

**Ohio Mental Health and Addiction Services (OhioMHAS)  
Community Plan Guidelines SFY 2014**

**Environmental Context of the Plan/Current Status**

1. Describe the economic, social, and demographic factors in the Board area that will influence service delivery.  
(NOTE: There will be an opportunity to discuss the possible effects of Medicaid expansion upon your local system in question #12.)

**The environment of the Adams, Lawrence, Scioto (ALS) counties ADAMHS Board, without question, is one of drugs, poverty, unemployment, crime, poor health, depression and anxiety. Drug use is not mentioned first by accident. The high use and abuse of illegal and prescription drugs is a major contributing factor to all aspects of the poor condition this environment has, currently, reached. Solutions or improvements, in some cases, are possible, but are stymied due to the wide spread and invasive stigma that accompanies the reach for help.**

**WHAT THE PROVIDERS SAID:**

**In the face to face discussions with the Boards' providers, the following comments were made regarding the environment and social conditions of the area:**

- **"high unemployment" "people have lost jobs; it's not that they never worked" "Blue Collar factory jobs are no longer here" "general absence of middle income jobs" "lots of entry level jobs but people get stuck there" "no way to better themselves"**
- **"more heating assistance this year"**
- **"provide lots of uncompensated care" "40% of our AoD cases are indigent" "men with no payer sources"**
- **"increased number of females with children are seen" "we are seeing more men with children, mom has abandoned them" "increased kids in foster care" number of kids in Children's' Services' foster care has doubled in the past year" "provide services to kids in schools, mostly" "most referrals from Juvenile Court Group Home" "many kids in classrooms have lost family members to drug overdoses"**
- **"all Heroin now that pill mills are gone"**
- **"depression is worsening" "hopelessness" "want 'magic pill' to feel better; want it quickly; therapy takes too long" "different clientele in a poor economy" "less motivation" "people talking negatively about the whole area"**
- **"provide outreach to the worried well"**
- **"family issues related to incarceration and addiction" "seeing women who come from STAR Justice Program"**
- **"hard to find prescribers" "use telemedicine, one doctor lives in Florida and treats via telemedicine" "primary care physicians have been prescribing Benzos and now have stopped so clients come to agencies to ask for them" "lack of outpatient psychiatric care"**

Each County has several available choices of mental health and/or substance abuse treatment agencies as indicated below. Note, an \* by an agency name indicates that it is a substance abuse only agency.

<b>ADAMS</b>	<b>LAWRENCE</b>	<b>SCIOTO</b>
<b>FRS Counseling</b>	<b>ILFamily Guidance Center</b>	<b>Shawnee Mental Health Center</b>
<b>Shawnee Mental Health Center</b>	<b>Shawnee Mental Health Center</b>	<b>The Counseling Center</b>
<b>The Counseling Center</b>	<b>Southern Ohio Behavioral Health</b>	<b>Community Counseling and Treatment Services, Inc. *</b>
	<b>Community Counseling and Treatment Services, Inc. *</b>	
	<b>Spectrum Outreach Services *</b>	
	<b>The NECCO Center</b>	
	<b>New Beginnings Behavioral Health *</b>	
	<b>Mended Reeds/Mental Health, Inc.</b>	

There is a great deal of stigma present in the Appalachian culture about people who have mental illness and use drugs. Add to that the long held beliefs, which include mistrust, related to medical professionals as well as a personal reluctance to seek help all of which are pervasive in the ALS region and you have a population reluctant to accept/seek treatment. Lack of insurance or private funds and eligibility restraints add to the lack of motivation to get help. The data provided below supports the presence of these conditions. It also shows a strong system of care available to the residents which include subsequent supports. (Preventing Chronic Disease, Appalachia: Where Place Matters in Health, September 15, 2006)

Adams, Lawrence, Scioto all have the following attributes in common:

- They are border counties-IMPACT: This brings people seeking services from each of the bordering states which takes its toll on the provider agencies and, possibly, robs residents from ALS of timely services. Also, it appears that occasionally, clients who “have burned their bridges” in other state hospital systems present in Ohio as new clients. When drugs are involved, this adds another layer of access to dealers and prescribers.
- They are Rural – IMPACT: Transportation issues due to distance and the economic features related to owning and maintaining reliable transportation make it difficult to access the services that are available.
- They are all within the Appalachian Region -IMPACT: The Appalachian culture and its relationship to MH stigma and the lack of stigma to alcohol use (which seems to have spilled over onto other drugs) is prevalent in this rural area. This presents special challenges to service provision in that it makes it more difficult to get a person with MH issues to seek treatment. The acceptance of alcohol and other drug use and their consequential outcomes (i.e. domestic violence) inhibits the users’ beliefs in the need for treatment. (Appalachia: Where Place Matters in Health)
- The Caucasian ethnic rates in all counties in this Board’s region are in the 90<sup>th</sup> percentile – IMPACT: The preponderance of Caucasian clinicians and clients result in a treatment atmosphere where there are very few cultural competency problems related to race.
- They all have good High School graduation rates – IMPACT: When a young adult does develop a need for services, the chances of responding to the “talk therapies” are greater.

Data Sources (2012 Ohio County Profiles; Ohio Bureau of Labor Information)

	<b>ADAMS</b>	<b>LAWRENCE</b>	<b>SCIOTO</b>
<b>Date County Established-<u>IMPACT</u>: N/A</b>	July 10, 1797	December 21, 1815	March 24, 1803
<b>Population-<u>IMPACT</u>: There are, potentially, more people who could need treatment, depending on the population.</b>	28,350 (2012)	62,109 (2012)	78,477 (2012)

<p>Area in square miles-  <b>IMPACT:</b> The more spread out the County is, could result in more transportation problems. Also, people living far from the treatment providers could be less apt to seek treatment or could go to a neighboring county thus impacting the home county's work force.</p>	584	455.4	612.3
<p>Population of largest city or village in the County- Providers  <b>IMPACT:</b> located in these populated cities/village can expect more activity. It will affect their staffing patterns.</p>	3,231 (West Union, Village)	11,135 (Ironton)	20,171 (Portsmouth)
<p>Percent of families that include married man and woman who both work-<b>IMPACT:</b> It is predictable that this type family will have employment based insurance and will go to their own physician and private hospitals.</p>	32.5% (n=2,473)	31.7 (n=5,355)	32.1 (n=6,522)
<p>Percent of females in a single occupant household and are working-<b>IMPACT:</b> It is predictable that this type family will have employment based insurance and will go to</p>	8.6% (n=653)	10.9 (n=1,837)	9.8 (n=1,987)

<p><b>their own physician and private hospitals.</b></p>			
<p><b>The most common household income in the County- <u>IMPACT</u>: One must wonder how people can live on this amount of income per year. These individuals will need treatment with anxiety and depression for the most part. They could, also, be in this income range due to their substance abuse. The children may act out because of bullying, hunger, depression, anger to name a few reasons. The Family and Children First Council and Children Services often will be involved in these cases.</b></p>	<p><b>\$10,000 to \$20,000 per year or 18% of the County population (n=2,019</b></p>	<p><b>\$10,000 to \$20,000 per year or 17.1% of the County population (n=4,205)</b></p>	<p><b>\$10,000 to \$20,000 per year or 18.8% of the County's population (n=5,661)</b></p>
<p><b>The most common age group in the county- <u>IMPACT</u>: It is predictable that a significant percent of slice of the population will have employment based insurance and will go to their own physician and private hospitals. It could also be assumed that the individuals on the older end of this cohort could be disabled in which case there could be Workman's Compensation Benefits</b></p>	<p><b>7,777 or 27.2% of people are 45 to 64 years of age</b></p>	<p><b>17,215 or 27.5% of people are 45 to 64 years of age</b></p>	<p><b>20,920 or 26.4% of people are 45 to 64 years of age</b></p>

<p>available or any number of different disability program coverage to pay their health costs. This group of people could access the Board's MH and/or Substance abuse providers or choose to go to their private physicians.</p>			
<p>Percent of families with income above the poverty level- <b>IMPACT:</b> It is predictable that this type family will have employment based insurance and will go to their own physician and private hospitals. They could also be retired with good benefits including health insurance.</p>	81.7% (n=6,364)	86.1% (n=14,767)	83.1% (n=16,349)
<p>Percent single mothers with income below the poverty level-<b>IMPACT:</b> This population is the one that Medicaid serves the most and they would likely use the Board's Medicaid providers should they or their children need MH and/or substance abuse treatment.</p>	38.3% (n=3,546)	41.7% (n=996)	40.3% (n=1,342)
<p>Number of people driving 60 or more minutes to work- <b>IMPACT:</b> These people are not retired, may have employee related</p>	1,812	1,539	2,042

<p>health insurance, are not on Medicaid and are spending disproportionate amounts of money on automobile expenses. They are not likely to be using the Public funded system of care.</p>			
<p>Number of housing units- <b>IMPACT</b>: These numbers could, perhaps, answer the question of why there is difficulty finding safe, affordable housing for clients who need it. The ratio of housing to population in each of the counties indicates that there is, on average, 44% more people than there are housing units. Given that much of the population represents, at least, two person families, one might speculate that there is just enough adequate housing in each county.</p>	12,927	27,644	34,220
<p>Number of housing units occupied- <b>IMPACT</b>:The ratio of occupied housing to housing is, on average, 87% in each county. The unoccupied housing is, perhaps, on the market or is not “safe” or “affordable” for the clients in need.</p>	10,905	24,479	29,788

<p>The most common range of monthly rental for a housing unit- <b>IMPACT:</b> Many MH clients receive SSI as their sole financial resource and, in 2013, that is \$710 per individual per month (less for married couples). Based on the rental ranges in the counties, these clients are forced, by circumstance, to live in subsidized housing or substandard housing. There are other barriers to housing, even subsidized, (i.e. a past felony conviction). Without housing, MH clients, indeed, anyone will have difficulty coping with their every day lives.</p>	<p>\$500 to \$600</p>	<p>\$600 to \$700</p>	<p>\$500 to \$600</p>
<p>Migration rate of people moving in and out of the county- <b>IMPACT:</b> Based on the high drug usage and subsequent crime rates, it is not surprising that SC experienced emigration in 2012. Now that the “pill mills” have been removed from the county, it will be interesting to watch the future migration rates for SC.</p>	<p>The number of people moving out of the County is almost exactly the same as those moving in.</p>	<p>The number of people moving out of the County is almost exactly the same as those moving in.</p>	<p>There was an increase of the number of people moving out of the County.</p>
<p>Total number of</p>	<p>34,424 or 82% of</p>	<p>72,170 or 86% of</p>	<p>85,103 or 92% of</p>

<p>vehicles for transportation- <b><u>IMPACT:</u></b> These numbers make it difficult to continue to say that transportation is a problem when people need to get to appointments. There are some mitigating factors; however. Are vehicles that do not run counted in the total? There are families with multiple vehicles. There could be only one family car and the breadwinner must use it to get to work. Using Adams County as an example, the 82% (if there is one vehicle per person) leaves 6,074 people without transportation in a large acreage county. Perhaps transportation remain an issue.</p>	<p>population</p>	<p>population</p>	<p>population</p>
<p>Number of people who vote- <b><u>IMPACT:</u></b> American Broadcasting Company (ABC) News reported, on 11/1/08, that research led by Ian Deary from Scotland’s University of Edinburgh found that “smarter folks voted more often, regardless of their occupation.” Being smarter may mean that if you are experiencing</p>	<p>61.7%</p>	<p>53%</p>	<p>67.3%</p>

symptoms of mental illness or addicted, you will seek out treatment.			
Number of people who have employee based health insurance- <b><u>IMPACT:</u></b> It is predictable that these people will go to their own physician and private hospitals.	42%	50.1%	67.3%
Number of children who have parent employee based health insurance- <b><u>IMPACT:</u></b> It is predictable that these children will go to their own physician and private hospitals. In addition, if the parents have a history of employment, the children were tended to by a pediatrician and will have less missed school days and are apt to be healthier overall.	28.5%	48.2%	50.2%
Crimes committed- <b><u>IMPACT:</u></b> These numbers are somewhat deceiving as they depict, for example, Adams County as being much safer than Scioto County. When one considers that Scioto County has a much larger population than Adams County, the picture changes. However, this equals out	303	1,130	3,794

<p>to be 100 crimes per 1000 people in AC while it is 100 crimes per 500 people in SC. So in this case the raw numbers do equal more crimes in SC. Regarding the effect this information has on MH and Substance abuse services, one must consider the type of crimes committed. If all the crimes in one county are Operating a Vehicle while Intoxicated (OVI) offenses, it has a different impact as there are special funds set aside, via the Indigent Drivers Alcohol Treatment (IDAT) rules in the Ohio Revised Code (ORC) 4511.191(H)(3)(a)], to provide services for people without funding who are convicted of these crimes. A person committed a different crime would have to have a funding source to receive treatment.</p>			
<p>Amount of dollars expended to provide public assistance- <b><u>IMPACT</u></b>: There is clearly a vast difference between the counties and the money spent on assisting low income</p>	<p>\$39,701,000.00</p>	<p>\$90,378,000.00</p>	<p>\$121,613,000.00</p>

<p><b>individuals. It is particularly interesting to note how these amounts are spent in relation to the poverty percentages. In other words, Adams County with the lowest number of public dollars spent has a high percentage (18.3%) of persons living below the poverty level. Lawrence County with the least number of people living below poverty (13.9%) spends more than double the public dollars than Adams does. Scioto County spends the most dollars on public assistance and 18.9% of its population lives below the poverty level.</b></p> <p><b>There is equity in Scioto County and one could expect to see Medicaid eligibilities proportionate to the population needing it. That does not seem to be the case as the providers are turning people away as they do not have a payer source. Perhaps the eligibility parameters need to be revisited.</b></p>			
<p><b>Unemployment rate- <u>IMPACT</u>: In addressing only Adams and Scioto Counties, this</b></p>	<p><b>10.3% in August, 2013 (4<sup>th</sup> highest rate in Ohio)</b></p>	<p><b>7.2% in August, 2013 (38<sup>th</sup> highest rate in Ohio)</b></p>	<p><b>10.8% in August, 2013 (3<sup>rd</sup> highest rate in Ohio)</b></p>

<p><b>information tells one that, unless there are minor children in the home, these large amounts of unemployed persons have only unemployment benefits coming into the household on a regular basis. Those benefits are time limited. Depression, anxiety, self medication used to cope (illegal street drugs, inappropriate use of Rx drugs and/or alcohol), accompany this situation. Treatment is available if the person seeks it, but they have no way of paying for the services. There is limited funding for indigent care available through the Board.</b></p>			
<p><b>Main provider of employment- <u>IMPACT</u>: Government employment is important in each county and serves as a major employer. Once established in a Government job, health and life insurance as well as decent wages are available. The comfort in knowing your family will be cared for now and in the future and there is money to live a comfortable life, the</b></p>	<p><b>Government and Services</b></p>	<p><b>Manufacturing and Government</b></p>	<p><b>Government</b></p>

<p>occurrence of mental health issues as well as addictions can be expected to lessen. Dr. Jitender Sareen found, in his longitudinal study of 34,653 Americans, that "...individuals with a household income less than \$20,000 per year were at increased risk for several lifetime mental health disorders and suicidal attempts compared to those participants who earned an annual income of \$70,000 or more."(IMA of South Florida, Dr. Dennis J. O’Leary, <u>News for Healthy Living</u>, 4/4/13) In addition he found that those who suffered a drop in income were susceptible to the addictive use of alcohol and other drugs.</p>			
<p>Nationally, 48 million people were without health insurance in the 1<sup>st</sup> quarter of 2013 (Center for Disease Control as reported by CNN; Americian Broadcasting Company, October, 2013.) <b>IMPACT:</b> When the Affordable Health Care Act goes into full effect, people living in the area’s communities will</p>	<p>Affects Adams County</p>	<p>Affects Lawrence County</p>	<p>Affects Scioto County</p>

<p><b>be able to treat health problems that would have gone untreated prior to having insurance. These same individuals will have less disposable income due to the payment of premiums.</b></p>			
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**Additional Sources of information Used in Chart Above:**

**Interviews with Provider Management Teams (2013)**

**SSA.gov**

**Elementsbehavioralhealth.com**

**Journal Archives of General Psychiatry**

**Portsmouth Daily Times**

**Assessment of Need and Identification of Gaps and Disparities**

2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gap issues and disparities, if any. (NOTE: ORC 340.03 requires service needs review of: (1) child service needs resulting from finalized dispute resolution with Family & Children First Councils; and, (2)

outpatient service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals)

This Board's needs assessment was completed in several stages. The primary indicators of the communities' needs came from the Provider agencies. Face to face interviews were conducted on site with each agency's management team. The Board Director and Clinical Consultant facilitated discussions around the key areas in the local system of care and the predictable needs based on the environmental findings. This included both MH and Substance Abuse concerns and issues. In addition, a town meeting was held by Ohio's Attorney General to discuss the current drug situation, specifically opiates that ravage Scioto and surrounding Counties. He commended Scioto County for the work that has been done and stated that he "wants to use the success Scioto County has had in dealing with the drug epidemic as a springboard for the statewide program".

Several areas of need are considered "givens" based on the professional literature, the consistency of Client grievances over time, the economic and cultural status of the region. Following is a summary of the needs identified through the above means that will be used to determine the Board's priorities.

Access problems in service provision, sometimes, mean there are simply more clients in need of specific services than there are clinicians and providers to meet that need. The substance abuse epidemic in this Board's area is a good example of that.

Dr. Harvey Siegal in his article *The "Perfect Storm": Drug Abuse Converges in the Heartland*, describes The Perfect Storm that gathered to create the opiate and heroin problems currently present in Ohio. He said, "We're seeing a convergence of things—a generation of young people willing to experiment with drugs, the arrival of new, powerful, prescription drugs on the scene, easy access to heroin and a compromised public health system. It all converges in a naïve population, leading to more addicted people, lives cut short through overdose and disease, and ongoing problems for our communities." ([www.med.wright.edu/citar/OSAM](http://www.med.wright.edu/citar/OSAM))

The Ohio Department of Health, in a conference specifically targeting drug use in Ohio described the High Risk Groups for Opioid Abuse and Death as:

- Men (for overdose deaths)
- Ages 25-54
- Caucasians
- Medicaid populations
- Rural population
- Mentally ill, especially with depression

The above demographics sum up the majority of the Board area client population with the exception of men as they are often not Medicaid eligible and, without a levy, this Board is not able to fund indigent clients with the exception of IDAT eligible individuals (more information on this group follows.)

Many agencies, however, do not hesitate to provide uncompensated care. With so many potential clients, agencies find that the first appointment is often made too long after the person's initial contact resulting in no-shows and cancellations. With this population, specifically, such a delay is not conducive to successful treatment.

Many clients and potential clients have transportation problems that prevent them from access to services. Money for gasoline by the middle or end of the month is gone (if it was ever available), automobiles and trucks have problems that are costly to repair, people live far distances from the providing agencies, they have no car at all, their licenses have been suspended and there is no public transportation except a small system in SC that is not particularly easy to use. Provider agencies have become creative in dealing with the transportation issues. Many of them have their own drivers and vehicles and provide round trip transportation to appointments. There are transportation grants that have been used over the years and JFS has a limited benefit to their clients who need to go to Medicaid funded appointments. That is limited to 17 round trips per year. That doesn't go far when you factor in all the appointments that a person has per year.

Access for people with private insurance and/or Medicare can also be difficult. Insurance companies are very specific about the credentials of persons providing MH or Substance abuse treatment. The local workforce does not always have enough of the specific credentials required to be able to treat the communities insured population. Also Medicare requires an Independently Licensed Social Worker to provide their treatment in MH and Substance abuse. They will not accept an Independent Counselor. The area has about a 50/50 split between these two types of clinicians.

Child care also limits access for people seeking treatment. It is expensive and often hard to find and maybe unreliable. Some agencies make it very clear that they will have staff available to care for the children when the parent is in the treatment session, but that does not apply to all agencies.

For some agencies it has been extremely difficult to contract with a psychiatrist that is not 100 or so miles away making it very difficult for the clients. Access is obviously a problem for these individuals.

Adams County as a whole has an access issue as there are only three agencies available to serve the entire county and they are all located in the small village of West Union located in the southern part of this geographically large county. This, by necessity, forces some people to go to agencies in neighboring counties ultimately affecting the economy of Adams County. Not only does this qualify as an access issue but is, also, obviously, a gap in services.

Another gap that was identified is the absence of long term safe and affordable housing. One interviewee asked about the congregate housing model from years ago and questioned why that couldn't be revisited. People had their own room and met together for meals and in a common living area for television, socialization etc. That describes many of the Adult Care Facilities (ACF) but the feel was more like the rooming houses of long ago. Actually it was voiced by several people that discussed the housing situation, that ACF's are "getting too big." The congregate living model seemed to produce a more homelike environment. There is also a need for Geriatric housing and one can expect that need to grow with the aging population. The Therapeutic Foster Care (TFC) network that was part of SMHC's array of services for many years has shrunk due to the retirements of several of the operators. It is and always has been difficult to find persons to operate TFC homes. The numbers of available places are now fewer and the need is far greater.

There is, occasionally, a need for psychological testing when working with children and, in this area, that is almost impossible to arrange. There are, simply, no psychologists practicing in Adams, Lawrence or Scioto county. Parents must be willing and able to transport their child to Cincinnati or Columbus for testing.

The area needs more prevention and early intervention services. It needs the availability of adequate detox services, particularly for individuals in residential treatment. More vocational services for the system's clients as well as the opportunity for education. More qualified counselors and therapists are needed to meet the needs of the people with health insurance which is about to become a greater need than ever with the President's announcement, as quoted in the New York Times on November 8<sup>th</sup>, which stated, in part, "...required to cover care for mental health and addiction

just like physical illnesses.” The president-elect of the American Psychiatric Association, Dr. Paul Summergrad, stated in the same article that this would end “the uniquely discriminatory form of prior authorizations and utilization review” that is now applied in emergency rooms for individuals presenting with symptoms of mental illness.

Interestingly enough, the discussions with providers around disparities in the system did indicate that persons with commercial insurance fall within groups of disparaged clients. Also identified in the disparity discussions were men without Medicaid, the working poor, transition aged youth and a small number of Hispanic individuals. It should be noted however, that the Hispanic population in the area has been encouraged to seek services when needed, but, as a group, seem reluctant to step forward for help.

Providers interviewed, which represented child serving agencies, stated that they were occasionally contacted to help with a case identified from their County’s Family and Children First Council. They willingly obliged. Some said they received small grants from the Council to run specific programs for local children.

People being discharged from state hospitals have presented problems in terms of outpatient follow-up care during this time of irregular crisis intervention services. When the new MH/AoD Crisis Stabilization Unit (MH/AoD CSU) is operational, clients can be admitted there as a step down unit and coordinating aftercare will be a smoother and more efficient operation. Another glitch in the discharge from State Hospitals has surfaced upon the switch to admitting ALS clients to the SBH in Cincinnati. The transportation for them to return to their home seemed very difficult for the hospital staff to coordinate. The patients were at risk when they missed the bus and were on their own when they arrived at the end of the trip with no one there to meet them. The Board worked with OhioMHAS to obtain the availability of the “hot spot” funds to contract with local transportation services to take the clients to the hospital in Cincinnati and return them upon discharge, directly, to their homes.

#### Strengths and Challenges in Addressing Needs of the Local System of Care

In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development. *(see definitions of “service delivery,” “planning efforts” and “business operations” in Appendix 2).*

3. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment? *(see definition “local system strengths” in Appendix 2).*
- **This is one of the five Board areas included in the Health Home pilot and the implementing agency, SMHC, is reporting successful outcomes.**
  - **There is more emphasis on continuity of care and an increased collaboration between agencies is noticeable.**
  - **Almost all provider agencies are willing to provide uncompensated care as needed.**
  - **The Board has heard reports that the MITS system of Medicaid reimbursement results in a much quicker turnaround for the agencies to receive their payments.**
  - **Providers have expressed a positive reaction to the Board now being more accessible to them and providing more transparency.**
  - **There is a sense that residents in communities want people off drugs for their own reasons not just for the users’ benefit.**
  - **While the area unquestionably needs more substance abuse prevention services, the ones that are currently being conducted are excellent. One provider reported that they have a method of keeping track of the clients who, as young children, participated their prevention programs. As adults these children are now teachers, social workers, college students and in other positive situations. This agency won the 2012 PRIDE Award for Innovation in an Educational Prevention Program.**
  - **Some Board providers have a great deal of longevity in the business, one as much as 40 years, and are well known in the communities and to long term clients.**
  - **An advocacy group of substance abuse providers, with members from three counties, is in the early stages of development and is using this as a means to increase access to the workforce in other counties.**
- a. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.
- **When the Health Homes are open across the State, SMCH may be willing to assist other agencies or lead a breakout session in a conference especially on the “lessons learned” piece**
  - **The positive response to the changes in this Board’s staffing and operations could be held out to other Boards, as a way to recover, if they find themselves in a similar situation.**
  - **The ALS Board began its recovery from several years of disorganization and poor management with the appointment of an Interim Director who subsequently was hired as the Executive**

Director, effective July 1, 2013. As a result of the new and competent management, progress is being made. There is confidence in the community and the service providers that the Board will emerge stronger and more effective than ever. In accomplishing this, strengths have been identified and built upon. Some of those strengths could be helpful to other Boards areas and in OhioMHAS as well. Those are identified below:

1. Review of agency chart documentation and completeness
2. Information Technology
3. Team building within the Board Staff
4. Cross training within the Board Staff
5. Community visibility of the Board

- The efforts of the Board to demonstrate a new and healthier relationship with all of the agencies seems to have served as a positive model of serving the interests of the county residents. A true continuum of care has emerged in some places, other than the Health Home, with provider agencies creating a complete network of health care under one umbrella in their own agency. This model can include all or several of the following health needs—early childhood prevention, school based services, primary health care, mental health treatment, substance abuse treatment, residential treatment, transitional housing, and, some, are currently leaning toward the development of permanent housing.

4. What are the challenges within your local system in addressing the findings of the needs assessment? (*see definition of “local system challenges” in Appendix 2*)

- Financial resources
- Clients getting to their appointments
- Waiting Lists for admission to some substance abuse residential programs
- Clients want medication; not therapy
- Providers are concerned about the needs of the new clients entering the system as Medicaid Expansion comes into effect; these will be people who may never have seen a dentist, an eye doctor or maybe a physician. There will be numerous health issues other than their presenting problem
- The people who have problems with alcoholism seem to be fading into the background and/or being pushed aside by the more prevalent prescription and “street” drug users
- Not enough prevention services available
- Evidenced Based Practices are very expensive though very effective; smaller agencies can’t afford to use them
- The available workforce is not meeting the needs; psychiatrists and independently licensed clinicians are

not readily available in the Board area's communities

- More and different services need to be available for Medicaid reimbursement
- Cost of electronics as related to technology is "killing them" stated one provider
- New competition setting up services in communities is sometimes perceived as "not playing by the rules"

The Board, as it moves forward with its operations, also, has several challenges facing it. They are:

1. A small staff
2. Successfully working to erase the poor reputation, locally and at the Department level that it had in the past.
3. Law suits and/or threats of litigation from previous employees
4. Learning new information and skills quickly
5. New, important and necessary projects appearing at a rapid pace; listed below are examples of work product, involving the Board, that did not exist this time last year:
  - The use of IDAT funds for treatment
  - The Recovery Requires a Community project
  - A grant, using Federal funds, to be operationalized as a Medication Assisted Treatment Drug Court in Scioto County
  - The Health Home at SMHC
  - The new MH/AoD CSU and Hot Line project at TCC
  - Became Fiscal Agent for SOLACE
  - Being one of the chosen Boards to work with NIATx on their buprenorphine and value of coaching project
  - The Board's hospitalized clients are being sent to SBH in Cincinnati and the resulting troubleshooting and need for transportation contracts.
  - An RFP, recently received, related to a Juvenile Justice and high risk youth project that is to be distributed to providers for follow up if interested
  - An opportunity to locate and reimburse the needed guardians for the hospitalized clients

- **Gambling funds and the process of using them to insure competent services in the area for individuals with gambling addictions**
- **Medicaid Expansion and the ramifications of that change in eligibility requirement to the Board's system of care**
- **The President's very recent dictum that stated true parity will be available for mental health and substance abuse services**

a. What are the current and/or potential impacts to the system as a result of those challenges?

**The Board's, current, challenges that could ultimately have an impact on addressing the findings of the needs assessment are listed below:**

**There seems to be a tendency to be somewhat cautious when dealing with the Board based on the past management's reputation. Some community entities, agency management and state department individuals were frustrated by Board communication and contacts in the recent past. The new management team must be especially forthright and transparent in its dealings with the public and private sectors related to the working of the area's mental and health and substance abuse issues.**

**The Board is currently, with no change planned in the immediate future, working with four FTE's and one clinical consultant. The impact of this situation could lead to burn out of current staff, delay in accomplishing goals, possible errors from multiple tasks with limited time frames and feelings of dread, rather than excitement, to take on new and time consuming projects.**

**The positive impact, however, of a small staff can be seen in relationships, cross training expertise and the staff's propensity for team work when needing to implement a new program or project to meet the needs of the area.**

b. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

**Due to of the examples cited below, this Board will not hesitate to ask for assistance from other Board and/or the Department.**

**The new Director of the Board will be the first to cite the importance of learning from Department held meetings and trainings. Also, other Board Directors have been very generous with their time and information that has been a great asset to the learning process involved in this complex position and system.**

**The Board has sent its Finance Officer to spend two days with a seasoned Finance Officer at another Board quite a distance away. This impact is both positive and negative. The person sent learned a great deal and has less anxiety around the work being done. However; the trip took the staff person away for work for two entire days and incurred**

**travel costs.**

5. Describe the Board's vision to establish a culturally competent system of care in the Board area and how the Board is working to achieve that vision (*see definitions of "cultural competence" and "culturally competent system of care" in Appendix 2*).

**This Board's Vision of a culturally competent system of care is one that provides services, for all individuals needing them, in a manner that enables the person needing assistance to feel comfortable and trusting enough in the treatment setting so that all his/her energy is available to work on the problem and not have to deal with conflicts and discomfort brought on by cultural bias.**

**For the most part, that occurs as a natural consequence of the clinical/provider staff being of the same culture as the clients; that being the Appalachian culture. While the strength of the beliefs and foundations in this local culture overrides change in attitudes toward other cultures, there are limited occasions when other cultures show up in the treatment scenario. That having been said; it is important to note that Appalachian cultural traits can surface as a subculture in minority groups such as African American and Hispanic. On those occasions the treatment milieu must be varied to take into account the individual being treated.**

**Age related generational differences are the most prominent discrepancies notable in the service delivery partnership within the agencies. Language, dress, attitudes, technology related to communication and judgment differ widely between large gaps in ages.**

**True example: A young, female case manager had an elderly African American woman diagnosed with Bi-Polar disorder who was getting ready for church. The case manager documents that the client's manic phase was beginning to surface because she (the client) was going to wear a very large, very colorful hat to church. Attending church is prominent in both Appalachian and African American cultures. Older women in the African American population will often wear hats, as the one described here, to church. Cultural elements here involve two different cultures, age, and gender.**

**Another issue that has a strong bearing in providing treatment is a well known contradiction within the Appalachian culture. People who come from families of several generations of Appalachian individuals, often, know "not to share their dirty laundry," and they also know that "around here we take care of our own." How do they do that if others don't know what is causing problems within a person or family?**

6. Considering the Board’s understanding of local needs, the strengths and challenges of your local system, what has the Board set as its priorities for service delivery including treatment and prevention and for populations? Below is a table that provides federal and state priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board’s priorities, and add the Board’s unique priorities in the space provided. For those federal priorities that are mandatory for the OhioMHAS and not selected by the Board, please check one of the reasons provided (e.g., no assessed local need, lack of funds to meet need, lack of necessary professional staff) or briefly describe the applicable reason.

**Priorities for the ADAMHS Board of Adams, Lawrence, Scioto Counties**

**Substance Abuse & Mental Health Block Grant Priorities**

**\*Priorities Consistent OHIOMAS Strategic Plan**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>SAPT-BG: Mandatory (for OhioMHAS):</b> Persons who are intravenous/injection drug users (IDU)	<ol style="list-style-type: none"> <li><b>1. Identification and estimation of the number of IV drug users in the Board's catchment's area.</b></li> <li><b>2. Learn which medications and/or treatment modalities are beneficial to these individuals.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Determine which providers treat IV drug users, which medication and/or which treatment modalities are used in which agency.</b></li> <li><b>2. Learn how many IV Drug Users were actualized treated in SFY13 and in which agency.</b></li> <li><b>3. Contact these providers for information sharing regarding outcomes.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Calculate the percentage of persons treated verses the estimated number of persons using IV's for their drug use.</b></li> <li><b>2. Review the SFY14 number of persons treated and compare to SFY13 and calculate the percentage treated verses the estimated number of IV users in the area.</b></li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)</b>	<ol style="list-style-type: none"> <li><b>1. Insure information is widely disseminated so that every pregnant woman with substance abuse issues is aware that help is available.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Publicity campaign</b></li> <li><b>2. Ask agencies to have appropriate brochures in their waiting rooms addressing the dangers of substance abuse while pregnant and where to go for treatment.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Data will show an increase in the numbers of pregnant women in treatment in the AoD agencies and/or residential facilities in this area.</b></li> <li><b>2. Data will show a decrease in the number of drug affected babies born.</b></li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>SAPT-BG: Mandatory: Parents with substance abuse disorders who have dependent children (NOTE: ORC 340.03 (A)(1)(b) &amp; 340.15 required consultation with County Commissioners and required service priority for children at risk of</b>	<ol style="list-style-type: none"> <li><b>1. In Board Quality Assurance meetings (QA), reiterate this mandate to all child serving and substance abuse agencies.</b></li> <li><b>2. Meet with the County Commissions</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. When conducting Utilization Review (UR) audits, there will be a specific attention given to such circumstances and the treatment will be examined for evidence that it has been addressed with either the child</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. UR notes and QA minutes will reflect the work done related to children who have parent with substance abuse issues.</b></li> <li><b>2. Meetings noted on Director's</b></li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

parental neglect/abuse due to SUDs)	in each county about this requirement.	and/or the parents.	calendar.	
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases	<ol style="list-style-type: none"> <li><b>The Board will contact the Health Departments in each County and note the number of active Tuberculosis cases they are aware of in their individual counties in the past two years.</b></li> <li><b>In addition, the Health Departments will be asked to comment on the existence of other communicable diseases, such as Hepatitis C and AIDS, within their county.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>Depending on the answers from each County, a copy of the protocol used when a case is identified, will be requested from the appropriate Health Department.</b></li> <li><b>Follow up information related to the status of the case(s) will be requested every six months using a Tickler System to insure that is accomplished.</b></li> <li><b>Depending on the status of the person afflicted with TB or another communicable disease, there will be more tracking or the case will be closed from the Board's records.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>At the end of each State Fiscal Year (SFY) a reports will be compiled using the collected information and will measure the outcomes identified.</b></li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH-BG:</b> Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	<ol style="list-style-type: none"> <li><b>Insure all MH agencies who serve children have policies and procedures in place if they plan to enroll and treat SED children.</b></li> <li><b>Continue efforts and plans to add a Children and Youth Crisis Stabilization Unit (CSU) to the Board's array of services.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>During QA and/or UR audits in area child serving agencies, review the policy and procedures in current use related to serving SED Children and Youth.</b></li> <li><b>Follow up on any grant or other funding opportunity that address the need for a Children's CSU.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>Documentation that provides results of any QA and/or UR audit conducted in any MH child Serving Agency</b></li> <li><b>The award of a grant or additional specified funding used to fund a Children's CSU</b></li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH-BG:</b> Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	<ol style="list-style-type: none"> <li><b>Insure all MH agencies who serve adults have policies and procedures in place if they plan to enroll and treat SMI Adults.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>During Board conducted QA and/or UR audits in area agencies, review the policy and procedures in current use related to serving SMI Adults.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>Documentation that provides results of any QA and/or UR audit conducted in MH agencies which serve adults</b></li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>MH&amp;SAPT-BG:</b> Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*	<ol style="list-style-type: none"> <li>1. Encourage the Board affiliated agencies to consider adding primary health care to the services available to their clients.</li> </ol>	<ol style="list-style-type: none"> <li>1. Upon review of the agencies' annual Agency Service Plans, note the agencies that do not offer primary care and discuss the idea in more depth with those that are interested.</li> </ol>	<ol style="list-style-type: none"> <li>1. If an agency that has expressed interest in providing integrated services actually does begin the process to provide it.</li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>MH&amp;SAPT-BG:</b> Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders	<ol style="list-style-type: none"> <li>1. The Board will continue to operate as the Fiscal Agency for the SOLACE group.</li> <li>2. When asked the Board will send a representative to SOLACE sponsored activities</li> <li>3. The Board will encourage Community Counseling to publicize the open meeting they have every Saturday evening for the residents of LC who are in recovery.</li> </ol>	<ol style="list-style-type: none"> <li>1. The Finance Director at the Board will be responsible for monitoring the use of the SOLACE funding and will report on a 6<sup>th</sup> month basis the findings to the Executive Director (ED) who in turn will include it in the Director's Report at the monthly Board of Directors' meeting.</li> <li>2. There will be a staff member available to attend SOLACE events as needed.</li> <li>3. Meet with management staff at Community Counseling to suggest they publicize the Saturday evening meeting they have for people in recovery.</li> </ol>	<ol style="list-style-type: none"> <li>1. The Finance Director will compile an annual report from the budgetary information on file showing the percentages of funding spent in separate categories.</li> <li>2. All SOLACE events will be briefly documented and given to the Board's Executive Director within one week of staff attendance.</li> <li>3. The Board knows the baseline number of current participants that attend this meeting. The Board will monitor this number on a six month basis to note growth in participants.</li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant</b>				
<b>*Priorities Consistent OHIOMAS Strategic Plan</b>				
<b>Treatment:</b> Veterans				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input checked="" type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): <b>Veterans will be treated at provider agencies if they present for services. There is a</b>

				VA outpatient clinic in SC and three VA Medical Centers in the area; one within 100 miles of each of the Board's counties.
<b>Treatment:</b> Individuals with disabilities				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): <b>Systems in place to serve this population</b>
<b>Treatment:</b> Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*	<ol style="list-style-type: none"> <li><b>1. Treatment and Recovery support has been a goal of this Board since it became clear, in 2010, that the area had a major problem in the illegal use of this class of drugs.</b></li> <li><b>2. This goal is and has been a major priority for the Board since it became clear in 2010 that Southern Ohio, specifically, Scioto County, was the Opiate Capital of the United State.</b></li> <li><b>3. Now that the Pill Mills have been removed, an upsurge in the use of Heroin has become the norm. It is more available and costs less than opiates and other prescription drugs. In addition, new and, even more, dangerous drugs are appearing "on the streets" in some metropolitan cities. Krolkodil (OhioMHAS, e-Update, November, 2013) and</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. New Substance Abuse Certified agencies have been opened in this area. Some are satellite clinics of existing agencies moving into other counties. There is one new agency in AC that is operating under the auspices of a different Board. While we have no formal arrangement with them, the Director has met with them and made the Board's presence known.</b></li> <li><b>2. The development and implementation of a local AoD CSU is a step toward helping people get through the withdrawal stage and on to the work of recovery.</b></li> <li><b>3. More attention is being given to the development of Narcotics Anonymous (NA) meetings and other Twelve Step Groups to assist in the Recovery process and status</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Overtime there will be new information regarding the numbers of individuals, locally, who are addicted to opiates and heroin. Comparison with the current numbers will indicate a certain measure of success or failure.</b></li> <li><b>2. Crime rate fluctuation is another indicator of the use of illegal drugs.</b></li> <li><b>3. Enrolled clients in the Substance Abuse Program should be consistently higher each year.</b></li> <li><b>4. One agency that conducts a Twelve Step group each Saturday night has reported a steady increase in attendance each week.</b></li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

	<p>Zohydro (m.motherjones.com) will soon be finding their way to Adams, Lawrence and Scioto counties.</p> <p>4. The Board will continue to endorse all efforts to decrease the numbers of opioid addicted individuals in the three county region. Public events, prevention efforts, outpatient treatment and residential services will be supported in any way possible by the ALS Board and its staff.</p>	<p>quo of the recovering person.</p> <p>4. Learn of all public, community events being held to publicize the dangers of opiates.</p> <p>5. Subscribe to e-mails and web sites from Health Departments (in each County), SOLACE, OhioMHAS Events, and Substance Abuse events as well as national organizations and associations. Learn of all public, community events being held to publicize the dangers of opiates.</p>		
<p><b>Treatment:</b> Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*</p>	<p>1. The Homeless Shelters in each County do not serve persons with behavioral health issues in a manner that would be useful over time. Their stays are, typically, short and the emphasis is more on families who are homeless than on individuals. The availability of safe and affordable permanent housing is a goal of this Board as part of the solution to the homeless situation in this area.</p>	<p>1 Board staff attended the recent Recovery Housing Conference to gain a more comprehensive knowledge base related to housing for individuals in recovery that provides a supportive environment and peer association.</p> <p>2 Two of the substance abuse treatment agencies have expressed interest in adding Recovery Housing to their array of services with the goal of making them permanent</p>	<p>1. Data will be kept related to the number of homeless persons admitted to the MH/AoD CSU and to a hospital.</p> <p>2. That data will be analyzed over time to compare it with previous information related to hospital admissions or other dispositions of homeless persons.</p>	<p>___ No assessed local need          ___ Lack of funds          ___ Workforce shortage          ___ Other (describe):</p>

		<b>housing.</b>		
<b>Treatment:</b> Underserved racial and ethnic minorities and LGBTQ populations				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): <b>Small demographic of racial, ethnic and LGBTQ</b>
Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>Treatment:</b> Youth/young adults in transition/adolescents and young adults				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): <b>MH agencies, serving SMI and SED clients, currently have a mechanism that automatically moves the youth in a seamless way into the adult programs</b>
<b>Treatment:</b> Early childhood mental health (ages 0 through 6)*				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Adopt a public health approach (SPF) into all levels of the prevention infrastructure				<input checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input checked="" type="checkbox"/> Workforce shortage (prevention specialists) <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Empower pregnant women and women of child-bearing age to engage				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds

in healthy life choices				<input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): <b>The SC Coalition has a project dedicated to this mission.</b>
<b>Prevention:</b> Promote wellness in Ohio's workforce				<input type="checkbox"/> No assessed local need <input checked="" type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*	<ol style="list-style-type: none"> <li>1. The Board will establish a network of gambling addiction prevention resources and outreach overtime. Currently the need rests on the prevalence of opportunities and exposure to gambling within range of the Boards' three counties. Those opportunities are quickly expanding. For example, a new Racino is opening soon on the east side of Cincinnati which is closer to AC than the current Cincinnati casino in operation.</li> </ol>	<ol style="list-style-type: none"> <li>1. The Board is working with The Voinovich School of Leadership and Public Affairs at Ohio University In an effort to determine the actual, current, need for services and community attitudes related to gambling. A mail-in survey designed to measure attitudes and participation was mailed to 1200 randomly chosen participants divided equally between the three counties.</li> <li>2. An invitation to each of the Board's addiction providers was made to send two of their staff, who will be working with gambling addiction prevention, to three session training at the Board's expense. This was done in an effort to prepare providers for this addition to the local array of services. No interest in this opportunity was expressed.</li> <li>3. A discussion group will be assembled from the addiction providers to examine this lack of interest and to address</li> </ol>	<ol style="list-style-type: none"> <li>1. The Survey results will be the core measurement at this time.</li> <li>2. Once prevention and treatment programs are established and operational, data will be kept with specific data points examined.</li> </ol>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): <b>A local group focuses on wellness issues in the workforce with include gambling addiction.</b>

		possible solutions.		
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<b>Board Local System Priorities (add as many rows as needed)</b>			
<b>Priorities</b>	<b>Goals</b>	<b>Strategies</b>	<b>Measurement</b>
SMI Adults treatment and support services	<ol style="list-style-type: none"> <li><b>1. Insure all MH agencies who serve adults have policies and procedures in place if they plan to enroll and treat SMI Adults.</b></li> <li><b>2. If an agency does include Serious Mental Illness (SMI) adults as a population they treat, insure that there are support services available from the agency itself or the case manager have linked them to appropriate support.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. During the Board UR audits, special care will be taken by the reviewers conducting the audit to examine the modes of treatment and the accompanying or follow up support that is provided for each SMI client that is reviewed.</b>  <b>If not found, a subsequent meeting will be held with the agency Director, the Clinical Director, the UR Reviewers and the Board's Executive Director to develop a Plan of Correction.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Utilization Review Audit Reports and, if necessary, a follow up visit after the correction plan has been in place six months.</b></li> </ol>
SED Children	<ol style="list-style-type: none"> <li><b>1. Insure all MH agencies who serve children have policies and procedures in place if they plan to enroll and treat Seriously Emotionally Disturbed (SED) children.</b></li> <li><b>2. Continue efforts and plans to add a Children and Youth Crisis Stabilization Unit (CSU) to the Board's array of services.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. During the Board UR audits, special care will be taken by the reviewers conducting the audit to examine the documentation of SED children as well as samples from the Children's Program in the Agency. Modes of treatment and the accompanying or follow up support that is provided to children and families will also be carefully reviewed in each Seriously Emotionally Disturbed (SED) child's chart.</b></li> <li><b>2. It is expected that if the work reviewed is</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Utilization Review Audit Reports and, if necessary, a follow up visit after the correction plan has been in place six months.</b></li> </ol>

		<p>acceptable, it would be so for every SED client. If sufficient evidence of acceptable treatment is not found, a subsequent meeting will be held with the agency Director, the Clinical Director, the UR Reviewers and the Board's ED to develop a Plan of Correction plan.</p>	
<p>Opiate Addicts</p>	<ol style="list-style-type: none"> <li>1. Treatment and Recovery support has been a goal of this Board since it became clear, in 2010, that the area had a major problem in the illegal use of this class of drugs.</li> <li>2 This goal is and has been a major priority for the Board since it became clear in 2010 that Southern Ohio, specifically, Scioto County, was the Opiate Capital of the United State.</li> <li>3 Now that the Pill Mills have been removed, an upsurge in the use of Heroin has become the norm. It is more available and costs less than opiates and other prescription drugs.</li> <li>4 The Board will continue to endorse all efforts to decrease the numbers of opioid addicted individuals in the three county region. Public events, prevention efforts, outpatient treatment and residential services will be supported in any way possible by the ALS Board and its staff.</li> </ol>	<ol style="list-style-type: none"> <li>1 New Substance Abuse Certified agencies have been opened in this area. Some are satellite clinics of existing agencies moving into other counties. There is one new agency in AC that is operating under the auspices of a different Board. While we have no formal arrangement with them, the Director has met with them and made the Board's presence known.</li> <li>2. The development and implementation of a local Detox Unit is a step toward helping people get through the withdrawal stage and on to the work of recovery.</li> <li>3. More attention is being given to the development of NA and other Twelve Step Groups to assist in the Recovery process and status quo of the recovering person. Learn of all public, community events being held to publicize the dangers of opiates.</li> <li>4. Subscribe to e-mails and web sites from Learn of all public community events being held to publicize the dangers of opiates. Subscribe to e-mails and web sites from Health Departments (in each County), SOLACE, OhioMHAS Events, and</li> </ol>	<ol style="list-style-type: none"> <li>1. Ohio Department of Health data will be monitored for noticeable decreases in the use of opiates in the area.</li> <li>2. Data will be kept by the new AoD Crisis Stabalization Unit related to numbers of admissions, multiple admissions, substances of choice, disposition upon discharge and length of stay (LOS).</li> <li>3. Records will be maintained related to staff attendance at each event.</li> </ol>

		<b>Substance Abuse events as well as national organizations and associations.</b>	
Pregnant Women using Substances	<ol style="list-style-type: none"> <li><b>1. The numbers of local babies being born with Neonatal Abstinence Syndrome (NAS) will decrease.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1 Insure information is widely disseminated so that every pregnant woman with substance abuse issues is aware that help is available.</b></li> <li><b>2 Publicity campaign</b></li> <li><b>3 Ask agencies to have appropriate brochures in their waiting rooms addressing the dangers of substance abuse while pregnant and where to go for treatment.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Ohio Department of Health will have data to reflect SFY14 information that will include numbers of babies born with NAS per county.</b></li> </ol>
Seamless Crisis Intervention Services	<ol style="list-style-type: none"> <li><b>1. The new MH/AoD CSU for both substance abusing clients and mentally ill clients along with the Detox Unit and the Hotline services will be up and running by the beginning of calendar year 2014.</b></li> <li><b>2. People who require the services of a hospital rather than the MH/AoD CSU will be admitted promptly and without difficulty.</b></li> <li><b>3. The problems there that have occurred with transporting individuals home upon discharge from the hospital will be corrected.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. All parties involved in the development of this project have been completing their responsibilities for the past three months and the target opening date is currently mid-November.</b></li> <li><b>2. The current Crisis Intervention (CI) services that have been in place for SFY13 will continue without interruption and with the monthly Utilization Review teleconferences to address any problems that have surfaced.</b></li> <li><b>3. Contracts were made with two different transportation services who pick up discharged clients and deliver them to their homes. OhioMHAS, authorized the use of the “hot spot” funds for this purpose.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Monitoring of the progress of the project and noting when the first client is admitted.</b></li> <li><b>2. The Board will be represented at the UR calls to note any situations that need attention and/or to monitor the seamlessness of the admission.</b></li> <li><b>3. The Board will be represented at the UR calls to note any transportation related situations that need attention and/or to monitor the seamlessness of the clients return to his home.</b></li> </ol>
State Hospital Bed Day Usage within range	<ol style="list-style-type: none"> <li><b>1. The, November 2013 opening of the MH/AoD CSU along with a functioning Hot Line at The Counseling Center in Portsmouth is expected to give the Board more control over their bed day usage.</b></li> <li><b>2. The Crisis Intervention (CI) and</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. The Board worked closely with the chosen provider, OhioMHAS, the Collaborative, the Board of Directors, the Board’s legal advisor to obtain the necessary funding, to be fair and legal about the physical placement of this project.</b></li> </ol>	<ol style="list-style-type: none"> <li><b>1. Data will be kept regarding number of hot line calls and disposition.</b></li> <li><b>2. Data will be kept regarding the MH/AoD CSU admissions, Length of Stay (LOS) and outcomes.</b></li> </ol>

	<p>Assessment services that the Board has used for the past year will remain in place at FRS, Inc. The combination of the two will equate to a CI system that will preserve the Board's bed day integrity, be more "client friendly" and provide a more seamless crisis system.</p>	<p>2. There will be media coverage of the opening and publicity as appropriate to insure that the community is aware of this new service and the continuation of the CI services through FRS, Inc.</p> <p>3. There has recently been a change in the availability of guardians which has, in the past, been a detriment to discharge for some clients. Once the guardians are in place, some "difficult to place" clients will leave the hospital making the bed day usage more realistic.</p>	<p>3. Data will be kept regarding the Detox unit admissions, LOS and outcomes.</p> <p>4. Data will continue to be kept regarding the CI services and dispositions of the crisis call.</p> <p>5. Satisfaction surveys will be available on discharge for the clients of the MH/AoD CSU.</p> <p>6. Hospital admission data will continue to be kept and monitored; comparing the numbers before and after the opening of the MH/AoD CSU.</p> <p>7. Information on the barriers to discharge is also being collected and will provide other goals that can be approached in the future to continue the work toward management of the bed day usage.</p>
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**Priorities (continued)**

7. What priority areas would your system have chosen had there not been resource limitations, and why? If you provide multiple priority areas, please prioritize.

Priority if resources were available	Why this priority would be chosen	
(1) Children’s Crisis Stabilization Unit	<p>This priority would be chosen by the Board and by OhioMHAS if the system of care currently in place that serves children in crisis could be carefully and completely examined by funders who have the means and authority to change it. Recently a 7 year old girl was presented to a local emergency room (ER) with a history of killing six small animals, sexually assaulting both of her brothers, one three years old and the other 9 years old and her mother who found her attempted to kill a seventh animal had dropped her off at the ER and left stating “she’s your problem now.” Efforts were exhaustive to find treatment for her on an inpatient basis at every facility in Ohio that the Social Worker could identify. Efforts were made to find such a facility in bordering States. Most facilities would not consider her and the ones that would did not as she was currently not exhibiting hospital worthy behavior. She had been tabularized at the ER. The end result was finding her a two to three day stay at a facility in West Virginia and getting Children’s Services involved. Usually a child in crisis, not as severe but in need of hospitalization, is sent to Children’s Hospital in Cincinnati. This is at least a three hour drive for some of the residents in this Board’s region. There needs to be a Crisis Stabilization Unit in the Region as many of these children could be stabilized in a few days, locally, if that type of service was available.</p>	
(2) Early Childhood mental health (0-6 years old)	<p>In the past, this Board, consistently, has been invited to apply for mini-grants to fund local Early Childhood Services as part of a statewide Request For Proposal (RFP). They were, subsequently, chosen to receive one of the grants from the Childhood Mental Health division of OhioMHAS, When similar grants were offered in SFY12, specific counties appeared to be invited to apply.</p> <p>The ALS Board would like, once again, to be part of the Early Childhood MH network across the State and hopes that, if such funding is available, ALS has the opportunity to apply.</p>	

8. Describe the Board's accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years.

**This Board came under new management on July 1, 2013 and with that came the commitment to visibility and transparency not just to the service providers but, also, to the communities which fall within the Board's region. The Board's role is a major factor contributing to the health and well being of the residents of the ALS counties. The following activities are ones in which the Board was a participant; not just to perform the assigned tasks, but to present itself in a new light to the local communities:**

- **Scioto County Drug Action Team**
- **Elder Abuse Awareness Rally**
- **Lawrence County Community Action Strategic Planning luncheon**
- **Area Agency of Aging annual volunteer recognition luncheon**
- **The monthly meetings of each counties' Family and Children First Council**
- **Adams County Behavioral Health Coalition**
- **Scioto County Port Authority was offered meeting space in the Board offices and accepted**
- **State Opiate Task Force**
- **Participated in the Health Department's Rally for Recovery**
- **Scioto County Health Coalition**
- **Participated in the Lawrence County Food Drive**
- **Attended open houses of two new Agency sites in Scioto County**
- **Participated in an agency 5K walk to raise awareness around substance abuse**
- **Attended multiple rallies and awareness raising events in Columbus regarding Medicaid Expansion**

9. Describe the interaction between the local system's utilization of the State Hospital, Private Hospital(s) and/or outpatient services and supports. Discuss any changes in current utilization that you expect/foresee

**A little background is necessary prior to describing the Crisis Intervention and Systems of Care at the ALS Board. Shawnee Mental Health Center (SMHC) operated a ten bed Crisis Stabilization Unit (CSU) in Portsmouth. It was effective, well known within the communities and served the clients and the Board well. It kept the hospital bed usage within a reasonable range and the clients received the respite from their lives as needed. Then the Board's previous Director chose to use the funding that supported the CSU, Hotline and the Crisis Intervention (CI) staff for a different program. Without funding, SMHC could no longer operate these services and, effective, 6/30/12 they were shut down.**

**One of the previous on-call workers, who had been a long time employee of SMHC, approached the Board with a plan to continue providing the CI responses himself and arrange for hospitalization, if needed. This would be on a contract basis. Because of the need for a supervisory signature, as a diagnosis would be involved, the plan expanded to a certified MH agency that would employ and pay him and the contract would be with the Board.**

**This has worked well for the Board except for occasional large spikes in the State Regional hospital admissions. The private hospitals in this areas are reluctant (read: refusing) to take MH clients from this area.**

**Speculation indicates that some of these hospitalized clients are ones that would have been more appropriately served in the CSU. Although it was never in doubt, this confirmed that there continued to be a place for Hotline and CSU services. Therefore, the Board found it necessary to speak to this need, at the Department level, the Collaborative level, the local level, its trade association and its Board of Directors.**

**The changes which are currently in their implementation stages are a direct result of the Board staff's efforts. A CSU along with a Ambulatory Detox Center affiliated with The Counseling Center, Inc. is due to open in mid-November. There will also be Hotline services operated from the CSU. For the first year the CI will continue to be provided per the contract with FRS Counseling.**

**While the Board's bed day usage has recently been closer to the number that was predicted, this new crisis plan with all of the necessary components will insure that the admissions are more appropriate and the numbers should remain reasonable.**

**The other change that affects Board clients, who are in crisis, is the need to have them hospitalized at the Summit Behavioral Health (SBH) hospital in Cincinnati. This is only while there is major construction occurring at the Appalachian Behavior Healthcare (ABH) hospital in Athens which is officially this Board's State Regional Hospital. This change has presented major issues for the patients, their families and the Board.**

**The switch in hospitals has only been in effect for a couple of months, but the problems for the clients and the Board are quickly surfacing. The most obvious drawbacks are those that affect the clients. The problems are all, currently, involving cultural obstacles and transportation.**

**The change has resulted in persons, with mental health issues, from rural areas that have lived within a primarily Caucasian and Appalachian culture all of their life, suddenly being taken to a large metropolitan area while at the same time not doing well within the parameter of their illnesses. This seems to be a recipe for a possible disaster. While that may be too strong a position for the Board to take, this situation certainly does cause the clients discomfort. There**

have been “acting out” episodes during the stays at SBH that, based on the history of the specific client, may not have happened at ABH.

In addition, those with supportive families who have historically transported the client to his/her home upon discharge, now must drive more miles into city traffic and congestion; use more gas and, at least the first time, getting lost in Cincinnati.

The Board knows this is a temporary situation and the families and patients are aware of that, but during this time it is predictable that there will be complaints.

Transportation has also become a serious issue for the clients who are alone and, often, without guardians. They have been required, by necessity, to return home via the “Go Bus,” that drops them off approximately 20 miles from their homes in counties that are, sometimes, not in the Board’s region. Because of this situation and SBH staff who have expressed concern, due to clients wandering off or not being picked up when they leave the bus, the Board has chosen to step in. It will use its “hot spot” funds to contract with local transportation companies to provide transportation directly to the clients’ homes. This plan shall be operationalized in the near future.

On another note, rumors have reached the Board that the move of this population will be permanent and they will continue being treated at SBH. If this idea does come to fruition, the Board is going on record as saying this does not seem to be in the best interests of the clients.

### Innovative Initiatives (Optional)

10. Many boards have implemented innovative programs to meet local needs. Please describe strategies, policy, or programs implemented during the past two years that increase efficiency and effectiveness that you believe could benefit other Ohio communities in one or more of the following areas?

a. Service delivery-

- Since SMHC was selected as one of the five pilot projects to test Health Homes in the State, the information and experience gained during the implantation phase, particularly, could be helpful to other Boards and/or agencies in the future.
- It is described below, the Board worked diligently on the Planning Process, but it was also necessary to work with the provider to identify the services needed, the funding for the services and the aftercare arrangements. Other Boards could benefit from the planning and implementation of the ALS Board around this project or ones similar.
- In discussions with staff at OhioMHAS and the App Care Collaborative, it was learned that the Board’s “hot spot” funds could be used to correct the transportation problems for patients being discharged from SBH. Steps were taken to use some of those funds, locally, to provide safer and more efficient transportation.
- The Board also learned that the problem arising from a dearth of volunteer guardians in the area, that the “hot spot” funds could also be used to pay for guardians which will facilitate the previously impossible discharges of long term clients who needed to be living in the

community.

b. Planning efforts-

- As the Board found itself without a CSU and Hotline services and, quickly, learned the necessity of having this system, the management team sought ways to fill this need. Funds were sought and found. An RFP was issued to the Board's provider panel and the Board of Directors selected the most promising candidate to develop and implement the plan. Meetings were held with OhioMHAS, the AppCare Collaborative and the chosen provider to, among other things, to work out the glitches. The end result is the opening of the new MH/AoD CSU along with a Hotline service. Such planning steps and protocols could be duplicated for other major projects and the Board is willing to share what it learned during this process with other Boards.

c. Business operations:

- In the past, under other management, this Board has made budget allocation decisions based on the previous SFY's agency allocations and their performance. This system did not allow for new providers to participate nor did it seem fair to the agencies which did not previously have access to the non-Medicaid funds. This SFY's allocation decisions were made from a review of specifically written RFPs that were submitted by agencies with an interest in the non-Medicaid funds that could be available.

d. Process development and coaching along with quality improvement

- This Board was chosen to be a part of a study conducted by NIATx that is designed to measure the value of using coaches to facilitate projects as opposed to not using them. Participating provider agencies are included but are using different but compatible projects. A secondary goal of the study is to increase the amount of clients that are prescribed buprenorphine in their treatment of opioid addiction. The Board chose the use of IDAT funds as a project as it also required participation from opioid addicted individuals. It seemed to be a natural fit. There has been significant time needed to conduct this project under the terms of the NIATx study. It did become clear, however, that, without the involvement of the Coach Leader at the Board and Coach from NIATx, the project would not have been completed with the same amount of quality and detail.
- Early in 2012 the Board was informed that, under ORC 4511.191(H)(3)(a), Indigent Driver Alcohol Treatment (IDAT) funds generated from the IDAT programs and sent to local Municipal; and Juvenile Courts had always been meant to be used to provide addiction treatment for indigent individuals who were convicted of a substance abuse related crime. The funds were to be administered by the local ADAMHS Boards. To implement this change in philosophy, use and participation from the courts, a great deal of work and restructuring the Board financial operations, the court referral mechanisms and the providers' treatment and reporting protocols. Several training and information meetings were held and Memos of Understanding needed to be written and signed by all the entities involved.
- The Board had discontinued all of its quality assurance and utilization review work some time ago by direction of the previous management. Those processes are being resumed as required by

**the ORC. Work has begun on establishing the protocols to insure consistency developing the means to monitor Quality and the Utilization of treatment services by the providers.**

- **In addition, the Board is resuming work in preparation for applying for the OACBHA Culture of Quality accreditation.**

Please provide any relevant information about your innovations that might be useful, such as: how long it has been in place; any outcomes or results achieved; partnerships that are involved or support it; costs; and expertise utilized for planning, implementation, or evaluation.

### **Advocacy (Optional)**

11. Please share a story (or stories) that illustrate the vital/essential elements you have reported on in one or more of the previous sections.

**Meet Joe, an adult client with schizoaffective disorder, he has been a client of Shawnee for over 25 years. He has a history of incarceration due to being violent with law enforcement and after becoming an adult he was hospitalized at least annually at the state psychiatric hospital. He has had diabetes and had chosen to ignore it for years. Since receiving integrated care and establishing a trusting relationship with the on-site primary care staff, his diabetes is now being treated actively. He knows how to check his blood sugar and has been fitted with special shoes. He has bought himself a bicycle and rides several times a week weather permitting. One of the Health Home Navigators is meeting with Joe to educate him on caring better for his disease. Joe is receptive and glad to participate. As far as smoking cessation, he states that he has quit for over 60 days, but he still uses smokeless tobacco. We are continuing to work on this. Joe says "Shawnee has been my family ever since I came here as a teenager."**

### **Open Forum (Optional)**

12. Please share other relevant information that may not have been addressed in the earlier sections. Report any other emerging topics or issues, including the effects of Medicaid Expansion, which you believe are important for your local system to share with the Departments or other relevant Ohio Communities.

- **Chris Jennings, a native of Ohio, reported on the 10/21/13 White House Blog that the recently passed Ohio's Medicaid Expansion will provide "270,000 previously uninsured residents" with Medicaid**

benefits. This will also benefit the state’s health care providers and, ultimately, benefit the economy.

- This Board has consistently reported that the local workforce is lacking in qualified, credentialed individuals to provide treatment in the local MH and Substance Abuse treatment agencies. This is now an even larger concern as many of those 270,000 persons will be seeking services from the behavioral health providers in the Board’s region.

In asking each provider for input into this questions, the following comments were given:

- At the Departments and in the field, the language has always been “the AoD side” or the “mental health side.” There was a request that since the departments have now merged, could we try to do away with the “sides” and refer to the entire field as Behavioral Health or something similar. It always felt like we were choosing sides according to one interviewee.

## Appendix 1: Alcohol & Other Drugs Waivers

### A. Waiver Request for Inpatient Hospital Rehabilitation Services

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

Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. **Medicaid-eligible recipients receiving services from hospital-based programs are exempted from this waiver as this wavier is intended for service expenditure of state general revenue and federal block funds.**

A. HOSPITAL	ODADAS UPID #	ALLOCATION

### B. Request for Generic Services

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

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION
The Counseling Center	6846	Hotline Service	\$101,000

**A Crisis Hotline service will be started at the new Crisis Unit that will be run by The Counseling Center/Compass Community Health in Scioto Co in December 2013. The service will be open to anyone over the age of 18 who calls in with a crisis or needs a referral to a mental health or alcohol drug agency in our area and it will be open 24/7/365 days.**

## Appendix 2: Definitions

**Business Operations:** Shared Resources, QI Business Plan, Financial Challenges, Pooled funding, Efficiencies, Strategic Planning, Contracts, Personnel Policies, etc.

**Cultural Competence:** (Ohio's State Inter-Departmental Definition) Cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.

**Culturally Competent System of Care:** The degree to which cultural competence is implemented as evidenced by the answers to these questions:

- Is leadership committed to the cultural competence effort?
- Are policies and procedures in place to support cultural competence within the system, including policies and procedures to collect, maintain and review caseload cultural demographics for comparison to the entire community?
- Are the recommended services responsive to each adult, child and family's culture?
- Is the client and family's cultural background taken into account in determining when, how, and where services will be offered?
- Is staff reflective of the community's racial and ethnic diversity?
- Is staff training regularly offered on the theory and practice of cultural competence?
- Are clients and families involved in developing the system's cultural competence efforts?
- Does Behavioral Health staff interact with adults, children and families in culturally and linguistically competent ways?
- Is staff culturally sensitive to the place and type of services made available to the adult, child and family?
- Does the system of care reach out to the diverse racial, ethnic, and cultural groups in the community?

**Local System Strengths:** Resources, knowledge and experience that is readily available to a local system of care.

**Local System Challenges:** Resources, knowledge and experience that is not readily available to a local system of care.

**Planning Efforts:** Collaborations, Grant opportunities, Leveraging Funds, Data Collection (e.g., Key Performance Indicators, Outcomes), Trainings

**Service Delivery:** Criminal Justice, School Based or Outreach, Crisis Services, Employment, Inpatient/Residential Services, Housing, Faith Communities, etc.