Ohio

UNIFORM APPLICATION
FY 2016/2017 - STATE BEHAVORIAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 06/30/2018
(generated on 09/01/2015 12.58.52 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2016
End Year	2017

State SAPT DUNS Number

Number	808847669
Expiration Date	

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

Agency Name	Ohio Department of Mental Health and Addiction Services
Organizational Unit	Office of Planning, Quality and Research
Mailing Address	OhioMHAS 30 East Broad Street, 8th floor
City	Columbus, OH
Zip Code	43215

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

First Name	Sanford
Last Name	Starr
Agency Name	Ohio Department of Mental Health and Addiction Services
Mailing Address	OhioMHAS 30 East Broad Street, 36th floor
City	Columbus, OH
Zip Code	43215
Telephone	614-644-8316
Fax	
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 Department of Mental Health and Addiction Services
Organizational Unit	Office of Planning, Quality and Research
Mailing Address	OhioMHAS 30 East Broad Street, 8th floor
City	Columbus
Zip Code	43215

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

First Name	Elizabeth
Last Name	Gitter
Agency Name	Ohio Department of Mental Health and Addiction Services
Mailing Address	30 East Broad Street, 36th Floor

City	Columbus
Zip Code	43215
Telephone	614-466-9963
Fax	
Email Address	Elizabeth.Gitter@mha.ohio.gov

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

From	
To	

IV. Date Submitted

Submission Date	9/1/2015 12:57:44 PM
Revision Date	

V. Contact Person Responsible for Application Submission

First Name	Elizabeth
Last Name	Gitter
Telephone	614-466-9963
Fax	
Email Address	Elizabeth.Gitter@mha.ohio.gov

Footnotes:

Alternate Contact Responsible for Submission of Block Grant: Sanford.Starr@mha.ohio.gov, phone 614-644-8316

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

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
Tile 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**
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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**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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 OPMâ€™s Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685-1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327-333), regarding labor standards for federally assisted construction subagreements.

10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g) protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).
12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION 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). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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 childrenâ€™s services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to childrenâ€™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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for childrenâ€™s services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tracy J. Plouck

Signature of CEO or Designee[1]: _____

Title: Director, Ohio Department of Mental Health and Addiction Services

Date Signed: _____

mm/dd/yyyy

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

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

77 SOUTH HIGH STREET • 30TH FLOOR • COLUMBUS, OHIO 43215-6117 • 614.466.3555

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2016

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

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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.
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

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2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tracy J. Plouck

Signature of CEO or Designee[1]: T Plouck

Title: Director, Ohio Department of Mental Health and Addiction Services

Date Signed: 8.26.15

mm/dd/yyyy

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

Footnotes:

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

77 SOUTH HIGH STREET • 30TH FLOOR • COLUMBUS, OHIO 43215-6117 • 614.466.3555

State Information

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Signature of CEO or Designee[1]: T Plouck

Title: Director, Ohio Department of Mental Health and Addiction Services

Date Signed: 8.26.15

mm/dd/yyyy

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

Footnotes:

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
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Signature of CEO or Designee[1]: _____

Title: Director, Ohio Department of Mental Health and Addiction Services

Date Signed: _____

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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

77 SOUTH HIGH STREET • 30TH FLOOR • COLUMBUS, OHIO 43215-6117 • 614.466.3555

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

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2. 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 Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. 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, day care, 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.

The authorized official signing for the applicant organization 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 sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human 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 DHHS mission to protect and advance the physical and mental health of the American people.

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.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tracy J. Plouck

Signature of CEO or Designee[1]: _____

Title: Director, Ohio Department of Mental Health and Addiction Services

Date Signed: 8·20·15

mm/dd/yyyy

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

Footnotes:

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

77 SOUTH HIGH STREET • 30TH FLOOR • COLUMBUS, OHIO 43215-6117 • 614.466.3555

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2016

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 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 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		
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

ASSURANCES - NON-CONSTRUCTION PROGRAMS

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

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

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

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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Name of Chief Executive Officer (CEO) or Designee: Tracy J. Plouck

Signature of CEO or Designee[1]: _____

Title: Director, Ohio Department of Mental Health and Addiction Services

Date Signed: 8·20·15

mm/dd/yyyy

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

Footnotes:

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:

Ohio Mental Health and Addiction Services does not lobby, and therefore, is not submitting this optional form.

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, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

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

1.1.1 Overview of Ohio's Mental Health and Addiction System

This Block Grant Plan serves as an application for two federal Block Grants awarded to states by the Substance Abuse and Mental Health Services Administration (SAMHSA) for federal fiscal years (FFY) 2016 and 2017. Proposed federal budgets estimate funding to Ohio for FFY 2016 at $64.1 million for Substance Abuse Prevention and Treatment (SAPT) Block Grant and $14.7 for Community Mental Health Services (MH) Block Grant. This statewide Block Grant Plan uses a system of care framework to explain Ohio's complex service system, provides a data-driven needs assessment, lists priorities, and goals with strategies and annual performance indicators. Additionally, the Plan responds to SAMHSA's questions in the Environmental Factors section. The plan is organized around SAMHSA's priority populations which include prevention, children with serious emotional disturbances (SED), adults with serious mental illness (SMI), and persons with substance use disorders (SUD). This plan also addresses persons with SED, SMI and/or SUD who are involved with the criminal justice system in a separate section due to differences in the systems of care. The Block Grant Plan is also integrated with OhioMHAS' Strategic Plan and the Community Plans prepared by Ohio's county behavioral health authorities (known as Boards) which plan, evaluate and fund mental health and addiction services.

During State Fiscal Year 2015, nearly 500,000 adults, youth and children received mental health and addiction treatment services through Ohio's publicly funded system. More than 7,700 adults received inpatient treatment in our six state-run regional psychiatric hospitals, a high percentage of whom had co-occurring addictions. These large numbers represent only those receiving direct services and do not include the thousands of Ohioans who benefit from education and outreach. (Ohio's use of "addiction treatment" includes treatment of gambling addiction as well as substance use disorders (SUD) as defined by SAMHSA.) (2015 OhioMHAS Annual Report)

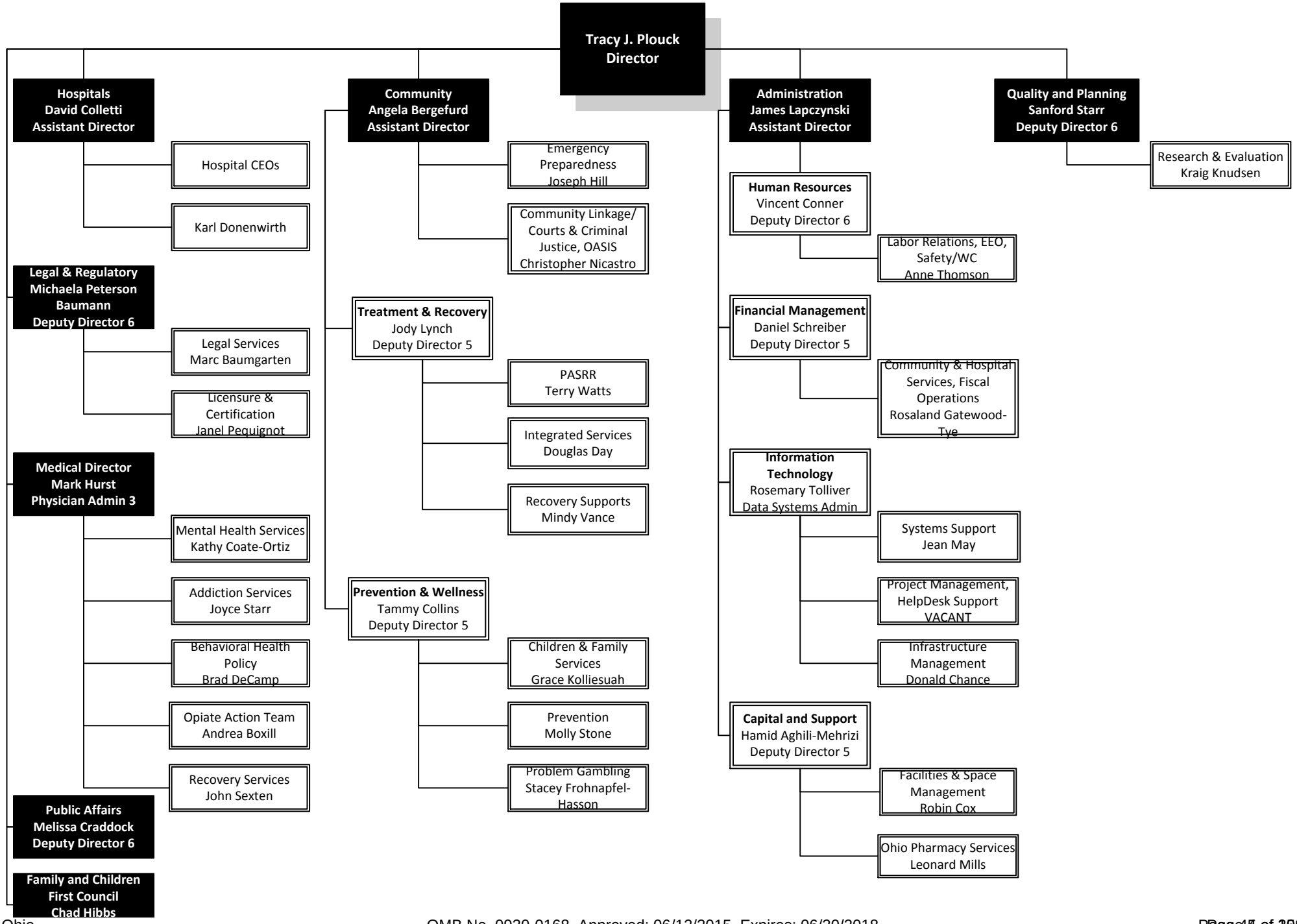
OhioMHAS oversees a statewide service network that includes 600 community treatment providers, 765 adult care facilities, 44 adult foster homes, 151 mental health residential providers, 183 driver intervention programs and 105 prevention providers. Additionally, OhioMHAS continues to operate the six regional psychiatric hospitals, and is providing SUD treatment within Ohio's prisons effective July 1, 2015. The department has a staff of approximately 2,400 (including 300 central office staff) and a budget of $696 million in fiscal year 2016 and $702 million in fiscal year 2017. OhioMHAS participates in the development of state health care policy through the Governor's Office of Health Transformation.

Ohio's state health care policy development is coordinated by the Governor's Office of Health Transformation (OHT) which has three major initiatives. The three initiatives are Modernize Medicaid, Streamline Health and Human Services and Pay for Value. Cabinet level agency directors and top leadership participate in the development of these three state initiatives. OhioMHAS serves on the governance committee for the first two of these initiatives. The Modernize Medicaid initiative is governed by OHT and the Medicaid cabinet which includes state departments for Aging, Mental Health and Addiction Services, Developmental Disabilities, health, and Medicaid with connections to Job and Family Services (employment and child welfare). The Streamline Health and Human Services initiative is governed by the Health and Human Services Cabinet. The Health and Human Services cabinet includes Medicaid cabinet agencies, OHT plus Departments of Job and Family Services, Administrative Services, and Budget Management. The Pay for Value initiative governance includes state departments for Administrative Services, Development (housing), Health, Insurance, Medicaid, Rehabilitation and Corrections, Tax, and Youth Services. Additionally, the Governor's External Advisory Council, Ohio Public Employees Retirement System and the Bureau of Workman's Compensation. The goal of these initiatives is to engage the private sector to set clear expectations for better health, better care and lower costs through improvements. For more detail, see the Ohio Health and Human Service Innovation Plan.
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=wTsf1ebtLMc%3d&tabid=119

Ohio Department of Mental Health and Addiction Services is a cabinet level agency which provides leadership for mental health and substance abuse in Ohio's state government operations and health care policy development. The Department is organized so that each office addresses both mental health and addiction services. Please see the Table of Organization on the next page for more information about how OhioMHAS is organized.

OHIO DEPARTMENT OF MENTAL HEALTH AND ADDICTION SERVICES

TABLE OF ORGANIZATION



Publicly funded behavioral healthcare in Ohio is a state-supervised, county-administered system of care. County Alcohol, Drug Addiction and Mental Health ADAMH Boards are responsible by state statute for planning, evaluating and contracting for substance abuse services for their counties with state oversight. In some counties these Boards are known as Mental Health and Recovery Service Boards. One county continues to have separate boards for addiction services and mental health services; this plan treats that county as a single Board area for planning purposes. OhioMHAS allocates funds to each of the 50 county and multi-county ADAMH Board areas which, in turn contract with and offer support to the substance abuse and mental health prevention and treatment programs in their counties.

In addition to federal and state funds allocated to the Boards by OhioMHAS, most Boards have local levies that also support behavioral healthcare. Boards with local levies use some of these funds to pay for treatment for persons with low incomes who do not have Medicaid or private insurance. However, with Medicaid expansion in Ohio, Boards have shifted more of their focus to prevention and recovery support services including housing, residential services, employment, and peer support that are non-medical services. Boards contract with treatment providers for prevention, and recovery supports as well as treatment services for persons without Medicaid or other insurance. In some cases, some non-urban Boards have chosen to contract with service providers which have home offices located in other Board areas. Additionally, "Medicaid-only" treatment providers operate in some areas and do not have contracts with Boards. These "Medicaid only" providers are making it more challenging for Boards to plan, evaluate and fund services in their areas in collaboration with other local service systems (justice, schools, child welfare, health, aging).

State Licensure and Certification of Providers

OhioMHAS licenses or certifies individual provider organizations with deeming used for organizations with national accreditation (e.g. JCHAO, CARF, and COA). These organizations are "deemed to have met OhioMHAS certification standards" which substitutes for most of OhioMHAS' certification requirements. Providers of Medicaid eligible services are required to have national accreditation in order to be licensed or certified by OhioMHAS. Consumer operated services, housing providers, and other providers which do not offer any Medicaid eligible services are not required to have national accreditation, and may be certified by OhioMHAS without national accreditation. OhioMHAS' state hospitals are certified by JCHAO.

Ohio has a wide variety of providers ranging from small niche providers with less than 10 employees to major comprehensive community behavioral health providers, some of which have expanded to multiple county ADAMH Board areas---which are scattered across the state. Ohio also has "Medicaid-only" provider which do not have contracts with Boards. Providers include community behavioral health providers, family service agencies, nationally recognized children's hospitals, consumer operated services and a rural community hospital which is also serves as the local community mental health provider. Most of the larger behavioral health

providers have been licensed and/or certified for both mental health and addiction services for many years, however, some have recently become dually credentialed. In order to provide a more complete description of Ohio's behavioral health system, this document includes a more complete description of service providers for each population served. For a complete list of providers, see: "Where to Get Help" on OhioMHAS' home page http://mha.ohio.gov/ .

OhioMHAS also operates a consumer-staffed toll-free information and referral line to assist citizens in finding help through Ohio's complex provider system. Below is a table with the number and types of providers licensed or certified by OhioMHAS. The first number is the total number, and the second number is the change since Ohio consolidated its state agencies for mental health and substance abuse services effective July 1, 2013.

Services Operated, Licensed or Certified by Ohio Mental Health and Addiction Services (OhioMHAS) Changes Between June 2013 and June 2015			
	Addiction Services Only	**Mental Health Services Only**	**Addiction & Mental Health Services**
Prevention providers	105 (-50)	unknown	
Driver intervention programs	183 (+87)		
Community treatment providers	178 (+12)	244 (-29)	178 (+45)
Consumer Operated and Peer Support		40 (+5)	
Adult care facilities- family		525 (-25)	
Adult care facilities - group		240 (-22)	
Adult foster homes		44 (+49)	
Mental Health Residential		151 (+151)	
Private psychiatric hospital units		76 (-5)	
Regional psychiatric hospitals (state-operated by OhioMHAS)		6 (0)	
Therapeutic community in state prisons	9 (+8)		
Substance abuse services in Ohio's state prisons			

The number of substance abuse treatment providers in Ohio has increased by more than 20% since the state of Ohio consolidated its substance abuse and mental health departments. A major factor in this increase is the Medicaid expansion to persons based on income alone (without meeting disability criteria) which resulted in $12.6 million in addiction services and $9.2 million in mental health services to persons who were previously unknown to the behavioral health system. (Plouck, 2015).

As described earlier, Ohio's addiction system includes 178 substance abuse only treatment providers, and 178 community behavioral health treatment providers which are certified by OhioMHAS to provide both addiction and mental health treatment. These community

behavioral health centers include providers which began as substance use disorder providers, as well as providers that began as mental health services or family services. The number of organizations certified for substance abuse services only increased by 7% (166 to 178), the larger increase was in the number of community behavioral health providers by 35% (133 to 178) which provide both substance abuse treatment and mental health services. These providers include small to medium size substance abuse providers which offer mental health assessment and counseling for persons with co-occurring disorders, but do not offer the full range of services (e.g. pharmacological management and Community Psychiatric Supported Treatment). Many of these providers are also community behavioral health care centers which offer outpatient substance abuse treatment, but do not offer residential services or detoxification. Some of these providers are large complex providers which provide a wide range of both mental health and substance abuse services.

Statewide Consumer and Family Organizations

Statewide Consumer and Family Operated Organizations support networking and provide recovery supports in a Recovery Oriented System of Care (ROSC). Leaders who emerge from these groups also participate in state policy development workgroups.

Three organizations have SAMHSA grants to promote consumer and family networks which include:

- Northern Ohio Recovery Association ("NORA" which networks persons in recovery from substance use disorders)
- Ohio Empowerment Coalition ("OEC" which networks mental health consumers)
- NAMI- Ohio which operates Ohio Federation for Children's Mental Health – networks parents of children with serious emotional disturbances (SED).

NORA uses a holistic recovery and healing approach in providing treatment services, and also seeks to prevent use of alcohol, tobacco and other drugs in addition to serving as a network for persons in recovery. NORA also functions as an advocacy group.

OEC is Ohio's statewide consumer organization which provides training for peer support services, serves as a statewide mental health consumer network, and also advocates for persons with serious mental illness. OEC also supports networking among the executive directors with lived experience who lead the 40 consumer operated services in Ohio, and the peers who participate in these services.

NAMI – Ohio has a business agreement to operate the Ohio Federation for Children's Mental Health. NAMI-Ohio also provides support for local affiliates which provide educational classes for parents of children with mental illness, family members of adults with mental illness and

adults with mental illness; classes are led by peers and/or family members who are trained facilitators. Many local NAMI affiliates also offer support groups for parents of children with SED, parents of adults with serious mental illness and co-occurring disorders, and persons with serious mental illnesses.

Additionally, other statewide organizations with consumer and family leadership include Ohio Advocates for Addiction Services, Multi-ethnic Advocates for Cultural Competence, Ohio Suicide Prevention Association and SOLACE for families who have lost a family member to addiction. Additionally, Mental Health of America and Depression Bipolar Support Alliance are active in multiple regions of the state. These organizations provide education and support to their members, persons in recovery and their families.

1.2.1 Behavioral Health Funding

Major funding sources for behavioral health services in Ohio are Medicaid, federal Block Grants to states, state General Revenue Funds, local tax levies, Medicare and market-based insurance plans. Medicaid is the largest source of funding sources for public behavioral health services in Ohio. As a form of medical insurance, Medicaid funding is available for "medically necessary" behavioral health treatment services for persons who are income eligible. Treatment is also funded by market-based insurance, Medicare, local tax levies (Boards), other federal grants, and fees for services.

Prevention, health promotion and recovery services (housing and employment) are funded by other funding sources and are not eligible for Medicaid reimbursement in Ohio. These funding sources include federal Block Grants, state General Revenue Funds, local behavioral health tax levies and other federal grants are used to fund non-medical services and recovery supports such as housing programs, employment and behavioral health services provided to persons in jails and prisons. State general revenue funds included in the budget passed by the State Legislature provide funding for state operated psychiatric hospitals, substance abuse treatment in Ohio's prisons, and some funding for community prevention, treatment and recovery supports.

The SAMHSA Block Grants are an important source of funding for non-medical services, as well as treatment services for persons without Medicaid, private insurance or other resources. In SFY 2014, the SAPT Block Grant provided about 80% of OhioMHAS' funding for prevention and about 26% for substance abuse treatment. The Mental Health Block Grant provides less than 2% of the funding for mental health services including suicide prevention, treatment and recovery supports. Medicaid was the major funder of both substance abuse and mental health treatment in SFY 2014 for Ohio's public behavioral health system.

OhioMHAS' budget includes state General Revenue Funds, SAMHSA Block Grants, other federal grants and other state funds. Funding for behavioral health Medicaid is included in the state's budget for the Ohio Department of Medicaid. OhioMHAS' Director participates in the Medicaid Cabinet coordinated by the Governor's Office of Health Transformation which includes Ohio Department of Medicaid, Ohio's state Medicaid agency and the directors from all cabinet level Medicaid agencies. OhioMHAS' provides leadership for behavioral health policy in Ohio's State Medicaid Plan.

1.3.1 Medicaid – Eligible Services in Ohio

In 2015 Ohio's behavioral health system has available the following services to persons of all ages that are included in OhioMHAS Certified Mental Health/Substance Use Disorder Service Rules. These services are eligible for Medicaid reimbursement under Ohio's current Medicaid state plan and are financed on a fee for service basis outside of Medicaid managed care plans. These medically necessary treatment services are also the same treatment services provided to persons with Medicare, market based insurance plans, county Boards with local tax levies, and other payors. Treatment services eligible for Medicaid reimbursement in Ohio include:

Mental Health Services

- Assessment, including Psychiatric Diagnostic Interview
- Crisis Intervention
- Behavioral Health Counseling – individual
- Behavioral Health Counseling - group
- Pharmacologic Management Service
- Partial Hospitalization
- Community Psychiatric Supportive Treatment – individual
- Community Psychiatric Supportive Treatment - group
- Health Home Services for Persons with Serious and Persistent Mental Illness (includes children and adults which replaces CPST/case management services for some persons)

Substance Used Disorder Services

- Assessment
- Ambulatory Detoxification
- Case Management
- Crisis Intervention
- Group Counseling

- Individual Counseling
- Intensive Outpatient
- Laboratory Urinalysis
- Medical/Somatic
- Methadone Administration

1.4.1 Major New State Initiatives

OhioMHAS' major initiatives that impact multiple priority populations include changes to Ohio's Medicaid benefit plan, addressing health disparities, and improving access to trauma-informed care. Additionally, OhioMHAS' Medical Director's Office will become responsible for SUD treatment in Ohio's state prisons effective July 1, 2016. Ohio's county ADAMH Boards are focusing on developing a Recovery Oriented System of Care.

Priorities in State Budget

OhioMHAS priorities in the state budget included Medicaid, Support for Children and Families including prevention and early intervention, Saving Lives – Every Life Counts, Criminal Justice Interface, Housing and Employment as Recovery Supports, Regional Psychiatric Hospitals and Medication. Support for Children and families include Strong Families/Safe Communities, Early Childhood Mental Health and Targeted Populations Prevention. Saving Lives includes Suicide Prevention, Trauma Informed Care and Enhancing Access to Naloxone (medication assisted treatment addiction). The Criminal Justice interface includes a Recovery Services Partnership with Ohio Department of Rehabilitation and Corrections in which OhioMHAS' Medical Director will oversee treatment services for addiction in the prisons. Additionally, the Criminal Justice Interface also includes Addiction Treatment, Specialty Dockets (court supervised treatment), Community Forensic Centers, Probate Court Costs, and Community Strategies to Impact Hospital Capacity. Housing and Employment as Recovery Supports included Residential State Supplement (for persons with disabilities, primarily mental illness), recovery (sober) housing, and Workforce and Employment. Regional psychiatric hospitals and funding for community medication (for persons not covered by Medicaid or insurance) were also included. State funding for mental health and substance abuse for prevention, treatment and recovery supports complements Medicaid funding, which is funded by federal and state funds. State funding also includes Substance Abuse, Mental Health, and Social Service Block Grant funds.

Continuum of Care

Ohio's SFY 2016-2017 Biennium Budget Bill requires the Department to ensure the availability of a continuum of care that includes essential elements for all individuals seeking behavioral health treatment and specific service elements for individuals seeking treatment for opiate or co-occurring drug addiction. The legislation specifies which services must be available within the

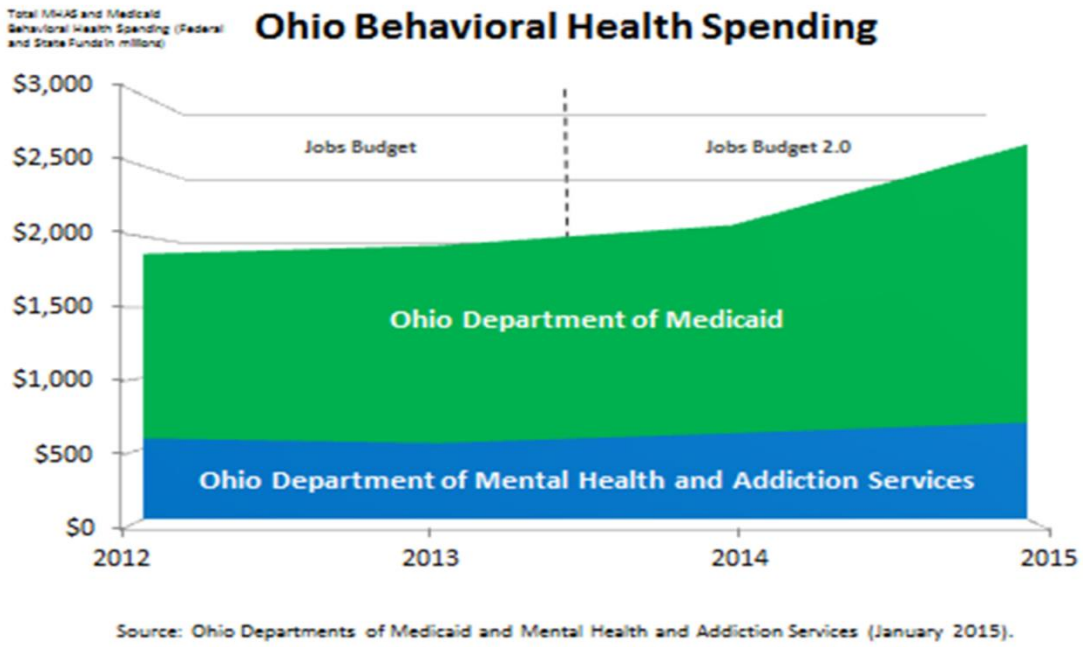
Boards service area while others can be regional. County boards that submit a budget to the Department that does not reflect the availability of all the essential elements of the required continuum of care shall have funds withheld. In addition the legislation stipulates the establishment of a waiting list policy and procedures for services and supports for opioid and co-occurring drug addiction. In response to the legislation, the department and its stakeholders have undertaken the following steps to prepare for these requirements that are effective September 15, 2016:

1. Identify and assure adequate delivery for required array of services and supports for the continuum.
2. Identify receipts and expenditures available and establish an allocation methodology to support the service array.
3. Establish a waiting list policy and procedures for services and supports for opioid and co-occurring drug addiction.

Changes in Ohio's Medicaid Benefit

OhioMHAS Director, Tracy Plouck, included in March 4, 2015 testimony to the Health and Human Services Budget Subcommittee on changes in Ohio's Medicaid benefit, in addition to the testimony provided by Ohio Department of Medicaid Director John McCarthy. In this testimony OhioMHAS Director Tracy J. Plouck described planned changes in Ohio's behavioral health benefit: "Ohio is a Medicaid expansion state which had a pent-up demand for behavioral health services. Approximately 17,252 individuals new to Ohio's behavioral health system accessed care (through September 30, 2014). These individuals received clinical care with a value of $21.8 million ($12.6 million addiction services, $9.2 million mental health).

Medicaid coverage has resulted in an influx of treatment resources for mental health and addiction, representing a once-in-a-generation opportunity to facilitate Medicaid and non-Medicaid services working together to meet the needs of Ohioans with mental health and addiction disorders. Central to the state's commitment to extend Medicaid access is the objective to connect more individuals to services and care that can be found in the community. This has been realized through the state's investment in mental health and addiction services. Today, people who just a year ago had nowhere to turn for health care now have close-by access to treatment and services through Medicaid and can access other needed recovery supports through OhioMHAS and its local partners.



Ohioans enrolled in Medicaid with behavioral health treatment needs represent 27 percent of Medicaid members but accounts for almost half (47 percent) of Medicaid spendj g. The most expensive five percent account for over half of the behavioral health expenditures. Only 50 percent of the behavioral health population on Medicaid is seen by providers certified by OhioMHAS. In order to strengthen the clinical services offered through the Medicaid program and to better integrate physical and behavioral health coverage, the Department of Medicaid and OhioMHAS are proposing significant reformation of the behavioral health benefit over the course of the FY 16-17 biennium. Key reforms will happen in three phases and will focus on individuals with high-end needs while also bending the cost curve in the long run:

1. Update billing codes and services definitions to align with national standards and to identify specific service activities. Mental health pharmacological management and alcohol and other drug, medical/somatic services are being targeted for this first phase update.
2. Budget neutral redesign of the behavioral health benefit that focuses on aligning services according to a person's acuity level and need. This will include the addition of several new services based on proven models, such as Assertive Community Treatment (ACT), Intensive Home Based Treatment (IHBT), high-fidelity wraparound, peer services, supportive employment, and residential services for substance use treatment. Also, Community Psychiatric Supportive Treatment (CPST), case management, and health home services will be disaggregated to allow specific components to be aligned to a person's acuity level and need.
3. Toward the end of the biennium, transition to managed behavioral healthcare in order to improve care coordination and outcomes. A year's worth of claims experience under the redesigned benefit will enable rates to be set for managed care. Final decisions have not

been made as to the requirements for and type of care management that will be used. Examples of models used by other states include the use of a specialty behavioral health plan, use of the state's main MCO (managed care organization) plans, or a hybrid approach."

Addressing Health Disparities through a Cultural and Linguistic Competency Plan Into Action: 2020 Strategic Vision OhioMHAS Commitment

OhioMHAS partnered with external stakeholders to develop a plan to use cultural and linguistic competence strategies to change "one size fits all" approaches in behavioral health care delivery to strategies that offer high-quality, person-centered care. The department has dedicated itself to providing appropriate, accessible services to Ohioans, who encompass a broad range of human differences such as ability and disability, age, educational level, ethnicity, gender, geographic origin, race, religion, sexual orientation, socio-economic status and values. OhioMHAS recognizes that its vision must entail supporting, endorsing and encouraging community system partners – including county and local entities – to identify, initiate and implement cultural and linguistic competence services for all recipients of care.

Benefits of Cultural and Linguistic Competence (CLC)

OhioMHAS acknowledges that there is significant evidence of health inequities and disparities disproportionately impacting outcomes experienced by minorities when compared to those experienced by the general population. To address inequities, the *OhioMHAS CLC Plan* provides state and local systems with the strategies necessary to achieve the following:

- Enhance workforce competency of race, ethnic and cultural groups in Ohio by increasing awareness of cultural and linguistic needs, treatment barriers and service gaps;
- Improve organizational procedures by adopting and promoting policies that enhance communication and community engagement; and
- Improve outcomes by assessing organizational activities and community services.

Goals include:

- Increase awareness of the significance of health disparities in behavioral health, their impact on the state, and the actions necessary to improve behavioral health outcomes for racial, ethnic, and underserved populations.
- Improve behavioral healthcare outcomes for racial, ethnic and underserved populations.
- Improve cultural and linguistic competency and the diversity of the behavioral health workforce.
- Improve data availability, coordination and utilization in research and evaluation outcomes.
- Strengthen and broaden leadership for promoting health equity at all levels.
- Collaborate with health and human service agencies to achieve health equity.

Trauma Informed Care

Since summer of 2013, an interagency workgroup comprised of leaders from OhioMHAS and Ohio Department of Developmental Disabilities (DODD) has been meeting to formulate plans to expand trauma informed care (TIC) across the state. As part of the TIC Initiative, six Regional TIC Collaboratives are being formed. The Regional Collaboratives will:

- Identify strengths, champions and areas of excellence as resources in TIC implementation identify gaps, weaknesses and barriers for implementation of TIC;
- Develop a repository of expertise, knowledge, and shared resources which will assist in dissemination of information and support the implementation of TIC throughout state, assuring that TIC opportunities are available everywhere
- Train individuals to serve as local/regional/state faculty to assist in the dissemination of TIC
- Develop implementation strategies specific to specialty groups as indicated such as developmental disabilities, children, older adults, and persons with substance abuse disorders.

OhioMHAS Partnership with Department of Criminal Justice and Rehabilitation (DRC)

In Testimony before the House Health and Human Services Subcommittee Ohio Department of Mental Health and Addiction Services FY 16-17, Budget House Bill 64, Director Tracy J. Plouck stated, "One of the most exciting and innovative opportunities proposed in the FY 16-17 budget is a new partnership with the Ohio Department of Rehabilitation and Corrections (DRC) to improve addiction services within the state prison system. According to DRC, approximately 50,495 individuals are incarcerated within DRC facilities. Of these, 80% have histories of addiction. Nearly 30,000 of those incarcerated have a considerable or moderate treatment need, but current resources limit treatment availability to reach approximately 4,500 of those in prison. Those who receive services to treat addiction have much lower recidivism rates than those who do not receive such services (10.4% for those treated vs. 27% for general population).

In order to make improvements and expand the reach of recovery services in the prisons, this budget leverages the clinical expertise and recovery-oriented mission of OhioMHAS partnered with DRC's success in keeping recidivism rates low to provide quality addiction services to more people within the walls of the state prisons. Enhanced care inside the prison walls includes adding to the recovery services staff to provide individual and group treatment and adding two therapeutic communities, a proven model of treatment that uses the influence of peers to promote recovery. Additional programming will encourage a seamless transition to services upon release to further lower the rate of recidivism, including a connection with the Medicaid program to ensure continued clinical services where applicable. Expanded use of Medication Assisted Treatment will further reduce the risk of future relapse.

The budget will also increase access to recovery supports, such as sober housing and employment services, upon release to ensure stable recovery and even further lower the recidivism rate. Employees of DRC's Bureau of Recovery Services will transfer to OhioMHAS and report under the direction of MHAS' Medical Director, Dr. Mark Hurst. However, the goal is to make the transfer with very little disruption to the staff, who will continue to work within the prisons, retain their DRC badges, and maintain their rates of pay and benefits.

1. Transfer current addiction treatment budget from DRC to MHAS.
This budget largely consists of personnel who will become employees of OhioMHAS.
2. Augment services within the state prison system to increase treatment resources to levels that meets identified need. This includes hiring additional personnel to work within the prison setting.
3. Expand resources for outpatient recovery supports and treatment for released inmates."

Ohio Association of County Behavioral Health Authorities (Boards') Initiative
Recovery Oriented System of Care

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, employment skills training, daily living skills, relapse prevention, spiritual support, anger management, transportation, GED support, substance abuse and/or mental health education, recovery coaching/peer support, parenting, peer mentoring, self-help and support groups.

Boards are major funders of recovery support services as recipients of local tax levies, as well as funds allocated from OhioMHAS which include state funds and federal grants including Block Grants. Additionally, Boards fund prevention services and treatment services for persons without Medicaid or other insurance. As funders in a home rule state, Boards are well positioned to have a recovery conversation in their communities with health and human service organizations, as well as consumers and family members.

Recovery is Beautiful is a campaign to change the conversation regarding recovery (from a mental illness or addiction) promoted by the Ohio Association of County Behavioral Health Authorities (OACBHA). The conversation is being joined by many persons with lived experience who are sharing their personal recovery stories including OACBHA leadership. http://www.oacbha.org/recovery-oriented_systems_of_c.php ***Recovery is Beautiful*** has provided nearly 100 presentations in local communities and promoted in nearly 100 events.

Recovery IS Beautiful is all about putting the needs of individuals and families requiring addiction and/or mental health programming first and foremost. In order to achieve this,

Recovery IS Beautiful has two major components: 1) is all about changing the conversation, and 2) is all about moving Ohio's community mental health and addiction system to a Recovery-Oriented System of Care. In order to ensure that individuals have access to care is one thing, but getting individuals and family members to want and believe that treatment works and people recover we must address the stigma that continues to be associated with mental illness and addiction.

Changing the Conversation

The ***Recovery IS Beautiful*** movement is working to provide individuals and families with hope and encouragement while changing the conversation in regards to mental illness and addiction. "We want people to know and understand that:

1. Mental illness and addiction are ***chronic illnesses.***

2. Both mental illness and addiction can be successfully treated: ***Treatment Works and People Recover****.*

3. ***Recovery is to be celebrated****. Individuals in recovery become active and contributing members of their communities.*

Ohio's Mental Health and Addiction Services System

Strengths

- Medicaid expansion has increased resources available for mental health and addiction (SUD) treatment services; persons in need of services can qualify on this basis of financial status.
- Partnership between OhioMHAS and Department of Rehabilitation and Corrections Services will increase access to SUD treatment within prisons which will be supervised by OhioMHAS' Medical Director.
- County Boards and persons in recovery collaborate to promote a recovery oriented system of care.

Needs

- Availability of a full continuum of care for treatment of substance use disorders (SUD) and co-occurring SUD and mental illness is not uniformly available; OhioMHAS is in the process of implementing a continuum of care to improve this.
- Ohio has health disparities among population groups; these are being addressed through a Cultural and Linguistic Competency Plan, Into Action: 2020 Strategic Vision OhioMHAS Commitment.
- Ohio's Medicaid Benefit is in need of redesign to better align services according to a person's acuity level and need; Ohio is developing a budget neutral redesign of the behavioral health benefit to address this.

1.5.1 Behavioral Health Promotion, Prevention and Early Intervention Services and Supports

Introduction

OhioMHAS supports a continuum of care using a public health model which includes health promotion, prevention, early intervention, treatment and recovery supports. Behavioral health promotion includes supporting wellness, early intervention and prevention of mental health and substance use disorders. Prevention and early intervention is addressed across the lifespan with a focus on children and their families to intervene as early in life as possible. The Governor is promoting *Start Talking* to encourage parents and young people to talk about substance use in order to reduce use. As Ohio transforms its health care system, behavioral health promotion is essential to keep costs down, to improve the quality of care and to increase satisfaction with care. Behavioral health promotion has an important role in preventing or delaying the onset of acute and chronic disorders. Promoting healthy environments, norms and behaviors is an important component of health reform.

Targeted Population

Primary prevention is directed towards Ohio's entire population of about 11.6 million persons in 2016. Ohio is a very diverse state which includes Appalachian counties, major cities (Cleveland, Cincinnati and Columbus), suburban counties, smaller cities, and rural northern communities typical of the upper Midwest. While Ohio's population is 83.2% white, 12.5% black or African American, 0.3% American Indian, 3.4% Latino, and 1.9% Asian, Ohio's individual counties have very different population mixes. For example, Cuyahoga County (Cleveland metropolitan area) population is 30.2% black or African American and 5.2% Latino. Holmes County is 0.4% African American and has a large Amish community whose members use horses and buggies for transportation for religious reasons. Adams County is a rural Appalachian county in which 97.6% of the county is white, 1.3% two or more races and 0.5% African American; the predominant culture is Appalachian across southern and eastern Ohio. Columbus, Ohio has the second largest Somali community in the United States as well as sizable Latino community. Cincinnati shares its metropolitan area with Kentucky, and has a population that is 67% white, 26% African American, 2.8% Latino, and 2.3% Asian. Ohio also has a number of counties with smaller cities (e.g. Toledo, Youngstown, Akron and Dayton) which also each have their own population mix and culture. Each of these local communities has an ADAMH Board which is responsible for funding, planning and evaluating services for their local communities.

OhioMHAS, ADAMH Boards and providers face challenges in addressing the prevention needs of new, emerging and under-represented populations in culturally competent ways. Ohio has

significant African American, Somali, Latino, Asian, Appalachian and Amish population groups. These new immigrant and refugee populations from Asia and North 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 served by Ohio's behavioral health system do not necessarily reflect those of persons in need of services, 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 behavioral health prevention, treatment and recovery providers to be adequately trained remains a priority.

OhioMHAS recognizes the need to be more inclusive in engaging Ohio's culturally diverse populations in prevention planning, coalition participation, and access to services. OhioMHAS is working to better engage Ohio's diverse populations in prevention planning and in coalition work. The goal is to ensure that all components of the Ohio prevention system are providing culturally appropriate prevention services and optimizing inclusion of these disparate populations in the system. In communities with large minority populations and high poverty rates, minority youth have increased vulnerability. It is imperative that communities understand the risk to these youth and how to address the issues to decrease the risk. The Urban Minority Alcoholism, Drug Abuse and Outreach Programs (UMADAOPs) play a significant role as subject matter experts in the area of cultural competence. As a part of the Strategic Planning Framework (funded by SAMHSA Grant), Ohio has also have developed a Cultural Competency Plan which is in the process of being implemented.

Additionally, the Multiethnic Advocates for Cultural Competence, Inc. (MACC) unveiled a State of Ohio Cultural Competence definition that was developed in 2010 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 begins to lay a foundation for building cultural competence, and the implementation of a 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 under-represented and underserved populations within the prevention system (including community coalitions).

Ohio's Prevention Providers

Ohio has a wide range of prevention providers. As Ohio is a home rule state in which fifty ADAMH Boards plan, evaluate and fund local services with state oversight, Ohio has fifty different behavioral health systems. Each ADAMH Board plans services which meet the needs of the local population, and builds on the institutions, organizations and personal relationships that shape local systems of care. Many Boards use a portion of their local tax levy to support prevention efforts which are tailored to the needs of the population in their communities which can lead to a more culturally sensitive system of care.

In order to build programs in local communities, OhioMHAS has found that community coalitions are the single most effective means of promoting alcohol, tobacco and other drug prevention across disciplines. Ohio has over 106 Drug Free Community Coalitions and more than 80 Suicide Prevention Coalitions. Additionally, OhioMHAS has partnered with ADAMH Boards and other provider systems including schools and health care systems to imbed prevention interventions into other systems such as schools, faith-based organizations, work places and health care systems. As Ohio's behavioral health system is so large and diverse, it is not possible to describe each individual prevention provider. However, OhioMHAS can describe some examples of providers to provide a picture of the state's prevention providers. Some examples of Ohio's prevention providers are:

Urban Minority Programs

- Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADOP) – UMADOPS provide prevention and treatment to African American and Hispanic communities in urban areas.

  Example: The Cleveland Hispanic UMADOP serves the Hispanic community with culturally sensitive prevention services and treatment services. Prevention programs include programs for teens at risk for addiction or of dropping out of school, driving while under the influence programs for adults and HIV prevention programs.

Women's Prevention Programs

- Urban Ounce of Prevention- The New Beginnings Project goal focuses on prevention and the following health-related issues: 1) adult female alcohol/ drug use and abuse during pregnancy; 2) infant mortality and low-birth weight; 3) cultivating healthy parent-child relationships; and 4) domestic violence.

Drug Free Community Coalition

- Drug Free Community Coalition- Hancock County Community Partnership - The Hancock County Community Partnership is submitting this application to create a substance abuse free Hancock County. The Partnership will address prevention goals

focusing on prevention of the onset of substance abuse, abuse, and addiction by working with other community organizations to develop awareness and educational programs during the year. The Partnership will contract with Family Resource Center of Northwest Ohio to deliver the evidence-based program Too Good For Drugs.

Opiate Advocacy – Community Prevention

- Drug Free Action Alliance- Grief, Advocacy & Prevention seeks to build grassroots coalitions through the Ohio GAP Network that will be linked with the Statewide Prevention Coalition Association (SPCA). This initiative will empower and train family engagement groups, link them to coalitions in their communities, and create a statewide advisory group. Through networking, training and mentoring, a strong emphasis will be placed on grief management, and building on it to offer grief peer coaching. Additionally, members will be trained in advocacy principles to take their zeal, and use it to effectively advocate and promote environmental change, as well as learn to use other evidence-based prevention strategies.

Screening and Brief Intervention and Referral to Treatment in Health Care

- Screening, Brief Intervention and Referral to Treatment (SBIRT) – SBIRT is provided at health centers, primary care practices, general hospitals and emergency departments. Patients receive a brief screening for substance abuse issues. Based on the results, brief intervention is provided at the health care site. If needed, referral for more treatment from a substance abuse provider is made.

Prevention in Partnership with Schools and Communities

- Safe Schools/Healthy Students - Greene County Educational Service Center is a partnership is to build state and local capacity to develop integrated, comprehensive, data-driven strategic plans. These plans will prevent, delay the onset or mitigate the seriousness of behavioral health problems through engaging youth, families and schools as agents of community change.
- Deaf Students - Family Services Association - Educating No Drugs uses culture-specific curricula and activities to create awareness and prevent alcohol and other drug use among K-12 Deaf, Hard-of-Hearing and Kids of Deaf Adults youth. Utilizing classroom instruction, campaigns, public service announcements, camping, leadership training and student-led events, 1600 students receive information, resources and activities to increase knowledge, build protective factors and strengthen drug-free peer culture.

Build Prevention Capacity

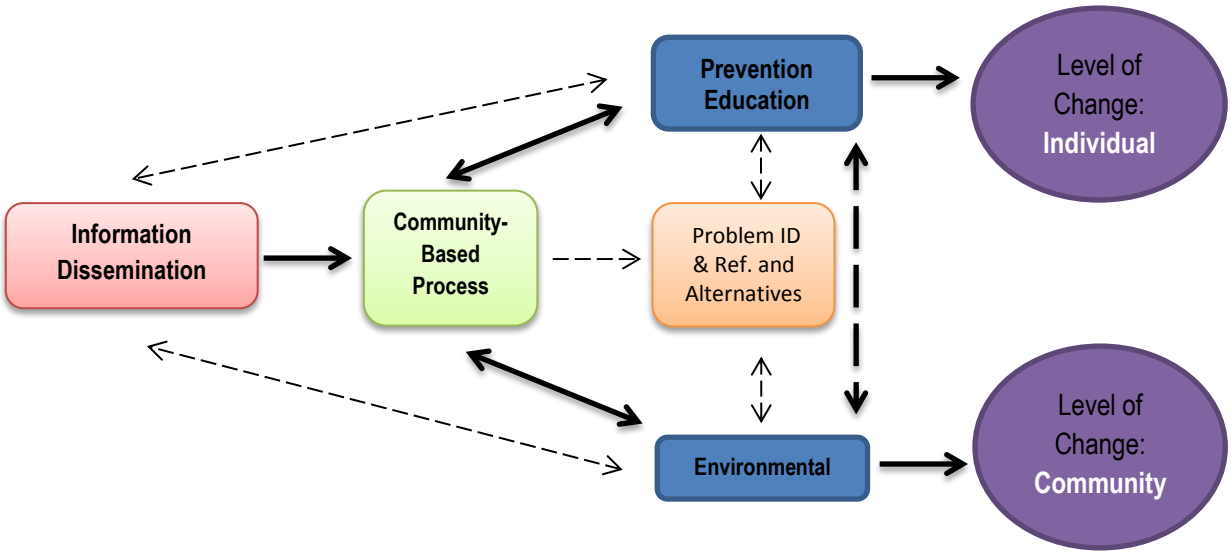
Prevention and Mental Health Wellness Taxonomy

Prevention and wellness 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, evidence-driven strategies intended to facilitate attitude and behavior change for individuals and communities. Ohio supports a public health approach to prevention and mental health wellness to address healthcare and early intervention efforts for all Ohioans.

Following the Public Health model, strategies implemented are based on the assessment of needs, resources and readiness conducted as part of the community planning process to ensure that funded strategies will address community risk and protective factors that either complicate or mitigate mental illness, addiction and other risk behaviors. These community and statewide prevention and wellness efforts benefit all Ohioans.

Behavioral health problems are complex and therefore cannot be adequately addressed without involving multiple systems that impact risk and protective factors. Risk factors are neurobiological factors, stressful events or psychosocial factors that increase an adolescent's vulnerability to poor outcomes. Protective factors help safeguard youth from poor outcomes. This framework suggests that outcomes grow out of the complex web of interactions of various domains including: genetic/individual, family, peers, school, community and society to prevent or ameliorate severe outcomes.

Ohio has updated its Prevention Continuum of Care Taxonomy based on a model for how the federal Center for Substance Abuse and Prevention's (CSAP) six prevention strategies are to be implemented for the greatest impact in Ohio 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 and mental illness prevention intersect. The focus on intended level of change and a further definition of strategies allows for the work of multiple systems to be integrated into one conceptual model.



Prevention education and environmental strategies are the main prevention strategies which have the strength to influence attitude, behavior and meet outcomes on their own. The other four strategies support the implementation of these two main strategies. All six strategies are needed as part of a comprehensive prevention and wellness 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 **information dissemination** and **community-based process**, these interventions often lack the benefits resulting from broad-based community support and opportunities for expansion and quality improvement.

Community-based process activities are essential to effectively implement 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 being able to benefit from services which exceed the scope of prevention. Alternative activities are implemented as a celebration of individual or community success. Alternative activities must be activities that will also contribute to addressing risk/protective factors and/or intervening variables identified in initial program development.

Increase Community Capacity

OhioMHAS has a historic process for community and statewide assessment and planning for prevention guided by state and federal law and regulation. State law requires that ADAMH Boards conduct community needs assessments for behavioral health services which are included in a Community Plan submitted to the state. Additionally, Ohio's state substance abuse authority has implemented an assessment as a part of the Ohio Strategic Planning Framework with a series

of grants from SAMHSA. In addition to current efforts, the Ohio Strategic Prevention Framework (SPF) Strategic Prevention Enhancement (SPE) Evaluation Team conducted a variety of assessments and inventories to inform the work of the SPE Consortium specifically around data collection. Ohio Community Plans, Ohio Family Health Study, and National Outcome Measures (NOMS) all inform Ohio's prevention planning efforts. This assessment process for all services is in Step 2 of this document.

Increase Community Capacity through Workforce Development (WFD) Plan

OhioMHAS has a goal to create a competent and diverse behavioral health prevention workforce through a structured two-year plan. The objectives for the plan are:

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

The WFD Plan will also include the updating and revision of the E-Based Academy to include the integration of behavioral health in the selection of educational sessions. OhioMHAS will also continue to maintain a connection with the Ohio Chemical Dependency Professionals Board (OCDPB) and ensure all training sessions follow the identified credentials and 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 International Credentialing & Reciprocity Consortium (IC&RC) exam.

Ohio possesses both individual and agency certifications for Prevention. Agency certification is provided by OhioMHAS and has minimum requirements and criteria that agencies must demonstrate to be a prevention certified agency. 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 http://mha.ohio.gov/Default.aspx?tabid=259.)

Prior to SFY 2013 there were three certification options for an individual to choose: Registered Applicant (RA), Ohio Certified Prevention Specialist I (OCPSI) and Ohio Certified Prevention Specialist II (OCPSII). The purpose of an RA was to enable an individual to begin the process of prevention certification while working in the field. While being supervised by an OCPS I or II, the RA could stay at this level for an unlimited time period.

The OCDPB realized that there were many individuals "parked" in the RA level, and they were not advancing forward to the OCPS I or II. It was decided that 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 two-year limit on the RA level. This addition of the OCPSA will increase the capacity of the prevention field in Ohio significantly.

Alignment of Prevention Service System with other Systems

Ohio's Strategic Prevention Framework (SPF)

Ohio has been awarded $8.13 million for the Strategic Prevention Framework Partnerships for Success Grant for 2014 – 2019 from SAMHSA/CSAP (Center for Substance Abuse Prevention). This grant builds on Ohio's 2009 five-year, Strategic Prevention Framework State Incentive Grant (SPF-SIG) totaling more than $10 million, and a 2011 Strategic Prevention Enhancement (SPE) Grant for $600,000. The SPF-PFS initiative will continue to enhance and strengthen the capacity of the state and local communities to build a sustainable, culturally competent infrastructure focusing on delaying the onset of alcohol and other drug use and reducing substance-related problems. To continue to develop capacity at the community level, Ohio is using training, technical assistance and coaching to provide intensive, ongoing support. These strategies lay a solid foundation for the soon to be funded sub-recipient communities, to work collaboratively with other community entities to address community prevention and needs. The PfS Advisory Committee will oversee the work and will collaborate with the SEOW and representatives of state agencies, foundations, universities, prevention providers and other community members.

Interagency Prevention Partnership

As a part of the SPF grants work, Ohio developed an Interagency Prevention Partnership (IPP) to oversee the grant processes, make policy recommendations, provide input into the development of plans, and to help guide the state substance abuse prevention system. Strengthening working partnerships has allowed the IPP members to explore the opportunities 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 transforms its healthcare delivery system. These efforts increase the mental health and substance abuse prevention system capacity and support for effective prevention services.

The IPP partners include the Ohio Departments of Health, Mental Health and Addiction Services, Education and Youth Services, along with representatives from the Ohio National Guard, the University of Cincinnati, Ohio University, Ohio Children's Trust Fund and the Ohio Suicide Prevention Foundation. Community level stakeholders include the Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP) Federation and the Licking County Juvenile Justice Association. These community stakeholders have strengthened decision

making related to community level collaboration. Having multiple disciplines at the table has allowed the creation of comprehensive plans aimed at closing state priority gaps related to capacity building and system enhancement tasks.

The IPP members developed a five-year strategic plan with four main goals and more than 20 actionable objectives. The group continues to discuss how to utilize available and planned resources, key personnel, and stakeholders to address concrete action steps and milestones for completion to meet the goals of the strategic plan. The expertise from all members of the IPP has enabled the plan to include goals, objectives and strategies for integrating a community-based, state supported holistic approach to mental health and substance abuse prevention.

Drug Free Community Coalitions and the Statewide Prevention Coalition Association
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. The Department also supports the Statewide Prevention Coalition Association (SPCA) and the Ohio Center for Coalition Excellence (OCCE) in 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 supports 80 Suicide Prevention Coalitions through a grant to the Ohio Suicide Prevention Foundation. Ohio has a rich history of coalition development. Ohio's community coalitions serve a number of geographically and culturally diverse populations; however, there are gaps in that service. A number of counties and board areas have very few, if any, community coalitions, while others have many. A few of the 29 federally funded Drug Free Community Coalitions have also received funding for the Sober Truth on Preventing Underage Drinking campaign. 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 members have. The focus of these groups is to help local communities increase capacity, increase use of environmental prevention strategies, and foster healthy communities.

The Ohio Center for Coalition Excellence was conceptualized to assist communities to mobilize substance abuse prevention efforts. Ohio Center for Coalition Excellence (OCCE) assists community groups to build their local collaborative capacity, to plan, implement, evaluate and sustain prevention strategies within communities. The goal continues to be to increase

capacity, change community environments and build healthy communities The OCCE works with the Underage Enforcement Training Center, Community Anti-Drug Coalitions of America and national and state experts to provide trainings that assist coalitions in strengthening coalition development and increasing impact within communities.

School Based Prevention

Safe Schools, Healthy Students (SS/HS)

Ohio was awarded a Safe Schools, Health Students grant in 2013 with the goal to build statewide and local capacity to develop comprehensive, data-driven strategic plans to prevent, delay the onset or mitigate the seriousness of behavioral health problems. A key aspect in the success of this goal is engaging youth, families and schools as agents of community change. Achievement of project goals will enhance system capacity and strengthen partnerships at the state and local levels. The partnership provides community-based models and mentors for other communities that wish to adopt comprehensive, integrated plans to provide effective behavioral health services and prevent youth violence. The focus isto promote healthy social/emotional development and to build safe and healthy family, school and community environments using the findings of the 2009 Institute of Medicine Report (IOM).

The project is a partnership between OhioMHAS, Ohio Department of Education and other state departments; state training, technical assistance and evaluation partners; and three local education agencies in rural counties including Greene County Educational Service Center, Northwest Ohio Educational Service Center in Williams County and Harrison Hills City Schools in Harrison County. Ohio estimates that approximately 620 children/youth per year (1,860 over the grant life) will receive direct early intervention or treatment services in the three counties, and approximately 98,000 households per year with children (more than 300,000 individuals over the grant life) will benefit from prevention services provided through this SAMHSA/CMHS grant through 2017.

Strong Families, Safe Communities

Governor Kasich and the State of Ohio are committed to improving care coordination and providing support for families with children in crisis who present a risk to themselves, their families, or others because of mental illness or a developmental disability. Many children who are at risk are not engaged in treatment programs and may not be known to the community until a crisis unfolds. Care coordination and targeted crisis intervention services can quickly stabilize a child's health. Support for these families in need will reduce risk of harm and help the family remain together. During spring 2013, the Ohio Departments of Developmental Disabilities (DODD) and OhioMHAS sought collaborative community proposals to establish treatment models of care that focus on crisis stabilization for children with intensive needs. This initiative

has engaged local systems to identify community-driven solutions that highlight collaboration across agencies to develop the best possible outcomes for children and families.

In July, 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.

Good Behavior Game

Ohio supports the **Good Behavior Game (GBG)** because it has shown both proximal and distal outcomes regarding student behavior, 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. 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 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 of strategies to make the game more effective; how to increase PAX (good behavior) when not playing the game; and what to do with children who are not responsive or have special needs. The fundamental units of behavioral influence that underlie effective prevention and treatment, or "kernels," introduced to participants have been used with a wide range of ethnic groups and diverse populations. The brain science behind the success of kernels is universally applicable.

Infuse Prevention Capacity into Other Systems

Positive Parenting and Screening, Brief Intervention and Referral to Treatment (SBIRT)

Ohio's public service system must seek out ways and means to encourage positive parenting skills and referrals to behavioral health services when identified through screenings. A number of models have been used successfully to influence positive parenting outcomes. The **Positive Parenting Program or Triple P** is an evidence-based public health approach for improving parenting practices and child welfare outcomes within a population. It can be implemented in a number of systems, including healthcare, child welfare, schools, behavioral health, child care, libraries, military and others. The principles of Triple P are:

- Ensuring a safe, engaging environment
- Creating a positive learning environment
- Using assertive discipline
- Having realistic expectations

- Taking care of yourself as a parent

The Office of Prevention and Wellness plans to introduce Triple P in the primary healthcare setting as part of the Screening, Brief Intervention and Referral to Treatment (SBIRT) project. It will working toward use of the model as behavioral and physical healthcare become more and more integrated.

Another successful model program supported by the Office of Prevention and Wellness is called **Building "Piece" of Mind and Purposeful Parenting**, and it is being championed in Ohio by the Ohio Academy of Pediatrics. This program provides simple handouts and tools to promote early childhood development from birth to age three, and offers additional tools to help young children grow with self-confidence, health and happiness. The six parts of Purposeful Parenting are being protective, personal, progressive, positive, playful, and purposeful so that parents and caregivers can decrease toxic stress. Decreasing toxic stress releases an in-born drive to grow, to learn, to contribute, and to connect with others. Purposeful Parenting helps children to be all that they can be. To learn more, please visit, http://www.ohioaap.org/building-piece-of-mind/.

OhioMHAS is working in partnership with Wright State University (WSU) in the development of Behavioral Prescriptions. WSU has extracted the active ingredients of many effective behavioral health programs and provided training on these "evidence-based" kernels to "non-usual care providers." This has allowed WSU to expand the breadth of universal prevention outside school-based practices and into the community to include: juvenile courts, parents, foster parents, piano teachers, babysitters, basketball coaches, etc. Further, according to Fruth, Mayer, Finnegan (2014), these "non-usual care providers" have demonstrated similar efficacy with evidence-based kernels after formal training as classroom teachers and behavioral health professionals.

Suicide Prevention

Approximately 1,400 Ohioans die by suicide each year. Males account for about 80 percent of Ohio's suicides, and firearms are used in more than 55 percent of completed suicides. Roughly 90 percent of people who complete suicide experience a mental health and/or substance use disorder that is untreated or under-treated at the time of death. It is estimated that more than 70 percent of youth who attempt or complete suicide have alcohol or illicit drugs in their systems; suicide is the number 2 cause of death for youth ages 19 to 24.

Because substance abuse, addiction and depression are key risk factors 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 strategies that 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. More than 5,000 people benefit from these efforts each year.

Suicide Prevention Community coalitions are committed to reducing stigma, which helps increase people's ability to seek help and ultimately prevent the loss of life from suicide. These coalitions provide training and education on suicide risk factors, warning signs (especially when combined with substance use/abuse), depression, and prevention strategies. Community collaboratives apply for mini-grants to develop and execute combined suicide/substance abuse/depression prevention strategies in their communities. The strategies developed are culturally relevant to the intended audiences and inclusive of local resources.

Additionally, suicide prevention is a public health priority and has support from both the Governor and the Legislature. The OhioMHAS Medical Director's Office and the Office of Prevention and Wellness are working collaboratively on the statewide suicide prevention plan. This plan compliments and enhances the work of the Foundation and other entities addressing this issue. The Department plans to contract with national expert(s) to assist in training and support the annual suicide prevention conference. Additionally, OhioMHAS will collaborate with existing suicide coalitions to identify effective local interventions and assist with replication across the state and enhance web-based resources for public awareness and education of general public, clinicians, gatekeepers, etc.

OhioMHAS will also work toward the development of an advisory group to guide these efforts. This group will assist to leverage other potential funding sources and help to monitor data to assess efficacy and effectiveness of interventions.

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.

Bureau of Workers' Compensation Drug-Free Safety Program and Safety Congress

The Drug-Free Safety Program (DFSP) offers a premium discount through the Ohio Bureau of Workers' Compensation (BWC) to eligible employers for implementing a loss-prevention strategy addressing workplace use and misuse of alcohol and other drugs, especially illegal drugs. In partnership with BWC, OhioMHAS assists in the yearly planning of the Ohio Safety Congress & Expo. The Congress is the largest regional safety and health conference in the nation, bringing in more than 6,000 attendees annually. In addition to the 225 exhibitors showcasing their latest safety innovations, products and services, there are 170 educational sessions offered on a variety of the hottest topics in the industry. Sessions are led by experts in their respective fields and all sessions offer continuing education credits.

Increase Workforce Capacity

Workforce development is a challenge for the prevention field 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 inequalities in salary and workloads. Young professionals come into the field and gain experience for a few years and move on to better paying positions. This coupled with the aging workforce in substance abuse prevention provides unique circumstances when looking at workforce development issues long-term. While Ohio is fortunate to have a relatively strong infrastructure supporting the prevention system at the state and local levels, a number of factors affect advancement of this system. These include periodic state budget reductions 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 OhioMHAS.

To address these issues and modernize Ohio's prevention system, the state 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 to implementing the IOM report recommendations is building awareness through major conferences and meetings. Seven sponsoring organizations held six different events to build awareness in Ohio between September 2012 and May 2014. Sponsoring organizations include Alcohol and Drug Abuse Prevention and Association of Ohio (ADAPAO), Drug Free Action Alliance, Ohio Prevention and Wellness Roundtable, Ohio Association of County Behavioral Health Authorities, OhioMHAS, Ohio Prevention Education Conference, and Ohio Early Childhood Conference. Ohio will continue to build on these efforts, and hold additional conferences and summits in 2016 and 2017. Additionally, the Drug Free Action Alliance will continue to 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 at the local level.

Empower Pregnant Women to Make Healthy Choices

Pregnant Women and Mothers of Dependent Children

The Department supports programs to address the prevention needs of women with a focus on pregnant women, and women with children and their families. 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 2016 - 2017 to create statewide interest in the learning community.

Fetal Alcohol Spectrum Disorders (FASD) Initiative

Each year, as many as 40,000 babies are born in the United States with an FASD, costing the nation about $4 billion, and yet, prenatal exposure to alcohol is the leading cause of preventable birth defects in the country. In conjunction with the state's FASD efforts, a public education campaign was developed titled, **Not a Single Drop**. An Ohio website https://notasingledrop.mh.state.oh.us/ redirects visitors to a website packed with information and resources for parent and community education on FASD issues. Radio and television Public Service Announcements (PSAs) are included with the campaign. Since the Department integration, the Not a Single Drop site needs to be updated.

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 Statewide FASD Steering Committee has worked to develop an integrated system for addressing the prevention and identification of fetal alcohol spectrum disorders (FASD).

A project implemented an Alcohol Screening Brief Intervention (ASBI) process in Ohio WIC (Women Infants and Children) in Montgomery County. This initiative allows for the screening of all WIC pregnant women for alcohol use, provision of brief interventions to all who screen positive, follows those receiving brief interventions during pregnancy and refers 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 decisions about reducing or completely ceasing drinking.

Maternal Depression

Perinatal Depression encompasses a wide range of mood disorders that can affect a woman during pregnancy and after the birth of her child. It includes prenatal depression, the "baby blues," postpartum depression, and postpartum psychosis. Ohio is 49th in the nation for infant mortality. Although African American babies are dying at double the rate of Caucasian counterparts, Caucasian babies are equally at risk. Of the many risk factors that impact a baby's failure to thrive, maternal depression and stress are significant factors. If the condition is interfering with the woman's ability to do what she needs to do for herself or her child, it can result in serious consequences. Screening is an easy, quick and affordable method of identifying women who may be struggling with depression. Successful efforts to prevent and treat maternal depression require an awareness of how common the disorder is, accurate identification of symptoms, and initiation of treatment as quickly as possible. Since depression occurs across all age, race, ethnic and economic groups, every new mother should be screened and educated about perinatal depression.

Support Families with Children and Youth

Start Talking!

Far too many Ohio families know the heartache of having a loved one deal with the nightmare of drug abuse. When that someone is a child or young adult, the emotional pain can be unbearable. But here is where it gets better: kids are up to 50 percent less likely to use drugs when their parents or other trusted adults talk with them about drug use and abuse. Understanding that this is not an easy discussion to begin, Governor John Kasich and First Lady Karen W. Kasich launched the Start Talking! statewide youth drug prevention initiative to help parents and other adults communicate better with kids. Based on research and what experts say are the best methods to engage kids, Start Talking! offers four ways for parents and other youth leaders to approach children and young adults:

- Know! focuses on the parents of middle school students and provides tips and tools offered by the Drug-Free Action Alliance.
- Parents360Rx is a national program from the Partnership for Drug-Free Kids that is designed to educate adults about the dangers found in their own medicine cabinets.
- 5 Minutes for Life engages student athletes and other young leaders as ambassadors.
- Resiliency Grants from the State to Ohio enable communities to build a strong prevention infrastructure by choosing among evidence-based programs t without local tax levies hat suit their unique needs. Resiliency Grantees have implemented more than 20 different research-based programs to help youth be and stay drug free.

As a whole, the Start Talking! Initiative aims to give students the courage to resist drugs and push back on peer pressure. Learn more about this initiative in its entirety at www.StartTalking.ohio.gov.

Parent Engagement Study

OhioMHAS seeks to support the empirical validation of a promising new practice to help families better manage their children's challenging behavior. The role of parents is vital in shaping children's growth, development and future achievements. However, families are often not sufficiently engaged by health care delivery systems around their children's wellness. This program evaluation effort seeks to improve family engagement and effectiveness in managing their children's problem behaviors by equipping them with a novel behavioral change method that can reduce preschool adjustment difficulties, preschool expulsion, emotional and social maladjustment, and subsequent potential problems in learning and behavioral concerns. The goal of this program evaluation effort is to determine that once trained in the **FLIP-IT®** model, the extent to which parents are able to affect decreases in negative behaviors and increases in positive behaviors in their children. The goal is to provide empirical support of the

FLIP-IT® model as a promising best practice for use by families to improve the emotional and behavioral functioning of their children.

Mental Health First Aid

Mental Health First Aid is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities — the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. Mental Health First Aid is offered in the form of an interactive 8-hour course that presents an overview of mental illness and substance use disorders. This course introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and reviews common treatments.

With OhioMHAS funding through the state legislature, the Ohio Association of County Behavioral Health Authorities (OACBHA) provided two of three trainings of trainers for Mental Health First Aid in the fall of 2013. Sixty (60) individuals completed the week-long course that prepared them to become certified trainers of the Mental Health First Aid curriculum. Following the completion of the three trainings, a cadre of trainers will be available throughout Ohio to conduct Mental Health First Aid training for community members. OACBHA will also be coordinating a learning collaborative for the certified Mental Health First Aid Trainers to provide continued learning and networking opportunities. Mental Health First Aid training will help the public identify, understand, and respond to signs of mental illnesses and substance use disorders.

Increase Access to Youth and Family Prevention Services

The Department funds prevention services primarily through allocations to ADAMH Boards and funding of statewide initiatives. The ADAMH Boards contract with prevention providers to support the development and implementation of a comprehensive array of primary prevention intervention programs to meet the needs of their local 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. These guidelines s ensure that 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

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 programs: 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, Youth Empowerment and Developmental Assets. These theories, in addition to evidence-based prevention strategies, provide a strong foundation toward supporting Youth-Led Prevention.

The 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 consists of an Adult Advisory Council (AC) and a Youth Council (YC) that are the driving forces behind the prevention initiatives and efforts established by the network to enhance youth-led prevention. 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 the YC developed a statewide social norming campaign called **We Are the Drug-Free MAJORITY!** This campaign launched with a rally at the Ohio Statehouse in May, 2012, with more than 600 youth participating and has continued with over 1200 attending in 2015. This rally is a celebration to recognize the spark of the drug-free youth movement and to maximize the power of positive peer influence. This celebration is spread throughout the state with satellite events at various locations.

The YC also wants to encourage, inspire, and promote a healthy lifestyle choice for all teens as the various youth-led groups take 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." Building awareness that most youth do not use substances communicates healthy expectations about alcohol and other drug-related behaviors.

The OYLPN has developed a Theory of Change for youth led programming in Ohio. Through the development of this theory of change, it became apparent that OYLPN impacted more than just substance abuse, but also impactedmental health promotion and wellness strategies; youth-led prevention takes a behavioral health approach to building resiliency and increasing protective factors in the youth and young adults of Ohio.

To further promote the message of 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. 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. The Youth Council developed and has adopted the tagline #BeAware. Their strategic plan for 2014 focuses on mental health issues specifically adolescent depression.

The next steps for the OYLPN are to continue to build capacity for youth empowerment in local communities and regions through the development of regional youth councils and the implementation of the Holden Model youth empowerment framework across the state.

Decreasing Youth Access to Tobacco – Synar Compliance

Synar

Section 1926 of the U.S. Public Health Services Act, referred to as the Synar Amendment, requires states to decrease youth access to tobacco. All states are required to have a law making the sale of tobacco products to minors illegal; conduct random, unannounced inspections of tobacco retail outlets in a scientific manner to check the compliance with state law; and report each year on the enforcement of state law activities conducted the previous year, enforcement plans for the coming year, and the extent of success in reducing the availability of tobacco products to minors. The law also requires states to meet established compliance rates (currently 80 percent rate of non-sales to youth) or be subject to up to a 40 percent reduction of Substance Abuse Treatment and Prevention (SAPT) Block Grant dollars for prevention and treatment services. In 2015, Ohio's compliance rate was 73.8 percent which put the state out of Synar compliance.

As an alternative to the 40 per cent SAPT Block Grant reduction, the state of Ohio elected to accept the federally offered alternative penalty. This alternative penalty requires the state of Ohio over the next two federal fiscal years to spend approximately $3.97 million in new state funds on youth tobacco access enforcement and educational programs/activities. The Ohio Department of Health (ODH) and OhioMHAS are working together to implement these programs and activities.

Compliance Checks
OhioMHAS works with the Ohio Department of Public Safety's Investigative Unit (OIU) to conduct enforcement activity for the state's Synar program.

Merchant Education
Merchant education is provided by the OIU. The **A.S.K.** (**Alcohol Server Knowledge**) program, formerly known as **H.E.L.P.** (**Hire Education for Liquor Permitted Premises**), provides merchants who sell alcohol with education about Ohio's alcohol and tobacco laws and skill building in checking identification and refusing sale. In 2015, the OIU gave 277 **A.S. K.** state-wide presentations with 3,545 attendees state-wide.

Merchants may also choose to receive training through other sources such as the **"We Card"** program. Educational material for employees is available via download from the OIU's homepage or by request from the OIU. The pamphlet entitled "Clearing the Air on Ohio's Tobacco Laws" is available in English, Spanish and Somali and was created for distribution through collaboration between OhioMHAS, OIU and the ODH.

Community Education
The OIU's "Sober Truth" program provides information about Ohio's tobacco and alcohol laws throughout the state. In 2015, the OIU gave 789 Sober Truth presentations with 27,865 attendees state-wide.

Programs Targeting At-Risk Populations

Urban Minority Alcoholism and Drug Abuse Outreach Programs
The primary purpose of the Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOPs) is to provide culturally appropriate prevention services to African-American and Hispanic/Latino American communities in Ohio. These programs were created by the Ohio legislature in the 1980s, and are supported by state and federal funds. All programming activities are structured to provide a foundation to build healthy communities, positive youth development, violence and substance free lifestyles. 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 support. The UMADAOPs are located in Akron, Cincinnati, Cleveland, Cleveland Hispanic, Columbus, Dayton, Lima, Lorain, Mansfield, Toledo, and Youngstown. Since their inception they have been a vital force in meeting the substance abuse education, prevention, treatment and recovery support needs of African and Hispanic/Latino Americans throughout the state of Ohio. The programs will remain central to OhioMHAS' cultural competency goals.

Ohio National Guard

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 current focus of this work is to build capacity 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.

To further the partnership with the ONG, OhioMHAS has reached outto the **Ohio 4-H Operation Military Kids (OMK)** project to help support resiliency in military families and children. 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 children to help them find positive ways to cope with the stress of parents' deployment. These efforts align with the Ohio Youth Led Prevention Network initiative; plans are to facilitate the development of youth-led prevention groups specifically for OMK youth.

This is not the entire picture of military families, however, because it does not account for all the branches of the service. By mapping the location of Army and Air National Guard and Army Reserves service members, the Department can use this data to target low capacity areas for youth-led network group expansion.

Focus on High Need Issues

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 use or abuse of the drug; 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 percent of all adolescents receiving publicly funded treatment services) reported marijuana as a primary, secondary, tertiary or quaternary drug of choice. Over half of all admissions to publicly 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 adolescents and in adulthood; this also includes physical health problems. There is a need in Ohio for increased prevention efforts among youth and young adults addressing marijuana use. The Drug Free Action Alliance and the Statewide Prevention Coalition Association along with ADAPAO, the association for Ohio preventionists are taking the lead on this issue. To kick-start this effort, a series of three Regional Summit professional learning experiences were provided in 2013; sessions have continued in 2014 and 2015 focused on this issue.

Opiate Epidemic Related Projects

Family Engagement Groups

Ohio is in the midst of a public health crisis due to the fast growth 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, and drug overdoses are also at an all-time high, averaging four deaths a day 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 communities to implement policy changes that can change environmental conditions that encourage drug abuse.

Prevention: Provide training and connection to local resources to promote community prevention services, especially to children and adolescents.

The Department, 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 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.

Drug Free Action Alliance 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 Drug Free Action Alliance plan to formalize training in the three focus areas to further assist family members in mobilizing their communities for change.

Opiate Task Forces

The creation of community Opiate Task Forces was seen as one of several strategies to better educate communities, young people, parents, other caring adults and healthcare practitioners about the dangers of opiate abuse and addiction. The Opiate Task Forces:

- Are designed to bring people and resources together from all sectors of the community impacted by the opiate issue and provide a structure for community response to the opiate epidemic.
- Engage communities to develop and pursue a unified goal, coordinate strategies, and pool resources.
- Work with ADAMH Boards to hold local events such as town hall meetings, community summits, prevention days, and lead or participate in drug take-back days.

Drug Take Back Days and Drop-off Boxes

OhioMHAS has partnered with the Drug Enforcement Agency, Ohio Department of Health, Office of the Attorney General, Drug Free Action Alliance and dozens of community groups and law enforcement organizations to hold prescription drug take back days throughout Ohio and to purchase hundreds of permanent drug drop-off boxes. These efforts are concrete solutions to getting prescription drugs out of home medicine cabinets where youth and adults can find them and potentially abuse them. All drug drop-off events include education about the importance of using only those medications that have been prescribed for you by a physician and not sharing prescriptions with anyone else.

Town Hall Meetings

Dozens of town hall meetings have been held throughout the state for discussion of the opiate epidemic and to share valuable tips on how to protect families and the community from opiate addiction and the dangers of overdose. The Town Halls were coordinated and led by Opiate Task Forces, ADAMH Boards, OhioMHAS, and Ohio Citizen Advocates for Addiction Recovery.

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 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.

Ohio College Initiative

OhioMHAS supports the Ohio College Initiative to Reduce High Risk Drinking which began in 1996, and brings together more than 46 college and universities. OhioMHAS provides funding to Drug Free Action Alliance, who partners with The Ohio State University Higher Education Center for Alcohol and Drug Misuse Prevention and Recovery(HECAOD) to implement this initiative. The Higher Education Center for Alcohol and Drug Misuse Prevention and Recovery (HECAOD) is the premier alcohol and drug misuse prevention and recovery resource for colleges and universities across the nation. HECAOD is a joint collaboration between The Ohio State University's College of Social Work, College of Pharmacy, Office of Student Life, Generation Rx Initiative and Collegiate Recovery Community. 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.

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. Training and technical assistance is also provided to colleges and universities to address issues of high risk drinking that focus on utilizing environmental strategies.

BUZZKILL

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 that 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 be customized.

Gambling in Prevention

Ohio for Responsible Gambling

With four new casinos and seven upgraded racetracks that now have video lottery terminals (electronic slot machines) in Ohio, four state agencies have joined together to form an initiative to combat problem gambling. The Ohio Lottery Commission (OLC), Ohio State Racing Commission (OSRC), Ohio Casino Control Commission (OCCC) and OhioMHAS have formed an initiative known as Ohio for Responsible Gambling (ORG). As the lead agency responsible for prevention and treatment of problem gambling, OhioMHAS serves as the behavioral health resource partner for the new organization. The Ohio for Responsible Gambling collaborative is building on existing programs and growing service capacity for Ohio families who may be affected by problem gambling now and in the future. ORG works to provide information and resources to individuals in need of services through the Ohio Problem Gambling Helpline (1-800-589-9966) and ORG's website, www.org.ohio.gov**.**

Prevention Services

A number of actions occurred in SFY 2014 and 2015 and will continue into SFY 2016 and beyond to ensure that the Ohio behavioral health service system and its partners have the appropriate tools to address prevention of problem gambling in the context of public health.

Prevention Regional Workforce Development

For SFY 2015, OhioMHAS awarded capacity-building grants for problem gambling services in the amount of $1.2 million. These funds currently support development and implementation of evidence-based and promising practice models for prevention and treatment of gambling disorder and encourage service systems that prioritize data collection toward achievement of effective

outcomes. The funded boards and agencies have taken varied approaches to bringing best practices to people in their communities.

Prevention of Problem Gambling

With grant dollars, approximately 120 prevention professionals from across the state were trained as trainers in the prevention model *Stacked Deck*, a curriculum for problem gambling prevention for young people ages 13-17. *Risky Business*, a prevention program developed for the ADAMHS Board of Montgomery County by Wright State University — for youth with criminal justice involvement — is also being piloted at several venues throughout the state and is being evaluated as a future evidence-based practice.

Risky Business

Juvenile justice-involved youth ages 13-17 - 423 participants in Montgomery, Franklin, Cuyahoga, and Mahoning counties; 19 additional youth received the control intervention.

- Risky Business participants showed a large significant improvement in all six curriculum lessons, pre-test to post-test; control group participants showed no improvement on post-test instrument.
- 96.6% of participants reported they liked the program.
- In an anonymous survey, 85.7% said they would recommend the program to friends.

E-based Gambling/Financial Wellness Program: The curriculum was developed in SFY 2015. Arrangements were made for piloting the program in SFY 2016 at Central State University, The Ohio State University, Bowling Green State University, University of Mount Union, and Youngstown State University.

Smart Bet: Drug Free Action Alliance is refining *Smart Bet*, a prevention curriculum for 18-25 year-old adults, and creating an online delivery system that will first be utilized at five college/university campuses to study its effectiveness.

Ohio Problem Gambling Resource and Training Center

OhioMHAS has taken steps to develop the Ohio Problem Gambling Resource and Training Center. The Resource Center promotes the recognition of problem/disordered gambling behavior, as well as identified characteristics of low-risk gambling, to this state. The learning module created by the Institute offers the opportunity for training and education services, which can be developed into classes and informational program materials on how to respond to and prevent gambling problems. The Ohio Problem Gambling Resource and Training Center has been moved to DFAA's web domain, and will continually be updated with resources for the healthcare professional.

Ohio Problem Gambling March Conference

Annually, the OhioMHAS has facilitated a Problem Gambling conference during national Problem Gambling Awareness Week in March. This event has been focused on problem gambling workforce development, bringing the most current evidence-based practices and national experts in the field to Ohio. Since 2002, this Problem Gambling Conference, funded in part by the Ohio Lottery Commission (OLC), has been Ohio's only statewide opportunity to learn the latest in prevention, intervention and treatment for individuals with problem gambling. Opportunities for networking among professionals have always been an important part of this event. Effective in 2014 and 2015, the conference became a stand-alone 1.5 days event that is hosted by the Ohio for Responsible Gambling (ORG) partners. Cost sharing among the ORG partners has allowed for more in-depth workforce capacity expansion sessions with national and internationally known keynote speakers. The next conference is scheduled for March 3-4, 2016.

Infusing Problem Gambling Prevention within Community Organizations

The Bureau of Problem Gambling Services within the Office of Prevention and Wellness recognizes the need to infuse education and resources through related programming and community partners. According to the ADAMH Board's Problem Gambling Plans, the Boards also see the overwhelming need to apply prevention strategies to problem gambling including information dissemination, education, community based process and environmental strategies. Population-based and environmental prevention strategies are essential to community success in prevention of problem gambling. It is expected that the strategies mentioned above will be particularly effective approaches for problem gambling because of the similarities between gambling and alcohol abuse. Both are illegal for youth; both may cause adverse consequences when frequency and duration increases for adults.

OhioMHAS and its partners take every opportunity to bring education and resources to partners. Activities include current and planned outreach to physicians and other healthcare providers, veterans' services, senior centers, drug-free community coalitions, Job and Family Services offices, clergy/religious groups, and others. Communities across the state are building problem gambling prevention components into existing evidence-based programs for prevention of risky behaviors. An example of this is the Life Skills curriculum.

Statewide and Community Problem Gambling Campaigns

The Ohio for Responsible Gambling partners are committed to ensuring that Ohioans have a constant, consistent message that gambling can be great entertainment, but too much gambling can cause problems for an individual or a family. To ensure that an effective, targeted message of safe and responsible gambling is disseminated, the Ohio Lottery Commission will fund a statewide campaign for SFY 2014-15 on behalf of ORG.

An inter-disciplinary group made up of representatives from ORG and the state's ADAMH Boards and agencies, met in December, 2012, to make recommendations for the campaign. This group then reviewed the proposed campaign in August 2013 to ensure adherence to evidence-based public health prevention and education practices. *I Lost a Bet* launched in early 2014, targeted toward a prime demographic for awareness of problem gambling – the young adult male. Ohioans reached with prevention messages in SFY 2014 totaled 2.04 million.

Launching in August 2015 is a new public health-focused Problem Gambling Awareness Campaign called "Be the 95%: If you gamble, be the 95% of people who gamble responsibly." This campaign is also being sponsored and funded by the ORG partners. It is targeted to reach influencers of potential problem gamblers.

The behavioral health system of care across the state is primed to take a responsible gambling message into the local communities. In ADAMH board areas where the young adult male has been determined by a needs assessment to be a target demographic, the community organizations will pick-up the new campaign and maximize it with local resources.

Treatment of Problem Gambling

The new Gambling Endorsement for Chemical Dependency Counselors was passed and took effect in March 2015. As of Aug. 1st, 10 CDCs have earned the Endorsement and seven have applications in process. After years of committed work by the behavioral health field, state leaders and the Ohio General Assembly, HB 483 enacted a provision that authorized the OCDPB to create and offer a Gambling Disorder Endorsement for professionals qualified to treat gambling disorder. The Endorsement became effective in March 2015 and is available for individuals who hold an active LCDC II, LCDC III, LICDC or LICDC-CS license.

In SFY 2014, 26,000 Ohioans were screened for gambling disorder and 924 received treatment for a gambling disorder diagnosis. In SFY 2014, 9,727 people called the Ohio Problem Gambling Helpline for assistance.

Problem Gambling Regional Training: The foundational Stage 1 and 2 training sessions for treatment of gambling disorder were offered regionally, along with new seminars to provide hands-on experiential training in treatment, care planning, and continuing care planning. This focus has been requested in the evaluations of gambling treatment trainings over the past year.

Competitive Grant Funding

Through competitive grant funding, seeded development of four new promising practices in Problem Gambling Treatment, including the Rupcich Model. This pilot study was design to discover the effectiveness of a new group-based facilitated, 12-week treatment curriculum on a sample of Ohio disordered gamblers and whether the curriculum positively influenced self-esteem, gambling cravings, and ultimately reduced gambling behavior among participants.

1.6.1 Children and Youth with Serious Emotional Disturbances (SED) Community Behavioral Health Services

System of Care for Children and Youth with Serious Emotional Disorders (SED)

Ohio's behavioral health system has a public health approach that builds upon established collaboration of state agencies and county ADAMH Boards. At the state level, the OhioMHAS Prevention and Wellness Office provides leadership for **treatment services for children and youth with serious emotional disturbances, as well as for mental health and substance abuse and gambling promotion and prevention.** Statewide interagency coordination among health agencies is led by Ohio Office of Health Transformation. This office coordinates the activities of the health and human services agencies. Ohio's child serving cabinet-level agencies include: Aging (disability network), OhioMHAS, Developmental Disabilities, Education, Health, Job and Family Services (employment, child welfare, social services/Title XX), Rehabilitation and Corrections (adult justice), and Youth Services (juvenile justice). At the community level, county and multi-county ADAMH Boards plan, evaluate and fund local mental health and addiction services for children and youth 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. Most Boards develop collaborative relationships with schools and universities, developmental disabilities providers, juvenile justice, child welfare, health departments and county commissioners. Additionally, Boards collaborate with these local child-serving organizations through local Ohio Family and Children First (OFCF).

Family and Children First

Ohio Family and Children First coordinates a single county-level System of Care (SOC) which serves children and youth with SED who receive services through multiple county governmental organizations. County Family and Children First partners include the local government organizations address mental health and addiction, developmental disabilities, juvenile justice, child welfare, and education. The purpose of the county Family and Children First Councils are to streamline and coordinate existing government services for families seeking services for their children. Each Family and Children First Council is mandated to perform four core functions: Engaging and Empowering Families, Coordinating Systems and Services, Building Community Capacity, all with an eye towards Shared Accountability among their local system partners. Each Family and Children First Council works collaboratively towards a vision that every child and family can thrive and succeed within healthy communities.

Ohio's Children's System of Care Providers	
Services	**Provided by:**
Care coordination for children who need services from multiple service systems	County-level Family and Children First organizations coordinate services for many children with multi-system needs. Additionally, CPST workers employed by community behavioral health providers coordinate care for children with less complex needs who may also be accessing services from multiple organizations.
Community behavioral health services and SAMHSA required elements of care	Local treatment providers provide the services. ADAMH Boards coordinate care at system level for their counties, and determine what services are available locally in addition to the Medicaid-eligible treatment services which are available statewide. Pomegranate
Social services & employment services	County Job & Family Services provide employment, child welfare and social services/Title XX. Additionally the Ohio Opportunities for persons with Disabilities provides some additional vocational and employment services.
Education	Schools with oversight from Ohio Department of Education
Disabilities in education act (IDEA)	Local schools with technical assistance from Ohio Dept. of Education
Developmental Disabilities	Ohio Department of Developmental Disabilities oversees County-level developmental disability boards which may have local tax levies to provide additional services; developmental disabilities providers; local developmental providers offer services and supports to individuals with developmental disabilities and their families
Juvenile justice	Department of Youth Services, County Juvenile Courts, OhioMHAS community linkage social workers provide linkage to community behavioral health services for offenders being released from Department of Youth Services facilities
Medical & dental	By referral for most children; for eligible Health Home enrollees;
Housing/foster care	Ohio Dept. of Job & Family Services; County Job & Family Services; Child welfare agencies; county juvenile court system all may be involved in these decisions
Behavioral health crisis services	State law requires Boards to assure local availability of crisis services from community behavioral health services
Behavioral health 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, licensure boards, Coordinating Centers of Excellence, trade associations – all offer training.
Health homes for SPMI	OhioMHAS, providers; this service is being replaced by a new behavioral health benefit for Medicaid recipients
Rural Providers	Providers, Boards, OhioMHAS
Partial hospitalization	Provided by many larger children's behavioral health providers.
Residential Treatment	Job and Family Services funds residential services which frequently includes partial hospitalization services funded by Medicaid and/or ADAMH Boards
Psychiatric hospitalization	Provided by community, university and children's hospitals, and funded by Medicaid, other insurance and Boards. Ohio does not have public inpatient psychiatric services for persons under age 18.

ENGAGE (System of Care) – Engaging the New Generation to Achieve Their Goals through Empowerment

In July 2013, the Ohio Department of Mental Health and Addiction Services (OhioMHAS) received a four-year System of Care Expansion Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This grant, called ENGAGE (Engaging the New Generation to Achieve their Goals through Empowerment), follows a SAMHSA System of Care Expansion Planning Grant awarded to the State of Ohio in September 2011, the purpose of which was to develop a cross-system four year strategic plan focused on expanding the System of Care framework for the target population. ENGAGE's target population is the following.

ENGAGE Target Population

Youth and young adults in transition (YYAT), ages 14 through 21 years, with serious emotional disturbance, who may have co-occurring disorders; and who are: a) at risk for involvement, currently involved, or previously involved with the child welfare or juvenile justice systems; or b) who may be at imminent risk of homelessness.

The purpose of ENGAGE is to reduce expenditures and improve outcomes related to physical and behavioral health, education, employment, and living stability for high risk youth and young adults through statewide System of Care expansion of the evidence-supported, research-based High Fidelity Wraparound practice.

At the end of SFY 2015 (June 2015), the ENGAGE grant has been implemented in 22 counties and enrolled approximately 120 youth into the High Fidelity Wraparound program. Additionally, a second group of over 150 individuals representing 20 counties, received Wraparound training. This brings the total to over 300 trained Wraparound facilitators.

Ohio's Children's Mental Health Service Providers

Ohio has a wide-range of providers that offer children's mental health services that are certified by OhioMHAS to provide outpatient services. Providers may have contracts to provide services with one or more ADAMH Boards, or be "Medicaid-only" providers. Some of these providers are also licensed by OhioMHAS to provide residential care, and some are also licensed to provide foster care by Ohio Department of Job and Family Services. Each Ohio community children's system of care is organized differently.

Many providers have evolved over the years to fill a community need, As a result, children's systems of care overlap communities, and vary widely among Ohio's Board areas counties. The service systems also vary widely in how integrated they are with primary health care, child

welfare, juvenile justice and developmental disabilities. While many of these children's providers developed from community behavioral health care centers, some evolved from children's hospitals, community hospitals, family service providers, child guidance centers, orphanages and foster care providers to meet the needs of local communities. Most provide SUD treatment services, as well as mental health treatment.

Some examples of Ohio's diverse children's providers include:

Community Behavioral Health Centers

- Woodland Centers, Inc. serves persons of all ages in a rural, Appalachian community. Services include out-patient mental health and SUD treatment services and school based services. http://www.woodlandcenters.org/childrens_programs.htm
- Child Adolescent Behavioral Health in Canton provides trauma-informed care, and has Trauma Focused Day Treatment. This agency became one of the first five nationally accredited Transitional Age Service Department to provide services to older adolescents and young adults; it also employs young adult peer supporters. It provides Early Childhood Prevention, Consultation and Treatment for children 0 – 6, and as well as an ADHD Program. http://www.childandadolescent.org

Child Guidance Center

- Child Guidance and Family Solutions in Akron which provides mental health services, as well as Integrated Co-occurring Treatment (ICT) for co-occurring mental health, and SUD for children and youth. http://cgfs.org/about/index.php?id=12

Family Service Agencies

- Jewish Family Service Association of Cleveland evolved to provide mental health, intellectual and developmental disability, domestic violence, emergency shelter, older adult, home care and college financial aid services to children and adults of all faiths. Lutheran and Catholic Service Agencies provide similar services in many communities. http://www.jfsa-cleveland.org/

Former Orphanage Evolved into Children's Behavioral Health Provider

- St. Joseph's Orphanage in Cincinnati evolved into providing behavioral health care for children and residential care for children including those with physical and/or developmental disabilities in urban area. Services include crisis stabilization unit, day treatment, outpatient services, education, medication management, therapeutic foster care, CFPT (case management) and Transition to Independence (TIP). http://stjosephorphanage.org/

Foster Care Provider with Mental Health Services

- SAFY (Specialized Alternatives for Families) is a foster care provider in many Ohio communities that expanded into mental health care in multiple states including Alabama, Indiana, Nevada and Oklahoma. http://www.safy.org/

Rural Community Behavioral Health Centers located within Regional Medical Center

- Firelands Regional Medical Center - Outpatient and Recovery Services provides a full range of community behavioral health services to persons of all ages in seven rural counties in multiple Board Areas. Firelands is a hospital and regional health care provider for rural counties in northern Ohio. http://www.firelands.com/services/behavioral-health.aspx

Children's Hospitals

- Nationwide Children's Hospital provides community behavioral health services at multiple sites in the greater Columbus area, and inpatient psychiatric services for children and youth living in central Ohio. As a major pediatric hospital and medical center, it provides a wide range of primary and specialized care for children with cancer and other serious diseases. Nationwide Children's Hospital in Columbus is also one of the largest pediatric research centers in the United States with major grants from National Institute for Health. http://www.nationwidechildrens.org/behavioral-health

As these examples suggest, Ohio has 50 Board areas with diverse children's providers. Each community's system of care has evolved very differently, and has very different levels of integration with primary health care, juvenile justice, developmental disabilities, substance use disorders, schools, and child welfare. Many of these organizations began their work as a health care or social service provider in a "non-mental health" system of care, and maintain integration with another system of care. As community agencies vary greatly in their service mix and history among Ohio communities, local systems of care vary widely for Ohio's children.

Continuum of Behavioral Health Care for Children with SED

Ohio is beginning a process to redesign its behavioral health continuum of care for persons of all ages. Currently 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 and trauma 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. Despite the number of services, Planning Council consumers and family members describe gaps in services for children who need

Intensive Home Based Services, High Fidelity Wrap Around, respite care, hospitalization, treatment foster care and/or other intensive services.

Community Mental Health Services - Eligible for Ohio Medicaid Reimbursement
Please see the description of Ohio's Behavioral Health Medicaid benefit services earlier in this document. Ohio does not offer state-operated inpatient psychiatric services for persons under 18. The ADAMH Board is responsible to ensure that inpatient services are available for children and youth under age 18. The county options are varied, but many so those services are provided by private, university and community hospitals offer inpatient services that are reimbursed through Medicaid or a private insurance provider. The board offers financial support as needed to the extent that resources are available.

Recovery support services which are not eligible for Medicaid reimbursement are:

- Therapeutic or Treatment Foster Care
- Residential Treatment Facility (RTF)
- Respite care
- Foster care
- Family peer support
- Information and referral

Evidence-based and promising treatment services in Ohio include:

- Multisystemic Therapy
- Intensive Home Based therapy
- Integrated Co-occurring Treatment (MH/SA for youth)
- Functional Family Therapy
- High Fidelity Wraparound
- Transition to Independence Process
- First Episode Psychosis (FIRST)
- Incredible Years

Most recovery supports, and some components of evidence-based practices are not eligible for Medicaid funding in Ohio. Block Grant, local tax levies, state General Revenue funds, are used to fund these services which are essential

Initiatives to Improve Children's Treatment

OhioMHAS has a number of statewide initiatives to improve services for children, youth, and transitional age youth/young adults, as well as many local initiatives to improve care led by Boards and providers. OhioMHAS' initiatives are funded by SAMHSA Block Grants and

program specific grants, private non-profit organizations and the state legislature. In addition to funding specific initiatives, OhioMHAS uses Mental Health Block Grant to fund the Center for Innovative Practices (CIP) of Case Western Reserve University. CIP offers technical assistance and training to providers to implement specific evidence based and promising practices including Multisystemic Therapy (MST), Intensive Home Based Therapy, and Integrated Co-occurring Treatment. For prevention and early intervention initiatives, please see the previous section of this document. Ohio' statewide initiatives which address treatment for children include:

Promoting Evidence-Based Care

Through direct staff consultation and with the guidance and training resources of the Bureau of Children and Families works with clinicians, agencies, and boards to disseminate therapeutic best practices. These practices are guided by theory, research and practice in the preventive areas of family support, early childhood intervention, and children's mental health treatment. These practices promote and enhance resiliency, improve outcomes/functioning level, and the behavioral health and wellbeing of children, parents, and families. Intensive home and community based treatment practices including but not limited to Multisystemic Therapy, Trauma-Informed Care, High Fidelity Wraparound, Incredible Years, Early Childhood Mental Health consultation, and school-based Care Teams are emphasized.

Early Childhood Initiatives

Maternal Depression

Perinatal Depression encompasses a wide range of mood disorders that can affect a woman during pregnancy and after the birth of her child. It includes prenatal depression, the "baby blues," postpartum depression, and postpartum psychosis. Of the many risk factors that impact a baby's failure to thrive, maternal depression and stress are significant factors. Please see the Prevention and Wellness section for a more complete description of this work.

Devereux Early Childhood Assessment (DECA) Classroom Environment Study

Partnering with Devereux Center for Resilient Children, OhioMHAS is examining the extent to which early childhood mental health consultation can positively impact early learning classroom environment. The primary goal of this study is to evaluate the usefulness of the DECA Preschool Program Reflective Checklists and associated strategies in promoting early learning classroom quality. The study is designed to help teachers reflect on and intentionally use practices to promote social and emotional health in preschool-aged children. Research supports that when teachers have more positive interactions with children and provide experiences and materials that are age appropriate, teachers improve classroom practices with young children; the result is that children have better social and emotional adjustment. The findings from the study have indicated when the classroom checklists are used to fidelity; that teachers and students experience improvements in their social and emotional adjustment.

Early Learning Challenge Grant – Race to the Top

During SFY 2013-14 the OhioMHAS has committed to improving mental, social and emotional wellness outcomes for Ohio's youngest citizens, children from birth to age 6, by investing in innovation and clinical best practices; Ohio has received national recognition as a state offering "compelling" successful work in a report by early childhood mental health policy advocates. Through partnership in the Governor's Race to-the-Top Early Learning Challenge Grant Initiative, OhioMHAS awarded $1.2 million in funding to early childhood mental health (ECMH) consultation; ECMH is consultation to parents and caregivers of children ages 0 – 6 with behavioral health issues. Working as part of a multiagency wellness team, ECMH consultants are focusing service provision on professional development and training to early childcare educators and professionals statewide.

The purpose of the Race to the Top four-year, 20 state national demonstration project is to model strategies states and communities can implement to increase the number of children in high quality child care settings with the goal of better preparing America's children for kindergarten readiness and long range academic success. Anticipated outcomes of the ECMH consultation project are improved family engagement, reduced expulsion rates from early child care settings and early linkage and referral to behavioral health services to prevent escalation and worsening of possible emotional or behavioral symptoms.

ECMH consultants have completed an aggressive master training agenda to prepare them to offer professional development trainings for the early childhood educators, professionals and the mental health field. This activity will continue through SFY 2016 focusing on Ohio's Early Learning and Development Standards, Social and Emotional Wellness, Effects of Childhood Trauma, Managing Challenging Behaviors, Culture of Poverty, Stress Management for Caregivers and an Early Child Mental Health 101 professional development topic.

Healthy Students & Safe Communities

Strong Families, Safe Communities

Governor Kasich and the State of Ohio are committed to improving care coordination and providing support for families with children in crisis who present a risk to themselves, their families, or others because of mental illness or a developmental disability. Many children who are at risk are not engaged in treatment programs and may not be known to the community until a crisis unfolds. Care coordination and targeted crisis intervention services can quickly stabilize a child's health. Support for these families in need will reduce risk of harm and help the family remain together. During spring 2013, the Ohio Departments of Developmental Disabilities (DODD) and OhioMHAS sought collaborative community proposals to establish treatment models of care that focus on crisis stabilization for children with intensive needs. This initiative

has engaged local systems to identify community-driven solutions that highlight collaboration across agencies to develop the best possible outcomes for children and families.

In July, 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. This work will continue into SFY 2016-2017 with $6 million in funding from the state legislature.

During FY2015 the Strong Families Safe Communities grants were awarded to 14 projects – 7 new and 7 continuing from FY2014- with cross-system collaborations occurring in 42 counties. Funded projects included a wide range of services and the establishment of a crisis text line. Services include early identification of at-risk youth, crisis response, intensive service coordination, crisis and planned respite, therapeutic mentoring, wrap-around services, family support and education, and individual/family treatment using trauma-informed approaches.

Additionally, most projects included training components intended to support professional development, organizational shifts and system transformation. Training topics included Trauma Informed Care, Strengthening Families, Virginia Student Threat Assessment Guidelines, Integrated Family and Systems Treatment, Youth Mental Health First Aid, Critical Incident Stress Management and safety planning. A full-day session for all funded projects took place in May, 2015 and promoted further collaboration and focused on successful approaches and sustainability plans.

Safe Schools/Healthy Students

The goal of the Ohio Safe Schools/Healthy Students (SS/HS) state and local partnership is to build statewide and local capacity to develop comprehensive, data-driven strategic plans to prevent, delay the onset or mitigate the seriousness of behavioral health problems. A key aspect in the success of this goal will be engaging youth, families and schools as agents of community change. Achievement of project goals will enhance system capacity and strengthen partnerships at the state and local levels. The partnership will provide community-based models and mentors for other communities that wish to adopt comprehensive, integrated plans to provide effective behavioral health services and prevent youth violence. The focus is to promote healthy social/emotional development and to build safe and healthy family, school and community environments using the findings of the 2009 Institute of Medicine Report (IOM).

The project is a partnership between OhioMHAS, Ohio Department of Education and other state departments; state training, technical assistance and evaluation partners; and three local

education agencies in rural counties including Greene County Educational Service Center, Northwest Ohio Educational Service Center in Williams County and Harrison Hills City Schools in Harrison County. Ohio estimates that approximately 620 children/youth per year (1,860 over the grant life) will receive direct early intervention or treatment services in the three counties, and approximately 98,000 households per year with children (more than 300,000 individuals over the grant life) will benefit from prevention services provided through this SAMHSA/CMHS grant.

Mental Health First Aid for Public

Mental Health First Aid is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities — the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. Mental Health First Aid is offered in the form of an interactive 8-hour course that presents an overview of mental illness and substance use disorders. This course introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and reviews common treatments.

With OhioMHAS funding through the state legislature, the Ohio Association of County Behavioral Health Authorities (OACBHA) provided two of three trainings of trainers for Mental Health First Aid in the fall of 2013. Sixty (60) individuals completed the week-long course that prepared them to become certified trainers of the Mental Health First Aid curriculum. Following the completion of the three trainings, a cadre of trainers became available throughout Ohio to conduct Mental Health First Aid training for community members. OACBHA coordinates a learning collaborative for the certified Mental Health First Aid Trainers to provide continued learning and networking opportunities. Mental Health First Aid training helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. More information is available at: http://www.mentalhealthfirstaid.org/cs/take-a-course/what-you-learn/

Mental Health First Aid in Schools

Ohio Department of Education has a Mental Health First Aid capacity building initiative that is funded by a SAMHSA/CMHS grant from 2014 – 2019. Through the "Making Ohio AWARE: Building Statewide Mental Health First Aid Capacity" initiative, Ohio will develop a modern, enhanced infrastructure to raise awareness of mental health needs among school-aged youth and increase statewide and local capacity to develop, implement, and sustain the delivery of integrated, comprehensive, evidence-based mental health and behavioral health services for youth and families. The efforts will occur through collaborative partnerships between the Ohio Department of Education, three partnering Local Education Agencies (Cuyahoga County, Warren County, and Wood County Educational Service Centers), State Management Team, the

Center for School-Based Mental Health Programs, the Ohio Mental Health Network for School Success, and other state departments. The project will promote a comprehensive and coordinated system for promoting wellness, safety and resilience built upon foundations of Positive Behavior Interventions and Supports, Safe Schools, and other support programs. Cross-sector assets and resources will be leveraged to build and support an effective interconnected systems workforce by increasing the number of individuals trained to deliver Youth Mental Health First Aid (YMHFA; 3 SEA trainers and 9 LEA trainers), the number of first responders trained in YMHFA (750 trained yearly and 3,750 trained throughout the project), and youth access to mental health services (for at-risk students identified within the 30 districts). The initiative will use data to inform decision making, emphasizing state-wide capacity building for evidence-based innovations. Across the project objectives, a key aspect in the success will be engaging youth, families, and schools as agents of community change. It is anticipated that achievement of project goals will enhance system capacity and strengthen partnerships by providing documented effective community-based models for other communities wishing to adopt comprehensive, integrated mental health promotion.

Suicide Prevention

See Prevention and Early Intervention for a description of Ohio's Suicide Prevention initiative which addresses persons of all ages.

Initiatives to Benefit Youth and Young Adults Receiving Treatment or Supports

First Episode Psychosis

The First Episode Psychosis (FEP) initiative offers evidence-based treatment to youth and young adults ages 15 – 25 who are have experienced their initial episode of psychosis. The treatment approach is team based and includes: specific medication protocols, family education and support, supported employment/education, relapse prevention, Cognitive Behavioral Therapy for Psychosis (CBT-P), and may include Assertive Community Treatment or other specialized interventions. The teams are person centered, and focus on the goals of the youth/young adults as related to education, work and quality of life. Treatment interventions begin within 18 months of the initial onset of psychosis. OhioMHAS' initiative funds five programs that serve nine counties. The goal is to expand the availability of FEP into other regions of the state. See the Environmental Factors section of this application for a detailed description of Ohio's FEP programs.

YouthMOVE Ohio

A major service gap in Ohio is youth involvement in the mental health system of care in a way that empowers youth to be able to advocate for themselves and for system change. OhioMHAS is committed to bridging this gap by collaborating with National Alliance on Mental Illness Ohio and YouthMOVE Ohio. This program expands, enhances and ultimately sustains the growing

youth voice through the development of a YouthMOVE statewide infrastructure which will consist of a network of local YouthMOVE chapters in counties throughout Ohio. By providing structure to youth voice, this program will better meet their needs and ultimately help youth transition successfully into adulthood and lead productive, meaningful lives.
YouthMOVE Ohio with support from OhioMHAS will continue to identify agencies/organization to host local YouthMOVE chapters who will receive training and technical assistance on the establishment of a successful chapter. YouthMOVE will continue the youth state leadership council with representation from five regions in the state to provide direction for YouthMOVE Ohio.

NAMI-Ohio

NAMI-Ohio collaborates with YouthMOVE, and has a business agreement with the Ohio Federation for Families of Children with Mental Illness which has a SAMHSA grant to network families of children with serious emotional disturbances. Parent/family education groups are available in many communities throughout Ohio through local NAMI chapters which receive technical assistance and training through NAMI-Ohio. NAMI educational groups include Basics, "*a signature educational program for parents and other caregivers of children and adolescents living with mental illness. The NAMI Basics course is taught by trained teachers who are the parents or other caregivers of individuals who developed the symptoms of mental illness prior to the age of 13.*" *http://www.namiohio.org/mental_health_support/basics*. Additionally, a similar Family-to-Family is available which focuses on schizophrenia, bipolar disorder and major depression. Additionally NAMI Family Support groups are available in many communities.

Ohio Adolescent Health Partnership (OAHP)

OhioMHAS is a key partner in the OAHP. The OAHP is a diverse group of agencies, organizations and individuals with expertise in adolescent health and wellness, with the common goal of supporting optimal health and development for all adolescents. By encouraging cooperation, communication and collaboration among the programs, institutions, communities and individuals dedicated to adolescent well-being, the OAHP will be uniquely positioned to provide leadership for local and statewide efforts to make progress in priority areas of adolescent health. OAHP has defined the target age range as 10-24 years.

Behavioral health is a key adolescent health issue area that combines the subjects of mental health and SUD under the umbrella of behavioral health due to their interconnectivity. An adolescent's ability to cope with stressors, be resilient, and practice sound judgment is imperative to supporting good mental health. The development of these skills and attributes can be affected by brain development as well as pre-existing mental health problems and SUD.
Goals identified by the OAHP with leadership from OhioMHAS are:

1. Rates of SUD and abuse of alcohol and other drugs will decrease among adolescents;

2. Behavioral and physical health services for adolescents will be more fully integrated to improve access and quality of care.

Adolescence is a unique developmental time in the lifespan of every individual. It is a time characterized by distinct and dramatic developmental, physical, social, emotional and intellectual changes. The physical and emotional changes that take place in adolescence are second only to the extensive changes that take place in infancy. Many lifestyle behaviors that contribute to or reduce risk for disease and disability in adulthood are developed in adolescence.

Integrating Behavioral Health into Other Systems

Trauma-Informed Care

OhioMHAS is supporting a statewide effort on use of trauma-informed care (TIC) approaches in collaboration with the Department of Developmental Disabilities (DODD). The target audience for this initiative includes individuals in the mental health, addiction and/or development disabilities systems, and the staff that are responsible for their treatment and support. Staff from the National Center for Trauma Informed Care (NCTIC) have trained all of the MHAS and DODD institutional staff on TIC principles, and the departments have hosted two annual conferences with NCTIC to promote basic education about TIC. Six regional collaboratives have developed and are working to identify local strengths, gaps and identification of local expertise. A statewide steering committee comprised of additional state departments (Job and Family Services, Department of Youth Services, Ohio Department of Health, etc.) and statewide trade organizations (Ohio Association of Child Caring Agencies, Public Child Services Association of Ohio, etc.) meet on a regular basis to share information about their respective initiatives in TIC for their specific target audience. In the coming year, the initiative will focus on clinical best practices in TIC and support for trained peers to assist persons with trauma histories.

Pediatric Psychiatry Network (PPN)

This network addresses the shortage of child psychiatrists by having psychiatrists at Ohio's medical schools provide "curbside clinical psychiatric consultation" to pediatricians, family practice physicians, APNs, PAs and other prescribing level providers who manage behavioral health conditions in children and youth within their local communities. Benefits include reduced wait times, earlier treatment which reduces morbidity and mortality, improved communication among the child's providers and reduced isolation of rural providers. PPN is a partnership between OhioMHAS and Academic Psychiatry Programs and affiliated Children's Hospitals. Cincinnati Children's Hospital houses and staffs the centralized call center. Nationwide Children's, Akron Children's, University of Toledo, Cincinnati Children's Hospital and Wright State University donate their time to take these calls and/or provide clinical expertise to PPN.) Additionally, Ohio Chapter of the American Academy of Pediatrics and the Ohio Family Practice Association market the program to their members. Ohio Department of Health also

promotes the use of PPN and partnership in developmental and behavioral health public health efforts throughout the state which includes NAMI.

Behavioral Health Juvenile Justice Projects

The Behavioral Health Juvenile Justice (BHJJ) initiative, a shared effort of the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and the Ohio Department of Youth Services (DYS), was created to enhance local options for providing services to juvenile offenders with serious behavioral healthcare needs. Pilot projects that started in a few Ohio counties in early 2000 have grown into a statewide initiative with strong support from state and local stakeholders.

The projects are designed to transform child-serving systems by enhancing their assessment, evaluation and treatment of multi-need, multi-system youth and their families. In addition, they provide the Juvenile Court judges an alternative to incarceration, which has been a key to their success. The community projects have shown significant positive impact on youth admissions to DYS facilities and positive outcomes reported at the time of program completion.

The projects serve youth ages 10-18 with a current DSM diagnosis and substantial impairment in behavioral, cognitive and/or affective domains. A majority of these youth enter their local program with co-occurring SUD, a history of violence and/or criminal behavior, history of exposure to trauma and/or domestic violence and history of involvement in multiple systems.

The BHJJ projects are required to provide evidence based interventions (examples include Multi-systemic Therapy, Hi- Fidelity Wraparound) and to engage the youth and their family/support systems in the treatment process. Many of the treatment services are provided in the youth's home and are intensive interventions. Providers are required to address the cultural and ethnic population that their county has historically admitted to Department of Youth Services (juvenile justice system). Although each program is different and based on local needs and resources, each program offers assessment, evaluation, and coordination of appropriate services and supports for the youth and their family.

The Begun Center for Violence Prevention Research and Education, Mandel School of Applied Social Sciences at Case Western Reserve University has been engaged to evaluate the BHJJ initiative. The staff works very closely with each county to ensure that their project data is collected and is shared in a way that is useful to that community and the state departments.

Summary

Ohio has local, overlapping systems of care serving children (and their families) with serious emotional disturbance, some of whom have co-occurring SUD. Each local system of care has multiple providers; some of these providers also provide primary health care, addiction treatment services, or foster care for the child welfare system. Mental Health Block Grant funds a portion of these services, and programs to improve services. Programs funded under these grant projects are building statewide comprehensive, integrated data-driven strategic plans that will prevent and mitigate the seriousness of behavioral health problems for infants, children, youths and families.

Strengths

- Provider network is strong, diverse and integrated into community systems of health and social services for children and youth in most Ohio communities.
- High treated rate of prevalence – top 5 state for treated prevalence of children in Mental Health of America study.
- Implementation of evidence based and promising practices in many Board areas including multi-systemic therapy (MST), Intensive Home Based Treatment, Integrated Co-occurring Treatment (ICT), Functional Family Therapy (FFT), Wraparound System of Care, and Transition to Independence Program (TIP).
- Organized mental health youth consumer organizations partner with youth-led drug free coalitions.
- Statewide transitional age youth/young adult system of care under development.

Needs

- Medicaid benefit package needs to be modernized to include specialized services for children with intensive service needs (e.g. high fidelity wraparound and Intensive Home Based Treatment); OhioMHAS is participating in the Governor's Office of Health Transformation work to develop a budget neutral redesign of Ohio's behavioral health benefit.
- Shortages of child psychiatrists; OhioMHAS is supporting the Pediatric Psychiatry Network to facilitate consultation for pediatricians and family practitioners who are prescribing psychiatric medication.
- Major differences in funding among local systems of care; these include some systems of care in rural and Appalachian areas without some of the specialized services needed by children with high levels of need. OhioMHAS is addressing these differences through the Continuum of Care work described in the first section.

1.62 Community Mental Health Services for Adults with Serious Mental Illness, Older Adults and Homeless

System of Care

System of Care for Adults with Serious Mental Illness (SMI)

Ohio's behavioral health system for adults is similar to the children's behavioral health system. It also operates on a public health approach that builds upon established collaboration of state agencies and county ADAMH Boards. At the state level, the OhioMHAS Medical Director's Office and the Office of Treatment and Recovery provides leadership for **treatment services and recovery supports for adults and older adults with serious mental illnesses.** Statewide interagency coordination among health agencies is led by Ohio Office of Health Transformation which coordinates the activities of the health and human services agencies, most of which serve persons of all ages. Ohio's health and human service agencies include: Aging (disability network), OhioMHAS, Developmental Disabilities, Education, Health, Job and Family Services (employment, child welfare, social services/Title XX), Medicaid, Rehabilitation and Corrections, and Opportunities for Ohioans with Developmental Disabilities (formerly Rehabilitation Services Commission, vocational/employment services for persons with disabilities). Additionally, regional medical centers, university hospitals, nursing facilities and other health care providers are also a part of this system of care.

System of Care for Older Adults with SMI

Ohio Department of Mental Health and Addiction Services (OhioMHAS) works across statewide systems to coordinate older adult population's efforts in Ohio. MyCare Ohio, a pilot program to integrate Medicaid and Medicare benefits within the managed care environment has been such an effort to curtail costs and coordinate care to older adults. Mental Health First Aid training which is an evidenced based training was offered to AETNA practitioners participating in the MyCare Ohio pilot. In partnership with NAMI Ohio, OhioMHAS provided Mental Health First Aid training to ACF's across the state. There are also efforts around the Balancing Incentive Program (BIP) through the Aging Disability Resource Network (ADRN) to standardize screenings to ensure no wrong door access and coordination with regard to older adults.

In addition, OhioMHAS participates on the Ohio Attorney General's Elder Abuse Commission. The Commission was the impetus to the Adult Protective Services (APS) finance workgroup which made recommendations to the legislature to enhance APS in the State of Ohio. Funding was appropriated to incentivize local county job and family services to plan, coordinate and collaborate and assist communities in leveraging resources with regard to older adult populations. OhioMHAS developed a behavioral health module to train first responders which included APS and law enforcement tasked with identification and enforcement of Elder Abuse.

The Department also participates on the Supreme Court for Adult Guardianship; new guardianship rules were approved this year. The Department will assist in the implementation of the 6 hour mandatory training to be a guardian in the State of Ohio.

Lastly, the Department's Screening, Brief Intervention and Referral to Treatment (SBIRT) Policy Steering Committee has an Older Adult Subcommittee that encompasses the Department of Aging as a partner. The committees aim is to collaborate and disseminate trainings on SBIRT within primary care settings and within the Older Adult Network in Ohio.

Homeless System of Care

Ohio's Project for Assistance from Transition from Homelessness (PATH) provides outreach services in counties with the highest rates of homelessness. In this program, outreach services are offered to homeless persons, a population which has high rates of mental illness and substance abuse with the goal of engaging them in services and supports. PATH workers go into areas where homeless people live and congregate, and build relationships. In some cases, Housing First, a mental health evidence-based practice, offering permanent supported housing first, without requiring treatment is offered. With this practice, staff works with individuals to engage them in services. This program uses a number of evidence based practices with homeless persons to connect them with community resources and engage them in social services, housing, and behavioral health services. Critical time Services and supports include permanent housing, social services, and community behavioral health services, if needed. Many of Ohio's PATH programs are being expanded to include persons with SUD without co-occurring mental illness, and enhanced with additional services through SAMHSA grants described later in this section.

Ohio Adult and Older Adult System of Care Providers	
Adult SMI Services	**Provided by:**
Mental health treatment	Includes community behavioral healthcare centers and community mental health centers with some integrated care centers in some parts of the state. Also includes some Medicaid-only providers, regional medical centers, federally qualified health care centers (FQHC).
Care coordination for adults who need services from multiple service systems	Community behavioral/mental health services provide through CPST (Community Psychiatric Supportive Treatment) Service. ADAMH Boards may facilitate care coordination for especially challenging cases.
Behavioral health crisis services	State law requires Boards to assure local availability of crisis services from community behavioral health services; training of workers is the responsibility of the providers and boards.
Information and referral, and warm lines	OhioMHAS maintains consumer-staffed Toll Free Bridge line, and many Boards fund this service in their communities
Peer support	Provided by approximately 60 consumer operated services, as well as by some community mental health service providers
Employment Services and Social Services	Provides employment, child welfare and social services/Title XX. Additionally the Ohio Opportunities for Disabilities (Rehabilitation Services Commission) provides some additional vocational and employment services. Supported Employment Services provided by some community behavioral health centers.
Developmental Disabilities (DD)	DD providers, most of which do not provide mental health services; persons with co-occurring DD/MH receive MH services from MH system; County DD and ADAMH Boards sometimes collaborate; and DD and MH providers may have care coordination meetings.
Criminal Justice	Mental health services available within Ohio's prisons provided by Ohio Department of Rehabilitation and Corrections. Some jails have mental health services. Mental health courts provide treatment services in some communities. OhioMHAS community linkage workers meet with offenders with SMI being released from prison to voluntarily link them with community services.
Medical & dental	By referral by CPST staff of community mental health centers; medical services provided by some integrated health care centers and Federally Qualified Health Care Centers (FQHCs)
Permanent housing	OhioMHAS licenses serviced enriched housing, group homes and foster homes;
Residential care/treatment – various kinds	Licensed by OhioMHAS, funded by OhioMHAS and other state agencies and local resources
Time Limited Housing – respite care, foster care, crisis care, temporary housing, transitional housing	Mental health providers offer these services in some communities
Psychiatric hospitalization	Provided by 76 community and university hospitals licensed by OhioMHAS, and 6 regional ("state") psychiatric hospitals operated by OhioMHAS
Home Choice	Assists persons with disabilities (including mental illness) and older adults to move from a nursing facility to home and community-based settings
Older Adult Services	
Twelve Area Agencies on Aging provide older adult services with oversight from Ohio Department of Aging	Respond to the needs of older adults as advocates, planners and funders. Services include in-home care, long term care consultation, PASSPORT (in-home care for persons meeting nursing facility levels of care), residential services and services coordination

Services for Homeless	Providers in Addition to SMI Providers
Outreach services	Community mental health centers and housing service providers funded by (SAMHSA funded) PATH program provide outreach services to homeless persons with SMI and co-occurring substance-use disorders funded by SAMHSA grant.
Cooperative Agreement to Benefit Homeless	SAMHSA CABHI grant provides funds to address homelessness among veterans and chronic homelessness; Expands outreach services and evidence based practices (e.g. Critical Time Intervention, Motivational Interviewing, Screening, Brief Intervention, and Referral to Treatment (SBIRT), SSI Outreach, Access and Recovery (SOAR) and Wellness Recovery Management Program (WRAP)
Housing	Ohio Department of Development, Metropolitan Housing Authorities, community shelter board
Behavioral health treatment	Community behavioral health providers, community mental health centers, addiction treatment providers

Community Mental Health Service Providers

Ohio's 50 Boards and providers have developed differently as Ohio's has home-rule in which health and social services are administered county and multi-county entities which have the authority to levy local taxes. For behavioral health, each Board negotiates with community providers and local governmental entities providing health, social service in order to plan, fund and evaluate their local service system. Many providers have expanded to provide service in more than one Board area, but often do not provide the same service in each area. Sometimes Boards choose to contract with providers based in other Board areas for recovery supports. Sometimes a provider offers Medicaid only services. The result is a negotiated process.

As a result, Ohio has 50 overlapping systems of care that are each organized differently. Some communities have community behavioral health care while others have community mental health centers with separate addiction treatment centers; many communities have a combination of mental health and behavioral health providers. In some communities, one organization is designated to provide crisis intervention, crisis stabilization and assessment services, but refers persons to other community behavioral health services for continuing care. Some communities have specialized housing providers. As a result, Ohio has a very complex behavioral health system that is challenging to describe.

Ohio has a diverse provider network of community mental health providers. Many of the providers have expanded to serve persons in multiple ADAMH Board areas, and provide different services in different communities. Most, but not all, of these providers provide most of the clinical treatment services that are eligible for Medicaid reimbursement. These services include mental health assessment, psychiatric diagnostic interview, crisis intervention, behavioral health counseling (individual or group), pharmacological management service, partial hospitalization, and community psychiatric supportive treatment (CPST, individual or group). CPST services include care coordination, treatment planning and supportive services. Most

larger community mental health/community behavioral health providers also provide some recovery supports (e.g. housing, employment, peer support and other non-medical services).

Ohio also has some niche providers that provide only one or two services, and some providers that provide a much larger range of services including primary medical care. Some consumer operated services provide only peer support services, and one provider provides only housing services. These providers include community mental health centers, behavioral health centers, and substance abuse inpatient facilities that have expanded into community behavioral health care. These providers also include a regional community hospital in a rural area has expanded into community mental health care. In one community, a behavioral health care center has become a Federally Qualified Health Care Center. In another community, a family service provider has expanded to provide services to serious mental illness, developmental disabilities and older adults. As it is not practical to describe all of the 412 providers, a representative group of providers is provided below.

Mostly Rural Services

Community Mental Health – Rural
Rural SMI and Amish

- Appleseed Community Mental Health Center is a community mental health center in a single rural county in north central Ohio. Programs include mental health services for adults and children with a full range of mental health services including crisis services. Community programs include an employee assistance program, housing, and community school liaisons. Safe Haven provides rape crisis and domestic violence services. Appleseed collaborates with a consumer operated services program, and has strong school-based program. Appleseed also serves an Amish Community. In a recent visit, the author saw a NAMI poster for an Amish-led family education group for persons with serious mental illness within the Amish community http://appleseedmentalhealth.com/get-involved

Community Behavioral Health – Appalachian/Rural
Rural SMI in Multi-County Area

- Scioto Paint Valley Mental Health Center is a group of six treatment centers that offer mental health and addiction services to residents of all ages in five rural counties, three of which are in Appalachia. (Ross, Fayette, Highland, Pike and Pickaway Counties). In Pickaway County, it is the only provider certified by OhioMHAS for mental health services, while the other four counties each have two or more providers. Services offered include mental health assessment, crisis intervention, mental health education, forensic evaluation, prevention, referral and information, behavioral health hotline, partial hospitalization, consultation, pharmacological management, community psychiatric

treatment (CPST), employment/vocational, social and recreational, and behavioral health counseling and therapy. http://www.spvmhc.org/

Regional Medical Center – Community Behavioral Health – Rural
SMI Provider in Rural Area with SAMHSA Supported Employment Grant

- Firelands Regional Medical Center operates community behavioral health services in a seven county rural area in northeastern Ohio. Programs include Firelands Counseling and Recovery Plan for persons with severe mental illness which includes integrated behavioral health and primary care; this program is only available in three counties. Services include individual, group, family and marital counseling, psychiatric services, hotline and crisis services, emergency behavioral health services, services for Spanish-speaking people and other populations including the hearing impaired, outpatient alcohol and other drug treatment, and inpatient psychiatric treatment. Firelands provides Supported Employment, as one of the two sites funded by a SAMHSA Supported Employment Grant to OhioMHAS.
  http://www.firelands.com/services/behavioral-health.aspx

Mostly Suburban

Behavioral Health – Suburban with Rural Expansion - First Episode Psychosis

- Coleman Professional Services, 5982 Rhodes Road, Kent, OH 44240 is certified by OhioMHAS to provide mental health assessment services, crisis intervention, mental health education, prevention service, consultation service, pharmacological management service, community supportive treatment (CPST), employment/vocational service, social and recreational service and behavioral health counseling and therapy service. Services are provided in seven counties in five Board areas in northeastern and northwestern Ohio. In addition to these services, Coleman also provides adult day services for persons with dementia in Portage County, supportive residential services, permanent housing placement, and addiction recovery services. Coleman is also has Youth Transitional Services and provides First Episode Psychosis Services.
  http://www.colemanservices.org/

Mostly Urban

Community Behavioral Health – Urban-Suburban-Rural
Homeless and Persons with Criminal Justice Involvement

- Talbert House, provides adult behavioral health, community care, courts and corrections, housing and youth behavioral health services in Brown, Butler Clinton, Hamilton and

Warren counties in greater Cincinnati area. Talbert House is an example of an urban substance use disorder program that has expanded into providing mental health and community services in adjacent areas. Talbert services include community housing. See 1.6.4 Substance Use Disorder Treatment section for a detailed description of SUD services. http://www.talberthouse.org/home/

Integrated Healthcare – Federally Qualified Health Care - Urban & Appalachian
Specialty SMI Services: Homeless, Older Adults, HIV+, Dual Diagnosis (SUD or DD)
SUD Services Include Medication Assisted Treatment

- Southeast Healthcare Services began as a community mental health center in Columbus, and is now a Federally Qualified Health Care Center. It also expanded into treatment for substance use disorders and homeless persons including offering psychiatrist services in a mobile van. Southeast has included peer specialists on their community treatment service teams since the 1980s. Southeast also has specialized programs for older adults, and persons with serious mental illness who are HIV+. Recently it acquired Center of Vocational Alternatives (employment services). It provides Medication Assisted Treatment for opiate abusers, and is providing integrated healthcare in Columbus Metropolitan Housing. Additionally, Southeast has specialized services for adult sex offenders and a batterer's intervention program. It also has services for children including intensive home based treatment, and prevention services in a suburban school district. Recently, it received an award for it art gallery that displays art from persons with mental illness and substance use as a way to break down stigma. http://www.southeastinc.com

Family Service Agency/Community Behavioral Health
Specialty Programs: SMI, older adults developmental disabilities, domestic violence

- Jewish Family Service Association (JFSA) of Cleveland provides community-based comprehensive services for persons of all ages with intellectual disabilities and mental illness regardless of religious affiliation. Services include housing, clinical services, recreational services and family support services. JFSA also provides specialized services for older adults to maintain independent living, as well as services for teens and families experiencing domestic violence. Recently, JFSA opened a medical clinic to provide integrated health care to the persons it serves. This organization developed from a family service agency, and has contracts with mental health, developmental disabilities, aging and human service county and/or state government organizations. http://www.jfsa-cleveland.org/

Community Behavioral Health – Urban – Recently Merged with SUD Treatment Provider SMI and Residential Services

- Zepf Center provides a full range of community behavioral health services to children and adults in Lucas County (Toledo), and is CARF accredited, and certified by OhioMHAS. Services include integrated care, residential services (group home and apartments), vocational services, counseling, community support, peer support and case management, group services, recovery program, medical services, and hospital team. The hospital team coordinates care with three community hospitals and one regional psychiatric hospital operated by OhioMHAS, and only recently affiliated with a substance use treatment providers. Zepf Center merged with CCRC, the county's largest SUD treatment provider according to the Lucas Board's 2014 Community Plan. http://www.zepfcenter.org/

Specialty Programs in Urban Areas

Consumer Operated Service (COS) – Mental Health – Urban
Specialty: Peer Services for SMI

- Thomas M. Wernert Center, Toledo, Ohio, certified by the Ohio Department of Mental Health to provide Consumer/Peer Operated Service (and no clinical services). The majority of the Board and staff are mental health consumers. While this consumer operated service does not include persons with substance use disorders only, others do. Services include educational activities including the Peer Enrichment Program, Peer Support/Peer Enrichment Class, Leadership, BRIDGES (Building Recovery of Individual Dreams and Goals through Education and Support), Wellness Management and Recovery, daily and weekly social activities (e.g. Friday Afternoon Supper Club), as well as support groups. Support Groups include Depression, Bipolar Support Alliance (DBSA), Dual Recovery Anonymous (DRA), Schizophrenics Anonymous, Women's Peer Club, Diabetes Support, and Computer Lab. Rural and suburban communities also have consumer operated services. Consumer operated services welcome persons with co-occurring disorders. Most consumer operated services have dual recovery programs to address SUD. Some consumer operated services are open to persons with SUD only, as well as persons who are not comfortable with seeking community behavioral health services. http://wernertcenter.org/

Housing, Residential Care and Housing Supports – Behavioral Health – Urban & Rural Homeless (PATH)

- Neighborhood Properties Inc. provides housing services and adult care to persons with mental illness and substance abuse services in greater Toledo. It owns 565 apartments in 62 locations in northwest Ohio and expanded into administering an Adult Care Facility Program which serves more than 100 consumers. Programs include permanent

supportive housing, homeless outreach (SAMHSA funded PATH program), homeless families, a fresh start for single mothers, young adults, and young adults with criminal justice involvement, homeless veterans, chronically homeless and Road to Recovery for persons with Substance Use Disorders. NPI also operates a service-rich environment program for difficult-to-place persons from rural counties in northwest Ohio which provides staff 24/7. http://www.neighborhoodproperties.org/

Crisis Stabilization/Pre-Screening - Urban

- Netcare Access provides 24-hour emergency services for mental health and substance abuse crisis intervention, and assessment for Franklin County adults and children in the greater Columbus area. Services include crisis respite, probate pre-screening and facilitation for hospitalization, if needed. Additionally, a crisis stabilization unit provides an alternative to psychiatric hospitalization; persons may stay up to seven days. This agency specializes in assessments, crisis services, crisis stabilization and pre-screening for involuntary hospitalizations and courts. This provider refers to community behavioral health providers for ongoing care for persons with SMI. www.netcareaccess.org

Providers and communities shape service delivery systems. While most counties have multiple providers, a few rural counties have a single provider. Urban communities are organized differently depending on decisions made by local ADAMH Boards and major providers which shaped each communities service system. Ohio's mental health providers include integrated health care centers, FQHCs, and community behavioral health services serving rural communities. Providers also include specialized housing providers, consumer operated services and specialized crisis care/assessment services. Specialized services for older adults with serious mental illness are available in some urban communities. The organization of the service delivery system varies by community, with specialized services available in most urban communities.

Community Hospitals

OhioMHAS licenses about 76 hospitals with private psychiatric units which provide inpatient psychiatric services to adults. Many Boards have contracts to fund service for indigent person at these hospitals which provide the majority of inpatient psychiatric care in Ohio. Ohio's psychiatric inpatient providers include community hospitals with psychiatric units, free standing psychiatric hospitals and university affiliated psychiatric units. Most Boards continue to have contracts with more than 76 community hospitals with psychiatric inpatient programs for civil inpatient services, and reserve OhioMHAS psychiatric hospitals for the difficult-to-know-how-to-treat patients and those on forensic status. Additionally, many Boards contract with crisis stabilization services (for up to seven days) that reduce the need for hospitalization.

OhioMHAS Operated Regional (state) Psychiatric Hospital (RPH) Care
OhioMHAS operates regional psychiatric hospitals (RPHs) in six locations across the state. These specialized facilities provide short-term, intensive treatment to inpatients, and also provide some outpatient care through community support network teams. Additionally, OhioMHAS operated hospitals provide comprehensive care to patients committed by the courts. These hospitals provide evidence-based treatment and are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and work with Boards and community providers. As of June 2012, 64% of the on-rolls patient population were on forensic status.

Tele-health
Video conferencing is being used for treatment team meeting that include two state-operated Regional Psychiatric Hospitals (RPHs), 18 community agencies and Ohio State University College of Medicine. This improves the treatment team process by increasing participation from the community agencies; offers patients the opportunity to meet with and plan with their provider. It also improves discharge planning processes, and reduces travel and time requirements on community agency staff. OhioMHAS has plans to expand video-conferencing to the four additional RPHs and may expand to include additional community partners.

Recovery Support Services

Recovery support services are the non-clinical services such as housing, employment and transportation that are essential to the recovery of many individuals from a serious mental illness. These services are planned, evaluated and funded by local ADAMH Boards. The Boards' association, the Ohio Association of County Behavioral Health Authorities is promoting a recovery oriented system of care among their members which fund many of these services through local tax levies. ADAMH Boards also partner with other local systems of care. The ADAMH Boards fund housing, employment, peer support, consumer operated services, transportation and other recovery supports with local tax levies and funds from OhioMHAS. OhioMHAS allocates most state and federal funds to ADAMH Boards or regional Board collaboratives for recovery supports. OhioMHAS awards federal PATH funds to Boards with the highest homeless populations, and also funds housing and some employment services.

Services for Homeless

Projects for Assistance in Transition from Homelessness (PATH) is a federally funded program that provides financial assistances through a formula grant 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. PATH funds can be used by local providers for a variety of services. Some PATH programs offer all of these services, while others focus on providing one of two of these services: outreach services, staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where individuals who are homeless require services; Assistance with identifying and securing appropriate housing. PATH services were expanded and enhanced in five urban counties in 2014 with a Cooperative Agreement to Benefit Homeless Individuals (CABHI) from SAMHSA, and will be expanded to more counties if Ohio receives a 2015 CABHI enhancement grant.

In SFY 2015, of the 12 projects/13 participating counties, we are projecting to serve/contact approximately 4,744 individuals and project to enroll 3,325. PATH programs are funded by OhioMHAS through ADAMH Boards that fund providers. The funded ADAMH Boards, and their corresponding PATH providers include:

- Butler County /Transitional Living, Inc.
- Columbiana County/The Counseling Center
- Cuyahoga County/Frontline, Inc.
- Franklin County/Southeast, Inc.
- Hamilton County/Greater Cincinnati Behavioral Health Services
- Lake County/Extended Housing, Inc.
- Lorain County/Cleveland Catholic Charities
- Lucas County/Neighborhood Properties, Inc.
- Mahoning/Trumbull Counties/Help Hotline, Inc.
- Montgomery County/Miami Valley Housing Opportunities
- Stark County/ICAN Solutions
- Summit County/Community Supportive Services

Housing Services

Housing and housing supports that facilitate persons in recovery is a long-standing 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. OhioMHAS provides funds for the operation of several housing programs, and also provides capital funds to build and improve existing housing for persons with serious mental illness and/or in recovery from addiction. Additional housing is funded by ADAMH Boards in many communities. Ohio's behavioral health system has four broad categories of housing and residential services which have several types under each which address the needs of persons with serious mental illness, substance use disorders and co-occurring mental illness. These categories are from Permanent Housing, Residential Care, Time-Limited/ Temporary and Residential Treatment. (OhioMHAS, Housing Categories and Definitions; Promoting Wellness and Recovery, July 2014).

Housing Categories and Definitions Crosswalk

Ohio Mental Health & Addiction Services

July 2014

Categories	Definition	Types of Housing	Examples
Permanent Housing	A housing setting that is voluntary and length of stay is resident-driven, not determined by a program. Housing may be scattered site apartments or single-family homes or a larger housing complex that is in the community of the individual's choice. Services and supports may be available to residents. Supports can be on-site or off-site depending on individual need and specific setting. Participation in supports and services may be voluntary or have some expectation of participation which is agreed to in the lease agreement addendum.	• Permanent supportive housing • Community residence • Recovery residence • Private apartments • Home ownership	• HAP • Housing as housing • Supportive housing • Person with Section 8 — private landlord • Level 1, 2, 3 • Sober house
Time-Limited/ Temporary	A short-term setting that can include room, board and/or personal care. A non-permanent setting that provides support needed for residents to return to previous housing setting; to move into a more permanent housing setting or a break from current housing. Most often treatment and/or services are part of facility rules. NOT intended as a permanent housing environment. Program rules include length of stay. This setting is not subject to tenant landlord law.	• Respite • Foster • Crisis • Temporary • Transitional	• Crisis bed • Crisis intervention • YMCA/YWCA • Boarding home • Respite care • Foster care • Step-down unit
Residential Care	A residential setting that includes room, board and personal care. Depending on resident's level of functioning and care needs, may have staffing 24 hours a day/seven days a week and assistance with activities of daily living. A congregate setting is usually included with this living environment Services are delivered as defined in license. A resident agreement that includes participation in services may be applicable. May or may not be a long term more permanent housing depending on level of care needed for the individual. Residential care is owned and operated by a private owner or provider agency. This type of housing is licensed and is not subject to tenant landlord law.	• Adult care facility (ACF)/ adult group home • Residential care facilities (Health) • Licensed DODD facility • child residential care/ group homes	• ACF • Supervised group living • MH Type II, III • Assisted living
Residential Treatment	A licensed facility staffed 24 hours a day/seven days a week that provides room, board, personal care and clinical services on-site as part of the treatment stay. Entrance into the facility is determined by clinical/medical need. Facility is owned and operated by a certified provider agency for the clinical/medical services provided on-site and may be affiliated with or within an inpatient continuum. This type of housing is licensed and is not subject to tenant landlord law. Reasons for this placement level of care are more clinically driven than environmental.	• Residential treatment • Non-medical community residential treatment (Level II-A) • Medical community residential (Level II-B)	• Level 4 recovery residence • Half-way house (Medical community residential) • MH Type I

Services to Reduce Institutionalization

Recovery Requires a Community (Home Choice)
This program provides flexible funding to assist persons who are moving from institutions, into the community, and supports Ohio's implementation of Olmstead. Home Choice Case Mangers and Transition Coordinators provide some flexible funding to individuals, and long term services are provided by community mental health centers with ADAMH Boards providing local oversight. These funds address gaps in funding for resources and supports for persons with serious mental illness who are leaving institutions such as nursing facilities and prisons. At the state level, this is a financial partnership between the Ohio Department of Medicaid and OhioMHAS which is part of the Money Follows the Person work.

Pre-Admission Screening and Resident Review (PASRR)
PASRR is a screening process required for individuals with serious mental illness before admission to a nursing facility. The purpose of this screening is to prevent individuals with serious mental illness to be institutionalized in nursing facilities solely because of their mental illness. The goal is to provide assessments of appropriate residential placements to promote the least restrictive level of care as required by the Olmstead Court decision while still allowing nursing facility placement when appropriate. For example, a person with schizophrenia may need a nursing facility care to recover from a broken hip. In an effort to expand the accessibility of this service, OhioMHAS expanded staffing from 5 days a week to 7 days a week in 2014.

Employment Services

Supported Employment/Individual Placement and Support (IPS)
IPS is an evidence based practice of supported employment, which is integrated and coordinated with mental health treatment and rehabilitation, designed to provide individualized placement and support to assist individuals with mental illness or co-occurring mental illness and substance use disorders to obtain, maintain, and advance within competitive integrated employment.

Ohio currently has 27 qualified IPS programs among its more than 400 behavioral health providers and is working to expand service capacity statewide with a SAMHSA funded supported employment grant, Ohio continues in its efforts to develop a robust infrastructure that includes sustainable funding. In SFY 2013, Ohio behavioral health agencies provided services to over 100,000 individuals but only provided IPS services to approximately 2,500 individuals: equating to only 2.5% of the population served.

Peer Services

Peer services are provided as a part of clinical treatment and recovery supports in a variety of ways in Ohio. OhioMHAS has a toll-free bridge line which provides information and referral

services. The toll-free bridge line is staffed by a team of persons in mental health and addiction recovery, and also employs peer support staff in its six regional psychiatric hospitals.

As peer support is not currently eligible for Medicaid reimbursement in Ohio, Boards and providers have incorporated peers as providers in a number of different ways. OhioMHAS has 29 separate organizations that are certified by OhioMHAS to provide self-help/peer support services. Some of these organizations are large providers with multiple sites. Others are small consumer operated services or club houses funded with local behavioral health tax levies. A few larger consumer operated services are CARF accredited, but most are not. Some large behavioral health providers employ peer support staff, and use non-Medicaid funds to fund peer services. Southeast, Inc. in Columbus, Community Support Services in Akron, and Greater Cincinnati Behavioral Health Services have employed peer support staff in their programs for many years.

Ohio is in the process of implementing a Medicaid 1915(i) program which is expected to include peer support as a service eligible for Medicaid reimbursement for a targeted population. This is expected to result in peer support becoming available to residents of more counties.

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.

Trauma Informed Care

See 1.61 Children and Youth with Serious Emotional Disturbances (SED) for information on this initiative that impacts all age groups and behavioral health populations served by OhioMHAS.

First Episode Psychosis

See 1.61 Children and Youth with Serious Emotional Disturbances (SED) for information on this initiative. Ohio is using the 5% set-aside from the Mental Health Block Grant to fund five programs serving nine counties. This evidence based practice provides treatment and recovery supports to youth and young adults ages 15 – 25 who are newly diagnosed with psychosis.

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. Ohio supports CCOEs that provide technical assistance and training to implement evidence-based treatment practices for adults:

- Assertive Community Treatment)
- Criminal Justice (Sequential Intercept Model)
- Mental Illness/Developmental Disabilities
- Substance Abuse and Mental Illness
- Supported Employment

Multi-ethnic Advocates for Cultural Competence and Related Activities

OhioMHAS funds MACC to provide cultural competence and diversity training to behavioral health providers. 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 organized a series of trainings for OhioMHAS and community staff. Each training addresses a specific cultural group, (e.g. Hispanic, LGBT) and includes presentations by community and university experts working with a specific population.

Cooperative Agreement to Benefit Homeless Individuals

OhioMHAS received a five-year grant from SAMHSA beginning in FFY 2014 to address chronic homelessness and homelessness among veterans. This grant expanded Program Assistance for Transition from Homelessness (PATH) in five urban counties to persons with substance use disorders without co-occurring mental illness, as well as to enhance services to all participants. Counties included in the 2014 CABHI grant are Cuyahoga (Cleveland), Franklin (Columbus), Hamilton (Cincinnati), Montgomery (Dayton) and Summit (Akron) Counties. This program will be expanded to additional PATH programs in Lucas (Toledo), Mahoning/Trumbull (Youngstown) and Stark (Canton) counties if OhioMHAS receives a 2015 CABHI Enhancement Grant for which it has applied. Ohio Mental Health and Addiction Services (OhioMHAS) and its partners will implement the Ohio Housing and Recovery Initiative to address housing and service gaps for chronically homeless veterans and non-veterans and homeless veterans in Evidence based treatment and recovery supports will be shared statewide through an enhanced infrastructure. Major partners include the Alcohol, Drug Addiction, and Mental Health (ADAMH) Boards and their providers, and the Ohio Housing and Homeless Collaborative (HHC).

Strategies/interventions include: 1) Expansion of Ohio Housing and Homeless Collaborative to promote collaboration, establish statewide initiatives and a statewide plan, improve Medicaid

access for homeless, ensure access to permanent supportive housing and promote evidence based practices, 2) Work with ADAMH Boards, providers, and local continua of care to prioritize permanent supported housing for chronically homeless and ensure access to integrated behavioral and primary health supports, 3) Expand PATH (Projects for Assistance in Transition from Homeless) to serve homeless veterans and chronically homeless with substance use disorders (SUD) and mental illnesses, 4) Implement evidence based practices of Critical Time Intervention (CTI); Housing First; Motivational Interviewing (MI); Screening, Brief Intervention, and Referral to Treatment (SBIRT), SSI Outreach, Access, and Recovery (SOAR), and Wellness Recovery Action Plan® (WRAP).

Three thousand (3,000) individuals will be screened for the initiative. Three hundred (300) individuals will be enrolled, housed, and served in the first year and a total of 900 individuals will be served over the grant period. Local and state staff will be trained in evidence based practices, and disseminate them statewide. An expanded statewide infrastructure will promote adoption of these evidence based practices throughout Ohio, and adopt policies and strategies to sustain them over many years.

Adult Care Facility/ Adult Foster Home Operator Incentive Program

This program is open to about 800 licensed homes, and raises the daily rate per resident from $44 to $72 for participating operators. In order to receive these funds, these operators must facilitate the linkage of the homes' residents with local mental health and substance use disorder providers according to their service needs. The purpose of these funds is to improve behavioral health and physical health outcomes for residents by incentivizing utilization of community resources while increasing revenue for home operators. These homes are for persons who are not able to live alone, but are successful with assistance with developing basic daily living skills. Although this type of housing is not fully-independent, it provides a service for those who need a structured environment.

Residential Services Supplement (RSS)

Residents who receive Residential Services Supplement (RSS) utilize the benefit to assist with accommodations, supervision, and personal care services, which helps them reside in the community in the least restrictive environment. Governor Kasich's FY 16 -17 proposed budget includes $15 million annually for RSS, and will fund an additional 800 slots. The Department recognizes that individuals may have needs in addition to the services paid for by RSS. The intent of the RSS Quality Payment is to provide ancillary payments directly to operators of those facilities that house residents receiving RSS in order to enhance the quality of care of the living environment for all residents. The intent of the RSS Quality Payment is to provide ancillary payments directly to operators of those facilities that house residents receiving RSS in order to enhance the quality of care of the living environment for all residents. RSS Quality Payment funds may be used to assist facilities with enhancing the quality of life for all residents, including

activities that promote community integration and improving living areas where residents engage in activities on a daily basis.

Supported Employment Grant

Ohio Mental Health and Addiction Services (OhioMHAS) and partners received a FFY 2014 – 2018 SAMHSA grant to implement the Ohio Supported Employment Project to reduce the high unemployment rates for young adults/adults with a severe and persistent mental illness who may have co-occurring substance use disorders. Daybreak in Montgomery County and Firelands in Erie/Ottawa Counties will implement new programs, and a committee will oversee statewide training, policy changes, and evaluation. The evidence based practice of Individualized Placement (IPS) Support Supported Employment will be shared statewide through training and technical assistance. IPS is one of few approaches with research evidence for this population to gain and maintain competitive employment. Major partners include community based behavioral health providers, ADAMH Boards, employers and Ohio Opportunities for Disabled.

Ohio's Services and Supports for Adults with SMI, Older Adults and Homeless

Strengths

- Diverse, well developed provider network providing services to adults with serious mental illness and co-occurring disorders.
- Strong investment in range of housing options for persons recovering from mental illness
- Enhancing recovery supports with SAMHSA grants to improve supported employment and address chronic homelessness and homelessness among veterans.

Needs

- Availability of transportation and housing for persons with serious and persistent mental illness (SPMI/SMI) is limited, especially in some areas of the state. OhioMHAS continues to invest state mental health operating and capital funds in housing, encourages Boards to collaborate to provide these services, and partners with Ohio Department of Development to enhance these services.
- First Episode Psychosis and Supported Employment are available in some areas; expansion of these recovery supports has the potential to increase employment, and reduce the number of persons who rely on Medicaid and disability income from the Social Security Administration.
- Ohio lacks specialized older adult behavioral health services in many communities; Ohio's state agencies are addressing them through a pilot program to address persons with dual Medicare and Medicaid eligibility, as well as partnering with other state agencies to address elder abuse and screening for substance misuse.

1.6.3 Substance Use Disorder Services including Individuals who are Intravenous Drug Users Pregnant Women Women/Parents with Dependent Children TB/Communicable Disease

System of Care

System of Care for Adults and Youth with Substance Use Disorders

Ohio's behavioral health system for adults with substance use disorders (SUD) includes health, medical and recovery support services provided by other systems of care. It also operates on a public health model that builds on established collaboration of state agencies and ADAMH Boards. At the state level, OhioMHAS Medical Director, and the Office of Treatment and Recovery Services provide leadership for treatment services and recovery supports for adults, youth and families impacted by SUDs. State agencies collaborating on SUD treatment include Job and Family Services (child welfare, employment, and social services), Ohio Department of Rehabilitation and Corrections, Ohio Supreme Court Ohio Department of Health, Education, Medicaid and regional medical centers. State agency work on health system reform is led by the Governor's Office of Health Transformation. The Health Department takes leadership in smoking cessation initiatives and in data collection. At the local level ADAMH Boards collaborate with courts with specialty dockets for persons with SUD and/or co-occurring SUD and mental illness, as well as county jails. These local and state collaborations provide a system of care for persons with SUDs in Ohio.

System of Care for Persons with Intravenous Drug Use and/or Opiate Addiction

Ohio has treatment programs to treat opioid addiction, intravenous drug use and addiction to multiple illicit drugs; this population uses the same system of care as services for all persons with SUDs. The major difference is that medication assisted treatment is more likely to be needed than for other treatment groups. Unfortunately, medication assisted treatment is not sufficiently available to meet community needs. OhioMHAS is working with the State Medical Board and State Pharmacy Board regarding the impact of their recent rule changes on SUD treatment programs, including, but limited to Opiate Treatment Programs. Additionally, the state is funding the Maternal Opiate Medical Support (MOMS) project. For more detail, please see **5.14 Medication Assisted Treatment**.

System of Care for Pregnant Women and Women with Dependent Children

ADAMH Boards, as well as providers, prioritize pregnant women and women with dependent children who seek treatment for SUD treatment services. All 50 of the ADAMH Boards prioritized this population in their 2014 Community Plans. These Community Plans also include an assurance that ADAMH Boards will work with their local child welfare programs to address the needs of the parents and children who are impacted by SUDs. Certified treatment providers

receiving funds are 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.

Additionally, OhioMHAS has a designated staff member who may be contacted to insure access to pregnant women who have difficulty accessing needed services in their home community. When needed, she will link pregnant women and women with dependent children to services outside of their ADAMH Board area. Many communities have women's gender specific treatment programs, and some urban communities have gender specific providers that specialize in treating women. In addition to treatment programs, women with dependent children need services for their children which are typically provided by county job and family services, and other social service agencies.

System of Care for Persons with Substance Use Disorders with Communicable Diseases
Sixty-six percent of the persons with SUDs with tuberculosis are found in 4 urban counties. The ADAMH Boards in these counties, and other counties in Ohio work with local Departments of Health to assure that TB and communicable diseases are engaged in treatment. A few behavioral health providers offer specialized services to adults who are HIV positive.

System of Care Providers for Adults and Youth with Substance Use Disorders (SUD)	
Services and Community Supports	**Provided by:**
SUD treatment - outpatient, detoxification and residential services (medical & non-medical)	Includes community behavioral health and SUD treatment providers with integrated care in some communities. Also includes some Medicaid-only providers, regional medical centers, federally qualified health care centers (FQHC).
Health care	Medical centers, clinics, community and children's hospital, county health departments, Federally Qualified Health Care Centers (FQHCs), oversight by Ohio Office of Health Transformation and Medicaid cabinet agencies
Behavioral health crisis services	State law requires Boards to assure local availability of crisis services from community behavioral health services; training of workers is the responsibility of the providers and boards.
Substance abuse outreach, prevention and treatment to urban minorities "UMADAOP"	UMADAOP offers treatment to African American and Hispanic urban populations with targeted services for youth, seniors, women, Spanish speakers and persons involved with criminal justice system.
Drug/behavioral health courts; treatment programs in jails and state prisons; community treatment linkage for offenders	Drug and veterans' courts provide treatment. SUD treatment provided by OhioMHAS within Ohio's state prisons. OhioMHAS community linkage workers meet with offenders with SUD prior to release from prison to link them with community services; community linkage service is voluntary. Some county jails have SUD treatment services.
Recovery housing	Housing which provides sober environment; may be provided by persons in recovery community or faith-based organization
Time limited housing	May be funded by ADAMH Boards in some communities
Peer support/recovery coaching	Provided by some SUD treatment providers
Employment Services	County Job and Family Services Agencies
Care coordination for adults who need services from multiple service systems	Community behavioral health and SUD treatment providers. ADAMH Boards and/or specialized court dockets may facilitate care coordination for challenging cases. Family and Children First coordinates care for high-need youth involved with multiple systems of care.
Twelve Step Meetings	Self-help groups led by volunteers in community
Other recovery support groups	Support groups which may be a community peer-led group, or may be a support group associated with a treatment setting.
Faith-based programs	Provided by religious organizations & faith-based recovery communities.
Medical & dental care	By referral of SUD treatment staff to area medical centers and clinics; sometimes provided by integrated health care centers, Federally Qualified Health Care Centers (FQHCs), or within prisons/jails by medical and dental staff.
Information and referral, and warm lines	211 Lines – provide information to community services for more than 90% of Ohio's population; OhioMHAS maintains consumer-staffed Toll Free Bridge line. Many ADAMH Boards fund this service in their communities which provides information about services and client rights.
Services for Intravenous Drug Users	**Additional Providers for Intravenous Drug Users**
Medication Assisted Treatment	Treatment facilities and physicians who meet DEA/legal requirements
Services for Women with Children	**Additional Providers for Women with Dependent Children**
Gender specific treatment	Women's specific treatment providers or programs who provide specialized tracks for women

Community programs for children	Head Start, Help Me Grow
Food assistance (SNAP), Ohio Works First, foster care, child care	County Job and Family Services
Housing and shelter	Women's recovery housing; battered women's shelters
Communicable diseases	**Additional Providers for Persons with Communicable Diseases**
TB, HIV, Hepatitis C	Treatment by county Departments of Health and behavioral health providers, with some targeted programs for persons who are HIV+

Treatment Providers

Ohio treatment services include outpatient services, detoxification and residential treatment; residential services may be either medical or non-medical. Outpatient services which are eligible for Medicaid reimbursement include assessment, ambulatory detoxification, case management, crisis intervention, group counseling, individual counseling, individual outpatient, laboratory urinalysis, medical/somatic and methadone administration service. Treatment and recovery supports are also provided through specialized court dockets which are described in the Criminal Justice section which follows this section. Recovery supports include the social, spiritual and peer supports which along with treatment facilitate the recovery. Recovery is defined as, "*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*"

While some Ohioans recover without treatment and/or recovery supports, most need the assistance of recovery supports, and the friends, family, social service agencies, courts and members of the recovery community who provide them. Recovery supports include housing, employment, education, transportation, child care, spiritual support, and peer support. Ohio's recovery community supports include Twelve Step groups, as well as individuals, faith-based organizations and other non-profit organizations which offer peer support, spiritual support, employment and sober housing to individuals in recovery and/or seeking recovery. Many important supports provided by members of the recovery community are beyond the scope of this plan. While many persons in recovery have friends and family who provide these supports, others with more challenges (e.g. poverty, co-occurring mental illness) may need more formal recovery support services. Recovery support providers are included in Ohio's system of care.

Community Behavioral Health and SUD Treatment Providers

Ohio has 356 SUD treatment providers. Many providers have contracts with multiple ADAMH Boards, and have multiple locations in non-contiguous ADAMH Board areas. Most detoxification and residential services are located in urban areas; access is limited. As required by the state legislature, OhioMHAS is developing a continuum of care to increase accessibility for persons who live in ADAMH Board areas that do not have detoxification and residential services.

Urban Minority Alcoholism and Drug Abuse Drug Outreach Programs (UMADAOP)
Address substance abuse prevention and treatment among its urban African American and Hispanic populations; they also have programs for persons who have had criminal justice involvement. Services include outreach/engagement, prevention and treatment. The programs were established by legislation in 1980 in eight communities, and have continued for 35 years. Cleveland has a Hispanic UMADAOP which has bilingual services.

Driver Intervention Programs
Driver intervention programs are available in most communities. Judges sentence persons convicted of driving under the influence in Ohio to these programs. Driver Intervention programs are typically conducted in a hotel with the requirement that the participant refrain from use of alcohol or other drugs during the 48 to 72 hour period. During this time, education is provided on the substance abuse and dependence, as well as the risks of driving under the influence. These programs provide an opportunity for persons with SUDs to identify the problem and to engage with SUD treatment professionals.

Ohio's Substance Use Disorder Treatment Providers

Ohio has a wide variety of SUD treatment providers, community behavioral health providers, integrated health services, regional medical centers and hospitals. Community behavioral health providers have different kinds of programs and services to address the needs of their populations. Many of these providers include same site access to additional health and/or social services. Most providers offer additional services consistent with a recovery oriented system of care, or refer consumers to non-medical recovery supports (e.g. recovery housing, employment, peer support, Twelve Step groups). Many also offer programs targeted to specific populations (e.g. Hispanic, youth, and women with young children.) As it is not feasible to describe each of Ohio's 50 ADAMH Board areas overlapping systems of care, a description of a variety of providers is provided in the next few pages. The intent is to provide examples of wide variety of providers to better describe Ohio's provider network.

Behavioral Health Providers in Major Metropolitan Areas

- Maryhaven "*provides integrated behavioral healthcare services with a specialization in addiction recovery care, to help men, women and adolescents restore their lives from addictive and mental illness*." Services are provided in Franklin County (Columbus area) with some services available in Delaware and Morrow counties.
    - *Medication-assisted opioid treatment* program for adults also includes a Motivational Stepped Care (MSC) Approach, daily medication, and additional services including assessment (medical and biopsychosocial), crisis intervention, case management, counseling (individual and group), urinalysis and other drug

screening, medication administration and dispensing, treatment planning, referral and linkage services and education
    - *Gender-specific women's programs* for pregnant women, women of color (Afrocentric), and women who completed outpatient services.
    - *Outpatient services* include ambulatory detoxification, and a general intensive outpatient services in a four to ten week program.
    - *Residential programs* including a sub-acute inpatient program and an outpatient program.
    - *Homeless services* include an Engagement Center to provide refuge for 42 men and 8 women per night with 24 hour medical care. Additional programs include housing first, outreach to homeless, and Community Shelter Rebuilding Lives Program.
    - *Adolescent services* include outpatient services, Multi-dimensional Family Therapy (evidence-based practice), Adolescent Community Reinforcement Approach/Continuing Care (after residential care), and the Maryhaven School.
    - *Court programs* include a range of programs connected to adult and juvenile court systems; driver intervention program is available in English and Spanish.
    - *Prevention services* including Saving Lives, Reconnecting Youth, Positive Leadership Program in high schools in Delaware and Morrow counties. https://www.maryhaven.com/

- Talbert House provides adult behavioral health, community care, courts and corrections, housing and youth behavioral health services in Brown, Butler Clinton, Hamilton and Warren counties in greater Cincinnati area. Services in 27 programs include:
    - Outpatient SUD and mental health services and case management delivered at Talbert House residential facilities and through federally qualified health care centers (FQHCs). Services may include symptom monitoring, and assistance with benefit applications, housing, medication, budgeting, vocational, and other specialty services.
    - Community care, available only in Hamilton County (Cincinnati), integrates an array of employment, primary care and food services across the agency. Services include community outreach, employment, fatherhood project, medical services, social enterprises and victim service center. Ohio Works First (welfare to work), Driver Intervention Program, employment services, fatherhood project, teen parenting, victim service center and workforce development area also included.
    - Court and corrections will be detailed in 1.64 (criminal justice), and includes seven programs.
    - Housing services include:
        - Permanent supportive housing, transitional housing and rent/vouchers/subsidies; housing in scatter sites and apartment buildings

        - Transitional housing for homeless men and veterans with substance use and mental health issues; treatment, case management and employment services included.
        - Recovering houses are alcohol and drug-free residential facilities for men and women which include peer support and recovery assistance to adults.
        - Special needs residential provide safe and secure housing to adults with mental illness and developmental disabilities.
        - Veteran's services including permanent and supported housing, and outpatient SUD and mental health services.
    - Youth behavioral health services include prevention, case management, outpatient treatment, and wraparound delivered in the community, schools and residential facilities.
        - Early childhood mental health prevention (ages 0 – 5), consultation and training.
        - Community behavioral health outreach prevention and education
        - Psychological testing for ages 5 – 18
        - School based services – after school programming, family peer support, school behavioral health services, school crisis team, therapeutic day school, school readiness, wraparound for youth with complex needs in least restrictive environment

    http://www.talberthouse.org/home/

Behavioral Health Providers – Not in Major Metropolitan Areas

- Coleman Professional Services in Allen, Auglaize, Hardin, Portage and Stark Counties in northeastern and northwestern Ohio; Addiction services include SBIRT, diagnostic assessment, individual and group counseling, case management, dual diagnosis and medication assisted treatment in ambulatory detoxification. Coleman also provides a full range of mental health services including Supported Employment and First Episode of Psychosis Services. http://www.colemanservices.org/

- Lake Geauga Recovery Centers (Mentor and Chadron); provides a range of SUD treatment services. Outpatient services include assessments, drug testing, individual counseling, group counseling, dual diagnosis, family group, video therapy and Geauga Jail Treatment Program. Additional services include ambulatory detoxification in collaboration with an urgent care center, residential treatment for women, residential treatment for men, and supportive housing for pregnant women and mothers with children ages 5 and under who may bring their children. Mental health counseling is also provided. http://www.lgrc.us/

- Recovery Council, a CARF accredited agency, provides SUD treatment services at offices in rural Pike and Ross counties; it is also the primary SUD treatment agency for three other rural counties included in this ADAMH Board area in which it does not have office. Outpatient care includes assistance with drug and alcohol addiction, other SUD treatment, mental health services, individual and group counseling, intensive outpatient programs, domestic violence counseling for men and women, life skill coaching, outreach services, educational groups, co-dependency counseling, parenting classes, anger management classes, drug testing, adolescent counseling, SUD assessment, substance abuse education, transportation services, and case management. This agency works with local Children's Services, Job and Family Services, local homeless shelter, Common Pleas Court and Community Action. Additionally, a women's residential (non-medical) treatment program with a transitional aftercare program is available. http://therecoverycouncil.org/

Integrated Health Services

- Columbus Area Integrated Health Services in Columbus include residential SUD treatment for men who may have criminal justice issues which use Afrocentric principles, as well as outpatient and intensive outpatient services. Suboxone (medication assisted treatment) is also available for those who qualify. Columbus Area also offers pharmacy services and integrated (primary) care, mental health services, and re-entry programs for persons who are released from prisons. http://www.columbus-area.com/

- Firelands Regional Medical Center provides outpatient SUD treatment services to adults, youth and families in a seven mostly rural county area in northeastern Ohio (Erie, Ottawa, Sandusky, Seneca, Huron, Lorain and Wyandot Counties). Firelands is also providing SBIRT (Substance Abuse, Brief Intervention and Referral to Treatment) in the inpatient hospital and two outpatient physician offices. Firelands includes a community hospital, community mental health services and is also the recipient of a SAMHSA Supported Employment Grant. http://www.firelands.com/services/behavioral-health.aspx

Faith-Based Family Service Organization

- Catholic Charities, Diocese of Cleveland, provides SUD treatment services in eight counties with the programs varying greatly by county, as well as mental health and other social and spiritual services. In most counties, one or two services are offered, usually non-intensive outpatient services for youth. In Cuyahoga County (greater Cleveland area), programs include adult outpatient, intensive outpatient and residential, gender specific programs for adults, Hispanic programs that are bilingual and gender specific, youth (ages 16 – 19) residential program, intensive outpatient for youth through age 21. Catholic Charities provides a wide range of services including mental health, foster care,

domestic violence/child neglect, employment and training services, youth services and older adult services. http://ccdocle.org/services

SUD Treatment Provider and Peer Recovery Organization

- Northern Ohio Recovery Association (NORA) is a community based substance abuse prevention and peer recovery organization. NORA provides culturally relevant chemical dependency services to youth, adults and families with young children in three counties in northeast Ohio (Cleveland, Akron, and Elyria). Outpatient and intensive outpatient services are offered. Residential treatment is offered with some services targeted for homeless women and female veterans, as well as a residential program for women who can include their children ages 10 and under. A day care center and chat/e-counseling is offered as a part of follow-up services to those who have completed treatment. NORA has a day care center. A program in Lorain County serves women who have been released from incarceration within the past two years. Medically monitored and supervised detoxification is provided by referral to a community partner. http://www.norainc.org/services

SUD Treatment Providers for Women

- First Step Home in the Cincinnati area serves women in recovery and their children. This agency provides individual and group SUD counseling, access to medical services, mental health assessments, life skills training, financial counseling, on-site child care, twelve step meetings and connections to job readiness programs. First Step Home also offers a comprehensive child and family development program for children ages 0 – 12 who are living with their mothers at the facility. The children receive daily support and therapy from one of the staff. Transitional housing is also available for families after the mothers complete the residential program. First Step Home received a MOMS grant which includes implementation of medication assisted treatment for opioid dependence for pregnant women. http://www.firststephome.org/

Substance Abuse Prevention and Treatment Providers for Urban Minority Populations
(Hispanic and African American)

- Hispanic Urban Minority Alcohol and Drug Addiction Outreach Program "UMADAOP" in Cuyahoga County (Cleveland) – Provides individualized recovery programs in men's and women's programs, with monolingual (Spanish) and gender specific aftercare for clients completing program. Access to Recovery Program (voucher program which pays for recovery supports for persons leaving prison); also provides gender specific treatment and aftercare for youth, and prevention services.
http://hispanicumadaop.com/our-services/hispanic-youth-center/

Recovery Supports and a Recovery Oriented System of Care

Ohio's ADAMH Boards are promoting a Recovery Oriented System of Care (ROSC) for persons with SUD and mental illness in partnership with OhioMHAS and local recovery communities. *A ROSC is a coordinated network of community-based services and supports that is person-centered and builds on the strengths and resilience of individuals, families and communities to achieve abstinence and improved health, wellness and quality of life for those with or at risk of drug and alcohol problems*. (Ohio Association of County Behavioral Health Authorities 2015) http://www.oacbha.org/docs/CSAT_ROSC_Definition.pdf

In promoting a ROSC system of care, OhioMHAS partners with ADAMH Boards to share in funding recovery supports that are the non-medical services and supports that are essential in recovery. The operational elements of a ROSC include:

- Collaborative decisions making
- Individualized and comprehensive services and supports
- Community-based services and supports
- Continuity of services and supports

ADAMH Boards are doing local assessments, and developing ROSC plans involving significant stakeholders (law enforcement, health, job and family services, children's services boards, schools, Family and Children First, developmental disabilities, and NAMI). These plans identified the need for recovery supports including housing, employment, peer support, and transportation. Additional recovery supports may include education, child care, twelve step groups, spiritual support and/or gender or culturally relevant supports.

Programs to Engage Persons with Substance Use Disorders

Community Linkage Services

OhioMHAS hired community linkage social workers to link offenders with SUD who are being released from prisons to community services. This is an expansion of an existing OhioMHAS community linkage program for persons with serious mental illness, and co-occurring SUD. Please see the next section on services for persons with SUD, SMI and/or SED involved with the criminal justice system.

Outreach Services to Homeless Persons – Cooperative Agreement to Benefit Homeless

OhioMHAS' 2014 Cooperative Agreement to Benefit Homeless Individuals (CABHI) funded by SAMHSA has officially expanded Projects for Assistance in Transition from Homelessness (PATH) to provide outreach to homeless persons with SUD without co-occurring mental illness. In this program, workers go to where people live (e.g. homeless camps, streets, shelters), develop relationships, and engage them in services. These services will link them to sober housing, treatment and recovery supports, as well as implement evidence-based practices such as Critical Time Intervention and Housing First. The counties included in the 2014 CABHI grant are

Cuyahoga (Cleveland), Franklin (Columbus), Hamilton (Cincinnati), Montgomery (Dayton) and Summit (Akron). OhioMHAS has applied for a 2015 CABHI enhancement grant that is expected to expand these services to PATH programs in Lucas (Toledo), Mahoning/Trumbull (Youngstown) and Stark (Canton) counties. Please see the CABHI Grant description.

Recovery Support Services

Access to Recovery

Ohio was awarded a third five-year Access to Recovery Grant starting in the spring of 2015. This three year grant for $7 million will continue to fund recovery supports for persons leaving prisons. This grant expands these services from northeastern Ohio to Franklin (Columbus), Hamilton (Cincinnati) and Montgomery (Dayton) counties. Ohio 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 SUD.

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. Subsequently, Lorain County was added. 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. 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.

Housing and Housing Supports

Sober housing is an important support for many persons in addiction recovery. OhioMHAS, ADAMH Boards, and local community organizations fund sober housing. With consolidation, housing for persons with SUD is being expanded with $5 million OhioMHAS capital dollars that

were previously limited to persons with mental illness. Additionally, the legislature allocated $5 million for SFY 2016 -2017 for recovery housing with a sober environment that is not permanent, but provides an environment that supports recovery. Some housing and residential treatment requires a SUD diagnosis.

For a summary of housing and residential care available to persons with SUDs and/or mental illness, please see page 70, OhioMHAS Housing Categories and Definitions Crosswalk in the previous section. All four categories, permanent housing, time-limited/temporary, residential care and residential treatment include housing for persons with SUD and co-occurring disorders. Housing includes recovery residences (alcohol and drug-free) and homes that provide room, board and personal care to individuals. Housing also includes time limited residential housing which include program rules, as well as residential treatment (medical and non-medical) for person with alcohol and other drug abuse and/or addictions.

Housing supports are also provided which assist individuals to obtain, maintain and live as independently as possible in the community. These services and/or supports can include some of the following: housing specialists, assistance with rent, utilities, deposited, services that assist with filling out housing applications, housing inspections or front desk staff.

Employment

Employment services are available to all Ohioans through regional OhioMeans Jobs Centers which will provide job search assistance. Persons seeking work can meet with an employment specialist. Employment specialist staff can help strengthen interviewing skills, improve resumes, identify transferable skills sets, and refer to community resources. Employment specialists can also provide information on occupational skills or on the job training opportunities. Additionally, training is available from Workforce Investment Act (WIA) certified training providers. Training providers include barber and beauty schools, career centers, dental/medical assistant training institute, community colleges, trucking schools, and practical nursing schools. http://www.employmentconnection.us/

Some community behavioral health providers (e.g. Coleman Professional Services) have expanded Supported Employment to include persons with SUD as well as persons with mental illness. At COVA, referrals come from public schools, child welfare, juvenile justice and families; programs include one specifically for youth. This can include job readiness, job placement services, and job coaching. Some of these services are limited by their funding source which may be for youth populations or persons with disabilities. As SUD is not considered a disability for Social Security purposes, some funding which is available to persons with co-occurring serious mental illness is not available to persons with SUD. This may limit the availability of some employment services.

Initiatives to Improve Services

Medication Assisted Treatment

In January 2011, Governor John R. Kasich announced that his administration would battle the opiate epidemic on all fronts. The Department was tasked with leading and coordinating cross-systems efforts to deal with increased addiction and overdose episodes caused by opiates. As part of this effort, the Governor's Cabinet Opiate Action Team (GCOAT) was established to address the ongoing opiate epidemic, with the goals of decreasing the misuse and abuse of opiates. Many initiatives have been launched under the umbrella of these workgroups and numerous positive accomplishments have occurred due to this inter-disciplinary work. Over the past year, GCOAT has focused on key initiatives ranging from formalizing a standard of care policy for prescribing opioids for non-terminal, non-cancer chronic pain to increasing access and availability of naloxone. While Ohio has seen major improvements in the fight against opiates, there is still much work to be done.

Ohio has promoted Medication Assisted Treatment (MAT) Programs which use buprenorphine, methadone or naltrexone to treat opiate dependence, in combination with counseling and recovery support services. Persons with opiate-dependence are more likely to recover if they receive medication assisted treatment than without it. According to a 2015 presentation, *Choosing among Medication Assisted Treatment Options for Opioid Use Disorders*, by Mark Hurst, M.D., Medical Director of OhioMHAS, and Brad DeCamp, all Medication Assisted Treatments improve abstinence rates when provided along with relapse prevention counseling.

Medication	With MAT (% Opioid Free)	Without MAT (% Opioid Free)
Naltrexone ER	36%	23%
Buprenorphine	20 – 50%	6%
Methadone	60%	30%

Comparative conclusions cannot be drawn due to lack of head-to-head comparative studies. All medication assisted treatment was provided along with relapse counseling.

Ohio has 15 licensed methadone programs as of December 2014 with multiple sites in Ohio's three most populated counties. OhioMHAS is working to expand the availability of medication assisted therapy, especially Suboxone. In conjunction with the federal government and with a grant from the Development Services Association Ohio funded a pilot project to open a federally certified Opioid Treatment Program (OTP) 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.

OhioMHAS has begun efforts to modernize its rules for MAT (which predominantly apply to its licensed methadone clinics). Recent statutory changes will require the OhioMHAS to regulate buprenorphine-only OTPs.

OhioMHAS has convened a group of state and federal enforcement bodies which include the state Medical Board, state Pharmacy Board, DEA, the Ohio Attorney General and Ohio Medicaid to discuss a protocol for notifying OhioMHAS when enforcement actions are imminent against OhioMHAS certified providers. There has also been discussion of broadening the protocol to notifying OhioMHAS when enforcement action is imminent with an OBOT program.

OhioMHAS has also awarded grants for Material Opiate Medical Support (MOMS) Project and the Addiction Treatment Project (ATP) which increases the availability of MAT. MOMS programs address the needs of pregnant women with SUD including opioid SUD. ATP provides MAT treatment services through specialty docket courts (e.g. drug and veterans courts.)

Maternal Opiate Medical Support (MOMS) Project

The M.O.M.S. project is a $4.2 million program supported by a $2.1 million investment from the Health Transformation Innovation Fund which is administered by the Office of Health Transformation, and the balance was funded from Medicaid dollars. OhioMHAS led the development of the request for proposals, coordinated an interagency review of the proposals, and is administering the M.O.M.S. project. The purpose of M.O.M.S. is to *"improve the health outcomes and reduce costs associated with extended hospital stays by neutralizing the impact of Neonatal Abstinence Syndrome (NAS). NAS is a complex disorder with a myriad of possible symptoms found in newborns and caused by exposure to addictive illegal or prescription drugs. The M.O.M.S. goals are threefold:*

1) *Develop an integrated maternal care practice model with timely access to appropriate mental health and addiction services that extend postpartum, including intensive home-based or residential treatment;*
2) *Identify best practices for obstetrical services relating to MAT, before, during and after delivery and develop a toolkit to support clinical practice; and*
3) *Conduct a pilot and evaluation with promising practices at 2-3 sites that will integrate the model into standard practices.* (Governor, State of Ohio, Communication Department Press Release, State Efforts to Fight Opiate Addiction Turns to Pregnant Mothers and Newborns, August 29, 2013)

Addiction Treatment Project

The Addiction Treatment Project (ATP) was legislatively established in the SFY14-15 state budget and $5 million was appropriated. Specialty-docket drug courts in Allen, Crawford, Franklin, Hardin, Hocking, Mercer and Morrow counties have enrolled 366 ATP participants between October 2013 and June 2015. Participating offenders receive treatment from a community addiction services provider certified by OhioMHAS. According to preliminary findings from project evaluators at Case Western Reserve University, 80 percent of the participants are between the ages of 18 to 34, almost 95 percent are white and the gender split is about even. Statistics are emerging that at discharge, the offenders who receive MAT, especially Vivitrol, report being drug-free more often than those who did not receive MAT. At the six-month follow-up point, no Vivitrol users reported using heroin in the previous 30 days.

Promoting Gender Specific Services for Women

The Ohio Women's Network (OWN) is a group of service providers, funded in part by OhioMHAS, provides leadership in the provision of women's gender specific and gender competent alcohol, tobacco and other drug rehabilitation programming for women; whose mission it is to strengthen collaboration and coordination among the various programs providing services to women and children; to develop and disseminate "best practices" among such programs; to improve identification and referral of substance abusing women by human services agencies; to assure women's access to clinically appropriate prevention and treatment and to increase awareness of women's SUD treatment and effective treatment technologies. OWN is affiliated with OhioMHAS. (OhioMHAS 2015)

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 SUD 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 SUD 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 SUD recovery is vital to family reunification and preservation, ODJFS and OhioMHAS have been working together to meet the multiple needs of children and families. In fact, Ohio Department of Alcohol and Drug Addiction Services (prior to becoming OhioMHAS) were nationally recognized by the Child Welfare League of America for progressively working to address the challenges of SUD among clients in the child welfare system.

Communicable Disease

OhioMHAS addresses its public health mandate to address TB among person with SUD by requiring that all local funding and auditing Board's require written Assurances that agencies receiving SAPT Block Grant funds for operating a program of SUD 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. Methadone maintenance programs are required to conduct TB screening and OhioMHAS checks client files on-site annually to verify this activity is being conducted. If the TB test shows a positive result, OhioMHAS verifies that a referral was made for medical treatment. OhioMHAS 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.

OhioMHAS 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. OhioMHAS 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. OhioMHAS assists county Boards and provider agencies with technical assistance for referrals for or counseling for TB testing.

Persons with SUD Involved with the Criminal Justice System

Persons with SUDs frequently are seen in courts, jails and in Ohio's prison system. Services for this population will be addressed separately in the next section, **1.64 Criminal Justice**.

Ohio's Services and Supports for Adults with Substance Use Disorders

Strengths

- Large, diverse provider network that benefited from Medicaid expansion. Persons new to the service system received clinical care worth $12.6 million in addiction services between January 1 and September 30, 2014.
- Recovery housing expanded by use of capital dollars not available before consolidation
- Medical director, a psychiatrist with a specialty in addiction, is promoting medication assisted treatment which increases credibility with the medical community.
- Culturally-specific and gender –specific programs available in urban communities.

Needs

- Availability of medication assisted treatment does not meet demand; Ohio is working to increase availability through the MOMS project with pregnant women, and the ATP pilot project through the courts.
- Residential services and detoxification has limited availability; implementation of continuum of care legislation described in the first section will address this.
- Recovery supports vary widely depending on local community tax levies; resources are being expanded through SAMHSA discretionary grants, Access to Recovery (ATR) and Cooperative Agreement to Benefit Homelessness (CABHI 2014 original grant and 2015 enhancement grant).

1.6.4 Services for Persons with SUD and/or Mental Illness Involved with Criminal Justice System

System of Care

Ohio Department of Mental Health and Addiction Services provides funding for treatment and recovery supports for adults and juveniles with 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. Federal and state funding for these programs flows through county ADAMH Boards to local behavioral health service providers. Additionally, most ADAMH Boards include persons involved with the criminal justice system as a priority population in their Community Plans, and many Boards fund some of these services with local tax levies. At the local level ADAMH Boards work with courts and law enforcement staff to plan, fund and evaluate treatment and recovery support services for this population. Recovery supports such as housing, transportation, education, employment and peer support are also provided by other local organizations which may or may not be affiliated with the ADAMH 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 (ODRC) currently has approximately 50,000 offenders with 13,000 (26%) participating in alcohol and other drug programming offered in Ohio's prisons, and approximately 8% (4,100) being considered SPMI[1] (ODRC). Additionally, many additional offenders with SUD and/or SPMI are incarcerated in local jails, or are on the dockets of municipal and juvenile courts. The majority of persons with SPMI involved with the criminal justice system 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 addiction world, and "Community Support System" within the mental health world.

[1] http://www.drc.ohio.gov/

System of Services for Persons with SUD and/or SMI Involved with Criminal Justice System		
Environment	**Services and Supports**	**Provided by:**
Community: Drug Courts	Clinical services, monitoring use, court supervision	Partnership among local courts, local addiction treatment providers, and County Job & Family Services (child welfare) with state support from the Supreme Court of Ohio, and OhioMHAS
Community Courts: Treatment Alternatives to Street Crime (TASC)	TASC identifies chemically dependent offenders, provides assessments and makes referrals for the most appropriate drug treatment.	Municipal and juvenile judges and TASC programs
Juvenile Justice Courts to enhance local options for providing behavioral health services	Evidence-based behavioral health interventions including Multi-systemic Therapy, Hi-Fidelity Wraparound	Local treatment programs which provide juvenile court judges with an alternative to incarceration
Programs for Offenders with SUD or SMI In Prison		
Prisons operated by ODRC	Treatment of Substance Use Disorders	Treatment staff for SUD are employed by OhioMHAS effective 7/1/15
Prisons operated by ODRC	Cognitive behavioral therapy, life skill classes, client led groups and community meetings	Therapeutic Communities: Two funded by OhioMHAS provide a structured day for offenders who are being released from prison
Prisons operated by ODRC and youth facilities operated by Department of Youth Services (juvenile justice)	For offenders nearing release, community linkage workers makes referrals and appointments to community behavioral health providers for treatment of SMI, SUD or co-occurring disorders; assists with application for Medicaid benefits.	Community Linkage Workers employed by OhioMHAS
Community Programs		
Community	Treatment for SMI and/or SUD for persons involved with courts and offenders released from prison or jail	Community mental health and addiction providers funded by OhioMHAS, ADAMH Boards, Medicaid and SAMHSA
Community	Drug free supportive transitional housing, GED Training, substance abuse education, relapse prevention, employment skills, transportation, domestic violence education, HIV/AIDS education, peer mentoring, daily living parenting classes, spiritual support, skills, family engagement, recovery coaching, anger management, self help and support groups (not including 12 step groups)	Access to Recovery (ATR) SAMHSA funded grant to OhioMHAS which funds recovery supports for returning offenders with SUD in selected urban counties.
Community	Recovery supports and "gap" needs for offenders returning to the community with SPMI (SMI) or SAMI.	Stop Gap Mini Grants funded by MH Block Grant; OhioMHAS awards funds to ADAMH Boards
Urban Communities	Employment/vocational training; GED/education; health education including AIDS/HIV/STD education; relationship; peer support; violence prevention; and crisis intervention services for offenders returning to community with SUD.	Circle for Recovery funded by OhioMHAS with SAPT Block Grant funds
Communities	Forensic mental health assessment	Clinicians funded by OhioMHAS, partially funded by MH Block Grant

Community Treatment

Drug Courts

Drug courts are a partnership among local courts, County Job & Family Services (child welfare), local addiction treatment providers, the Supreme Court of Ohio, and OhioMHAS. The local courts operate the drug courts; the County Job & Family Services provides protective custody and supervision for parents with SUD with dependent children. The local addiction treatment providers provide clinical services and participation on the drug court teams, and the Supreme Court provides certification to allow judges to operate the courts. The goals of these partnerships are to increase abstinence, decrease recidivism, reduce commitments to adult and juvenile corrections facilities, increase protective supervision decisions by the child protection system, decrease protective custody decisions and increase family reunification.

In SFY 2014, OhioMHAS funded drug courts served 1,100 adult offenders and 40 juvenile offenders and parents involved with the child protection system. Ohio's drug courts save the state money through reduced recidivism, reduced commitments to the adult and juvenile prisons, and reduced permanent placements of minor children into the foster care system.
Comparative costs are as follows:

- Annual cost to incarcerate an adult in a DRC institution: $25,814 (source: Vera Institute of Justice (2/29/12)
- Annual cost to incarcerate a juvenile in a DYS institution: $161,497 (source: Columbus Dispatch (12/30/12)
- Annual cost per child foster care costs in Ohio: $3,650 to $73,000 (source: Annie E. Casey Foundation 4/9/2013)

Treatment Alternatives to Street Crime (TASC) for Substance Abusers

TASC was created to address an 800% increase in correctional spending over the past two decades, coupled with the opiate epidemic. 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 counseling, 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. Community partners include County Common Pleas Courts, municipal and juvenile courts. These partners refer offenders to TASC and work collaboratively with the programs. The courts' probation departments provide community control supervision to the TASC participants. The goals are to increase abstinence, decrease recidivism, reduce commitments to adult and juvenile correction facilities and increase completion of treatment. In SFY 2014, TASC programs served over 6,800 adult and juvenile

offenders. TASC programs save the state money through reduced recidivism and reduced commitments to the adult and juvenile prisons. Comparative costs are as follows:

- Annual cost to incarcerate an adult in a DRC institution: $25,814 (source: Vera Institute of Justice (2/29/12)
- Annual cost to incarcerate a juvenile in a DYS institution: $161,497 (source: Columbus Dispatch (12/30/12)

Behavioral Health Juvenile Justice Projects
Please see the last two pages of the Treatment – Children with SED section for a description.

Access to Recovery
See 1.63 Substance Use Disorders for a description of this SAMHSA grant which provides recovery support services to adult offenders with SUD being released from state prisons in most urban areas in Ohio.

Programs within Prisons

Therapeutic Communities for SUD
Ohio's Therapeutic Communities prepare offenders for integration back into the community during the time period of prison incarceration after their release. This program teaches offenders how to provide peer to peer treatment group sessions and to develop and enhance life skills. The goal of the program is to facilitate continuity of treatment of SUD after release through intervention just before release. Success is measured by the number of participating offenders who engage in community treatment programs after release, and keep all scheduled appointments after release from the Therapeutic Community. The Therapeutic Communities Program facilitates continuity of behavioral health care for persons leaving the prison system by assisting in policy development, sharing of information, identifying and addressing needs, monitoring outcomes, and providing problem-solving assistance. Therapeutic communities promote reduced recidivism rates for persons with SUD, and increases pro-social behavior.

OASIS, Ohio's first therapeutic community, has provided substance abuse services within the Pickaway Correctional Institution for 23 years. The goals of the OASIS program are to address anti-social behaviors including addictions and criminal behavior. This is accomplished by creating a client community that is a microcosm of the larger outside community. The community has a very structured day that includes clinicians, Lead groups, Cognitive Behavioral Therapy (CBT) classes, client led groups and community meetings. Every member also has a job and role in the therapeutic community. The community members give each other feedback throughout the treatment about one another's behaviors. In this microcosm, the clients have the opportunity to learn and practice pro-social behaviors and responses. Experiential cognitive restructuring is at the base of the therapeutic community approach.

Community Linkages (Continuity of Behavioral Health Treatment at Release)
The Community Linkage program links offenders being released from state prisons or juvenile justice youth facilities with SPMI (subgroup of SMI), SED, or with significant SUD treatment needs with community behavioral health appointments or other supports *prior to the offender's release*. Ohio Department of Rehabilitation and Corrections (ODRC) and Ohio Department of Youth Services (ODYS) provide behavioral health treatment for adult and youthful offenders while they are incarcerated; SUD treatment in ODRC prisons is provided by OhioMHAS staff effective July 1, 2015. Both ODRC and ODYS work with Community Linkage staff at each institution across the state to assist with continuity of care for offenders. They provide qualifying offenders with appointments and referrals to supports that promote successful re-integration into the community after discharge, such as housing and health care services. Local ADAMH Boards assist with continuity of care for adult and youthful offenders by contracting with local providers to provide post-release appointments in all 88 counties. Community linkage staff is employees of OhioMHAS and supervised by an independently licensed social worker.

The purpose of the program is to link offenders with SPMI and/or SUD on Ohio Department of Rehabilitation and Correction's (state prisons) health caseload with community mental health appointments and other supports prior to the offender's release date; the goal is to facilitate successful reintegration into the community for offenders. The offenders served are being released from Ohio Department of Rehabilitation and Corrections with SPMI and/or considerable alcohol and drug issues. This program has been working with offenders at ODRC with SMI/ SPMI (including many with co-occurring SUD) for almost 20 years. In 2013, the program expanded to providing linkage services to youthful offenders on the mental health caseload at Ohio Department of Youth Services (juvenile justice) in 2013. In 2014, this program was expanded to include linkage services for offenders with considerable SUD treatment needs. The program has served approximately 1600 offenders each year and is expected to serve more offenders in 2016 – 2017 due to the expansion to persons with SUD.
http://mha.ohio.gov/Default.aspx?tabid=197

The Community Linkage Program facilitates continuity of behavioral health care for persons leaving the prison system by assisting in policy development, sharing of information, identifying and addressing needs, monitoring outcomes, and providing problem-solving assistance. The program promotes reduced recidivism rates for persons with behavioral health challenges, and facilitates recovery. Additionally, the Community Linkage program assists eligible offenders in applying for Social Security benefits and Medicaid to improve access to health care including behavioral health treatment. The goals of the Community Linkage Program include;

- Continuity of mental health care for offenders leaving an ODRC prison who are identified with SPMI or SUD or leaving an ODYS facility with SPMI.

- Reduce recidivism of persons with behavioral health needs who are involved in the criminal justice system
- Increase access to health care by assisting with Medicaid application prior to release
- Reduced de-compensation rates of released offenders to increase chances at recovery and successful reintegration
- Reduced relapse rate for persons with SUD
- Facilitate problem solving between the corrections and behavioral health system and offenders related to accessing community behavioral health services
- Enhance public safety by arranging post-release behavioral health services, recovery supports and benefits

Community Programs for Released Offenders

Community Behavioral Health Services

Community providers of SUD and SMI treatment serve offenders. In urban areas, specialized programs for offenders returning to the community are common, and briefly mentioned in some of the descriptions of providers in the previous two sections. Most ADAMH Boards prioritize this population in their community plans and their funding decisions. Additionally, ADAMH Boards, courts and jails collaborate in many communities to address local needs.

Access to Recovery (ATR)

Offenders released from prison living in participating urban communities receive vouchers that can be used for recovery supports. See the description of this program in Step 1, Substance Use Disorder.

Stop Gap Mini Grants for Returning Offenders with SPMI or SAMI

OhioMHAS awarded a total of $500,000 in 15 mini-grants from the Mental Health Block Grant to ADAMH Boards in SFY 2015 to address needs of offenders released from local jails or state prisons with SPMI (a subgroup of SMI) who may also have co-occurring substance abuse and mental illness (SAMI). Each ADAMH Board identified specific needs in their community for their mini-grants, so the specific needs addressed varied. The purpose of the mini grant was to assist offenders with various needs as they work to become productive members of society**.** It also allows the providers to help offenders with special requests that may fall outside of their regular resources. The indicators of success are that offenders maintain stay out of jail and prison, work and live independently.

Circle for Recovery (Post-Release SUD Treatment – Urban Minority Programs)

The Circle for Recovery is an OhioMHAS funded program for adult offenders being released from Ohio Department of Rehabilitation and Corrections with a history of SUD who are referred by SUD treatment staff within the prisons; the program also accepts self-referrals. Services provided include employment/vocational training; GED/education; health education including

AIDS/HIV/STD education, relationship building, peer support, violence prevention, and crisis intervention services. This program is offered by UMADAOPs (Urban Minority Alcohol, Drug Addiction Outreach Programs) which have been providing prevention services to African Americans, Hispanics and other minorities in Ohio's cities since established by legislation in the 1980s. More recently these programs have been certified to provide SUD treatment services. The goals of the UMADAOP's include reduce recidivism of offenders, increase employment and GED completion, reunite offenders with families, and increase the number of offenders receiving services. The Urban Minority Alcohol and Drug Addiction Outreach Programs (UMADAOP's) Program facilitates continuity of behavioral health care for persons leaving the prison system by assisting in policy development, sharing of information, identifying and addressing needs, monitoring outcomes, and providing problem-solving assistance. The success of this program is a partnership among ADAMH Boards, Ohio Department of Rehabilitation and Corrections, and behavioral health providers.

Forensic Evaluation and Monitoring

OhioMHAS funds ten regional forensic centers to perform pre-trial forensic evaluations for Courts of Common Pleas and risk assessments for people being discharged from state hospitals on conditional release. OhioMHAS also partially funds the work of forensic monitors who oversee the treatment and risk management of people on conditional release. Those eligible for conditional release include individuals who have been found Not Guilty by Reason of Insanity (NGRI) or Incompetent to Stand Trial (IST). OhioMHAS provides oversight and technical assistance to both the forensic centers and forensic monitors.

However, in spite of these initiatives, barriers remain for this population including: housing and employment restrictions for felons and the double stigma of being an ex-offender with mental illness and/or an addiction. Additionally, non-urban areas lack population-specific programs for ex-offenders. 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. However, with Medicaid expansion, and the assistance of community linkage staff, these barriers are decreased.

Ohio's Services and Supports for Persons with Substance Use Disorders and/or Mental Illness Involved in Criminal Justice System

Strengths

- OhioMHAS' Community Linkage program links offenders released from Ohio prisons and youth facilities with SUD and/or mental illness with treatment and recovery services in the community.
- Ohio has a large number of courts with specialty dockets for individuals with SUD and SMI including some veterans' court.
- OhioMHAS is partnering with Department of Rehabilitation and Corrections; treatment of SUD within Ohio's prisons is being supervised by OhioMHAS Medical Director effective July 1, 2015. SUD treatment staff is being increased about 50%.
- Mini grants will be made available for post-release treatment for offenders with SUD and/or SPMI.

Needs

- While funding for SUD treatment within the prisons is being increased, this funding is not sufficient to provide treatment for all offenders with SUD.
- Limited coordination of employment services and job training for SMI offenders being released from prison.
- Lack of coordination between county ADAMH Boards regarding residency issues for SMI and SUD offenders being released from prison.

Planning Steps

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

Narrative Question:

This step should identify the unmet services needs and critical gaps in the state's current systems, as well as the data sources used to identify the needs and gaps of the populations relevant to each block grant within the state's behavioral health system, especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet these unmet service needs and gaps.

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 (NSDUH), the Treatment Episode Data Set (TEDS), the National Facilities Surveys on Drug Abuse and Mental Health Services, the annual State and National Behavioral Health Barometers, and the Uniform Reporting System (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should 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 SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance abuse prevention, 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.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the National Survey of Substance Abuse Treatment Services (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the Behavioral Health Barometers. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the Healthy People Initiative[18] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[18] http://www.healthypeople.gov/2020/default.aspx

Footnotes:

Step 2: Assessment of Need

Assessment of Need Section

In this section, OhioMHAS identifies unmet needs and critical gaps of several populations with focus on substance abuse, mental health, integrated care and recovery supports in a recovery-oriented system of care. This section also addresses prevention needs by providing information about alcohol, tobacco and other drug usage among Ohioans.

Sources of Information and Data

The primary sources of information and data that OhioMHAS relies upon in determining need and gaps are Board's Community Plans, State Epidemiological Outcome Workgroup (SEOW) data, SAMHSA Behavioral Health Barometer, Ohio Substance Abuse Monitoring Network (OSAM), Ohio Family Health Surveys, and Mental Health Consumer Surveys (MHSIP for adults and YSS-F for families of children). Client service data, outcomes, and demographic data are obtained from the MACSIS/MITS data system as well as the OHBHIS (OHBHIS is Ohio's data system to collect the SAMHSA TEDS-MH data for Block Grant Implementation Reports.)

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/MITS 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 Workgroup (SEOW) data
10. Focus groups

Staff from the OhioMHAS Medical Director's Office and the Office of Quality, Planning and Research review the Board's Community Plans and prepares Synthesis Reports which are used to inform Ohio's Block Grant Plan. Additionally, the SAPT/MH Block Grant sub-awardees are

required to indicate which National Outcome Measures (NOMS) are being addressed by their projects. For a summary of Board Priorities, please see the table on the next page:

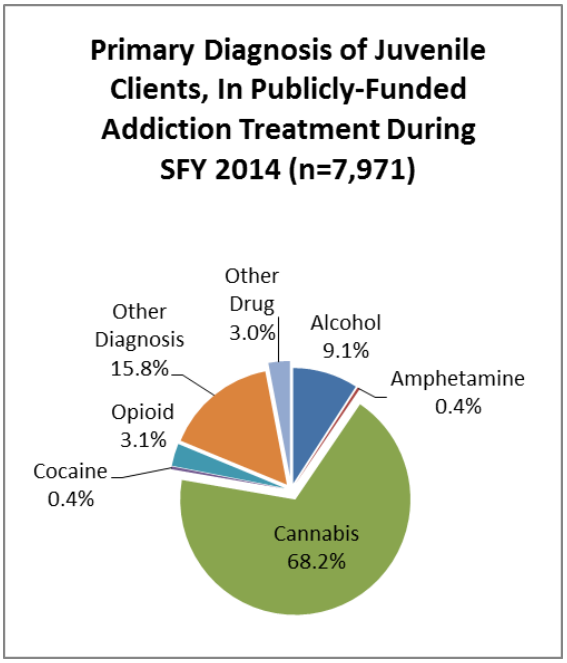
Summary of Reported Priorities

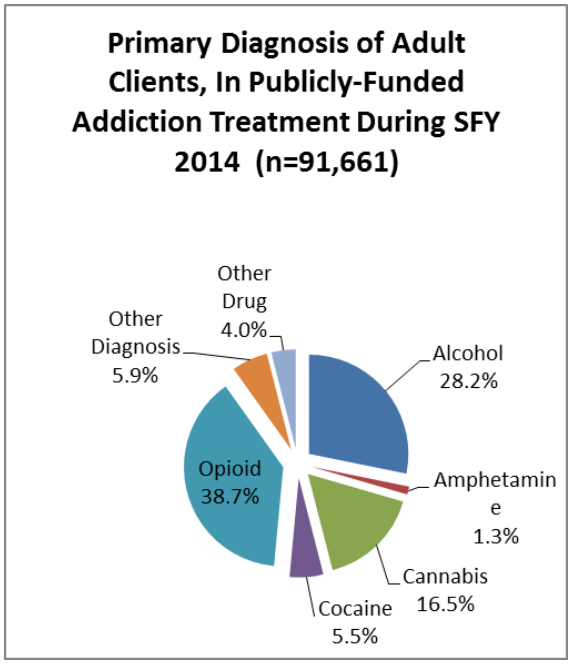
Priority	Appalachian	Rural	Metropolitan	Small City	Suburban	Total
Number of Boards	13	11	7	6	13	50
Intravenous Drug Users	12 (92%)	9 (82%)	6 (86%)	6 (100%)	10 (77%)	43 (86%)
Pregnant with Substance Use Disorders (SUD)	12 (92%)	10 (91%)	7 (100%)	6 (100%)	12 (92%)	47 (92%)
Parents with SUD	13 (100%)	11 (100%)	5 (71%)	6 (100%)	12 (92%)	47 (92%)
Persons with SUD & Communicable Diseases - Tuberculosis & Other	8 (62%)	5 (45%)	5 (71%)	5 (83%)	9 (69%)	32 (64%)
Children with Serious Emotional Disorders	13 (100%)	11 (100%)	5 (71%)	6 (100%)	13 (100%)	48 (96%)
Adults with Serious Mental Illness	12 (92%)	10 (91%)	7 (100%)	6 (100%)	12 (92%)	47 (94%)
Health Integration	12 (92%)	10 (91%)	6 (86%)	5 (83%)	13 (100%	46 (92%)
Recovery Support Services	12 (92%)	9 (82%)	7 (100%)	6 (100%)	13 (100%)	46 (92%)
Veterans	9 (69%)	8 (73%)	5 (71%)	5 (83%)	12 (92%)	39 (78%)
Individuals with Disabilities	8 (62%)	6 (55%)	5 (71%)	6 (100%)	10 (77%)	35 (70%)
Opiate Addicted	12 (92%)	9 (82%)	7 (100%)	6 (100%)	13 (100%)	47 (94%)
Homeless Persons	11 (85%)	7 (64%)	7 (100%)	6 (100%)	13 (100%)	44 (88%)
Underserved Racial, Ethnic, LGBTQs	5 (38%)	5 (45%)	4 (57%)	4 (67%)	8 (62%)	26 (52%)
Youth & Young Adult	9 (69%)	9 (82%)	6 (86%)	4 (67%)	12 (92%)	40 (80%)
Early Childhood Mental Health (0-6)	8 (62%)	11 (100%)	6 (86%)	6 (100%)	10 (77%)	41 (82%)
Public Health	10 (77%)	10 (91%)	6 (86%)	3 (50%)	10 (77%)	39 (78%)
Lifespan Prevention	10 (77%)	10 (91%)	6 (86%)	5 (83%)	12 (92%)	43 (86%)
Pregnant -Prevention	6 (46%)	8 (73%)	5 (71%)	4 (67%)	9 (69%)	32 (64%)
Workforce Wellness	8 (62%)	7 (64%)	3 (43%)	4 (67%)	11 (85%)	33 (66%)
Problem Gambling	10 (77%)	10 (91%)	7 (100%)	6 (100%)	12 (92%)	45 (90%)

Priority Group Key		Federal priority SUD treatment populations
		Federal priority mental health treatment populations
		Federal (SAMHSA) service priorities
		Additional priorities - state selected
		Prevention priorties
		State piority: Gambling (new)

Which Drugs Are the Focus of Addiction Treatment in Ohio?

OhioMHAS provided publicly funded addiction treatment to 99,632 people in SFY 2014. Most individuals received treatment were adults (92%); small percentages were juveniles (8%). Based upon primary diagnosis, cannabis (marijuana) (68%) was most diagnosed for juveniles (age 17 and under) followed by alcohol (9%) as shown in the graphs below. Adults most often received a primary opiate diagnosis (39%) followed by alcohol (28%) and cannabis (17%). Among adults, just under half of females (47%) and 29% of males had an opiate diagnosis.

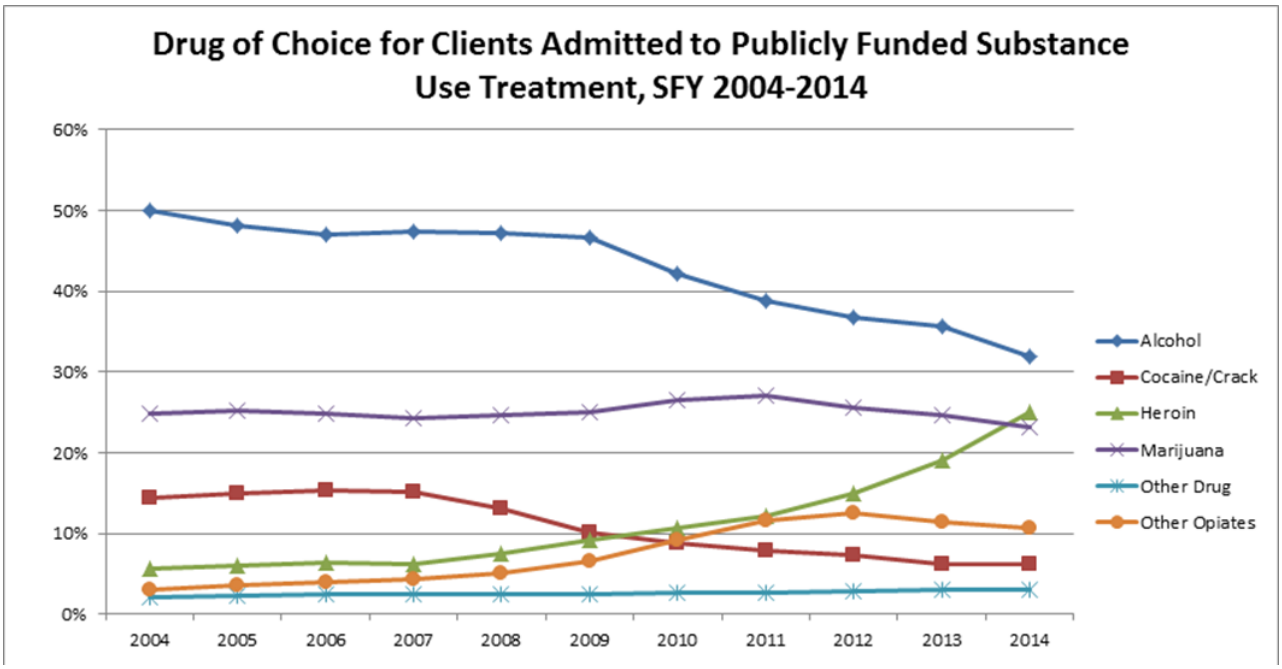




Data Source: Multi-Agency Community Service Information System (MACSIS)

The top three drugs of choice of clients receiving publicly-funded treatment services in 2014 were alcohol, heroin and marijuana. As the graph below illustrates, there has been an increasing trend in heroin as drug of choice. Alcohol was reported the most predominant drug of choice, for nearly a third of clients; heroin was identified second in predominance at roughly 25%, and marijuana was third most identified drug of choice, for just under a quarter of clients. In general, downward trends are seen for the various other substances with the exception of "other drugs" which have been stable over time as drug of choice.

Based on these figures, as well as SEOW and OSAM alcohol and drug prevalence data among Ohioans, this Plan focuses on data for these substances of abuse. In addition, data on SAMHSA-defined priority populations are also included in the federal statutory requirements for the SAMHSA Block Grants.



Note: Clients without a valid drug of choice were eliminated from this analysis.
Source: Ohio Behavioral Health Data (OHBH), SFY 2004-2014, analysis by OHIOMHAS.

State Epidemiological Outcomes Workgroup (Focus: Population Data for Prevention)
The purpose of the federally-funded Ohio State Epidemiological Outcomes Workgroup (SEOW) is to provide communities with data needed to improve prevention planning and implementation for alcohol, tobacco, and other drugs (ATOD). The previous federal Strategic Prevention Framework (SPF)/State Incentive Grant (SIG) and new Partnerships for Success (PFS) grant supports the work of the SEOW which is responsible for collecting, analyzing, and reporting substance use incidence, prevalence and consequence data.

Center for Substance Abuse Prevention's (CSAP) SPF is a data-driven framework for developing comprehensive plans that address substance abuse and related consequences. Even though Ohio's SPF grant is finished Ohio is continuing to utilize the SPF for both prevention and treatment where possible. In particular Ohio identified that Rural and Appalachian counties were in need to extensive capacity building around strategic planning and identified those counties as the priority for the PFS grant Ohio's SEOW is a critical component in enabling the state to implement the SPF with these counties. Ohio's SEOW is tasked with improving prevention assessment, planning, implementation, and monitoring through data collection and analysis efforts to assess ATOD use and consequences to drive decision-making for effective and efficient allocation of prevention resources throughout the state.
Ohio's SEOW objective is to improve prevention needs assessment, planning, implementation, and monitoring through the application of systematic and analytical assessment of the causes and consequences of ATOD use, misuse and abuse. The SEOW includes data on:

- Alcohol use
- Driving under the influence

- Tobacco use
- Drug use (marijuana, cocaine, non-medical use of prescriptions, ecstasy, steroid, inhalant, and methamphetamines)
- Mental Health (Major Depression, Mental illness, Major Depressive Episode, Serious Mental Illness, Serious Psychological Distress, Serious Thoughts of Suicide, Suicide death rate)
- Alcohol, Tobacco, and Drug-related consequences (accidental drowning, chronic Hepatitis B, Hepatitis C, tuberculosis rates, alcohol-related motor vehicle crashes, heroin and opioid-related poisonings, drug seizures, property crime, unintentional drug deaths)
- Gambling consequences (monthly income at bankruptcy, poverty rate, property crime)
- Substance use indicators include measures of age of initial use, current use, lifetime use, current binge use, heavy use, use and driving, use during pregnancy, and per capita use.

Sources for these indicators include:

- Behavioral Risk Factor Surveillance System (BRFSS)
- Centers for Disease Control (CDC)
- National Forensics Laboratory Information System
- Ohio Department of Commerce, Division of Liquor Control (ODC-LC)
- Ohio Department of Development (ODD)
- Ohio Department of Education (ODE)
- Ohio Department of Health Data Warehouse (ODH)
- Ohio Department of Job and Family Services (ODJFS)
- Ohio Department of Public Safety (ODPS)
- SAMHSA National Survey on Drug Use and Health (NSDUH)
- Uniform Crime Report (UCR)
- US Census Small Area Income & Poverty Estimates (SAIPE)
- US Drug Enforcement Administration (USDEA)
- Web-based Injury Statistics Query and Reporting System (WISQARS)
- Youth Risk Behavior Surveillance Survey (YRBSS)

Where available SEOW indicators are reported by: county, by geographical classifications, gender, race, and grade/age. In Ohio, the SEOW was established around the Expert Prevention Panel, a previously-existing epidemiological workgroup, made up of experts from Ohio in the prevention research and evaluation field. The SEOW produces state and county-level epidemiological profiles that summarize alcohol and other drug consumption patterns and associated consequences. These profiles are described below.

Ohio's SEOW is a multidisciplinary group of experts in prevention, research, and evaluation. The SEOW produces state, and county-level epidemiological profiles that summarize ATOD

consumption patterns and associated consequences. The goal of Ohio's SEOW is to merge epidemiology with data analysis, management, and usage regarding disorders that threaten the health and well-being of Ohioans. Ohio's SEOW provides an online resource of current and historical data represented in tables and graphs, facts and brief literature reviews, definitions, data limitations and sources as utilized for each indicator on the website. The website includes national data, and state and county profiles:

- National data – Tobacco, alcohol, illicit drug (including misuse of prescription drugs) and mental health data are collected and analyzed using several nationwide surveys such as the Youth Risk Behavior Surveillance Survey (YRBSS), the Behavioral Risk Factor Surveillance System (BRFSS), and the National Survey on Drug Use and Health (NSDUH).
- State Epidemiological Profile – State profile data are available in prepared reports; data can be view viewed in tables and graphs for planning and evaluation.
- County Epidemiological Profile Reports – Current county-level data are available on the SEOW website; however county profile reports are outdated. Updated profile reports will be available in 2016 on Ohio's Network of Care website and allow comparison of behavioral health indicators by demographics .

SEOW is facilitating collaboration between Behavioral Health and Public Health. The Ohio Department of Mental Health and Addiction Services (OhioMHAS) and Ohio Department of Health (ODH) have partnered together to move the display of SEOW data to the ODH Data Warehouse, essentially creating an integrated, comprehensive, one-stop-shop approach to accessing all Ohio health-related data.
The interagency partnership will:

1. Transition all SEOW data to the ODH Data Warehouse;
2. Make the the new state youth survey, the Ohio Healthy Youth Environments Survey (OHYES!) data accessible via the ODH Data Warehouse;
3. Make behavioral health data more available to the public by also putting select SEOW and OHYES data on the Network of Care website. Network of Care will house the county profile reports.

Some data will be housed both on the ODH Data Warehouse and the Network of Care. The ODH Data Warehouse will house all of the detailed data. Webinars will be available that show stakeholders how to access data and more detailed crosstabs will be available on the warehouse. The Ohio Network of Care website will be more of a dashboard. One benefit of the Network of Care is that it is accessible to the general public and will co-locate mental health and public-health data to hopefully facilitate more integrated planning at the state and local levels.

The Ohio Healthy Youth Environments Survey (OHYES!)

To provide local and updated data on youth issues, OhioMHAS collaborated with the Ohio Departments of Education, Health and other system stakeholders to develop a new statewide student survey. The Ohio Healthy Youth Environments Survey (OHYES!) is an anonymous and voluntary survey conducted online in schools across the state; students in grade 7 through 12 are eligible to participate. The first administration is planned for fall 2015.The survey will be conducted every four years; however, communities may elect to administer it annually.
The survey includes questions on the following topics:

- Demographics
- Alcohol, Tobacco and Vapor Products
- Marijuana and Prescription Drugs
- Bullying, Safety and Violence
- Physical Health & Well-being
- Mental Health
- School Success, School Climate and Safety
- Gambling
- Family and Peer Factors, Community Environment
- Sexual Behavior and Suicide (optional)

State and community data will be available to all stakeholders on the Network of Care and the Health Data Warehouse. In addition, District and School-level results will be available by password on the Data Warehouse.

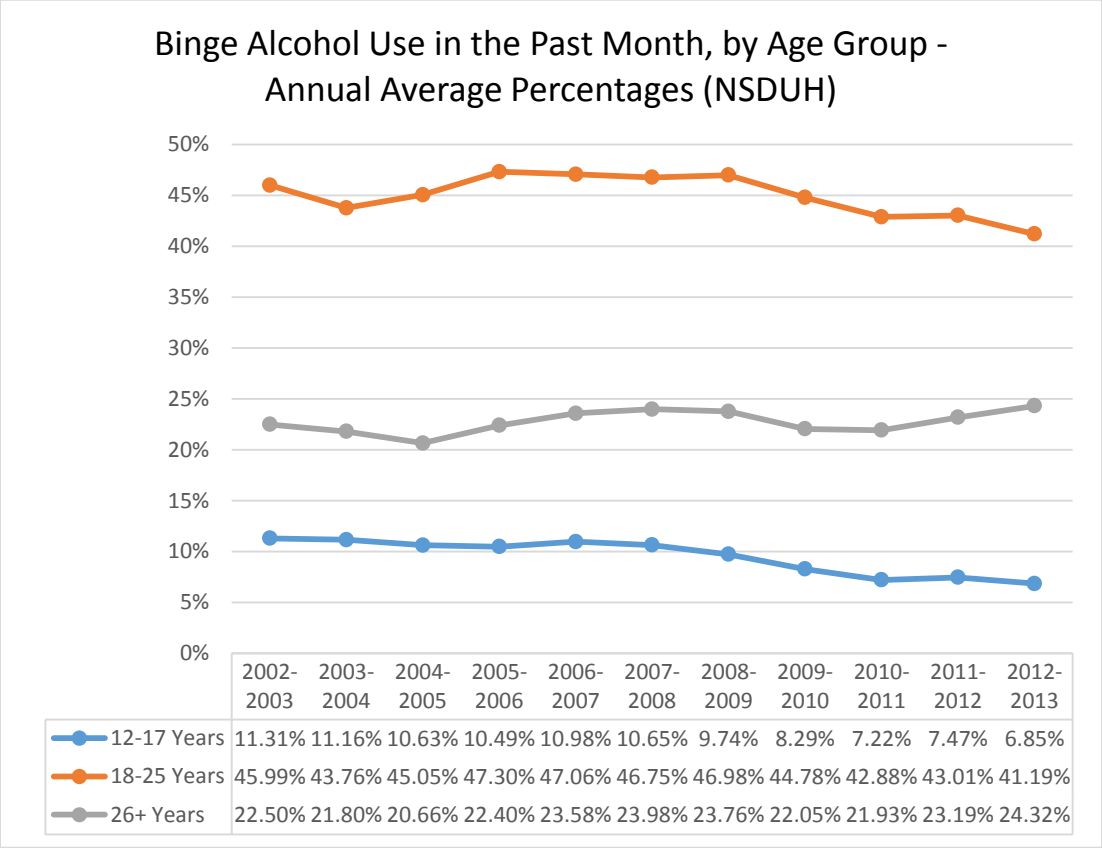
Results are used by schools, state and local agencies, organizations and communities to assess and monitor the health and safety of Ohio youth. Survey data provide a snapshot of youth health behaviors in each county across the state and serves as a valuable tool in better understanding the interrelated needs in youth program planning, implementation, and evaluation. The data are essential for strategic planning, prioritizing needs and allocating limited resources.

Estimating Ohio's Prevalence of Alcohol Abuse and Dependence and Unmet Need

The data on the next two pages indicates that alcohol abuse is common, especially among the general population, with the highest rates of alcohol abuse and dependence among young adults ages 18 – 25 in Ohio. About 41% of that age group engages in binge drinking (i.e. drinking five or more drinks on the same occasion), an indicator of alcohol abuse. According to 2012-2013 NSDUH estimates, about 13.6% of Ohioans age 18 – 25 were in need of treatment for alcohol dependence or abuse at a specialized behavioral health facility, <u>but are not receiving these services</u>. During the same period, youth ages 12 – 17, 6.9% engaged in binge drinking; 3% were in need of treatment but did not receive treatment services. Over the past ten years, both binge drinking and the number of youth who need treatment but are not receiving it have declined. These are indeed positive outcomes among Ohio's youth and young adults.

Outcomes for adults ages 26 and over are not as positive. The trend over the past ten years indicates adults engaging in binge drinking has increased from 22.5% to 24.3%. While the percentage needing but not receiving treatment remained about the same. The latest NSDUH data for 2012-2013 reveals that among adults, 24.3% engaged in binge drinking and 5.7% needed but did not get treatment.

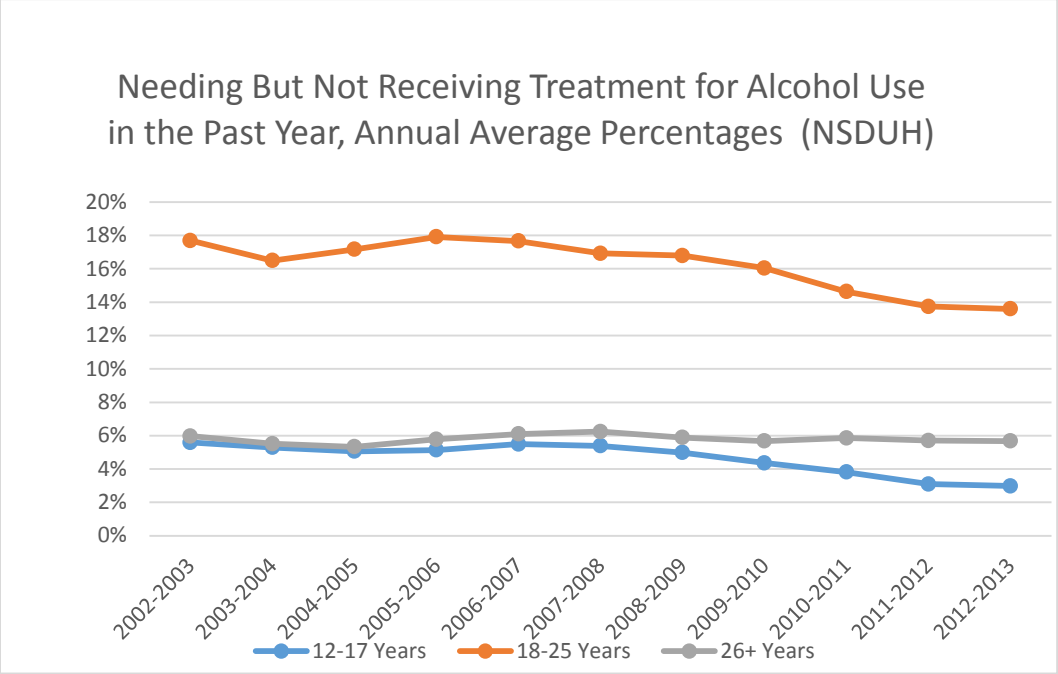
Boards identify alcohol abuse and dependence as a continuing problem in many communities. Alcohol use is commonly reported for all age groups in Ohio. According to BRFSS 5-year trend data, all age groups represented (except the upper extreme of age 65 and over), had percentages for last 30 day alcohol in the range of 50% - 67% for each year from 2008-2013. Per capita alcohol consumption is one of the most commonly used measures of alcohol use trends over time. According to data from the Ohio Department of Commerce, Division of Liquor Control, per capita retail sales of bottles of liquor (i.e. alcohol content 21% and above) from 2005 to 2014 has steadily increased from 2.95 to 4.80 bottles.



	2002-2003	2003-2004	2004-2005	2005-2006	2006-2007	2007-2008	2008-2009	2009-2010	2010-2011	2011-2012	2012-2013
12-17 Years	11.31%	11.16%	10.63%	10.49%	10.98%	10.65%	9.74%	8.29%	7.22%	7.47%	6.85%
18-25 Years	45.99%	43.76%	45.05%	47.30%	47.06%	46.75%	46.98%	44.78%	42.88%	43.01%	41.19%
26+ Years	22.50%	21.80%	20.66%	22.40%	23.58%	23.98%	23.76%	22.05%	21.93%	23.19%	24.32%

NOTE: Binge Alcohol Use is defined as drinking five or more drinks on the same occasion (i.e., at the same time or within a couple of hours of each other) on at least 1 day in the past 30 days.

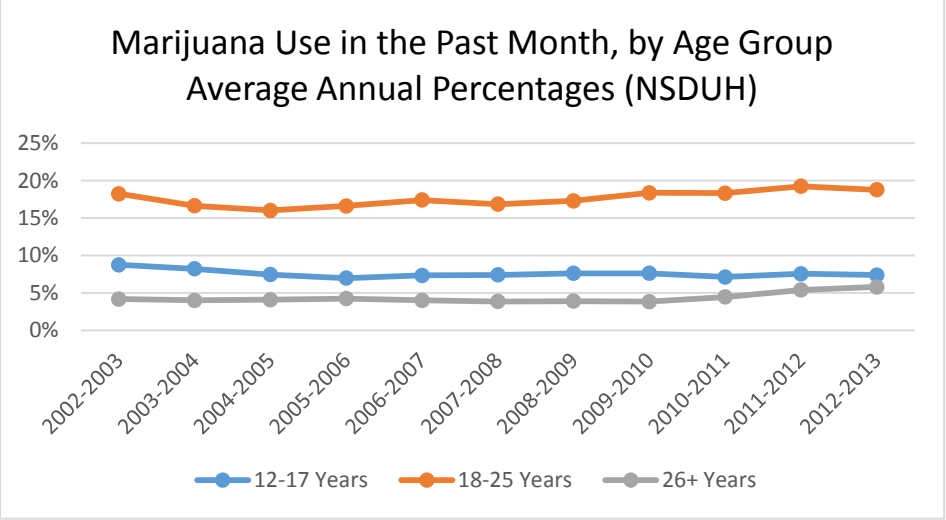
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health (NSDUH) from Ohio SEOW data.



NOTE: 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). Source: NSDUH, Ohio SEOW data.

Estimating Marijuana Use in Past Month by Age Group

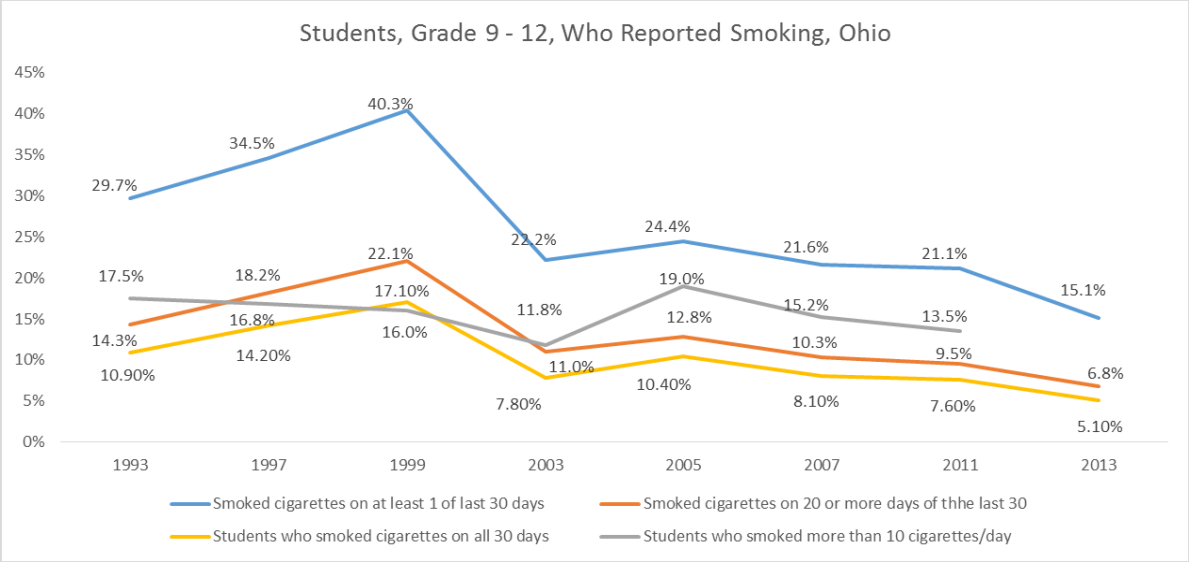
About 19% of Ohio's young adults (ages 18 – 25), 7% of youth and 6% of adults ages 26 and over used marijuana during the past month according to 2012-2013 NSDUH. As with alcohol, the age group with the highest percentage of abusers is young adults (ages 18-25). Marijuana is the most common reason for referral for SUD treatment among youth (ages 12 -17) and is a focus for both prevention programs and addiction treatment services targeting Ohio youth.



Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health from Ohio SEOW data.

Estimating Youth Tobacco Use

Youth Risk Behavior Surveillance System (YRBSS) data for 2013 indicated 21.7% of high school students reported current use of *any* tobacco product, including cigarettes, smokeless tobacco, or cigars; this percentage is down from 28% as reported for 2011. Since 2005, a downward trend has been seen, as graphed below, in youth cigarette use. In 2013, cigarettes were smoked by 15.1% of high school students on at least 1 or more days in the last 30 days, 7% smoked on 20 or more days, and 5.1% reported they smoked on all 30 days of the last 30 days. Students also responded about their current use of cigars (11.5%) and smokeless tobacco products (8.6%).

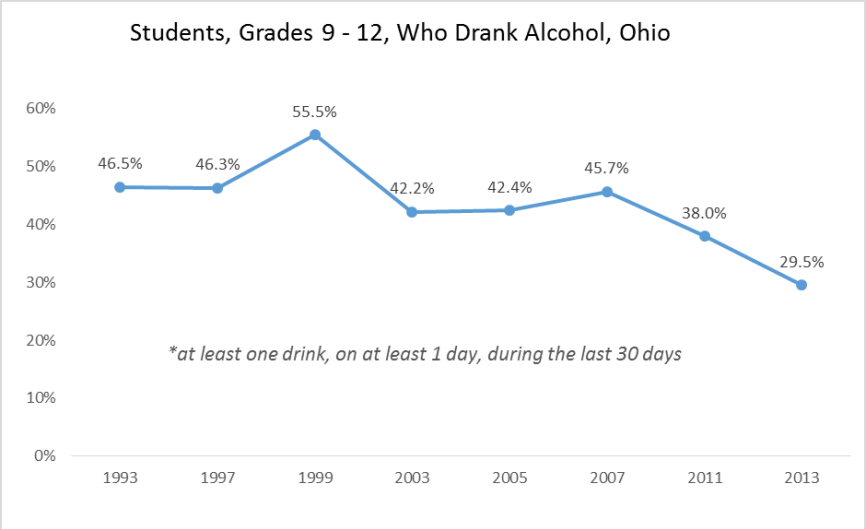


Source: Youth Risk Behavior Surveillance System (YRBSS), Centers for Disease Control and Prevention (CDC) from Ohio SEOW data.

YRBSS data revealed a decrease in students ever trying cigarettes (even one or two puffs) from 69% in 1993 to 52% for the latest data available for this indicator from 2011; a corresponding decrease was seen in students reporting they had smoked a whole cigarette before age 13 (for the first time) from 27% to 14% for the same time period.

Estimating Youth Alcohol Use

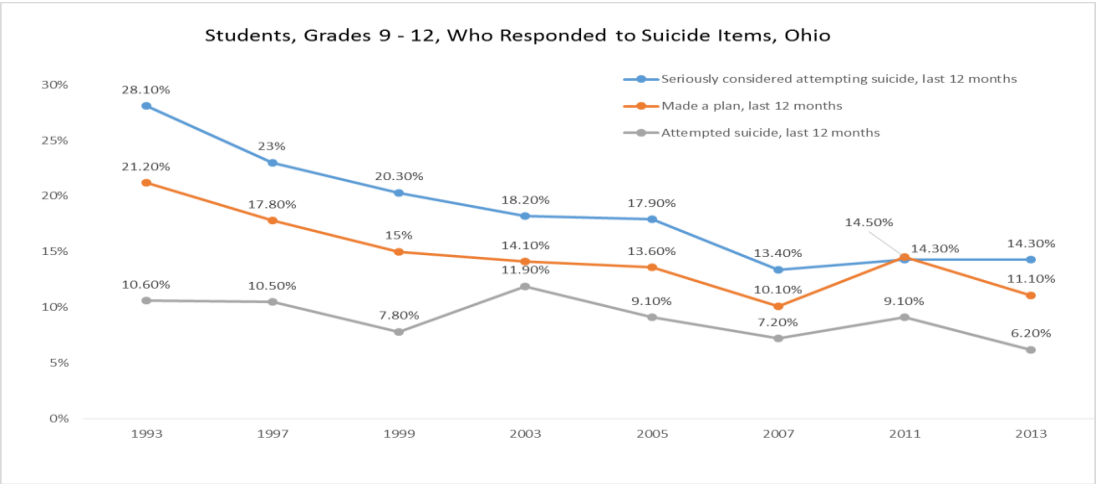
In 2013, almost 30% of youth indicated they had consumed alcohol (i.e. at least one drink on at least 1 day during the last 30 days). As graphed below, the trend for youth who reported drinking in the last month has declined since a high of 55% was seen in 1999.



Source: Youth Risk Behavior Surveillance System (YRBSS), Centers for Disease Control and Prevention (CDC) from Ohio SEOW data.

Estimating Youth Suicide

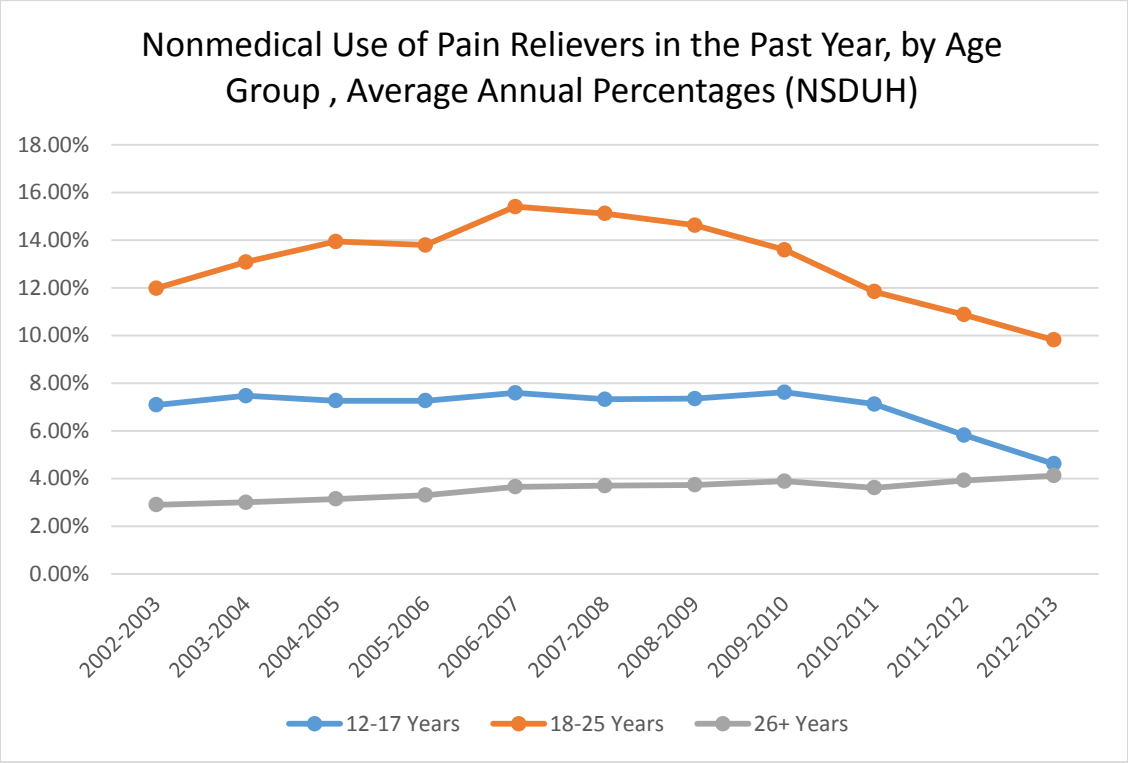
Recent youth suicides in Ohio, as reported by the media, were attributed to bullying and the stress of trying to fit in. ODH Vital Statistics data for 2012 provided there were 18 suicides for those age 5 to 14 and 177 suicides for young adults age 15 to 24. According to YRBSS 2013 results, Ohio has experienced a downward trend in students considering suicide with a high of 28.1% (1993) to lows of 13.4% (2007) and 14.3% (2013). Suicide attempts have remained fairly stable, ranging from 10.6% (1993) to a low 6.2% (2013) and a high of 11.9% (2003).



Source: Youth Risk Behavior Surveillance System (YRBSS), Centers for Disease Control and Prevention (CDC). Form Ohio SEOW data.

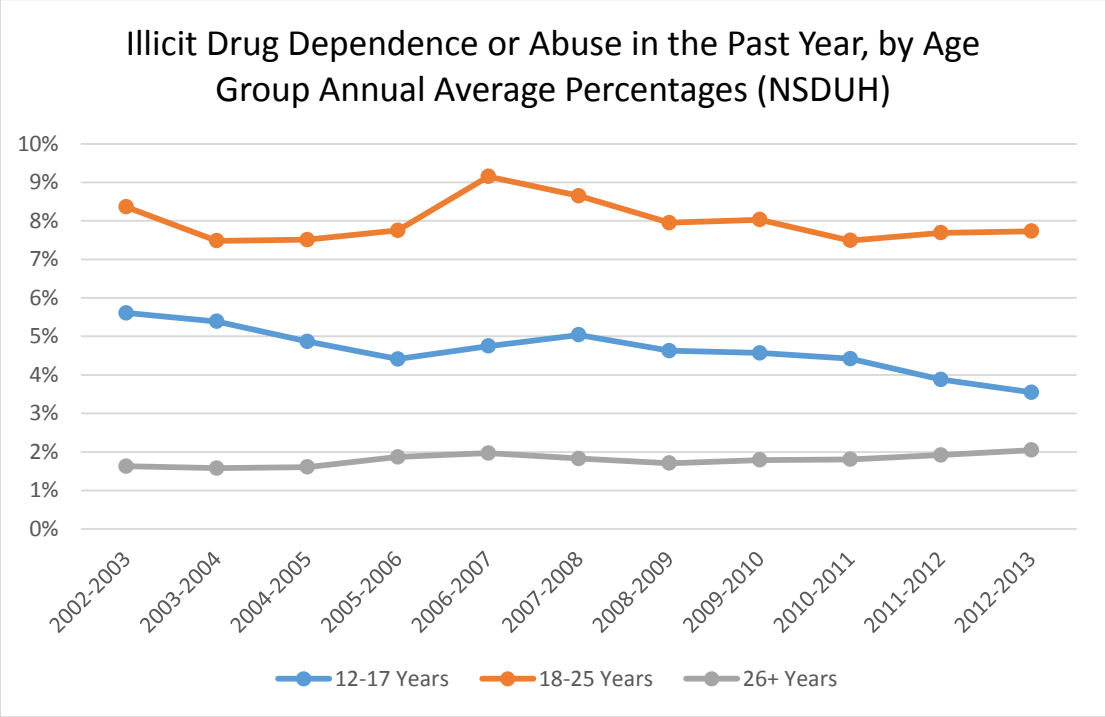
Non-Medical Use of Pain Relievers

Ohioans use non-medical pain relievers in significant numbers. This behavior can develop into a substance use disorder, especially with use of opioid pain medications. In Ohio, "pill mills" were identified as a major problem, and have been shut down with legal action in some communities. Additionally, people acquire non-medical prescription drugs from the family medicine cabinet or buy them on the street. Prescription opioids are expensive and heroin which is cheaper, has gained in popularity. Below is a graph which shows the nonmedical use of pain relievers over a ten year period for three age groups in Ohio. While the trend is downward for youth and young adults, and is unchanged for adults ages 26 and over the unintentional overdose deaths attributed to use of opioids and heroin has increased a staggering 413% since 1999, according to Ohio Department of Health; further discussion and data on these drugs are provided in the document.



Estimating Other Drug Use among Ohioans

Ohio population data indicates opiate abuse is a significant problem among adults. Among adults receiving publicly-funded addiction treatment, 29% adults (ages 18+) and 47% of adult women were treated for opiate dependence during SFY 2014 The graph below indicates illicit drug use among youth (ages 12- 17) has decreased from 5.6% to 3.6% over a ten year period. Use for young adults (ages18 – 25) remains at about 8%, and for adults (ages 26+), use remains around 2%.



Priority Populations for the Substance Abuse Prevention and Treatment (SAPT) Block Grant:

IV Drug Use

There is growing concern about the widespread use of heroin in Ohio. Numerous factors have been identified as causing a shift towards increased heroin use and subsequent overdose deaths. According to Ohio Substance Abuse Monitoring (OSAM) Network reports, active and recovering users, treatment providers and law enforcement often report that illicit users of prescription opioids move to heroin use due to higher availability and lower prices. Generally prescription opioids sell for $1-2 per milligram, so the cost is extremely high. Further, some pain pills are more sought after or harder to get, so they sell for more; for example, street price of an 8 mg Dilaudid pill was most recently reported as costing as much as $30-60 in one region of the state. Additionally, heroin prices have remained far less for a similar high, while supply has notably increased.

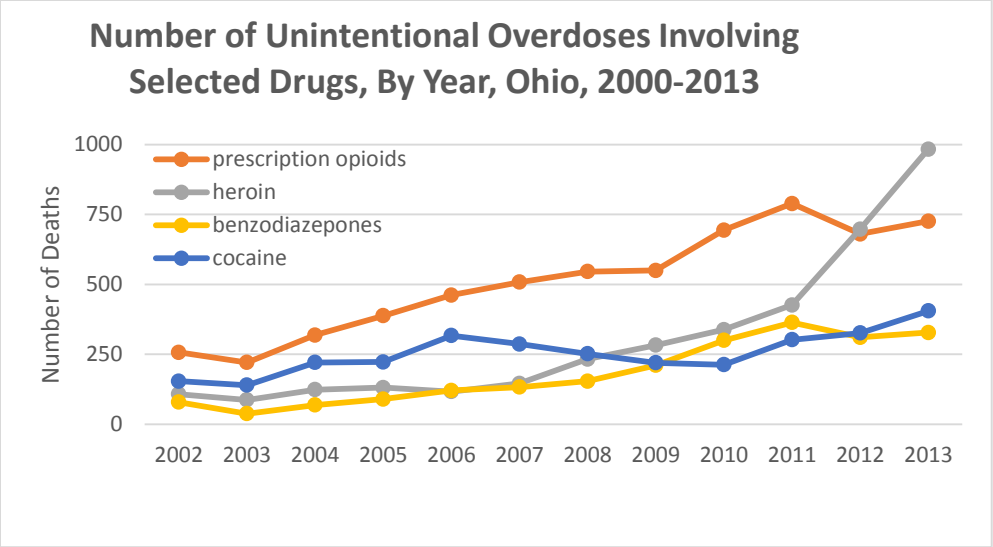
OSAM participants throughout Ohio continued to report intravenous injection (aka “shooting” or “banging”) as the most common route of administration for heroin followed by snorting.

Participants frequently estimated that the majority of heroin users begin by snorting it and progress to injecting it.

According to the Ohio Behavioral Health Module in SFY 2012, IV-drug use was most popular among heroin users (79.6%), followed by methamphetamine users (18.4%), prescription opioid users (8.9%), and crack cocaine users (1.4%) for clients reporting on primary through tertiary drugs of choice and routes of administration. As a primary drug of choice, users reported the following injections: heroin 7,100 times, prescription opioids 785 times, methamphetamine 76 times, and crack cocaine 12 times.

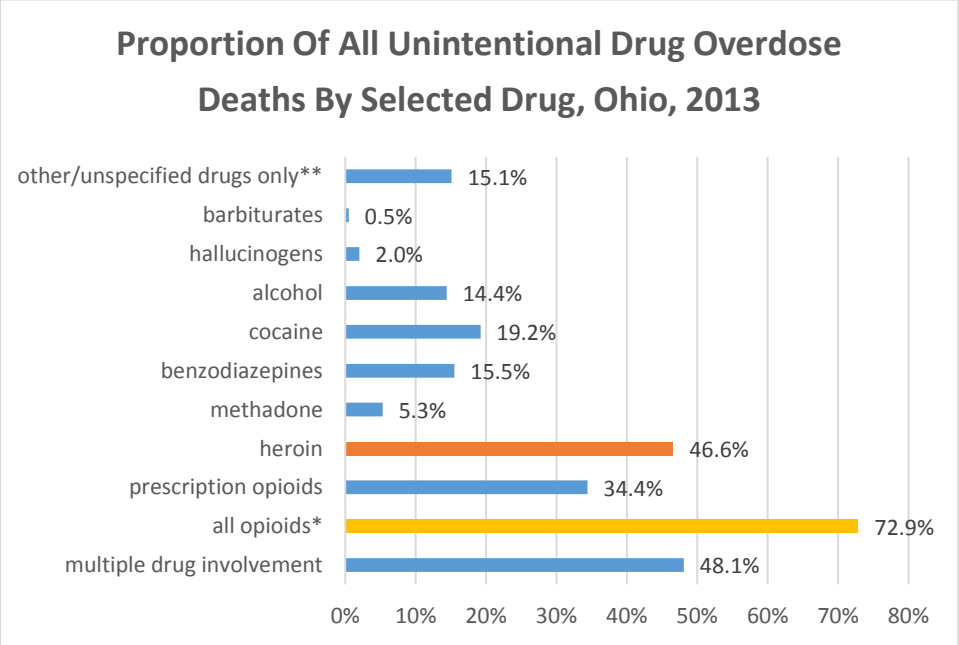
Heroin was identified as the primary drug of choice by 8,509 clients (15.2%) for those receiving treatment services in SFY 2012 (Source: MACSIS, 2012 data). The three counties with the highest percentages of clients reporting heroin as a drug of choice were Marion (47.1%), Knox (36.4%) and Hardin (28.2%), all categorized as rural (OHMHAS-MAPS). According to the newer SFY 2015 MACSIS/MITS data, opioids were identified as the primary drug of choice by 39% of all persons receiving treatment in Ohio's public system, and 47.2% of females. Treatment service data yielded an increase in the number of clients with a primary diagnosis of opioid abuse and dependence from 5,790 in SFY 2001 to 24,833 in SFY 2012, representing a 329% increase. Data clearly indicate that heroin use is increasing at an increasing rate.

ODH Vital Statistics reveal that Ohio has seen a 413% % increase in drug overdose deaths from 1999 to2013; opioids (prescription or heroin) remain the driving factor behind the unintentional drug overdose epidemic in Ohio. In 2013m there was a sizeable shift in prescription opioid-related overdose deaths to heroin-related deaths. As graphed below, heroin-involved deaths increased from 16% (233) in 2008 to a high of 47% (983) in 2013 for all drug overdoses, which represents a 322% increase. Heroin overdose deaths significantly surpassed prescription opiates deaths in 2013 and was associated with more than twice as many fatal overdoses as cocaine. The graph also depicts the trend in heroin overdose deaths occurring since 2002.



Source: Ohio Department of Health; Office of Vital Statistics from Ohio SEOW data.

The selected drugs implicated in intentional overdose deaths are graphed below. Nearly three-quarters (1,539; 72.9 %) of the drug overdoses involved any opioid (prescription opioid or heroin) in 2013, higher than in 2012 (1,272; 66.5 %). Contributing factors to the recent rise in heroin-related overdose in Ohio include a growing opioid-addicted population, shutdown of southern Ohio's pill mills, recent scrutiny around prescribed opioids, tamper-resistant prescription opioid formulations, increasing quantity and purity of heroin and decreasing cost of heroin compared to prescription opioids.

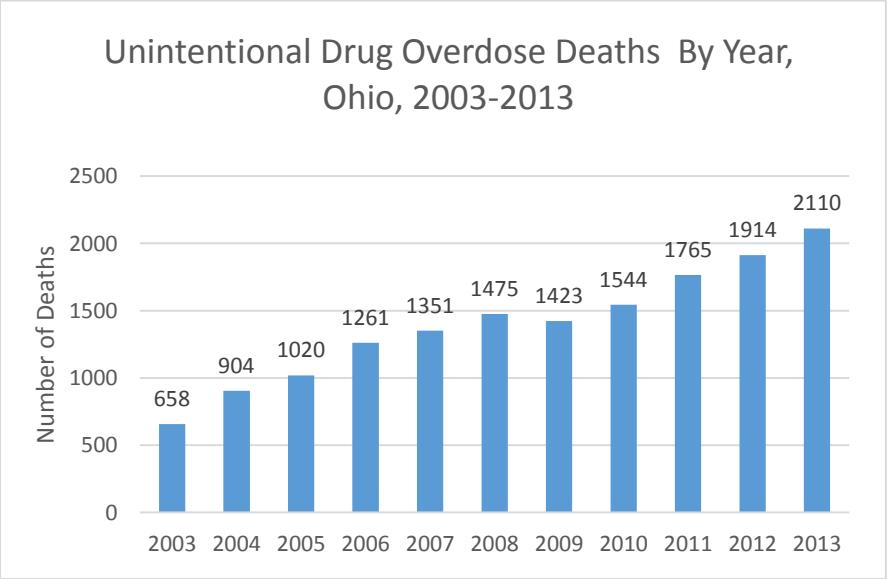


Source: Ohio Dept. of Health; Office of Vital Statistics, Analysis by Injury Prevention Program
*Includes prescription opioids and heroin.
** Includes only those instances where no other drug than T50.9 (other/unspecified) is listed.

Men aged 25–34 years were at highest risk for fatal heroin overdoses. From 2012 to 2013, heroin overdose deaths increased a staggering 41.0% across the one year period (Source: ODH Office of Vital Statistics; Violence and Injury Prevention Program).
Ohio's percentages may be even higher than reported as more than one-sixth (17 %) of the cases, no specific drug was identified in death certificate data. As such, reported drugs are likely under-estimates of their true contribution to the burden of fatal drug overdose in Ohio.

Findings from the 2013 Ohio Coroner Survey: Fatal Drug Overdose Investigation, a survey conducted of Ohio coroners in January 2013 by the Ohio State Coroners' Association (OSCA), in partnership with the Ohio Department of Health (ODH) found that only 78.4% of suspected overdose cases received toxicology testing in 2012. Of those cases where toxicology testing was performed, only 57.5% of coroners documented specific drugs responsible for overdose deaths in Part 1 (Cause of Death/Underlying Cause of Death) on the death certificate. One barrier was that the specific drug was not ascertainable in situations of poly-substance overdoses.

According to the National Institute on Drug Abuse (NIDA), half a million Americans are now addicted to heroin, with four out of five recent heroin initiates reporting previous use of prescription opioids non-medically. The CDC's Morbidity and Mortality Weekly Report (MMWR) of October 3, 2014, entitled "Increases in Heroin Overdose Deaths — 28 States, 2010 to 2012", cites a number of jurisdictions in the United States with substantial increases in heroin overdose death rates since 2010 with some using prescription opioid pain relievers (OPRs) non-medically who switched to or also using heroin.
In Ohio, this continuing national drug trend is mirrored; ODH's 2013 data revealed 2,110 deaths were due to unintentional drug overdose, with nearly 73% implicating opiates which included heroin and prescription painkillers.



Data includes Ohio residents who died due to unintentional drug poisoning (primary underlying cause of death X40-X44).Sources: Ohio Dept. of Health, Office of Vital Statistics, Analysis by Injury Prevention Program; US Census Bureau (population estimates). Timely state surveillance data are necessary to target Ohio's prevention efforts in the face of rapid changes in drug use patterns. Prevention, treatment, and response strategies aimed at reducing both heroin and OPR use and overdose deaths are identified areas of need.

Ohio Substance Abuse Monitoring Network (OSAM) Drug Trend Report

January 2015 Executive Summary – Selected Sections

The Ohio Substance Abuse Monitoring (OSAM) Network consists of eight regional epidemiologists (REPIs) located in the following regions of the state: Akron-Canton, Athens, Cincinnati, Cleveland, Columbus, Dayton, Toledo and Youngstown. The OSAM Network conducts focus groups and individual qualitative interviews with active and recovering drug users and community professionals (treatment providers, law enforcement officials, etc.) 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 the Ohio Department of Mental Health and Addiction Services (OhioMHAS) with a real-time method of providing accurate epidemiological 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 January 30, 2015. It is based upon qualitative data collected from July 2014 through January 2015 via focus group interviews. Participants were 331 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 110 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 2014 through January 2015. OSAM research administrators in the Office of Quality, Planning and Research at OhioMHAS 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.

Heroin

The current availability of heroin remains high throughout OSAM regions; availability has increased in six of the eight regions during the past six months. Many participants stated that heroin is now easier to obtain than marijuana and cocaine. Participants throughout regions

referred to economic reasons for the increase in heroin availability, noting that heroin is easier to get than pain killers, heroin is cheap and dealers are making a lot of money selling heroin.

A number of treatment providers, too, speculated that heroin use has increased because hospitals have limited the use of opioids, so it's much harder to get pain medication than heroin which has resulted in fewer pain pills on the street. They also attributed the decrease in opioid availability to community efforts to collect unused medication via drop boxes. Law enforcement saw a correlation between the "*crackdown on pill doctors*" with increasing use of heroin. However, some treatment providers in Akron-Canton noted a trend in younger clients reporting using heroin straight away without the traditional progression from pain medication to heroin. Likewise, several treatment providers in Toledo reported more people coming to them addicted to heroin who have not done other drugs prior to using heroin.

Reported Change in Availability of Heroin during the Past 6 Months			
Region	**Current Availability**	**Availability Change**	**Most Available Type**
Akron-Canton	High	Increase	Brown Powdered
Athens	High	No Consensus	Black Tar and Brown Powdered
Cincinnati	High	Increase	Brown Powdered
Cleveland	High	Increase	Brown/White Powdered
Columbus	High	Increase	Black Tar and Brown Powdered
Dayton	High	No Consensus	Brown/White Powdered
Toledo	High	Increase	Brown Powdered
Youngstown	High	Increase	Brown/White Powdered

Participants throughout OSAM regions reported the overall current quality of heroin as moderate to high, rating current quality most often as '7' or '8' on a scale of '0' (poor quality, "garbage") to '10' (high quality). Participants most often noted that the overall quality of heroin has either remained the same or has decreased during the past six months; participants in Cincinnati only most often reported increased quality. However, participants continued to commonly report that the quality of the drug depends on from where it comes. Toledo participants explained that heroin dealers are so prevalent that they must deliver a high-quality product to maintain customers, although participants in more rural areas reported variability in quality.

Participants reported that the color of powdered heroin usually ranges from dark brown to light brown, but can also be gray and whitish in color. The consistency of powdered heroin was described by participants as ranging from rocky and chunky to powdery. Participants universally indicated that heroin is often cut (adulterated) with other substances. Participants reported that the top cutting agents for powdered heroin are prescription opioids; specifically mentioned were fentanyl, morphine, Percocet® and Vicodin®. Additional cuts mentioned included nutritional

supplements (creatine, protein powder and vitamin B-12), powdered cocaine and sedative-hypnotics (Klonopin®, NoDoz®, trazadone and Xanax®). Reportedly, brown powdered heroin and black tar heroin are also cut with aspirin, baby laxative, bath salts, brown sugar, darker drinks (cocoa powder, coffee and colas) and shoe polish; white powdered heroin is also cut with baby formula, powdered sugar and regular sugar. The BCI London Crime Lab reported that a lot of powdered heroin cases that are processed in the lab are a heroin-fentanyl mixture, sometimes even straight fentanyl.

Cincinnati participants reported that most users in the region are seeking white powdered heroin due to the high potency of the drug. Reportedly, the danger of using fentanyl-cut heroin is well understood, but most participants expressed seeking it out despite their understanding of possible overdose danger. Several participants shared stories of friends who died using fentanyl-cut heroin. Additionally, Toledo treatment providers explained that unbeknownst to users, some 'china white heroin' is currently being cut with powdered cocaine. Thus at treatment intake, while many clients report they used heroin cut with fentanyl, client testing often reveals that in many cases, participants have ingested heroin cut with cocaine.

Crime labs throughout OSAM regions most often noted the following cutting agents for heroin: caffeine, diphenhydramine (antihistamine), fentanyl, mannitol (diuretic), quinine (antimalarial) and triacetin (glycerin triacetate, a food additive).

Current street jargon includes many names for heroin. Several names referred to the color of the heroin; for instance, "dirty brown" or "brownies" for brown powdered heroin and "china white" or "snowflake" for white powdered heroin. An Athens region participant reported "scramble" as a street name for heroin mixed with morphine, while a Toledo region toxicologist reported hearing "super smack" as a street name for heroin mixed with fentanyl.

Current Street Names of Heroin	
Most Common Names	boy, dog (dog food), dope, H
Other Names	brown, dirt, fire, Ron, smack

Current street prices for heroin were consistent for small quantities, but variable for larger quantities among regions: 1/10 gram most often sells for $20; 1/2 gram sells for $40-80; a gram sells for $60-300. Participants continued to indicate that price is often dependent on type, quality and location of purchase. Athens participants commonly reported obtaining heroin for less money by traveling out of their region to larger cities like Columbus. Akron-Canton treatment providers reported a growing trend of clients who report obtaining heroin via the Internet. The majority of participants in Dayton continued to report most often purchasing capsules (aka "caps") of powdered heroin, while Toledo participants reported that small amounts of powdered heroin are typically sold in "packs" or "papers," which are often folded lottery tickets and small

amounts of black tar heroin are typically wrapped in foil and sold in “balloons” or “baggies.” Toledo participants also reported that dealers often give out free samples of heroin.

Universally, participants throughout regions continued to report that the most common route of administration for heroin remains intravenous injection (aka “shooting” or “banging”), followed by snorting. Participants frequently estimated that the majority of heroin users begin by snorting and progress to shooting the drug.

Participants reported that injection needles are very easily obtained from a dealer, family and friends who are diabetic, medical supply stores and, while not everyone agreed, from pharmacies. Many participants reported obtaining needles at pharmacies, especially if they are able to intelligibly feign being a diabetic or needing them for someone who is a diabetic. Other participants, however, reported that pharmacies are “cracking down” and requiring proof that the individual asking for syringes needs them for insulin. Reportedly, needles obtained from a dealer or fellow heroin user tend to be more expensive than needles purchased from stores. Needles on the street sell for $1-5 each depending on the size and how desperate the user appears.

Clean needle availability varies throughout regions as some participants reported being able to obtain them easily through pharmacies, while others reported being required to have a prescription. Participants divulged that many users will steal them from stores, homes and medical facilities. Still other participants said it is common practice to re-use needles from other users or merely finding them on the ground and re-using those. Participants throughout regions reported concerns over the availability of clean, unused needles and of sharing needles. Several participants reported fear of being turned away by a pharmacy and would share needles as an alternative. Disposal of used needles is another concern participants shared. Many participants suggested a community needle exchange program to help address their needle concerns.

Participants and community professionals most often described typical users of heroin as males and females, 30-40 years of age and younger, predominantly white and often someone who began using prescription opioid medication, but switched to heroin because it is cheaper. However, treatment providers in Akron-Canton observed an increase in the number of African-Americans using heroin during the past six months to a year, and law enforcement in that region also observed an increase in younger, teenage individuals using heroin during the past six months.

Participants and community professionals reported that heroin is often used by itself or in combination with other drugs. Reportedly, bath salts, cocaine (crack and powder) and methamphetamine are used with heroin to “speedball,” which means using these stimulant drugs with heroin either simultaneously or alternately in order to experience the highs and lows of the different drugs. Marijuana, ‘molly’ (powdered MDMA) and prescription opioids are reportedly

used with heroin to intensify or balance out the effect of the drug or to increase the quality of cheap heroin. Despite general knowledge that sedative-hypnotics, especially benzodiazepines, used with heroin are dangerous and potentially lethal, participants still reported using these with heroin in order to help 'nod out' (fall asleep).

Substances Most Often Combined with Heroin
Alcohol, Crack Cocaine, Marijuana, Methamphetamine, Powdered Cocaine, Sedative-Hypnotics

Prescription Opioids

Prescription opioids remain highly available throughout all OSAM regions, with the exception of Cincinnati where current street availability is reportedly moderate. Availability of these drugs has decreased during the past six months for Akron-Canton, Cleveland and Toledo. Participants and community professionals who reported decreased availability cited doctor, pharmacy and law enforcement interventions as reasons. Specifically, they reported that it is currently more difficult for users to acquire pain pills, especially the ones most wanted such as Dilaudid® and OxyContin® due to increased regulation of these medications; doctors and emergency rooms are not dispensing these medications as regularly as previous. Law enforcement also attributed the decrease in availability to the closure of several "pill mills" in the area as well as doctors prescribing pain medications less often.

Participants explained that some prescription opioids remain highly available, but not preferred because many of these pills were re-formulated with abuse-deterrent that makes them more difficult to inject. Several participants suggested that tramadol (a non-narcotic pain reliever, generic form of Ultram®) is becoming more available due to an increase in doctors prescribing this particular drug as opposed to other opioids. Some participants noted that although prescription opioids are available, many users' drug of choice has switched to heroin and thus decreased the demand for these drugs and their subsequent availability.

Reported Change in Availability of Prescription Opioids during the Past 6 Months			
Region	**Current Availability**	**Availability Change**	**Most Widely Used**
Akron-Canton	High	Decrease	Opana®,Percocet®, Vicodin®
Athens	High	No Change	Dilaudid®, Percocet®, Roxicodone®, Ultram®, Vicodin®
Cincinnati	Moderate	No Change	Percocet®, Vicodin®
Cleveland	High	Decrease	Percocet®
Columbus	High	No Change	Percocet®, Vicodin®
Dayton	High	No Consensus	Percocet®, Vicodin®
Toledo	High	Decrease	Tramadol, Ultram®, Vicodin®
Youngstown	High	No Change	Opana®, OxyContin®, Percocet®

Current street jargon includes many names for prescription opioids (aka "candy," "chicklets," "skittles," or "tic-tacs"). Participants reported the following common street names for many of the prescription opioids available to street-level users. Note, Percocet®, Roxicet® and Roxicodone® are typically considered the same by participants, so they share similar names. For example, Roxicodone® 30 mg is often referred to as "perk 30."

Current Street Names of Prescription Opioids	
Dilaudid®	Ds
Fentanyl	patches, suckers
Lortab®	tabs
Methadone	coffins, dones, wafers, waffles
Norco®	beans, narcs, norks,
Opana®	OPs, pandas
OxyContin®	jelly beans, OPs, oxies,
Percocet®	beans, blues, smurfs (5 mg); jerks, perks, Ps, school busses, tens (10 mg)
Roxicodone®	15s (15 mg); 30s, perk 30s (30 mg); roxies
Tylenol®3	terminators
Ultram®/Tramadol	Ts, trams
Vicodin®	aspirin, baby vikes (5 mg); candies, seven-fifties, sevens (7.5 mg); 10s (10 mg); vickies, vikes, Vs

Many different types of prescription opioids are currently sold on Ohio's streets. Reports of current street prices for prescription opioids varied between type and OSAM region. However, generally prescription opioids sell for $1-2 per milligram. Many participants noted that prescription opioids have become more expensive. Participants indicated that price is often determined by several factors including the dealer or source, what the user wants, how desperate the user is, and quantity. For example, participants in Athens reported that Dilaudid® 8 mg sells for $30-60. In addition to obtaining prescription opioids on the street from dealers, participants also reported getting them from physicians and people with prescriptions, including older individuals.

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 most common route of administration for illicit use remains snorting, followed by oral consumption (including chewing, crushing pills and wrapping in tissue to swallow, aka "parachuting") and intravenous injection (aka "shooting"). Fewer participants mentioned shooting prescription opioids, and those who did, commonly noted that working around abuse-deterrent formulations for snorting and

shooting is difficult and time consuming. In Athens, participants reported that smoking of prescription opioids off of foil is another common route of administration.

A profile of a typical illicit user of prescription opioids did not emerge from the data. Participants and community professionals throughout regions continued to report typical illicit users as everybody. However, many respondents of both groups noted heroin users and persons with a legitimate physical pain problem who become addicted to the drugs for regular illicit use.

Prescription opioids are often used in combination with other substances. The majority of participants explained that using other substances with prescription opioids increases the high, particularly alcohol and benzodiazepines. Reportedly, cocaine and methamphetamine are used with these drugs for the 'speedball' effect, which is when users seek out the dual effects of the drugs either by using them simultaneously or by alternating their use. In addition, an Akron-Canton participant reported a growing trend of using Adderall® with prescription opioids.

Substances Most Often Combined with Prescription Opioids
Alcohol, Heroin, Marijuana, Powdered Cocaine, Prescription Opioids, Sedative-Hypnotics

Marijuana

Marijuana remains highly available throughout OSAM regions. The only changes in availability during the past six months were increased availability for Athens and Columbus regions. Athens participants cited harvest as a reason for the increase. By August 14, 2014 Athens and Meigs counties led the state with over 2,500 plants seized (www.athensnews.com, Aug. 20, 2014). Additionally, the BCI London Crime Lab reported that the number of marijuana cases it processes has increased during the past six months and the American Court and Drug Testing Services reported that 19.2 percent of the 2,878 individuals screened through its Columbus and Lancaster labs during the past six months were positive for marijuana.

Reported Change in Availability of Marijuana during the past 6 months		
Region	**Current Availability**	**Availability Change**
Akron-Canton	High	No change
Athens	High	Increase
Cincinnati	High	No change
Cleveland	High	No change
Columbus	High	Increase
Dayton	High	No change
Toledo	High	No change
Youngstown	High	No change

Participants reported high quality for all types of marijuana. The majority of the participants agreed that high quality marijuana was more readily available than lower quality product. However, Youngstown participants explained that it was harvest season, so even the lower quality product was of good quality. Participants and treatment providers continued to report preference of high-grade, hydroponic marijuana over typical commercial-grade product. Several Cincinnati participants admitted to purchasing higher quality marijuana through the U.S. mail. In addition, Akron-Canton law enforcement reported an increase of marijuana coming into the region in the form of food products (baked goods or candy), often via U.S. mail.

Akron-Canton, Athens, Cleveland, Columbus and Dayton participants and community professionals cited an increase in high quality marijuana availability, including increased use of concentrates and extracts, during the past six months. Concentrates and extracts take the form of oil or wax (aka "dabs") and have a very high concentration of THC (tetrahydrocannabinol). Athens community professionals noted an increase in this form of the drug; treatment providers particularly noted hearing about marijuana oils and dabs from adolescents.

Current street jargon includes countless names for marijuana. Participants provided general names for marijuana, as well as names for low- and high-grade marijuana. Additional names often refer to the strain of the marijuana; many times referring to flavor or color of veins in the marijuana: For example, "blueberry," "bubblegum," "downtown brown," "purple" and "white widow."

Current Street Names of Marijuana	
General	**pot, smoke, weed**
Low grade	bobby brown, bud, dirt, mids, regular (reggie, reg), schwag, trees
High grade	chronic, dank, dro, kill (killer, killa), kush, loud
Concentrates and extracts	dabs, teamsters

Reported prices for marijuana were variable throughout OSAM regions. Low-grade marijuana is the cheapest form of the drug, while high-grade marijuana sells for significantly more. High-grade marijuana is also more variable in price depending on quality of the drug. Most currently, for low-grade marijuana, a "blunt" (cigar) or two "joints" (cigarettes) sell for $5; a gram sells for $10; 1/4 ounce sells for $20-25 (and as high as $40 in some locations); an ounce sells for $80-100; and a pound sells for $800 on average. For high-grade marijuana, a blunt or two joints sell for $10-20; a gram sells for $20; 1/8 ounce sells for approximately $60; 1/4 ounce sells for about $100; an ounce can sell for $250-320; and a pound sells for up to $5,000. Participants did not provide pricing information for marijuana concentrates and extracts.

Participants continued to report smoking as the most common route of administration for marijuana. Additional methods reported include an increase in vaporizing the oils and smoking dabs, as well as oral ingestion of marijuana. Several regions indicated an increase in THC-laced candies, snacks and baked goods.

A profile of a typical marijuana user did not emerge from the data. Participants and professionals described marijuana users as everyone. Columbus participants noted that lower-grade marijuana is primarily used by people of lower socio-economic status, as well as habitual users, due to lower cost of the drug. Treatment providers indicated that marijuana is one of the hardest drugs for their clients to quit; if clients make it through treatment, they often continue using marijuana, often due to social acceptability of the substance.

Participants and community providers continue to report that marijuana is most often used in combination with nearly any other substance.

Substances Most Often Used in Combination with Marijuana
Alcohol, Crack Cocaine, Heroin, Methamphetamine, PCP, Powdered Cocaine, Prescription Opioids, Prescription Stimulants(Adderall®), Sedative-Hypnotics (Xanax®)

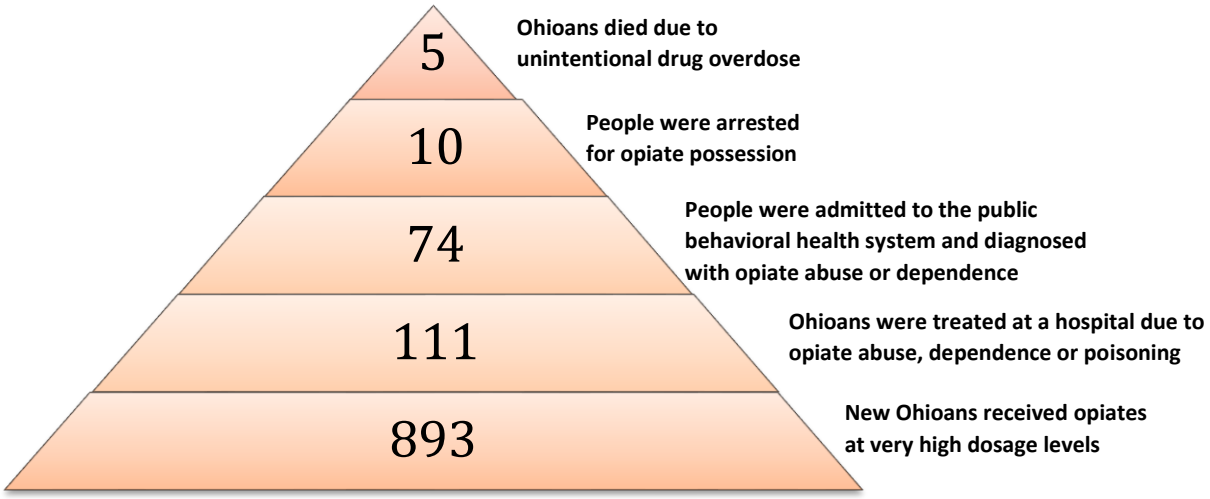
Note: Selected sections of the January 2015, 2015 OSAM Executive Summary from the June 19, 2015 draft which did not address priority populations were excluded; these included reports on use of powdered cocaine, crack cocaine, ecstasy, sedative-hypnotics, methamphetamine and prescription stimulants, prescription opioids, Suboxone, synthetic marijuana, and other drugs. Alcohol use is not addressed by this report. The full report is available at: http://mha.ohio.gov/Portals/0/assets/Research/OSAM-TRI/January-2015-Full-Report_Surveillance-of-Drug-Abuse-in-the-State-of-Ohio.pdf

Additional Data to Assess Need among Block Grant's Priority Populations

IV Drug Use/Opiate Abuse

Opiate abuse has exacted a heavy toll on Ohio. From hospital emergency departments to addiction treatment facilities, every part of Ohio's health system has been impacted by opiate addiction. Even law enforcement efforts have been touched by the opiate epidemic, as more and more opiates are seized every year throughout the state. Of greatest concern is the dramatic rise in unintentional drug overdoses, claiming nearly 2,000 lives every year. While there are regional differences in health indicators and interdiction efforts, no part of Ohio has been left untouched during this crisis. Here are a few sobering statistics about the opiate epidemic in Ohio.

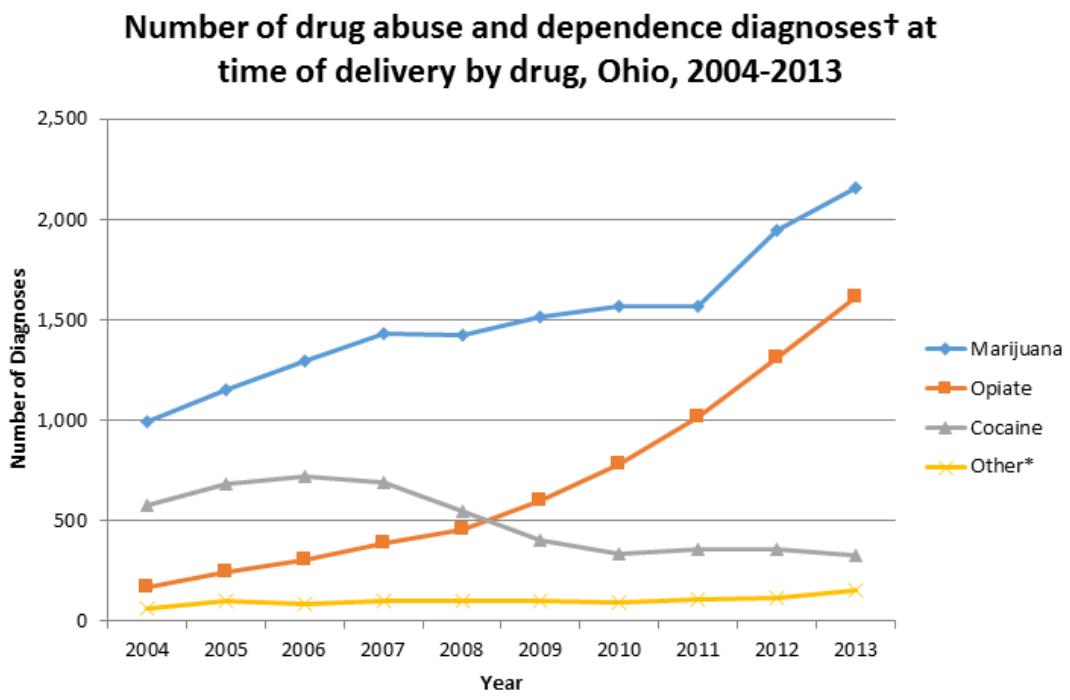
Every single day in 2012:



Massatti, R. R. (In press). *Opiate Use in Ohio, 2011-2013.* Columbus, OH: Ohio Department of Mental Health and Addiction Services.

Pregnant Women and Drug Use

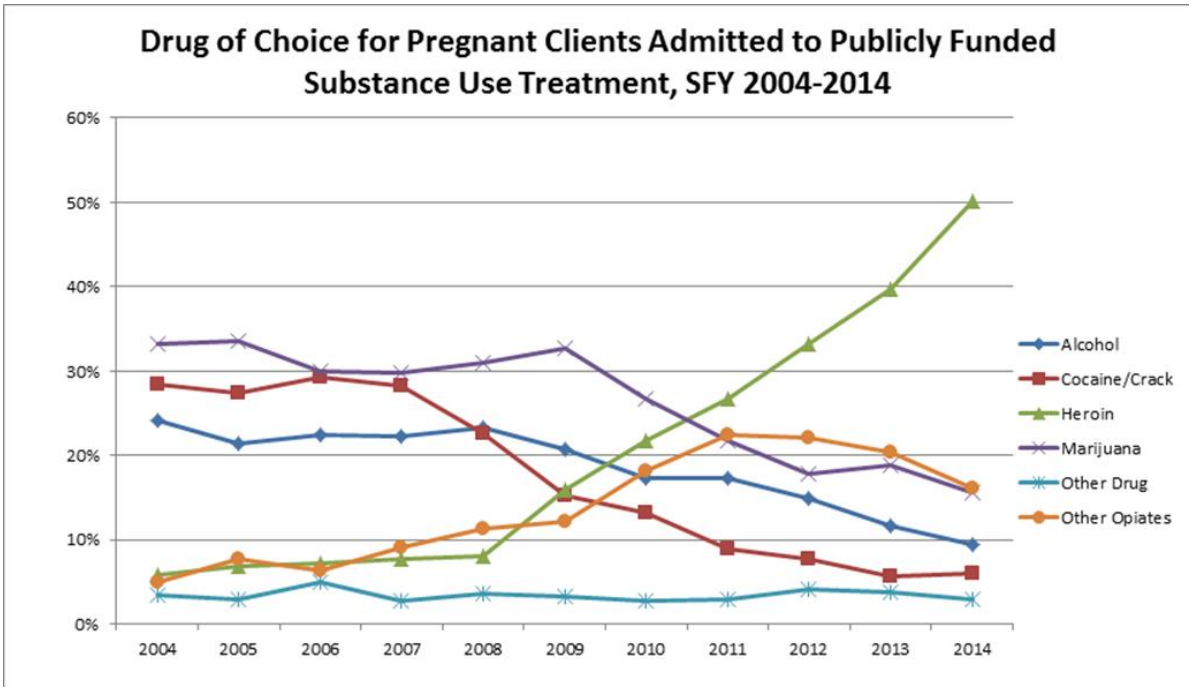
Women may be diagnosed with a variety of drug abuse and dependence conditions at time of delivery. Historical data, graphed below, demonstrate marijuana abuse or dependence was the most often diagnosed substance of abuse or dependence in pregnant women between 2004 and 2013. A spike in marijuana-related diagnoses occurred between 2011 and 2013, with cases rising from 1,564 to 2,160 (38.1%). This increase was likely due to the country's changing attitude toward marijuana; national news outlets frequently reported about passage of laws in Washington and Colorado in 2012. Since 2006, cocaine abuse or dependence for pregnant women at time of delivery has steadily declined 54.6% in juxtaposition to the diagnosis of opiate abuse or dependence, which has steadily risen from 171 cases in 2004 to 1,614 cases in 2013 (844%). Women diagnosed with abuse and dependence of other drug classes remained relatively stable between 2004 and 2013.



†A woman could have multiple diagnoses
* Other may refer to drugs like hallucinogens and amphetamines

Source: Ohio Hospital Association

According to OhioMHAS's Neonatal Abstinence Syndrome and Drug Use Among Pregnant Women in Ohio: 2004-2011 report, more than 4,200 pregnant women were admitted to treatment between 2004 and 2011. The percentage of pregnant women in treatment is relatively small compared to the percentage of all women in treatment (2.5 %), but it has been growing steadily over time. In fact, the number of pregnant women admitted for addiction treatment grew 83% from 2004 to 2011. While data are not available for every pregnant woman, most women (84%) gave birth while receiving treatment services. Heroin was reported as the drug of choice for about 50% of pregnant women who received treatment services. Downward trends are seen for the other reported drugs with the exception of "other drugs" which remained stable over time.



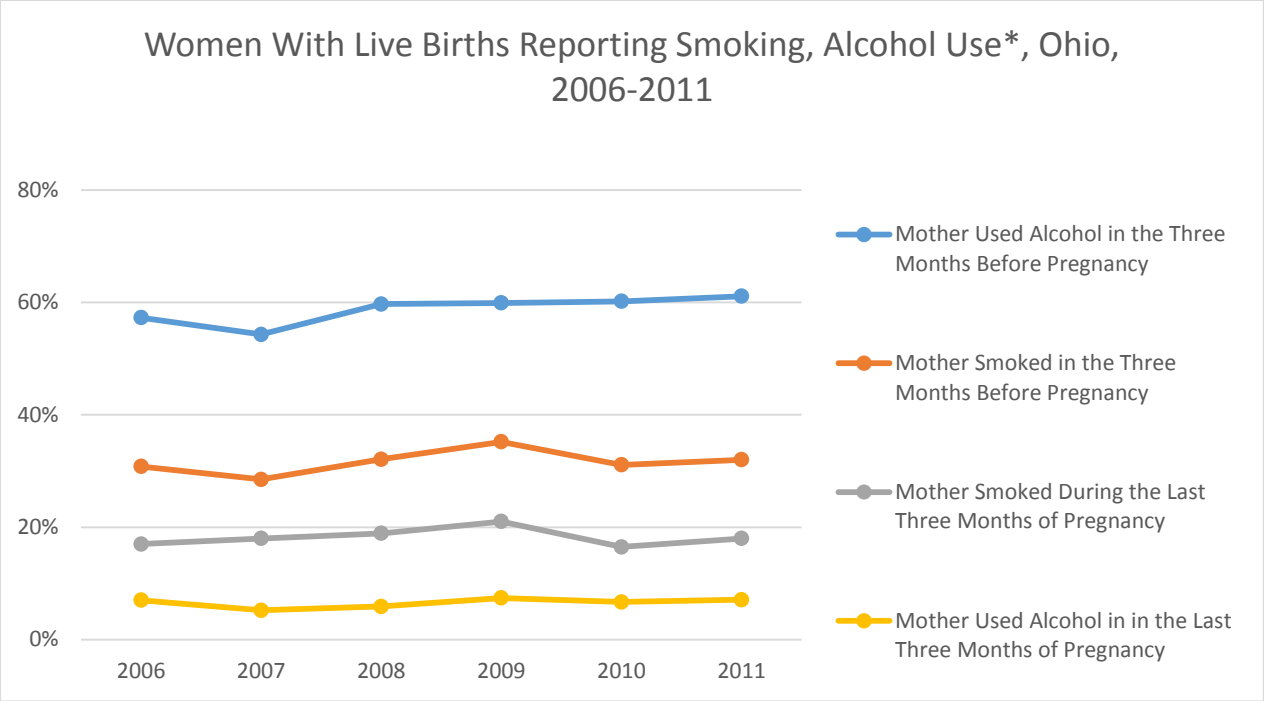
Note: Clients without a valid drug of choice were eliminated from this analysis.
Source: Ohio Behavioral Health Data (OHBH), SFY 2004-2014, analysis by OhioMHAS.

Pregnant Women and Use of Tobacco and Alcohol

Ohio Department of Health's Pregnancy Risk Assessment Monitoring System (PRAMS) collects population-based data on topics related to pregnancy and early infancy. Most recent data from 2011 were obtained. Nearly 60% of Ohio mothers (in PRAMS) reported drinking 3 months before pregnancy and 32% reported smoking 3 months prior to pregnancy. The graph below indicates that the same group of pregnant women reported drinking (18%) and smoking (7%) in their last 3 months of pregnancy. Prenatal alcohol use is linked to Fetal Alcohol Spectrum Disorders (FASD). The costs of FASD in Ohio reach beyond associated short-term complications to lifelong service provision for education, vocational, residential and social supports.

According to the CDC, smoking during pregnancy remains one of the most common preventable causes of infant morbidity and mortality; there is an increased risk for sudden infant death syndrome (SIDS) and for numerous pregnancy complications.

Almost one in three women who had a live birth in Ohio in 2011 smoked in the three months before becoming pregnant and just under 20% still smoked during the last trimester of pregnancy.

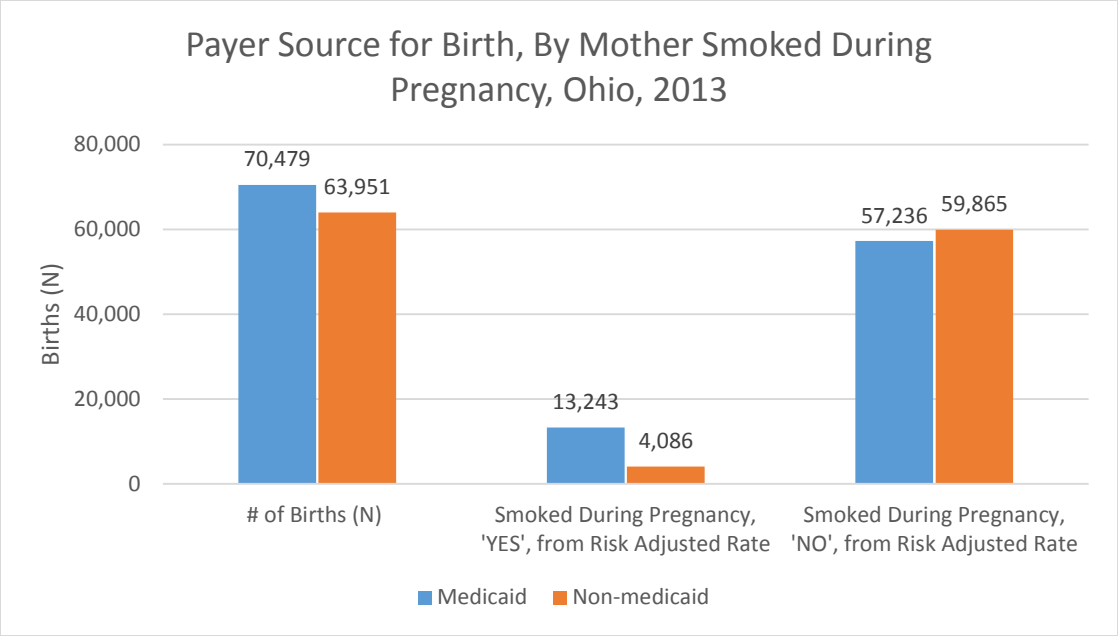


*Measure of alcohol use sometimes used as proxy for alcohol use during very early pregnancy

Source: Ohio Pregnancy Risk Assessment Monitoring System (PRAMS), Ohio Department of Health

Ohioans are turning more to the government-sponsored Medicaid program when it comes to paying for births. Ohio's Office of Medicaid's 2014 Report on Pregnant Women, Infants, and Children provides data on smoking during pregnancy. In Ohio, Medicaid plays a significant role in access to health care for pregnant women and children, paying for over half (52 %) of the births in 2013. Comparisons are made between the Medicaid and non-Medicaid beneficiaries based on the linkage of ODH Vital Statistics birth files to Medicaid birth and delivery claims data.

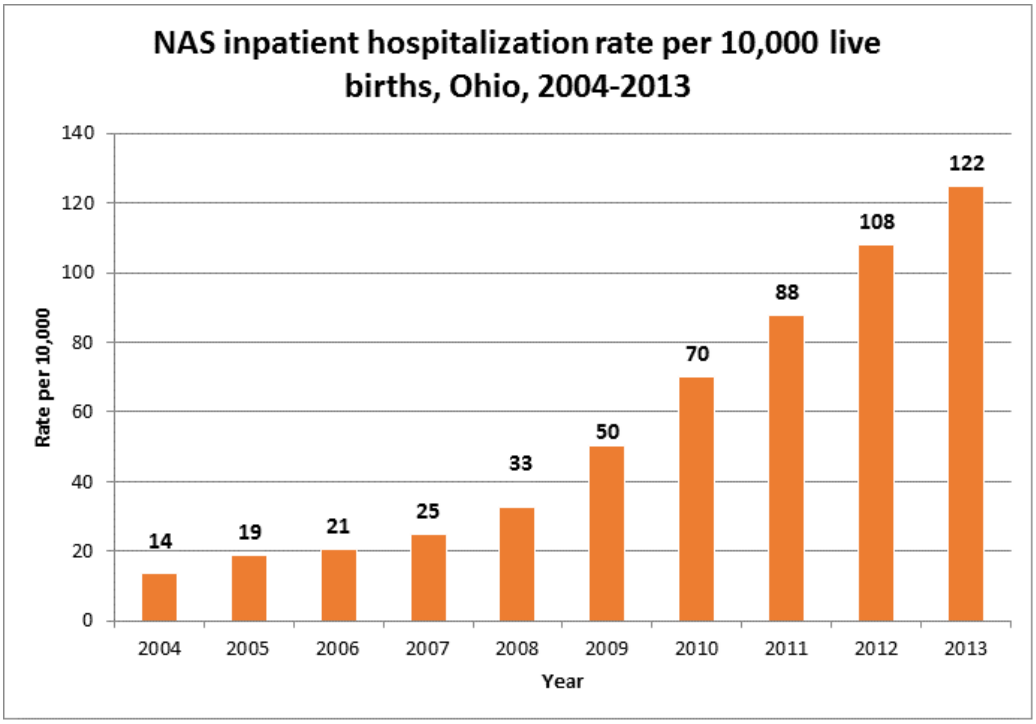
In the United States, 5-8 % of preterm deliveries, 13-19% of term low-birth-weight deliveries, 23-34 % of SIDS, and 5-7 % of preterm-related deaths are attributable to prenatal smoking. There are financial costs associated with maternal smoking resulting from intensive care and increased hospital stays. Notable differences were seen between the Medicaid and non-Medicaid mothers. Smoking during pregnancy yielded risk adjusted rates of 18.79 versus 6.39, for Medicaid and Non-Medicaid mothers, were self-reported, respectively. With an adjusted relative risk greater than one (i.e. 2.94), smoking during pregnancy is higher risk in the Medicaid population than the non-Medicaid population for prematurity and low birth weight for 2013. During pregnancy, smoking cessation was less likely in the Medicaid group.



Source: Ohio Department of Medicaid; (2014). Report on Pregnant Women, Infants, and Children.

Neonatal Abstinence Syndrome Initiative

Drug abuse during pregnancy is occurring at an alarming rate. According to the Ohio Department of Health and Ohio Hospital Association, increasing numbers of infants are being diagnosed with Neonatal Abstinence Syndrome (NAS). Approximately 10,401 hospitalizations resulted from NAS in inpatient and outpatient settings between 2004 and 2013, with over 7,600 being in inpatient settings. In 2004, the average inpatient admissions rate for infants diagnosed with NAS was 14 per 10,000 live births, while in 2013 the rate grew to 122 per 10,000 live births (750%).



Data from the Multi-Agency Community Services Information System (MACSIS) show the increasing prevalence of alcohol and other drug use among pregnant women. From 2004 to 2011, the number of pregnant women with a primary, secondary or tertiary diagnosis of opiate addiction rose from 513 to 845, representing a 68 percent increase. The cost of NAS to Ohio's health system is staggering. In 2007, the average service charge was 7.23 times greater for infants diagnosed with NWS. By 2011, the average service charge decreased for infants with NWS, but it was still 4.68 times the service charges for all infants.

Other Drug Abuse

Seventy percent of children age 1 or younger placed in Ohio's foster system are children of parents with substance use disorders involving opiates and cocaine. Children raised in substance-abuse environments are vulnerable to the toxic stress common within families struggling with addiction. Toxic stress results in problems—some lasting a lifetime. These problems may include depression, anxiety, PTSD and behavioral and learning difficulties, as well as significant attachment problems. (Child Welfare Opiate Engagement Project, 2014, Supporting Infants, Toddlers and Families Impacted by Caregiver Mental Health Problems, Substance Abuse and Trauma: A Community Action Guide)

Parents with Substance Abuse Disorders who have Dependent Children

Ohio's Child Welfare Engagement Project is a collaboration led by the Public Children's Services Association in Ohio which studies the impact of parents with opioid addiction on children involved with child welfare system, and made recommendation. The collaboration

included Children's Services at the state (Job and Family Services) and county level, OhioMHAS, Ohio Department of Medicaid, the Supreme Court of Ohio, the Ohio Attorney General's Office, Ohio Hospital Association, and the Office of Criminal Justice. The group issued a white paper which summarizes the impact of parental substance abuse on substantiated child abuse and neglect cases.
http://www.pcsao.org/perch/resources/downloads/cw-opiate-white-paper-final-9-18-14.pdf

Nationally, between 60 percent and 80 percent of substantiated child abuse and neglect cases involve a parent or guardian abusing substances.

In Ohio, the percentage of parents or pregnant women referred for publicly-funded alcohol or drug treatment services by Child Welfare Agencies has been consistently around 10%, as seen the table below, for last few years.

Percentage of Parents and Pregnant Women Referred to Publicly Funded AOD Treatment by Child Welfare Agency

State Fiscal Year	Parents	Pregnant Women
2010	12%	12%
2011	13%	12%
2012	11%	9%
2013	10%	9%
2014	11%	10%

Data Source: Ohio Behavioral Health Data (OHBH).

Among the nearly 86,000 cases entering Ohio's child welfare system annually, parents with opiate and/or cocaine abuse consume the most resources. During the past five years, the percentage of cases involving heroin or cocaine has risen from 15% to 25% of the case load. During the past three years, heroin abuse has increased more than cocaine abuse. This impact in Ohio on children is:

- Half the children whose parents are not involved in cocaine and/or heroin leave foster care within four months. If the parents are using cocaine and/or heroin, half the children leave care within nine months.
- Children of opiate and/or cocaine dependent parents are at risk of permanent separation from their parents when parents are not able to complete the dependency treatment within the time limits imposed by the 1998 Adoption and Safe Families Act.

The group reviewed evidence based practices and the research finding supporting those practices. These practices and their impact is:

- Family drug courts are among the most effective programs for inducing parents to enter and complete substance abuse treatment. Families involved in both SAFERR program

and family drug court in Butler County, Ohio were more likely to complete drug treatment.

- The Screening Assessment for Family Engagement, Retention and Recovery (SAFERR) program promotes child safety and family well-being by streamlining and coordinating child welfare services, treatment services and actions by the courts overseeing the children and parents. In Ohio, Butler County implementation showed that 13.4% of

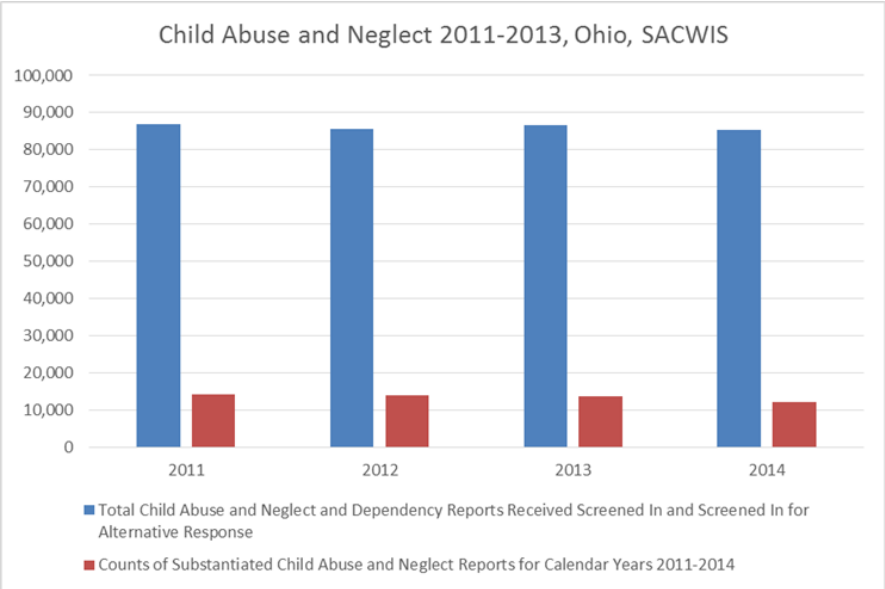
- Medication Assisted Treatment (MAT) combined with behavioral health treatment results in a long-term recovery rate of at least 50%, while relapse rates for opiate addicts without MAT are 80% - 90%.

This group recommended:

I. Implementation of Screening and Assessment for Family Engagement, Retention and Recovery (SAFERR) model.
II. Increase the number of family dependency drug courts
III. Establish time-limited prioritization of drug treatment counseling and recovery services for child welfare cases
IV. Increase access to Medication Assisted Treatment
V. Expand access to recovery support and intensive child welfare case management; this model helped reunify children and parents twice as effectively as traditional models.

Child Abuse and Neglect Cases Involving Drugs

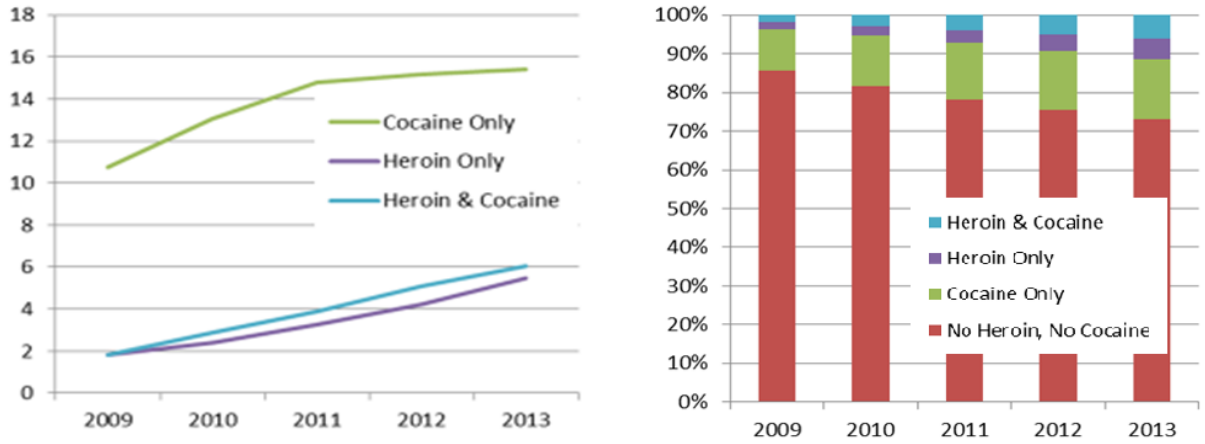
Child abuse and neglect data are provided in the graph below from Ohio's Department of Job and Family Services' (ODJFS) Statewide Automated Child Welfare Information System (SACWIS). According to ODJFS, there have been about 86,000 screened-in cases per year which included a variety of assessments.



Source: Ohio Department of Job and Family Services, SACWIS--Statewide Automated Child Welfare Information System.

ODJFS case notes were text-mined to find “heroin” and “cocaine”; findings indicate that since 2009, there has been a decreasing proportion of non-heroin and non-cocaine cases; however, an increasing proportion of heroin and cocaine cases have been identified. The graph below provides the break-out for years 2009 to 2013.

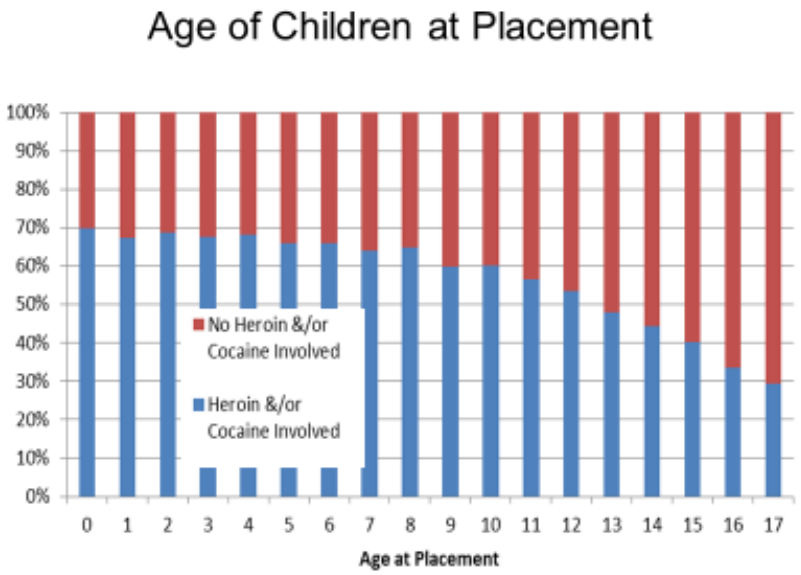
Child Welfare Cases Involving Heroin and Cocaine, Ohio 2009-2013



Source: Ohio Department of Job and Family Services, Office of Families and Children, 2014 Opiate Conference County Behavioral Health Authorities, July, 1, 2014

ODJHS examined the duration of time that cases were open by drug type. There was a shorter duration (cases open less than 60 days) for 50% of the no-heroin/no-cocaine cases. A longer duration (cases open than 180 days) for 50% of the heroin and cocaine cases. Furthermore, the heroin and cocaine cases re-opened at a faster rate than non-heroin and non-cocaine cases, with 18% remaining open longer than 2 years.

The graph below shows differences by age. For younger children, the percentage of cases involving heroin and/or cocaine use is high (70% of children under age 1) while for older children, the percentage of cases involving heroin and/or cocaine is lower (30% of children age 17). While there are no data available to identify the specific causes, drug involvement is a contributing factor in cases of abuse/neglect.



Source: Ohio Department of Job and Family Services, Office of Families and Children, 2014 Opiate Conference County Behavioral Health Authorities, July, 1, 2014

For the children who were put in placement due to parent heroin and cocaine involvement, the statistics for reunification, show a lengthy separation, as half of children where no heroin or cocaine were involved leave placement within 120 days versus 270 days for children where heroin and/or cocaine were involved.

Substance abusers with communicable diseases (TB, STD, HIV)
Ohio continues to address treatment of TB among persons with SUD as mandated by federal statute. The need for this is declining as evidenced by Ohio Department of Health data on tuberculosis (TB) cases in Ohio. In 2014 Ohio Department of Health had 156 cases of TB reported, which translated to 1.3 cases per 100,000 persons. Sixty-six percent of these TB cases occurred within Cuyahoga, Franklin, Hamilton, and Montgomery Counties. This represents a decrease from 2010 when 190 cases were reported. (Ohio Department of Health)

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 169.4 by June 30, 2014. 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. (Ohio Department of Health)

The number of reported hepatitis C cases in Ohio has increased per 100,000 populations from 0.2 in 2009, 0.1 in 2010 – 2012, to 1.0 in 2013. While the number of persons is small ranging from 26 in 2009 to 116 in 2013, this trend exposes more people to this disease which can be transmitted by blood and bodily fluids. The increase in opiate addiction which is associated with risky behavior may be the contributing factor to this increase. (Ohio Department of Health)

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). 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 caseloads 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

[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.

[2] Ibid

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 estimated138,044 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." This is a slight decrease from 139,483 children in 2013.

Treated Prevalence - In SFY 2014, Ohio's public mental health system served a total of 141,624 children ages 0 – 17 which included 94,860 children ages 9- 17. For children ages 9 – 17, the ages matching NRI's prevalence data, 96,813 (70.5%) of the 138,044 children estimated to need treatment were served. Using more restrictive criteria for Ohio's definition of SED, 65,626 (47.5%) of the 138,044 children ages 9 – 17 were served.[3]

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 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 46,764 (33%) of the children served by Ohio's mental health system in 2014. 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 481,221 adults (ages 18+) with severe mental illness (SMI) using the NASMHPD-NRI most recent prevalence estimates for SFY 2013. Ohio's public mental health system provided services to 260,218 adults in SFY 2014. Of these 260,218 adults receiving treatment, 113,799 met Ohio's SPMI (Severely and Persistently Mental Illness) 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, 54% (234,880 of 481,221) of Ohio's adults who need mental health services are receiving them from the public mental health system. Additionally, an estimated 24% (113,799 of 481,221) of the persons with SPMI are receiving services. As Ohio's definition for SPMI is more restrictive than SAMHSA's definition of SMI, the total number of persons receiving services (54%) 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

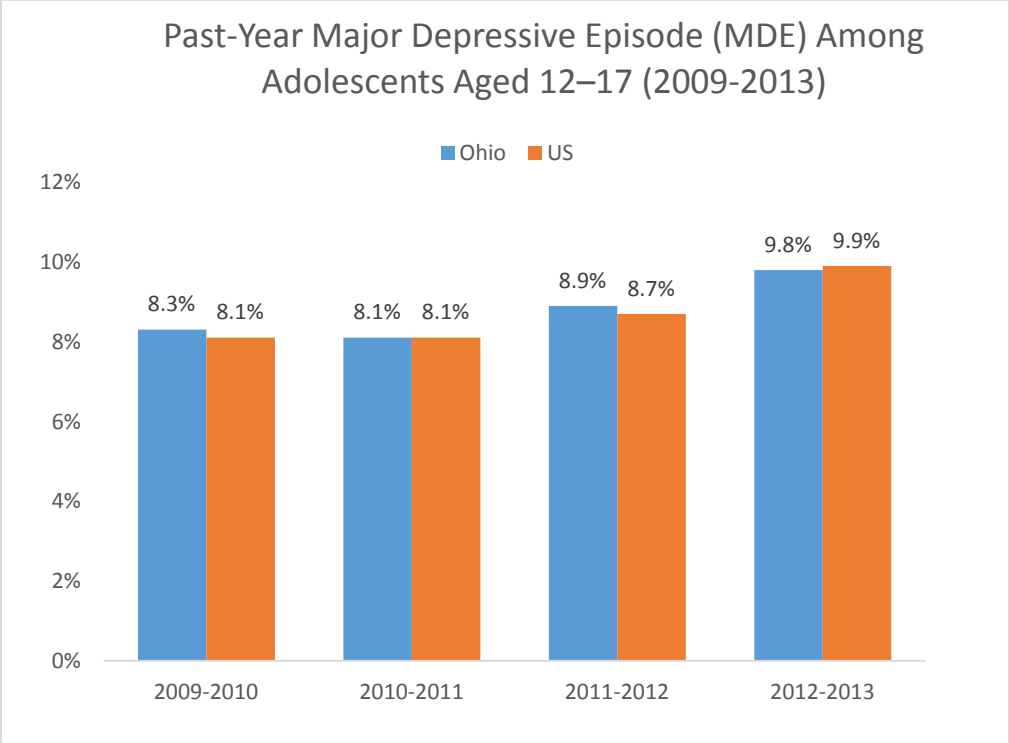
[3] Ohio SFY 2014 Mental Health Block Grant Report, December 1, 2014

private sector, anti-depressants from their family physicians, or services from Federally Qualified Health Care (FQHC) Centers.

SAMHSA Behavioral Health Barometer, Ohio, 2014

Population based data from SAMHSA's behavioral health barometer also demonstrates need for mental health services. Among Ohioans, age 12 – 17, 9.8% experienced a Major Depressive Episode during the past year. Ohio's rates are similar to national rates.

Past-Year Major Depressive Episode (MDE) Among Adolescents Aged 12–17 in Ohio and the US (2009-2013)

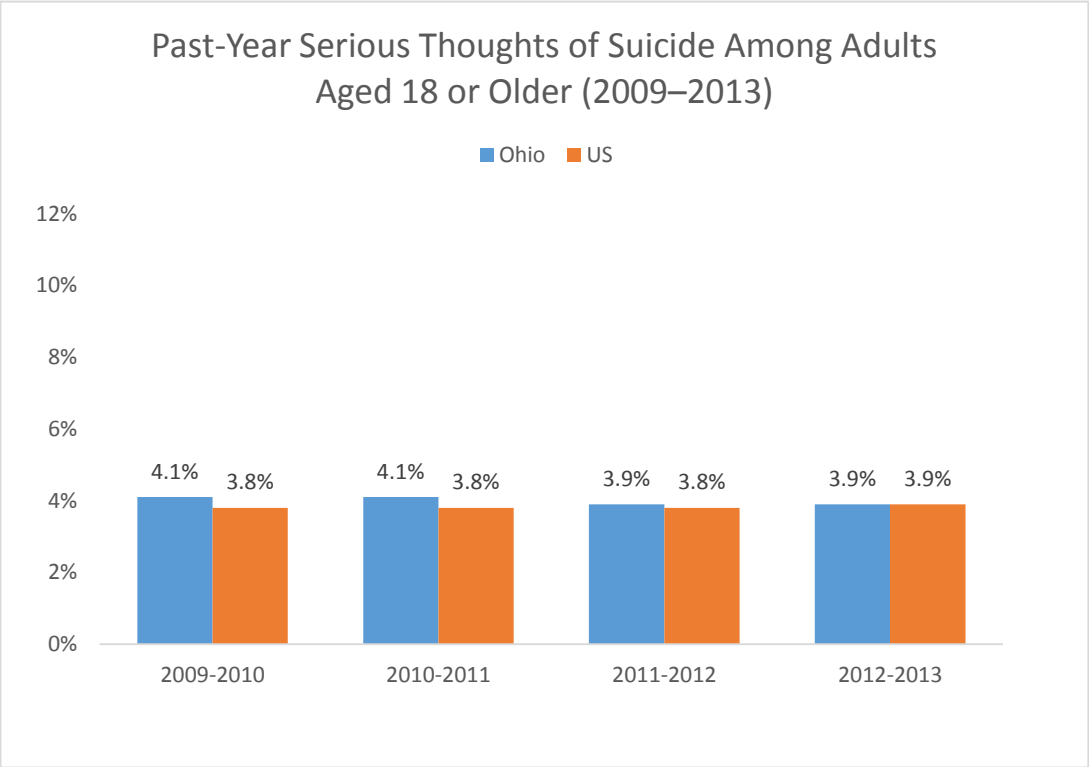


Ohio's percentage of MDE among adolescents was similar to the national percentage in 2012-2013.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009 to 2013.

Serious Thoughts of Suicide

Suicide is a significant cause of death among persons with mental illness. The SAMHSA 2014 Behavioral Health Barometer indicates that about 4% of adult Ohioans had serious thought of suicide in the past year. Ohio data is similar to the national average.

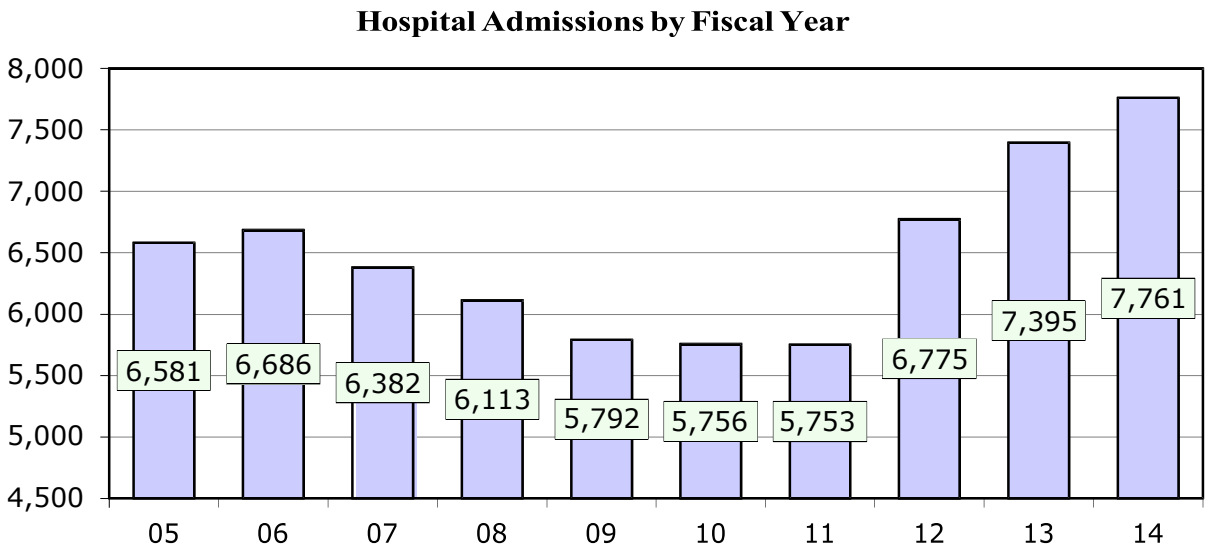
Past-Year Serious Thoughts of Suicide Among Adults Aged 18 or Older in Ohio and the US (2009–2013)



Ohio's percentage of adults with suicidal thoughts was similar to the national percentage in 2012–2013.
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use; Included in SAMHSA Behavioral Health Barometer, 2014

Regional (State-Operated) Psychiatric Hospitals

The operation of six quality psychiatric hospitals remains a core priority for the Ohio Department of Mental Health and Addiction Services. As previously mentioned, the department operates a total of 1,181 beds at six facilities across Ohio. Since 2011, admissions have increased by approximately one-third.



OhioMHAS has closely examined its data and there is not one single reason for the increase in admissions. In general, the state hospitals are subject to the ever-changing health care environment, just like every other provider. We continue to work toward potential solutions to the increase in admissions, including working with the Department of Medicaid to better integrate state services with the Medicaid benefit. While that work continues, the reality is that increased admissions mean increased costs. Our hospitals take pride in their track record of pursuing cost savings and increasing efficiency. In 2006, the average cost per bed day was $570 compared to $585 in 2013. Further efficiencies are being pursued by identifying cost savings in drug prescription practices, efforts to reduce outside contracts for physician coverage, and by re-bidding utility contracts. (Plouck, 2015)

Homeless

OhioMHAS completed a needs assessment of homeless for its successful 2014 CABHI (Cooperative Agreement to Benefit Homeless Individuals from SAMHSA; these five urban counties included 56% of the homeless in Ohio. In the five (5) Ohio OHRI counties, the ADAMH Boards indicated that about 25% of persons who are homeless are seriously mentally ill, as compared to all Ohioans of whom about 6.6% reported a mental health impairment in the Ohio Medicaid Assessment Survey. These ADAMH Boards estimated that 26% of homeless persons have chronic SUD as compared to 7% of all Ohioans with alcohol abuse and 4% other drug dependence (Ohio SEOW/NSDUH data). The demographics of this population are as follows:

Persons who are homeless are also more likely to be unemployed. Research indicates that 40% of homeless men are veterans as compared to 34% in the general population. According to the National Coalition for the Homeless, “Who is Homeless?”, only 13% of the urban homeless population are employed. This compares to 59% employed among the general population according to the Bureau of Labor Statistics.

	State	Cuyahoga	Franklin	Hamilton	Montgomery	Summit
Population	11,570,808	1,256,111	1,195,537	802,038	534,325	540,811
Ethnicity						
Amer. Ind.	0.3%	0.3%	0.3%	0.3%	0.2%	0.2%
Black	12.55%	30.2%	21.8%	25.9%	21.1%	14.6%
White	83.4%	64.8%	70.7%	69.5%	74.4%	80.6%
Hispanic	3.3%	5.1%	5.0%	2.7%	2.4%	1.8%
Asian	1.8%	2.9%	4.3%	2.1%	1.9%	2.4%
Multiple	2.0%	1.9%	2.9%	2.1%	2.4%	2.1%
Gender						
Male	48.9%	47.5%	48.7%	48.1%	48.1%	48.4%
Female	51.1%	52.5%	51.3%	51.9%	51.9%	51.6%
Sexual Orientation						
Lesbian	79,144	8,603	8,334	5,492	3,656	3,720
Gay	149,958	16,300	15,520	10,407	6,928	7,048
Bisexual	166,620	18,111	17,245	11,563	7,698	7,831

Needs of Persons with Serious Mental Illness who are Homeless

John Hopkins' Institute for Policy Studies, The Severely Mentally Ill Homeless: Housing Needs and Housing Policy indicates that the needs of the SMI homeless can be divided into two parts: the need for safe, decent, fair and affordable housing, and the need for supportive assistance. The needs for supportive assistance can range from peer support, case management, transportation, assistance in accessing benefits (e.g. Medicaid, food stamps, heating assistance), and assistance in maintaining an apartment, as well as access to treatment and recovery supports. This population will also benefit from Critical Time Intervention, an evidence based practice in which time-limited case management is designed to prevent homelessness and other adverse outcomes following discharge from hospitals, shelters, prisons and other institutions. Housing First, another evidence-based practice, provides immediate access to housing with a standard lease agreement (without requiring acceptance of treatment as a condition of housing.) Ohio Housing Recovery Initiative (OHRI) will expand supportive services for persons experiencing serious mental illness and homelessness, as well as encourage communities to provide housing options.

Needs of Persons with Chronic Substance Abuse who are Homeless

This population needs housing, as well as supportive assistance in a recovery-oriented system of care. The needs for peer support, case management, transportation, assistance in accessing benefits and assistance in maintaining an apartment, as well as access to treatment is critical for this population as well. Access to sober and damp housing, which provides a recovery-supporting environment, as well as access to Twelve Step groups and other recovery support services is needed. Ohio's OHRI will expand PATH (Projects for Assistance from Homelessness) services to this population. 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.

Older Adults

About 15.1% of Ohioans are older adults ages 65+ as compared to 14.1% in the United States. (Census Data – State Facts 2013). As compared to adults ages 18 – 64, older adults (65+) has more chronic health problems; this increases the need to integrate behavioral health services with primary care.

According to information on SAMHSA's website, "The prevalence of substance use disorders among older adults remains relatively constant until they reach the age of 60. After that, the rate of those disorders drops to about 6%. Data from the 2013 NSDUH highlights similar findings:

- Only 23.8% of people ages 65 and up in 2013 had ever used illegal drugs in their lifetime, while the lifetime rates of use were 49.8% for those ages 60 to 64 and more than 50% for each age group from ages 19 to 59.
- The prevalence of heavy alcohol use in 2013 was lower among adults ages 65 and up (2.0%) than among all other adult age groups.

Some aspects of mental health also improve with age. For example, in 2012, 13.4% of adults ages 65 or older had a form of mental illness while the rates were more than 17% for each age group from 18 to 64. In addition, 1.9% of adults aged 65 or older had serious thoughts of suicide in the past year, while the national average was 3.9%. However, many older adults still experience mental distress associated with limitations in daily activities, physical impairments, grief following loss of loved ones, caregiving or challenging living situations, or an untreated mental illness such as depression.

Depression affects more than 6.5 million Americans ages 65 and up. Depression in older adults is closely associated with substance abuse and disability. If left untreated, depression in this population increases the risks of cognitive decline and suicide.

About 25% of older adults have some type of mental health problem, such as a mood disorder not associated with normal aging. Older adults with mental disorders are less likely than those without them to be nonsmokers, to eat a healthy diet, or regularly engage in moderate physical activity."

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Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's NBHQF. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at http://www.samhsa.gov/data/quality-metrics/block-grant-measures. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).

3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Step 2: Quality and Data Collection Readiness

1. ***Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).***

Client-level data are collected at the provider level. Client-level data include services rendered, client demographics, and episode of care (TEDS-MH) information. The state's information system has very limited ability to identify program-level data.

2. ***Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).***

The state's current data collection and reporting system depends in part on Medicaid claims data, on non-Medicaid expenditures reported by local behavioral health authorities, and on the combined (SA/MH) TEDS-MH episode of care data submitted by providers. OhioMHAS does not collect Medicaid data; rather, Ohio Medicaid shares information with OhioMHAS that is specific to behavioral health services provided by agencies certified by the State Substance Abuse and Mental Health Authority (SSA and MHA).

3. ***Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client identifying information)?***

No, OhioMHAS is not able to report the proposed population-based measures on tobacco, marijuana and alcohol use, prescription drug misuse, suicidal ideation, substance use screening and cessation, or PHQ-9 scores because these data are not collected by Ohio Medicaid.

4. ***If not, what changes will the state need to make to be able to collect and report on these measures?***

The state of Ohio's behavioral health care system is administered through local control; meaning 50 local boards are ultimately responsible for the delivery of care to persons receiving publicly funded health services. As noted above, because of the design of Ohio's public behavioral health system, the state of Ohio currently has no agreed upon universal system to collect client-level outcomes. The state will need to upgrade its current OHBH system to include a number of the draft measures. These draft measures would need to be adopted by each board and provider. Instituting these new measures would require upgrading our state's OHBH system and newly established local data capture systems developed by individual Boards. Providers will have to modify their electronic health records, if they even exist. This will come at considerable cost to the state of Ohio and its provider agencies. The collection of these measures is considered a cost center to providers that cannot be captured through billing. To re-design existing systems would likely require years of negotiation and legislative mandates, which are unpopular amongst the behavioral health community

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Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

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

Priority Type: SAP

Population(s): PP, Other (Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Increase family communication around drug use

Objective:

1) Improve health by decreasing abuse of alcohol and other drugs (including tobacco) among Ohioans.
2) Decrease incidence of substance use disorders and mental illness among Ohioans.

Strategies to attain the objective:

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 Black)
3) Promote family engagement
4) Fund UMADAOP prevention to reach minority communities
5) Support Military Initiative

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Family Communication around Drug Use - Youth Response

Baseline Measurement: CY 2011 - 2012 - 56.5%; CY 2013 - 2014 = 54.40%

First-year target/outcome measurement: 55%

Second-year target/outcome measurement: 55%

Data Source:

NSDUH Questionnaire; Prevention NOMS data; Youth response

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]

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Family Commuication around Drug Use - Parents Response

Baseline Measurement: CY 2011 - 2012 = 90.0%, CY 2013 - 2014 = 89.1%

First-year target/outcome measurement: 90%

Second-year target/outcome measurement: 90%

Data Source:

NSDUH Questionnaire; prevention NOMS data

Description of Data:

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::

Priority #: 2

Priority Area: Incease access to evidence-based prevention practices.

Priority Type: SAP

Population(s): PWWDC

Goal of the priority area:

Increase the percentage of funded projects implementing evidence-based practices.

Objective:

Increase capacity of communities to implement evidence based practices.

Strategies to attain the objective:

1. Annual conference
2. Statewide and regional trainings
3. Workforce capacity building initiatives
4. Changes in policy
5. Cross system collaboration

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of interventions funded that are evidence-based

Baseline Measurement: baseline = 28%

First-year target/outcome measurement: 29%

Second-year target/outcome measurement: 30%

Data Source:

Grants Management System Data

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 3

Priority Area: Increase availability of medication assisted treatment (MAT).

Priority Type: SAT

Population(s): IVDUs

Goal of the priority area:

Increase availability of medication assisted treatment (MAT)

Objective:

Expand board and treatment program authority to utilize FDA-approved medications in addition to methadone. Encourage creation of OTCs

Strategies to attain the objective:

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 of persons who receive MAT
Baseline Measurement:	SFY 2012 = 4,964, SFY 2013 = 5379
First-year target/outcome measurement:	SFY 2014 = 5390
Second-year target/outcome measurement:	SFY 2015 = 5400

Data Source:

MACSIS-MITS/OHBH systems; MACSIS-MITS is a claims based data system. OHBH collects client demographics, admission and discharge information and NOMS (National Outcome Measures).

Description of Data:

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 MITS 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 #:	4
Priority Area:	Persons receiving treatment for opioid dependence.
Priority Type:	SAT
Population(s):	PWWDC, IVDUs

Goal of the priority area:

Improve treatment outcomes for persons receiving treatment for opioid dependence, especially women with dependent children.

Objective:

Increase percentage of opiate addicted individuals who have successful disposition at discharge (all goals met)

Strategies to attain the objective:

1. Fund provision of culturally competent, gender specific treatment.
2. Collaborate with child welfare system to coordinate services for parents involved with child welfare system.
3. Collaborate with criminal justice system.
4. Fund drug courts.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Percent of persons with opioid dependence/abuse who are discharged from treatment with all goals met
Baseline Measurement:	SFY 2012 = 23.8% SFY 2013 = 22.1%,

First-year target/outcome measurement: SFY 2014 = 22.2%

Second-year target/outcome measurement: SFY 2015 = 22.3%

Data Source:

Annual Performance Indicators to measure goal success
OH-BH (Ohio TEDS)

Description of Data:

Utilize dispositional data of OHBH closure records to determine number of opiate addicted individuals who were discharged with all goals met (successful).

Data issues/caveats that affect outcome measures::

Discharge records are under-reported in the OHBH. In recent years, there has been a drop-off in TEDS reporting.

Priority #: 5

Priority Area: Pregnant women who have a substance use disorder

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Pregnant women receiving treatment for SUD will meet their treatment goals.

Objective:

Increase the percentage of pregnant women who complete treatment with all goals met as measured by a successful disposition at discharge.

Strategies to attain the objective:

1. Fund culturally competent, gender specific treatment
2. Evaluate evidence and promising practices through MOMS pilot projects which provide treatment for pregnant women.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of women who complete treatment wtih all goals met as measured by disposition code at discharge

Baseline Measurement: SFY 2012 = 22.1%, SFY 2013 = 22.1%

First-year target/outcome measurement: SFY 2014 = 22.2%

Second-year target/outcome measurement: SFY 2015 = 22.3%

Data Source:

MACSIS-MITS/OHBH data systems. MACSIS-MITS is a claims-based data system. OHBH collects client demographics, admission and discharge information and NOMS.

Description of Data:

MACSIS-MITS/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::

The total number of pregnant women whose outcome is measured is small enough, that data fluctuations are normal.

Indicator #: 2

Indicator: Percent of drug-free births

Baseline Measurement: SFY 2012 = 91%; SFY 2013 = 79.4%

First-year target/outcome measurement: SFY 2014 = 79.5%

Second-year target/outcome measurement: SFY 2015 = 79.6%

Data Source:

MACSIS-MITS/OHBH data systems

Description of Data:

Utilize MACSIS-MITS/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 #: 6

Priority Area: Parents wtih SUD who have dependent children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Increase family reunification for parents/caregivers involved in child welfare system (prevent loss of custody)

Objective:

Increase the number of parents with SUD who retain custody of their children.

Strategies to attain the objective:

1. Provide culturally competent treatment to parents/caregivers of children involved with the child welfare system.
2. 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 parents receiving SUD treatment who report having at least one child living at home and who are discharged as successful per disposition code.

Baseline Measurement: SFY 2011 – 35.70%; SFY 2012 39.0%; SFY 2013 Projection 31.1%

First-year target/outcome measurement: 31.2%

Second-year target/outcome measurement: 31.3%

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 #: 7

Priority Area: Children with Serious Emotional Disturbances (SED)

Priority Type: MHS

Population(s): SED

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.

Objective:

Increase percentage of children with SED who receive treatment services.

Strategies to attain the objective:

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 (known as ENGAGE.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children with any mental illness served by Ohio's mental health system.

Baseline Measurement: SFY 2012 -130,304; SFY 2013 -137,740; SFY 2014 -141,624

First-year target/outcome measurement: 141,630

Second-year target/outcome measurement: 141,640

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; Ohio has a more restrictive definition than SAMHSA.

Baseline Measurement: SFY 2013 - 57,977; SFY 2014 – 66,626

First-year target/outcome measurement: 66,630

Second-year target/outcome measurement: 66,640

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 2013 – 42% SFY 2014 – 47%

First-year target/outcome measurement: 47.5%

Second-year target/outcome measurement: 48%

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::

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

Baseline Measurement: SFY 2013 – 69% SFY 2014 – 70%

First-year target/outcome measurement: 70.5%

Second-year target/outcome measurement: 71%

Data Source:

Same as previous indicator

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 #: 8

Priority Area: Adults wtih Serious Mental Illness

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Maintain and expand accessibility to public mental health services for adults with SMI

Objective:

Provide mental health services for persons for persons with serious mental illness.

Strategies to attain the objective:

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 #:	1
Indicator:	Number of adults receiving services in Ohio's mental health system
Baseline Measurement:	SFY 2012 -234,880; SFY 2013 244,118; SFY 2014 – 260,218
First-year target/outcome measurement:	260,250
Second-year target/outcome measurement:	260,300

Data Source:

MITTS/OHBH/MACSIS

Description of Data:

Number of adults who receive public mental health services each fiscal year

Data issues/caveats that affect outcome measures::

Indicator #:	2
Indicator:	Adults with SPMI receiving public mental health services (using Ohio's restrictive definition of SPMI)
Baseline Measurement:	SFY 2012 105,288; SFY 2013 109,034; SFY 2014 113,799
First-year target/outcome measurement:	113,900
Second-year target/outcome measurement:	114,000

Data Source:

MITS/OHBH/MACSIS

Description of Data:

Number of adults who receive public mental health services each fiscal year

Data issues/caveats that affect outcome measures::

Indicator #:	3
Indicator:	Treated Prevalence of Adults with SPMI (using criteria more restictive than SAMHSA's SMI definition)

Baseline Measurement: SFY 2012 -22.05%; SFY 2013 22.74%, SFY 2014 23.65%

First-year target/outcome measurement: 23.80%

Second-year target/outcome measurement: 23.9%

Data Source:

MACSIS/MITS and OHBH

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::

Indicator #: 4

Indicator: Treated Prevalence of All Adults (which is closer approximation of SAMHSA's SMI definition)

Baseline Measurement: SFY 2012 -49.19%; SFY 2013 49.19%; SFY 2014 54.07%

First-year target/outcome measurement: 54.20%

Second-year target/outcome measurement: 54.30%

Data Source:

MACSIS/MITS and OHBH; estimates of SMI prevalence from NASMHPD-NRI

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 #: 9

Priority Area: Employment status of persons who receive publically funded behavioral health services

Priority Type: SAT, MHS

Population(s):

Goal of the priority area:

Increase the number of persons who become employed

Objective:

Establish baseline of formal employment status of individuals receiving publically funded behavioral health services upon receipt service during a fiscal year

Strategies to attain the objective:

1. Create environment in which behavioral consumers can be connected to employment opportunities
2. Introduce and expand employment services for behavioral health consumers

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of behavioral consumers unemployed during the first quarter of the state fiscal year who have employment during the fourth quarter of the state fiscal year.

Baseline Measurement: 2009 through 2014

First-year target/outcome measurement: to be determined from 2009 - 2014 data

Second-year target/outcome measurement: to be determined from 2009 - 2014 data

Data Source:

MACSIS-MITS and Ohio Department of Jobs and Family Services Wage/Match database

Description of Data:

Data issues/caveats that affect outcome measures::

Priority #: 10

Priority Area: Peer Support - Increase the number of peers trained in supporting mental health and addiction recovery.

Priority Type: SAT, MHS

Population(s): SMI, PWWDC, IVDUs

Goal of the priority area:

Increase the availability of peer support by trained

Objective:

Train peers in peer support.

Strategies to attain the objective:

1. Recruit applicants
2. Screen training applicants
3. Provide peer support training manual to trainees
4. Provide training for supervisors
5. Provide continuing education opportunities for peer supporters.
4. Schedule & hold trainings for new peer supporters
5. Online testing for peer supporters who complete training
6. Increase number of facilitators (trainers) in Southeast Ohio to meet capacity.
7. Hold conference
8. Provide supervision training
9. Offer refresher training for peer facilitators.
9. Online testing

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of peer supporters who are trained

Baseline Measurement: FY 2014 - 195 trained

First-year target/outcome measurement: 250

Second-year target/outcome measurement: 500

Data Source:

OhioMHAS peer support data

Description of Data:

List of persons completing peer support training

Data issues/caveats that affect outcome measures::

Priority #: 11

Priority Area: Criminal Justice

Priority Type: SAT, MHS

Population(s): PWWDC, IVDUs, Other (Criminal/Juvenile Justice)

Goal of the priority area:

Percent of criminal justice involved clients who are discharged as successful per disposition

Objective:

Improve client outcomes

Strategies to attain the objective:

1. Support evidence-based and promising practices
2. Maintain collaborative partnership with criminal justice system.
3. Provide necessary tools and skills to Community Linkage Social Work staff inclusive of motivational interviewing techniques (from Substance Abuse/Mental Illness evidence based practices
4. Work cooperatively with community stakeholders to assure quick access to clinical treatment appointments and other supports needed

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of Eligible Offenders with SMI enrolling (voluntarily) in Communitiy Linkage Social Work Service

Baseline Measurement: SFY 12 85%; SFY 13 87%; SFY 14 91.7%

First-year target/outcome measurement: 90%

Second-year target/outcome measurement: 90%

Data Source:

Community Linkage Program 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::

Indicator #: 2

Indicator: Percent of ciminal justice-involved clients treated for SUD who successfully complete treatment as measured by disposition code

Baseline Measurement: SFY 2013 33.9%; SFY 2014 30.30%

First-year target/outcome measurement: 30.40%

Second-year target/outcome measurement: 30.50%

Data Source:

OHBH

Description of Data:

Utilize dispositional data of OHBH closure records to determine percent of criminal justice-involved clients who were discharged with all goals met (successful).

Data issues/caveats that affect outcome measures::

Footnotes:

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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	$85,016,541		$396,878,000	$6,929,888	$67,562,972	$117,314,306	$0
a. Pregnant Women and Women with Dependent Children*	$21,031,938		$1,000,000	$0	$0	$0	$0
b. All Other	$63,984,603		$395,878,000	$6,929,888	$67,562,972	$117,314,306	$0
2. Substance Abuse Primary Prevention	$26,908,090		$0	$11,239,188	$9,470,618	$13,180,014	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. HIV Early Intervention Services	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary Prevention**							
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)							
10. Administration (Excluding Program and Provider Level)	$5,877,724		$0	$1,022,998	$51,994,869	$24,574,394	$0
13. Total	$117,802,355	$0	$396,878,000	$19,192,074	$129,028,459	$155,068,714	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

A. SABG is lower by approximately $10.4 million because of a cash alignment strategy, which holds 2 quarters in reserve for fund timing differences.

B. Medicaid includes expansion in Ohio.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Activity	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			$29,594,098	$0	$421,316,666	$0	$0
6. Other 24 Hour Care		$7,361,158	$0	$10,668,642	$61,120,858	$123,029,714	$0
7. Ambulatory/Community Non-24 Hour Care		$19,461,698	$2,027,122,000	$24,246,270	$119,931,062	$284,801,860	$0
8. Mental Health Primary Prevention**		$0	$0	$3,053,220	$17,466,514	$19,268,080	$0
9. Evidenced Based Practices for Early Intervention (5% of the state's total MHBG award)		$1,524,030	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$1,491,941	$0	$408,292	$76,937,455	$80,444,382	$0
13. Total	$0	$29,838,827	$2,056,716,098	$38,376,424	$696,772,555	$507,544,036	$0

* Prevention other than primary prevention

** It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Footnotes:

A. MHBG - CMH FFY 15 NOA of $15,076,166; CMH FFY16 NOA of $14,762; total $29838,827 budgeted for State Fiscal Years 2016 - 2017.

B. Medicaid includes expansion in Ohio.

Planning Tables

Table 3 State Agency Planned Block Grant Expenditures by Service

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	SABG Expenditures	MHBG Expenditures
Healthcare Home/Physical Health	$	$
General and 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;		
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	$	$
Individual 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	$	$
Crisis Residential/Stabilization;		
Clinically Managed 24 Hour Care (SA);		
Clinically Managed Medium Intensity Care (SA) ;		
Adult Mental Health Residential ;		
Youth Substance Abuse Residential Services;		
Children's Residential Mental Health 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	$	$
Total	$0	$0

Footnotes:

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Expenditure Category	FY 2016 SA Block Grant Award
1 . Substance Abuse Prevention* and Treatment	$46,266,503
2 . Substance Abuse Primary Prevention	$14,648,036
3 . Tuberculosis Services	
4 . HIV Early Intervention Services**	
5 . Administration (SSA Level Only)	$3,206,031
6. Total	$64,120,570

* Prevention other than primary prevention

** 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by CDC, National Center for HIV/AIDS, Hepatitis, STD and TB Prevention. The HIV Surveillance Report, Volume 24, will be used to determine the states and jurisdictions that will be required to set-aside 5 percent of their respective FY 2016 SABG allotments to establish one or more projects to provide early intervention services for HIV at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state does not meet the AIDS case rate threshold for the fiscal year involved. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would be allowed to obligate and expend FY 2016 SABG funds for EIS/HIV if they chose to do so.

Footnotes:

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Strategy	IOM Target	FY 2016
		SA Block Grant Award
Information Dissemination	Universal	$1,700,000
	Selective	$300,000
	Indicated	
	Unspecified	
	Total	$2,000,000
Education	Universal	$5,500,000
	Selective	$800,000
	Indicated	$155,000
	Unspecified	
	Total	$6,455,000
Alternatives	Universal	$400,000
	Selective	$25,000
	Indicated	$10,000
	Unspecified	
	Total	$435,000
Problem Identification and Referral	Universal	$300,000
	Selective	$100,000
	Indicated	$250,000
	Unspecified	
	Total	$650,000

Community-Based Process	Universal	$1,500,000
	Selective	$200,000
	Indicated	$10,000
	Unspecified	
	Total	$1,710,000
Environmental	Universal	$1,500,000
	Selective	$75,000
	Indicated	
	Unspecified	
	Total	$1,575,000
Section 1926 Tobacco	Universal	$288,000
	Selective	
	Indicated	
	Unspecified	
	Total	$288,000
Other	Universal	
	Selective	
	Indicated	
	Unspecified	
	Total	
Total Prevention Expenditures		$13,113,000
Total SABG Award*		$64,120,570
Planned Primary Prevention Percentage		20.45 %

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award	
Universal Direct	$6,400,000	
Universal Indirect	$4,500,000	
Selective	$1,500,000	
Indicated	$425,000	
Column Total	$12,825,000	
Total SABG Award*	$64,120,570	
Planned Primary Prevention Percentage	20.00 %	

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Targeted Substances	
Alcohol	b
Tobacco	e
Marijuana	b
Prescription Drugs	b
Cocaine	e
Heroin	b
Inhalants	e
Methamphetamine	e
Synthetic Drugs (i.e. Bath salts, Spice, K2)	e
Targeted Populations	
Students in College	b
Military Families	b
LGBT	e
American Indians/Alaska Natives	e
African American	b
Hispanic	b
Homeless	e
Native Hawaiian/Other Pacific Islanders	e
Asian	e
Rural	b
Underserved Racial and Ethnic Minorities	b

Footnotes:

Planning Tables

Table 6a SABG Resource Development Activities Planned Expenditures

Planning Period Start Date: 10/1/2015 Planning Period End Date: 9/30/2017

Activity	FY 2016 SA Block Grant Award			
	Prevention	Treatment	Combined	Total
1. Planning, Coordination and Needs Assessment	$65,000	$0	$0	$65,000
2. Quality Assurance	$15,000	$0	$0	$15,000
3. Training (Post-Employment)	$0	$0	$0	
4. Education (Pre-Employment)	$0	$0	$0	
5. Program Development	$0	$0	$0	
6. Research and Evaluation	$0	$0	$0	
7. Information Systems	$0	$0	$0	
8. Total	$80,000			$80,000

Footnotes:

Planning Tables

Table 6b MHBG Non-Direct Service Activities Planned Expenditures

Planning Period Start Date: 7/1/2015 Planning Period End Date: 6/30/2017

Service	Block Grant
MHA Technical Assistance Activities	$4,738,094
MHA Planning Council Activities	$16,000
MHA Administration	$1,491,941
MHA Data Collection/Reporting	$255,000
MHA Activities Other Than Those Above	
Total Non-Direct Services	$6501035

Comments on Data:

Ohio has historically used Mental Health Block Grant to provide technical assistance and training for providers of treatment and recovery supports including peer support, housing, and employment. Mental Health Block Grant funds Coordinating Centers for Excellence which provide resources to implement evidence based practices. It also funds statewide consumer and family organizations to provide educational classes and support groups for person with lived experience and their families. The FY 2016 - 2017 budget is similar to SFY 2015 actuals. MHA administration is reported consistent with Table 2 for SFY 2016 and SFY 2017.

Footnotes:

Environmental Factors and Plan

1. The Health Care System and Integration

Narrative Question:

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[26] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but “[h]ealth system factors” such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[27] It has been acknowledged that there is a high rate of co- occurring mental illness and substance abuse, with appropriate treatment required for both conditions.[28] Overall, America has reduced its heart disease risk based on lessons from a 50-year research project on the town of Framingham, MA, outside Boston, where researchers followed thousands of residents to help understand what causes heart disease. The Framingham Heart Study produced the idea of "risk factors" and helped to make many connections for predicting and preventing heart disease.

There are five major preventable risks identified in the Framingham Heart Study that may impact people who live with mental illness. These risks are smoking, obesity, diabetes, elevated cholesterol, and hypertension. These risk factors can be appropriately modified by implementing well-known evidence–based practices[29] [30] that will ensure a higher quality of life.

Currently, 50 states have organizationally consolidated their mental and substance abuse authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[31] Specific to children, many children and youth with mental illness and substance use issues are more likely to be seen in a health care setting than in the specialty mental health and substance abuse system. In addition, children with chronic medical conditions have more than two times the likelihood of having a mental disorder. In the U.S., more than 50 percent of adults with mental illness had symptoms by age 14, and three-fourths by age 24. It is important to address the full range of needs of children, youth and adults through integrated health care approaches across prevention, early identification, treatment, and recovery.

It is vital that SMHAs' and SSAs' programming and planning reflect the strong connection between behavioral, physical and population/public health, with careful consideration to maximizing impact across multiple payers including Medicaid, exchange products, and commercial coverages. Behavioral health disorders are true physical disorders that often exhibit diagnostic criteria through behavior and patient reports rather than biomarkers. Fragmented or discontinuous care may result in inadequate diagnosis and treatment of both physical and behavioral conditions, including co-occurring disorders. For instance, persons receiving behavioral health treatment may be at risk for developing diabetes and experiencing complications if not provided the full range of necessary care.[32] In some cases, unrecognized or undertreated physical conditions may exacerbate or cause psychiatric conditions.[33] Persons with physical conditions may have unrecognized mental challenges or be at increased risk for such challenges.[34] Some patients may seek to self-medicate due to their chronic physical pain or become addicted to prescribed medications or illicit drugs.[35] In all these and many other ways, an individual's mental and physical health are inextricably linked and so too must their health care be integrated and coordinated among providers and programs.

Health care professionals and consumers of mental illness and substance abuse treatment recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[36]

SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[37] Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between mental and substance abuse treatment providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as federally qualified health centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including electronic health records (EHRs) and telehealth are examples of important strategies to promote integrated care.[38] Use of EHRs – in full compliance with applicable legal requirements – may allow providers to share information, coordinate care and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, care, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[39] and ACOs[40] may be important strategies used by SMHAs and SSAs to foster integrated care. Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes.

The Affordable Care Act is an important part of efforts to ensure access to care and better integrate care. Non-grandfathered health plans sold in the individual or the small group health insurance markets offered coverage for mental and substance use disorders as an essential health benefit.

SSAs and SMHAs also may work with Medicaid programs and Insurance Commissioners to encourage development of innovative demonstration projects and waivers that test approaches to providing integrated care for persons with mental illness and substance use disorders and other vulnerable populations.[41] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[42]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[43] Roughly, 30 percent of dually eligible persons have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[44] SMHAs and SSAs also should collaborate with Medicaid, insurers and insurance regulators to develop policies to assist those individuals who experience health coverage eligibility changes due to shifts in income and employment.[45] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or finding a provider.[46] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should ensure access and integrated prevention care and recovery support in all vulnerable populations including, but not limited to college students and transition age youth (especially those at risk of first episodes of mental illness or substance abuse); American Indian/Alaskan Natives; ethnic minorities experiencing health and behavioral health disparities; military families; and, LGBT individuals. SMHAs and SSAs should discuss with Medicaid and other partners, gaps that may exist in services in the post-Affordable Care Act environment and the best uses of block grant funds to fill such gaps. SMHAs and SSAs should work with Medicaid and other stakeholders to facilitate reimbursement for evidence-based and promising practices.[47] It also is important to note CMS has indicated its support for incorporation within Medicaid programs of such approaches as peer support (under the supervision of mental health professionals) and trauma-informed treatment and systems of care. Such practices may play an important role in facilitating integrated, holistic care for adults and children with behavioral health conditions.[48]

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[49] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists and others will need to understand integrated care models, concepts and practices.

Another key part of integration will be defining performance and outcome measures. Following the Affordable Care Act, the Department of Health and Human Services (HHS) and partners have developed the NQS, which includes information and resources to help promote health, good outcomes and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[50]

SAMHSA recognizes that certain jurisdictions receiving block grant funds – including U.S. Territories, tribal entities and those jurisdictions that have signed compacts of free association with the U.S. – may be uniquely impacted by certain Affordable Care Act and Medicaid provisions or ineligible to participate in certain programs.[51] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment and recovery support for persons with, or at risk of, mental illnesses and substance use disorders.

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 charged with coordinating 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 consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?
2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the 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?
6. Is the SSA/SMHA is involved in the various coordinated care initiatives in the state?
7. Is the SSA/SMHA work with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

10. Indicate tools and strategies used that support efforts to address nicotine cessation.
    - Regular screening with a carbon monoxide (CO) monitor
    - Smoking cessation classes
    - Quit Helplines/Peer supports
    - Others_____
11. The behavioral health providers screen and refer for:
    - Prevention and wellness education;
    - Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
    - Recovery supports

Please indicate areas of technical assistance needed related to this section.

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Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.1 Health Care System & Integration

1. Which services in Plan Table 3 of the application will be covered by Medicaid or by QHPs as of January 1, 2016?

Prevention & Wellness	MH	SUD
SBIRT (Screen, Brief Int. & Referral to Treatment)		
Brief Motivational Interviews		
Screen & Brief Int. for Tobacco Cessation		
Parent Training		
Facilitated Referrals		
Relapse Prevention		
Wellness Recovery Support		
Warm line		
Engagement Services		
Assessment	X	X
Specialized Evaluation (Psych. & neurological)		
Services planning (includes crisis planning)	X	X
Consumer/Family Education		
Outreach		
Outpatient Services		
Individual evidence-based therapies		
Group therapy	X	X
Family therapy		
Multi-family therapy		
Consultation to Caregivers		
Medication Services		
Medication management	X	
Pharmacotherapy (including MAT)		X
Laboratory services		
Community Support Services		
Parent/Caregiver Support		
Skill building (social, daily living, cognitive)		
Case management	X	X
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		
Interactive Communication Tech. Devices		
Trained behavioral health interpreters		
Intensive Support Services		
Substance abuse intensive outpatient services		X
Partial hospitalization	X	
Assertive community treatment		
Intensive home based treatment		
Multi-systemic therapy		
Intensive case management		
Out-of-Home Residential Services		
Crisis residential/stabilization		
Clinically Managed 24-Hour Care		
Clinically Managed Medium Intensity Care		
Adult Mental Health Residential		
Adult Substance Abuse Residential		
Children's Mental Health Residential Services		
Youth Substance Abuse Residential Services		
Therapeutic Foster Care		
Acute Intensive Services		
Mobile crisis services		
Medically Monitored Intensive Inpatient		
Peer based crisis services		
Urgent care services		
23 hour crisis stabilization services		
24/7 crisis hotline services		

2. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs and Medicaid?
The Ohio Department of Medicaid (ODM) and OhioMHAS has an interagency agreement that includes monitoring access to M/SUD services by Medicaid eligible Ohioans.

3. Who is responsible for monitoring access to M/SUD services by the QHPs? Briefly describe the monitoring process.
The Ohio Department of Insurance is responsible.

4. Will the SMHA and/or SSA be involved in reviewing any complaints or possible violations or MHPAEA?
OhioMHAS is not involved in reviewing MHPAEA complaints.

5. What specific changes will the state make in consideration of the coverage offered in the state's EHB package?
There are none at this time.

6. Is the SSA/SMHA involved in the various coordinated care initiatives in the state?
OhioMHAS is working with ODM under the guidance of the Governor's Office of Health Transformation to redesign the community Medicaid behavioral health benefit. One component of the project is targeted at addressing comprehensive coordinated care in preparation for incorporation into the Medicaid managed care program.

7. Is the SSA/SMHA works with the state's primary care organization or primary care association to enhance relationships between FQHCs, community health centers (CHCs), other primary care practices, and the publicly funded behavioral health providers?
OhioMHAS is not directly working with the state's primary care organizations/associations. We do support local initiatives that involve publically funded behavioral health providers and other local primary care resources in forming partnerships and relationships that will enhance the overall healthcare coordination and access to services for our shared populations.

8. Are state behavioral health facilities moving towards addressing nicotine dependence on par with other substance use disorders?
The Ohio Department of Mental Health and Addiction Services tracks and reports tobacco use data for adults and youth as a requirement of federal State Epidemiological Outcomes Workgroup (SEOW) grant funding. The tobacco use data is obtained from a variety of sources. Including the Centers for Disease Control and Prevention's Behavioral Risk Factor Surveillance System (CDC BRFSS), National Survey on Drug Use and Health (NSUDH), and the Ohio Department of Health (ODH). The tracked metrics include current tobacco use, risk perception, and tobacco related consequences.

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 (CEBP) 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. Additionally, health home service providers are strongly encouraged to provide tobacco cessation services as part of the health promotion activity covered by the monthly case rate payment. Health home service providers are responsible for reporting the percentage of tobacco-using consumers who received tobacco cessation intervention for data collection and quality outcomes measurement.

9. What agency/system regularly screens, assesses, and addresses smoking among persons served in the behavioral health system?

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 (CEPB) 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. 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 has also utilized 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 participating community behavioral health centers (CBHCs). Additionally, health home service providers are strongly encouraged to provide tobacco cessation services as part of the health promotion activity covered by the monthly case rate payment. Health home service providers are responsible for reporting the percentage of tobacco-using consumers who received tobacco cessation intervention as required for data collection and quality outcomes measurement.

10. Indicate tools and strategies used that support efforts to address nicotine cessation. • Regular screening with a carbon monoxide (CO) monitor
• Smoking cessation classes
• Quit Helplines/Peer supports
• Others_____

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 (CEBP) 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. The CEBP has conducted a series of regional trainings throughout Ohio on the proper assessment, pharmacological and psychosocial interventions for people who use tobacco. The CEBP has partnered with the Ohio Department of Mental Health and Addiction Services, the Ohio Office of Medical Assistance, Pfizer Medical Education Grant and the Smoking Cessation Leadership Center to engage individuals with severe mental illness and/or substance use disorders in discussions about changing their use of tobacco products.

11. The behavioral health providers screen and refer for:
• Prevention and wellness education;
• Health risks such as heart disease, hypertension, high cholesterol, and/or diabetes; and,
• Recovery supports.
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. 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.

No technical assistance is requested at this time.

Environmental Factors and Plan

2. Health Disparities

Narrative Question:

In accordance with the *HHS Action Plan to Reduce Racial and Ethnic Health Disparities*[52], *Healthy People, 2020*[53], *National Stakeholder Strategy for Achieving Health Equity*[54], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, and people living with HIV/AIDS or other chronic diseases/impairments) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS standards).[55]

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The top Secretarial priority in the Action Plan is to "[a]ssess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[56]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, in accordance with section 4302 of the Affordable Care Act, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status.[57] This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations.[58] In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the population they intend to serve. 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, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and 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. 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. For states to address the potentially disparate impact of their block grant funded efforts, they will 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).

Please consider the following items as a guide when preparing the description of the healthcare system and integration within the state's system:

1. Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?
2. Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.
3. Are linguistic disparities/language barriers identified, monitored, and addressed?
4. Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.
5. Is there state support for cultural and linguistic competency training for providers?

Please indicate areas of technical assistance needed related to this section.

[52] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[53] http://www.healthypeople.gov/2020/default.aspx

[54] http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf

[55] http://www.ThinkCulturalHealth.hhs.gov

[56] http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf

[57] http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208

[58] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.2 Health Disparities

1. ***Does the state track access or enrollment in services, types of services (including language services) received and outcomes by race, ethnicity, gender, LGBT, and age?***
   The state tracks access and enrollment through a statewide billing system. The system tracks types of services received by race, ethnicity, gender, and age. An admission/discharge outcomes system tracks disability and LGBT status in addition to the other categories. Community programs funded by other SAMHSA grants also collect similar data categories; these grants include *Transforming Lives through Supported Employment, Ohio's Projects for Assistance in Transition from Homelessness (PATH), Screening, Brief Intervention, and Referral to Treatment (SBIRT), Cooperative Agreement to Benefit Homeless Individuals (CABHI), and Access to Recovery (ATR).*

2. ***Describe the state plan to address and reduce disparities in access, service use, and outcomes for the above subpopulations.***
   In January, the state published its plan (Into Action: 2020 Strategic Vision, Cultural and Linguistic Competency Plan) to address and reduce disparities in access, service use, and outcomes for the above subpopulations. The plan model is based on the *National Stakeholder Strategy for Achieving Health Equity*. The plan has 6 strategic goal areas (i.e., Awareness; Access to Care across the Lifespan; Cultural and Linguistic Competency; Data, Research, and Evaluation; Leadership Development; and Health and Human Service Systems Transformation) and includes strategies and action steps that will enable the state to infuse key recommendations within the system in five years**.**

3. ***Are linguistic disparities/language barriers identified, monitored, and addressed?***
   Linguistic disparities (impacting deaf individuals) have been identified through a statewide collaborative. The collaborative has identified two key areas to address disparities: 1) Engagement, which includes identifying ASL (American Sign Language) video resources to promote access for local services and state resources; and 2) Workforce, which includes development of collaborative partnerships with colleges and universities to improve the delivery of linguistic programs and increase the pipeline of diverse bi-lingual students into specialized careers (or at a minimum, more general training) in behavioral health. The focus on workforce development also includes developing a concept to direct grants to agencies for the purpose of improving access of qualified interpreters within the behavioral health, as well as and identifying standards and a certification process for interpreters related to behavioral health**.**

4. ***Describe provisions of language assistance services that are made available to clients served in the behavioral health provider system.***
   The state has a policy to ensure that any employee doing business with an individual that speaks English as a second language must utilize an interpreter or develop the necessary translated materials to facilitate communication. All local providers are expected to adhere to Title VI.

5. ***Is there state support for cultural and linguistic competency training for providers?***
The state has already funded 7 trainings to support cultural and linguistic competency for providers. Another 22 trainings will be funded between now and June 30, 2015.

No technical assistance is requested at this time.

3. Use of Evidence in Purchasing Decisions

Narrative Question:

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including mental health and substance abuse services. Over the past several years, SAMHSA has received many requests from CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance abuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states use of the block grants for this purpose. The NQF and the Institute of Medicine (IOM) recommend that evidence play a critical role in designing health and behavioral health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. Since 2001, SAMHSA has sponsored a National Registry of Evidenced-based Programs and Practices (NREPP). NREPP[59] is a voluntary, searchable online registry of more than 220 submitted interventions supporting mental health promotion and treatment and substance abuse prevention and treatment. The purpose of NREPP is to connect members of the public to intervention developers so that they can learn how to implement these approaches in their communities. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with (SED). The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[60], The New Freedom Commission on Mental Health[61], the IOM[62], and the NQF.[63] The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[64] SAMHSA and other federal partners (the Administration for Children and Families (ACF), the HHS Office of Civil Rights (OCR), and CMS) have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, identify specific strategies for embedding these practices in provider organizations, and recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. These are services that have not been studied, but anecdotal evidence and program specific data indicate that they are effective. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocols (TIPs)[65] are best practice guidelines for the treatment of substance abuse. The Center for Substance Abuse Treatment (CSAT) draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPs, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPs is expanding beyond public and private substance abuse treatment facilities as alcohol and other drug disorders are increasingly recognized as a major problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation (KIT)[66] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.
2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?
3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?
4. Does the state use a rigorous evaluation process to assess emerging and promising practices?
5. Which value based purchasing strategies do you use in your state:
    a. Leadership support, including investment of human and financial resources.
    b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
    c. Use of financial incentives to drive quality.

d. Provider involvement in planning value-based purchasing.

e. Gained consensus on the use of accurate and reliable measures of quality.

f. Quality measures focus on consumer outcomes rather than care processes.

g. Development of strategies to educate consumers and empower them to select quality services.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

Please indicate areas of technical assistance needed related to this section.

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[59] Ibid, 47, p. 41

[60] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[61] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[62] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[63] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[64] http://psychiatryonline.org/

[65] http://store.samhsa.gov

[66] http://store.samhsa.gov/product/Assertive-Community-Treatment-ACT-Evidence-Based-Practices-EBP-KIT/SMA08-4345

Please use the box below to indicate areas of technical assistance needed related to this section:

Ohio may request technical assistance at a later time in this area. For more information, please see the last two paragraphs of the attachment.

Footnotes:

5.3 Use of Evidence in Purchasing Decisions

1. Describe the specific staff responsible for tracking and disseminating information regarding evidence-based or promising practices.

OhioMHAS program area staff has general knowledge of evidence-based or promising practices. Through the course of their daily activities, information is shared with staff at community behavioral health programs, county Boards and the public in general. OhioMHAS staff share SAMHSA TIPs (by referral and by giving out published TIPs in paper/PDF formats) and by referral to the NREPP website. Nationally recognized evidence and promising practice experts are oftentimes brought into Ohio to present at local and state level conferences/meetings/trainings.

2. How is information used regarding evidence-based or promising practices in your purchasing or policy decisions?

Currently, OhioMHAS implements purchase of evidence-based/promising practices through our grants management process. Specific evidence-based/promising practices can be required in order to qualify for grant funding. On the policy front, OhioMHAS encourages and assists community behavioral health programs in staying informed on evidence-based/promising practices to help them respond to behavioral health needs across the continuum of prevention, treatment and recovery support.

3. Are the SMAs and other purchasers educated on what information is used to make purchasing decisions?

Ohio's SMA currently purchases community mental health service on a fee for service basis that does not directly include use of evidence-based or promising practices. In our consultative role with Ohio's SMA, OhioMHAS recognizes and recommends a flexible Medicaid program that would not prevent the implementation of evidence-based/promising practices.

4. Does the state use a rigorous evaluation process to assess emerging and promising practices?

OhioMHAS does not currently independently evaluate or assess emerging and/or promising practices.

5. Which value based purchasing strategies do you use in your state:

a. Leadership support, including investment of human and financial resources.

Yes.

b. Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.

Yes.

c. Use of financial incentives to drive quality.

Yes.

d. Provider involvement in planning value-based purchasing.

Yes.

e. Gained consensus on the use of accurate and reliable measures of quality.

Yes.

f. Quality measures focus on consumer outcomes rather than care processes.

Yes.

g. Development of strategies to educate consumers and empower them to select quality services.

No.

h. Creation of a corporate culture that makes quality a priority across the entire state infrastructure.

Yes.

i. The state has an evaluation plan to assess the impact of its purchasing decisions.

No.

Please indicate areas of technical assistance needed related to this section.

OhioMHAS is currently involved in a number of state wide initiatives related to completing the merging of the previous cabinet level addiction agency and mental health agency. One significant area of work related to the merger is consolidating and updating our program certification practices. At the same time, Ohio has undertaken a major initiative under the guidance of Governor Kasich's Office of Health Transformation (OHT) to address the rebuilding of community behavioral health system capacity. The OHT white paper on this scope of work is available here:
http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=3ex6FYrAIU4%3d&tabid=252

One component of the OHT initiative is the transition of community behavioral health services covered by Medicaid from the fee for service payment methodology to managed care incorporation. While reference to managed care coverage of behavioral health services often times is received with general negativity, there are significant financial and coverage opportunities that can be leveraged with this change. OhioMHAS may request technical assistance from SAMHSA as these projects continue to progress.

4. Prevention for Serious Mental Illness

Narrative Question:

SMIs such as schizophrenia, psychotic mood disorders, bipolar disorders and others produce significant psychosocial and economic challenges. Prior to the first episode, a large majority of individuals with psychotic illnesses display sub-threshold or early signs of psychosis during adolescence and transition to adulthood.[67] The "Prodromal Period" is the time during which a disease process has begun but has not yet clinically manifested. In the case of psychotic disorders, this is often described as a prolonged period of attenuated and nonspecific thought, mood, and perceptual disturbances accompanied by poor psychosocial functioning, which has historically been identified retrospectively. Clinical High Risk (CHR) or At-Risk Mental State (ARMS) are prospective terms used to identify individuals who might be potentially in the prodromal phase of psychosis. While the MHBG must be directed toward adults with SMI or children with SED, including early intervention after the first psychiatric episode, states may want to consider using other funds for these emerging practices.

There has been increasing neurobiological and clinical research examining the period before the first psychotic episode in order to understand and develop interventions to prevent the first episode. There is a growing body of evidence supporting preemptive interventions that are successful in preventing the first episode of psychosis. The National Institute for Mental Health (NIMH) funded the North American Prodromal Longitudinal study (NAPLS), which is a consortium of eight research groups that have been working to create the evidence base for early detection and intervention for prodromal symptoms. Additionally, the Early Detection and Intervention for the Prevention of Psychosis (EDIPP) program, funded by the Robert Wood Johnson Foundation, successfully broadened the Portland Identification and Early Referral (PIER) program from Portland, Maine, to five other sites across the country. SAMHSA supports the development and implementation of these promising practices for the early detection and intervention of individuals at Clinical High Risk for psychosis, and states may want to consider how these developing practices may fit within their system of care. Without intervention, the transition rate to psychosis for these individuals is 18 percent after 6 months of follow up, 22 percent after one year, 29 percent after two years, and 36 percent after three years. With intervention, the risk of transition to psychosis is reduced by 54 percent at a one-year follow up.[68] In addition to increased symptom severity and poorer functioning, lower employment rates and higher rates of substance use and overall greater disability rates are more prevalent.[69] The array of services that have been shown to be successful in preventing the first episode of psychosis include accurate clinical identification of high-risk individuals; continued monitoring and appraisal of psychotic and mood symptoms and identification; intervention for substance use, suicidality and high risk behaviors; psycho-education; family involvement; vocational support; and psychotherapeutic techniques.[70] [71] This reflects the critical importance of early identification and intervention as there is a high cost associated with delayed treatment.

Overall, the goal of early identification and treatment of young people at high clinical risk, or in the early stages of mental disorders with psychosis is to: (1) alter the course of the illness; (2) reduce disability; and, (3) maximize recovery.

****It is important to note that while a state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED.

Please indicate areas of technical assistance needed related to this section.

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[67] Larson, M.K., Walker, E.F., Compton, M.T. (2010). Early signs, diagnosis and therapeutics of the prodromal phase of schizophrenia and related psychotic disorders. Expert Rev Neurother. Aug 10(8):1347-1359.

[68] Fusar-Poli, P., Bonoldi, I., Yung, A.R., Borgwardt, S., Kempton, M.J., Valmaggia, L., Barale, F., Caverzasi, E., & McGuire, P. (2012). Predicting psychosis: meta-analysis of transition outcomes in individuals at high clinical risk. Arch Gen Psychiatry. 2012 March 69(3):220-229.

[69] Whiteford, H.A., Degenhardt, L., Rehm, J., Baxter, A.J., Ferrari, A.J., Erskine, H.E., Charlson, F.J., Norman, R.E., Flaxman, A.D., Johns, N., Burstein, R., Murray, C.J., & Vos T. (2013). Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010. Lancet. Nov 9;382(9904):1575-1586.

[70] van der Gaag, M., Smit, F., Bechdolf, A., French, P., Linszen, D.H., Yung, A.R., McGorry, P., & Cuijpers, P. (2013). Preventing a first episode of psychosis: meta-analysis of randomized controlled prevention trials of 12-month and longer-term follow-ups. Schizophr Res. Sep;149(1-3):56-62.

[71] McGorry, P., Nelson, B., Phillips, L.J., Yuen, H.P., Francey, S.M., Thampi, A., Berger, G.E., Amminger, G.P., Simmons, M.B., Kelly, D., Dip, G., Thompson, A.D., & Yung, A.R. (2013). Randomized controlled trial of interventions for young people at ultra-high risk of psychosis: 12-month outcome. J Clin Psychiatry. Apr;74(4):349-56.

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.4 Prevention for Serious Mental Illness

OhioMHAS is not addressing prevention for serious mental illness (psychosis) at this time. The Department is concentrating its efforts on First Episode Psychosis.

No technical assistance is requested at this time.

Environmental Factors and Plan

5 Evidence-Based Practices for Early Intervention (5 percent set-aside)

Narrative Question:

P.L. 113-76 and P.L. 113-235 requires that states set aside five percent of their MHBG allocation to support evidence-based programs that provide treatment to those with early SMI including but not limited to psychosis at any age.[72] SAMHSA worked collaboratively with the NIMH to review evidence-showing efficacy of specific practices in ameliorating SMI and promoting improved functioning. NIMH has released information on Components of Coordinated Specialty Care (CSC) for First Episode Psychosis. Results from the NIMH funded Recovery After an Initial Schizophrenia Episode (RAISE) initiative[73], a research project of the NIMH, suggest that mental health providers across multiple disciplines can learn the principles of CSC for First Episode of Psychosis (FEP), and apply these skills to engage and treat persons in the early stages of psychotic illness. At its core, CSC is a collaborative, recovery-oriented approach involving clients, treatment team members, and when appropriate, relatives, as active participants. The CSC components emphasize outreach, low-dosage medications, evidenced-based supported employment and supported education, case management, and family psycho-education. It also emphasizes shared decision-making as a means to address individuals' with FEP unique needs, preferences, and recovery goals. Collaborative treatment planning in CSC is a respectful and effective means for establishing a positive therapeutic alliance and maintaining engagement with clients and their family members over time. Peer supports can also be an enhancement on this model. Many also braid funding from several sources to expand service capacity.

States can implement models across a continuum that have demonstrated efficacy, including the range of services and principles identified by NIMH. Using these principles, regardless of the amount of investment, and with leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, every state will be able to begin to move their system toward earlier intervention, or enhance the services already being implemented.

It is expected that the states' capacity to implement this programming will vary based on the actual funding from the five percent allocation. SAMHSA continues to provide additional technical assistance and guidance on the expectations for data collection and reporting.

Please provide the following information, updating the State's 5% set-aside plan for early intervention:

1. An updated description of the states chosen evidence-based practice for early intervention (5% set-aside initiative) that was approved in its 2014 plan.
2. An updated description of the plan's implementation status, accomplishments and/ any changes in the plan.
3. The planned activities for 2016 and 2017, including priorities, goals, objectives, implementation strategies, performance indicators, and baseline measures.
4. A budget showing how the set-aside and additional state or other supported funds, if any, for this purpose.
5. The states provision for collecting and reporting data, demonstrating the impact of this initiative.

Please indicate areas of technical assistance needed related to this section.

[72] http://samhsa.gov/sites/default/files/mhbg-5-percent-set-aside-guidance.pdf

[73] http://www.nimh.nih.gov/health/topics/schizophrenia/raise/index.shtml?utm_source=rss_readers&utm_medium=rss&utm_campaign=rss_full

Please use the box below to indicate areas of technical assistance needed related to this section:

Ohio is considering making a request for technical assistance for this project, and is considering several alternatives at this time.

Footnotes:

5.5 Evidence-Based Practices for Early Intervention (5% Set Aside) – SFY 2016
First Episode Psychosis (FEP) – 5% Set Aside

Describe the state's assessed need for the target population and proposed evidence-based programs; provide an explanation for why this population was chosen, a description of planned activities, and a budget showing how the set-aside will be spent.

Target Population – OhioMHAS will use the 5% Set Aside to fund two regional providers to provide services to *"youth and young adults, ages 15 – 25 that have experienced their first psychotic episode. Persons served by the grant must have one of the qualifying diagnoses: Brief Psychotic Episode, Psychosis NOS, Schizophreniform, Bipolar I with Psychotic Features, Major Depression with Psychotic Features, Schizoaffective Disorder, Delusional Disorder, or Schizophrenia. Some of these individuals may have a co-occurring addiction and would not be outside the criteria if a qualifying mental health diagnosis is present." (OhioMHAS RFP)*

Since the 5% set aside could not fully support clinical services for all individuals with FEP in Ohio counties, OhioMHAS issued a competitive Request for Proposal (RFP) consistent with state procurement rules. Based on this process, OhioMHAS selected Coleman Behavioral Health and Greater Cincinnati Behavioral Health through this competitive process. Projects were funded for two consecutive years based on the availability of SAMHSA funds.

Coleman began providing FEP in 2012 in Portage County and has expanded its FEP services to four additional counties. Additionally, Coleman in collaboration with another provider, Zeph Center, has developed a FEP team serving Lucas and (Toledo) and Wood Counties (Bowling Green) in northwestern Ohio. Coleman and Zeph Center will provide services to seven Ohio counties in the northern part of the state (east and west).

The second project operated by Greater Cincinnati Behavioral Health (GCB), began providing FEP services to residents of Hamilton and Clermont Counties in southeastern Ohio by the latter part of 2014. GCB operates specialized case management teams using the Transition to Independence Process (TIP) Model, and identified a need to develop services for those with FEP, as the newly diagnosed often do not have the pre-existing multi-system engagements that qualify them for the Transition to Independence teams. Both Hamilton and Clermont counties are recipients of the SAMHSA System of Care Grants and have focused on the transition age youth population. The FEP projects have complemented the other services and supports that they have developed in these communities.

All of the mentioned providers (in nine counties) will partner with the Best Practices in Schizophrenia Treatment (BeST) Center at Northeast Ohio Medical University. The BeST Center, developed with support and funding from the Margaret Clark Morgan Foundation, a private foundation, provides technical assistance and training to providers implementing FEP in Ohio. Currently, five counties (Summit, Portage, Trumbull, Mahoning and Cuyahoga counties in northeastern Ohio) have implemented FEP programs in collaboration with the BeST Center. These counties implemented FIRST, a Coordinated Specialty Care (CSC) approach, which is an early identification and treatment of schizophrenia program. It is designed to treat individuals (aged 15 to 40) experiencing a first episode of a schizophrenia-spectrum disorder: schizophrenia, schizophreniform disorder, schizoaffective disorder and psychotic disorder not otherwise

specified. Only a small number of studies have broken down the yearly incidence rate of first episode psychosis by diagnostic category and presented these rates accordingly. Cumulative yearly incidence rates of the diagnostic categories appropriate for FIRST in these studies ranged from 20.1 to 52.98/100,000 (Baldwin et al., 2005 and Burns & Esterhuizen, 2008, respectively). Due to the broad range of yearly incidence, a range of 20-30 individuals per 100,000 of the population is a conservative estimate of the likely number of individuals who experience a first episode of a schizophrenia-spectrum disorder in a given year. Utilizing the U.S. Census Bureau 2012 population estimate, the 20-30/100,000 range per year is provided below for the counties implementing FEP in Ohio.

County / Region	**Population** (source: U.S. 2012 Census)	**Number of Individuals Expected to Experience a First Episode of a Schizophrenia Spectrum Disorder per year**
Portage County	161,451	32 - 48
Stark County	374,868	75 - 112
Wood County	128,200	26 - 38
Lucas County	437,998	88 - 131
Allen, Auglaize & Hardin Counties	182,599	37 - 55
Hamilton County	804,520	160 - 240
Clermont County	290,218	40 - 60
Counties Served by 5% Set Aside	**2,379,218**	**476 - 714**
Ohio Total	**11,570,808**	**2,314 – 3,471**

(1) ***A statement addressing why the target population was chosen.***

OhioMHAS selected the target population to include a broad range of diagnoses typical of persons experiencing their first psychotic episode. As these diagnoses may differ across community clinical settings, a broad range of psychotic disorder diagnoses was included. Also, having a broad range of psychotic diagnoses makes the program more feasible by allowing sufficient number of persons to implement the FEP program outside of major urban areas.

OhioMHAS selected a more limited geographical area through a competitive request for proposals as required by state procurement rules. Applicants were required to include at least two Board areas. As a result, Ohio's FEP program will include urban, suburban and rural counties.

(2) A brief budget allocation and narrative explaining how the state intends to expend the 5% set aside. (General line items and budgeted amounts: i.e. -Program Staff Position-; Training; etc.)

Ohio issued a competitive RFP for $763, 722 to fund two providers up to $382,000 per year to implement FEP services in more than one (county) Board area. Initial funding is for two years (SFY 2015 – 2016) with future funding dependent upon on federal funds and project outcomes. The two providers plan to operate 5.5 teams. GCB served 59 persons under age 25 with psychotic diagnoses in FY 2013, and will offer outreach to the estimated 80% of the persons

with these diagnoses who are not currently being served in Hamilton and Clermont Counties. Coleman provided FEP services to 20 persons in Portage County in FY 2013 and will expand services to six additional counties by partnering with Zeph Center, a large CMHC in Lucas County (Toledo).

Ohio's 5% Set Aside for First Episode Psychosis	Total MH Block Grant Expenditure	Other Funds
Personnel	$353797	$358,875
Fringe Benefits	$94,488	$100,485
Consultants	$229,130	
Subscriptions	$0	
Supplies	$1,200	
Printing & Copying	$600	
Rent/Lease	$8,918	$11,232
Phone/Utilities	$1,235	$3,370
Maintenance/Repair	$0	
Rentals	$0	
Insurance	$1,800	
Motor Vehicles	$0	
Travel	$10,093	$2,981
Food	$0	
Conference/Training/Registration	$0	
Equipment/Computer	$4,960	
Indirect	$58822	
Funds Awarded to Projects	$762,016	$473,573

The combined budgets of these two programs include:

Personnel costs in column B include clinical staff for 5.5 teams. Staff includes Team Coordinator/Director, Case Manager, Supported Employment Specialists, Individual Therapist/Counselor, Family Therapist, Psychiatrist, and Director (10%). **Fringe benefits** include FICA, Worker's Compensation, OBES, Life/Disability, retirement and dental.

Non-personnel costs in column B include:
Consultants - The Best Center for Schizophrenia at Northeastern Ohio Medical School was independently selected by both applicants to provide contractual services that include expert

training, consultation, and technical assistance in the implementation of specialty first-episode psychosis treatment.

Supplies are general office supplies, housekeeping supplies, small desktop consumables, and curriculum materials.

Printing & Copying – copier rental and supplies

Rent/Lease for space and utilities allocation at the project site.

Phone/Utilities required for this project.

Insurance for property, general, umbrella and malpractice.

Travel - mileage at 45 cents per mile, and project specific/training related travel

Equipment/Computer – 4 laptops ($1000 each) and 2 cell phones ($40/month)

Indirect – GCB has a federal indirect cost rate of 12% with exclusion of consultant costs. Coleman used an indirect rate of 7% for costs associated with the Project Director, administrative services, executive office billing, records, payroll, IT, building operations and Human Resources.

The remaining block grant funds in the amount of $1706 were provided for the five county teams (approximately $341 per team) for networking; traveling between the FEP sites; and to support additional training. The project leaders will provide specific details regarding the outcome of these activities at the end of the grant period.

Response to SAMHSA's Specific Questions:

1. Specific Diagnostic Category:
Ohio's set aside funds for First Episode Psychosis (FEP) projects, are dedicated toward individuals with one of the following qualifying diagnoses: Brief Psychotic Episode, Psychosis NOS, Schizophreniform, Bipolar I with Psychotic Features, Major Depression with Psychotic Features, Schizoaffective Disorder, Delusional Disorder, or Schizophrenia. Some of these individuals may have a co-occurring addiction and would not be outside the criteria if a qualifying mental health diagnosis is present.

2. Describe the Evidence Based Programs Using the Set-Aside
The funded agencies (totaling five teams in nine counties) are providing Cognitive Behavior Therapy for psychosis (CBT-p); Assertive Community Treatment (ACT), Motivational Interviewing (MI), Individual Resiliency Training (IRT) and Supported Employment. Case management staff/teams are trained to use the Transition to Independence Process (TIP) Model. The agencies used the Block Grant funds to contract with the Best Practices in Schizophrenia Treatment (BeST) Center at Northeast Ohio Medical University for training and consultation to implement the Coordinated Specialty Care (CSC) approach for the FEP projects.

3. Alternative Use of Funds, other than EBPs:

Ohio identified that the first year of the grant would be development for some of the project teams and staff. So, in this initial year about one/third of the total funds were contracted by the provider for consultation, technical assistance and specialized training. The projects chose to contract with the BEST Center for training on the CSC Model and the CBT-p and for the specialty training for psychiatrists. The funds were directed toward staff salaries/benefits, supplies, rental space, insurance, phone/utilities, equipment/computers, staff travel and indirect costs (administrative). The projects each developed networking plans, met with non-traditional partners (hospital emergency room staff, high school, college and university staff and primary care providers as examples) and developed marketing materials for ongoing recruitment.

4. Data Collection Efforts being Used to Demonstrate the effectiveness of the Programs for the Target Population:

The projects are using a standardized Outcome Review Form and the Clinician-Rated Dimensions of Psychosis Symptom Severity scale (psychiatrist rated) both at admission and at six month integrals. The Outcome and Review Form is completed by the client, the team leader, individual resiliency trainer, and supported employment/education specialist or case manager. This form was developed by the BeST Center. In addition, staff administers the Daily Living Activities-20 Functioning Scale and the Ohio Consumer Outcomes Survey to all clients who receive case management services annually. This allows for ongoing reporting and analysis.

5. Technical Assistance Requested

OhioMHAS is considering making a request for some technical assistance for this project, and is currently considering several alternatives.

Environmental Factors and Plan

6. Participant Directed Care

Narrative Question:

As states implement policies that support self-determination and improve person-centered service delivery, one option that states may consider is the role that vouchers may play in their overall financing strategy. Many states have implemented voucher and self-directed care programs to help individuals gain increased access to care and to enable individuals to play a more significant role in the development of their prevention, treatment, and recovery services. The major goal of a voucher program is to ensure individuals have a genuine, free, and independent choice among a network of eligible providers. The implementation of a voucher program expands mental and substance use disorder treatment capacity and promotes choice among clinical treatment and recovery support providers, providing individuals with the ability to secure the best treatment options available to meet their specific needs. A voucher program facilitates linking clinical treatment with other authorized services, such as critical recovery support services that are not otherwise reimbursed, including coordination, childcare, motivational development, early/brief intervention, outpatient treatment, medical services, support for room and board while in treatment, employment/education support, peer resources, family/parenting services, or transportation.

Voucher programs employ an indirect payment method with the voucher expended for the services of the individual's choosing or at a provider of their choice. States may use SABG and MHBG funds to introduce or enhance behavioral health voucher and self-directed care programs within the state. The state should assess the geographic, population, and service needs to determine if or where the voucher system will be most effective. In the system of care created through voucher programs, treatment staff, recovery support service providers, and referral organizations work together to integrate services.

States interested in using a voucher system should create or maintain a voucher management system to support vouchering and the reporting of data to enhance accountability by measuring outcomes. Meeting these voucher program challenges by creating and coordinating a wide array of service providers, and leading them though the innovations and inherent system change processes, results in the building of an integrated system that provides holistic care to individuals recovering from mental and substance use disorders. Likewise, every effort should be made to ensure services are reimbursed through other public and private resources, as applicable and in ways consistent with the goals of the voucher program

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.6 Participant Directed Care

- Yes, strategies for person-centered planning have been included in Ohio's systems for care for more than a decade. Ohio's draft for a 1915i Medicaid waiver for a subpopulation of persons with serious mental illness includes the language "person-centered planning."
- The Access to Recovery grant funds self-directed care using a voucher system for a limited population of persons in recovery from addiction involved with the criminal justice system in Ohio. Ohio has implemented the Access to Recovery grant with a recovery oriented focus.
- Ohio is not requesting technical assistance in this area.

Environmental Factors and Plan

7. Program Integrity

Narrative Question:

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds.

While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 USC §§ 300x–5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 USC § 300x– 55, SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for substance abuse, SAMSHA will release guidance imminently to the states on use of block grant funds for these purposes. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The Affordable Care Act may offer additional health coverage options for persons with behavioral health conditions and block grant expenditures should reflect these coverage options. The MHBG and SABG resources are to be used to support, not supplant, individuals and services that will be covered through the Marketplaces and Medicaid. SAMHSA will provide additional guidance to the states to assist them in complying with program integrity recommendations; develop new and better tools for reviewing the block grant application and reports; and train SAMHSA staff, including Regional Administrators, in these new program integrity approaches and tools. In addition, SAMHSA will work with CMS and states to discuss possible strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance abuse programs, and activities for adults with SMI and children with SED.

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. These strategies may include:(1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (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 use of behavioral health benefits in light of utilization review, medical necessity, etc. 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Does the state have a program integrity plan regarding the SABG and MHBG funds?
2. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers?
3. Describe the program integrity activities the state employs for monitoring the appropriate use of block grant funds and oversight practices:
    a. Budget review;
    b. Claims/payment adjudication;
    c. Expenditure report analysis;
    d. Compliance reviews;
    e. Client level encounter/use/performance analysis data; and
    f. Audits.
4. Describe payment methods, used to ensure the disbursement of funds are reasonable and appropriate for the type and quantity of services delivered.
5. Does the state provide assistance to providers in adopting practices that promote compliance with program requirements, including quality and safety standards?
6. How does the state ensure block grant funds and state dollars are used for the four purposes?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.6 Program Integrity – Assuring SA/MH Block Grant Funds Spent Appropriately

The Ohio Department of Mental Health and Addiction Services (Ohio MHAS) has personnel dedicated towards monitoring of Block Grant Funds provided to the Community. We deploy a two pronged approach to safeguard public funds. The first is a Risk Based monitoring (foresight approach) and the second is an On-Site Visit (hindsight approach), described as follows:

Risk Based monitoring (foresight approach – before the year is over):
At the beginning of each State Fiscal Year, the Community Monitoring Section begins with sending and collecting an annual Questionnaire from our subrecipients. The purpose of the questionnaire is to obtain any changes Year-Over-Year from our subrecipients (i.e. – Key employee turnover, change in accounting systems, any irregularities, etc.). We also analyze the subrecipients' budget vs. their actual spending, audit findings, and various financial analyses to assist us in assigning risk factors so we may properly monitor our vulnerabilities. The Community Monitoring Section within Ohio MHAS has developed an in-house Risk Model whereas we will feed information to manage/mitigate our risk. Each indicator is designed to allow us to understand what actions we must take to better safeguard public funds.

On-Site Visits (hindsight approach – after the year is over):
The onsite visit consists of audit techniques whereas we have designed procedures to test supporting documentation to validate compliance with Laws, Rules, Regulations, and Contract Agreements. Within our procedures, we will validate our subrecipients have properly accounted for the expenditures of public funds pass-through from Ohio MHAS. The on-site visit also serves as a validation to our "Risk Based Monitoring" to ensure that techniques in place (before the year was over) are effective. The on-site visit approach can only serve as "What should have occurred" since it can only detect what happened in prior years and the Risk Based approach is designed to detect potential problems before they occur. On an annual basis, the Community Monitoring Manager will determine if any updates to either approach are necessary to maintain an effective Subrecipient Monitoring Program.

8. Tribes

Narrative Question:

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the 2009 Memorandum on Tribal Consultation[74] 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.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds 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 and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that 67% of American Indian and Alaska Natives live off-reservation. SSAs/SMHAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the state. States shall not require any tribe to waive its sovereign immunity in order to receive funds or 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.

Please consider the following items as a guide when preparing the description of the state's system:

1. Describe how the state has consulted with tribes in the state and how any concerns were addressed in the block grant plan.
2. Describe current activities between the state, tribes and tribal populations.

Please indicate areas of technical assistance needed related to this section.

[74] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.8 Tribes

Ohio has no federally designated tribes with which to consult.

Environmental Factors and Plan

9. Primary Prevention for Substance Abuse

Narrative Question:

Federal law requires that states spend no less than 20 percent of their SABG allotment on primary prevention programs, although many states spend more. Primary prevention programs, practices, and strategies are directed at individuals who have not been determined to require treatment for substance abuse.

Federal regulation (45 CFR 96.125) requires states to use the primary prevention set-aside of the SABG to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance abuse. The program must include, but is not limited to, the following strategies:

- Information Dissemination provides knowledge and increases awareness of the nature and extent of alcohol and other drug use, abuse, and addiction, as well as their effects on individuals, families, and communities. It also provides knowledge and increases awareness of available prevention and treatment programs and services. It is characterized by one-way communication from the information source to the audience, with limited contact between the two.
- Education builds skills through structured learning processes. Critical life and social skills include decision making, peer resistance, coping with stress, problem solving, interpersonal communication, and systematic and judgmental capabilities. There is more interaction between facilitators and participants than there is for information dissemination.
- Alternatives provide opportunities for target populations to participate in activities that exclude alcohol and other drugs. The purpose is to discourage use of alcohol and other drugs by providing alternative, healthy activities.
- Problem Identification and Referral aims to identify individuals who have indulged in illegal or age-inappropriate use of tobacco, alcohol or other substances legal for adults, and individuals who have indulged in the first use of illicit drugs. The goal is to assess if their behavior can be reversed through education. This strategy does not include any activity designed to determine if a person is in need of treatment.
- Community-based Process provides ongoing networking activities and technical assistance to community groups or agencies. It encompasses neighborhood-based, grassroots empowerment models using action planning and collaborative systems planning
- Environmental Strategies establish or changes written and unwritten community standards, codes, and attitudes. The intent is to influence the general population's use of alcohol and other drugs.

States should use a variety of strategies that target populations with different levels of risk. Specifically, prevention strategies can be classified using the IOM Model of Universal, Selective, and Indicated, which classifies preventive interventions by targeted population. The definitions for these population classifications are:

- Universal: The general public or a whole population group that has not been identified based on individual risk.
- Selective: Individuals or a subgroup of the population whose risk of developing a disorder is significantly higher than average.
- Indicated: Individuals in high-risk environments that have minimal but detectable signs or symptoms foreshadowing disorder or have biological markers indicating predispositions for disorder but do not yet meet diagnostic levels.

It is important to note that classifications of preventive interventions by strategy and by IOM category are not mutually exclusive, as strategy classification indicates the type of activity while IOM classification indicates the populations served by the activity. Federal regulation requires states to use prevention set-aside funding to implement substance abuse prevention interventions in all six strategies. SAMHSA also recommends that prevention set-aside funding be used to target populations with all levels of risk: universal, indicated, and selective populations.

While the primary prevention set-aside of the SABG must be used only for primary substance abuse prevention activities, it is important to note that many evidence-based substance abuse prevention programs have a positive impact not only on the prevention of substance use and abuse, but also on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. This reflects the fact that substance use and other aspects of behavioral health share many of the same risk and protective factors.

The backbone of an effective prevention system is an infrastructure with the ability to collect and analyze epidemiological data on substance use and its associated consequences and use this data to identify areas of greatest need. Good data also enable states to identify, implement, and evaluate evidence-based programs, practices, and policies that have the ability to reduce substance use and improve health and well-being in communities. In particular, SAMHSA strongly encourages states to use data collected and analyzed by their SEOWs to help make data- driven funding decisions. Consistent with states using data to guide their funding decisions, SAMHSA encourages states to look closely at the data on opioid/prescription drug abuse, as well as underage use of legal substances, such as alcohol, and marijuana in those states where its use has been legalized. SAMHSA also encourages states to use data-driven approaches to allocate funding to communities with fewer resources and the greatest behavioral health needs.

SAMHSA expects that state substance abuse agencies have the ability to implement the five steps of the strategic prevention framework (SPF) or an equivalent planning model that encompasses these steps:

1. Assess prevention needs;
2. Build capacity to address prevention needs;
3. Plan to implement evidence-based strategies that address the risk and protective factors associated with the identified needs;
4. Implement appropriate strategies across the spheres of influence (individual, family, school, community, environment) that reduce substance abuse and its associated consequences; and
5. Evaluate progress towards goals.

States also need to be prepared to report on the outcomes of their efforts on substance abuse- related attitudes and behaviors. This means that state-funded prevention providers will need to be able to collect data and report this information to the state. With limited resources, states should also look for opportunities to leverage different streams of funding to create a coordinated data driven substance abuse prevention system. SAMHSA expects that states coordinate the use of all substance abuse prevention funding in the state, including the primary prevention set-aside of the SABG, discretionary SAMHSA grants such as the Partnerships for Success (PFS) grant, and other federal, state, and local prevention dollars, toward common outcomes to strive to create an impact in their state's use, misuse or addiction metrics.

Please consider the following items as a guide when preparing the description of the state's system:

1. Please indicate if the state has an active SEOW. If so, please describe:
    - The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
    - The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
    - The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).
2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.
3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
4. Please describe if the state has:
    a. A statewide licensing or certification program for the substance abuse prevention workforce;
    b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and
    c. A formal mechanism to assess community readiness to implement prevention strategies.
5. How does 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)?
6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.
7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.
8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.
9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?
10. What process data (i.e. numbers served, participant satisfaction, attendance) 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?
11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to collect on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.9 Primary Prevention for Substance Abuse

1. Please indicate if the state has an active SEOW. If so, please describe:
• The types of data collected by the SEOW (i.e. incidence of substance use, consequences of substance use, and intervening variables, including risk and protective factors);
• The populations for which data is collected (i.e., children, youth, young adults, adults, older adults, minorities, rural communities); and
• The data sources used (i.e. archival indicators, NSDUH, Behavioral Risk Factor Surveillance System, Youth Risk Behavior Surveillance System, Monitoring the Future, Communities that Care, state-developed survey).

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 ADAMH 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 alcohol, tobacco and other drug (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 Research Triangle Institute (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 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.

While the members 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,

ADAMH 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.

In 2015, through a collaborative effort with the Ohio Department of Health, all the SEOW data is being transitioned to the existing ODH data warehouse and the Network of Care, a contracted platform through Trilogy. This will allow communities to access local data and provide reports comparing local data to state and national data.

For the past decade, Ohio has been working toward the development of a statewide youth survey that would provide county level data communities. The IPP has been working on this and as a result of the collaborative efforts of the SPE and through funding from the Governor's Office the Ohio Healthy Youth Environments Survey (OHYES!) has been developed. This will enhance the ability for communities to have local data, assess their needs and develop prevention services targeted to those needs. The first round of the OHYES! will be administered in the fall of 2015 with anticipated data availability in February, 2016.

2. Please describe how needs assessment data is used to make decisions about the allocation of SABG primary prevention funds.

OhioMHAS has a historic process for community and statewide assessment and planning for prevention guided by state and federal law and regulation. State law requires that ADAMH Boards conduct community needs assessments for behavioral health services which are included in a Community Plan submitted to the state. Additionally, Ohio's state substance abuse authority has implemented an assessment as a part of the Ohio Strategic Planning Framework with a series of grants from SAMHSA. 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 Strategic Prevention Framework (SPF) Strategic Prevention Enhancement (SPE) Evaluation Team conducted a variety of assessments and inventories to inform the work of the SPE Consortium specifically around data collection. Ohio Community Plans, Ohio Family Health Study, and National Outcome Measures (NOMS) all inform Ohio's prevention planning efforts.

Community Assessment, Planning and National Outcome Measures

ADAMH Boards are required by Ohio law to prepare and submit to OhioMHAS a "Community Plan" for the provision of alcohol, drug addiction and mental health services in their board service areas. The Community Plan requires Boards to state whether they are addressing a list of federal and state priority populations and briefly describe the strategies used. Staff from the OhioMHAS Medical Director's Office and the Office of Quality, Planning and Research review the Board's plans and prepare synthesis reports. The synthesis reports are used to inform Ohio's Block Grant Plan. Additionally, the SAPT/MH Block Grant sub-awardees are required to indicate which National Outcome Measures (NOMS) are being addressed by their projects.

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. 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 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. The Network has been integral in OhioMHAS' ability to respond to media inquiries; to aid local ADAMHS Boards and provider 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.

3. How does the state intend to build the capacity of its prevention system, including the capacity of its prevention workforce?
Please see Step 1: Increase Community Capacity through Workforce Development Plan in 1.5.1 Prevention and Early Intervention

4. Please describe if the state has: a. A statewide licensing or certification program for the substance abuse prevention workforce; b. A formal mechanism to provide training and technical assistance to the substance abuse prevention workforce; and c. A formal mechanism to assess community readiness to implement prevention strategies.
Please see Step 1: Increase Community Capacity through Workforce Development Plan in 1.5.1 Prevention and Early Intervention

5. How does 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)?
The state utilizes the SEOW data to understand the nature, extent, and underlying causes of alcohol- and/or other drug-related problems. The Department utilizes this data to guide funding processes and develop new initiatives to address need. **.** The SEOW provides the state and communities with much needed data needed for planning, monitoring and evaluation. The SEOW will continue to be responsible for the collection, analysis, and reporting of substance use incidence, prevalence and related data and National Outcome Measures (NOMs) through making use of national survey data and Memorandums of Understanding (MOU's) with the Ohio Department of Health, Ohio Department of Job and Family Services, the Ohio Department of Development and other Ohio agencies. Although the majority of consumption data on underage drinking and prescription drug abuse used by the SEOW is gleaned from 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), the PFS SEOW will work to identify reliable and valid sources of secondary data for participating communities.

This grant will allow the SEOW to perform a critical function in identifying local data sources to assist communities in utilizing the SPF as a data-driven planning framework to assist in developing comprehensive plans to prevent underage drinking and prescription drug abuse. It will also provide Ohio the opportunity to conduct various SEOW specialized data collection projects identified as needed by sub-recipients in the assessment and planning phases. Through the broadening of the types and sources of data collected for our SEOW in recent years, we have discovered there is a dearth of data on several groups in high need for prevention services such as LGBTQ, rural youth and young people experiencing trauma. These funds will allow us to fill the assessment gaps, and select interventions better suited to address the intervening variables

contributing to underage drinking and prescription drug abuse in Ohio's rural communities. As new data becomes available, it will be analyzed and made available on the SEOW website.

6. Does the state have a strategic plan that addresses substance abuse prevention that was developed within the last five years? If so, please describe this plan and indicate whether it is used to guide decisions about the use of the primary prevention set-aside of the SABG.

Ohio used Substance Abuse Mental Health Services Administration (SAMHSA), Strategic Prevention Framework (SPF) Strategic Prevention Enhancement (SPE) grant funds to convene a cross-system, consortium of key stakeholders including state agencies, foundations, universities, prevention providers and other community members to develop a 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. Ohio focused SPE efforts toward achieving the following outcomes:

- Strengthening and enhancing current prevention infrastructure to support more strategic, collaborative and comprehensive systems of community-oriented prevention.
- Assessing the current state of the overall prevention infrastructure, identifying gaps and developing a long-term, data-driven strategic plan to enhance and further strengthen the state prevention system to better meet the emerging needs of all populations across communities.
- Fostering a more responsive, interactive Ohio state prevention system that can better address and adjust to the complexities of evolving health care initiatives and its fiscal implications for the state and communities.
- Through stronger, more strategically aligned prevention infrastructures, Ohio will be better positioned to apply the Strategic Prevention Framework (SPF) process to implement data-driven, evidence-based prevention programs, policies and practices across its communities.

Ohio has updated its Prevention Continuum of Care Taxonomy, and has 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 Strategy Action Plan provided in the next section.

Prevention Education and Environmental strategies are seen as the primary 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 primary strategies. All six strategies in appropriate proportions are needed as part of a comprehensive prevention approach.

Ohio's SPE strategic plan addresses the items provided in SAMSHA's SPE Strategic Plan Checklist. However, since consolidation of the two Departments we are continuing to utilize systemic processes in place that serve as the foundation of interagency work on behavioral health under a public health framework.

Action steps are provided for each project under the Strategic Priority Areas. Lead stakeholders are identified for each project and a timeline is provided for each action step. 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.

10 Essential Public Health Services List
The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Strategic Priority 3: Develop & promote **evidence-based,** culturally competent, policies & practices that support & **integrate** prevention at multiple levels across systems.					
Project 4: Encourage use of the Strategic Prevention Framework (SPF).	a. Encourage use of the Strategic Prevention Framework.	On-going	SPF-SIG Advisory	5, 8, 10	
	1. Determine the "What's in it for me" for communities and develop a fact sheet for distribution.	August - December 2012	SPF-SIG Advisory		Planning & Implementation
	2. Identify a SPF champion.	August - December 2012	SPF-SIG Advisory		Public Health Capacity & Resources
	3. Develop and recommend a funding allocation system that support SPF processes.	August - December 2012	SPF-SIG Advisory		Planning & Implementation
	4. Develop a technical assistance/training consortium for SPF.	On-going	SPF-SIG Advisory		Public Health Capacity & Resources
	5. Use SPF SIG Sub-recipients to mentor, train and to disseminate SPF to other areas	On-going	SPF-SIG Advisory		Public Health Capacity & Resources
Project 5: Identify and define multi-faceted prevention services that are cost-effective and feasible for Ohio.	a. Identify and define multi-faceted prevention services that are cost-effective and feasible for Ohio.	On-going	SPF-SIG Advisory	9, 10	
	1. Conduct a literature review to assess expected outcomes versus cost.	August - December 2012	EBP Workgroup		Planning & Implementation
	2. Assess necessary resources to implement recommendations.	August - December 2012	EBP Workgroup		Public Health Capacity & Resources
	3. Recommend best practices and evidenced-based practices for Ohio.	August - December 2012	EBP Workgroup		Planning & Implementation
	4. Provide evidence of outcomes and continue to streamline programs.	On-going	EBP Workgroup		Performance Management & Quality Improvement
Project 6: Review and promote culturally competent policies and practices, using a multi-level approach.	a. Review and promote culturally competent policies and practices, using a multi-level approach.	On-going	EBP Workgroup	5, 8, 9, 10	
	1. Identify, review, revise and promote current culturally competent policies and practices	January - June 2013	EBP Workgroup		Planning & Implementation
	2. Provide information to all stakeholders for review	January - June 2013	EBP Workgroup		State-Local Relationships
	3. Utilize existing or develop training curriculum, and train field.	January - June 2013	EBP Workgroup		Public Health Capacity & Resources
Project 7: Provide workforce development regarding population-based strategies at multiple levels.	a. Provide workforce development regarding population-based strategies at multiple levels.	On-going	Workforce Development Workgroup, OCDB Prevention Committee	5, 8	
	1. Assess current future workforce needs	Aug-12	SPE Evaluation Team		Planning & Implementation
	2. Determine minimum level knowledge level of current state of science for prevention specialists.		Workforce Development Workgroup, OCDB Prevention Committee		Planning & Implementation
	3. Provide standardized prevention education to prevention personnel, and conduct other workforce development efforts.		Workforce Development Workgroup, OCDB Prevention Committee		Public Health Capacity & Resources
Strategic Priority 4: Use relevant **data** to assess community strengths to select programs, practices, and strategies and help evaluate their effectiveness.					
Project 8: Implement a statewide youth survey that provides county-level data.	a. Implement a statewide youth survey that provides county-level data.			1, 2	
	1. Find a champion among all the groups needing data from a statewide youth survey at the state and local levels.	August - December 2012	SPE & SEOW		State-Local Relationships
	2. Examine process across other states and assess their fit for Ohio	Aug-12	SPE Evaluation Team		Planning & Implementation
	3. Find a funding mechanism that is mindful of healthcare reform and political will.	January - June 2013	SPE & SEOW		Planning & Implementation
	4. Involve local level (grassroots)	January - June 2013	Roundtable		State-Local Relationships
Project 9: Seek opportunities to extend existing adult data collection to include prevention.	b. Seek opportunities to extend existing adult data collection to include prevention.			1, 2	
	1. Find a champion among all the groups needing data from a statewide survey at the state and local levels.	August - December 2012	SPE & SEOW		State-Local Relationships
	2. Inventory all adult data collection tools.	Aug-12	SPE Evaluation Team		Planning & Implementation
	3. Inform stakeholders about the importance of collecting prevention data across lifespan.	August - December 2012	SPE & SEOW		Public Health Capacity & Resources
	4. Modify current systems.	January - June 2013	SPE & SEOW		Planning & Implementation
	5. Share data to inform policy	January - June 2013	SPE & SEOW		Planning & Implementation
Project 10: Evaluate action plan.	c. Evaluate action plan.			9	
	1. Develop a system for collecting and analyzing program-related information from the field so good information can go back out to the field for quality improvement.	June - December 2012	ODADAS, PIPAR Workgroup		Planning & Implementation
	2. Use OCPSII survey regarding EPHS as baseline to measure change in knowledge and attitude.	Aug-12	SPE Evaluation Team		Public Health Capacity & Resources

7. Please indicate if the state has an active evidence-based workgroup that makes decisions about appropriate strategies in using SABG primary prevention funds and describe how the SABG funded prevention activities are coordinated with other state, local or federally funded prevention activities to create a single, statewide coordinated substance abuse prevention strategy.

Ohio's EBP has received extensive training on the SPF as well as other evidence based practices, and serve as our experts to review various innovative community programs and practices and state –level processes and guidance documents. Ohio's EBP has already been involved in other projects and provided feedback and recommendations to Ohio's Youth Led Prevention Network Resource Guide as well as the Ohio Coalition Center for Excellence designation. Currently Ohio's EBP consists of statewide SPF PFS Project team members, state department representatives and local ADAMHS Boards and prevention providers. From the very beginning, Ohio insisted that the EBP be sustained beyond the SPF grant because of the need for a formalized structure and process to increase evidence-based prevention practice in Ohio.

8. Please list the specific primary prevention programs, practices and strategies the state intends to fund with SABG primary prevention dollars in each of the six prevention strategies. Please also describe why these specific programs, practices and strategies were selected.

In SFY15, OhioMHAS funded 180 providers. 64 of the 220 intervention types funded in SFY15 were evidence-based for a total of 29%. This is the first fiscal year we have included interventions funded by board allocations in the totals. Previously, only our grant programs were included in this total due to lack of availability of data.

SFY 16 is a continuation grant year, so we will continue historic funding practices which are based on Board Community Plans. However, when the new prevention rules go into effect approximately July 1, 2016, only evidence-based interventions will be funded by OhioMHAS. For SFY16 we plan to fund the following evidence-based practices. Those interventions in bold will be the focus for our funding for SFY17.

<u>Prevention Education:</u> **LifeSkills, Creating Lasting Family Connections, Positive Family Support/Family Check-Up, Strengthening Families, Alcohol Literacy Challenge, Keepin' it R.E.A.L. (Refuse, Explain, Avoid, Leave),** Across Ages, Active Parenting, Actively Caring for People, Aiming High, All Stars, An Apple A Day, Athletes Training and Learning to Avoid Steroids (ATLAS), Guiding Good Choices , Communities Mobilizing for Change on Alcohol (CMCA), Communities that Care, Community Connections, Community Trials Intervention to Reduce High-Risk Drinking (RHRD), Crossroads of Parenting and Divorce; Children of Divorce Intervention Program, DARE To Be You, Hooked on Fishing Not on Drugs, Incredible Years, Kognito - Family of Heoes, Lions-Quest Skills for Adolescence, Maintaining African American Traditions (MAAT), Minimize Risk Maximize Life (MRML), Olweus Bullying Prevention, Parents as Teachers, Positive Action (PA), PRIME for Life, Project ALERT, Project KIND,

Project Northland, Project SUCCESS, Project Toward No Drug Abuse, Reconnecting Youth (RY), Second Step, The New Beginnings Program, Thinking For A Change, Too Good For Drugs (TGFD)/Too Good for Violence

Environmental Strategies**:** **PAX GBG, Peers Making Peace, behavioral health literacy campaigns, social norm campaigns and other media, advocacy and policy**, server training, BUZZKILL: Serve Under 21 and the Party's Over, Parents Who Host Lose the Most, etc.

Community-Based Process: **Coalitions**

9. What methods were used to ensure that SABG dollars are used to fund primary substance abuse prevention services not funded through other means?

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

10. What process data (i.e. numbers served, participant satisfaction, attendance) 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?

The web-based application, Proving Ohio's Prevention Success (POPS), collects required federal data for the SAPT Block Grant including, demographics, numbers served by strategy, evidence based programs and objectives that can be rolled up into showing achievement in the National Outcome Measures for prevention: abstinence, school/employment, criminal justice and social support/social connectedness

11. What outcome data (i.e., 30-day use, heavy use, binge use, perception of harm, disapproval of use, consequences of use) does the state intend to college on its funded prevention strategies and how will this data be used to evaluate the state's prevention system?

Ohio will continue to utilize the National surveys to collect statewide data related to 30-day use, heavy use, binge use, perception of harm, disapproval of use and consequences of use. Once the new OHYES! survey data is available, Ohio will utilize this data and have the ability to look at local level data that will assist in evaluating the state's prevention system.

Environmental Factors and Plan

10. Quality Improvement Plan

Narrative Question:

In previous block grant applications, 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, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and 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 to this application, states should submit a CQI plan for FY 2016-FY 2017.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.10 Quality Improvement Plan

Quality Monitoring and Improvement Plan
Ohio Department of Mental Health and Addiction Services

Quality improvement plans focused on changes in a specific outcome rely upon good indicators or measures that assess services or programs. Quality indicators can be measured by multiple stakeholders: funders and health plans, public health systems (local, state, and national), people with mental illnesses, providers, and accreditation agencies. The Department recognizes that it is important to demonstrate effectiveness for multiple stakeholders; however, Ohio emphasizes local leadership and flexibility, and reducing regulatory and administrative burden on Boards and providers. Therefore, the plan measures are generally limited to state-level policies and procedures and currently available data. At this time The Department's quality agenda is focused on monitoring and assurance measures. The Department is in the process of creating a Performance Measures Dashboard and determining how this dashboard will be utilized. The Department anticipates using some of these measures to create benchmarks and a continuous quality improvement agenda.

The Department's mission is the promotion and establishment of behavioral health as a cornerstone of health and wellness for individuals, families and communities throughout Ohio. This mission is accomplished through six responsibilities, which are outlined below to help provide a conceptual context for quality improvement:

1. Support and monitor local systems of care.

The Department funds, reviews and monitors community mental health programs, in part, through 50 county-level community behavioral health boards (hereinafter referred to as "Boards") for Ohio's 88 counties. These Boards are local authorities that contract for services provided by community organizations (private for-profit and non-profit), the public psychiatric hospitals operated by The Department, and private psychiatric hospital beds. The Department's Office of Licensure and Certification provides regulatory oversight to these community mental health agencies, private psychiatric hospital inpatient units, and community residential programs. Certified/licensed agencies, public hospitals and private hospitals are required to develop and implement performance improvement activities as part of the certification and/or accreditation process. Funding for community mental health services comes from federal (Medicaid and Block Grant), state (General Revenue Funds), and local sources (levies).

<u>NIATx Process Improvement Model</u>: The Department has the capability of offering training and technical assistance in the NIATx model for process improvement to behavioral health providers and Boards. The NIATx goal is to improve access and retention by focusing on one or more of the four AIMS (reduce waiting times, reduce no-shows, increase continuation, and increase admissions).

A number of alcohol and other drug providers and boards have adopted the NIATx model for process improvement for performance management purposes over the past years. This has been facilitated in Ohio by earlier initiatives funded through the Robert Wood Johnson Foundation as well as SAMHSA (i.e., STAR-SI). Based on data, which supports that the longer a person is in

treatment the more likely they will have successful outcomes, the goal for treatment is to increase retention using one or more aims: reduce wait time, reduce no shows, increase admission and increase continuation. First Step Home is an example of excellence using the NIATx model. First Step Home is a residential and outpatient treatment program and has transitional housing for women in recovery and their children. Located in Cincinnati, Ohio this agency has employed the NIATx tools and techniques since 2010. Results include an increase in intake by 138 percent between 2011 and 2014 from 135 to 322; in housing units by 188 percent during this same period of time from 18 to 52; in operating cash by $219,000 between 2011 and 2013; and in fee-for-service revenues by $833,000 between 2011 and 2104. However, one of the biggest accomplishments is that staff feels they are directly responsible for policy and the agency direction. http://www.niatx.net/News/NewsDetails.aspx?id=1140

Medicaid Services

Ohio's Medicaid Program currently covers ten services for Substance Use Disorders which include Assessment, Ambulatory Detoxification, Case Management, Crisis Intervention, Group Counseling, Individual Counseling, Intensive Outpatient, Laboratory Urinalysis, Medical/Somatic and Methadone Administration. Ohio's Medicaid Plan currently covers ten mental health services for those who are eligible: physician and non-physician assessment, group and individual case management, crisis intervention, group and individual counseling, pharmacological management, partial hospitalization and Health Home Services for Persons with Serious and Persistent Mental Illness.

Measures that are collected and reported to the Substance Abuse and Mental Health Services Administration (SAMHSA) for each Block Grant and are available for inclusion in the Performance Measures Dashboard include:

- ✓ Number of consumers receiving Integrated Dual Diagnosis Treatment (IDDT) for Substance Abuse and Mental Illness
- ✓ Number of episodes of physical restraint used in community mental health agencies per year
- ✓ Mental Health Statistics Improvement Program (MHSIP)[1] and Youth Services Survey for Families (YSS-F):
  - Percent reporting Access to Services
  - Percent reporting Quality and Appropriateness of Services/Cultural Competence
  - Percent reporting Participation in Treatment Planning
  - Percent reporting General Satisfaction with Care

[1] The MHSIP and YSSF are sent out annually to a stratified random sample of people who receive or have received public mental health system services within the last year. The MHSIP will be longitudinal after this year's administration; there will be three data points on a randomized, statewide survey. The data will be longitudinal but not individual-level data.

Block Grant

A portion of the Substance Abuse and Mental Health Block Grant funds are allocated to Ohio's 50 Boards on a modified per capita basis that recognizes population, poverty and prevalence factors, while requiring that resources be used to support one or more of four priority areas identified by The Department: safety net services (community services for individuals who are not covered under Medicaid) and crisis intervention; housing; services for children with serious emotional disorders; and support for consumers involved with the justice system, including re-entry to the community. Additionally, Block Grant funds support advocacy and best practices projects through specific grants for projects overseen by The Department staff. There are limited data reporting requirements for Boards, and project reporting has been focused on successful completion of activities as opposed to outcomes. Data available from projects include:

State Dedicated Purpose, Funds, State General Revenue Funds (GRF) and Local Levies

The Department relies on state GRF for a portion of its budget, and allocates a portion of these funds are allocated to Boards to purchase community services. Most Boards also receive funding through local tax levies. State and Board levy funds may be used to serve individuals who have Medicaid insurance or those who do not have Medicaid to pay for **non-Medicaid** services (e.g. housing, employment). For individuals without insurance, levy dollars can also pay for Medicaid eligible services.

Supportive Services: Through state and local levy dollars, Boards support a number of services not covered by Medicaid that are essential in helping people with mental illness emotional disturbances and substance use disorders recover. These services include, but are not limited to: outpatient treatments for non-Medicaid individuals; medication assistance; prevention activities; housing; residential treatment; recovery supports such as education, employment/vocational assistance, consumer operated services, and peer supports; and evidence-based practices (EBPs) such as IDDT, ACT[2], IHBT[2], and transportation.

Measures of supportive services currently reported by The Department for the Block Grant that will be available for use in the Performance Measures Dashboard include:

- ✓ Number of consumers receiving Evidence-based practices (from the OH-BH[3] database) including: Assertive Community Treatment (ACT), Multi-systemic Therapy (MST), Supported Employment (SE),
- ✓ National Outcomes Measure (NOM): Percent of consumers who move from homelessness to housed (MHSIP and YSS-F)
- ✓ Percent of consumers with Serious Mental Illness (SMI) who are employed (OH-BH)
- ✓ Percent of persons receiving Supported Employment who find employment
- ✓ Living arrangement (OH-BH)

Other measures collected by The Department that will be available for the Performance Measures Dashboard include:

[2] ACT and IHBT are scheduled to become Medicaid-covered services in July 2013.

[3] The Ohio Behavioral Health (OH-BH) is a web application tool for providers to enter client-level data at intake, yearly update and discharge.

- ✓ Number of adults who move out of institutions into the community as a result of assistance by Money Follows the Person (MFP) program
- ✓ Number of persons receiving recovery supports for community living from the Residential State Supplement (RSS) program
- ✓ Number of Peer Support Specialists completing training for certification in Ohio

Provide quality inpatient services.

The state's responsibility to provide public hospital care is defined in Ohio's constitution. Six Regional Psychiatric Hospitals (RPH) provide comprehensive inpatient care to approximately 1,000 people daily and specialize in providing short-term and intensive treatment. About 60% of the hospital population is forensic patients that are committed by an Ohio criminal court. The hospital system also provides outpatient services in a community-supported environment. Each hospital has a Quality Improvement Director and creates and implements its own Quality Assurance and Improvement Plan that meets their national accrediting bodies' standards.

The Department developed a Hospital System of Care Initiative to acknowledge and promote improvements in the quality, consistency and efficiency of the clinical care within the RPH system. This initiative created work teams dedicated to three primary priority areas: 1) Safety (Risk Reduction), which includes reducing suicide risk, increasing clinical patient engagement, and medication management; 2) Access (Bed Management), which includes utilization management, bed management, and clinical practice; and 3) Quality (Standards of Care), which includes readiness, best practices, and critical thinking. Next steps include developing standard and efficient data collection system to monitor safety, access, and quality; developing performance-specific training initiatives; and developing internal and external communication processes around performance. The Department has created three dashboards, a System of Care Dashboard, a Medical Director Dashboard, and a Pharmacy Dashboard. These Dashboards are currently focused on Quality Assurance; The Department is determining which of these tracked measures should be targeted for Quality/Performance Improvement.

The System of Care Dashboard includes these measures:

- ✓ State hospital utilization per 1,000 population*
- ✓ Number of state hospital readmissions for adults (30 days, 180 days)*
- ✓ Civil Patients Median Length of Stay
- ✓ Number of Civil Patients Over 30 Days and Forensic Over 180 Days
- ✓ Seclusion and Mechanical Restraint Episodes
- ✓ Employee Patient Contact Injuries
- ✓ Medication Errors
- * Reported to SAMHSA in the Block Grant

The Medical Director Dashboard includes these measures:

- ✓ Concurrent Antipsychotic Treatment
- ✓ New Generation Antipsychotic Use
- ✓ Mean New Generation Dose
- ✓ Multiple Antipsychotics at Discharge
- ✓ Multiple Antipsychotics at Discharge with Appropriate Justification

The Pharmacy Dashboard includes these measures:

- ✓ Median Verification Time of Pharmacy Orders
- ✓ Transactions from the ADMs
- ✓ STAT orders
- ✓ Direct Purchase Orders of Out of Stock and Non-Stocked Drugs

2. Improve services to children/adolescents.

As with adults with Serious Mental Illness (SMI), community mental health services for children and youth with Serious Emotional Disturbances (SED) are funded from federal (Medicaid and Block Grant), state, (GRF) and local sources. The nine Medicaid-covered services are reimbursed for Medicaid-covered children up through age 21. One variation between the adult and children/youth system is that the cost containment rules limiting the number of units covered can be waived upon request.

Measures for children and adolescents that are reported for the Block Grant and under consideration by The Department for the Performance Measures Dashboard include:

- ✓ Number of children with SED receiving public mental health services
- ✓ Number of episodes of physical restraint used in 1) ODMH-licensed children's residential facilities per bed per year; and 2) community mental health agencies (not sure if this is available)
- ✓ NOM: Educational enrollment (OH-BH)
- ✓ Youth Services Survey for Families (YSS-F):
  - Percent of parents reporting Access to Services
  - Percent of parents reporting Outcome from Services
  - Percent of parents reporting Participation in Treatment Planning
  - Percent of parents reporting General Satisfaction with Care
  - Percent of parents reporting Cultural Sensitivity of Providers
  - Percent of parents reporting increased School Attendance
  - Percent of parents reporting Social Connectedness
  - Percent of parents reporting decreased Criminal Justice Contacts
  - Percent of parents reporting Suspensions/Expulsions in past year
  - Percent of parents reporting Arrests in past year

3. Improve linkages to criminal justice system.

The interface between the behavioral health and criminal justice systems in Ohio is significant. The Department collaborates with law enforcement, courts, jails and prisons, consumers and family members to identify issues and seek solutions. The Department collaborates with its constituencies to develop policies, propose programs, assist with legislation and provide consultation, education and training. The programs and measures that have measures that may be included in the Performance Measure Dashboard include:

- The Community Linkage Program links severely mentally ill offenders (adults and youth) to community mental health services upon release from state correctional facilities.
  - ✓ Number and percent of offenders exiting the Ohio Department of Rehabilitation and Correction (ODRC)/ODYS with (SPMI)/SED who are linked with mental health services upon release

- The Department works with the Ohio Department of Rehabilitation and Correction, Office of Criminal Justice Services, Supreme Court of Ohio and other agencies to support reentry services in the areas of housing, benefits, treatment, forensic peer specialists, employment, trauma-informed care and medication provision for people leaving jails, prisons and regional psychiatric hospitals with a forensic status.
  - ✓ Number of offenders with SPMI who are linked with mental health services upon release

4. ***Number of offenders with SUD who are linked with addiction services upon release. Conduct research to address system priorities.***

   - ✓ SAMHSA NOMs: Satisfaction with Care, Access, Quality and Appropriateness, Participation in Treatment, and Cultural Competence for both Substance Use Disorders and Mental Illness

Consumer Outcomes

The Department requires each agency to collect consumer outcomes in order to improve its ability to provide quality mental health services (Ohio Administrative Code (OAC) 5122-28-04). According to state guidelines, consumer outcomes are indicators of health or well-being for an individual or family as measured by statements or observed characteristics of the consumer/family, not characteristics of the system. These measures provide an overall status measure with which to better understand the life situation of a consumer or his or her family. Since Ohio is a home rule state that emphasizes local leadership and flexibility, OhioMHAS' has goal of reducing regulatory and administrative burden on Boards and providers; as a result, agencies are not required to report mental health consumer outcomes to OhioMHAS. Agencies are directed to meet their accrediting body standards for measurement of outcomes and performance improvement for use within their agencies.

To support The Department's Block Grant reporting of the NOMs, the MHSIP and YSS-F surveys are used, and the OH–BH. The following outcome measures will be available for use in The Department's Performance Measurement Dashboard:

- NOMs for social functioning, social connectedness, and consumer perception of care are collected through randomized sampling of consumers with the MHSIP and YSS-F survey instruments. The MHSIP and YSS-F surveys are mailed annual to a randomized sample of mail surveys of adult consumers and parent/guardians of child and adolescent consumers. Consumers are given the option of responding to the surveys using paper forms and pre-paid business envelopes, a toll-free bridge line, or through SurveyMonkey.

- Client-level NOMs for employment status/school suspensions, living situation, and criminal justice involvement are collected through the OH-BH. The OH-BH is a data collection tool for reporting basic client-level programmatic data. Providers are directed to enter data at intake, yearly update and/or discharge. In addition to the SAMHSA

NOMs, OH–BH is a source for the following information: admission and referral data, demographics, special population designation, payer source, and some basic physical health data. The OH-BH is new for community mental health providers and submission of client-level records is voluntary until July 1, 2013 for mental health providers. The Department has awarded six grants to 13 community mental health providers in six Board areas to identify data collection and reporting problems, develop evaluation and quality improvement tools, determine record submission benchmarks, and facilitate Quality Improvement strategies through a Learning Community.

Projects for Assistance in Transition from Homelessness (PATH). The Department receives funds from the Center for Mental Health Services, to administer PATH. PATH services are for people with SMI, including those with co-occurring substance use disorders, who are experiencing homelessness or are at risk of becoming homeless. PATH services include community-based outreach, mental health, substance abuse, case management and other support services, as well as a limited set of housing services. Data available from PATH that are under consideration for the Performance Measures Dashboard include:

- ✓ Number of PATH clients who received services (Habitation and Rehabilitation, Mental Health Services, Alcohol and Drug Treatment Services, Case Management, Supportive Services in Residential Settings, Primary Health Services, Coordination, and Security Deposits)
- ✓ Percent of PATH clients who obtain housing by county
- ✓ Percent of PATH clients who receive income benefits as a result of PATH
- ✓ Percent of PATH clients who become employed as a result of PATH
- ✓ Percent of PATH clients who received medical insurance as a result of PATH
- ✓ Percent of PATH clients who received primary medical care as a result of PATH

5. Protect rights of people receiving services (grievances and Toll Free Bridge Line at OhioMHAS staffed by consumers)

Providers are required to give persons receiving services a copy of client rights at the time they begin services, and post these rights. Each provider and ADAMH Board has a clients' rights officer who is required to take complaints and grievances. At the state level, complaints are referred back to the local system whether it is an agency, board or hospital, or to the client rights' officer at each regional psychiatric hospital. Grievances of providers which have national accreditation are referred back to the provider, as required by regulations regarding "deeming" of providers with national accreditation as having met OhioMHAS certification standards. The OhioMHAS' clients' rights officer investigates grievance appeals from those agencies without deemed status, private psychiatric hospitals, residential facilities and regional psychiatric hospitals. OhioMHAS does not use any of the complaints or grievance to improve services, but do expect that the local system use them to improve theirs.

OhioMHAS maintains a The Toll Free Bridge Line staffed by a team of persons with lived experience with mental illness and/or a SUD who are supervised by OhioMHAS' Client Rights Officer. The Toll Free Bridge line is a dedicated phone line responding to the questions and concerns of mental health consumers, their families and friends. This line provides a central

contact point for consumers around the state, to contact the department to help them navigate the complexities of the mental health system. One essential element of recovery-oriented mental health systems is peer support, as such all calls on the Toll Free Bridge are answered by trained peers.

In FY 2015 the Toll Free Bridge Line received over 10,000 calls. These calls covered many topics that include but are not limited to, service inquiries, how to file complaints and grievances, treatment plan issues, peer support, and how to apply for benefits.

The Toll Free Bridge takes calls from 8am to 5pm Monday through Friday and has voice mail for those who call after hours. Each call received after hours is returned the next business day. For those who call who are in crisis and need immediate help, a live transfer is immediately made to a local crisis center.

6. Response to emergencies and critical incidents

Emergencies

For community mental health and addiction services, Ohio Revised Code requires that ADAMH Boards assure the availability of behavioral health crisis services in their areas. OhioMHAS monitors availability through its Office of Licensure and Certification. Additionally, OhioMHAS has rules and procedures in place to assure availability of crisis services.

Critical Incident Reporting

Community and Residential Reporting

In accordance with Ohio Administrative Code (OAC) 5122-26-13 and OAC 5122-30-16 Incident Notification and Risk Management Community (outpatient) and Residential programs must forward reportable incidents to the Department within 24 hours of their discovery, exclusive of weekends and holidays. SUD treatment programs and Adult Care Facilities have similar rules with slight variations. This reporting may be through the Web Enabled Incident Reporting System (WEIRS), fax, email, or hard copy. Upon receipt of any incidents not reported electronically, our office enters them into our Web Enabled Incident Reporting System (WEIRS) and then they are forwarded to the assigned surveyor.

Each incident is triaged in a timely fashion according to urgency, level of severity, negative outcomes, risk to health and safety, etc. In some cases the surveyor contacts the agency and requests a summary of their investigation results related to the incident. The surveyor may discuss the incident with agency leadership and may request a summary of the agency action plan. For more serious incidents, i.e. restraint related injuries with medical injuries, substantiated abuse, etc.; the Department may conduct an on-site investigation related to the incident which may result in disciplinary action, such as a corrective action plan, probationary status, etc. The number and type of reportable incidents per agency can be tracked through WEIRS and reports can be generated to determine if there has been an increase in type and/or number of incidents.

These Ohio Administrative Code rules also require all Community and Residential providers to submit a six month incident data report to the Department that identifies numbers and types of seclusion, restraint, and injuries to staff during the utilization of seclusion/restraint. The Office of Quality, Planning and Research extracts this data from WEIRS, analyzes the data, and formulates a report that can be utilized for benchmarking by the providers.

State-operated Regional Psychiatric Hospitals' (RPH) quality assurance is operated in accordance with OAC 5122-3-13(D). Regional psychiatric hospital (RPH) must document and report in accordance with the stated provisions of this rule and on the incident notification report/form (DMHAS-0120a) prescribed by the department. Upon completion of the form (DMHAS-0120a), all incidents must be entered into the department electronic incident database within the Patient Care System (PCS).

The employee who discovers or witnesses an incident, or to whom an incident is reported, is responsible for documenting the incident (DMHAS-0120a), cooperating in the investigation, and providing the investigating officer or staff with a complete statement or statements as needed.
A process is in place which documents the incident, states whom to alert depending on the type of incident, and states what kind of an investigation is required.

Each Regional Psychiatric Hospital has a Quality Assurance Director. The Quality Assurance Director, Chief Executive Officer of the Hospital and other top managers review the data and assimilate it into their decision making. Data includes how much seclusion, restraints, and assaults occur. Root cause analysis and intense analysis is used. Staff does training and safety. Material goes to Medical Director, since OhioMHAS currently has a vacancy for the system wide Quality Assurance Director position. The current focus is on seclusion and restraint.

Environmental Factors and Plan

11. Trauma

Narrative Question:

Trauma [75] is a widespread, harmful and costly public health problem. It occurs as a result of violence, abuse, neglect, loss, disaster, war and other emotionally harmful experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed, that is, based on the knowledge and understanding of trauma and its far-reaching implications.

The effects of traumatic events place a heavy burden on individuals, families and communities and create challenges for public institutions and service systems [76]. Although many people who experience a traumatic event will go on with their lives without lasting negative effects, others will have more difficulty and experience traumatic stress reactions. Emerging research has documented the relationships among exposure to traumatic events, impaired neurodevelopmental and immune systems responses, and subsequent health risk behaviors resulting in chronic physical or behavioral health disorders. Research has also indicated that with appropriate supports and intervention, people can overcome traumatic experiences. However, most people go without these services and supports.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions.

In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often themselves re-traumatizing, making it necessary to rethink doing “business as usual.” These public institutions and service settings are increasingly adopting a trauma-informed approach guided by key principles of safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues, and incorporation of trauma-specific screening, assessment, treatment, and recovery practices.

To 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 approach consistent with “SAMHSA’s Concept of Trauma and Guidance for a Trauma-Informed Approach”. [77] 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 supportive and avoid traumatizing the individuals again. It is suggested that the states uses SAMHSA’s guidance for implementing the trauma-informed approach discussed in the Concept of Trauma [78] paper.

Please consider the following items as a guide when preparing the description of the state’s system:

1. Does the state have policies directing providers to screen clients for a personal history of trauma and to connect individuals to trauma-focused therapy?
2. Describe the state’s policies that promote the provision of trauma-informed care.
3. How does the state promote the use of evidence-based trauma-specific interventions across the lifespan?
4. Does the state provide trainings to increase capacity of providers to deliver trauma-specific interventions?

Please indicate areas of technical assistance needed related to this section.

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75 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*

76 http://www.samhsa.gov/trauma-violence/types

77 http://store.samhsa.gov/product/SMA14-4884

78 *Ibid*

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.11 Trauma

OhioMHAS supports the concept that trauma informed assessment, interventions and treatment be available to individuals in the behavioral health system across the lifespan. 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 (Joint Commission, CARF, COA, etc.). State rules and requirements are established with these national standards as guides, but do not specifically require that the providers screen clients for trauma and refer to trauma-focused therapy.

OhioMHAS encourages that providers offer a range of treatment options and that trauma-focused therapy is an option for persons with a trauma history. The Department provides state funds to Boards that are responsible for the services in their respective region/counties. Many providers are specifically trained in trauma informed assessment and treatment, but not all areas of Ohio offer the same access to services or to trained providers. Through our work in the past year as a state department and in support of the six regional collaboratives many more organizations are focusing on trauma assessments and treatment options for their clients/patients.

We are interested in technical assistance from SAMHSA to achieve more consistent practices in assessment and referral to trauma-focused therapy throughout the state. In particular, how to assess the need of persons throughout the lifespan, then identify specific practices to meet that need with current resources.

Trauma Informed Care Planning Framework

OhioMHAS' Trauma Informed Care Planning Framework is built on collaboration with the Ohio Department of Developmental Disabilities (DODD) for persons in the mental health, addiction and developmental disabilities systems.

Our goals for the coming year include;

- Offer access to electronic educational tools for clinical staff, administrators, peer support staff and others. Initially, we plan to offer modules that break down the approached contained in TIP 57 and eventually other educational materials will be developed and shared.
- Continued focus on trauma training for direct care staff in the DODD Centers and at the Regional Psychiatric Hospitals (RPHs) and OhioMHAS and DODD Central office staff.
- Implement Culture of Safety approach within the RPHs, with clinical staff (multi-disciplinary) leadership, patient involvement and evaluation based on data.
- Determine a process to increase the availability of trauma-specific therapies for clinical staff. Ultimately, increase the numbers of persons who can provide trauma treatment.
- Identify how peers and family members are currently involved in Trauma Informed Care (TIC) initiatives and support continued inclusion and collaboration with the statewide initiative (MHAS and DODD)

- Monitor the number of organizations trained in the TIC Train-the-Trainer model, and gather feedback from community partners. This will inform next steps.

Accomplishments to Date

- Second Trauma Informed Care Summit, June 17, 2015 highlighting programs in Ohio that are using TIC approaches; Initial TIC Summit held in June, 2014
- Six Regional Collaboratives are meeting with support from the state departments. Goal is to develop local expertise, highlight strengths and gaps in community systems, to increase collaboration and to offer training by local experts
- On-site Trauma 101 training of administrative, clinical and support staff at all RPHs and DODD Centers
- Establishment of staff and patient safety initiative in RPHs – Culture of Safety
- Launch of TIC research study in collaboration with Ohio State University College of Social Work
- TIC Internal Team – comprised of key OhioMHAS and DODD staff to provide direction to the statewide project
- TIC Project Coordinator position established in 2014
- Statewide Advisory Committee made up of stakeholder and partner organizations that offer potential to collaborate with other initiatives, resources and assist with consistency.
- Partnership with National Center for Trauma-Informed Care (NCTIC) for training events, consultation and assistance in developing and training on a Train the Trainer model.
- Utilizing the train-the-trainer model, provided *Trauma-Informed Approach: Key Assumptions and Principles* training to 170 persons statewide throughout the six Regional Collaboratives.

12. Criminal and Juvenile Justice

Narrative Question:

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one third meet criteria for having co-occurring substance abuse and mental health problems. Successful diversion from or re-entering the community from detention, jails, and prisons is often dependent on engaging in appropriate substance use and/or mental health treatment. Some states have implemented such efforts as mental health, veteran and drug courts, crisis intervention training and re-entry programs to help reduce arrests, imprisonment and recidivism.[79]

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 use 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.[80] [81] 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 use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[82]

Expansions in insurance coverage will mean that many individuals in jails and prisons, who generally have not had health coverage in the past, will now be able to access behavioral health services. Addressing the behavioral health needs of these individuals can reduce recidivism, improve public safety, reduce criminal justice expenditures, and improve coordination of care for a population that disproportionately experiences costly chronic physical and behavioral health conditions. Addressing these needs can also reduce health care system utilization and improve broader health outcomes. Achieving these goals will require new efforts in enrollment, workforce development, screening for risks and needs, and implementing appropriate treatment and recovery services. This will also involve coordination across Medicaid, criminal and juvenile justice systems, SMHAs, and SSAs.

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. 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 a 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 consider the following items as a guide when preparing the description of the state's system:

1. Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?
2. Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?
3. Do the SMHA and SSA coordinate 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. Are cross-trainings provided 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?

Please indicate areas of technical assistance needed related to this section.

[79] http://csgjusticecenter.org/mental-health/

[80] The American Prospect: In the history of American mental hospitals and prisons, *The Rehabilitation of the Asylum*. David Rottman,2000.

[81] 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.

[82] 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

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.13 Criminal and Juvenile Justice

1. ***Are individuals involved in, or at risk of involvement in, the criminal and juvenile justice system enrolled in Medicaid as a part of coverage expansions?***
   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. In addition, ODRC has started a Medicaid Pre-Release Enrollment Program for all eligible inmates which will include persons with SUD only. They are doing this in three Ohio prisons and plan to expand to 11 prisons by the end of calendar year 2015. ODRC is enrolling all eligible inmates in Medicaid including SUD offenders, and is eventually expected to do all Medicaid applications for offenders being released from prison.

2. ***Are screening and services provided prior to adjudication and/or sentencing for individuals with mental and/or substance use disorders?***

   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. OhioMHAS awarded 30 grants to counties that targeted individuals with mental health and/or addictions involved in the criminal justice system. These projects were able to reduce state and local correction costs and reduce recidivism while promoting public safety and behavioral health treatment.

3. ***Do the SMHA and SSA coordinate 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?***
   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 10 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. ***Are cross-trainings provided 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?***

OhioMHAS provides Crisis Intervention trainings, regional forensic trainings, an annual forensic conference, as well as training on specific treatment models working with SMI individuals including those with both SMI and SUD.

Please indicate areas of technical assistance needed related to this section.

No technical assistance is requested at this time.

13. State Parity Efforts

Narrative Question:

MHPAEA generally requires group health plans and health insurance issuers to ensure that financial requirements and treatment limitations applied to M/SUD benefits are no more restrictive than the requirements or limitations applied to medical/surgical benefits. The legislation applies to both private and public sector employer plans that have more than 50 employees, including both self-insured and fully insured arrangements. MHPAEA also applies to health insurance issuers that sell coverage to employers with more than 50 employees. The Affordable Care Act extends these requirements to issuers selling individual market coverage. Small group and individual issuers participating in the Marketplaces (as well as most small group and individual issuers outside the Marketplaces) are required to offer EHBs, which are required by statute to include services for M/SUDs and behavioral health treatment - and to comply with MHPAEA. Guidance was released for states in January 2013.[83]

MHPAEA requirements also apply to Medicaid managed care, alternative benefit plans, and CHIP. ASPE estimates that more than 60 million Americans will benefit from new or expanded mental health and substance abuse coverage under parity requirements. However, public awareness about MHPAEA has been limited. Recent research suggests that the public does not fully understand how behavioral health benefits function, what treatments and services are covered, and how MHPAEA affects their coverage.[84]

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. SMHAs and SSAs should collaborate with their state's Medicaid authority in ensuring parity within Medicaid programs.

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.

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?
2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?
3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Please indicate areas of technical assistance needed related to this section.

[83] http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SHO-13-001.pdf

[84] Rosenbach, M., Lake, T., Williams, S., Buck, S. (2009). Implementation of Mental Health Parity: Lessons from California. Psychiatric Services. 60(12) 1589-1594

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.13 State Parity Efforts

Please consider the following items as a guide when preparing the description of the state's system:

1. What fiscal resources are used to develop communication plans to educate and raise awareness about parity?

None at this time.

2. Does the state coordinate across public and private sector entities to increase consumer awareness and understanding about benefits of the law (e.g., impacts on covered benefits, cost sharing, etc.)?

Not at this time.

3. Does the state coordinate across public and private sector entities to increase awareness and understanding among health plans and health insurance issuers of the requirements of MHPAEA and related state parity laws and to provide technical assistance as needed?

Not at this time.

Please indicate areas of technical assistance needed related to this section.

14. Medication Assisted Treatment

Narrative Question:

There is a voluminous literature on the efficacy of FDA-approved medications for the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for medication-assisted treatment of these disorders is described in SAMHSA TIPs 40[85], 43[86], 45[87], and 49[88]. SAMHSA strongly encourages the states to require that treatment facilities providing clinical care to those with substance use disorders be required to either have the capacity and staff expertise to use MAT or have collaborative relationships with other providers such that these MATs can be accessed as clinically indicated for patient need. Individuals with substance use disorders who have a disorder for which there is an FDA-approved medication treatment should have access to those treatments based upon each individual patient's needs.

SAMHSA strongly encourages states to require the use of FDA-approved MATs for substance use disorders where clinically indicated (opioid use disorders with evidence of physical dependence, alcohol use disorders, tobacco use disorders) and particularly in cases of relapse with these disorders. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please consider the following items as a guide when preparing the description of the state's system:

1. How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?
2. What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?
3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

Please indicate areas of technical assistance needed related to this section.

[85] http://store.samhsa.gov/product/TIP-40-Clinical-Guidelines-for-the-Use-of-Buprenorphine-in-the-Treatment-of-Opioid-Addiction/SMA07-3939

[86] http://store.samhsa.gov/product/TIP-43-Medication-Assisted-Treatment-for-Opioid-Addiction-in-Opioid-Treatment-Programs/SMA12-4214

[87] http://store.samhsa.gov/product/TIP-45-Detoxification-and-Substance-Abuse-Treatment/SMA13-4131

[88] http://store.samhsa.gov/product/TIP-49-Incorporating-Alcohol-Pharmacotherapies-Into-Medical-Practice/SMA13-4380

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.14 Medication Assisted Treatment

1. ***How will or can states use their dollars to develop communication plans to educate and raise awareness within substance abuse treatment programs and the public regarding medication-assisted treatment for substance use disorders?***

OhioMHAS has had recent discussions with the State Medical Board and State Pharmacy Board regarding the impact of their recent rule changes on substance abuse treatment programs, including but not limited to, Opiate Treatment Programs (OTPs). These Boards have agreed to partner with the Department to issue a joint guidance on recent Ohio regulatory changes as well as the scheduling of Tramadol and the use of telemedicine.

The Governor's Cabinet Opiate Action Team (GCOAT) has released a "Health Resource Toolkit for Addressing Opioid Abuse." The toolkit provides guidance on everything from building a local coalition to prevent overdose deaths to promoting responsible prescribing practices; it addresses expanding access to Medication-Assisted Treatment and embracing specialized docket programs to close the revolving door of addiction and crime. This resource includes technical support contacts at the state level, guidance on accessing relevant data and trend information as well as a checklist for building an effective local response.

2. ***What steps and processes can be taken to ensure a broad and strategic outreach is made to the appropriate and relevant audiences that need access to medication-assisted treatment for substance use disorders, particularly pregnant women?***

In 2013, OhioMHAS received a $2.1 million investment from the Health Transformation Innovation Fund which is administered by the Office of Health Transformation to fund the Maternal Opiate Medical Support (M.O.M.S.) project. The purpose of M.O.M.S. is to "improve the health outcomes and reduce costs associated with extended hospital stays by neutralizing the impact of Neonatal Abstinence Syndrome (NAS). NAS is a complex disorder with a myriad of possible symptoms found in newborns and caused by exposure to addictive illegal or prescription drugs. The M.O.M.S. goals are threefold:

1) Develop an integrated maternal care practice model with timely access to appropriate mental health and addiction services that extend postpartum, including intensive home-based or residential treatment;
2) Identify best practices for obstetrical services relating to MAT, before, during and after delivery and develop a toolkit to support clinical practice; and
3) Conduct a pilot and evaluation with promising practices at 2-3 sites that will integrate the model into standard practices.

The Ohio Colleges of Medicine Government Resource Center (GRC) and the Health Services Advisory Group (HSAG) will coordinate and manage the development and implementation of MOMS model of care toolkits, quality improvement efforts, and evaluation. The toolkit will be developed with clinical leaders in obstetrics and maternal health, behavioral health, and opiate addiction recovery from a panel of clinical advisors. Performance measures related to early identification and engagement, use of clinical best practices, and treatment retention will be collected throughout the implementation process and used to guide and promote improvement activities in monthly action period calls with the pilot sites. An evaluation will be conducted to identify promising treatment practices with the ultimate goal of reducing Neonatal Intensive Care Units (NICUs) stays by 30%.

3. What steps will the state take to assure that evidence-based treatments related to the use of FDA-approved medications for treatment of substance use disorders are used appropriately (appropriate use of medication for the treatment of a substance use disorder, combining psychosocial treatments with medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, advocacy with state payers)?

OhioMHAS is partnering with the Ohio Supreme Court, SAMHSA and the National Association of Drug Court Professionals (NADCP) on a Medication Assisted Treatment (MAT) Policy Forum. The intent of the meeting is to identify best practice uses of MAT for opiate addicted offenders involved in drug courts and other aspects of Ohio criminal justice system.

Ohio's overdose death rate continues to be too high, with approximately 1,272 deaths due to opioid overdose in 2012. One way that OhioMHAS will have an impact on reducing overdose death is to make naloxone, a drug that immediately reverses the effect of an opiate overdose, more available to first responders, family, and friends of individuals who are fighting addiction. The demand for naloxone has increased dramatically as a result of House Bill 170 from last General Assembly which expanded the use of naloxone, and the future potential of House Bill 4 will further increase demand. The price has also increased, as naloxone is currently on the national drug shortage list. By partnering with other stakeholders, such as Ohio Department of Health (Project DAWN), county/city health districts, the Ohio Board of Pharmacy, the Ohio Attorney General, and law enforcement, these funds will be used to enhance access across the state, reduce preventable deaths, and encourage people to enter treatment.

The Addiction Treatment Project (ATP) was legislatively established in the SFY14-15 state budget and $5 million was appropriated. Specialty-docket drug courts in Allen, Crawford, Franklin, Hardin, Hocking, Mercer and Morrow counties have enrolled 366 ATP participants between October 2013 and June 2015. The program will be expanded in SFY 2016-2017. Participating offenders receive treatment from a community addiction services provider certified by OhioMHAS and Medication Assisted Treatment (MAT) either buprenorphine or long acting injectable naltrexone. According to preliminary findings from project evaluators at Case Western Reserve University, 80 percent of the participants are between the ages of 18 to 34, almost 95 percent are white and the gender split is about even. Statistics are emerging that at discharge, the offenders who receive MAT, especially long acting injectable naltrexone, report being drug-free more often than those who did not receive MAT. At the six-month follow-up point, no Vivitrol users reported using heroin in the previous 30 days.

15. Crisis Services

Narrative Question:

In the on-going development of efforts to build an evidence-based robust system of care for persons diagnosed with SMI, SED and addictive disorders and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises.

SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, Practice Guidelines: Core Elements for Responding to Mental Health Crises[89] ,

> "Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. The array of services and supports being used to address crisis response include the following:

Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Please indicate areas of technical assistance needed related to this section.

[89]Practice Guidelines: Core Elements for Responding to Mental Health Crises. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427

Please use the box below to indicate areas of technical assistance needed related to this section:

Ohio could use technical assistance from SAMHSA with developing and implementing strategies to improve and expand peer run crisis respite programs, suicide prevention screening, family engagement, and crisis respite. In addition, Ohio could use technical assistance to develop training and support for housing providers that would teach direct service staff how to de-escalate situations themselves instead of reaching out to law enforcement. This would allow individuals to remain in the community instead of being sent to a hospital. Ohio could also use technical assistance from SAMHSA in brainstorming new approaches to crisis services that would improve our continuum of care. Finally, Ohio could use technical assistance to develop state and local partnerships that would provide continuity for individuals leaving crisis stays transitioning into community.

Footnotes:

5.16 Crisis Services

Ohio's crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. Ohio will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach on Ohio will provide the infrastructure to improve care coordination and outcomes, manage costs and better invest resources. Ohio will use the following array of services and supports to address crisis response including but not limited to:
Crisis Prevention and Early Intervention:

- Wellness Recovery Action Plan (WRAP) Crisis Planning
- Psychiatric Advance Directives
- Family Engagement
- Safety Planning
- Peer-Operated Warm Lines
- Peer-Run Crisis Respite Programs
- Suicide Prevention

Crisis Intervention/Stabilization:

- Assessment/Triage (Living Room Model)
- Open Dialogue
- Crisis Residential/Respite
- Crisis Intervention Team/ Law Enforcement
- Peer delivered services
- Mobile Crisis Outreach
- Collaboration with Hospital Emergency Departments and Urgent Care Systems

Post Crisis Intervention/Support:

- WRAP Post-Crisis
- Peer Support/Peer Bridgers
- Follow-Up Outreach and Support
- Family-to-Family engagement
- Connection to care coordination and follow-up clinical care for individuals in crisis
- Follow-up crisis engagement with families and involved community members

Technical Assistance
Ohio could use technical assistance from SAMHSA with developing and implementing strategies to improve and expand peer run crisis respite programs, suicide prevention screening, family engagement, and crisis respite. In addition, Ohio could use technical assistance to develop training and support for housing providers that would teach direct service staff how to de-escalate situations themselves instead of reaching out to law enforcement. This would allow individuals to remain in the community instead of being sent to a hospital. Ohio could also use technical assistance from SAMHSA in brainstorming new approaches to crisis services that

would improve our continuum of care. Finally, Ohio could use technical assistance to develop state and local partnerships that would provide continuity for individuals leaving crisis stays transitioning into community.

16. Recovery

Narrative Question:

The implementation of recovery-based approaches is imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.

Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of health (access to quality health and behavioral health treatment), home (housing with needed supports), purpose (education, employment, and other pursuits), and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual's mental or substance use disorder. This includes the use of psychotropic or other medications for mental illnesses or addictions to assist in the diminishing or elimination of symptoms as needed. Further, the use of psychiatric advance directives is encouraged to provide an individual the opportunity to have an active role in their own treatment even in times when the severity of their symptoms may impair cognition significantly. Resolution of symptoms through acute care treatment contributes to the stability necessary for individuals to pursue their ongoing recovery and to make use of SAMHSA encouraged recovery resources.

SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:

Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.

In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders.

States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Drop-in centers
- Peer-delivered motivational interviewing
- Peer specialist/Promotoras
- Clubhouses
- Self-directed care
- Supportive housing models
- Recovery community centers
- WRAP
- Evidenced-based supported
- Family navigators/parent support partners/providers
- Peer health navigators
- Peer wellness coaching
- Recovery coaching
- Shared decision making
- Telephone recovery checkups
- Warm lines
- Whole Health Action Management (WHAM)
- Mutual aid groups for individuals with MH/SA Disorders or CODs
- Peer-run respite services
- Person-centered planning
- Self-care and wellness approaches
- Peer-run crisis diversion services
- Wellness-based community campaign

employment

SAMHSA encourages states to take proactive steps to implement recovery support services, and is seeking input from states to address this position. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, 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.

Recovery is based on the involvement of consumers/peers and their family members. States should 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 engage individuals and families in developing, implementing and monitoring the state mental health and substance abuse treatment system.

Please consider the following items as a guideline when preparing the description of the state's system:

1. Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?
2. How are treatment and recovery support services coordinated for any individual served by block grant funds?
3. 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?
4. 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? Does the state have an accreditation program, certification program, or standards for peer-run services?
5. Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?
6. Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).
7. Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?
8. Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.
9. Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.
10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?
11. Describe how the state is supporting the employment and educational needs of individuals served.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.16 Recovery

1. ***Does the state have a plan that includes: the definition of recovery and recovery values, evidence of hiring people in recovery leadership roles, strategies to use person-centered planning and self-direction and participant-directed care, variety of recovery services and supports (i.e., peer support, recovery support coaching, center services, supports for self-directed care, peer navigators, consumer/family education, etc.)?***

Yes, OhioMHAS is developing a Strategic Plan which incorporates recovery values, and will incorporate material from this plan. OhioMHAS plans to issue a request for proposal to fund training for 500 new peer support staff. The state legislature appropriated funds for additional community housing. Additionally, OhioMHAS is participating in Governor Kasich's efforts to increase employment through activities with a Supported Employment grant and research activities on consumer employment.

- OhioMHAS has hired people in leadership positions who are self-identified consumers, and has made it a preferred characteristic in some job descriptions leading supported employment, housing and peer services programming.
- Person-centered planning is included in service standards, and trainings. OhioMHAS is funding training for up to 500 new peer supporters, and will also support continuing education for peer support staff and training for supervisors.
- OhioMHAS in partnership with the Ohio Office of Health Transformation, and Ohio Department of Medicaid is incorporating peer support into behavioral health Medicaid redesign. Persons with lived experience on OhioMHAS staff and Planning Council are a part of that work. OhioMHAS certified 40 providers of consumer operated services and peer support.

2. ***How are treatment and recovery support services coordinated for any individual served by block grant funds?***

   Regardless of funding sources, Ohio's rules require that an individual service plan be developed jointly by a treatment staff member and a consumer.

3. ***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?***

   Ohio's peer training program addresses all of these populations.

4. ***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? Does the state have an accreditation program, certification program, or standards for peer-run services?***

   Yes. OhioMHAS provides training for clinical staff and peers.

OhioMHAS certifies consumer operated services organizations which are required to have a Board which is 51% or more persons with lived experience.

The state offers Supervisory Trainings for Providers who employ Peer Supporters. There is no accreditation program. Currently, the state is working on a certification for Peer Supporter.

5. ***Does the state conduct empirical research on recovery supports/services identification and dissemination of best practices in recovery supports/services or other innovative and exemplary activities that support the implementation of recovery-oriented approaches, and services within the state's behavioral health system?***
   OhioMHAS Office of Quality, Planning and Research has both conducted and funded university staff to conduct research activities on peer support.

6. ***Describe how individuals in recovery and family members are involved in the planning, delivery, and evaluation of behavioral health services (e.g., meetings to address concerns of individuals and families, opportunities for individuals and families to be proactive in treatment and recovery planning).***
   - Ohio's Behavioral Health Medicaid Redesign Committee includes consumers and family members from Planning Council, NAMI- Ohio, and Ohio Empowerment Coalition (statewide consumer organization). This committee is led by the Ohio Office of Health Transformation with collaboration from Ohio Department of Medicaid, OhioMHAS and other state agencies in the state's Medicaid Cabinet.

   - OhioMHAS includes consumers and family members on grant advisory groups to ENGAGE (Children's System of Care Grant—focused on transition age youth), Supported Employment Grant, and other grants and initiatives.

   - OhioMHAS requires that the governing boards of the ADAMH Boards includes a consumer and a family member, and monitors these applications.

   - Ohio MHAS requires Boards to conduct a needs assessment as a part of their Community Plans. This needs assessment includes consumer and family input---- typically from a survey, focus group or advisory group. Consumer and Family Partnership Team provides stipends and travel expenses for consumers and family members who serve on Planning Council and other statewide committees for service development.

- 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.

- Individuals with lived experience 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 members evaluate service delivery. OhioMHAS prevention office provides many opportunities for recipients of prevention services to evaluate prevention, treatment and recovery support services

7. ***Does the state support, strengthen, and expand recovery organizations, family peer advocacy, self-help programs, support networks, and recovery-oriented services?***
   Yes. OhioMHAS provides some funding to Ohio Empowerment Coalition and NAMI-Ohio which provide consumer and/or family education. Ohio Empowerment Coalition provided consumer leadership to the development of peer support. OhioMHAS also certifies consumer-operated services which are required to have at least 51% of their board members who are consumers.

8. ***Provide an update of how you are tracking or measuring the impact of your consumer outreach activities.***
   OhioMHAS requires reports from Ohio Empowerment Coalition and NAMI-Ohio which track these activities.

9. ***Describe efforts to promote the wellness of individuals served including tobacco cessation, obesity, and other co-morbid health conditions.***
   Health Homes for SPMI may include these services. The benefit configuration for this service and Community Psychiatric Supportive Treatment is being reconfigured.

10. Does the state have a plan, or is it developing a plan, to address the housing needs of persons served so that they are not served in settings more restrictive than necessary and are incorporated into a supportive community?

OhioMHAS' Block Grant Plan, as well as OhioMHAS Strategic Plan both address housing. Please also see information in the next section 5.17 Community Living and the Implementation of Olmstead. 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 and state psychiatric hospitals to less restrictive community integrated housing. Additionally,

OhioMHAS uses capital funds and partners with housing funders and Boards to fund permanent supportive housing, as well as Out of Home Residential Services. This work is being expanded to Recovery Housing (sober living).

11. Describe how the state is supporting the employment and educational needs of individuals served.

Please see Supported Employment in Section 1.6.1 for Adults with SMI, and Access for Recovery in Section 1.63 Substance Use Disorders Treatment. OhioMHAS has a Supported Employment Grant from SAMHSA, which funds two additional programs and infrastructure development. Additionally, OhioMHAS funds Case Western Reserve University to provide technical assistance and training to providers and Boards to operate Supported Employment programs. OhioMHAS is also partnering with Ohio Department of Job and Family Services to better address the employment needs of persons with mental health and addiction issues.

Environmental Factors and Plan

17. Community Living and the Implementation of Olmstead

Narrative Question:

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in Olmstead v. L.C., 527 U.S. 581 (1999), provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated arrangement appropriate and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to Section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office of Civil Rights (OCR) cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other residences that have institutional characteristics to house persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

It is requested that the state submit their Olmstead Plan as a part of this application, or address the following when describing community living and implementation of Olmstead:

1. Describe the state's Olmstead plan including housing services provided, home and community based services provided through Medicaid, peer support services, and employment services.
2. How are individuals transitioned from hospital to community settings?
3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?
4. Describe any litigation or settlement agreement with DOJ regarding community integration for children with SED or adults with SMI in which the state is involved?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.18 Community Living and Implementation of Olmstead

Ohio's Olmstead Plan was developed as a partnership by Ohio Departments of Medicaid, Aging, Developmental Disabilities, Mental Health, Alcohol and Drug Addiction Services, Health, Rehabilitation Services, Education and Insurance. State agencies have collaborated to rebalance the state Medicaid system to better support home and community services. A Ohio Olmstead Task Force http://www.ohioolmstead.org/ includes representatives of multiple disability groups, and meets at the state Opportunities for Ohioans with Disabilities. OhioMHAS promotes recovery supports which enable consumers to live in the least restrictive environment.

Ohio does not have any litigation or settlement with DOJ regarding community integration for which the state is involved.

Individuals are transitioned to the community from community hospitals and regional psychiatric hospitals through care coordination between hospital social workers and CPST (Community Psychiatric Supportive Treatment) staff. For a few persons who have long stays exceeding six months in regional psychiatric hospitals, there are state funds in an "access program" to assist with a transition plan to the community.

OhioMHAS partners with Ohio Department of Medicaid in a "HOME Choice" program which provides Medicaid recipients with additional resources and support to move persons with behavioral health diagnoses out of nursing facilities. By assisting individuals with additional supports, it helps to enforce the Olmstead decision, but also to reduce the cost to the State of Ohio for service delivery as well as other systems who serve individuals with behavioral health diagnoses. This program provides recovery resources for individuals where "gaps" in their service plans were identified that inhibited their departure from an institutional setting.

Ohio was recently awarded a HUD 811 grant in which the target population for these community based permanent housing units are those individuals transitioning from nursing homes, regional psychiatric hospitals and community hospitals. Ohio is anticipating 650 new units of permanent housing available to individuals that are dispersed throughout local communities.

Ohio's ADAMH Boards and local consumer operated services promote social inclusion in local communities. Ohio ADAMH Boards provide funding for housing subsidies integrated within the community as a bridge subsidy until section 8 vouchers become available. The Department uses capital funding to partner with local systems and other state funding sources to develop housing for individuals within the system. The funding is primarily targeted for permanent supportive housing that provides choice and access to community supports. Additionally, Planning Council members have participated in a film festival, Reel Abilities to promote social inclusion of persons with a variety of disabilities in cities across the country. This year, some Cincinnati participants were able to include a couple films on persons with mental illness. http://www.cincyra.org/

18. Children and Adolescents Behavioral Health Services

Narrative Question:

MHBG funds are intended to support programs and activities for children with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious mental disorder that contributes to substantial impairment in their functioning at home, at school, or in the community.[90] Most mental health disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24.[91] For youth between the ages of 10 and 24, suicide is the third leading cause of death.[92]

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21.[93] Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

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 more than 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.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or substance use disorders and co-occurring disorders and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child's, youth's and young adult's functioning in their home, school, and community. The system of care approach provides individualized services, is family driven and youth guided, and builds on the strengths of the child, youth or young adult and their family and promotes recovery and resilience. Services are delivered in the least restrictive environment possible, and using evidence-based practices while providing effective cross-system collaboration, including integrated management of service delivery and costs.[94]

According to data from the National Evaluation of the Children's Mental Health Initiative (2011), systems of care[95]:

- reach many children and youth typically underserved by the mental health system;
- improve emotional and behavioral outcomes for children and youth;
- enhance family outcomes, such as decreased caregiver stress;
- decrease suicidal ideation and gestures;
- expand the availability of effective supports and services; and
- save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious 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 consider the following items as a guide when preparing the description of the state's system:

1. How will the state establish and monitor a system of care approach to support the recovery and resilience of children and youth with serious mental and substance use disorders?
2. What guidelines have and/or will the state establish for individualized care planning for children/youth with serious 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?
6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?
7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.

Please indicate areas of technical assistance needed related to this section.

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[90] Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children - United States, 2005-2011. MMWR 62(2).

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Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.18 Children and Adolescents 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 System of Care (SOC) communities are required to use TEO. Furthermore, ENGAGE is working with 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 this outcome database in order to track effectiveness of local SOC implementation.

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 will support the expansion of system of care throughout Ohio with communities adopting Wraparound or the Transition to Independence Process (TIP) 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.

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 Ohio Family and Children First Cabinet Council. Ohio's ENGAGE SOC implementation grant has a management team with membership represented by Mental Health & Addiction Services, Job & Family Services, Health, Developmental Disabilities, Youth Correctional Services, and most recently, Medicaid. . The management team works in partnership to address the behavioral health needs of youth and young transitional adults in these systems.

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?

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.

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, the Office of Quality, Research and Planning 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).

6. Has the state identified a liaison for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse treatment and recovery support services? If so, what is that position (with contact information) and has it been communicated to the state's lead agency of education?

Safe Schools, Healthy Students (SS/HS)
The goal of the Ohio Safe Schools/Healthy Students (SS/HS) state and local partnership is to build statewide and local capacity to develop integrated, comprehensive, data-driven strategic plans to prevent, delay the onset or mitigate the seriousness of behavioral health problems. The project is a partnership between the Ohio Departments of Mental Health and Addiction Services and Education and other state departments.

A key aspect in the success of this goal is engaging youth, families and schools as agents of community change. Three local educational systems are participating in this grant, and they will provide documented effective community-based models for other communities that wish to adopt comprehensive, integrated plans to provide effective behavioral health services and prevent youth violence in schools and communities. The focus of selected activities will be to promote healthy social/emotional development and to build safe and healthy family, school and community environments using the findings of the 2009 Institute of Medicine Report (IOM).

Positive Behaviors Interventions and Support (PBIS)
On January 15, 2013, the Ohio State Board of Education approved a policy on Positive Behavior Interventions and Support (PBIS) and Restraint and Seclusion predicated upon the OAC 3301-35-15. The Ohio Department of Education (ODE) is building a statewide PBIS rollout focusing on the building of positive interventions and culture and to prevent the need for the use of restraint or the use of seclusion. The use of a non-aversive effective behavioral system such as Positive Behavioral Intervention and Supports (PBIS) will be used to create a learning environment that promotes the use of evidence-based behavioral interventions, thus enhancing academic and social behavioral outcomes for all students. Restraint or seclusion will not be used, except when there is an immediate risk of physical harm to the student or others, and will occur only in a manner that protects the safety of all children and adults at school. This ODE policy applies to all Ohio school districts and is in effect.

PBIS will be an important part of the Safe Schools/Healthy Students partnership, and OhioMHAS supports this initiative as a key piece of service system infrastructure to prevent and reduce behavioral health problems in school-age youth.

7. What age is considered to be the cut-off in the state for receiving behavioral health services in the child/adolescent system? Describe the process for transitioning children/adolescents receiving services to the adult behavioral health system, including transition plans in place for youth in foster care.
The target population for the System of Care grant is youth and young adults in transition ages 14 to 21 years. The State and some individual counties have defined transition aged youth as up to 24 years. The State serves this older population with other state funds and programs, including the "Strong Families, Safe Communities" state grant. This expanded age range recognizes that

lived experiences, especially with a traumatic impact, and/or a developmental disability, require attention to individual behavioral health needs. Through the coordinated care approach of the Wraparound model, transition to independence is built in, and facilitated by the Wraparound team. This results in a coordinated transition from the youth system into the adult system.

19. Pregnant Women and Women with Dependent Children

Narrative Question:

Substance-abusing pregnant women have always been the number one priority population in the SAMHSA block grant (Title XIX, Part B, Subpart II, Sec.1922 (c)). A formula based on the FY 1993 and FY 1994 block grants was established to increase the availability of treatment services designed for pregnant women and women with dependent children. The purpose of establishing a "set-aside" was to ensure the availability of comprehensive, substance use disorder treatment, and prevention and recovery support services for pregnant and postpartum women and their dependent children. This population continues to be a priority, given the importance of prenatal care and substance abuse treatment for pregnant, substance using women, and the importance of early development in children. For families involved in the child welfare system, successful participation in treatment for substance use disorders is the best predictor for children remaining with their mothers. Women with dependent children are also named as a priority for specialized treatment (as opposed to treatment as usual) in the SABG regulations. MOE provisions require that the state expend no less than an amount equal to that spent by the state in a base fiscal year for treatment services designed for pregnant women and women with dependent children.

For guidance on components of quality substance abuse treatment services for women, States and Territories can refer to the following documents, which can be accessed through the SAMHSA website at http://www.samhsa.gov/women-children-families: *Treatment Improvement Protocol (TIP) 51, Substance Abuse Treatment; Addressing the Specific Needs of Women; Guidance to States; Treatment Standards for Women with Substance Use Disorders; Family-Centered Treatment for Women with Substance Abuse Disorders: History, Key Elements and Challenges.*

Please consider the following items as a guide when preparing the description of the state's system:

1. The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.
2. Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.
3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.
4. Discuss who within your state is responsible for monitoring the requirements in 1-3.
5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
    a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
    b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

5.19 Pregnant Women and Women with Dependent Children

Please consider the following items as a guide when preparing the description of the state's system:

1. ***The implementing regulation requires the availability of treatment and admission preference for pregnant women be made known and that pregnant women are prioritized for admission to treatment. Please discuss the strategies your state uses to accomplish this.***
   - OhioMHAS Grant Assurances state "Treatment facilities receiving SAPT Block Grant funds "will ensure that each pregnant woman in the state who seeks or is referred for and would benefit from treatment services is given preference in admission and will publicize the availability to such women of services from the facilities and the fact that women receive such preference [Section 1927(a)].
   - Inclusion in community plan; Boards are asked by OhioMHAS to address prioritizing pregnant women in the Community Plans they submit to the Department. Boards prioritize this population in their community plans, and may include specific requirements in contracts with providers.
   - Education and technical assistance and technical assistance provided by OhioMHAS staff to Boards and women's gender specific programs.
   - Collaboration through the Women's Network which includes women's gender-specific providers who advocate for women's treatment, and collaborate to improve services to women.
2. ***Discuss how the state currently ensures that pregnant women are admitted to treatment within 48 hours.***
   - OhioMHAS uses same strategies as in response to #1.
   - Grant assurances state, In the event that a treatment facility has insufficient capacity to provide treatment services to pregnant women seeking services, the facility must immediately make a referral to the local ADAMHS/ADAS Board to facilitate admission into another treatment program. If no other treatment program is available, the Board must make a referral to the State. If no other treatment facility in the state is available or the client refuses to attend treatment in another area, interim services must be made available within 48 hours. Boards typically include this in contracts with providers.

3. Discuss how the state currently ensures that interim services are provided to pregnant women in the event that a treatment facility has insufficient capacity to provide treatment services.

- OhioMHAS staff will provide assistance in making referrals across Board areas. A designated Women's Gender Specific program lead is responsible for making these referrals. Through contacts with providers in the Women's Network, other providers and Boards, she is able to ensure a referral is made when a facility has insufficient capacity to provide treatment services.

4. Discuss who within your state is responsible for monitoring the requirements in 1-3.

The Women's Gender Specific Program lead, Jackie Doodley, is responsible for monitoring that these requirements are met. She is an experienced, seasoned staff who knows the recovery community, especially the women's gender specific programs well. She is located within the Bureau of Health Integration which has extensive provider contact.

5. How many programs serve pregnant women and their infants? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP.)

Programs Serving Pregnant Women	
Level of Care	**Number of Programs**
Hospital Based	*0*
Residential	*13*
Intensive Outpatient	*22*
Outpatient	*39*

a. How many of the programs offer medication assisted treatment for the pregnant women in their care?

There are 40 gender specific providers that either provide or contract MAT services for women.

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where pregnant women can receive MAT? If so, where are they?
Yes, MAT programs are in short supply in all areas of the state. As of SFY 2015, Ohio has 15 programs providing methadone services. The three largest urban counties that include Cleveland, Columbus and Cincinnati have multiple programs. The northwestern part of the state only has one program, and southern and southeastern Ohio has only one program.

6. How many programs serve women and their dependent children? Please indicate the number by program level of care (i.e. hospital based, residential, IPO, OP)
a. How many of the programs offer medication assisted treatment for the pregnant women in their care?
There are 40 gender specific providers that either provide or contract MAT services for women.

Level of Care	Total Number of Programs
Hospital Based	*0*
Residential	*13*
Intensive Outpatient	*22*
Outpatient	*39*

b. Are there geographic areas within the State that are not adequately served by the various levels of care and/or where women can receive MAT? If so, where are they?

Ohio has some rural areas in southeastern Ohio and northwestern Ohio where MAT and residential services are less available. Ohio is currently working on a continuum of care mandated by the state legislature to better address some of these service gaps within the limits of the funds available.

Please indicate areas of technical assistance needed related to this section.

Environmental Factors and Plan

20. Suicide Prevention

Narrative Question:

In the FY 2016/2017 block grant application, SAMHSA asks states to:

1. Provide the most recent copy of your state's suicide prevention plan; describe when your state will create or update your plan, and how that update will incorporate recommendations from the revised National Strategy for Suicide Prevention (2012).
2. Describe how the state's plan specifically addresses populations for which the block grant dollars are required to be used.
3. Include a new plan (as an attachment to the block grant Application) that delineates the progress of the state suicide plan since the FY 2014-2015 Plan. Please follow the format outlined in the new SAMHSA document Guidance for State Suicide Prevention Leadership and Plans.[96]

Please indicate areas of technical assistance needed related to this section.

[96] http://www.samhsa.gov/sites/default/files/samhsa_state_suicide_prevention_plans_guide_final_508_compliant.pdf

Please use the box below to indicate areas of technical assistance needed related to this section:

None

Footnotes:

Ohio Suicide Prevention Foundation

Strategic Plan 2013-2016

Susan Farnham, Chair OSPF Board of Directors
Carolyn Givens, Executive Director

Connecting for Life

Art by Rhonda Miller

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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 age[2]. 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)*.

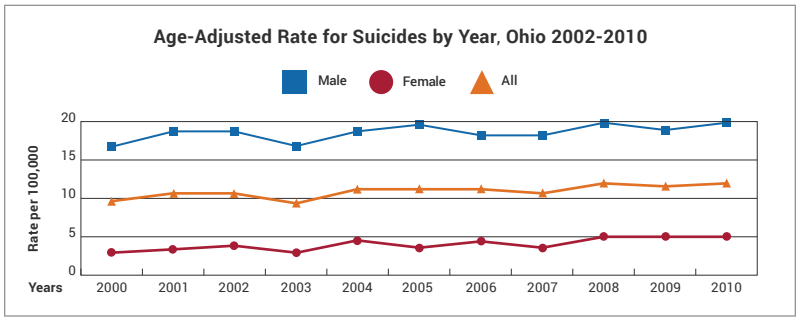

Figure 1. *Source: Ohio Department of Health, Vital Statistics*

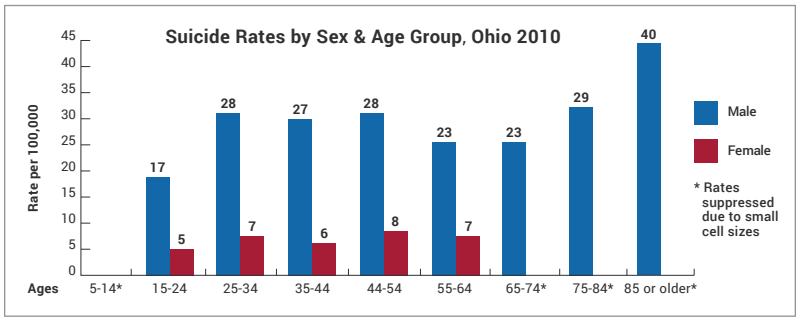

Figure 2. *Source: Ohio Department of Health, Vital Statistics*

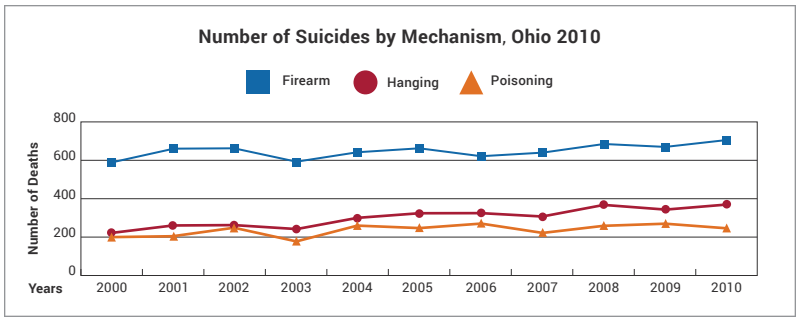

Figure 3. *Source: Ohio Department of Health, Vital Statistics*

[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 2013-1016 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 LBGTQ 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 LBGTQ 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

APPENDIX

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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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and Mental Health Consultant

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Susan Farnham, Board Chair
Dean Turner, Vice Chair
Eddie Allen
Gina Bentle
Mark E. McDaniel
Vickie Whitacre, MD,
Joan Wyler

Ohio Suicide Prevention Foundation Advisory Committee
Dean Turner
John Logan
Nettie Ferguson
Josephine Ridley
Mike Gordon
Valerie Connolly
Mindy Vance
Carole Vesely
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Christopher Nicastro
Liz Gitter
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Ohio Department of Alcohol and Drug Addiction Services
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Nettie Ferguson, Franklin County ADAMH Board

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Carole Vesely, Stark County Crisis Center
Joan Wyler, Talbert House

Ohio Suicide Prevention Foundation Staff and Consultants
Carolyn Givens
Cheryl Holton
Ellen Anderson, Ph. D.
William O. Donnelly, Ph.D.
Yvette Jackson, Dr. Divinity
Jeannette Harrison, Facilitator

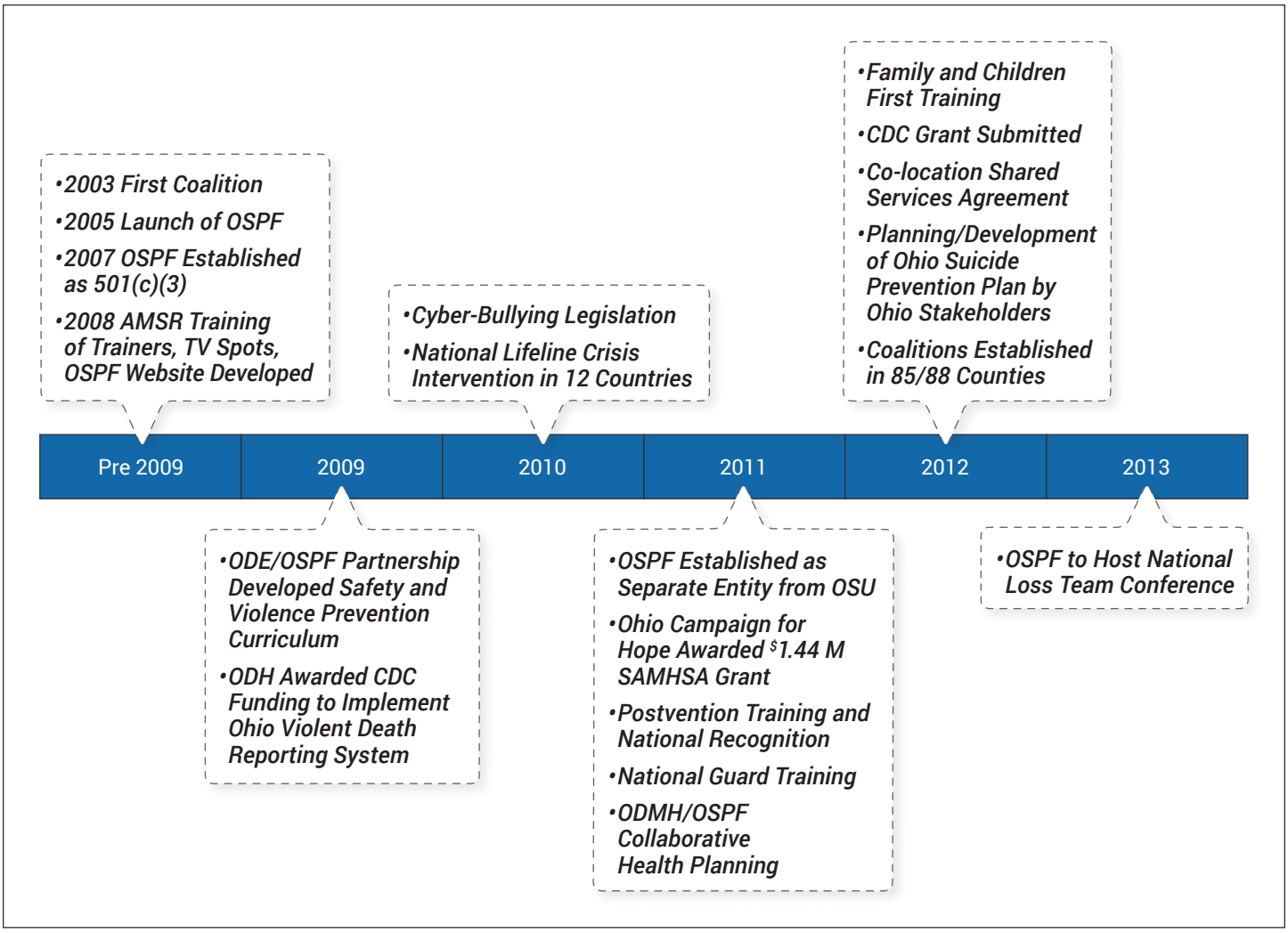
Note: Survivors of Suicide Loss are members of the various groups listed above and represent participation from a consumer level when it comes to the impact of suicide on an individual or family

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

Suicide Prevention – August 2015 Update

Because substance abuse, addiction and depression are key risk factors in suicide deaths and attempts, OhioMHAS provides ongoing support to the Ohio Suicide Prevention Foundation (OSPF) in implementing its mission to promote suicide prevention which is a public health issue. This mission advances evidence-based awareness, intervention, treatment and post-vention strategies to support all Ohio-based suicide prevention efforts. Its ultimate goal is to save the lives of hundreds of Ohioans who are at risk. Additionally, suicide prevention has support from both the Governor and the Legislature. OhioMHAS is working collaboratively with the Suicide Prevention Coalition on the statewide suicide prevention plan.

Surveillance data assists in framing the focus of the Suicide Prevention Foundation activities with local communities. For instance, approximately 1,400 Ohioans die by suicide each year. Males account for about 80 percent of Ohio's suicides, and firearms are used in more than 55 percent of completed suicides. Roughly 90 percent of people who complete suicide may experience either a mental health and/or substance use disorder that are untreated or under-treated at the time of death. It is estimated that more than 70 percent of youth who attempt or complete suicide have alcohol or illicit drugs in their systems; suicide is the second leading cause of death for youth ages 19 to 24.

Suicide Prevention Foundation in conjunction with local community coalitions develops strategies to address these issues. The goals of the local coalitions are to reduce stigma, implement and sustain evidence based approaches. Evidence based and other approaches include Mental Health First Aid, LOSS Teams, CALM, various screening tools, crisis intervention/hotlines and treatment. These approaches provide access to prevention, intervention, treatment and post-vention services. The Suicide Prevention Foundation awards grants to community collaborative to develop and execute these strategies that are culturally relevant.

OhioMAS has formed an advisory group to focus on target populations with high suicide risk factors. The members of the Advisory Committee will be able to collaborate on specific initiatives, streamline efforts, leverage resources, and monitor data to assess efficacy and effectiveness of interventions. Examples include the identification of appropriate training and treatment modalities, the creation and infusion of media guidelines. In addition, the department will work with national expert(s) to assist in fostering and enhancing activities to reduce Ohio's Suicide rate.

Ohio's Suicide Prevention Plan is included in the attachments.

Environmental Factors and Plan

21. Support of State Partners

Narrative Question:

The success of a state's MHBG and SABG programs 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. Examples of partnerships may include:

- The SMA 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 any Medicaid populations;
- The state justice system authorities working 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, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of emergency management/homeland security and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please consider the following items as a guide when preparing the description of the state's system:

1. Identify any existing partners and describe how the partners will support the state in implementing the priorities identified in the planning process.
2. Attach any letters of support indicating agreement with the description of roles and collaboration with the SSA/SMHA, including the state education authorities, the SMAs, entity(ies) responsible for health insurance and the health information Marketplace, adult and juvenile correctional authority(ies), public health authority (including the maternal and child health agency), and child welfare agency, etc.

Please indicate areas of technical assistance needed related to this section.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

5.21 Support of State Partners

OhioMHAS relies heavily on strategic partnerships; these partnerships are detailed throughout this grant application. Some examples of these partnerships included are:

Governor's Office of Health Transformation, the Ohio Medicaid Cabinet, and the Ohio Health and Human Services Cabinet: Ohio's state health care policy development is coordinated by the Governor's Office of Health Transformation (OHT) which has three major initiatives. The three initiatives are Modernize Medicaid, Streamline Health and Human Services and Pay for Value. Cabinet level agency directors and top leadership participate in the development of these three state initiatives. OhioMHAS serves on the governance committee for the first two of these initiatives. The Modernize Medicaid initiative is governed by OHT and the Medicaid cabinet which includes state departments for Aging, Mental Health and Addiction Services, Developmental Disabilities, health, and Medicaid with connections to Job and Family Services (employment and child welfare). The Streamline Health and Human Services initiative is governed by the Health and Human Services Cabinet. The Health and Human Services cabinet includes Medicaid cabinet agencies, OHT plus Departments of Job and Family Services, Administrative Services, and Budget Management. The Pay for Value initiative governance includes state departments for Administrative Services, Development (housing), Health, Insurance, Medicaid, Rehabilitation and Corrections, Tax, and Youth Services. Additionally, the Governor's External Advisory Council, Ohio Public Employees Retirement System and the Bureau of Workman's Compensation. The goal of these initiatives is to engage the private sector to set clear expectations for better health, better care and lower costs through improvements. For more detail, see the Ohio Health and Human Service Innovation Plan. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=wTsf1ebtLMc%3d&tabid=119

Other major partners whose work is detailed in the first section of this document are:

- County behavioral health authorities known as "Boards" which plan, evaluate and contract for mental health and substance use disorder treatment and prevention services.
- Statewide consumer and family organizations
- Providers
- Urban Minority Alcoholism, Drug Abuse and Outreach Programs (UMADAOP)
- Ohio Department of Medicaid
- Department of Criminal Justice and Rehabilitation Services System
- Ohio Department of Developmental Disabilities (trauma informed care)

Major partners for prevention include UMADAOPs, women's prevention programs, drug free community coalitions, Drug Free Action Alliance, health care systems for SBIRT, schools, providers and Boards. See first few pages of prevention section for details.

For treatment of SED, SMI and SUD, as well as the criminal justice section, please see System of Care tables at the beginning of each section for a list of the major partners and their activities.

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application

Narrative Question:

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating mental health and substance abuse agencies, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance abuse, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance abuse prevention and treatment advisory council to ensure that the council reviews issues and services for persons with, or at risk for, substance abuse and substance use disorders. To assist with implementing a BHPC, SAMHSA has created Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.[97]

Additionally, Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. 300x-51) applicable to the SABG and the MHBG, 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 block grant 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 SAMHSA.

For SABG only - describe the steps the state took to make the public aware of the plan and allow for public comment.

For MHBG and integrated BHPC; States must include documentation that they shared their application and implementation report with the Planning Council; please also describe the steps the state took to make the public aware of the plan and allow for public comment.

SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

Please consider the following items as a guide when preparing the description of the state's system:

1. How was the Council actively involved in the state plan? Attach supporting documentation (e.g., meeting minutes, letters of support, etc.).
2. What mechanism does the state use to plan and implement substance abuse services?
3. Has the Council successfully integrated substance abuse prevention and treatment or co-occurring disorder issues, concerns, and activities into its work?
4. Is the membership representative of the service area population (e.g., ethnic, cultural, linguistic, rural, suburban, urban, older adults, families of young children)?
5. Please describe the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families and other important stakeholders, and how it has advocated for individuals with SMI or SED.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[98]

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[97] http://beta.samhsa.gov/grants/block-grants/resources

[98] There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) 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 (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Please use the box below to indicate areas of technical assistance needed related to this section:

Footnotes:

Ohio Community Recovery Support Planning Council

August 28, 2015

Virginia Simmons
Grants Management Officer
Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 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 application for Substance Abuse and Mental Health Block Grants for fiscal years 2016 – 2017. The Block Grant Committee reviewed a draft version of the application, and recommended that the Council approve the Block Grant Plan; a list of recommendations is attached. Additionally, the Council has met with Director Tracy Plouck to discuss the mental health and addiction services.

Sincerely,

Patrick Coburn
Chair
Ohio Community Recovery Support Planning Council

Attachment

Cc Tracy Plouck
Angie Bergefurd
Jody Lynch
Tammy Collins
Mark Hurst, MD
Sanford Starr
Liz Gitter

Planning Council's
SFY 2016 – 2017 Block Grant Plan Recommendations

- Require that families of children receiving services be informed about Family and Children First during admission process.
- Promote pooled funding (versus shared funding) for behavioral health services which makes a smoother process that is less traumatic for families.
- Support more outreach to schools to educate teachers about behavioral health
- Increase services around youth dealing with LGBT identity that may increase the need for mental health and addiction services.
- Increase availability of Medication Assisted Treatment.
- Improve access and funding for peer support services.
- Address the need for supportive services for youth transitioning from juvenile to adult systems. Supportive services include linkage to services, housing, transportation, getting a driver's license.
- Address transportation to access behavioral health services for all ages.

5.22 Planning Council Involvement in Plan

Behavioral Health Planning Processes
Ohio has three state-level related mental health and substance abuse planning processes. Two of these processes are led by OhioMHAS, and the third is led by the Governor's Office of Health Transformation. Planning Council has participated in all three of these processes.

OhioMHAS leads two integrated planning processes for the Substance Abuse and Mental Health Block Grant Plan, and the OhioMHAS Strategic Plan. These two planning processes incorporate the same information from external stakeholders (including Planning Council) OhioMHAS staff and other state agency staff. External stakeholders include health care, criminal justice, system, child welfare system, schools, businesses, state and local government, and behavioral health system stakeholders. Behavioral health stakeholders include mental health and addiction providers, county ADAMH Boards, and Medicaid managed care plans. OhioMHAS staff works with stakeholders and staff to develop two complementary plans----the OhioMHAS Strategic Plan which focuses on state priorities and the Block Grant Plan which aligns state priorities with SAMHSA priorities. OhioMHAS also participates in state-level health care policy planning as a member of Ohio's Medicaid Cabinet; the Behavioral Health Medicaid Benefit Redesign Committee is being managed by Governor Kasich's Office of Health Transformation through the Medicaid Cabinet. Planning Council has been involved in all three planning processes.

OhioMHAS Strategic Plan – Planning Council Involvement – November 2014
The Planning Council participated in a planning exercise for OhioMHAS' Strategic Plan in their November 2014 meeting; this work is integrated into Block Grant Plan. OhioMHAS completed this same exercise with several stakeholder groups. The chair and vice-chair of Planning Council also participated in the key external stakeholder planning work which used the same process as was used with the Planning Council. Written documentation of the Planning Council's participation in this process is attached, and is very similar to the recommendations made for the Block Grant Plan in June 2015.

Block Grant Plan – Planning Council Involvement – June 2015
The Block Grant Committee of Planning Council members reviewed the Block Grant Plan, and submitted written comments and recommendations. To maximize participation, the review was organized by populations; so committee members could choose the population(s) they reviewed. Each committee member was asked to submit written comments and recommendations which were shared with the other committee members. After developing their individual comments and recommendations, the Block Grant Committee met to discuss their individual reviews and make recommendations as a group to the full Council.

These recommendations were shared with Planning Council members who had received draft copies of the Block Grant Plan. The Council was invited to vote to support the Plan which is documented with a letter included in this section. Additionally, the full Planning Council made some modifications to the recommendations which will be shared with OhioMHAS leadership; these are attached to the letter. These recommendations are very consistent with Planning Council's recommendations to OhioMHAS' Strategic Plan.

The comments from the Block Grant Committee were also incorporated into the final version of the Block Grant Plan.

Governor's Office of Health Transformation – Planning Council Participation on Committees
Planning Council has a representative on the Behavioral Health Redesign (of Medicaid benefit) Committee of stakeholders. Additionally, NAMI-Ohio and Ohio Empowerment Coalition (mental health consumer statewide organization) have representation on this committee as well as on Planning Council.

Diversity of Membership
Planning Council membership reflects the diversity characteristics of the population served; membership includes persons from various racial and ethnic groups, LGBT, rural, and veterans. The Council's seats for persons in recovery and family members are evenly divided among representatives of SUD advocacy and mental health advocacy communities. Membership includes individual persons in recovery, family members, and representatives of advocacy organizations, as well as representatives of state agencies, providers and ADAMH Boards. Additionally, the Council has representatives from the three organizations that have SAMHSA consumer/family network grants (Ohio Empowerment Coalition, Northern Ohio Recovery Association (SUD recovery), and NAMI-Ohio/Ohio Federation for Children's Mental Health (children).

Ohio Department of Mental Health and Addiction Services
Strategic Plan Development – November 21, 2014
Theme/Priority Worksheet

Theme/Priority: Access **Stakeholder Group: Planning Council**

Facilitators (Replaced with Team Members)	Barriers	Strategies	Collaborators	Success
Alainn Herrell Meghan McNeil Craig Comedy Donna Thomas Jennilee Mohler	• Properly assessing barriers to care per specific population • Lack of understanding of population. • How courts deal with crime & drug use • Lack of information & knowledge about cost of access to care • Investment by the state for re-entry • Cultural competence throughout the continuum of care	• Accurately identify clients' perception of barriers • Focus groups per population by people with appropriate knowledge/lived experience	• Legislature • Consumer operated services • Treatment organizations • Community based agencies	
		• Demographic barriers		
		• Peer support & consumer operated services (COS)		

Theme/Priority: Access **Stakeholder Group: Planning Council**

Facilitators (Replaced with Team Members)	Barriers	Strategies	Collaborators	Success
	• Access to care per population—compare • How courts deal with criminal drug use/lack of information & knowledge about the cost of access to care. • Investment by the state • ? (can't read handwriting) • Depart of Corrections • Health records	• Accurately identify clients • Perception of barriers • Focus groups per population • Demographic barriers • Peer support • Director of health can work with directors of prisons & Ohio Empowerment Coalition	• Consumer Operated Services • Legislature • State Departments • Community board agencies	
		• COS Consumer Operated Services • Transportation? • AA & NA • Culturally competent		

Theme/Priority: Access to Services **Stakeholder Group: Planning Council**

Facilitators (Replaced with Team Members)	Barriers	Strategies	Collaborators	Success
Gail Thomas Sara Sheline Sandy Keys Kim Meals Sheryl Hirsh	1. No or limited services in rural areas 2. Availability of needed services 3. Decrease the stigma & discrimination associated 4. Cultural competence	• Create partnerships w/ community stakeholders	• Hospitals • Health care workers • County officials • Schools • Clergy/faith based leaders • People in recovery	• No or shorter wait lists/periods • Lower death rates
		• Educational opportunities for general & professional populations	• Justice/ law enforcement • Elected officials • ADAMH Boards • Family members	• Active community member • Family (re)unification • Dissemination of community services • Stronger/healthy community
		• Town hall type meeting to connect/link community		

Theme/Priority: Continuum of Care **Stakeholder Group: Planning Council**

Facilitators (Replaced with Team Members)	Barriers	Strategies	~~Collaborators~~ Strategies	Success
Collaborators: legislators, OhioMHAS, advocacy groups, school districts, ADAMH Boards, psychiatrist, counselors (mental health & addiction)				
Cheryl Crayden Sarah Smitley Katie Dillon Lizzy Copper Mickey Scoville (young adult & family perspective)	• Transportation, schools don't understand the issues of mental illness and addiction. • Problem of participation • Need a place for teens with mental illness & addiction to get together • Take kids out of school • Available providers, psychiatrists, counseling, peer support, liability, homeless, communication, calling someone.	• Taxi, bus & vans to take you to appointment • Provider give contact info to patient • Stable mailing address • Education of school staff	• Teen support groups with case management & peer support • Community support for homeless	• Placement of psychiatrists or counselor in schools • More housing • Mandated education for school staff, especially teachers
		• Caseworker to work with kids who are home schooled or do online school • Making 504 plan more enforceable • More training for teachers in ways to work with kids; mandate training for them for mental illness & addiction	• More affordable housing • Homeless survivor classes • Housing for people who are not in recovery	• More peer specialists • Including family members in the treatment process • Legal case worker with wraparound services

Theme/Priority: Continuum of Care (continued from previous page) **Planning Council**

Facilitators (Replaced with Team Members)	Barriers	Strategies	~~Collaborators~~ Strategies	Success
		• School & families work together & develop plan together • Mental health & addiction providers in the schools • More providers with evening appointments or private practice providers. • Funding more peer support specialists	• Transitional housing • More group homes • Case worker to work with kids with legal problems & work with families & schools	• More funding for group home or inpatient treatment for mental illness and addiction • Facility for teens and adults that had peer support services, with place to study school work, shower, & eat. Sleep for 8 hours up to 24 hours.

Theme/Priority: Continuum of Care **Planning Council**

Facilitators/Team	Barriers	Strategies	Collaborators	Success
Sue Williams, ODJFS Dan Arnold, Medicaid Jane Byrnes, Aging Mark Smith, Education, scribe Perspective: State employees of other departments	• Cost • Information sharing • Housing eligibility criteria by previous homelessness • Transition & support to facilitate	• Cost • Increased General Revenue Funds (GRF) • Increased federal funds embedded in the current system	• ODMH – "Home Choice" • Mental health – permanent housing solution. Housing First? • Aging – PASSPORT/Home Choice • Child welfare/juvenile justice/ ENGAGE	• More funding • Increase efficiency • Increase efficiency in "hot spots" • (Biggest) bang for the buck (targeted investment) • Focus on outcomes, not process
		• Information sharing • Inter-program collaboration (shared services) • Patient centered medical home	• All service providers address FERPA/HIPAA confidentiality • Community cultural bias re: sharing information	• BIP (Nursing facility diversion) • Targeting hot spots • Data cohesion (data flows) • Culturally sensitive data collection • Education on data limitations
		• Housing • Change in HUD definition of "homeless"	• Dept. of Medicaid • OhioMHAS • Dept. of Aging • ADAMH Boards • HUD (federal housing agency) • Attorney General's	• Less homeless • Less vulnerability • Homeless, human trafficking connection recognition • More options/flexibility

Priority/Theme: Access **Planning Council**

Facilitators (Replaced with Team Members)	Barriers	Strategies	Collaborators	Success
Sue Williams, Job & Family Services (child welfare) Dan Arnold, Medicaid Jane Byrnes, Aging Mark Smith, Education, scribe Perspective: State employees of other departments		• Community/ school-based health care centers—(students, community, seniors) • Open telemedicine options • Target tele-practice to optimal populations to open F2F (family to family) availability	• ODE • ODM • OMAS • ODA • Public/private strategic partnership	• Tele- practice as part of service continuum
		• Collaboration with business (e.g. minute clinic) • Clarify of provider certification versus site certification • Peer Supported providers	• Libraries (computer access) • Business space • Managed care	• Increased service options
		• Address stigmas with education • Collaboration with existing school, public, vocational transit	• Community providers	• More transport access

Theme Priority: Consumer & Family Involvement (Continuum of Care) **Planning Council**

Facilitators	Barriers	Strategies	Collaborators	Success
• Well developed, consumer & family input in program planning of ADAMH funded programs & services	• Counties unable to share fiscal resources	• Regional conferences • Inter county collaborative planning for service dollars to follow individual consumers	• WMR (Wellness Management & Recovery) • OEC (Ohio Empowerment Coalition • NAMI • ADAMH • State legislators	• Wiser use of funds • Less hospitalization • Less police involvement • Healthier community
• Develop consumer & family input to continuum of care	• Getting organizations to collaborate sharing all resources for the good of consumers & family members	• Network of county and organizations to collaborate & share valuable resources with consumers & families (both MH & AoD)	• All state organizations	• Better service to all, less hospitalization, jail and mental health facility cost
		• Find alternative funding for Certified Peer Support Services & county collaboration		

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2016

End Year: 2017

Name	Type of Membership	Agency or Organization Represented	Address, Phone, and Fax	Email (if available)
Greg Collier	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Toledo, OH 43608	gjcollier8@att.net
Vacant Seat	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)			
Joseph DeMangeont	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Canton, OH 44708	Joede@sssnet.com
Pat Coburn	Others (Not State employees or providers)		Cincinnati, OH 45230	Pat@coburns.us
Sandra Keyes	Others (Not State employees or providers)		Columbus, OH 43221	sandrakeys@columbus.rr.com
Bob Cross	Others (Not State employees or providers)		Columbus, OH 43221	Bcross41@yahoo.com
Joseph Demangeont	Others (Not State employees or providers)		Canton, OH 44708	joede@sssnet.com
Lizzy Copper	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Waverly, OH 45690	rc902613@ohio.edu
Sarah Nerad	Others (Not State employees or providers)		Columbus, OH 43221	sarah@ptrassociates.com
John Dellick	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Canfield, OH 44406	jdellick80@student.egcc.edu
Sara Sheline	Others (Not State employees or providers)		Lancaster, OH 43130	shelinesara@yahoo.com
Cheryl Crayden	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Orrville, OH 44667	cherylcrayden@zoominternet.net
Sarah Smitley	Parents of children with SED		Sylvania, OH 43560	smsmitley@yahoo.com
Meghan McNeil	Parents of children with SED		Columbus, OH 43229	Mmcneil@ohioempowerment.org
Vacant Seat	Others (Not State employees or providers)			
Mickey Scoville	Others (Not State employees or providers)		Mentor, OH 44060	micnbud@hotmail.com
			Organizational	

David Caperton	Others (Not State employees or providers)	Representative, Ohio Citizens Advocates for Addiction Recovery Medina, OH	autoseller1110@yahoo.com
Dennis Hitchcock	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Organizational Representative, Ohio Empowerment Coalition Holland, OH 43258	dennishitchcock@me.com
Betsy Johnson	Parents of children with SED	Organizational Representative, NAMI - Ohio Columbus, OH	Betsy@namiohio.org
Jennilee Mohler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	Organizational Representative, Represents PAIMI Walbridge, OH 43465	JJWBJ1@gmail.com
Vacant Seat	Family Members of Individuals in Recovery (to include family members of adults with SMI)	Organizational Representative, Multi-ethnic Advocates for Cultural Competence	
Angela Schoepflin	Parents of children with SED	Organizational Representative, Ohio Federation for Children's Mental Health St. Paris, OH	Seigna72@hotmail.com
Jane Brynes	State Employees	State agency: Aging Columbus, OH	jbyrnes@age.com
Barbara Miller	State Employees	State agency: Development (housing) Columbus, OH 43215	barbara.miller@development.ohio.gov
Mark Smith	State Employees	State agency: Education Columbus, OH 43215	Mark.Smith@education.ohio.gov
Liz Gitter	State Employees	State agency: mental health & addiction Columbus, OH 43215	Elizabeth.Gitter@mha.ohio.gov
Daniel Arnold	State Employees	State agency: Medicaid Columbus, OH 43215	Daniel.Arnold@medicaid.ohio.gov
Gail Thomas	State Employees	State agency: Social Services Block Grant (Title XX) Columbus, OH 43215	gail.thomas@jfs.ohio.gov
Sue Williams	State Employees	State agency: child welfare Columbus, OH	Sue.Williams@jfs.ohio.gov
Donna Thomas	State Employees	State agency: rehabiliation and corrections Columbus, OH 43215	Donna.Thomas@odrc.state.oh.us
Darin McCoy	State Employees	State agency: Employment (rehabilitation services commission) Columbus, OH 43235	Darin.McCoy@ood.ohio.gov
Vacant Seat	State Employees	OH	
Kimberly Meals	Providers	Community Support Services, 150 Cross Street Akron, OH 44311	mealskim@cssbh.org
Vacant Seat	Providers	Children's Mental Health provider	
Cathy Davis	Providers	NORA - SUD Recovery Wickliffe, OH 44092	cdavis@norainc.org
Domina Page	Providers	Women's SUD Treatment, 1059 Market Street Troy, OH 45373	dpage@mcrcinc.org

Vacant Seat	Providers		
Craig Commedy	Providers	UMADAOP (urban minority SUD) Columbus, OH	columbus@umadaopfc.com

Footnotes:

Others (Not State employees or providers) are representing persons in recovery from substance use disorders and/or their families. State agencies for aging, housing, education, employment, mental health, Medicaid, social services, child welfare, & corrections (criminal justice) are represented. State agency is included on address line of each entry as a work around to WebBGAS glitch.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2016

End Year: 2017

Type of Membership	Number	Percentage
Total Membership	44	
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)	2	
Parents of children with SED*	4	
Vacancies (Individuals and Family Members)	3	
Others (Not State employees or providers)	9	
Total Individuals in Recovery, Family Members & Others	25	56.82%
State Employees	10	
Providers	6	
Federally Recognized Tribe Representatives	0	
Vacancies	3	
Total State Employees & Providers	19	43.18%
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	2	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	4	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	6	
Persons in recovery from or providing treatment for or advocating for substance abuse services	15	

* 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?

Block Grant Committee members reviewed the application, submitted written comments and recommendations, and met to review the Block Grant Plan as a group. The Block Grant Committee made a written list of recommendations to the Planning Council. Planning Council voted to support OhioMHAS' Block Grant Application, and made modifications to the recommendations drafted by the Block Grant Committee. These recommendations are attached to the letter signed by the acting chair for Planning Council.

Footnotes:

Substance Abuse and Mental Health Services Administration
SAMHSA
1 Choke Cherry Road • Rockville, MD 20857
www.samhsa.gov • 1-877-SAMHSA-7 (1-877-726-4727)

JUL 6 2015

Ms. Tracy J. Plouck
Ohio Department of Mental Health
30 East Broad Street, 36th floor
Columbus, OH 43215

Dear Ms. Plouck:

The Substance Abuse and Mental Health Services Administration's (SAMHSA) Center for Mental Health Services (CMHS) invites you to apply for the Mental Health Block Grant (MHBG) for federal fiscal year (FY) 2016. The FY 2016-2017 Uniform Application (0930-0168), which will serve as the application to the Secretary for the MHBG for FY 2016, must include funding agreements, assurances, certifications and planning tables for FY 2016.

The FY 2016-2017 Uniform Application is available electronically via the Block Grant Application System (Web-BGAS). An Adobe Acrobat version of the FY 2016-2017 Uniform Application may be downloaded from SAMHSA's block grant website. A copy of the authorizing legislation (42 USC § 300x-21 et seq) available on Web-BGAS under the Frequently Asked Questions section as well as SAMHSA's block grant website.

The FY 2016 Justification of Estimates for Appropriations Committees, includes a table of the estimated State/Territory allotments for the FY 2016 MHBG. However, a final FY 2016 Departments of Labor, Health and Human Services, Education (Labor-HHS-ED) and Related Agencies appropriations bill is pending. Upon enactment of the FY 2016 appropriations for Labor-HHS-ED and related agencies, a final allotment table for FY 2016 MHBG will be sent to you and uploaded on BGAS. In the interim, please refer to the enclosed FY 2016 MHBG allocation as authorized by the Consolidated Appropriations Act, 2016 (P.L. 112-74) for purposes of completing the FY 2016 Intended Use Plan (Table 7) and related planned expenditure checklists (Table 6 & Table 8).

All states and jurisdictions are required to prepare and submit their respective FY 2016-2017 Uniform Applications on or before September 1, 2015. All states and jurisdictions are required to execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. EST. When a state or jurisdiction executes the "Application Complete" function, the Web-BGAS records "Application Completed by State User." This is SAMHSA's only evidence that a state or jurisdiction has complied with the statutory requirement regarding the September 1 receipt date.

Any state or jurisdiction planning to submit a combined FY2016-2017 Uniform Application must execute the "Application Complete" function not later than Tuesday, September 1, 2015 at 11:59 p.m. SAMHSA's block grant programs are subject to an annual audit pursuant to the Office of Management and Budget Circular A-123, "Management's Responsibility for Internal Controls," and one of the controls involves a review of how SAMHSA ensures states' and jurisdictions' compliance with the statutory receipt dates as described in sections 1917(a)(1) and 1932(a)(1) of Title XIX, Part B, Subpart I and Subpart II of the PHS Act, respectively.

The contact person for questions related to MHBG business management issues is:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, Room 7-1109
Rockville, Maryland 20857
TEL. (240) 276-1422

Please submit a single copy of the Funding Agreements, Assurances Non-Construction Programs, Certification and Lobbying Disclosure Form, signed by the state's chief executive officer or designee, to SAMHSA and upload an electronic copy to Web-BGAS using the Attachments Tab. If one or more of the documents described above is signed by a designee, please include a current delegation of authority letter(s) from the state's chief executive officer. Forwarding any paperwork related to the FY 2016-2017 Uniform Application to any other addressee results in processing delays. To ensure express/overnight mail delivery, please use the following address:

Ms. Virginia Simmons
Grants Management Officer
Office of Financial Resources, Division of Grants Management
Substance Abuse and Mental Health Services Administration
1 Choke Cherry Road, 7-1109
Rockville, Maryland 20850
Telephone: (240) 276-1422

Questions of a fiscal or programmatic nature should be directed to your respective State Project Officer within CMHS's Division of State and Community Systems Development. Enclosed is a State project officer directory.

Sincerely,

Paolo del Vecchio, M.S.W.
Director
Center for Mental Health Services
Substance Abuse and Mental Health Services Administration

cc: Liz Gitter
Tammy Collins
Steve Copper

Enclosures:
2016 MHBG Prospective Allotments
MHBG Project Officer Directory