

**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.)

**Economic Factors:**

Ashland County reflects the sluggish recovery that has been experienced throughout the state and nation. There are several local manufacturing industries that have either significantly reduced their workforce, have relocated, or have been completely dissolved. Some new startups have been experienced however. U.S. Department of Labor statistics indicate Ashland County's unemployment rate has changed from 10.4% in August of 2010 to **6.9%** in August of 2013. This change reflects a 37% *decrease* in the local unemployment rate. Shrinking local government funding from Columbus has made optimal funding of services/programs reliant on local funding challenging. Just recently (November – 2013), a 25 cent sales tax increase to support Children Services was soundly defeated.

The Board and its partners have continued to observe a downturn in the number of consumers of mental health and/or alcohol/drug services with insurance which may be related to the changes noted in employment. This is expected to result in higher percentages of the cost of services being born by the Board. Insurance coverage for clients, when present, has been steadily declining in quality as well as coverage. Given current economic conditions the Board has noticed an increase in the number of Medicaid eligible individuals seeking behavioral health services. With Medicaid Expansion poised to take effect, the Board and its partners are optimistic that quality coverage may be available to those previously uninsured (*to be discussed in question #12*).

Between SFY 2006 and 2010, the Board saw a 20 percent reduction in state funds, or \$473,000. With this in mind, Board members chose to replace a 5-year 1-mill levy in November 2010. The replacement levy passed comfortably with over 57% of the vote. Local levy funding will help restore approximately \$200,000 thru utilization of current property valuations. However, the Department's decision to utilize a skewed formula for funding increases in SFY 2014 combined with reductions in other line items and a "fix" to the SAPT program resulted in flat funding to the County. The Board is hopeful that leadership at ODMHAS will decide to use a more equitable formula for any new funds available in SFY 15 (i.e., straight per capita on NEW funding). The Board has appreciated the Department's position to discuss formula changes on additional/new funding **only**.

The Budgetary Planning Efforts for SFY 14-15 and beyond are challenging. The uncertainty of Medicaid Expansion and the Affordable Care Act (ACA) on behavioral health services are unmistakable. Additionally, current legislation is being pursued that would "carve-in" the behavioral health Medicaid benefit into the larger State Medicaid plan. The effects of this are as yet unknown but could include the introduction of managed care and changes in service rates that could greatly destabilize the local system of care.

The Board's planning efforts continue to evolve based on feedback received each year. The Board has tried to be sensitive and reduce the administrative burden to agencies in the application process while at the same time ensuring that Board members and staff have all the information necessary to make sound decisions regarding support and funding.

### Social & Demographic Factors:

Ashland County is a rural county with a number of light industrial facilities. The U. S. Census Bureau estimates that the population in Ashland County in 2012 was **52,962** and has decreased an estimated **0.3%** from 2010. It is in the outer reaches of the growth corridor from Akron/Cleveland and Columbus. This is influenced by its location on I-71. Much of the growth continues to be in the Northwest area of the county and also in a suburban-like ring around the county seat of Ashland.

The county and city government has a relatively new justice center, which holds the county jail, the Sheriff's Department, City Police and Municipal Court. Combined with the passage of a behavioral health levy this has allowed for the development of improved alcohol/drug services on-site at the jail.

There continues to be little racial diversity in the county with 2012 census data reporting a White/Caucasian rate of 97.4%. The county does have a sizable Amish population that engages in behavioral health services with the Board's largest contract agency.

The Board's only contract alcohol/drug provider is the **Ashland County Council on Alcoholism & Drug Abuse (ACCADA)**. ACCADA has been an extremely stable agency serving the needs of Ashland County for more than 25 years. ACCADA provides out-patient services, jail services and is the Board's gatekeeper for residential and detox services. ACCADA provides services that are accessible, client-centered and cost-effective. **Appleseed Community Mental Health Center** is the primary mental health contract agency of the board. They provide the entire array of outpatient services including crisis intervention services and 24/7 Hotline services. The board also contracts with **Catholic Charities Community Services** for limited mental health and drug/alcohol prevention services. Additionally, the Board has recently contracted with the **Visiting Nurse Association** of Ohio around services integrating primary physical and behavioral health. Finally the board contracts with **Lifeworx**, for consumer-operated services. Each of the agencies listed above, have made significant contributions to the development of this Community Plan.

### 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)

#### -Needs Assessment (Mental Health and Drug/Alcohol Prevention):

The Board recognizes the importance of preventative services. When determining prevention needs the Board employs a similar process to that used when determining treatment needs. The Board considers historical and emerging need trends. Additionally, the Board considers the mission of the Board and the Board's strategic plan. Determining need can only occur thru ongoing and continuous collaboration with the Board's partners (Stakeholders). Partners most often include: A.C.C.A.D.A. (AoD Agency), Appleseed (MH Agency), Lifeworx (Consumer Operated Program) VNA (Integrated Primary and Behavioral Health) & Catholic Charities (MH Agency) community partners (General Public, Juvenile Court, FCFC, DJFS, Schools, etc.) The Board is keenly aware that without this process of including key stakeholder groups in its considerations and discussions, determining prevention needs would be incomplete. In short, the Board "Listens, Talks and Tracks."

- Data Sources Utilized:

Contract Agency Assurances and Required Reporting; MCD/MACSYS Billings; FCFC Monthly Reporting; School-Community Liaison Program Reporting; Board's AoD Committee; Board's Planning and Finance Committee Meetings;

- Data Source Types:

Quantitative and Qualitative data was collected.

- Methodology:

Interview and discussion (large and small meetings), phone conferencing and email as well as feedback from prevention facilitators.

- Time Frames:

SFY 2013 thru first quarter of SFY 2014.

- Stakeholders Involved:

Family and Children First Council; Juvenile Justice (Court, Detention & Probation); Criminal Justice (Courts; Police & Jail); General Public; Contract Providers (Mental Health & Drug/Alcohol); Board members; County Commissioners

- Results:

School Based Alcohol, Tobacco and Other Drugs (ATOD) and suicide prevention programming. Emphasis on evidence-based prevention programs.

Older adult and targeted adult Mental Health prevention focusing on suicide prevention, mental health and addictions.

Needs Assessment (*Mental Health and Drug/Alcohol Treatment*):

- The Board recognizes the importance of treatment services. When determining treatment needs the Board employs a similar process to that used when determining prevention needs (Listen, Talk and Track). The Board considers historical and emerging need trends. Additionally, the Board considers the mission of the Board and the Board's strategic plan. Determining need can only occur thru ongoing and continuous collaboration with the Boards partners (Stakeholders). Partners most often include: A.C.C.A.D.A. (AoD Agency), Appleseed (MH Agency), Lifeworx (Consumer Operated Program) Visiting Nurses Association (Primary & Behavioral Health) & Catholic Charities (MH Agency) community partners (General Public, Juvenile Court, FCFC, DJFS, Schools, etc.) The Board is keenly aware that without this process of including key stakeholder groups in its considerations and discussions, determining treatment needs would be incomplete.

- Data Sources

Medicaid/MACSYS; Board Provider Network; Board Community Partners

- Data Types

Quantitative Data (i.e., Medicaid/MACSYS Costing/Volume Data) and Qualitative (i.e., Provider and Community Partner Feedback and Formalized Satisfaction Survey's).

- Methodology

Volume of Service by population groupings, gender, diagnostic criteria analysis;

Cost of Service by population groupings, gender, diagnostic criteria and analysis ; and

Aggregate analysis of satisfaction survey data based on highest/lowest rated.

- Time Frames

SFY 2013 thru first quarter of SFY 2014.

- Stakeholders Involved

Board Provider Network; Board Community Partners (Schools, Juvenile Court, DJFS/Children Services, Family and Children First Council, Local University, Local Hospital, Police/Sheriff, Board Planning and Finance Committees;

- Results

Continued provision of Mental Health and AoD Assessment, Crisis Intervention, Counseling (individual & group), Community Psychiatry Supportive Treatment (individual & group), Hotline, AoD Residential/Detox and Pharmacological Management services.

Specific Sections:

1. Child service needs resulting from finalized dispute resolution with Family & Children First Councils:

The Board has a continuing and close relationship with our local FCFC. The Coordinator is housed at the Board and the Board acts as the administrative agent for Council. The Board works with FCFC and any behavioral health child service needs resulting from finalized dispute resolution with the Council. This is not something that happens with any regularity.

2. Outpatient service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals:

The Board and its primary contract agency (Appleseed) has a good working relationship with our Regional Psychiatric Hospital (HBH). Staff at the Board and Appleseed regular participate in monthly conference calls with HBH regarding admission and discharge concerns. The only articulated outpatient need expressed by HBH is the availability of 24/7 staffed group homes. This need is met utilizing existing housing resources with intensive off-site services and supports.

Access issues, gap issues and disparities:

AoD Prevention Access

There continue to be no major issues or concerns with regard to accessing prevention services in the county at this time. This is due in large part to the local levy funded "School-Community Liaison Program." This prevention program is active in every school district in the county and has consistently shown very strong outcomes in improving attendance, behavioral issues and academic issues.

AoD Treatment Access

With respect to access issues related to treatment services, the primary challenge remains accessing detox/residential services. The regional Medical Detox and Hospital Residential treatment program closed its doors in FY 04. This closing has made Detox/Residential services more difficult to access. A.C.C.A.D.A. continues to act as the Boards designee/gatekeeper in placing consumers in need of Detox/Residential services. While A.C.C.A.D.A. has developed a contract with Glenbeigh and other State Detox/Residential providers the logistics of arranging services at a much further distance are significant. With this in mind, the Board has increased funding for Detox/Residential and has been able to maintain those levels for multiple years. Recent changes in Columbus have allowed for easier funding of the Medication Assisted Treatment (MAT) program. Need for this service has leveled off in SFY's 2013-14. While Ashland County does not offer Intensive Outpatient services, A.C.C.A.D.A. intensifies existing individual and group treatment to meet the needs of persons

### MH Prevention Access

Neither the Board, its contract agencies nor community partners have identified any access issues/concerns for mental health prevention services. With the merger of ODMH and ODADAS the Board is optimistic that MH Prevention Efforts will receive additional support and attention. There is much that can be learned from the years of prevention work done at ODADAS.

### MH Treatment Access

The biggest challenge in accessing Mental Health Treatment and Recovery Support services is the service of youth/adult Pharmacological Management (Psychiatric Services). Waiting lists can range from 4-6 weeks for routine appointments with crisis situations receiving appointments within 2 weeks.

### Gaps/Disparities

At present the Board does not feel that it has significant gaps in services. However, additional Federal/State funding for Early Childhood Mental Health, Transitional Aged Youth, and programs supporting persons served who are desirous to taper off of psychiatric medications are needed.

## 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*).

### Mental Health/Drug/Alcohol Prevention Needs:

*School Based Alcohol, Tobacco and Other Drugs (ATOD) and suicide prevention programming. Emphasis on evidence-based prevention programs. Older adult and targeted adult Mental Health prevention focusing on suicide prevention, mental health and addictions.*

**Strengths** (Resources, knowledge and experience that is readily available to a local system of care.)

The Board and its Mental Health and Drug/Alcohol contract providers are well positioned to meet the identified MH/AoD Prevention needs outlined above. All three agencies have successful histories of providing quality prevention services in the county. They are all well respected by other county partners and have staff with adequate training, expertise and support to meet the stated needs. Business operations are healthy. Each organization is financial viable utilizing a combination of funding sources, including grant based and fee-for-service. Service Delivery involves populations/partners (Schools, Seniors, Agencies serving seniors) with long-standing and positive relationships. Touching on Planning Efforts, each agency is oriented services around evidence based approaches and collecting data around key performance indicators (i.e., Improved Attendance, Grades, etc.) and outcomes (i.e., increased awareness of ATOD harm, increased awareness of suicide prevention techniques).

### Mental Health/Drug/Alcohol Treatment Needs:

*Continued provision of Mental Health and AoD Assessment, Crisis Intervention, Counseling (individual & group), Community Psychiatry Supportive Treatment (individual & group), Hotline, AoD Residential/Detox , Consumer Operated and Pharmacological Management services.*

**Strengths** (Resources, knowledge and experience that is readily available to a local system of care.)

Similar to Prevention Needs the Board and its Mental Health and Drug/Alcohol contract providers are well positioned to meet the identified MH/AoD Treatment needs outlined above. Each agency has a successful history of providing quality treatment services in the county. They are all well respected by other county partners and have staff with adequate training, expertise and support to meet the stated needs. Business operations are healthy. Each organization is financial viable utilizing a combination of funding sources, including grant based and fee-for-service. Service Delivery involves populations/partners (Schools, Community, Hospital, Criminal Justice/Courts, Private Providers, Local Physicians, etc.) with long-standing and positive relationships. Touching on Planning Efforts, each agency is oriented services around evidence based approaches (Supported Employment, Intensive Home Based Services, Cognitive Behavioral Therapy, etc.) and collecting data around key performance indicators (i.e., Change in works status, less involvement with CJ systems, etc.) and outcomes (i.e., improved perception of service outcomes, improved functioning & social connectedness). Regarding Consumer Operated Services the Board is investigating improved space for the program and the Director is scheduled to be certified as a Peer Support Specialist in SFY 14.

- a. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.

Our Board and contract agencies would be willing to provide assistance in any areas discussed above with regards to prevention and treatment. Owing to the fact that the county is small and funding limited, there's a sense that we've been successful by being creative and thinking "outside the box." We're willing to share our experiences to those interested.

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*).

Mental Health/Drug/Alcohol Prevention Needs:

*School Based Alcohol, Tobacco and Other Drugs (ATOD) and suicide prevention programming. Emphasis on evidence-based prevention programs. Older adult and targeted adult Mental Health prevention focusing on suicide prevention, mental health and addictions.*

Challenges Include:

Largely, there are no challenges in this area. To the extent challenges exist they would most likely be experienced in the areas of resources and experience in the realm of mental health prevention. Mental Health Prevention is an area the Board and contract agencies have had the least experience with and our therefore continuing to learn the most effective/efficient methods of implementing programs of this type. Additionally, resources to assist with Older Adult Mental Health Prevention is scarce in our experience.

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

Current and potential impacts are seen in a limited sense with regards to the extent or scope of programming that can/will be offered and therefor the number of persons in the county that can benefit.

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

To the extent grant based funding or more permanent funding is available for Mental Health Prevention efforts, the Board would be appreciative.

Mental Health/Drug/Alcohol Treatment Needs:

*Continued provision of Mental Health and AoD Assessment, Crisis Intervention, Counseling (individual & group), Community Psychiatry Supportive Treatment (individual & group), Hotline, AoD Residential/Detox, Consumer Operated and Pharmacological Management services.*

Challenges Include:

There are no pressing challenges in meeting the identified MH/AoD Treatment Needs above. It is more likely that challenges will come as a result of policy changes on a state/national basis that will effect local providers. For example, any substantial change in the BH Medicaid rates would affect our local agencies negatively. How the State manages the "Health Home" rollout may impact local agencies. Additionally, information technology requirements (E.H.R. and MACSIS replacement) may affect our provider's ability to meet identified MH/AoD Treatment needs.

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

Current – No identified impacts.

Potential – If local providers cannot negotiate some of the challenges identified it's likely that a disruption of services or, at a minimum, service continuity could emerge.

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

We are open to assistance in how our agencies might navigate the need for Electronic Health Records, Health Information Exchanges and a new Non-Medicaid billing/adjudication system.

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 MHRB of Ashland County remains committed to the continuous learning process necessary for Cultural Competency. The Board's vision is to create an environment that brings hope and improves the quality of life for persons affected by mental illness and substance abuse. Our values are that everyone is entitled to live a quality life in the community. Services should be: person centered, priority directed, recovery focused, comprehensive & holistic, high quality/research based, accountable and client driven.

Below is our response to the answers to *Appendix 2*:

- *Is leadership committed to the cultural competence effort?*

-Both Board and Provider leadership is committed to the Vision & Values Statements articulated above. This is demonstrated thru client feedback, both direct and anecdotal thru direct communications and objectively thru yearly client satisfaction measures which include cultural competence questions.

- *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?*
  - Data collected from yearly Outcomes/Satisfaction Data and Service Utilization Data reflect the cultural demographics as reflected in U.S. Census Data.
- *Are the recommended services responsive to each adult, child and family's culture?*
  - According to regular bi-annual surveys, over 95% of respondents agree or strongly agree that services are culturally sensitive.
- *Is the client and family's cultural background taken into account in determining when, how, and where services will be offered?*
  - According to regular bi-annual surveys, over 95% of respondents agree or strongly agree that services are culturally sensitive.
- *Is staff reflective of the community's racial and ethnic diversity?*
  - Yes; given current Census Data, staff are reflective of Ashland County's racial and ethnic diversity.
- *Is staff training regularly offered on the theory and practice of cultural competence?*
  - Somewhat; this could be strengthened through better tracking of trainings that meet this standard. Trainings do occur but how often and which staff attend should be improved.
- *Are clients and families involved in developing the system's cultural competence efforts?*
  - Yes, via their feedback on Satisfaction and Outcomes surveys.
- *Does Behavioral Health staff interact with adults, children and families in culturally and linguistically competent ways?*
  - Given the Satisfaction and Outcomes survey data, yes.
- *Is staff culturally sensitive to the place and type of services made available to the adult, child and family?*
  - Yes, this is tracked through the 'Perception of Access' Scale as part of the MHSIP and YSS-F measures
- *Does the system of care reach out to the diverse racial, ethnic, and cultural groups in the community?*
  - Yes, via events like the Amish Health Fair & BH Outreach to the Amish Community

## 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 Ashland County Mental Health & Recovery Board**

**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)   | Prioritized due to the rise in opiate addiction in the county (consists of rapid intake and referral to physician)  | Education and Harm Reduction addressed as part of treatment   | Track patient specific education at local hospital<br>Use of flexible funding<br># of IV drug users   | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><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)   | Prioritized for treatment when they present   | To ensure that Women who are pregnant with substance use disorders are seen first   | Track the number of women seeking services and the time from initial contact to treatment   | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><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) | Prioritized for treatment when they present   | Continue to work with the Commissioners (via JFS-Children Services) and the Family and Children First Council to ensure those parents with substance abuse disorders and dependent children are prioritized | Track the number of men/women seeking services and the time from initial contact to treatment<br>Track the number of youth/families referred to ACCADA for treatment vs. how many present for treatment | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):            |
| <b>SAPT-BG:</b> Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases  |   |   |   | <input checked="" type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe): |
| <b>MH-BG:</b> Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)   | The Board intends to continue to provide a full continuum of Behavioral Health Services for persons diagnosed as SED including: Diagnostic Assessment, Counseling, CPST, and Pharm Mgt services | Utilize existing/emerging contract agencies for the provision of services   | Utilize the MHISP (Adult) and YSS-F (Youth) measures to gauge system level consumer outcomes and satisfaction<br>Utilize MACSIS/Medicaid data to verify amount, duration type and frequency of services | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):            |
| <b>MH-BG:</b> Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)   | The Board intends to continue to provide a full continuum of Behavioral Health Services for persons diagnosed as SMD including: Diagnostic Assessment, Counseling, CPST, and Pharm Mgt services | Utilize existing/emerging contract agencies for the provision of services   | Utilize the MHISP (Adult) and YSS-F (Youth) measures to gauge system level consumer outcomes and satisfaction<br>Utilize MACSIS/Medicaid data to verify amount, duration type and frequency of services | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><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*   | Begin to integrate primary and behavioral health within the county  | Utilizing 'Hot Spot' funding increase hours of the Wellness Coordinator (hired thru Visiting Nurses) to integrate PH/BH for persons in the MH system.                          | Track number of persons assisted; and outcome(s) of assistance  | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><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                      | Train local persons in recovery as Peer Support Specialists or Recovery Coaches   | Work with the Heartland Collaborative via the Hot Spot initiatives to secure trainers/consultants. Train volunteers from Lifeworx, ACCADA, Board, etc.                         | Track number of persons trained and employed  | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):  |
| <b>Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant</b><br><b>*Priorities Consistent OHIOMAS Strategic Plan</b> |   |  |   |   |
| <b>Treatment:</b> Veterans   | Work to establish Paula Caplan's "Listening to Veterans: The Welcome Johnny & Jane Home Project" in the County                | Work collaboratively with other Counties to train listeners and listening coaches in Ashland to be available to veterans struggling with mental health and/or addiction issues | Track number of listeners;<br>Track number of listening coaches;<br>Track number of Vets participating                                      | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):  |
| <b>Treatment:</b> Individuals with disabilities  |   |  |   | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input checked="" type="checkbox"/> Other ("disabilities" is not defined and therefore not addressed) |
| <b>Treatment:</b> Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*          | A continued focus of the Board and ACCADA. Work to improve/enhance the local Medication Assisted Treatment program            | Partner with ODMHAS, other Boards and Agencies implementing M.A.T. programs for opportunities to improve/enhance programming   | Track number of persons in the program;<br>Track outcomes for person in the program;<br>Track adaptations/modifications made to the program | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):  |
| <b>Treatment:</b> Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*                           | Continue to support efforts to provide stable housing to at-risk or homeless persons with mental health or addiction concerns | Provide rental subsidy funding to assist Appleseed housing efforts. Active in Homeless Coalition. Providing Support to ACCESS Homelessness Program                             | # of Persons Assisted<br># of Persons maintaining residence   | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):  |

| <b>Treatment:</b> Underserved racial and ethnic minorities and LGBTQ populations  |  |  |   | <input checked="" type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):  |
|---|--|--|---|--|
| Priorities  | Goals  | Strategies   | Measurement   | Reason for not selecting   |
| <b>Treatment:</b> Youth/young adults in transition/adolescents and young adults   | Work with ODMHAS to secure funding to build on locally funded TAY activities                     | As available apply for TAY grant funding thru the ODMHAS (e.g. Engage Grant) to build TAY activities and programming<br>If available in SFY 15, consider utilizing 'Hot Spot' funding to increase TAY activities and programming | Degree of success in securing Engage grant or other TAY grants available<br><br>Percentage of SFY 15 Hot Spot funding used for TAY activities/programming     | <input type="checkbox"/> No assessed local need<br><input checked="" type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):  |
| <b>Treatment:</b> Early childhood mental health (ages 0 through 6)*   | Work with ODMHAS to secure funding to build on locally funded ECMH activities                    | As available apply for ECMH grant funding thru the ODMHAS to build ECMH activities and programming<br>If available in SFY 15, consider utilizing 'Hot Spot' funding to increase ECMH activities and programming                  | Degree of success in securing grant funding for ECMH activities/programming<br><br>Percentage of SFY 15 Hot Spot funding used for ECMH activities/programming | <input type="checkbox"/> No assessed local need<br><input checked="" type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):  |
| <b>Prevention:</b> Adopt a public health approach (SPF) into all levels of the prevention infrastructure                            | Use an approach that fits local needs  | Use Prescription Drug Abuse initiative as a potential model. Ensure Evidence Based Practices are used.   |   | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):   |
| <b>Prevention:</b> Ensure prevention services are available across the lifespan with a focus on families with children/adolescents* | Continue Prevention Services for ATOD for school based youth. Prescription Drug Abuse initiative | Contract with CCCS and ACCADA for the provision of ATOD prevention services for school aged youth, Transitional Aged Youth; Seniors (SALT)   | # of Students Served;<br>Gains on Pre/Post Tests;<br># of Schools reached<br># of TAY; # of Seniors   | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):   |
| <b>Prevention:</b> Empower pregnant women and women of child-bearing age to engage in healthy life choices                          |  |  |   | <input type="checkbox"/> No assessed local need<br><input checked="" type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input checked="" type="checkbox"/> Other (Outside the scope of behavioral health): |
| <b>Prevention:</b> Promote wellness in Ohio's workforce   |  |  |   | <input type="checkbox"/> No assessed local need<br><input checked="" type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input type="checkbox"/> Other (describe):  |

|  |  |  |  |   |
|--|--|--|--|---|
| <b>Prevention:</b> Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations* | Begin to integrate Problem Gambling Prevention/Screening strategies in Community AoD agency and in School Aged Prevention activities | Work with ACCADA to implement these gambling initiatives in SFY 14 | # of Identified Problem Gamblers;<br># of Problem Gambling Prevention Activities;<br>Gains on Pre/Post Tests | <input type="checkbox"/> No assessed local need<br><input type="checkbox"/> Lack of funds<br><input type="checkbox"/> Workforce shortage<br><input checked="" type="checkbox"/> Other (describe): very limited need |
|--|--|--|--|---|

| <b>Board Local System Priorities (add as many rows as needed)</b> |   |   |  |
|---|---|---|--|
| Priorities  | Goals   | Strategies  | Measurement  |
| Jail Based AoD Programming  | Engage persons in AoD education, prevention and treatment while at the Jail and prepare for ongoing services at discharge | Provide program/staffing at the jail thru contract with ACCADA  | Persons receiving Assessment; Individual/Group Counseling; Case Mgt; and Screening & Education         |
| School-Community Liaison Programming                              | Engage youth/families/school staff to reduce/prevent behavioral & academic challenges                                     | Continue the School-Community Liaison Program in the county in partnership with the schools and Appleseed | # of referrals made & follow thru rate; % Improvement in Academic Performance, Behavioral & Attendance |
| Multi-Generational Mentoring Programming                          | Bring together at-risk youth and seniors in a program that benefits the mental health of both                             | Continue the MGM Program at the Golden Center thru partnership with Catholic Charities                    | # of youth/mentors involved in the program and completing  |
| Supported Employment  | Assist persons diagnosed with "SPMI/SPMI" with competitive employment and/or meaningful activity                          | Continue/enhance S.E. Programming at Appleseed Community Mental Health Center                             | # of participants employed pt/ft or involved in school/volunteer activities                            |
| Housing for Homeless SPMI/SPMI                                    | Assist persons with "SPMI/SPMI" in securing and maintaining housing as part of an overall recovery plan                   | Provide & Evaluate Board funding of rental subsidy for this population                                    | # of persons housed and ability to maintain residence; engage in services                              |
| Suicide Prevention  | Increase community awareness and prevention of persons who may be considering suicide                                     | Continue county-wide Suicide Prevention rollout using the Question Persuade Refer (QPR) model             | # of gatekeeper trainings provided in the county   |
| Alternatives to ADHD Programming                                  | Work with parents/youth with behavioral challenges find alternatives to medication based approaches                       | Continue to fund/evaluate ADHD Alternative programming  | # of youth/adults in programming; % improvement in YSS-F scores  |
| Intensive Home Based Treatment                                    | Work with "SED" youth and families to improve socio-emotional health and functioning                                      | Continue to fund/evaluate the I-FAST program of Intensive Home Based Treatment                            | # of youth/adults in programming; % improvement in YSS-F scores  |
| Consumer Operated Services  | Provide space/programming to assist adults in recovery from MH/AoD achieve their goals                                    | Continue to fund/evaluate/enhance Lifeworx, the consumer operated program in Ashland                      | # of persons attending and attending groups  |
| Wellness Coordinator Activities                                   | Assist persons with/without SMI/SPMI who need assistance in connecting with local supports/helps                          | Continue to fund/evaluate 'Hot Spot' pilot with the Visiting Nurses Association                           | # of persons seen and diverted to natural supports   |

**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) Psychiatric Drug Withdrawal Programming   | Over the last 25-30 years there's been an incredible increase in the prescription of psychiatric drugs to those in the behavioral health system. Many are suffering due to side effects of the medication but don't have access to safe, physician monitored, drug withdrawal programs. This priority is consistent with the Board's adoption of Medication Optimization principles.   |
| (2) Soteria/Open Dialogue Options for Persons experiencing crisis and first episode psychosis | Our county has limited options to divert people from in-patient psychiatric hospitalization and/or limit hospital length of stay by having available and appropriate step-down options; increasing our capacity for <b>Soteria</b> ( <a href="http://www.moshersoteria.com/articles/soteria-and-other-alternatives-to-acute-psychiatric-hospitalization/">http://www.moshersoteria.com/articles/soteria-and-other-alternatives-to-acute-psychiatric-hospitalization/</a> ) Projects and <b>Open Dialogue</b> ( <a href="http://www.umassmed.edu/psychiatry/globalinitiatives/opendialogue.aspx">http://www.umassmed.edu/psychiatry/globalinitiatives/opendialogue.aspx</a> ) that specifically works with persons experiencing first-episode psychosis would greatly benefit county residents. |
| (3) Trauma-Informed and Trauma-Specific programming for the county                            | Resources have limited the Board's ability to enact both Trauma-Informed and Trauma-Focused programming throughout the county. The ability to do this and do it well is very likely to increase the effectiveness of behavioral health services and outcomes for persons with a history of trauma.   |

## 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.

Selective collaboration accomplishments include:

Collaborating with our local JFS we were successful in receiving a \$100,000 Community Innovation Grant to plan for improved services to youth at-risk of out of home placement;

Collaborating with renowned author and psychologist Paula Caplan, our local University (Ashland University) as well as two contiguous county organizations, we were able to launch the 'When Johnny and Jane Come Marching Home Listening Project'

Collaborating with local/regional consumers, providers and boards we were able to host the 6<sup>th</sup> annual Respect Success Value and Purpose (RSVP) conference with over 170 attendees;

Collaborating with our local sheriff and police we were able to participate in drug take back awareness activities and secure funding for permanent 'drop boxes' to aid the collection efforts over the long term;

Collaborating with several community partners including area seniors, social services and law enforcement we were able to have monthly Seniors and Law enforcement Together (SALT) meetings in SFY 13;

Collaborating with our local jail, AoD agency probation/parole and judges we applied for the CJ-BH Grant thru ODMHAS;

Collaborating with local providers, boards, schools, Margret Clark Morgan (MCM) Foundation and medical staff, Suicide Prevention training (Question Persuade Refer (QPR)) was provided to 333 medical staff and 520 non-medical staff in the four county area;

Collaborating with a local health clinic, Mental Health agency, and MCM an educational DVD on Oral Health for persons diagnosed with mental illness was created and being disseminated locally and statewide;

Collaboration with area chambers of commerce, hospitals, Ashland University, Boards and providers led to an investigation of actual (versus anecdotal) prevalence of persons failing pre-employment screenings due to drug use;

Collaboration with our contract providers as well as private providers in ongoing training activities the MHRB has been able to foster a recovery oriented culture and more integrated system of care in our community;

Collaboration with multiple service and provider organizations thru MHRB staffs' participation on boards/committees (i.e., Rotary, Salvation Army, Alternative School, Council on Aging, Dental Clinic, Nursing Homes, North Central College, and Center for Nonviolence); and

Ongoing Collaboration with local school systems to continue the very successful 'School-Community Liaison Program'

## 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

### State Hospitals:

As mentioned earlier, the Board and its primary Mental Health contract agency (Appleseed) have productive relationships with our regional state hospital (Heartland). Agency/Board staff participate in regular calls with HBH staff around admission and discharge issues. Additionally, agency staff visit HBH in person as the situation warrants to attend team meetings, meet with the client/family members, and discuss issues around admission and discharge. Finally, Board staff regularly attend Heartland Collaborative meetings held at the hospital to interact with hospital staff around multiple issues (i.e., medical clearance protocols, Doctor to Doctor processes, tracking initiative from ER visits to HBH admission, etc.).

SFY 2014 hospital usage (civil admits) is running slightly ahead of historic averages owing to an increase in out of county persons without local agency involvement showing up in the ER experiencing a psychiatric crisis. These individuals are frequently without adequate supports or resources (i.e., insurance) to manage the crisis situation. This trend is likely to continue in SFY 15. Forensic admissions remain extremely low which is typical for Ashland County. This is not anticipated to change in SFY 15.

### Private Hospitals:

The Board via Appleseed has a good relationship with Private Hospitals. Each year the Board allocates funding to be used at the discretion of the contract agency responsible for Crisis Intervention Services (Appleseed) in minimizing State Hospitalizations. The primary intent of these funds is to utilize Private Hospitals or other less intensive levels of care, where appropriate, to avoid state hospitalization placements. Med-Central Mansfield, Summa St. Thomas/Barberton and Akron Children's Hospital are the three private hospitals most often used by Ashland County. While the Board hasn't noticed an increase in private hospitalization we have noticed an increase in the amount of time it takes for persons to be admitted. We don't anticipate any significant increases in private hospital utilization in SFY 15.

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

**NO RESPONSE**

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.

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.

-Examples of "Success Stories" from the Board Levy Funded School-Community Liaison are highlighted below:

**School/Community Liaison Success Stories for April-June 2013**

A boy from a family of 6 other siblings really wanted to play baseball, but his mom couldn't afford it. A liaison was able to get the fee waived and give him a sign-up form so he could get registered. He was so excited; he rode his bike back to the school to turn in the form the same day.

A liaison worked with a student who was having attendance issues and not wanting to go to school. The student worked hard to come to school daily and on time for the last few weeks of school and the liaison was able to reward her with a McDonald's lunch, which was her choice.

A school liaison was able to assist with funds to help a young high school mom be able to go to her senior prom. She didn't have the money for both herself and her date, so the school liaison was able to find funding for her ticket. Afterwards, the student told the liaison that she had a wonderful time and she was so glad she was able to do something "normal" for once.

A school liaison attended most of the field trip and craft days with the girls' empowerment group from the Safe Haven/Rape Crisis Domestic Violence Shelter, and was able to really build relationships with several of the girls.

A school liaison coordinated a bullying awareness day for all 6<sup>th</sup> and 7<sup>th</sup> graders in her district. She was able to bring in a group from Ashland University called "Sticks & Stones & Words", who performed during all 6<sup>th</sup> and 7<sup>th</sup> grade history classes.

A liaison worked with an Ashland County Community Academy student and her mother to get them to commit to working on their relationship with each other. The mother had previously shared reluctance in participating in the student's counseling and agreed to only go if the student was comfortable with her mother attending.

Through donations from local hair stylists, a liaison was able to make sure 5 young ladies had the opportunity to get their hair done for prom. If not for these donations they would not have been able to engage in that special prom ritual.

A school liaison was able to celebrate her first year working at the Ashland County Community Academy by watching over 50 students graduate and celebrate with over 230 family members and friends.

A liaison assisted a student with multiple emotional disorders by rearranging the student's class schedule to leave school before lunch each day. The student only had 2 core classes and the rest of the school day was study halls. The student's mother was then able to observe her and take her to counseling appointments when needed.

A liaison facilitated a meeting with Smetzer Counseling and a mother and daughter who were in need of counseling. They otherwise would have been unable to afford the insurance deductible and co-pays.

A liaison was able to assist a family in applying for Medicaid. The liaison also helped the family work on relationship issues and encouraged the mother to set boundaries with both her children and extended family members.

A liaison assisted a school, family and community with the processing of a student's passing in a car accident. The liaison assisted school administration with crisis response and opened up the school for students and

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.

-Medicaid Expansion

While some details remain unclear, it seems very likely that Ashland County, like all counties, will see an increase in persons eligible for insurance coverage through Medicaid via the expansion. Assuming a large percentage of persons eligible in fact sign up and the benefits are comparable to current BH Medicaid Carve out benefits, Ashland should see an increase in State GRF funding being “freed up” that can be used for persons still not eligible for insurance and/or for services not reimbursed via Medicaid or other insurance (i.e., Recovery Supports). It would be disruptive if a commensurate reduction in State GRF were tied to the projected “increase” Medicaid Expansion would bring to a given county. There are many reasons why an individual may not enroll in Medicaid or Medicaid Expansion not the least of which would include lack of knowledge and/or ability. Funds that are made available because of Medicaid Expansion can be reinvested into the local system of care to try and shore up a decade of cuts to the Behavioral Health system that has left it woefully underfunded. The application of an inequitable funding formula in SFY 14 and the likely repeat in SFY 15 reinforces the need for these State GRF funds to remain at current levels. A current issue for Boards is how to manage those persons eligible for insurance, either through the exchanges or Medicaid/Medicaid Expansion who choose not to enroll. Should Boards continue to pay for services for these persons using “Non-Medicaid” GRF funding rather than on persons who aren’t eligible for any insurance or for services that aren’t covered by insurance?

-Role of Boards post-ACA

As components of the law continue to change/be modified, Boards are unsure of the ultimate effects of the Affordable Care Act. What does seem clear is that the role of Boards will likely shift away from classic service provision (Pharmacologic Management; Counseling and Community Psychiatric Supportive Treatment) to recovery supports (MH/AoD Prevention, Peer Support Services, and Housing). There will be a need for Boards to work closely with insurers and managed care to try and maintain a continuum of care that is both comprehensive and works seamlessly for those it is there to assist.

-Re-conceptualizing Human Suffering/Distress

Perhaps the most powerful opportunity for change in the community behavioral health system lies with the re-conceptualizing of what are now labeled “mental disorders” or “mental illnesses” to normal human suffering or distress. Decades of pathologizing normal human suffering/distress as “disorder” or “illness” has led to an explosion in the use of psychiatric drugs as frontline “treatments” for those seeking help. The rise in psychiatric drugs is well documented and the negative effects are just now starting to be considered in main stream research publications (Whitaker, Harrow and Wunderlick) and media (i.e., New York Times, Consumer Reports, etc.). Off-label prescribing of so-called “anti-psychotics” to children (some as young as 2 years of age) has had deadly results (Rebecca Riley). Where has the “decade of the brain” left us? What has been the result of the massive increase in the use of psychiatric drugs in the treatment of “mental disorders”? As demonstrated by Whitaker and others, a corresponding rise in the number of persons labeled as “mentally ill” and receiving disability benefits related to their “mental illness” Is more of the same the answer? Even the head of the National Institute of Mental Health (NIMH) Thomas Insel has admitted that early conceptualizations of mental illness as “biochemical imbalances”

was both incorrect and overly simplistic. Further, Insel has acknowledged that the diagnostic labeling system (DSM) employed for the last 30+ years is not valid. The NIMH will not be using the DSM system as they continue their research to understand the etiology of mental disorders. If Boards, providers and community partners can understand normal human suffering and distress as just that, rather than “medicalizing” these experiences alternative approaches to helping through non-drug approaches or approaches that employ psychiatric drugs strategically and for short durations, a real change is possible.

#### References:

Wunderink L, Nieboer RM, Wiersma D, Sytema S, Nienhuis FJ. Recovery in Remitted First-Episode Psychosis at 7 Years of Follow-up of an Early Dose Reduction/Discontinuation or Maintenance Treatment Strategy: Long-term Follow-up of a 2-Year Randomized Clinical Trial. *JAMA Psychiatry*. 2013 Jul 3

Harrow M, Jobe TH. Does Long-Term Treatment of Schizophrenia With Antipsychotic Medications Facilitate Recovery? *Schizophrenia Bulletin* 2013, Mar 19.

Whitaker, Robert (2010). "Anatomy of an Epidemic". Crown.

Thomas Insel, Director's Blog: <http://www.nimh.nih.gov/about/director/index.shtml>

Antipsychotic drugs a last resort for these 5 conditions: <http://www.consumerreports.org/cro/2013/12/treating-anxiety-adhd-depression-insomnia-and-ptsd-with-newer-antipsychotics/index.htm>

Drugs Used for Psychotics Go to Youths in Foster Care: <http://www.nytimes.com/2011/11/21/health/research/study-finds-foster-children-often-given-antipsychosis-drugs.html? r=0>

## 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.