

**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.).

Allen, Auglaize and Hardin Counties

*Allen County* is a rural farming and manufacturing community. With a population of over 105,141 it stands out as the largest county between Montgomery, Lucas, and Franklin. A few significant demographics: Persons under 18 – 23.5%; Persons 65 and older – 15.3%; White – 84%; African American – 12.2% Allen County experiences significant poverty with 14.7% of residents below the poverty level. Lima stands out in the region as having the most diverse population. Lima also experiences significant poverty with 18% living below the poverty level and has recently been identified as 39<sup>th</sup> in the nation for crime. The Lima City Schools while making significant progress over the past years still struggles with graduation rates, graduating just over half of its students. Because of the range of services and the diversity of populations, Lima has experienced a migration from surrounding counties over the years of people seeking both treatment and anonymity.

*Auglaize County* is a rural farming community with some manufacturing in the western part of the county with a population of 46,699. The population is fairly homogenous and affluent with over 96% of the population being white. It is the most prosperous of the three counties with only 7.8% of the population living under the poverty level.

*Hardin County* is a rural farming community with a population of 31,818. Kenton is the county seat and Ada is the home of Ohio Northern University. There is a high degree of poverty similar to that of Allen County at 14.7% of the population living under the poverty level. While over 96% of the population is white there is present in the county both Appalachian and Amish cultures. As a result the population often does not seek help being more family focused and in the case of the Amish very bound to religious authority direction. Hardin County has experienced an explosion in opiate use in the past two years.

Criminal Justice & Economy

There has been a 12% increase in the number of adult referrals from the criminal justice system rising from 13% in 2009 to 25% in 2010. This has been a significant factor in the increase in the number of males being served by 5% and has changed the ratio of males to females by 7% male.

The *Forensic Strategies Workgroup: Final Report* indicates that Allen-Auglaize-Hardin Counties is 27<sup>th</sup> in utilization of Forensic Hospital Bed Days. The workgroup also noted the dramatic difference in the length of stay difference between civil and forensic beds: 2009 – Civil Median LOS = 26 while Forensic Median LOS is 100 (2008 Forensic Median LOS was 264). Lima has been ranked 39<sup>th</sup> in the nation for crime. This makes the work of local task forces dedicated to collaboration between the behavioral health system and the criminal justice system more crucial than ever in order to create new processes for serving these special forensic populations.

Ohio Department of Rehabilitation and Correction data for CY 2011 indicates the following:

- Allen County
  - 499 Violent Crimes
  - 3,894 Property Crimes
  - 2 Murders
- Auglaize County
  - 8 Violent Crimes
  - 277 Property Crimes
  - 0 Murders
- Hardin County
  - 12 Violent Crimes
  - 926 Property Crimes
  - 0 Murders

Referrals from the criminal justice system and crime clearly have an impact on the service delivery system. 60% of inmates serve less than a year in prison.

The economy has had a significant impact upon clients as well. The current living status of over 46% of all clients is listed as “living in other’s home” this represents a 20% increase in clients who do not live in their own housing. Clients identifying “living on their own” dropped 21% from 63% to only 42%. And almost 5% of adult consumers identify Public Assistance as their source of income, up by 3%.

The most significant factor impacting families is poverty. Agencies report that many more parents seeking services for their children are not able to pay for the services.

#### Race and Age

Race: Allen County stands out with 33% of all referrals for mental health services being African American. Allen County’s African American demographic is 11.7% indicating a significant number of African Americans are seeking services. And 25% of all referrals for alcohol and drug treatment are African American.

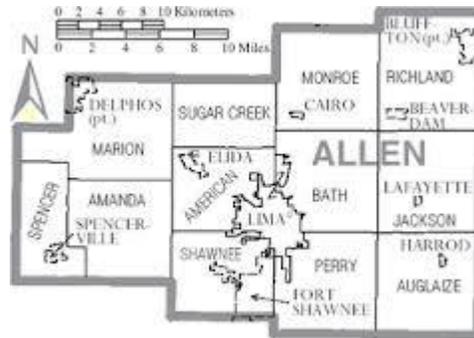
Age: There has been a 32% increase in youth age 5 and under being served from 39 in 2009 to 57 in 2010. Even though the number is still low for persons over age 65, the number served in this age group went from 6 in 2009 to 15 in 2010 and we expect this trend to continue.

#### Opiate Use

Opiate Use has had a significant impact with Hardin County being the hardest hit. The drug task force in Hardin County reports arresting 7 – 10 individuals a week on drug charges mostly opiate use. Yet opiate addiction has become a significant problem for this entire region as seen in the statistics below provided by the State Opiate Action Team.

**Allen County Total Opiate Doses Prescribed (2011): 6,112,018**

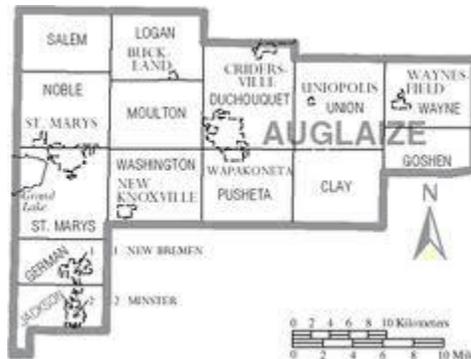
- Allen County Population: 106,331
- 2008: 57.3 doses/capita
- 2009: 54.9 doses/capita
- 2010: 55.6 doses/capita
- 2011: 57.5 doses/capita
- 2012: 58.0 doses/capita



- Overdose Deaths:
- 2007 = 6
- 2008 = 9
- 2009 = 5
- 2010 = 5
- 2011 = 9
- Average = 7.4/100,000

**Auglaize County Total Opiate Doses Prescribed 2011: 2,392,399**

- Auglaize County Population: 45,949
- 2008: 49.8 doses/capita
- 2009: 50.6 doses/capita
- 2010: 52.0 doses/capita
- 2011: 52.1 doses/capita
- 2012: 55.0 doses/capita

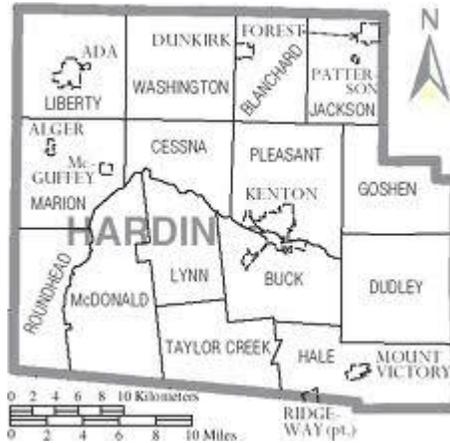


- Overdose Deaths:
- 2007 = 2
- 2008 = 3
- 2009 = 3
- 2010 = 3
- 2011 = 3
- Average = 5.7/100,000

**Hardin County Total Opiate Doses Prescribed 2011: 2,236,516**

- Hardin County Population: 32,058

- 2008: 68.4 doses/capita
- 2009: 67.8 doses/capita
- 2010: 69.3 doses/capita
- 2011: 69.8 doses/capita
- 2012: 68.0 doses/capita
  
- Overdose Deaths:
- 2007 = 6
- 2008 = 6
- 2009 = 3
- 2010 = 6
- 2011 = 6
- Average = 17.9/100,000



Demand for Treatment Services

Agencies report a significant increase in demand for services particularly from persons who have been impacted by the financial downturn and find themselves for the first time without insurance coverage. Many of these persons seeking treatment do not “qualify” for service subsidy because of their level of care and are referred to support groups or other community providers. In FY 2013 there were 3044 Assessment completed in all three counties.

FY 2012 Access Data Adults

County	SBIRT	DAs	%DAs
Allen	361	294	81%
Hardin	74	61	82%
Auglaize	63	41	65%

FY 2013 Access Data Adults

County	SBIRT	DAs	%DAs
Allen	482	386	80%
Hardin	98	52	53%
Auglaize	68	44	65%

Prevention

Recently completed needs assessments in both Allen and Auglaize counties reveal significant needs for early intervention and prevention services.

*Auglaize County*

- Suicide - 5% of adults and 13 % of youth seriously considered attempting suicide in the past 12 months
- Youth Smoking – ages 12 – 13: 2%; ages 14 – 16: 16%; ages 17-18: 29%
- Youth Binge Drinking – ages 12-13: 27%; ages 14-16: 64%; ages 17-18: 79%
- Youth Marijuana Use – ages 13 or younger: 1%; ages 14-16: 7%; ages 17 or older 14%

## Allen County

- Suicide - 5% of adults and 13 % of youth seriously considered attempting suicide in the past 12 months
- Youth Smoking – ages 12 – 13: 8%; ages 14 – 16: 21%; ages 17-18:15%
- Youth Binge Drinking – ages 12-13: 73%; ages 14-16: 60%; ages 17-18: 68%
- Youth Marijuana Use – ages 13 or younger: 4%; ages 14-16: 22%; ages 17 or older 16%

These statistics are alarming in the numbers of youth and adults who are contemplating suicide and the number of youth in both counties who are using alcohol, tobacco, and marijuana.

Some Additional Issues:

### Education Issue

- No High School Diploma
- Allen – 12.5%
- Auglaize – 10.9%
- Hardin – 13.5%

Inability to pass drug screen for employment – Opiate Addiction

Stigma associated with addiction, suicide, mental illness, and family violence

### Economic

- Income reduction leads middle class families to more working poor families that may have insurance, but can't pay the deductible or co pay for therapy or they are above the income guidelines for Medicaid. Many parents working 2 jobs to make ends meet which makes it difficult to engage everyone in the family in services
- Allen County unemployment: 8.5%
- Auglaize County unemployment: 6.4%
- Hardin County unemployment: 8.1%

### Social

- Difficulty finding the individuals/families that are in the highest need for services as they do not always present to the community mental health centers. Need to engage individual/families in more unique ways – breaking down barriers to service provision – go to where they are at – schools, homes, neighborhood centers, creating the health homes, etc.

### Demographic

- Need clinical staff who can work with a wide range of ages, cultural backgrounds, etc. as mental health disorders transcend our traditional “teenage” behavioral problems. Service provision needs to occur as early as possible to minimize the negative effects of mental illness
- Allen County (population 106,331): 83% White / 17% Minority; Poverty – 24% below 150% poverty level; <18 poverty – 25%
- Auglaize County (population 45,949): 98% White / 2% Minority; Poverty – 14% below 150% poverty level
- Hardin County (population 32,058): 97% White / 3% Minority; Poverty – 25% below 150% poverty level

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)

The Board is committed to ongoing dialogue and feedback from consumers, family members, key informants, referral sources, the faith community, other social services organizations, and the communities we serve. The Board holds the value that the hallmark of a highly effective system of care is the integration of customer feedback into planning and services. These sources of information form the foundation of our qualitative data loop, and provide insight into areas for qualitative investigation.

The Board utilizes the data funnel methodology to collect, refine, and decide. This method is a multi-tiered process that has been highly successful in developing Board priorities and identifying gaps in the community system. The data funnel tiers bring together current research, broad-based community needs assessment, and key informant feedback. These elements reflect both quantitative data and qualitative analysis. The data is then filtered through key informants and then refined into Board policy, priorities, and contracts.

**Tier One** of the data funnel represents the meta-analysis of current research on best practices, trends in treatment and recovery supports, results of community needs assessments, and the realities of the current funding environment. The Board gathers this data throughout the planning year.

**Tier Two** of the data funnel represents the passing of the meta-analysis findings through the key informant process. The Board utilizes content-specific task forces and key informant focus groups to respond to the data and localize the findings. Examples of Tier Two process key informants include the Board's task force on Dual Diagnosis for Persons with Developmental Disabilities/Mental Illness, the standing task force on Mental Illness and Law Enforcement/ Criminal Justice, standing committees of the Family and Children First Councils, NAMI Hope Alliance and the Family Advisory Council, and other groups in each county.

**Tier Three** of the data funnel represents the presentation of findings to Board committees and the Board committee of the whole. The Board utilizes two standing committees to review the information. The Joint Mental Health/AOD Planning Committee is the group charged with programmatic overview. The committee takes information from Tier One and Tier Two, as well as recommendations from the Alcohol and Other Drug Standing Committee, and reviews the information in light of current programming and needs. The Joint Mental Health/AOD Planning Committee then makes recommendations to the Finance Committee and ultimately the full Board.

Recent Tier One Activities:

- Literature reviews on best practice approaches.
- Training staff, board members, and agency personnel on health care reform, system implications of reform, and current/projected fiscal situations.
- Training staff and agency personnel in the Strategic Prevention Framework (SPF) planning model.
- Training staff and agency personnel in Access to Recovery/Recovery Coaching models.

- Training staff and agency personnel in PAX Good Behavior Game.
- Conducting a Community Summit on Children and Youth At Risk and At Promise with Dr. Dennis Embry.
- Conducting training with agency personnel, board staff and community businesses on drug-free workplace issues, including community readiness assessment.

Recent Tier Two Activities:

- Development of a draft Board Performance Plan for FY 2014 – FY 2016 based on SAMSHA’s Eight Strategic Initiatives. The Board Performance Plan organizes these eight initiatives into four categories: 1) Funding (Health Care Reform Implementation, Public Awareness and Support); 2) Evidence Base Practices (Housing and Homelessness, Prevention of Substance Abuse and Mental Illness); 3) Community Partnerships (Military/Veteran’s Issues, Trauma and Justice); and 4) High Performance Systems (Health Information Technology, and Data , Outcomes, and Quality). The draft of the Board Performance Plan has been shared at all Family and Children First Council Meetings, agency advisory meetings, and at all standing collaborative task forces (Law Enforcement, Dual Diagnosis, etc.). The draft Performance Plan was also made available to constituents on the Board’s web site and noted on the Board’s Facebook page.
- Consumer focus groups with persons engaged in opiate treatment programs. The Board facilitated two focus groups of approximately 1.5 hours each with 23 participants.
- Utilized the Strategic Prevention Framework (SPF) workgroup (approximately 15 participants) to break into project-based workgroups to address identified needs using the SPF model.
- Development of a levy committee and work groups to address resource development.
- Per ORC 340.03 conducted key informant interviews with agency personnel responsible for the transition of persons at the State hospital to outpatient services. The recommendations were as follows:
  - Need for improved discharge planning from the state hospital. Often, the hospital recommends levels of care that are not necessarily available in the community.
  - The Board appreciates recently instituted discharge planning meetings that are occurring weekly.

Recent Tier Three Activities:

- Review and discussion of draft Performance Plan with Board committees.
- Board retreat training to develop long-range funding strategies and priorities.
- Conducted levy.

Per ORC 340.03, there were no dispute resolutions among members of the Family and Children First Councils in any of the counties served by the Board.

Upcoming Activities:

The Board is collaborating with local hospitals to complete Community Assessments required under the Affordable Care Act. The Board is also collaborating with local health departments to design and conduct Community Health Assessments

(CHA) and to operationalize the findings of these assessments in the Community Health Improvement Plans (CHIP).

### 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*).
  - Open Gate which is a local community one-stop where residents can seek services and begin intake processes for over 15 agencies
  - 15 agency staff who are trained in SPF
  - Over 100 local teachers are trained in the PAX Good Behavior Game; with 4 local agency staff trained as PAX coaches
  - Community Workforce development thru collaborations with Working Partners , Chamber of Commerce, and the Economic Development group for Drug Free Workplace program development
  - 16-bed Crisis Stabilization Unit that serves all three counties
  - a. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.
    - Open Gate
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*).

Our local hospital that houses the psychiatric unit for our board service area does not currently do compelled medications on their unit. All patients who are refusing medications on their unit are requested to be sent to the Regional State Psychiatric Hospital. Any patients who have a history of refusing medications on their unit are often times not admitted based on history, again, being admitted to the Regional State Psychiatric Hospital.

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

This impacts our system as many patients who need inpatient hospitalization must be admitted to the Regional State Psychiatric Hospital since the local hospital will not compel medications.
  - b. Identify those areas, if any, in which you would like to, receive assistance from other boards and/or state departments.
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).*

The Mental Health & Recovery Services Board of Allen, Auglaize and Hardin Counties helps facilitate understanding of the cultures of our staff, contract agency personnel, consumers, family members, and community by promoting cultural competency. The knowledge encompasses understanding of differences and respecting the individuality of those with whom we interact. We are fortunate to have the Lima UMADAOP (Urban Minority Alcohol and Drug Abuse Outreach Program) who provides training and technical assistance on cultural competence, as well as culturally-specific programming.

Board staff are involved in many cultural competence activities and the Board has recently hosted forums on Race and Mental Health in Our Community, dialogues on LGBTQ issues in collaboration with local LGBTQ groups, and was a major sponsor of the State PFLAG Conference (Parents and Families and Friends of Lesbians and Gays). Currently, representatives of the Board serve on several state cultural competence initiatives and committees.

We are a diverse collection of communities. Within our Board area, we have an urban center in Lima, Ohio, with approximately 26% of persons in the community self-identifying as black or African American. In the rural sections of the Board catchment area, populations are predominantly white but still contain significant diversity. We also know that within our area, there are significant populations of persons who are lesbian, gay, transgender, bisexual, questioning (LGBTQ). While our major adult contract agency no longer offers clinical services which are specific to persons who self-identify as LGBTQ, the Board funds Safe Spaces, a free support group designed for people of the LGBTQ community to meet and talk with others experiencing the same unique social and emotional challenges. The group is facilitated by two board-funded facilitators who are from the LGBTQ community or strong allies. There are currently no specific services for youth who self-identify as LGBTQ. However, the children’s agency offers traditional counseling services for these youth and their families.

In Hardin County, one of the most economically challenged counties outside of Appalachia, there is a large population of persons who are Amish, and a strong culture of poverty. Auglaize County, while more affluent, has many diverse groups, and communities that are often mistrustful of outside assistance.

These circumstances combine to challenge us in areas of consumer and family member satisfaction. Both of our major contract agencies report in their Quality Improvement reports that their consumers with mental illness and/or addictions who are African American are disproportionately involved in the criminal justice programming.

### Priorities

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 Allen, Auglaize and Hardin Counties**

**Substance Abuse & Mental Health Block Grant Priorities  
\*Priorities Consistent OHIOMAS Strategic Plan**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)	All IDUs will have access to initial screening within 72 hours.	SBIRT Recovery Coaching/ATR	Number of SBIRTS completed Length of time from SBIRT to 1 <sup>st</sup> apt Access and utilization data from ATR	<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:</b> Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	All women who are pregnant will have access to initial screening within 72 hours and high-risk detox if indicated.	SBIRT Recovery Coaching/ATR High-risk detox	Number of SBIRTS completed Length of time from SBIRT to 1 <sup>st</sup> apt Access and utilization data from ATR Referrals to High Risk detox	<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:</b> Mandatory: Parents with substance abuse disorders who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Children of parents with SUDs will receive evidence-based interventions.	Family and Children First/ Family Stability Teams	Number of referrals Groups for children of people with substance use disorders.	<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:</b> Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases	N/A			<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>MH-BG:</b> Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Ensure fidelity to proven treatments for persons with the highest acuity mental illness and addiction – youth.	IHBT Intensive Wraparound Tele-psychiatry	Agency performance agreements Quarterly Quality Improvement reports	<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)	Ensure fidelity to proven treatments for persons with the highest acuity mental illness and addiction – adults.	Crisis stabilization CPST Counseling Integrated physical/behavioral health Peer support Housing	Agency performance agreements Quarterly Quality Improvement reports	<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*	Adult clients will have access to on-site integrated physical health care.	Primary care will be offered on site at Coleman Behavioral Health.	Number of referrals to primary care providers.	<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	Adult clients will have access to on-site screening and assessment services	Recovery Coaches currently implemented in Hardin County will be implemented in all three counties	Number of referrals Length of time abstinent Stable Housing Employment	<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 checked="" type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Individuals with disabilities	Persons with dual-diagnosis will receive integrated treatment planning.	MIDD pooled funding task force.	Number of integrated treatment plans Completed treatment plans and outcomes.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*	Persons who are addicted to opiates will have access to recovery supports through ATR and Medication Assisted Treatment	Recovery Coaches Established relationships w/in the Community(Faith Based) Provide Tx Services Established Staff Expertise w/solutions Support of Law Enforcement/Criminal Justice MAT	ATR Trainings MAT medication process flows and initiation/retention	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*	Persons with mental illness will have access to safe, affordable housing.	Continuum of housing options Transitional/permanent	Number of persons housed Outreach initiatives for persons who are homeless Integration with community-based housing strategies	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
<b>Treatment:</b> Underserved racial and ethnic minorities and LGBTQ populations	Persons who are LGBTQ will have access to community-based supports	Board-funded support group.	Number of outreach efforts and number of persons attending the support group.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage

				__ Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>Treatment:</b> Youth/young adults in transition/adolescents and young adults				<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>Treatment:</b> Early childhood mental health (ages 0 through 6)*	Children ages 0 – 6 will have appropriate screenings and mental health support services.	Incredible Years Dina School Early Childhood Consultation	Utilization and agency quality improvement reports	<input 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> Adopt a public health approach (SPF) into all levels of the prevention infrastructure	All prevention programming will utilize the SPF framework	Cross-training in SPF model SPF Consultation (Ryan Training)	All programs conform with SPF process.	<input 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 <input type="checkbox"/> Other (describe):
<b>Prevention:</b> Empower pregnant women and women of child-bearing age to engage in healthy life choices				<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> Promote wellness in Ohio's workforce	Local businesses will have access to current drug-free workforce services	We Care At Work Consultation/Training (Working Partners) AOD Treatment provider – specialty workforce programming Onsite SBIRT	Number of companies trained by cohort	<input 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> Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*	Community residents will have access to services for problem gambling	Problem gambling support group Screening Public information/information dissemination Treatment providers trained.	Currently being established.	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):



**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) PAX Good Behavior Game expansion	Excellent evidence-based strategy that is in high demand.
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
(12)	
(13)	
(14)	
(15)	

## Collaboration

8. Describe the Board's accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years.
- YMCA and Peer Support / Clubhouse program – The local YMCA has provided space for our peer support program called “Changing Seasons.” The location has proven to be very convenient and as a result daily attendance averages over 65 people. The program is adopting WMR and recently rolled out the program to the community.
  - FCFC in 3 counties – This continues to be an effective way to create collaborations in the prevention and the treatment areas for children and families. It's most significant outcome is that fewer formal team meetings are necessary since agencies are working together to effectively wrap services around families.
  - Reentry Coalition – This coalition evolved from long standing law enforcement and criminal justice task force created in 2004. The Reentry Coalition has been working to improve access to housing, jobs, services, peer supports and legal issues.
  - Open Gate Allen County – began in June of 2012 and is a monthly “one stop” for anyone in the community that needs to connect with multiple agencies. More than 30 agencies participate in Allen County that has served almost 600 people
  - Open Gate Hardin County – began in June of 2013 with the same purpose as Allen County. More than 15 agencies participate once a month and in 5 months of operation have served almost 150 residents.
  - Auglaize Criminal Justice Task Force – Auglaize Law Enforcement Center is nationally recognized for its reentry efforts based on a wide array of community programming.
  - MIDD – Meeting since 2005 this collaboration has been recognized by the State for its excellence in wrap around programming for persons with dual diagnosis.
  - HP 2020 – Exploring the broader implications of health and behavioral health, this collaboration brings together behavioral health and health providers across the community.
  - Activate Allen County – This coalition comprised of the City of Lima, Allen County Commissioners, Health Department, YMCA, Federally Qualified Health Center, Ohio State University, Ohio Northern University, Rhodes State College, University of Northwestern Ohio, St. Rita's Medical Center, Lima Memorial Health Systems, the Mental Health and Recovery Services Board, and Regional Planning to name a few is focused on creating policy and infrastructure changes to create a healthier population with special emphasis on Obesity, smoking cessation, nutrition, and exercise.
  - Horizons Alliance – Just two years old, this alliance of boards is seeking to create effective and efficient collaborations in programming as well as administrative functions.
  - Suicide Coalitions – Suicide Coalitions and support groups exist in all three counties and have been very active. The Suicide Coalitions have been focused on getting Kognito Training to all of the schools in the three counties.
  - Housing Consortium and Continuum of Care – Since 2003 the Mental Health and Recovery Services Board has been a lead participant on these two housing collaborations which has resulted in the opening of two 4 unit apartment complexes as well as plans for a 48 unit complex to open in the next year.
  - We Care at Work – This newly formed collaboration seeks to bring in the business community a robust drug free workplace policy along with resource mobilization to intervene earlier in problematic substance use and abuse and to identify addiction and dual diagnosis issues earlier.
  - Intersystem and Family Stability Teams in Allen, Auglaize, and Hardin Counties work together to create treatment interventions and resource sharing for children and families with challenging problems that would overwhelm any one system of care.

*To name a few of the coalitions and collaborative efforts underway.*

## Inpatient Hospital Management

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

There has been a significant decrease in the admission practice of the local psychiatric inpatient unit at St. Rita's combined with an increase in the demand for inpatient services, resulting in a significant increase in the number of state hospital admissions in the past 2 years. We anticipate that this trend will continue.

In the meantime the Board in conjunction with its Designated Agency, Coleman Behavioral Services has instituted a number of innovative practices and programs in an effort to assist residents to get into treatment sooner as well as provide for more intensive levels of care.

Here are a few of the programs the Board had recently initiated:

- a. Access Services – SBIRT is available in all three counties through Coleman Behavioral Health: Lima (Walk-In Service - 8:00 AM – 8:00 PM seven days a week); St. Mary's and Kenton (Walk-In Service 5 days a week)
- b. Crisis Stabilization Unit – Recently expanded to 16 beds with nursing and medications
- c. Nurse Care Navigator – Embedded at St. Rita's from Coleman has increased the "show rate" from 15% to over 75% from inpatient to outpatient services
- d. Discharge Planning Meeting with NOPH – Team created to meet with NOPH twice weekly to facilitate discharges.

Lima is a "magnet" for the area with the availability of crisis services as well as St. Rita's Psychiatric Unit. We anticipate this increased trend will continue.

However, only 4% of those who are currently "in care" are presenting for hospitalization. The majority of those presenting for admission are new patients.

## 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

We Care At Work – This is an innovative project that incorporates developing a robust and tailor made drug free workplace policy within a business, employee and supervisor training, and mobilizing behavioral health system resources to address the problem of adult workforce substance use and abuse with the goal of keeping people on the job through education, intervention, and treatment.

PAX GBG – Developed through the PAXIS Institute, Dr. Dennis Embry, over 100 teachers have been trained along with 4 PAX Coaches in school districts in all three counties. 100 teachers are currently on the waiting list to be trained. Results have been stunning in the PAX classroom and there are currently school districts

who want every teacher trained.

Open Gate – This originally began as a reentry coalition project and soon expanded to address the needs of Allen and Hardin Counties for a once a month “one stop” experience of essential agencies. In less than 18 months over 600 people have connected to multiple agencies, programs and services with over 30 agencies regularly participating.

Hope Recovery Center – Since its opening in October, 2013 the Recovery Center located in Kenton, Ohio has served over 35 people with opiate addiction. It is connected to IOP at Coleman, MAT at the FQHC and is an integral part of the newly certified Hardin County Drug Court. The core of the Recovery Center is a Corps of 4 Recovery Coaches at a location that is open 6 days a week from 9:00 AM to 7:00 PM. The Recovery Center and the Recovery Coaches have already become an integral part of the program to address the epidemic opiate issue in Hardin County.

CISM – Critical Incident Stress Management Team is overseen by Chief Rick Skilliter, Bluffton Ohio. Originally the CISM team responded to calls from emergency services to help deal with traumatic responses to fires, accidents, shooting, etc. Since 2012 the team has expanded its response to school tragedies. The team has responded to four schools in the Board’s jurisdiction helping teachers, counselors, and administration bring calm, order and control to often chaotic situations. The team has been trained in responding to school tragedies and bring a very specific protocol with them that quickly restores order to school environments.

- b. Planning efforts
- c. Business operations
- d. Process and/or quality improvement

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.

### **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.

## 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 waiver 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

## 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.