 with individuals holding a current prevention or treatment credential. The survey will close mid-August in order to meet reporting requirements. The two key objectives to the survey are the following.

1. To provide data to profile the prevention workforce in Ohio and to inform workforce development efforts with Ohio's prevention workforce, and
2. To understand how Ohio's prevention workforce views the importance of the Essential Public Health Services.

Instrumentation. The 2012 Workforce Development Survey included two modules of questions. Module 1 (Appendix C) focuses on training and workforce development needs and was administered with all sampled individuals. Module 2 (Appendix C) focuses on the perceived importance of the Essential Public Health Services (EPHS) to prevention in Ohio and was administered with individuals holding an OCPS II credential. The SPE evaluation team used an iterative approach to design the questionnaire used for the 2012 Workforce Development Survey.

The first module on workforce development is designed to provide Ohio with a data-informed profile of the prevention workforce and to inform planning for future workforce development and training efforts. The questions in this module were adapted from a 2008 survey fielded with prevention professionals in Maine by the Edmund Muskie School of Public Service at the University of Southern Maine (Hartley, et al., 2008). Draft versions of the survey were reviewed by the SPE Evaluation Team, prevention services staff at OHIOMHAS, and by Ohio's Prevention and Wellness Roundtable. This review process provided extensive feedback that resulted in a survey instrument that better fit the context of Ohio and the upcoming challenges and changes to the prevention system.

The second module on perceived importance of the ten Essential Public Health Services (EPHSs) was adapted from the State Public Health System Performance Assessment Instrument that was created as part of the National Public Health Performance Standards Program (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007). The ten Essential Public Health Services represent the spectrum of public health services that should be provided by states and local communities. The SPE evaluation team used the State Public Health System Performance Assessment Instrument to develop 44 questions measuring the perceived importance of Essential Public Health Services 1 to 5 and 8 to 10. EPHSs 6 and 7

were omitted from the instrument because they do not directly relate to the focus of the SPF-SPE grant. As with the first module, the SPE evaluation team used an iterative process to review and refine the questions and used feedback and suggestions from SPE evaluation team members and OHIOMHAS staff to improve the questions and to tailor them to prevention in Ohio. This second module of questions on the EPHS was administered only to respondents who indicated that they held an OCPS II credential. As described below, in order to minimize survey burden, OCPS II respondents were randomly assigned to receive questions on only two of the eight EPHSs included in module 2 of the survey.

Sampling. The target population for the 2012 Workforce Development Survey is prevention practitioners and workers in the state of Ohio who held one of 19 different prevention or treatment credentials or who were Registered Applicants (and working to obtain a prevention credential). Under Ohio Revised Code, the Ohio Chemical Dependency Professionals Board (OCDPB) is required to maintain a database containing the names and contact information of all Registered Applicants and credentialed prevention and treatment professionals. The sampling frame for this survey was drawn from the 6,347 individuals listed in the OCDPB database who either had an active prevention or treatment credential or who were considered active Registered Applicants. Prior to beginning fieldwork for the survey, Evaluation Team members reviewed the information in the sampling frame. In a few cases, there were minor errors in either individual's names or contact information. Evaluation Team members made these minor corrections prior to the start of fieldwork to maximize the accuracy and efficiency of the sampling frame. As noted above, the first module of questions on training and workforce development will be administered to all 6,347 individuals listed in the OCDPB. Module 2, which focuses on the EPHS, will be administered to at least 135 individuals who currently held an OCPS II certification.

Next Steps. Fieldwork for the 2012 Workforce Development Survey will begin in late July 2012 and will be completed in mid-August 2012. The survey will be fielded using Qualtrics and is designed so that personalized survey invitation emails will be sent to each sampled respondent. The personalized e-mail describes the purpose of the survey and includes a link to the web-based survey. In keeping with best practices, we will deploy three reminder emails for the survey.

For the OCPSII module (which was fielded with the Workforce Development Survey) we randomly assigned OCPSIIs to receive only items related to 2 of the 8 EPHS included in order to decrease survey burden. A total of 36 OCPSII completed this module of questions (approximately 15 OCPSIIs per EPHS) for a response rate of 27% (computed by comparing the 36 completed OCPSII modules to the 135 OCPSIIs included in the sample).

Key data provided as part of the 2012 Workforce Development Survey include:

- Profile of Ohio's Prevention Workforce
- Credentials
- Currently providing services
- Years in prevention
- Most Important Type of Prevention
- Familiarity with Key Prevention Concepts and Constructs
- Training Needs and Preferred Modalities

Key data provided as part of the OCPSII module focused on the perceived importance of the ten Essential Public Health Services (EPHSs). Ratings were made using a five point "importance scale" that included the following response categories:

- Not at all important

- Not very important
- Unsure
- Somewhat important
- Very Important

All mean scores were greater than 4.13, between “somewhat important” and “very important.”

Utilizing the results from these surveys as well as some historical documentation from past surveys the WFD committee identified an overall committee goal and three goals for the plan itself. Each of these goals has a state level and local level components. The draft is included below.

Current Draft of Workforce Development Plan

Goal: Create a sufficient, prepared, positioned, marketable, competent and diverse behavioral health prevention workforce through a structured two year plan for Ohio which will integrate behavioral health prevention with public health, educate the field on behavioral health prevention/promotion and population based strategies and define promote common language across systems.

Objectives for the WFD plan:

- Define and promote a common language for prevention across systems.
- Continue to educate field on behavioral health, prevention/promotion and population-based strategies.
- Integrating behavioral health in and with Public Health.

Each of these goals contains a state level and regional/community level component. For **Goal #1**, the WFD Workgroup, the Interagency Prevention Consortium and the Ohio Chemical Dependency Professionals Board will provide the state level work. They will create a crosswalk between substance abuse, mental health and public health prevention utilizing the current MHAS Prevention and Wellness Taxonomy and the Guiding Prevention Science documents as foundation. This work will be executed through statewide conferences (ie: OPEC, ADAPAO, Prevention Academy and UMADAOP) collaborative work on statewide committees, e-based Academy and the Departments website. Regional and community level work will focus on promoting the state plan through local educational opportunities.

For **Goal #2**, the state level work will be done through many of the training/conferences listed under Goal #1, as well as technical assistance provided by the Prevention Program Specialists, the Prevention Fellowship program started by the members of the Prevention and Wellness Roundtable and continued collaborative efforts on statewide committees and task forces. The WFD Workgroup would also like to see the utilization of a Statewide WFD Coordinator to guide these efforts. On the regional/community level the WFD committee will work to establish a regional workforce development consortium that will look at regional and local needs to ensure they are met and to ensure they are addressed in the state agenda. They could also provide regional and local learning collaborative(s) for sharing lessons learned, networking and establishing common outcomes. It is anticipated that the ADAMHS/ADAS Boards will also play in integral role in this work through funding and support to build capacity in their areas.

Goal #3 will require the same collaboration and coordination at the state level as Goals #1 & #2. The Department’s Prevention & Wellness Specialists will take the lead in ensuring that behavioral health is being integrated into public health through their work on statewide committees, conference planning and the development of marketing strategies. They will work with the members of the Prevention and Wellness Roundtable and the Interagency Prevention

Consortium to create elevator speeches, crosswalks, white papers and position papers that will frame our work in ways that others can understand and see the benefits of the integration. Most of this work will be done initially at the state level, though community and local partners will be utilized to identify and engage other fields and systems.

Other pieces of the WFD plan will include the updating and revision of the e-based academy to include the integration of behavioral health in the selection of educational sessions, continue to produce resources such as the Guiding Prevention/Promotion Science documents, distance learning and ensuring a connection with the OCDPB credentials/domains. It is the expectation that there will be a Substance Abuse Specialist Skills Training in each region annually and one statewide opportunity along with opportunities for test/prep study groups for the IC & RC exam.

Ohio possesses both individual and agency certifications for Prevention. Agency certification is provided by OhioMHAS and has minimum requirements and criteria agencies must show to be a prevention certified agency. Agencies must complete an application and an agency site review is conducted to ensure application is accurate. The agency must show policies and procedures that meet the requirements as well as show evidence of culturally appropriate interventions and qualified personnel that are implementing the interventions. Agencies are certified for three year time periods after which they can participate in a renewal process. (the complete rules document can be found at www.mha.ohio.gov in certification).

Individuals are certified through the Ohio Chemical Dependency Professionals Board. Prior to SFY 13 there were three options for an individual to choose from: Registered Applicant (RA), Ohio Certified Prevention Specialist I (OCPSI) and Ohio Certified Prevention Specialist II (OCPSII). The purpose of an RA was to get enable an individual to begin the process of prevention certification while working in the field. They must be supervised by and OCPS I or II and initially could stay at this level for an unlimited time period. The requirements for an OCPS I & II vary in that the different levels require different educational criteria and work experience hours.

The OCDPB realized that there were many individuals “parked” in the RA level and they were not advancing forward to the credential which was the intent. So in working with the OCDPB Prevention Committee, it was decided that maybe the creation of an Ohio Certified Prevention Specialist Assistant (OCPSA) would help individuals who may not have the required educational hours or work experience to move forward and provide an opportunity for them to complete their credential. The committee developed educational criteria and scope for the OCPSA and put a 2 year limit on the RA level.

It is anticipate that the addition of the OCPSA will increase the capacity of the prevention field in Ohio significantly. It is the thought that the RA level was so stagnant because many individuals wanted to move forward but due to educational and work experience requirements, and unemployment issues due to the economic downturn they could not.

4-Evaluation

Ohio has developed a new, web-based system, Proving Ohio’s Prevention Success (POPS), to manage all prevention programmatic, budgeting, performance management and reporting requirements. The new system will fulfill all Block Grant Reporting requirements and will allow for performance management at both the outcome and process level. A Workgroup of users developed the system. The objectives of the new system are to provide the following.

- Establish a secure and centralized online grant and allocation application functionality for prevention that can be utilized by both authorized internal staff and community stakeholders.
- Automate funding to streamline the grant and allocation process and improve efficiency, accountability and service delivery.
- Promote prevention and stakeholder ability to monitor progress and performance.
- Support prevention compliance with state and federal reporting requirements.
- Position OHIOMHAS Division of Prevention Services for emerging health system transformation by adopting a continuous quality improvement grants management partnership that leverages our collective resources and extends our collective capacity.

The new system has each step of the SPF imbedded in various components. A logic model approach taking into account the link between need, target population, intervening variables, strategy selection and prevention intervention selection is being used to gather outcomes. Data will be synthesized using Dr. David Julian's results continuum for categorizing and aggregating varied programmatic outcomes. Dr. Julian is Director of Community Planning and Evaluation at The Ohio State University Center for Special Populations.

The Niatx process improvement model will be used the process evaluation component of the system. OHIOMHAS staff have worked with Niatx staff over the last two years to modify the process for prevention as well as treatment services. A module of the new system will allow reporting of Niatx project results and learnings.

5- Infusion of the SPF

Ohio was awarded the competitive five-year, Strategic Prevention Framework State Incentive Grant (SPF-SIG) totaling more than \$10 million, funded by the Substance Abuse and Mental Health Administration's (SAMHSA) Center for Substance Abuse Prevention (CSAP) in July 2009. The SPF- SIG Initiative is enhancing the capacity of the state and counties to build a sustainable, culturally competent infrastructure focusing on delaying the onset of alcohol and other drug use and reducing substance-related problems.

To develop capacity at the community level, Ohio is utilizing training, technical assistance and coaching to provide intense, ongoing support to the 13 SPF SIG sub-recipient communities. This work is helping to lay a solid foundation for the sub-recipient communities, to mobilize, promote, evaluate and/or enhance existing locally driven drug-free community coalitions to address community substance abuse prevention needs. The 13 SPF SIG sub-recipient communities have been thoroughly trained in implementation of the SPF, and 35 of 37 other community Boards have participated in training to become familiar with the framework. An additional eight board areas have requested intensive technical assistance in the SPF which will be provided in SFY 2014 to assist them in redesigning their prevention systems in their catchment areas.

The consolidation of ODADAS and MH will support the infusion of prevention into other systems to better Champion Prevention. The new Office of Prevention and Wellness at OhioMHAS is comprised of individuals from five different disciplines: children and families mental health, substance abuse prevention, criminal justice, communications and substance abuse treatment. This combination encapsulates not only a wealth of skills and knowledge, but also the connections with other state partners and communities to assist in the infusing prevention into other systems. Three groups have been the priority to engage in this effort in SFY 2013. They included community coalitions, other state agencies and higher education.

These efforts are summarized below. Work is just starting on adding the medical community as a priority for engagement in infusing prevention into their service system. This area will be the focus of work in SYF 2014.

The Department was moving forward with this initiative prior to the consolidation working with the coalitions in the state. Coalitions are a prime target for infusion of the SPF across the state due to their engagement of multiple community sectors. Training and technical assistance provided a well-rounded view regarding the importance of representation of all community sectors on coalitions. The role that they all can play and in concert the positive impacts that can be made in the community. This was well received at the community level and we have mirrored this at the state level. We have worked diligently with the Office of the Attorney General and have provided general education that has significantly increased their knowledge and awareness of what does and does not work in prevention. They have become an active partner in our work and we have had discussions regarding the increased participation of law enforcement in our efforts.

The Consortium has been instrumental in our efforts to infuse prevention into other systems. We have ensured that individuals from other systems such as: youth services, education, faith-based organizations, child welfare, juvenile court, law enforcement and public health are represented on the SPF Advisory Committee, the EBP workgroup and the SPE/Interagency Policy Consortium. This provides opportunities for discussion, education and planning as to how prevention resources can be coordinated to better enhance everyone's services.

The Department has been working with four colleges/universities to infuse prevention into their curriculum. Wright State University, Ohio University, Miami University and the University of Cincinnati currently working on the development of a bachelor's level degree, a thematic sequence and/or master's level leadership degree.

6. Percentage of SAPT Award to Communities and State

20% of the SAPT award is designated to Primary Prevention. Of the \$ 12,529,575 designated for prevention, \$11,903,096 goes to communities and \$626,479 remains at the state to support primary prevention administrative costs.

7. Evidence-Based Practice Workgroup

The Evidence-Based Practice (EBP) Workgroup, consisting of key state partners, has been integral in the facilitation of the SPF process. The Department and SPF EBP Workgroup will ensure all sub-recipient comprehensive strategic plans are based on a data driven process and include goals, objectives and measures reflecting the cultural values, linguistic characteristics and socio-economic factors of each community, prior to implementation. The SPF EBP Workgroup provides guidance on the implementation of effective, evidence-based policies, programs and practices. This work continues to assist the state in moving toward a more cohesive and collaborative system that coordinates and maximizes resources to support the sustainability of the statewide infrastructure.

During the initial phases of the SPF SIG grant, the development of capacity at the state level involved training on the SPF-SIG process provided by CSAP's Central Regional Expert Team to all stakeholders involved in the initiative. This training has been the foundation the SPF SIG the SPF SIG training team and the Regional Prevention Coordinators have utilized to

strengthen existing stakeholder relationships and support the system. The Central RET serves as a resource for the state and provides technical assistance as needed. The utilization of the SPF process has increased system capacity by ensuring state and local resources are targeted to AOD prevention services that have been demonstrated to be effective.

To develop capacity at the community level, Ohio has utilized training, technical assistance and coaching to provide intense ongoing support to the sub-recipient communities. This work has helped to lay a solid foundation for the sub-recipient communities, to mobilize, promote and/or enhance existing locally driven drug-free community coalitions to address community AOD needs. Ohio's prevention infrastructure supports a broad view of AOD prevention by focusing on both risk and protective factors and developmental assets related to substance abuse prevention. Through the development of community strategic plans, communities identify target priority areas, intervening variables and contributing factors to address. Sub-recipient communities have used the information gathered in their needs assessment to focus on environmental strategies as they develop their implementation plan.

In addition to the training resources identified above we have utilized our partnership with Central RET to build a cadre of Substance Abuse Prevention Specialist Training (SAPST) trainers and have utilized these trainers to provide training to the communities. Many of the community members have also had the opportunity to participate in the SAPST Training of Trainers which further strengthens the training and technical assistance capacity across the state. Existing community level capacity building activities include; ongoing training and technical assistance for the sub-recipients, coalition members and other community stakeholders, development of a community planning team, strengthening of relationships across systems at the local level and ongoing effective communication.

Communities who did not receive a SPF SIG sub-recipient grant have been provided the opportunity to develop capacity through needs assessment and training and technical assistance as part of the state wide system development.

Prevention staff has extensive experience providing technical assistance and fostering relationships with ADAMHS/ADAS Boards and prevention providers throughout the state of Ohio. They work intensively with sub-recipients in the field and assist with training sub-recipients as well as conduct site visits with the Boards and Providers in their regions. Global Insight, the contracted training team for the SPF SIG project, has been in the training and professional speaking industry for close to 20 years. They have over 100 years of combined team experience with an extensive background in online training, coaching, consulting, assessment and evaluations. They have training and technical assistance experience in a variety of areas including; drug and alcohol, leadership, cultural competency, team building, empowerment, professional/personal development, community outreach and collaboration, quality assurance process improvement, marketing, project management, community needs assessments, capacity building, focus groups and strategic planning. They also are SAPST trainers and have additional experience in research and the implementation of evidence based prevention strategies.

In 2012, a total of 28.4% of funded prevention interventions were evidence-based to fidelity. The goal for SFY 2015 is 50% of funded prevention interventions will be evidence-based to fidelity.

Percent of prevention interventions by strategy	2011	2012	Goal for SFY 15
Alternatives	19%	18%	3%
Community-Based Process	14%	14%	15%
Education	28%	28%	30%
Environmental	7%	6%	35%
Information Dissemination	25%	27%	15%
Problem ID and Referral	7%	7%	2%

Below is a list of evidence-based prevention programs by provider.

Provider Name

Intervention Name

Akron-Urban Minority Alcoholism Drug Abuse Outreach Program Inc. (6838) - 665 West Market Street

LifeSkills Training - High School

Akron-Urban Minority Alcoholism Drug Abuse Outreach Program Inc. (6838) - 665 West Market Street

Risk Reduction Activities

Akron-Urban Minority Alcoholism Drug Abuse Outreach Program Inc. (6838) - 665 West Market Street

LifeSkills Training - Elementary School

Akron-Urban Minority Alcoholism Drug Abuse Outreach Program Inc. (6838) - 665 West Market Street

LifeSkills Training - Middle School

Alcohol and Chemical Abuse Council of Butler County Ohio Inc. (2965) - 2935 Hamilton Mason Road

Project SUCCESS

Alcohol and Chemical Abuse Council of Butler County Ohio Inc. (2965) - 2935 Hamilton Mason Road

Project SUCCESS

Alcoholism Council of the Cincinnati Area NCADD (1267) - 2828 Vernon Place

Second Step

Alcoholism Council of the Cincinnati Area NCADD (1267) - 2828 Vernon Place

KUUMBA SUMMER ENRICHMENT PROGRAM

Alcoholism Council of the Cincinnati Area NCADD (1267) - 2828 Vernon Place

LifeSkills Training - High School

Alcoholism Council of the Cincinnati Area NCADD (1267) - 2828 Vernon Place

LifeSkills Training - High School

Amethyst Inc. (8442) - 515-519 South High Street

Celebrating Families

Ashland County Council on Alcoholism and Drug Abuse (1010) - 310 College Avenue	Project ALERT
Asian Services In Action Inc. (11209) - 3631 Perkins Avenue	Problem Identification and Referral
Asian Services In Action Inc. (11209) - 3631 Perkins Avenue	CAM Summer Camp
Asian Services In Action Inc. (11209) - 3631 Perkins Avenue	Parenting Program
Asian Services In Action Inc. (11209) - 3631 Perkins Avenue	After-School CAM
Baldwin-Wallace College Binge Drinking Prevention (8039) - 275 Eastland Road	Baldwin-Wallace High Risk Drinking Prevention Program
Bayshore Counseling Services Inc (6662) - 1218 Cleveland Road	S.T.A.R.- Sharing, Teamwork, Acceptance and Relationships
Bayshore Counseling Services Inc (6662) - 1218 Cleveland Road	S.T.A.R.- Sharing, Teamwork, Acceptance and Relationships
Bellefaire Jewish Children's Bureau (2447) - 22001 Fairmount Boulevard	SAY - Social Advocates for Youth school based counseling
Bellefaire Jewish Children's Bureau (2447) - 22001 Fairmount Boulevard	SAY Summer Leadership Institute
Big Brothers Big Sisters of Lorain County (8226) - 1917 North Ridge Road East	Big Brothers/Big Sisters
Big Brothers Big Sisters of Lorain County (8226) - 1917 North Ridge Road East	Big Brothers/Big Sisters
Bowling Green State University Binge Drinking & Violence Prevent. (8207) - 116 Health Center Building	Bystander Intervention
Bowling Green State University Binge Drinking & Violence Prevent. (8207) - 116 Health Center Building	CHOICES
Bowling Green State University Binge Drinking & Violence Prevent. (8207) - 116 Health Center Building	Peer Education
Catholic Charities Services (9019) - 2012 West 25th Street	Just Say No Summer Puppet Show Program
Catholic Charities Services (9019) - 2012 West 25th Street	Hispanic Services Coalition
Catholic Charities Services (9019) - 2012 West 25th Street	Lions-Quest Skills for Adolescence
Catholic Charities/Ashland (12762) - 1260 Center Street	Ashland Connects to Teens (ACT) Teen Mentoring
Center for Alcoholism and Drug Addiction Services (1400) - One Elizabeth Place	Strengthening Families Program

Center for Alcoholism and Drug Addiction Services (1400) - One Elizabeth Place	Strengthening Families Program
Center for Families & Children (10608) - 4500 Euclid Avenue	PIR (Problem Identification and Referral)
Center for Families & Children (10608) - 4500 Euclid Avenue	Girls Circle
Center for Families & Children (10608) - 4500 Euclid Avenue	RapArt Drug Free Activities
Center for Families & Children (10608) - 4500 Euclid Avenue	ARISE
City of Kettering (8355) - 3600 Shroyer Road	Partners For Healthy Youth
City of Kettering (8355) - 3600 Shroyer Road	Partners For Healthy Youth
Clermont Recovery Center (3249) - 1088 Wasserman Way	Community Prevention Services
Clermont Recovery Center (3249) - 1088 Wasserman Way	After-School Program
Clermont Recovery Center (3249) - 1088 Wasserman Way	School-Based Prevention Services
Clermont Recovery Center (3249) - 1088 Wasserman Way	After-School Program
Clermont Recovery Center (3249) - 1088 Wasserman Way	School-Based Prevention Services
Clermont Recovery Center (3249) - 1088 Wasserman Way	Community Prevention Services
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	ATOD Education for Adults
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	Supporting the Prevention of Underage Drinking
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	Preventing Underage Drinking in Our Neighborhood
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	Reconnecting Youth (RY)
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	Bag It Up, Bring It Down
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	FRIENDS HELPING FRIENDS
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	GED is a First Step
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	SOBER Minds
Coalition for a Drug-Free Greater Cincinnati (12864) - 2330 Victory Parkway	CDFGC Student Drug Use Survey, Local Coalition Building

Community Action for Capable Youth (4893) - 1495 West Longview Avenue	LifeSkills Training - Elementary School
Community Action for Capable Youth (4893) - 1495 West Longview Avenue	LifeSkills Training - Elementary School
Community for New Direction (6750) - 2096 West Mound Street	Latino Program - Develontal Assets/Protective Factors
Community for New Direction (6750) - 2096 West Mound Street	Latino Program - Develontal Assets/Protective Factors
Community Solutions Association (10503) - 320 High Street NE	W.O.N.E.
Community Solutions Association (10503) - 320 High Street NE	Ohio Teen Institute
Community Solutions Association (10503) - 320 High Street NE	Community Based Prevention
Community Solutions Association (10503) - 320 High Street NE	School development and coordination
Consolidated Care (6756) - 1521 North Detroit Street	SAMHSA's Strategic Prevention Framework (SPF)
Covenant Adolescent CD Treatment & Prevention Center (6782) - 1515 West 29th Street	TUTORING (ACADEMIC)
Covenant Adolescent CD Treatment & Prevention Center (6782) - 1515 West 29th Street	Life Skills, Learning to Live Drug Free, ABC Drug Prevention
Covenant Adolescent CD Treatment & Prevention Center (6782) - 1515 West 29th Street	PROBLEM IDENTIFICATION AND REFERRAL
Covenant Adolescent CD Treatment & Prevention Center (6782) - 1515 West 29th Street	SAFE AND DRUG FREE ACTIVITIES
Covenant Adolescent CD Treatment & Prevention Center (6782) - 1515 West 29th Street	PROBLEM IDENTIFICATION AND REFERRAL
Crossroads Counseling Services (1118) - 255 West Main Street	Active Parenting Now
Crossroads Lake County Adolescent Counseling Service (1318) - 8445 Munson Road	Olweus Bullying Prevention
Crossroads Lake County Adolescent Counseling Service (1318) - 8445 Munson Road	AOD Community Coalition and Prevention Plan
Crossroads Lake County Adolescent Counseling Service (1318) - 8445 Munson Road	Red Oak Camp
Darke County Recovery Svs dba Marie Dwyer Recovery Ctr (10652) - 228 North Barron Street	Project Northland
Darke County Recovery Svs dba Marie Dwyer Recovery Ctr (10652) - 228 North Barron Street	Class Action
Darke County Recovery Svs dba Marie Dwyer Recovery Ctr (10652) - 228 North Barron Street	The Bully Proof Kit
Drug-Free Action Alliance (9405) - 6155 Huntley	Ohio College Initiative to Reduce High-Risk

Road	Drinking
Drug-Free Action Alliance (9405) - 6155 Huntley Road	Ohio Youth-Led Prevention Network
Drug-Free Action Alliance (9405) - 6155 Huntley Road	Ohio Center for Coalition Excellence
Drug-Free Action Alliance (9405) - 6155 Huntley Road	Enforcing Underage Drinking Laws year 2
Drug-Free Action Alliance (9405) - 6155 Huntley Road	Enforcing Underage Drinking Laws year 1
Drug-Free Action Alliance (9405) - 6155 Huntley Road	Ohio Center for Coalition Excellence
Drug-Free Action Alliance (9405) - 6155 Huntley Road	Enforcing Underage Drinking Laws year 2
East Cleveland Neighborhood Center Teen Turf Drop In Center (2435) - 13830 Euclid Avenue	Reconnecting Youth (RY)
East Cleveland Neighborhood Center Teen Turf Drop In Center (2435) - 13830 Euclid Avenue	Reconnecting Youth (RY)
EVE Inc. (2293) - P.O. Box 122	Alternative Activities
EVE Inc. (2293) - P.O. Box 122	Youth and Adult Education
EVE Inc. (2293) - P.O. Box 122	LifeSkills Training - Middle School
EVE Inc. (2293) - P.O. Box 122	Alternative Activities
EVE Inc. (2293) - P.O. Box 122	Youth and Adult Education
EVE Inc. (2293) - P.O. Box 122	Life Skills
FACTS/New Alternatives (1220) - 45 Olive Street	Project Toward No Drug Abuse
FACTS/New Alternatives (1220) - 45 Olive Street	LifeSkills Training - Middle School
FACTS/New Alternatives (1220) - 45 Olive Street	Drug Free Community Coalition
FACTS/New Alternatives (1220) - 45 Olive Street	Drug Free Community Coalition
FACTS/New Alternatives (1220) - 45 Olive Street	Project Toward No Drug Abuse
FACTS/New Alternatives (1220) - 45 Olive Street	Gallia-Jackson Mentoring Program
FACTS/New Alternatives (1220) - 45 Olive Street	LifeSkills Training - Middle School
Family Recovery Center (1052) - 964 North Market Street	Per Capita
Family Recovery Center (1052) - 964 North Market Street	Per Capita
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Thinking For Change-Dr. Samenow
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Prevention Coalition
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Jail/Court Population Education Programs
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	prevention dissemination
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Youth at Risk

Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Jail/Court Population Education Programs
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Jail/Court Population Education Programs
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Youth at Risk
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Thinking For Change-Dr. Samenow
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Prevention Coalition
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	prevention dissemination
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Youth Led Prevention
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Youth Led Prevention
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Community-Based Process
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Jail Education
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Community Education
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Community-Based Process
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Community Information Dissemination and Alternative Activities
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Youth Led Prevention
Hancock Co. Community Partnership for Substance Abuse Prevention (2947) - 438 Carnahan Avenue	Too Good For Drugs (TGFD)
Hancock Co. Community Partnership for Substance Abuse Prevention (2947) - 438 Carnahan Avenue	Hancock County Community Coalition
Harbor (3126) - 4334 Secor Road	Incredible Years
Harbor (3126) - 4334 Secor Road	Starting Early
Health Recovery Services (6755) - 224 Columbus Road	Team Athens Community Coalition
Health Recovery Services (6755) - 224 Columbus Road	Safe Dates
Health Recovery Services (6755) - 224 Columbus Road	At-risk Residential Programs
Health Recovery Services (6755) - 224 Columbus Road	Community Awareness Programs
Health Recovery Services (6755) - 224 Columbus Road	Teen Institute School Based Meetings

Health Recovery Services (6755) - 224 Columbus Road	Second Step
Health Recovery Services (6755) - 224 Columbus Road	Youth Led Prevention
Health Recovery Services (6755) - 224 Columbus Road	GJM Community Prevention and Education Programs
Health Recovery Services (6755) - 224 Columbus Road	Safe Dates
Health Recovery Services (6755) - 224 Columbus Road	Meigs Mentoring
Health Recovery Services (6755) - 224 Columbus Road	Second Step
Health Recovery Services (6755) - 224 Columbus Road	Teen Institute School Based Meetings
Hispanic Urban Minority Alcoholism and Drug Abuse Outreach Program (2466) - 3305 West 25th Street	Adapted Lions Quest
Hispanic Urban Minority Alcoholism and Drug Abuse Outreach Program (2466) - 3305 West 25th Street	Positive Action (PA)
Hispanic Urban Minority Alcoholism and Drug Abuse Outreach Program (2466) - 3305 West 25th Street	Youth Center Coalition
Hispanic Urban Minority Alcoholism and Drug Abuse Outreach Program (2466) - 3305 West 25th Street	Positive Action (PA)
Jackson City Schools (12871) - 450 Vaughn Street	Social marketing campaign event
Jackson City Schools (12871) - 450 Vaughn Street	Social marketing campaign event
Jefferson Behavioral Health System (7063) - 3200 Johnson Road	Local interventions
Jefferson Behavioral Health System (7063) - 3200 Johnson Road	Local interventions
Kent State University Health Promotion Program (3402) - 316 White Hall	Local Program
Kent State University Health Promotion Program (3402) - 316 White Hall	Local Program
Kenyon College (3138) - 221 North Auckland Street	Last Call
Lake Area Recovery Center (1017) - 2801 C. Court	Prevention
Lake Area Recovery Center (1017) - 2801 C. Court	Prevention
Lake-Geauga Recovery Centers Inc (1225) - 209 Center Street	Collaborations and Coalitions
Lake-Geauga Recovery Centers Inc (1225) - 209 Center Street	Geauga Prevention
Lake-Geauga Recovery Centers Inc (1225) - 209 Center Street	Chardon Community Action Team

Liberty Center Connections (10039) - 104 Spink Street	CIRCLE Coalition
Lima Urban Minority Alcohol Drug Abuse Outreach Program (5004) - 809 W. Vine Street	UMADAOP C.A.P.E. Mentoring
Lima Urban Minority Alcohol Drug Abuse Outreach Program (5004) - 809 W. Vine Street	UMADAOP Community Awareness
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Parenting Challenges
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Eduvention
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Strengthening Families Program for 12 to 16
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Building Blocks
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	LifeSkills Training - Middle School
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Atheletes Training and Learning to Avoid Steroids (ATLAS)
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Eduvention
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Strengthening Families Program for 12 to 16
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Parenting Challenges
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Building Blocks
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	Atheletes Training and Learning to Avoid Steroids (ATLAS)
Lorain County Alcohol and Drug Abuse Services (2147) - 1882 East 32nd Street	LifeSkills Training - Middle School
Lorain Urban Minority Alcoholism and Drug Abuse Outreach Program (1942) - 2314 Kelly Place	Strengthening Families Program
Lorain Urban Minority Alcoholism and Drug Abuse Outreach Program (1942) - 2314 Kelly Place	Reconnecting Youth (RY)
Lorain Urban Minority Alcoholism and Drug Abuse Outreach Program (1942) - 2314 Kelly Place	Strengthening Families Program
Lorain Urban Minority Alcoholism and Drug Abuse Outreach Program (1942) - 2314 Kelly Place	Empowering our Future
Lorain Urban Minority Alcoholism and Drug Abuse Outreach Program (1942) - 2314 Kelly Place	Blended Programs
Mallory Center for Community Development (10470) - 3262 Beekman Street	Substance Abuse Awareness and Prevention Strategies (SAAPS)
Mansfield UMADAOP (5005) - 400 Bowman Street	All Stars

Meridian Community Care (1366) - 527 North Meridian Road	Project ALERT
Meridian Community Care (1366) - 527 North Meridian Road	PANDA2
Meridian Community Care (1366) - 527 North Meridian Road	Information Dissemination
Meridian Community Care (1366) - 527 North Meridian Road	Too Good For Drugs (TGFD)
Meridian Community Care (1366) - 527 North Meridian Road	PANDA2 Camp
Miami University (8040) - 421 South Campus Ave	MU Bacchus Student Engagement Initiative
Miami University (8040) - 421 South Campus Ave	MU Bacchus Student Engagement Initiative
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	Suicide Coalition
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	SPAN
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	Student Assistance Services
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	River Valley Community Coalition
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	Creative Options
Multi-Development Services of Stark County (10500) - 618 Fulton Road NW	MSYL Youth Development
Multi-Development Services of Stark County (10500) - 618 Fulton Road NW	LIFE Youth Development Program
Muskingum Behavioral Health (1422) - 601 Underwood Street	Muskingum County Peer Prevention
Muskingum Behavioral Health (1422) - 601 Underwood Street	Character Education Classes
PathStone (8255) - 2-453 County Road V	Strengthening Families Program
Pathways of Central Ohio (1325) - 1627 Bryn Mawr Drive	Clean and Sober Parenting
Pathways of Central Ohio (1325) - 1627 Bryn Mawr Drive	Wellness Partnership - 9839
Pathways of Central Ohio (1325) - 1627 Bryn Mawr Drive	Incredible Years
Pathways of Central Ohio (1325) - 1627 Bryn Mawr Drive	Active Parenting (Evidence-Based NREPP)
Pathways of Central Ohio (1325) - 1627 Bryn Mawr Drive	Parents as Teachers (Evidence-Based Strengthening Americas Families)
Perry Behavioral Health Choices (1431) - 203 North Main Street	Alpha

Perry Behavioral Health Choices (1431) - 203 North Main Street	Jr. Sr. High School ATOD Education
Perry Behavioral Health Choices (1431) - 203 North Main Street	LAFF Camp
Perry Behavioral Health Choices (1431) - 203 North Main Street	Community Events
Pickaway Area Recovery Services (1433) - 110 Highland Avenue	Life Skills
Pickaway Area Recovery Services (1433) - 110 Highland Avenue	Drug Free Work Place
Pickaway Area Recovery Services (1433) - 110 Highland Avenue	MATRIX
Pickaway Area Recovery Services (1433) - 110 Highland Avenue	ATOD dissemination and activities
Pickaway Area Recovery Services (1433) - 110 Highland Avenue	AOD Education
Pickaway Area Recovery Services (1433) - 110 Highland Avenue	Problem Identification and Referral
Pickaway Area Recovery Services (1433) - 110 Highland Avenue	Small Group Education
Pike County Recovery Council (1446) - 111 North High Street	Summer Fun Program
Pike County Recovery Council (1446) - 111 North High Street	Community Based Strategies/Coalition Building
Pike County Recovery Council (1446) - 111 North High Street	AOD Education
Pike County Recovery Council (1446) - 111 North High Street	Wednesday Group
Pike County Recovery Council (1446) - 111 North High Street	Community Based Strategies/Coalition Building
Pike County Recovery Council (1446) - 111 North High Street	Wednesday Group
Pike County Recovery Council (1446) - 111 North High Street	Summer Fun Program
Pike County Recovery Council (1446) - 111 North High Street	AOD Education
Prevention Partners - A Program of Behavioral Connections (13020) - 13415 Eckel Junction Road	Prevention Partners Coalition
Prevention Partners - A Program of Behavioral Connections (13020) - 13415 Eckel Junction Road	PASA Teen Board
Prevention Partners - A Program of Behavioral Connections (13020) - 13415 Eckel Junction Road	Communities Mobilizing for Change on Alcohol (CMCA)

Prevention Partners - A Program of Behavioral Connections (13020) - 13415 Eckel Junction Road	Communities Mobilizing for Change on Alcohol (CMCA)
Prevention Partners - A Program of Behavioral Connections (13020) - 13415 Eckel Junction Road	PASA Teen Board
Prevention Partners - A Program of Behavioral Connections (13020) - 13415 Eckel Junction Road	Prevention Partners Coalition
Project Impact-Dayton Inc. (3423) - 115 East Third Street	Strengthening Families Program
Quest Recovery and Prevention Services (1491) - 1341 Market Avenue North	LifeSkills Training - Middle School
Quest Recovery and Prevention Services (1491) - 1341 Market Avenue North	Positive Action (PA)
Quest Recovery and Prevention Services (1491) - 1341 Market Avenue North	Project ALERT
Quest Recovery and Prevention Services (1491) - 1341 Market Avenue North	Leadership and Resiliency Program (LRP)
Quest Recovery and Prevention Services (1491) - 1341 Market Avenue North	All Stars
Ravenwood Mental Health Center (1224) - 695 South Street	Prevention Groups
Recovery & Prevention Resources (1144) - 118 Stover Drive	Too Good for Violence
Recovery & Prevention Resources (1144) - 118 Stover Drive	Too Good For Drugs (TGFD)
Recovery Resources (6973) - 3950 Chester Avenue	HALO (Healthy Alternatives for Little Ones)
Recovery Resources (6973) - 3950 Chester Avenue	PRIME for Life
Recovery Resources (6973) - 3950 Chester Avenue	PIR
Recovery Resources (6973) - 3950 Chester Avenue	DARE To Be You
Rio Grande Health and Prevention Services (3709) - 218 North College Avenue	Freshman 911/Wellness
Rio Grande Health and Prevention Services (3709) - 218 North College Avenue	Freshman 911/Wellness
Sandusky County Health Department (11231) - 2000 Countyside Drive	Creating Environmental Change
Sandusky County Health Department (11231) - 2000 Countyside Drive	Creating Environmental Change
Scioto Paint Valley MHC (1463) - 4449 State Route 159	Modified Asset Building, Positive Adolescent Choices Training and Life Skills training
Scioto Paint Valley MHC (1463) - 4449 State Route 159	Modified Asset Building, Positive Adolescent Choices Training and Life Skills training
Solutions Behavioral Healthcare Inc (1383) - 246 Northland Drive	Risk and Protective Factors, Developmental Assets, The Red Flags Program & Too Good For Drugs

Solutions Behavioral Healthcare Inc (1383) - 246 Northland Drive	Medina County Job and Family Services
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	Prime for Life
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	Community Engagement
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	Too Good For Drugs (TGFD)
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	LifeSkills Training - Elementary School
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	LifeSkills Training - High School
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	Strengthening Families Program
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	Too Good For Drugs (TGFD)
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	LifeSkills Training - High School
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	LifeSkills Training - Elementary School
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	Community Engagement
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	Strengthening Families Program
Solutions Community Counseling and Recovery Centers (10630) - 50 Greenwood Lane	Prime for Life
St. Vincent Mercy Medical Center (8095) - 2213 Cherry Street	Life Skills
St. Vincent Mercy Medical Center (8095) - 2213 Cherry Street	Parenting-Plus and P.I.P.E. (Partners in Parenting Education)
Summit Co. Community Partnership, Inc. (2953) - 111 East Glenwood Avenue	Coalition Training and Support
Sylvania Community Action Team (8498) - 4747 North Holland-Sylvania Road	Community Drug Drop Off Project
Sylvania Community Action Team (8498) - 4747 North Holland-Sylvania Road	Community Drug Drop Off Project
Talawanda School District (13154) - 131 W Chestnut St	Coalition for a Healthy Community Sector Sustainability Plans
Talawanda School District (13154) - 131 W Chestnut St	Coalition for a Healthy Community Sector Sustainability Plans
Talbert House - Adult Services (1281) - 4531 Reading Road	Community Based Process with school personnel and community members

Talbert House - Adult Services (1281) - 4531 Reading Road	Camp Wasington Youth Information Dissimination
Talbert House - Adult Services (1281) - 4531 Reading Road	Alternative Activities for Camp Washington Youth
Team Athens (0) - 7990 Dairy Lane	Modified Bridgebuilders Coalition
Team Athens (0) - 7990 Dairy Lane	Modified Bridgebuilders Coalition
The College of Wooster (8201) - 1189 Beall Avenue	College of Wooster ATOD Prevention Project (based on Environmental Management Approach)
	LifeSkills Training - Middle School
The Columbus Urban League (3201) - 788 Mt. Vernon Avenue	
The Columbus Urban League (3201) - 788 Mt. Vernon Avenue	LifeSkills Training - Middle School
The Crossroads Center (1258) - 311 Martin Luther King Dr	Education and Community Services to Adults
The Crossroads Center (1258) - 311 Martin Luther King Dr	Mentoring Program
The Crossroads Center (1258) - 311 Martin Luther King Dr	Community Organization
The Crossroads Center (1258) - 311 Martin Luther King Dr	Information and Referral Services
The Crossroads Center (1258) - 311 Martin Luther King Dr	Education and Community Services to Adults
The Crossroads Center (1258) - 311 Martin Luther King Dr	Criminal Justice Program
The Crossroads Center (1258) - 311 Martin Luther King Dr	Education and Community Services for Older Adults
The Crossroads Center (1258) - 311 Martin Luther King Dr	Aim High Peer Leadership Program
The Crossroads Center (1258) - 311 Martin Luther King Dr	Violence Interruption Process
The Crossroads Center (1258) - 311 Martin Luther King Dr	Educational advancement
The Crossroads Center (1258) - 311 Martin Luther King Dr	Information and Referral Services
The Crossroads Center (1258) - 311 Martin Luther King Dr	Community Organization
The Giving Tree Inc (6689) - 335 Buckeye Blvd.	LifeSkills Training - Middle School
The Giving Tree Inc (6689) - 335 Buckeye Blvd.	LifeSkills Training - Elementary School
The Giving Tree Inc (6689) - 335 Buckeye Blvd.	Active Parenting Now in 3
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Second Step
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Girl Power

The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Too Good For Drugs (TGFD)
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Drugs Don't Work in the Mahoning Valley
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	PANDA2
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Ohio Teen Institute
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Second Step
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Too Good For Drugs (TGFD)
Townhall II (1452) - 155 North Water Street	Tobacco Education Program
Townhall II (1452) - 155 North Water Street	Personal Body Safety Program
Townhall II (1452) - 155 North Water Street	Youth-Led Projects
Townhall II (1452) - 155 North Water Street	Project ALERT
Townhall II (1452) - 155 North Water Street	Pregnancy and Parenting Program
UMADAOP (1043) - 1 Elizabeth Place	LifeSkills Training - High School
UMADAOP (1043) - 1 Elizabeth Place	Strengthening Families Program
UMADAOP (1043) - 1 Elizabeth Place	Elder Care Program
UMADAOP (1043) - 1 Elizabeth Place	Elder Care Program
UMADAOP (1043) - 1 Elizabeth Place	LifeSkills Training - High School
UMADAOP (1043) - 1 Elizabeth Place	Strengthening Families Program
UMADAOP (1043) - 1 Elizabeth Place	African American Families Project
UMADAOP of Franklin Co. Inc. (11203) - 510 East Mound Street	UMADAOPFC Summer Youth Program
UMADAOP of Franklin Co. Inc. (11203) - 510 East Mound Street	UMADAOPFC Summer Youth Program
Unified Health Solutions, Inc. (1406) - 1133 Edwin C Moses Blvd	Participant Assistance
Unified Health Solutions, Inc. (1406) - 1133 Edwin C Moses Blvd	Creating Lasting Family Connections (CLFC)
Unified Health Solutions, Inc. (1406) - 1133 Edwin C Moses Blvd	Communtiy Prevention Education and Collaboration
Unison Behavioral Health Group Inc (12717) - 1212 Cherry Street	Affecting change throught the use of social media
Unison Behavioral Health Group Inc (12717) - 1212 Cherry Street	Affecting change throught the use of social media
University of Akron Research & Sponsored Programs (8485) - 302 Buchtel Common	MACPRIDE Coalition
University Settlement Inc (1257) - 4800 Broadway	Keepin' it R.E.A.L. (Refuse, Explain, Avoid, Leave)
University Settlement Inc (1257) - 4800 Broadway	Keepin' it R.E.A.L. (Refuse, Explain, Avoid, Leave)
University Settlement Inc (1257) - 4800 Broadway	Keepin' it R.E.A.L. (Refuse, Explain, Avoid, Leave)

Urban Minority Alcoholism and Drug Abuse Outreach Program (1036) - 3021 Vernon Place	Strengthening Families Program
Urban Minority Alcoholism and Drug Abuse Outreach Program (1036) - 3021 Vernon Place	Strengthening Families Program
Urban Minority Alcoholism and Drug Abuse Outreach Program (1036) - 3021 Vernon Place	Strengthening Families Program
Urban Minority Alcoholism and Drug Abuse Outreach Program (1036) - 3021 Vernon Place	Strengthening Families Program
Urban Minority Alcoholism and Drug Abuse Outreach Program (1068) - 2447 Nebraska Avenue	Life Skills for Adults
Urban Minority Alcoholism and Drug Abuse Outreach Program (1068) - 2447 Nebraska Avenue	LifeSkills Training - High School
Urban Minority Alcoholism and Drug Abuse Outreach Program (1068) - 2447 Nebraska Avenue	Positive Action (PA)
Urban Minority Alcoholism and Drug Abuse Outreach Program (1068) - 2447 Nebraska Avenue	Positive Action (PA)
Urban Minority Alcoholism and Drug Abuse Outreach Program (1068) - 2447 Nebraska Avenue	Healthy Workplace
Urban Minority Alcoholism and Drug Abuse Outreach Program (1068) - 2447 Nebraska Avenue	Healthy Workplace
Urban Minority Alcoholism and Drug Abuse Outreach Program (1117) - 1327 Florencedale Avenue	UMPP
Urban Minority Alcoholism and Drug Abuse Outreach Program (1117) - 1327 Florencedale Avenue	WTSP
Urban Minority Alcoholism and Drug Abuse Outreach Program (1117) - 1327 Florencedale Avenue	ICMI Youth Mentoring Prevention Program
Urban Minority Alcoholism and Drug Abuse Outreach Program (1117) - 1327 Florencedale Avenue	ADAS Per Capita Prevention Program
Urban Ounce of Prevention Services - Exodus Program (2292) - 1735 South Hawkins Avenue	New Beginnings
Urban Ounce of Prevention Services - Exodus Program (2292) - 1735 South Hawkins Avenue	BUILDING DREAMS
Warren Urban Minority Alcoholism and Drug Abuse Outreach Program, Inc. (1148) - 4087 Youngstown Road SE	Reconnecting Youth (RY)
Warren Urban Minority Alcoholism and Drug Abuse Outreach Program, Inc. (1148) - 4087 Youngstown Road SE	Aiming High For Excellence

Warren Urban Minority Alcoholism and Drug Abuse Outreach Program, Inc. (1148) - 4087 Youngstown Road SE	Kids Express
Wright State University School of Professional Psychology (8278) - 9N Edwin C Moses Boulevard	Second Step
Wright State University School of Professional Psychology (8278) - 9N Edwin C Moses Boulevard	Second Step
Your Human Resource Center (1537) - 2587 Back Orrville Road	Youth Led Prevention
Your Human Resource Center (1537) - 2587 Back Orrville Road	Education
FRS Counseling (1299) - 313 Chillicothe Avenue	Project SUCCESS
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	Student Assistance Services
Personal & Family Counseling Services of Tusc. Valley Inc. (8310) - 1433 Fifth Street NW	Takin' It To The Schools
Talbert House - Adult Services (1281) - 4531 Reading Road	Local Problem Identification and Referral Services
Talbert House - Adult Services (1281) - 4531 Reading Road	LifeSkills Training - Middle School
Talbert House - Adult Services (1281) - 4531 Reading Road	Second Step
Bowling Green State University Binge Drinking & Violence Prevent. (8207) - 116 Health Center Building	Late Night Programming
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Youth Led Prevention
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	Youth Led Prevention
University of Toledo Binge Drinking Coalition Proj. (8203) - 2801 West Bancroft Street	University of Toledo - High Risk Drinking Project
Consolidated Care (6756) - 1521 North Detroit Street	Project SUCCESS
Crossroads Lake County Adolescent Counseling Service (1318) - 8445 Munson Road	Parent Project group will be offered in Willoughby and Painesville.
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Huron County Alternative School
Firelands Counseling and Recovery Services (6745) - 292 Benedict Avenue	Huron County Alternative School
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	LifeSkills Training - Middle School
Firelands Counseling and Recovery Services (6832) - 777 North Sandusky Street	LifeSkills Training - Elementary School

Noble Behavioral Health Choices (1425) - 48 Olive Street	LifeSkills Training - Middle School
Pathways Counseling Center (1454) - 835 North Locust Street	Junior Educational Development Institute
Pathways Counseling Center (1454) - 835 North Locust Street	FRIENDS
Shaker Heights Youth Center, Inc. (1081) - 17300 Van Aken Blvd.	LifeSkills Training - High School
Shaker Heights Youth Center, Inc. (1081) - 17300 Van Aken Blvd.	LifeSkills Training - Elementary School
Solutions Behavioral Healthcare Inc (1383) - 246 Northland Drive	Project ALERT
UMADAOP of Franklin Co. Inc. (11203) - 510 East Mound Street	UMADAOPFC After School Program
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	Morgan County Fair Booth
Community Solutions Association (10503) - 320 High Street NE	Classroom and Education programs
Community Solutions Association (10503) - 320 High Street NE	Project ALERT
Community Solutions Association (10503) - 320 High Street NE	LifeSkills Training - High School
Community Solutions Association (10503) - 320 High Street NE	Too Good For Drugs (TGFD)
Community Solutions Association (10503) - 320 High Street NE	LifeSkills Training - High School
Greene County Educational Service Center (10197) - 360 East Enon Road	Students Opposed to Drugs and Alcohol
Greene County Educational Service Center (10197) - 360 East Enon Road	Students Opposed to Drugs and Alcohol
Greene County Educational Service Center (10197) - 360 East Enon Road	Talking With Your Students About Alcohol (TWYSAA)
Greene County Educational Service Center (10197) - 360 East Enon Road	Talking With Your Students About Alcohol (TWYSAA)
Greene County Educational Service Center (10197) - 360 East Enon Road	Project ALERT
Greene County Educational Service Center (10197) - 360 East Enon Road	Project ALERT
Pathways Counseling Center (1454) - 835 North Locust Street	Alternative Opportunity Center ATOD Education Group
Greene County Educational Service Center (10197) - 360 East Enon Road	Support Groups

Greene County Educational Service Center (10197) - 360 East Enon Road	Support Groups
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	Aiming High-Academics
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	Too Good For Drugs (TGFD)
Cleveland Urban Minority Alcoholism Outreach Project (1584) - 1215N East 79th Street	LifeSkills Training - Middle School
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Lions-Quest Skills for Adolescence
Alcohol and Drug FREEDOM CENTER of Knox County (1311) - 106 East Gambier Street	Community Youth Program (CYP)
Alcohol and Drug FREEDOM CENTER of Knox County (1311) - 106 East Gambier Street	Community Youth Program (CYP)
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Professional In-service Training Series
The Neil Kennedy Recovery Clinic (1365) - 2151 Rush Boulevard	Professional In-service Training Series
Africentric Personal Development Shop (2915) - 1409 East Livingston Avenue	AFAR Domestic Violence Program
Africentric Personal Development Shop (2915) - 1409 East Livingston Avenue	AFAR Domestic Violence Program
Community Health Center (1508) - 725 East Market Street	PANDA Youth Staff
Community Health Center (1508) - 725 East Market Street	Project PANDA
Community Health Center (1508) - 725 East Market Street	Project ALERT
Community Health Center (1508) - 725 East Market Street	School and Community Programs
Community Health Center (1508) - 725 East Market Street	PANDA Youth Staff
Community Health Center (1508) - 725 East Market Street	Project ALERT
Community Health Center (1508) - 725 East Market Street	Project PANDA
Community Health Center (1508) - 725 East Market Street	School and Community Programs
East Akron Community House (12835) - 550 South Arlington Street	Healthy Living
East Akron Community House (12835) - 550 South Arlington Street	Positive Exposure

East Akron Community House (12835) - 550 South Arlington Street	Positive Exposure
Northwest Counseling Services (1195) - 1560 Fishinger Road	Big Brothers/Big Sisters
Project Linden (1212) - 1410 Cleveland Avenue	LifeSkills Training - Elementary School
The Schottenstein Chabad House - The Friendship Circle (10537) - 207 East 15th Avenue	Mentoring Children with Special Needs
The Schottenstein Chabad House - The Friendship Circle (10537) - 207 East 15th Avenue	Mentoring
The Schottenstein Chabad House - The Friendship Circle (10537) - 207 East 15th Avenue	Student Mentoring
The Schottenstein Chabad House - The Friendship Circle (10537) - 207 East 15th Avenue	Mentoring
The Schottenstein Chabad House - The Friendship Circle (10537) - 207 East 15th Avenue	Student Mentoring
The Schottenstein Chabad House - The Friendship Circle (10537) - 207 East 15th Avenue	Mentoring Children with Special Needs
Pathways Counseling Center (1454) - 835 North Locust Street	Girls Circle
Gallia County Local Schools Guiding Children to Live Success. (2938) - 230 Shawnee Lane	PRIDE
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	Prom Promise
Morgan Behavioral Health Choices (1547) - 915 S. Riverside Drive	Prom Promise
Africentric Personal Development Shop (2915) - 1409 East Livingston Avenue	Imhotep Learning Institute Summer Day Camp
Africentric Personal Development Shop (2915) - 1409 East Livingston Avenue	Imhotep Learning Institute Summer Day Camp
Scioto County Counseling Center (6846) - 1634 11th Street	Youth Outreach Clubs
Alcoholism Council of the Cincinnati Area NCADD (1267) - 2828 Vernon Place	KUUMBA SUMMER ENRICHMENT PROGRAM
Family Service Association Community (10020) - 2211 Arbor Blvd	Positive Youth Development
Meridian Community Care (1366) - 527 North Meridian Road	Information Dissemination
Meridian Community Care (1366) - 527 North Meridian Road	PANDA2 Camp
Meridian Community Care (1366) - 527 North Meridian Road	Too Good For Drugs (TGFD)
Meridian Community Care (1366) - 527 North Meridian Road	PANDA2

IV: Narrative Plan

N.2. Evidence Based Prevention and Treatment Approaches for the MHBG (5 percent)

Narrative Question:

States are being asked to utilize at least five percent of their MHBG funds to award competitive grants to implement the most effective evidence-based prevention and treatment approaches focusing on promotion, prevention and early intervention. States that receive two percent or more of the total FY 2014 state allotment will be required to implement a competitive sub award process. States should describe how they intend to implement the competitive grants and/or sub award process.

Footnotes:

N. 2. Evidence Based Prevention and Treatment Approaches for MHBG

Ohio has a long history of using MHBG to fund technical assistance and training for providers and Boards to implement evidence-based and promising practices. As a result, Ohio has Coordinating Centers of Excellence (CCOEs) which provides training and technical assistance to Ohio's providers, as well as to some providers in other states, to implement evidence-based practices. Additionally, Ohio Suicide Prevention Foundation (OSPF), funded by MHBG, also has a competitive Garrett Lee Smith Grant from SAMHSA to implement evidence-based suicide prevention practices. While this funding was originally competitively bid, the Coordinating Centers of Excellence and OSPF funding has not been competitively re-bid in recent years. The rationale is that the CCOEs and OSPF have developed infrastructures that could not easily be replicated by new grantees. For example, OSPF developed and provides training and support to 80 local suicide prevention coalitions which provide support and post-vention (after suicide) intervention for families in some communities. This well-developed infrastructure would take years for a new grantee to replicate. Therefore, OhioMHAS has chosen not to competitively bid that award for a number of years. Similar decisions have been made about re-bidding CCOEs that have developed resources and relationships which could not be easily replicated.

Ohio has bid enough of its MHBG funds for evidence-based and promising practices to exceed the 5% threshold set by SAMHSA. For FFY 2014 Ohio will award \$920,000 (6.4%) of its SFY 2014 MHBG Budget through competitive bidding to fund evidence-based prevention and early intervention for children ages 0 – 6, and implementation of Health Homes. The MHBG funds for Health Homes includes funds for technical assistance and training for providers to include evidence based and promising practices within Medicaid Health Homes for adults and children with serious and persistent mental illness. Please see the table on the next page for Ohio's allocations for competitive bidding for funding of EBPs.

The total amount of MHBG funding awarded to support technical assistance and training for evidence based prevention and treatment practices for FFY 2014 was \$14,301,404 (19.1%) of the budget. This amount is consistent with Ohio's long tradition of allocating a portion of the MHBG funds for system improvement projects that fund technical assistance and training. Please see the table on the next page for Ohio MHBG allocations for EBP implementation.

Ohio's Competitive Bidding Process – For competitively bid grants, OhioMHAS designates a program staff member to develop the RFP (Request for Proposal). The RFP includes a description of the work to be funded, deliverables expected, the amount of the award, and a deadline for applying for the award, as well as questions to which the applicant must respond in writing. A formal public notice of the RFP is sent to a list of stakeholders that includes the statewide provider associations, Board association, statewide consumer and family organizations, and posted on the OhioMHAS website. Additionally, any other potential applicants may be contacted by the project manager, and the notice of the RFP is distributed by the e-newsletter and/or list serv.

In order to review the proposals, the project manager develops a list of criteria associated with points for the review team. The project manager convenes the review team, which reviews and scores each of the proposals. The review team reads, scores and ranks the applications, and

decides which organization(s) will be funded. After that decision is made, the project manager notifies the applicants, and initiates a Notice of Award to the organizations with the winning proposals.

Ohio's Mental Health Funding of Evidence-Based Projects			
	Total Amount	Competitively Bid?	Amount Bid Competitively
Early Childhood MH Consultation – Race to the Top	\$320,000	Yes	\$320,000
Early Childhood MH Consultation - Other	\$100,000	Yes	\$100,000
Center for Innovative Practices Coordinating Center for Excellence – Case Western Reserve University; provides technical assistance for MST and other children's EBPs	\$292,500	No	
Ohio Suicide Prevention Foundation	\$233,750	No	
Criminal Justice CCOE	\$190,000	No	
Substance Abuse/Mental Health CCOE – Case Western Reserve	\$527,500	No	
Mental Illness/Developmental Disability CCOE – Ohio State University	\$85,500	No	
Wellness Management & Recovery CCOE; will implement Stanford Univ. Chronic Disease Self-Management EBP – Southeast Inc.	\$229,050	No	
Supported Employment (SE) – Consumer Operated Services – Ohio Empowerment Coalition which collaborates with SE CCOE	\$85,500	No	
Supported Employment CCOE – Case Western Reserve University	\$171,000	No	
Health Home/Health Integration	\$500,000	Yes	\$500,000
Total EBP & Promising Practice (PP) Expenditures	\$2,734,800		\$920,000
Total SFY 2014 MH Block Grant Budget	\$14,301,404		\$14,301,404
Total EBP & PP Expenditures/Total SFY 2014 MH BG Budget	19.1%		6.4%

IV: Narrative Plan

O. Children and Adolescents Behavioral Health Services

Narrative Question:

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with over 160 grants awarded to states and communities, and every state has received at least one CMHI grant. In 2011, SAMHSA awarded System of Care Expansion grants to 24 states to bring this approach to scale in states. In terms of adolescent substance abuse, in 2007, SAMHSA awarded State Substance Abuse Coordinator grants to 16 states to begin to build a state infrastructure for substance abuse treatment and recovery-oriented systems of care for youth with substance use disorders. This work has continued with a focus on financing and workforce development to support a recovery-oriented system of care that incorporates established evidence-based treatment for youth with substance use disorders.

SAMHSA expects that states will build on this well-documented, effective system of care approach to serving children and youth with behavioral health needs. Given the multi-system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports in the system of care approach includes non-residential services, like wraparound service planning, intensive care management, outpatient therapy, intensive home-based services, substance abuse intensive outpatient services, continuing care, and mobile crisis response; supportive services, like peer youth support, family peer support, respite services, mental health consultation, and supported education and employment; and residential services, like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification.

Please answer the following questions:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?
3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

Footnotes:

O. Children's and Adolescent Behavioral Health Services

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with mental and substance use disorders?

Outcomes measurement will be incorporated into agencies' Electronic Health Records (EHR) through Ohio's *Treatment Episode Outcomes (TEO) system*. TEO captures all SAMHSA required National Child Outcome Measures (NOMS) for both children and adults, including overall functioning and recovery, and a variety of indicators for physical health and chronic disease. All SOC communities will be required to use TEO. Furthermore, ENGAGE intends to purchase *Synthesis, a case management software system* specifically designed to align with all SOC values and principles. SOC Communities will be required to enter service and cost data into Synthesis in order to track effectiveness of local SOC implementation. Synthesis has been used in several SAMHSA SOC sites across the United States, including Tapestry in Cuyahoga County.

2. What guidelines have and/or will the state establish for individualized care planning for children/youth with mental, substance use and co-occurring disorders?

Ohio currently has Health Homes available to individuals with chronic diseases, including SED. The ENGAGE SOC implementation plans to increase youth and young adults access to Health Homes to ensure individualized care planning occurs for those that qualify for such a service.

In addition, Ohio will support the expansion of system of care throughout Ohio with communities adopting Wraparound or the Transition to Independence process so youth and young adults will have an individualized care and transition plan. Several of Ohio's communities currently have wraparound or TIP in place. The Family and Children First statute support wraparound principles as part of its mandated service coordination process. With ENGAGE SOC implementation, the following activities will occur:

- i. Establish policies, rules and/or law to integrate transition planning beginning no later than age 14 for all systems providing care/service coordination to YYAT.*
- ii. Adopt a universal, culturally, linguistically, and developmentally relevant transition plan for all systems to use; and specify expectations for its use.*
- iii. Increase transition plan accessibility via the web-based Ohio Benefit Bank that will manage, store information, and authorize others to access the YYAT transition plans.*
- iv. Support the development of transition teams in SOC ready communities that use an integrated, cross-system, youth-guided, young adult-driven, and family driven care coordination process through rules, policies, and/or law.*
- v. Provide needed training (i.e. Wraparound, TIP) to advance local SOC communities' readiness to serve the diverse YYAT populations. The transition teams will utilize Wraparound or TIP to identify needed services (e.g. life skills development, peer support, integrated care, housing, legal, supportive employment, education, and transportation).*

- 3. How has the state established collaboration with other child- and youth-serving agencies in the state to address behavioral health needs (e.g., child welfare, juvenile justice, education, etc.)?
- The state established collaboration to address the behavioral health needs of children, youth and young adults through the former Ohio Family and Children First Cabinet Council and is now spearheaded by the Health and Human Services (HHS) Cabinet. Ohio's ENGAGE SOC implementation grant will be overseen and guided by the HHS Cabinet. The HHS Cabinet will be comprised of the following departments who will work in partnership with ODMHAS to address the behavioral health needs of youth and young adults in multiple systems:
 - Dept of Job and Family Services
 - Dept of Medicaid
 - Dept of Developmental Disabilities
 - Dept of Health
 - Dept of Education
 - Dept of Aging
 - Dept of Youth Services
 - Dept of Rehabilitation and Correction
 - Opportunities for Ohioans with Disabilities Agency
 - Office of Budget and Management
 - Board of Regents
 - Office of Health Transformation
-
- 4. How will the state provide training in evidence-based mental and substance abuse prevention, treatment and recovery services for children/adolescents and their families?
 - i. Through the ENGAGE SOC implementation grant, Ohio plans to develop a sustainable workforce training program that will provide training in evidence-based mental and substance abuse prevention, treatment and recovery services. This workforce training program will be trauma-informed, developmentally appropriate, culturally and linguistically competent, and embrace the SOC framework. The training will focus on services, supports, and resources (e.g. peer support, wraparound, TIP, resiliency, Strategic Prevention Framework, technology utilization for service delivery, evidence-based practices, and housing). Family members and YYAT will be recruited to serve as co-trainers and will be compensated. In addition, ENGAGE will require all 17 ODMH funded Residency and Training Programs at colleges and university to train psychiatry residents and nurses in Health Homes, IHBT, ACT, Peer Support, and other evidence-based treatment models for YYAT through didactic and practical experiences.
- 5. How will the state monitor and track service utilization, costs and outcomes for children and youth with mental, substance use and co-occurring disorders?

The ENGAGE SOC evaluation design is a multi-group pretest-posttest design with follow-up measures. Projected over the four years: **2,000 YYAT will receive intervention through Ohio's ENGAGE SOC**. Data collection will occur at intake, every six months for as long as the consumer

receives services as part of the grant program, and at discharge. Participation in the program and the evaluation will be voluntary and with informed consent. Individuals can participate in ENGAGE SOC regardless of whether they participate in the evaluation. If a participant drops out of treatment or is discharged prior to completing treatment, the SOC coordinator will work with staff to locate the participant and complete the measures. In similar studies, ORE has achieved an 85% retention rate through the use of monetary incentives, good relationships with agencies, mail-out reminders, and a system which tracks change in client contact information.

The *CMHS National Child Outcomes Measures* for Discretionary Programs (NOMS) instrument will assess mental illness symptomatology; functioning; employment/education; crime and criminal justice; stability in housing; access-number of person served by age, gender, race, and ethnicity; rate of readmission to psychiatric hospitals; social support/social connectedness; and client perception of care. Data will be collected through a structured interview by trained YYAT or Family Members at time of enrollment, every six months for as long as the consumer receives services as part of this grant program, and at discharge.

The *Global Assessment of Functioning* (GAF; American Psychiatric Association, 1994) will be used to measure psychological, social, and occupational functioning over time. GAF ratings range from 1 to 100 and are divided into 10-point increments. The *Ohio Youth Functioning and Problem Scales* (OYFP; Ogles, Melendez, Davis, & Lunen, 1999) will be administered on all program participants. Scales for YYAT, parent, and worker measure problem severity, functioning, hopefulness and satisfaction. Both the Problem Severity subscale ($\alpha = .90$ for parent clinical sample) and the Functioning subscale ($\alpha = .93$ for parent community sample) exhibit good internal consistency. *All interview/survey questions are available in Spanish.*

ENGAGE Participant Satisfaction, level of consumer and family involvement, quality of the implementation process, and ability to provide feedback will be rated quarterly for the duration of the grant (4 years). Questions are similar to standard satisfaction questions and all responses are rated on a 5-point scale (See Attachment 2 for all additional measures).

IV: Narrative Plan

P. Consultation with Tribes

Narrative Question:

SAMHSA is required by the 2009 Memorandum on Tribal Consultation to submit plans on how it will 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 opinions between parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision making with the ultimate goal of reaching consensus on issues.

For the context of the Block Grants awarded to tribes, 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 be attended by elected officials of the tribe or their designees. SAMHSA is requesting that states provide a description of how they consulted with tribes in their state, which 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. If a state does not have any federally-recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect. For states that are currently working with tribes, a description of these activities must be provided in the area below. States seeking technical assistance for conducting tribal consultation may contact the SAMHSA project officer prior to or during the Block Grant planning cycle.

Footnotes:

Ohio has no federally recognized tribes.

IV: Narrative Plan

Q. Data and Information Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked each state to:

- Describe its plan, process, and resources needed and timeline for developing the capacity to provide unique client-level data;
- List and briefly describe all unique information technology systems maintained and/or utilized by the state agency;
- Provide information regarding its current efforts to assist providers with developing and using EHRs;
- Identify the barriers that the state would encounter when moving to an encounter/claims based approach to payment; and
- Identify the specific technical assistance needs the state may have regarding data and information technology.

Please provide an update of your progress since that time.

Footnotes:

Q. Data and Information Technology

The Patient Care System (PCS) is the official system for patient data for the public hospitals operated by the Ohio Department of Mental Health and Addiction Services (MHAS). A wide variety of information is collected, including admission, discharge, billing, medication orders, legal and other patient information. Ohio MHAS also operates an encounter-based outpatient billing system called Multi-Agency Community Information System (MACSIS). This outpatient payment information system compiles behavioral health care services for both Medicaid paid and non-Medicaid paid services. Ohio MHAS also operates an outpatient admissions record system called the OH BH (Ohio Behavioral Health) for reporting client characteristics and outcome information.

Ohio's lead agency for health information technology strategy is the Ohio Health Information Partnership (OHIP), which includes a behavioral health committee. OHIP is a non-profit entity charged with assisting physicians and other providers with implementation of health information technology throughout Ohio.

IV: Narrative Plan

R. Quality Improvement Plan

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked 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, based on valid and reliable data, that will describe the health of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that services, to the extent possible, continue reflect this 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 emergencies, critical incidents, complaints and grievances. In an attachment, states must submit a CQI plan for FY 2014/2015.

Footnotes:

Q. Data and Information Technology

The Patient Care System (PCS) is the official system for patient data for the public hospitals operated by the Ohio Department of Mental Health and Addiction Services (MHAS). A wide variety of information is collected, including admission, discharge, billing, medication orders, legal and other patient information. Ohio MHAS also operates an encounter-based outpatient billing system called Multi-Agency Community Information System (MACSIS). This outpatient payment information system compiles behavioral health care services for both Medicaid paid and non-Medicaid paid services. Ohio MHAS also operates an outpatient admissions record system called the OH BH (Ohio Behavioral Health) for reporting client characteristics and outcome information.

Ohio's lead agency for health information technology strategy is the Ohio Health Information Partnership (OHIP), which includes a behavioral health committee. OHIP is a non-profit entity charged with assisting physicians and other providers with implementation of health information technology throughout Ohio.

IV: Narrative Plan

S. Suicide Prevention

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to:

- Provide the most recent copy of your state's suicide prevention plan; or
- Describe when your state will create or update your plan.

States shall include a new plan as an attachment to the Block Grant Application(s) to provide a progress update since that time. Please follow the format outlined in the new SAMHSA document [Guidance for State Suicide Prevention Leadership and Plans](#) available on the SAMHSA website at [here](#).

Footnotes:



Ohio Suicide Prevention Foundation

Strategic Plan 2013-2016

Susan Farnham, Chair OSPF Board of Directors
Carolyn Givens, Executive Director



Connecting for Life

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A. Introduction

The **Ohio Suicide Prevention Foundation (OSPF)**, a non-profit 501(c)(3), has served Ohio as a focus and a catalyst for the prevention of suicide since 2005. Its energy and activity is targeted on promoting suicide prevention as a public health issue, supporting evidence-based practices in awareness, intervention and methodology, and working for the elimination of stigma and the increase of help-seeking behavior that surrounds the brain illnesses of depression, other mental illness and addiction. There are many definitions of prevention or suicide prevention. OSPF adheres to the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (*SAMHSA*) construct that prevention is different from intervention and treatment in that it is aimed at general population groups who may differ in their risk for developing behavioral health problems. The Institute of Medicine defines three broad types of prevention interventions:

- 1. Universal preventive interventions** take the broadest approach, targeting “the general public or a whole population that has not been identified on the basis of individual risk” (*O’Connell, 2009*). Universal prevention interventions might target schools, whole communities, or workplaces. *E.g., community policies that promote access to early childhood education, implementation or enforcement of anti-bullying policies in schools, education for physicians on prescription drug misuse and preventive prescribing practices, social and decision-making skills training for all sixth graders in a particular school system*
- 2. Selective preventive interventions** target “individuals or a population sub-group whose risk of developing mental disorders [or substance abuse disorders] is significantly higher than average”, prior to the diagnosis of a disorder (*O’Connell, 2009*). Selective interventions target biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population. *E.g., prevention education for new immigrant families living in poverty with young children, peer support groups for adults with a history of family mental illness and/or substance abuse*
- 3. Indicated preventive interventions** target “high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorder” prior to the diagnosis of a disorder (*IOM, 2009*). Interventions focus on the immediate risk and protective factors present in the environments surrounding individuals. *E.g., information and referral for young adults who violate campus or community policies on alcohol and drugs; screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries (<http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/levels-risk-levels-intervention/2>)*

Two significant affirmations form the impetus for this revision of OSPF’s strategic plan:

- First, the Ohio Department of Mental Health, as well as, the Department of Health and multiple community stakeholders have encouraged, endorsed and trusted OSPF as the statewide steward and resource partner for Ohio’s suicide prevention effort. OSPF accepts this stewardship role and recognizes the accompanying need for broadening its scope of efforts and collaborations; but, also, being as specific, as possible, in defining its strategies and results.
- Second, in September 2012, the U.S. Department of Health and Human Services (*HHS*) Office of the Surgeon General and National Action Alliance for Suicide Prevention released 2012 National Strategy for Suicide Prevention: Goals and Objectives for Action (*Washington, DC: HHS, September 2012*). This national plan represents a comprehensive, long-term approach to suicide prevention. “The goal of saving lives, as measured by sustainably lower national and regional suicide rates, can only be achieved by a mosaic of coherent actions that complement each other.” The National Strategy hopes to energize and sustain the efforts of those who already are engaged in suicide prevention and identifies areas where future contributions can make a difference in advancing suicide prevention in communities. OSPF has reviewed the national plan and strives to be in concert with national goals and objective, and, moreover, to advance them.

OSPF is led by a dedicated and organized board whose members represent a variety of geographical interests and expertise in the suicide prevention and public health fields. (*See appendix*) This board directs and monitors a diverse mix of funding sources including, but not limited to, public and private grants, state line-items, bequests, and products. An active board committee structure allows others to become involved in OSPF activities, especially the establishment of regular information sharing mechanisms and a variety of public and legislative relations programs.

B. Mission & Vision

The **Mission** of OSPF is to promote suicide prevention as a public health issue and advance evidence-based awareness, intervention, and methodology strategies that will support priority populations and healthy communities.

The **Vision** of OSPF is, by 2016, through the leadership and stewardship of OSPF, Ohio will have culturally appropriate and strongly supported local capacity for prevention and reduction of suicides and will promote and emphasize statewide efforts for suicide reduction and prevention services for Ohioans throughout their lifespan.

C. Ohio Suicide Data

Suicide is a significant public health problem in Ohio. In 2010, 1,420 Ohioans died by suicide.¹ According to the Centers for Disease Control and Prevention, suicide is a leading cause of death for Ohioans 10-64 years of age and the second-leading cause of death for young Ohioans 15-34 years of age². Suicides in Ohio out-number homicides 2 to 1, and in 2010 more Ohioans died from suicide (1,420) compared to motor vehicle crashes (1,155).¹

Between 2000 and 2010 the death rate from suicide has increased by 27% from 9.5 per 100,000 persons in 2000 to 12.1 per 100,000 in 2010 (Figure 1).

Overall, males in Ohio are four times more likely to die by suicide compared to females. Between 2000 and 2010 rates for both males and females have increased. The suicide rate for males has increased by more than 18% from 16.9 to 20.0 per 100,000 persons; whereas the rate for females has increased by 45% from 3.3 to 4.8 per 100,000 persons (Figure 1).

The highest rates of suicide are among males aged 85 and older followed by males age 25-34, 45-54 and 35-44 year of age (Figure 2).

The majority of suicides (51%) resulted from firearms followed by hanging (26%) and poisoning (17%). Other mechanisms accounted for less than 7% of deaths. Between the time period of 2000 and 2010, the number of suicides as a result of hanging increased by 71% from 217 to 370 deaths. For the same time period suicides resulting from firearms and poisoning increased by 22% and 17%, respectively (Figure 3).

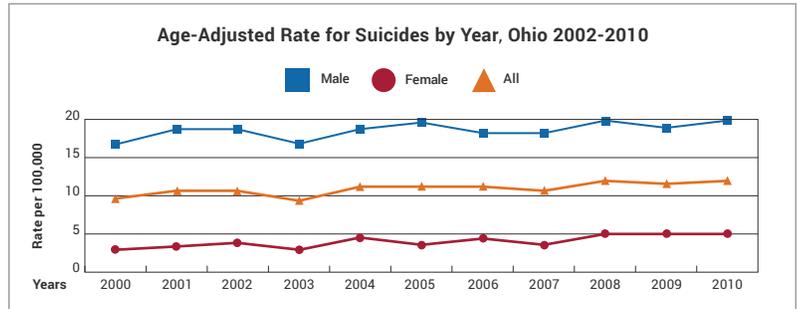


Figure 1. Source: Ohio Department of Health, Vital Statistics

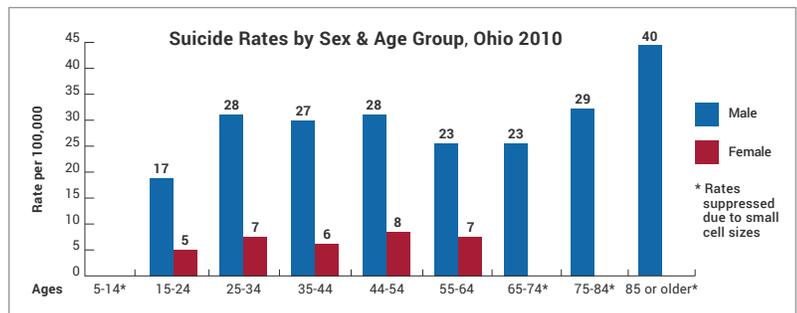


Figure 2. Source: Ohio Department of Health, Vital Statistics

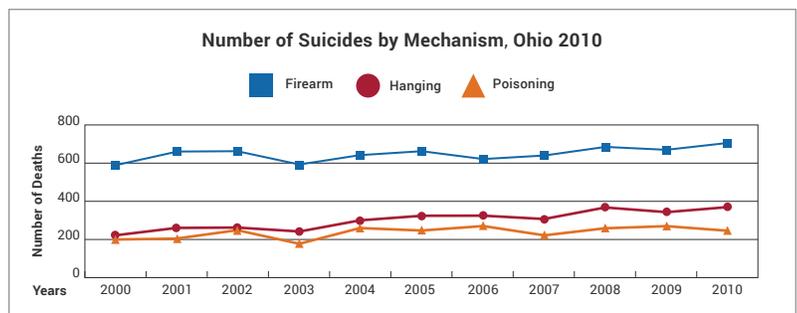


Figure 3. Source: Ohio Department of Health, Vital Statistics

¹ Falb M., Beeghly, B.C. (2013). *The Burden of Injury in Ohio 2000-2010*. Violence and Injury Prevention Program, The Ohio Department of Health: Columbus, OH

² Centers for Disease Control and Prevention. (2013) *WISQARS: Leading cause of death, Ohio 2010*. Retrieved at www.cdc.gov/injury/wisqars/leading_causes_death.html

Among young adults suicide is a serious problem. In 2011, approximately 1 in 7 or 14% of Ohio high school students reported to have seriously considered suicide in the past 12 months.

Female high school students (18%) were more likely to report suicide ideation than males (11%).¹ In addition, approximately 1 in 10 or 9% of Ohio high school students reported to have attempted suicide in the past 12 months.¹ The percentage of students who reported at least one suicide attempt was similar by sex and race or ethnic groups.¹

Also, in 2011, 1 in 25 or 4% of Ohio high school students reported an injury resulting from a suicide attempt in the last 12 months.¹ Ninth grade students were 2 times more likely to report a suicide attempt related injury than students in grades in 10, 11 or 12.¹

Roughly 90% of suicides are by persons who have been undiagnosed or untreated for depression, other mental illnesses and/or addiction. Ohio's average annual medical cost for suicide per year is \$3,879,185 and work loss costs for suicide per year are \$921,766,767.

D. Strategic Actions

The Strategic Plan 2013-2016 presents the organization's focus and direction for the next three years; it is more than an update of the board's initial plan (2008-2012). The past seven years of business maturity, county infrastructure development, increasing collaborations and recognition, have positioned OSPF to adopt a broader statewide stewardship role and systemic approach for moving prevention efforts up-stream, more fully integrating prevention and public health, and promoting sustainability for state and local suicide prevention programs.

The development of the strategic plan began in the summer of 2012 with a stakeholders planning retreat (See appendix for list of participants). This full day working session identified past accomplishments, future challenges, and elicited system-wide strategic themes for emphasis or concern. This compilation was reviewed and revised by the OSPF board and resulted in six strategic themes that would move the organization and the state towards accomplishment of its mission and vision. These themes are:

1. "Push" Suicide Prevention Upstream Through the Life Cycle
2. Foster the Use of Public Health Approaches for Suicide Prevention
3. Strengthen the Local Coalitions
4. Enhance Professional Education and Development
5. Prioritize Work with Military Personnel
6. Increase the use of Social Media, Technology, and Targeted Communications to Advance Social Marketing

For each of these strategic areas, OSPF Actions and Targeted Results specify and prioritize directions for 2013-2016 and lend structure to the next three annual work plans and operating budgets. In addition, **Blue text** references those parts of the National Strategy that relate to each of Ohio's strategic themes.

In addition, a seventh strategy, **Funding and Resource Development**, was added by the stakeholder review group. The complexity of the health services arena and the emphasis on wellness, community health, and universal prevention require, not only more funding contributors, but different ways of operating, different partnerships, and different financial, funding, and resource policies for OSPF.

1. "Push" Suicide Prevention Upstream

Many people may be surprised to learn that suicide was one of the top 10 causes of death in the United States in 2009. And death is only the tip of the iceberg. For every person who dies by suicide, more than 30 others attempt suicide. Every suicide attempt and death affects countless other individuals. Family members, friends, coworkers, and others in the community all suffer the long-lasting consequences of suicidal behaviors.

¹ Falb M., Beeghly, B.C. (2013). *The Burden of Injury in Ohio 2000-2010*. Violence and Injury Prevention Program, The Ohio Department of Health: Columbus, OH

Suicide prevention requires a combination of universal, selective, and indicated strategies. 9 Universal strategies target the entire population. Selective strategies are appropriate for subgroups that may be at increased risk for suicidal behaviors. Indicated strategies are designed for individuals identified as having a high risk for suicidal behaviors, including someone who has made a suicide attempt.

The goals and objectives in this strategic direction seek to create supportive environments that will promote the general health of the population and reduce the risk for suicidal behaviors and related problems.

Suicide prevention efforts have largely focused on activities to identify and provide help for those who are at-risk for suicide, but suicide prevention should also occur prior to the onset of risk to prevent the development of risk. Such “upstream” or universal prevention approaches may be able to reduce risk of suicide by eliminating the underlying causes and related behaviors. Suicide information, prevention, crisis intervention, and postvention must be integrated as part of a healthy, supportive environment “in which someone who is experiencing problems feels comfortable seeking help, and where families and communities feel empowered to link a person in crisis with sources of care and assist the person in attaining or regaining a meaningful life.” (U.S. Department of Health and Human Services (HHS) Office of the Surgeon General and National Action Alliance for Suicide Prevention)

Programs that help youth develop skills to cope with stress or that assist communities develop effective anti-bullying school environments, are examples of universal prevention that lower the risk of suicide and, subsequently, create inviting and healthy communities.

Specific OSPF Actions

- Engage a wide variety of partners, including organizations and programs that promote the health of children, youth, families, working adults, older adults, and others in the community in integrating suicide prevention in their work
- Create a specific “campaign” for suicide information and prevention targeted to patient centered medical homes and federally qualified health centers (FQHC)
- Promote, with all community partners, the necessity and inclusion of postvention plans; the responses after a suicide occurs to prevent further loss and support to survivors as they heal

Targeted Results

- Increase number and variety of partners; such as organizations and programs that promote the health of children, youth, families, working adults, older adults, and others in the community in integrating suicide prevention in their work, involved in OSPF activities
- Pilot with one patient centered medical home and one FQHC: full inclusion of “upstream” or universal prevention approach
- Inventory of “upstream” prevention resources applicable to grades K-12 and make available on website

2. Foster the Use of Public Health Approaches for Suicide Prevention

Suicide is a serious public health problem that causes immeasurable pain, suffering, and loss to individuals, families, and communities nationwide. The National Strategy’s fourth strategic direction addresses suicide prevention surveillance, research, and evaluation activities, which are closely linked to the goals and objectives in the other three areas. Public health surveillance refers to the ongoing, systematic collection, analysis, interpretation, and timely use of data for public health action to reduce morbidity and mortality. In contrast, research and evaluation are activities that assess the effectiveness of particular interventions, thereby adding to the knowledge base in the area of suicide prevention.

The collection and integration of surveillance data should be expanded and improved. In addition, although some evidence is available regarding the effectiveness of particular interventions and approaches, there is a need to assess the effectiveness of new and promising practices.

Public health approaches to suicide prevention involve surveillance, epidemiology, prevention research, communication, education programs, policies, and systems change. Ohio is rich in resources related to these approaches; but not organized or focused on suicide prevention or wellness promotion. Reporting, data management, and epidemiology should help describe the incidence and prevalence of the Ohio suicides and how suicide affects particular groups. These reports would help track trends in suicide rates over time, highlight changes in groups at risk and help evaluate suicide prevention efforts.

Specific OSPF Actions

- Work with university partners and state agencies to advocate for better scientific information (*surveillance, epidemiology, and prevention research*)
- Develop educational materials on suicide and suicide prevention for primary care and public health sites
- Collaborate with data reporting and management entities, epidemiologists, and county departments to improve consistency of incidence and prevalence data and Ohio Violent Data Reporting System
- Support and collaborate with partners to improve data quality and disseminate suicide data

Targeted Results

- A research advisory group to create an Ohio Research Agenda for Suicide Prevention that includes needed research, funding opportunities, and research dissemination
- Task Force of state epidemiologists and suicide prevention coordinators and local reporting entities to recommend ways to enhance the development of local reports on suicide and suicide attempts, and to integrate data from multiple data management systems
- Portfolio of current and Ohio research on suicide and suicide prevention and post on Website
- Brief assessment tool for emergency rooms and public health sites
- Collaborate with ODMH and Nationwide Children's Hospital to develop an electronic pediatric assessment tool
- Data dashboards developed for 50% of Local Coalitions
- Partner with Ohio Department of Health to produce a report that describes the incidence of suicide in Ohio, particularly among population and age groups by county

3. Strengthen the Local Coalitions

Suicide prevention is often organized differently at the state/territorial, tribal, and local levels, which can make it difficult for the many agencies and programs involved in suicide prevention to work collaboratively. Increased coordination of suicide prevention activities among these various partners could help improve services and outcomes, while promoting the greater sustainability of suicide prevention efforts over the long term. The type of collaboration that will work best may vary by state/territory, tribe, or community. Clarifying each agency's areas of focus and responsibility may be an important first step. This clarification can make it easier for different agencies to work together and to obtain support for their respective suicide prevention efforts. It also may be useful to identify a lead agency at the state and local levels that could help bring together different partners with a role to play in suicide prevention.

Currently, 85 Ohio counties have developed community coalitions that provide the structure for allied groups to pursue coordinated strategies for education and increased public awareness of suicide prevention. In 2013-2016, OSPF will strengthen the services and impact that these coalitions have on the lives of local constituents and the wellness of local communities.

Specific OSPF Actions

- Establish routine and consistent contact with coalitions by staff and board of OSPF
- Promote focus on "upstream" or universal prevention at local coalition level
- Support and encourage local coalition's participation in Drug-Free Action Alliance's Ohio Center for Coalition Excellence and the Statewide Prevention Coalition Association (SPCA)
- Determine baseline local coalition services and accomplishments
- Promote the use of evidence-based prevention programs
- Educate local coalitions regarding OSPF and National Strategy initiatives and priorities

Targeted Results

- Convene a yearly meeting of coalitions at OSPF annual conference
- Implement a template and schedule for board member and advisory board member meetings with local coalitions
- Provide training and resources on universal prevention approaches
- An online means of exchanging information and contacts between and among coalitions; *e.g., Skype and LinkedIn*
- Guidelines for baseline local coalition service menu and accomplishments
- Contract with an evaluator to do a formative and summative evaluation or needs assessment for coalitions which would include, but not be limited to: inventory of activities; volume, expectations, membership, penetration, and costs

4. Enhance Professional Education and Development

All community-based and clinical prevention professionals whose work brings them into contact with persons with suicide risk should be trained on how to address suicidal thoughts and behaviors and on how to respond to those who have been affected by suicide.

Although this goal focuses on reducing access to lethal means among individuals at risk, evidence for means restriction has come from situations in which a universal approach was applied to the entire population. Professionals who provide health care and other services to patients or clients at risk for suicide and their families and other caregivers are in a unique position to ask about the presence of lethal means and work with these individuals and their support networks to reduce access. These professionals may include health care providers, social service workers, clergy, first responders, school personnel, professionals working in the criminal justice system, and others who may interact with individuals in crisis. These providers can educate individuals with suicide risk and their loved ones about safe firearm storage and access, as well as the appropriate storage of alcoholic beverages, prescription drugs, over-the-counter medications, and poisons that may be available in the household. However, many may fail to do so, or do so only when a patient is identified as being at a very high risk for suicide.

While enhanced suicide prevention education is important for all community-based individuals who may come in contact with those at-risk for suicide, the pre-service and continuing education of those working in the health and social services fields is an important strategy for Ohio and its local communities. Current collaborations have obtained continuing education accreditation for most OSPF sponsored programming. However, the richness of higher education resources in Ohio provides a variety of opportunities for strengthening core competencies, continuing education and licensing requirements.

In addition, reducing access to means of suicide that are highly lethal and commonly used is a proven strategy for decreasing suicide rates; both at the selective and universal prevention levels. OSPF will work with its partners in the health and social service fields to encourage more priority on screening and reduction of lethal means with individuals, families, and communities.

Specific OSPF Actions

- Continue collaboration with universities and professional accreditation boards to accredit OSPF sponsored trainings and conferences
- Include suicide and suicide prevention education in professional and para-professional certification and licensing requirements
- Expand gatekeeper training particularly for military personnel
- Promote prevention, intervention, and postvention best practices
- Seek alternative partners for educational efforts such as school systems, VA, emergency rooms

Targeted Results

- Maintain professional CEU/CME for OSPF sponsored trainings and conferences
- Explore including suicide prevention skills and knowledge as part of licensing and certification requirements for primary care physicians, nurses, social workers, mental health counselors and other social service workers
- Pilot with one major hospital integrating prevention, intervention, and postvention topics into routine continuing education program
- Distribution of “Toolkits” for prevention, intervention, and postvention best practices
- Develop, distribute, and post on website an inventory on resources and best practices relevant to lethal means for those working in health and social services fields

5. Focus on Military Personnel

Suicide is one of the most important concerns of our time. Suicide among those who serve in our Armed Forces and among our veterans has been a matter of national concern.

The Centers for Disease Control and Prevention (CDC) estimates that veterans account for approximately 20% of the deaths from suicide in America.

Membership in a military culture may be one of the most powerful and enduring determinants of a person’s values, beliefs, expectations, and behaviors. Rarely is military service considered a minor event in a person’s life. Often, the values and identities they acquired on active duty will continue to be important as they move forward. However, service personnel and veterans are at increasing risk of self-harm. Research indicates that suicide, Post Traumatic Stress Disorder (*PSTD*), and Traumatic Brain Injury (*TBI*) rates are increasing alarmingly among veterans. The VA estimates that a veteran takes his or her own life every 80 minutes – 6,500 suicides per year. That’s 20% of all suicides in the United States. In 2012, it was estimated that Ohio had over 800,000 veterans.

Specific OSPF Actions

- Gain and promote throughout state and partnerships a deeper understanding of the military culture in order to enhance programs and services to especially returning vets and armory personnel
- Promote evidence-based practices for working with military personnel
- Expand gatekeeper training to military personnel; especially squad leaders
- Integrate information about suicide signs and symptoms into programs for military family members
- Determine best means of producing computer-based trainings for military use
- Promote military representation within local coalitions

Targeted Results

- Guidance to local coalitions and on military culture and working with military personnel
- Compile, distribute, and post on website a portfolio of evidenced-based best practices
- Showcase local projects at OSPF conferences , newsletters, and other OSPF communications
- Increase participation of military personnel and military family members in local coalitions
- Increased number of squad leaders and other appropriate personnel participating in gatekeeper training
- Decision on feasibility and implementation of computer-based trainings for military use

6. Advance The Use Of Social Media, Technology, And Targeted Communications

Suicide prevention efforts must consider the best ways to use existing and emerging communication tools and applications, such as websites and social media, to promote effective suicide prevention efforts, encourage help seeking, and provide support to individuals with suicide risk.

Communication efforts should target defined audiences, or segments of the population, such as groups with higher suicide risk, school personnel, or others. Demographic factors, such as age, income, or gender, may be used to identify different audience segments, along with factors related to the action being promoted. Efforts promoting behavior change should convey a clear call to action and provide specific information the audience needs to act.

OSPF will explore the use of social media and technology advances such as Facebook, smart-phones and relevant apps, tablets, and Twitter, to promote effective suicide prevention, encourage help seeking behaviors, and support communities, coalitions, and individuals. Additionally, communication campaigns and social marketing approaches will be targeted to specific audiences. Priority audiences include military personnel and families, primary care sites, grades K-12, and the LGBTQ community.

Information from federal and national agencies offer valuable guidance as a starting point for developing specific application and campaigns.

Specific OSPF Actions

- Create a social media and technology workgroup comprised of local coalition members and youth to develop recommendation for local coalitions and OSPF communication strategies
- Promote use of social media at OSPF conferences
- Develop, at least, three target communication campaigns

Targeted Results

- A resource inventory for use of social media in suicide prevention
- Targeted communication materials for military personnel and families, primary care sites, grades K-12, and the LGBTQ community
- General suicide prevention “infomercial” video to be used on website and in public sites
- Newsletter section providing information about new and emerging technology including, but not limited to, behavioral health “apps”, treatment technologies, and relevant social networking sites

7. Funding and Resource Development

The Ohio Suicide Prevention Foundation recognizes that the successful accomplishment of its strategic plan requires increasing the resources available, judicious decision making on expending and distributing funds, and creating sustainable funding sources for both OSPF and local coalitions.

Specific OSPF Actions

- Many of the specific actions outlined in other strategies will be initiated with an understanding that new partners, collaborators, and contributors will have a financial stake in the success of the particular action
- Continue to apply for grants that advance the mission of Ohio and OSPF. This may include seeking grants from different state and federal entities; as well as other foundations and private funders
- Seek out statewide business and industry entities that might partner with OSPF and contribute valuable organization and management resources
- Work with local coalitions to develop sustainable funding and resources

Targeted Results

- Increase funding and resources from, at least, three non-state agency entities
- At least, one statewide grant awarded to OSPF
- Add, at least, two members to the board of directors with business, corporate, or resource development experience
- Develop and present to local coalition representatives guidance for developing coalition sustainability

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Glossary

Prevention: A strategy or approach that reduces the likelihood of risk of onset or delays the onset of adverse health problems, or reduces the harm resulting from conditions or behaviors.

Universal preventive interventions take the broadest approach, targeting “the general public or a whole population that has not been identified on the basis of individual risk” (O’Connell, 2009). Universal prevention interventions might target schools, whole communities or workplaces.

E.g., community policies that promote access to early childhood education, implementation or enforcement of anti-bullying policies in schools, education for physicians on prescription drug misuse and preventive prescribing practices, social and decision-making skills training for all sixth graders in a particular school system.

Selective preventive interventions target “individuals or a population sub-group whose risk of developing mental disorders [or substance abuse disorders] is significantly higher than average”, prior to the diagnosis of a disorder (O’Connell, 2009). Selective interventions target biological, psychological, or social risk factors that are more prominent among high-risk groups than among the wider population.

E.g., prevention education for new immigrant families living in poverty with young children, peer support groups for adults with a history of family mental illness and/or substance abuse.

Indicated preventive interventions target “high-risk individuals who are identified as having minimal but detectable signs or symptoms foreshadowing mental, emotional, or behavioral disorder” prior to the diagnosis of a disorder (IOM, 2009). Interventions focus on the immediate risk and protective factors present in the environments surrounding individuals.

E.g., information and referral for young adults who violate campus or community policies on alcohol and drugs; screening, consultation, and referral for families of older adults admitted to emergency rooms with potential alcohol-related injuries.

<http://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/levels-risk-levels-intervention/2>

Postvention: the provision of crisis intervention, support and assistance for those affected by a completed suicide.

Local Coalition: a voluntary local community collaboration that provides the structure for allied groups to pursue coordinated strategies for education and increased public awareness of suicide prevention. 85 of Ohio’s 88 counties have established local coalitions for suicide prevention.

Best practices: Activities or programs that are in keeping with the best available evidence regarding what is effective.

Evidence-based programs: Programs that have undergone scientific evaluation and have proven to be effective.

Gatekeepers: Those individuals in a community who have face-to-face contact with large numbers of community members as part of their usual routine. They may be trained to identify persons at risk of suicide and refer them to treatment or supporting services as appropriate. Examples include clergy, first responders, pharmacists, caregivers, and those employed in institutional settings, such as schools, prisons, and the military.

Means: The instrument or object used to carry out a self-destructive act (*E.g., chemicals, medications, illicit drugs*)

Means restriction: Techniques, policies, and procedures designed to reduce access or availability to means and methods of deliberate self-harm.

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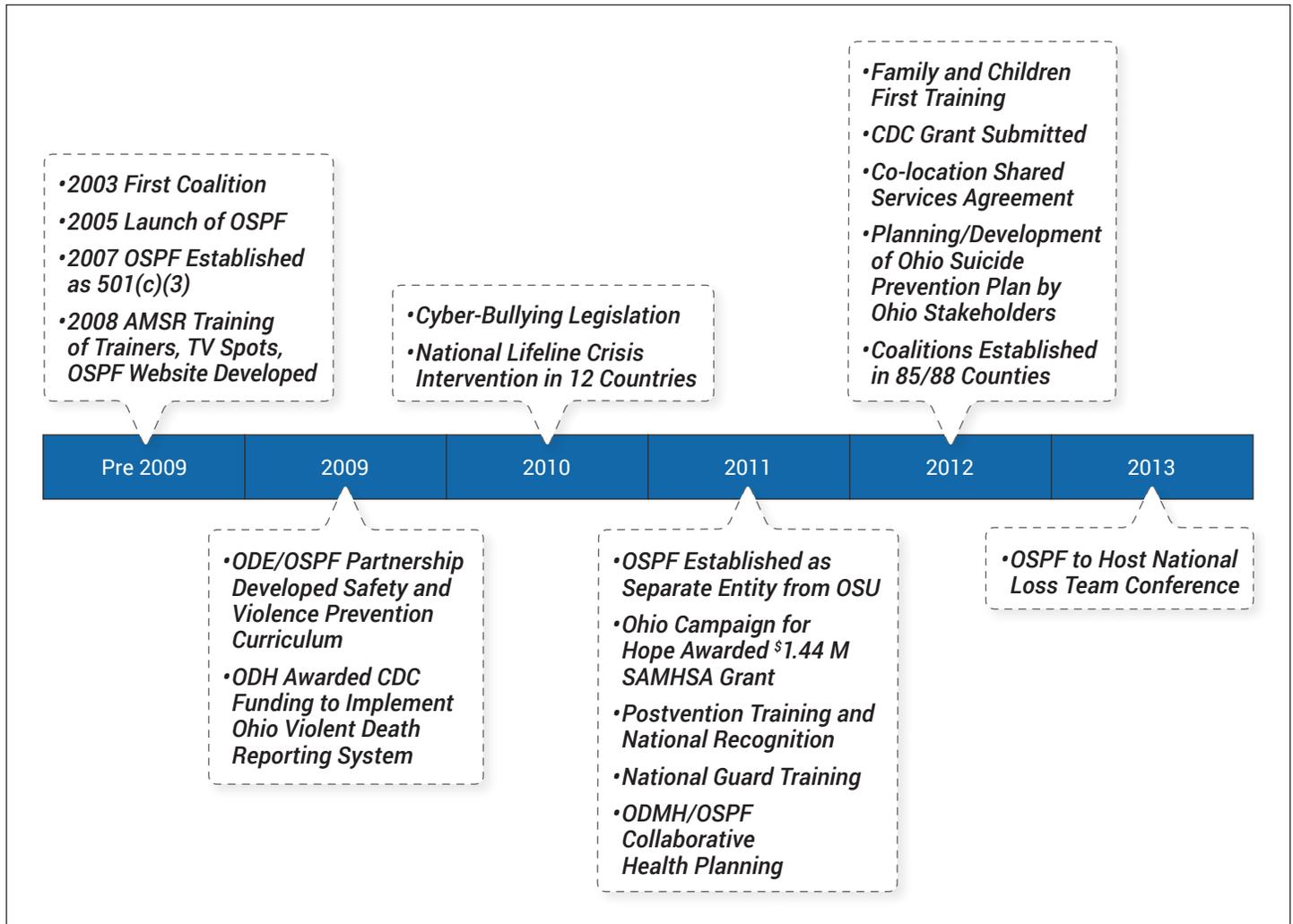
Note: Survivors of Suicide Loss are members of the various groups listed above and represent participation from a consumer level when it comes to the impact of suicide on an individual or family

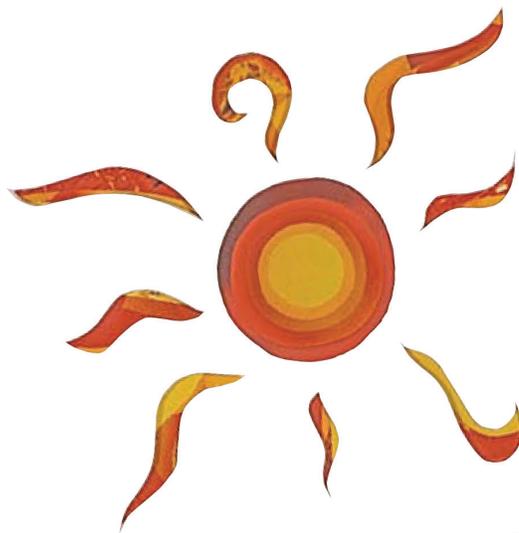
Accomplishments

The Ohio Suicide Prevention Foundation is thankful to the Ohio Department of Mental Health as well as the Ohio Department of Alcohol and Drug Addiction Services for the tremendous financial commitment that has been made to OSPF for over the past seven years. The encouragement and support that both Departments have provided has been paramount in helping to change the culture of health care in Ohio. OSPF accomplishments over the past seven years have been more than organizational. OSPF has given a voice to and received recognition for the issues of suicide and, especially the promotion of suicide prevention, intervention, and postvention best practices throughout Ohio. The following are some of the major accomplishments for OSPF and Ohio's suicide prevention efforts.

- ☑ *OSPF was launched in September 2005*
- ☑ OSPF became a 501(c)(3) in 2007
- ☑ At the end of SFY 2012, 85 of 88 County Suicide Prevention Coalitions established
- ☑ Since the inception of Ohio's Suicide Prevention efforts \$1,073,500 has been award to the community
- ☑ Gatekeeper trainings specifically designed to educate the public on the warning signs of suicide and steps to take to decrease risk with roughly 7,000 Ohioans trained. Eight Annual Suicide Prevention Conferences have been provided specifically to help enhance and transfer knowledge to County Suicide Prevention Coalitions
- ☑ 5 Annual Conferences have been provided specifically for survivors of suicide loss. OSPF website serves as the resource repository for suicide prevention
- ☑ A monthly OSPF E-newsletter is provided highlighting both national and state suicide prevention activity as well as up-to-date information on mental health and substance abuse
- ☑ OSPF provides advocacy and education related to suicide prevention to the Ohio Legislature, news media, Ohio businesses, other state agencies and a host of County partners
- ☑ OSPF established as separate entity from Ohio State University on June 30, 2011
- ☑ August 2011 OSPF awarded \$1.44 million three year SAMHSA Garrett Lee Smith Grant; Ohio's Campaign for Hope: Youth Suicide Prevention Initiative for Youth 15-24
- ☑ Summer 2012 OSPF joined Community for New Direction, Multiethnic Advocates for Cultural Competence and Mental Health America of Franklin County in a shared services agreement. Co-located to 2323 West 5th Ave. Grandview, sharing office services as much as possible
- ☑ Postvention Activities - OSPF is recognized as having the most Loss Teams in the world; 18 Coalitions sent 5 person teams to be trained in the evidence-based practice by Dr. Frank Campbell at the 8th Annual OSPF 2011 Conference
- ☑ OSPF has been asked to host to the National Loss Team Conference in September, 2013

Ohio Suicide Prevention Foundation (OSPF) Timeline





Depression is Among the Most Treatable of Psychiatric Illnesses



The Four County Suicide Prevention Coalition of Fulton, Williams, Henry and Defiance Counties held a "Stomp on the Stigma Campaign" on the Defiance College campus in September 2012. Throughout the month of September 180 pairs of shoes were displayed around the sidewalk at the College representing the 180 suicide deaths of Ohio Youth ages 15-24 in 2010.



Connecting for Life

IV: Narrative Plan

T. Use of Technology

Narrative Question:

In the FY 2012/2013 Block Grant application, SAMHSA asked states to describe:

- What strategies the state has deployed to support recovery in ways that leverage ICT;
- What specific application of ICTs the State BG Plans to promote over the next two years;
- What incentives the state is planning to put in place to encourage their use;
- What support system the State BG Plans to provide to encourage their use;
- Whether there are barriers to implementing these strategies and how the State BG Plans to address them;
- How the State BG Plans 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;
- How the state will use ICTs for collecting data for program evaluation at both the client and provider levels; and
- What measures and data collection the state will promote to evaluate use and effectiveness of such ICTs.

States must provide an update of any progress since that time.

Footnotes:

T. Use of Technology

OhioMHAS communicates with the public and stakeholders through Facebook, Twitter, YouTube and Flickr. OhioMHAS sends publications (such as News Now and the e-Update) via email to those who have signed up on our listserv. The Department's communication staff also post updated information on our website to keep the public informed about what our agency is doing.

YouTube Videos - By googling "Ohio Department of Mental Health and Addiction Services" on YouTube, anyone can find dozens of YouTube videos which include presentations on the budget, the strategic plan and many other topics by a variety of behavioral health leaders to Ohio's citizens. Director Plouck uses YouTube to provide weekly updates to staff on department business. She has also occasionally done video presentations for conferences and/or the SAMHSA Mental Health Block Monitoring Visit in August 2013 when she had a schedule conflict.

Engaging Youth and Young Adults First Responders - OhioMHAS developed a video to provide young people with information to be first responders to people in emotional crisis. The video is set up so that the viewer chooses different scenarios and responses. The six state hospital campuses regularly use video conferencing for meetings. Additionally, OhioMHAS also uses video conferencing for continuing education offerings.

Tele-health - The Department of Mental Health and Addiction Services Hospital Services Office has convened a Tele-Health workgroup to develop guidelines that support treatment team meetings via video conferencing technology. The guidelines address video connection between the state hospitals and community agencies for treatment team/discharge planning. The workgroups coordinate training, education and resolution of clinical decisions for purposes of improving overall performance of the state hospital system. The scope of these services will be within the individual providers' clinical privileges and ethical responsibilities. In addition, OhioMHAS has partnered with external entities to conduct state wide trainings for local funding and auditing boards, certified behavioral health treatment, prevention and recovery support provider; criminal justice entities, veterans, deaf community groups and other advocacy groups.

The Department supports increased access for persons in state hospitals to treatment planning, consultation and additional services. OhioMHAS will continue to coordinate information that supports the creation of tele-health services in Ohio for community based mental health and addiction services. Additionally, OhioMHAS will continue to provide opportunities for providers to present what they are doing in tele-health to a statewide and national audience.

Linking Community Agencies to State Hospitals - Community agencies that are linking into the state hospital tele-health system will not be charged for this service. The agency will need to ensure compatibility with the state system, and that secure and confidential processes are in

place. The tele-health project that is in process with the state hospitals will promote integration with primary health care and behavioral health providers consistent with the State BG Plan. MHAS is promoting the development of Health Care Homes for adults so that primary care needs of individuals returning to the community can be addressed.

Public-Private Hospital Partnership - In addition, Ohio has developed a Public-Private Partnership initiative that promotes collaboration between state hospitals (public) and private hospitals. It is possible that this partnership will include tele-health activities being used to benefit patient care and support continuity of services.

Evaluation - The Tele-health project with the state hospitals will begin with a pilot. MHAS research office staff participates in the Tele-health work group and will assist in evaluating the effectiveness of the program pilot. The goal is to include input from the patients, family members and community providers to improve the program and process as indicated.

IV: Narrative Plan

U. Technical Assistance Needs

Narrative Question:

States shall describe the data and technical assistance needs identified during the process of developing this plan that will facilitate the implementation of the proposed plan. The technical assistance needs identified may include the needs of the state, providers, other systems, persons receiving services, persons in recovery, or their families. Technical assistance includes, but is not limited to, assistance with assessing needs; capacity building at the state, community and provider level; planning; implementation of programs, policies, practices, services, and/or activities; evaluation of programs, policies, practices, services, and/or activities; cultural competence and sensitivity including how to consult with tribes; and sustainability, especially in the area of sustaining positive outcomes. 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.

1. What areas of technical assistance is the state currently receiving?
2. What are the sources of technical assistance?
3. What technical assistance is most needed by state staff?
4. What technical assistance is most needed by behavioral health providers?

Footnotes:

U. Technical Assistance Needs

In 2013, just prior to consolidation, ODADAS participated in two SAMHSA technical reviews, the first from the Center for Substance Abuse Treatment (CSAT) and the second from the Center for Substance Abuse Prevention (CSAP). While CSAP made recommendations in their site report to ODADAS, there were no formal technical assistance needs identified.

The Center for Mental Health Services (CMHS) visited the consolidated agency in August 2013. At this time, OhioMHAS has not identified any technical assistance needs. This may change once the formal site review reports are released.

IV: Narrative Plan

V. Support of State Partners

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, and education providers, as well as other state, local, and tribal governmental entities. States should identify these partners in the space below and describe how the partners will support them in implementing the priorities identified in the planning process. 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, entity(ies) responsible for health insurance and health information marketplaces (if applicable), adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and 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.⁴⁵ 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 justice system authorities that will work with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with mental and substance use disorders who come in 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, including efforts focused on enrollment.
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal 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 and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system. Specific service issues, such as the appropriate use of psychotropic medication, can also be addressed for children and youth involved in child welfare.
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities.

⁴⁵ SAMHSA will inform the federal agencies that are responsible for other health, social services, and education

Footnotes:

V. Support of State Partners

Health Homes for Individuals with Chronic Health Conditions: Collaboration with the Governor's Office of Health Transformation - The Governor's Office of Health Transformation was created by Executive Order 2011-02K signed by Governor John Kasich on January 13, 2011. The Office of Health Transformation was created to address Medicaid spending issues, plan for long-term efficient administration of the Ohio Medicaid program, and act to improve overall health system performance in Ohio. The Executive Order requires all Cabinet Agencies, Boards and Commissions to comply with any request or directives issued by the OHT Executive Director or the director's designee. Participating agencies under OHT are the Office of Budget and Management, Ohio Department of Administrative Services, Ohio Department of Job and Family Services, Ohio Department of Developmental Disabilities, Ohio Department of Mental Health, Ohio Department of Alcohol and Drug Addiction Services, Ohio Department of Health, and Ohio Department of Aging.

Strong Families, Safe Communities Project - During Spring 2013, the Ohio departments of Developmental Disabilities (DODD) and Mental Health & Addiction Services (OhioMHAS) sought collaborative community proposals to establish treatment models of care that focus on crisis stabilization for children and youth with intensive needs. This initiative will engage local systems to identify community-driven solutions that highlight collaboration across agencies to develop the best possible outcomes for children and families.

On July 2, 2013, DODD and OhioMHAS announced awards of nearly \$3 million out of a \$5 million grant to seven community partnerships to implement the Strong Families, Safe Communities project and to provide care coordination and crisis intervention services for youth at risk of harming themselves or others due to a mental illness or developmental disability. In addition to the grant awards, the project will train mental health and developmental disabilities services professionals in crisis intervention.

Access To Recovery - Access to Recovery (ATR) is a multi-year competitive discretionary grant program funded by the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT). ATR is a federal initiative which provides vouchers to clients for the purchase of alcohol and other drug (AoD) treatment and recovery support services. 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 treatment and recovery support services.

The former Ohio Department of Alcohol and Addiction Services (ODADAS) was first awarded the ATR grant in 2007 with a renewal award in 2010. Ohio's implementation of ATR is called, "Choice for Recovery" and it focuses specifically on adult men and women with an AoD diagnosis who are re-entering their community - initially implemented in Cuyahoga, Mahoning, Stark and Summit Counties with a later addition of Lorain County- following incarceration or other criminal justice system involvement. In order to access services, clients must be over 18 years of age, have an AoD diagnosis (current, or in remission), be a resident of one of the five counties listed above, have an income at or below 200 percent of the poverty level, and have a

history of criminal justice involvement. Clients are also required to have an AoD treatment assessment within the past year.

At the conclusion of the initial three year award period, 6,435 consumers had been provided treatment and recovery support services. ODADAS was awarded a second round of funding to continue the project in SFY 2010. ATR continues to provide Treatment and Recovery Support Services to the identified population established with the second round of funding, however, this new round allowed an additional County (Lorain) for geographic expansion and a newly identified population (adolescents) to be served for the duration of the grant.

Behavioral Health/ Juvenile Justice (BHJJ) -In partnership with the Ohio Department of Youth Services (ODYS), OhioMHAS 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.

Ohio Department of Youth Services (DYS) Re-Entry - This is a collaborative project of OhioMHAS, the ADAMHS/ADAS Boards and the Ohio Department of Youth Services that provides assessments, case management services, drug and alcohol testing, and life skills for offenders who are released from the state's juvenile prison system. DYS reentry projects are operating in Athens, Hocking, Vinton, Cuyahoga, Hamilton, Mahoning, Summit, Stark and Lucas Counties. In addition, this project provides funding for Smith House, a Therapeutic Community for youth transitioning from DYS institutions back to their communities.

Community Linkage Social Work Program – Ohio Department of Rehabilitation and Corrections and OhioMHAS have a formal partnership agreement for this program in which OhioMHAS social workers link offenders with SMI with clinical behavioral health services and recovery supports. Most of these offenders also have co-occurring substance use disorders. Additionally, this program recently expanded to include youth offenders being released from DYS.

Ohio's Coordinating Centers of Excellence (CCOES) - Ohio's Coordinating Centers of Excellence (CCOEs) were established by the former Ohio Department of Mental Health to promote the implementation of evidence-based practices and clinical best practices that address critical needs of adults and children affected by serious emotional disturbances and/or mental illness. Each of Ohio's seven CCOEs are supported by OhioMHAS and comprised of a unique mix of collaborative partners, including Ohio universities, consumer and family advocacy groups, research entities, provider organizations and local mental health boards. Their primary audience is agency-based mental health practitioners. They also work with other systems of care (e.g., substance abuse, criminal justice, education, rehabilitation services and developmental

disabilities). Each CCOE promotes a specific practice through training, consultation, fidelity assessment and/or outcomes evaluation. Partners in this effort include Case Western Reserve University, the University of Toledo, Wright State University, Northeastern Ohio University's College of Medicine and Pharmacy, Ohio Rehabilitation Services Commission, the Lorain County Community Mental Health Board, Ohio Department of Developmental Disabilities, Ohio Developmental Disabilities Council and Ohio's chapter of National Alliance on Mental Illness (NAMI Ohio).

The Governor's Cabinet Opiate Action Team - Under Governor John R. Kasich's leadership, the Governor's Cabinet Opiate Action Team (GCOAT) was established to address the continuing epidemic of misuse and abuse and overdose from prescription opioids. The GCOAT consists of five working groups: (1) Treatment--includes Medication Assisted Treatment; (2) Professional Education; (3) Public Education; (4) Enforcement; and (5) Recovery Supports. Partners in this effort include the Ohio Bureau of Worker's Compensation, Ohio Department of Health, Ohio Department of Public Safety, State Medical Board of Ohio, State Pharmacy Board of Ohio and the Ohio Attorney General's Office.

OHIOCARES - OHIOCARES is a collaboration of the Ohio Adjutant General, the Ohio Department of Mental Health and Addiction Services, community behavioral health boards and provider organizations to improve access to timely and appropriate community services to veterans, service members and their families.

A key purpose of OHIOCARES is to enhance the "safety net" of community behavioral health services available for military personnel and their families and to complement the services available through the Department of Veterans Affairs and Vet Centers by linkages with county alcohol, drug and mental health boards and behavioral health care providers.

Public- Private Partnership Initiative - Leadership from the Ohio Department of Mental Health and Addiction Services (OhioMHAS), the Ohio Association of County Behavioral Health Authorities (OACBHA), the Ohio Council of Behavioral Health and Family Services Providers, and the Ohio Hospital Association (OHA) developed the Private Public Partnership initiative. This initiative was developed to support collaboration between Ohio's hospital/community systems; share innovative approaches/best practices and develop common goals to enhance outcomes for our consumers.

This concept was rolled out at the Public/Private Inpatient Psychiatric Services Leadership Conference on November 16, 2012. More than 250 individuals attended that event, which included presentations focused on several innovative, collaborative strategies throughout the Ohio. The conference encouraged regional groups meet and identify actionable work plans.

Faith Based Initiatives - Faith is rooted in the traditions, beliefs and values of most cultures. It shapes world views and provides an important way for people in the community to come together and receive information. When experiencing mental illness, people often return to their faith-based roots for support to understand their illness. Faith-based initiatives offer great

opportunities for organizations to partner with institutions of faith to share information with parishioners on recovery and resiliency for overall wellness.

One of the faith-based initiatives that the Ohio Department of Mental Health & Addiction Services (OhioMHAS) supports is Tova's N.E.S.T. (Nutrition, Education, Sleep, Therapy) Inc.

The vision of Tova's N.E.S.T. is to raise the awareness of the African American faith-based community, populations at risk and other systems regarding mental health issues, substance abuse disorders and suicide prevention. It also works to eliminate stigma while promoting recovery and resiliency.

Therapeutic Communities - The Ohio Department of Mental Health and Addiction Services (OhioMHAS)- created and is supportive of a full continuum of care using the Therapeutic Community method of treatment. This continuum includes: institutional programs, community based correctional facilities, county jail, halfway houses, community residential, outpatient and TC self-help groups. These programs have a client focus that can be: male or female, adult or juvenile, correctional or non-correctional, or dual diagnosis. The Department provides training and technical assistance upon request.

The Therapeutic Community approach has been proven to be a most effective method for clients to address their alcohol and/or drug dependence and related behaviors. During the course of their residential treatment they develop and practice new behaviors, which support a substance free life style. The Therapeutic Community forms a client community that is a microcosm of the larger outside community. In this way the community becomes a method of change. The community members throughout the treatment give each other feedback about one another's behaviors. In this microcosm the clients have the opportunity to learn and practice pro-social behaviors and responses.

Each client will earn their way through phases based on their clinical goals and community behavior. With each phase movement, the client's responsibilities and privileges are increased. The client's final phase is the reentry phase in which their transitional issues are addressed. These include, but are not limited to, sober support (AA, NA, CA, Winners Circle) employment, family issues, ongoing treatment (mental health) and physical health.

ODADAS, in cooperation with ODRC, opened a Therapeutic Community inside the Pickaway Correctional Institution for men. The program originated in 1992 as the first male prison based Therapeutic Community in Ohio. Due to its success, this program has been expanded to 178 beds. The OASIS program in 2005 created the first IPP (Intensive Program Prison) TC at the request of ODRC. The IPP units are designed to provide inmates with focused intense treatment for identified areas of concern. This part of the OASIS program was chosen to present the program to the World Federation of Therapeutic Communities world conference in September 2006. The program became the first institutional based TC to be accredited by the American Correctional Association in Ohio.

Indigent Drivers Alcohol Treatment Fund - The Indigent Drivers Alcohol Treatment Fund was created by Am. Sub. SB 131 of 118th General Assembly. The Ohio Revised Code (RC

4511.191(H) (1)) requires an Indigent Drivers Alcohol Treatment Fund for each county and municipality where there is a municipal court. RC 4511.191(H) (1) also requires each county to establish a juvenile court Indigent Drivers Alcohol Treatment Fund. RC 4511.191(F)(2)(c) states that the money "shall be used only to pay the cost of alcohol and drug addiction treatment program attended by an offender...who is determined by the judge... not to have the means to pay for attendance at the program". RC 4511.191(H) (3) goes on to say that the offender needs to be a drunken driving offender, who is ordered to attend drug and alcohol treatment. Payment shall only be made by court order. Ohio has been fortunate to have a funding stream to access the appropriate AoD (alcohol and other drug) treatment services to assist indigent offenders convicted of operating a vehicle under the influence of alcohol or drugs. The indigent drivers alcohol treatment fund (IDAT) allows courts in Ohio to utilize necessary treatment services for offenders charged with OVI who would otherwise not be able to afford such services. Funding may also be utilized for the continued use of an electronic monitoring device in conjunction with treatment services when clinically necessary.

Treatment Alternatives to Street Crime (TASC) - The Ohio TASC initiative began in 1991 with the inception of the Preble County TASC Program which is funded in its entirety by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). Within one year, six additional TASC programs were established through a collaborative funding agreement between the Office of Criminal Justice Services and ODADAS. The State implemented the TASC model to improve the delivery of alcohol and other drug treatment services for the offender population. On July 1, 1996, ODADAS became the sole funder of the original seven TASC programs. The Department now funds fourteen TASC programs statewide.

TASC's mission is to build a bridge between the criminal justice and treatment systems which have differing philosophies and objectives. The model targets nonviolent alcohol and drug dependent felons and misdemeanants and has enhanced existing correctional supervision programs. TASC identifies chemically dependent offenders, provides assessments and makes referrals for the most appropriate drug treatment. Other key functions include case management services and drug testing. TASC case managers work closely with judges, probation officers, jail administrators and treatment providers to provide effective and comprehensive programming.

Ohio Drug Courts - The Ohio Supreme Court is a key partner with OhioMHAS in developing and expanding Ohio's drug courts. A drug court is a specialized docket that handles cases involving substance abusing offenders through comprehensive supervision/ case management, drug testing, treatment services and immediate sanctions and rewards. Family drug court programming is also in place for drug involved parents who are charged with abuse/neglect/dependency of their minor children.

Each drug court creates a team that meets with the judge to staff cases, provide updates and make recommendations based on participant performance. The drug court team is made up of: probation officers, prosecutors, defense counsel, TASC personnel, substance abuse treatment counselors, school officials, children services personnel and other ancillary service providers.

Circle for Recovery - OhioMHAS partners with the Ohio Department of Rehabilitation and Correction, therapeutic community, Urban Minority Alcoholism and Drug Abuse Outreach

Programs (UMADAOPs) and others to improve the service delivery system for African-Americans and non-dominant cultural groups who have been incarcerated upon re-entry. Circle for Recovery programs provide culturally relevant relapse prevention, re-entry and recovery support services. The services provided include employment, education, family re-unification and social reintegration services, peer support, health education including violence prevention services and crisis intervention services.

Adoption and Safe Families Act - Ohio's response to Adoption and Safe Families Act, H.B. 484, was signed into law on December 17, 1998. This bill exceeded the federal standards by specifying that child abuse or neglect associated with parental substance abuse could be grounds for termination of custodial rights. FRS also emphasized the need to provide timely and appropriate treatment necessary to facilitate family reunification. Each state fiscal year, four million dollars is allocated for the provision of treatment to families who are in danger of having their children removed from their homes due to abuse and neglect as a result of substance abuse. FRS charged OhioMHAS, in cooperation with the Ohio Department of Jobs and Family Services to develop a statewide plan to prioritize substance abuse services for families involved in the child welfare system. The following tasks were also delineated in the bill:

- Improve accessibility and timeliness of alcohol and other drug services for the FRS population;
- Define information sharing needs and methods for addressing confidentiality issues;
- Request that the General Assembly appropriate an amount of funds to be used by the Departments to pay for services under Section 340.15 of the Ohio Revised Code;
- Jointly review and amend the plan as necessary; and
- Submit a joint report on the progress made under the plan to the Governor, Speaker of the House and President of the Senate not later than July 1st of each even-numbered year, addressing needs assessment, treatment capacity and the number of individuals who received services

Child welfare professionals have long recognized the impact of parental substance abuse on child maltreatment. Daily, caseworkers must accurately assess each child's safety based on the parent's level of functioning. The dynamics of substance abuse, a chronic condition often characterized by relapse, particularly challenge caseworkers to evaluate the parent's ability to provide needed care and supervision within a safe environment. The shortened time frames for establishing permanency mandated by H.B. 484 (i.e., the child welfare agency must file a motion addressing permanency if the child has been in care 12 of 22 months) further intensify the need to concurrently address the problems of substance abuse and child maltreatment.

Given the multiple demands for effective client care, OhioMHAS and ODJFS continue to identify treatment needs, gaps in services, and opportunities for joint programming to address them. Data for the current 484 needs assessment have been derived from a variety of sources including: the Alcohol, Drug Addiction and Mental Health Services/Alcohol and Drug Addiction Services (ADAMHS/ADAS) Boards, Public Children's Services Agencies (PCSAs), ODADAS Community Plan Updates, OhioMHAS research project findings, OhioMHAS' and ODJFS' information systems, the Public Children's Services Association of Ohio (PCSAO), *System of Care* project analyses, Ohio's Strategic Plan to address Fetal

Alcohol Spectrum Disorders (FASD), the federal Child and Family Services Review, the Ohio Department of Health (ODH), and reports from the Supreme Court of Ohio's Specialized Docket Programs.

Ohio Family and Children First – OhioMHAS collaborates with other child serving agencies in this statewide coordination of local Family and Children First organization which coordinate care for children whose service needs span multiple systems of care. These systems of care typically include a combination of mental health and addiction service, child welfare services, juvenile justice, developmental disabilities, special education and/or physical disabilities. This collaboration is supported by a formal interagency agreement.

Parent Advocacy Connection – NAMI-Ohio and OhioMHAS have a formal agreement for parents of youth with SED to work with other families facing similar issues to provide advocacy and mentorship. For example, PAC staff may attend IEP (Individual Educational Plan) conferences with parents, and mentor them on advocating for their children in working with school officials.

Race to the Top Early Learning Challenge Grant – OhioMHAS partners with Ohio Department of Education through a formal agreement in a formal competitive grant process to hire 17 early childhood consultants. These consultants will work with parents and teachers for children at-risk of being removed from classrooms for behavioral issues.

Early Childhood Mental Health Consultation – ODJFS – Child Welfare has a formal agreement to partner with ODMH on early childhood mental health consultation to parents, caregivers, daycare centers and pre-schools to reduce the risk of specifically identified children being removed from schools or daycare for emotional problems. This is long standing program which pre-dates the new Race to the Top Early Learning Challenge Grant.

Help Me Grow – OhioMHAS has a formal agreement to collaborate with Ohio Department of Health on this program which provides intervention for pre-school children in their homes.

Adult Care Facilities Repairs – Ohio Housing Finance Agency has a formal agreement with OhioMHAS to collaborate on the critical repairs of adult care facilities. Many of these “mom & pop” adult care facilities are small operators who provide care for a few persons with serious and persistent mental illness who experience significant disability due to their mental illness and/or other co-occurring conditions including developmental disabilities, substance abuse, cardiovascular disease and/or diabetes. Repairs are basic structural repairs such as fixing leaky roofs.

Peer Support – Ohio Rehabilitation Services Commission, OhioMHAS and Boards have a program in which local Boards match RSC funds to pay for peer support training, and paid internships as peer support staff in local mental health systems. Additionally, OhioMHAS has funded Ohio Empowerment Coalition, the statewide consumer organization, to provide peer support training.

IV: Narrative Plan

W. State Behavioral Health Advisory Council

Narrative Question:

Each state is required to establish and maintain a state Behavioral Health Advisory Council (Council) for services for individuals with a mental disorder. While many states have established a similar Council for individuals with a substance use disorders, that is not required. SAMHSA encourages states to expand their required Council's comprehensive approach by designing and use the same Council to review issues and services for persons with, or at risk of, substance abuse and substance use disorders. In addition to the duties specified under the MHBG statute, a primary duty of this newly formed Council will be to advise, consult with, and make recommendations to SMHAs and SSAs regarding their activities. The Council must participate in the development of the MHBG state plan and is encouraged to participate in monitoring, reviewing, and evaluating the adequacy of services for individuals with substance abuse and mental disorders within the state. SAMHSA's expectation is that the State will provide adequate guidance to the Council to perform their review consistent with the expertise of the members on the Council. States are strongly encouraged to include American Indians and/or Alaska Natives in the Council; however, their inclusion does not suffice as tribal consultation. In the space below describe how the state's Council was actively involved in the plan. Provide supporting documentation regarding this involvement (e.g., meeting minutes, letters of support, etc.)

Additionally, please complete the following forms regarding the membership of your state's Council. The first form is a list of the Council members for the state and second form is a description of each member of the Council.

There are strict state Council membership guidelines. States must demonstrate (1) that the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council and (2) that no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services. States must consider the following questions:

- What planning mechanism does the state use to plan and implement substance abuse services?
- How do these efforts coordinate with the SMHA and its advisory body for substance abuse prevention and treatment services?
- Was the Council actively involved in developing the State BG Plan? If so, please describe how it was involved.
- Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into the work of the Council?
- Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
- Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders.

Footnotes:



August 20, 2013

Virginia Simmons
Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road
Rockville, MD 20857

RE: Ohio's Substance Abuse and Mental Health Block Grant Application

Dear Ms. Simmons.

The Ohio Community Support Planning Council voted to support the Ohio Department of Mental Health and Addiction Services first combined Substance Abuse and Mental Health Block Grant application for fiscal years 2014 – 2015. The Block Grant Committee reviewed a draft version of the application, and recommended that the Council approve the Plan. Additionally, the Council has met with Director Tracy Plouck to discuss the mental health system, as well as made some funding recommendations.

Sincerely,

Patrick Risser
Chair
Ohio Community Recovery Support Planning Council

W. State Behavioral Health Advisory Council

State staff drafted the Substance Abuse and Mental Health Block Grant with input from Planning Council and other stakeholders including local Boards, providers and stakeholder organizations. State staff also gathered additional information to use in the Block Grant Plan from local Community Plans and OhioMHAS' draft Strategic Plan. Also, Behavioral Health Leadership, Treatment Roundtable and Prevention Roundtable provide additional information from their constituents for the Plan.

Planning Council hears presentations from many of these groups mentioned in the preceding paragraph, meets with the Director twice a year, and has a committee to review the draft Block Grant Plan. The committee commented on the Plan, and recommended approval by the full Council of the Plan. The Council voted to support the Plan at their August 17, 2013 meeting. The Chairperson signed the attached letter stating that the Council voted to support the Plan.

For SFY 2014 – 2015, the Council reviewed a combined Mental Health and Substance Abuse Block Grant Plan, and made comments to staff who previously worked for both state agencies. The Council changed its by-laws effective July 1, 2013 to include substance abuse, prevention and treatment, as well as co-occurring disorders. Staff members with expertise in addiction disorders recruited the new members representing addiction services and worked with an ad hoc committee of Planning Council members. Additional staff members and persons in recovery with addiction expertise met with a small group of Planning Council members to draft the by-laws to change the scope and membership of the Council. Since then, the Council has had one meeting at which organizational representatives from addiction services were included. Specific individuals in recovery from addiction and family members have been invited to the next meeting. We hope to complete the process of fully integrating addiction services into the Council's activities over the next six months.

The Council has representatives of various ethnic and linguistic groups, as well as rural, suburban and older adult members. Families of young children are also represented.

Council members gather information from their communities and advocacy activities in Ohio's mental health and substance abuse system. They hear presentations at Council meetings, and ask many questions of staff including Director Tracy Plouck. Council members were invited to comment on OhioMHAS' Strategic Plan, as well as the Mental Health Block Grant.

IV: Narrative Plan

Behavioral Health Advisory Council Members

Start Year:

End Year:

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Mark Smith	State Employees		Ohio Dept. of Education , 25 S. Front Street Columbus, OH 43235 PH: 614-301-4902	Mark.Smith@ode.state.oh.us
Sue Williams	State Employees		Ohio Dept. of Job & Family Services - Child Welfare, 50 West Town St., 6th floor Columbus , OH 43215 PH: 614-752-1119	susan.williams@jfs.ohio.gov
Robyn Hoffman	State Employees		Ohio Dept. of Rehabilitation and Corrections , 770 N. Broad Street Columbus, OH 43215 PH: 614-373-2515	Robyn.Hoffman@odrc.ohio.gov
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
Karen Fabiano	State Employees		Department of Development - housing, 77 S. High Street Columbus, OH 43216 PH: 614-466-3144	Karen.Fabiano@development.ohio.gov
Brynes Jane	State Employees		Ohio Dept. of Aging, 50 West Broad Street Columbus, OH 43215 PH: 614-728-5950	jbrynes@age.state.oh.us
Esther Branscome	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Lancaster, OH 43130	mrsbranscome@gmail.com
Steve Copper	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Waverly , OH 45690	stillmeadowfarms@yahoo.com
Ken Jones	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Cincinnati, OH 43219	jones7990@yahoo.com
Pat Risser	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Ashland, OH 44805	patrickrisser@gmail.com
Cassandra Rufat	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Nelsonville, OH 45764	rufat@att.net

Individuals in Recovery (to

Raphael Weston	include adults with SMI who are receiving, or have received, mental health services)	Columbus, OH 43215	raphaelweston@yahoo.com
Jeannie Copper	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Waverly , OH 43590	stillmeadowfarms@yahoo.com
Angela Scheopfin	Parents of children with SED	Represents Ohio Federation for Children's MH- NAMI St. Paris, OH 43072	seigna72@hotmail.com
Linda Gable	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Multi-ethnic Advocates for Cultural Competence Columbus, OH 43231	lgable38@yahoo.com
Gloria Walker	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI - Ohio Cincinnati , OH 45207	gwconsultingandeducation@earthlink.net
Victoria Webb	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Ohio Empowerment Coalition Mentor, OH	webvj3@hotmail.com
Deborah Miller	Providers	5400 Edalbert Drive Cincinnati, OH 45239 PH: 513-519-8908	deb.million@sjokids.org
Jennifer Moses	Providers	Zeph , 6605 West Central Avenue Toledo, OH 43617	jmoses@zepfcom.com
Dontavius Jarrells	Providers	Ohio Assoc. of County BH Authorities (Board Assoc.), 33 N. High St., Suite 500 Columbus, OH 43215 PH: 614-224-1111	Djarrells@oacbha.org
Debbie Moscardino	State Employees	Ohio Dept. of Medicaid, 30 E. Broad St. Columbus, OH 43215 PH: 614-752-3633	Debra.Moscardino@medicaid.ohio.gov
Carrie Haughawout	State Employees	Department of Insurance, 400 E. Campus View Blvd. W A2 Columbus, OH 43215 PH: 614-728-1015	Carrie.Haughawout@insurance.ohio.gov
Cheryl Crayden	Parents of children with SED	Orville, OH 44667	cherylcrayden@zoominternet.net
Kathleen Stanley	Parents of children with SED	Creston , OH 44217	kpez0718@aol.com
Amy Eaton	State Employees	Dept. of Job & Family Services, 50 W. Town St., 6th floor, Social Services Block Grant Columbus, OH 43215 PH: 614-752-1119	amy.eaton@jfs.ohio.gov
Sarah Nerad	Others (Not State employees or providers)	Dublin, OH 43016	sarah@ptassociates.com
Sarah Smitley	Parents of children with SED	Van Wert, OH	smsmitley@yahoo.com
Sara Sheline	Others (Not State employees or providers)	Lancaster , OH 43130	sheinesara@yahoo.com
Richard Russell	Others (Not State employees or providers)	Portsmouth , OH 45662	quitsthecat@hotmail.com
Walter Asbury	Others (Not State employees or providers)	Canal Winchester, OH 43110	waltasbury@hotmail.com

Jennilee Mohler	Others (Not State employees or providers)	PAIMI representative Perrysburg , OH 43551	JJWBJ1@hotmail.com
Kathy Newman	Others (Not State employees or providers)	SOLACE - representative Portsmouth, OH 45662 PH: 740-357-0559	kathryn4378@yahoo.com
Myrtle Boykin-Lighton	Providers	809 W. Vine Street OH 45814 PH: 419-699-6648	mwlighton@yahoo.com
Domina Page	Providers	1059 N. Market St. Troy 45373 PH: 937-335-4534	dpage@mrcrinc.org
Francisco Alfonzo	Providers	3305 W. 25th Street Cleveland, OH 44109 PH: 216-485-5702	falfonzo@hispanicumadaop.org
Patrick Colburn	Others (Not State employees or providers)	Cincinnati , OH	pat@coburns.us
Love Singleton III	Providers	1524 Roland Ave. NE, Youth addiction provider Canton, OH 44705 PH: 330-453-8252	loves@questrs.org

Footnotes:

Ohio changed its by-laws effective July 1, 2013 to include an equal number of persons representing addiction issues and persons representing mental health issues, and has filled most of the new seats. Since our membership terms expire December 30, 2013, we are in a transition phase where we bringing on new members as terms expire. We expect to have all of our new members in place by January 1, 2014. Additionally, Dontavius Jarrells, who represents the Ohio Association of County Behavioral Health Authorities is incorrectly listed as a "provider" because there is no place to list a non-profit organizations which represent county governments (ADAMH/ADAS/CMH Boards) on WebBGAS---which really belongs in the state employee/provider category.

IV: Narrative Plan

Behavioral Health Council Composition by Member Type

Start Year:

End Year:

Type of Membership	Number	Percentage
Total Membership	39	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	7	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	<input type="text" value="1"/>	
Others (Not State employees or providers)	7	
Total Individuals in Recovery, Family Members & Others	22	56.41%
State Employees	9	
Providers	7	
Federally Recognized Tribe Representatives	0	
Vacancies	<input type="text" value="1"/>	
Total State Employees & Providers	17	43.59%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="8"/>	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	<input type="text" value="3"/>	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	11	
Persons in recovery from or providing treatment for or advocating for substance abuse services	<input type="text" value="10"/>	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

Planning Council had a committee review the Block Grant Plan, and supported the Plan as written. Please see letter signed by Chair in the previous section, W. State Behavioral Health Council.

Footnotes:

Planning Council is expected to be at 50% representatives for addiction services and 50% for mental health services by January 1, 2014. The Council changed its by-laws effective July 1, 2013 to incorporate addiction services. Since terms don't expire until December 31, 2013, we will

wait six months to fill some seats. The majority of seats have already been filled.

IV: Narrative Plan

X. Enrollment and Provider Business Practices, Including Billing Systems

Narrative Question:

Each state is asked to set-aside three percent each of their SABG and MHBG allocations to support mental and substance use service providers in improving their capacity to bill public and private insurance and to support enrollment into health insurance for eligible individuals served in the public mental and substance use disorder service system. The state should indicate how it intends to utilize the three percent to impact enrollment and business practices taking into account the identified needs, including:

- Outreach and enrollment support for individuals in need of behavioral health services.
- Business plan redesign responsive to the changing market under the Affordable Care Act and MHPAEA.
- Development, redesign and/or implementation of practice management and accounts receivable systems that address billing, collection, risk management and compliance.
- Third-party contract negotiation.
- Coordination of benefits among multiple funding sources.
- Adoption of health information technology that meets meaningful use standards.

Footnotes:

X. Enrollment and Provider Business Practices Including Billing Systems

OhioMHAS did not set aside three percent of the SABG and MHBG for this planning period for enrollment and provider business practices.

IV: Narrative Plan

Y. Comment on the State BG Plan

Narrative Question:

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) requires that, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the State BG Plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to the Secretary of HHS.

Footnotes:

Y. Comment on the State Block Grant Plan

The Ohio Department of Mental Health and Addiction Services' combined FY 2014 - 2015 Substance Abuse and Mental Health Block Grant Application is made available on the Department's web site for review and comment. Notification is sent to County Commissioners, ADAMHS/ADAS/CMH Board executive directors, mental health and addiction provider executive directors, and key constituents and associations including Ohio Association of County Behavioral Health Authorities, Ohio Council of Behavioral Healthcare Providers, Ohio Citizen Advocates for Chemical Dependency Prevention and Treatment, Ohio Empowerment Coalition, Drug Free Action Alliance, NAMI-Ohio, Ohio Association of Child Caring Agencies, Public Children Services Association of Ohio, Alcohol and Drug Abuse Prevention Association of Ohio, Ohio Association of Convenience Stores, and Ohio Community Recovery Planning Council.

The Department will also maintain a pdf version of the Block Grant on its website for both the general public and key constituents identified above. Notification of the addition of this posting will be made through the Department's E-update communications.

Public comments are rare and generally involve questions regarding who can apply for the block grant. All public comments/inquiries receive a response.