

**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**

The Mental Health & Recovery Board of Clark, Greene and Madison Counties (MHRB) consistently reviews economic data on the counties served. All three have been adversely affected by the economic downturn and slow recovery. Greene County has seen the least overall impact, showing a median household income in 2012 dollars of \$57,992 (\$9,746 higher than the state median household income of \$48,246). Madison County is also above the state median at \$54,647. Clark County is \$4,562 below the state median. Clark County has a poverty rate of 17.7% or 24,285 residents living in poverty. The Ohio poverty rate is 16.3%. Greene County’s poverty rate is 13.4% and represents 21, 920 residents. Madison County’s rate is 11.1% or 4,779 residents. This means that 50,984 people are living in poverty in the three counties in the MHRB area. Other economic indicators reviewed by MHRB include:

Indicator	Clark	Greene	Madison
Retail Sales per capita	\$9,977	\$12,776	\$22,988
Retail sales	\$1,398,675	\$2,029,318	\$958,649
Total number of firms	8,821	12,073	3,019
Homeownership rate	68.1%	68%	71.1%
Median value of owner-occupied housing units	\$108,100	\$159,600	\$148,000
In the labor force (ages 16 and older)	109,758 (61%)	131,416 (64.3%)	34,810 (58.7%)

These indicators demonstrate that Greene County has the healthiest economy of the three counties. It is encouraging that homeownership rates are at or above (Madison County) the state rate. While the three counties are close to the state average of those ages 16 and older in the labor force (64.3%), we know from conversations with community partners, memberships in local Chambers of Commerce, and involvement with civic clubs and the faith community that many of those in the labor force are not earning a living wage.

Given these economic considerations, it is encouraging that there is strong support in all three counties for behavioral health levies. The most recent behavioral health levies in Clark, Greene and Madison Counties have passed with robust numbers. Local communities seem willing to support renewals and reject new or replacement levies. Indicative of property values in local communities, a 1.65 mill replacement levy in Clark County would generate only \$60,000 more annually than a renewal.

An economic factor likely to arise in MHRB communities in the near future is the impact of access to gaming establishments. Numerous gaming facilities and types of gaming will soon be easily accessible from any part of

the MHRB three county area. MHRB continues to monitor screening reports from providers in preparation for the impact of gaming on service delivery and local economies.

## **SOCIAL**

The MHRB closely follows education and related issues in the three counties. Approximately 6% of the population in the three county area is age 5 and under. Slightly over 21% are 18 and under. The area is rich in higher education opportunities with six universities, 2 community colleges and close access to public and private higher education in counties contiguous to Clark, Greene and Madison. In the population 25 and older high school graduation rates (and equivalencies) are near the state percentage of 88.2%: Clark at 86.1%, Greene at 92.4%, and Madison at 85%. The picture is not so bright when reviewing those with a bachelor's degree or more: The state percentage is 24.7% while Clark is 17%, Greene is 34.5% and Madison is 17.6%.

As more research has become available, both the behavioral health system and the educational system have paid increasing attention to the essential role played by social and emotional learning in educational and community environments. The MHRB has been strongly influenced by the Institute of Medicine 2009 Report: *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. As a recipient of dollars to provide consultation on early childhood mental health and as a result of seeing a remarkably positive impact of the PAX Good Behavior Game® (GBG®), the MHRB has placed a high priority on working with community partners to provide training and implementation funding for the GBG® in area classrooms as well as community and neighborhood settings. With a three county population of 19,600 children ages 5 and under the MHRB has embraced every opportunity to introduce evidence-based approaches that increase protective factors through children learning the skills associated with self-regulation.

As with the entire state, the MHRB is challenged with the dramatic rise in the use of opiates, both those prescribed and those purchased illegally. This change in the social fabric of our communities is requiring MHRB to approach recovery services differently. While medication assisted treatment has been available within the Board area for several years, the demand for services and the risk of relapse and the concomitant danger of overdose have brought us to look more closely at the supports needed for a sustained recovery. To address this concern the MHRB will convene interested parties in all three counties in January 2014 to identify recovery supports necessary for maintaining sobriety. The goal is the development of recommendations for consideration in the allocations process.

## **DEMOGRAPHIC**

Population is relatively stable in the three county area. Between April 1, 2010 and July 1, 2012, Clark and Madison Counties saw population losses of 0.8% (1,106 residents) and 0.9% (389 residents) respectively. Greene gained 1.2%, growing by 1,943 residents. The numbers within age groups of the population are not changing significantly, although we will likely see increases in the next few years in the segment of the population reaching 65. The racial and ethnic mix of the population is also relatively stable. Additional demographic information is incorporated in the Economic and Social sections of this question.

## 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)

### FORMAL

Formal needs assessments have recently been completed in Clark and Madison Counties with the aid of the Center for Urban & Public Affairs at Wright State University. Methodology for both needs assessments included telephone surveys, focus groups and interviews with key informants. The Clark County assessment was under the aegis of the Combined Health District and resulted in several community meetings that evolved into five task forces based on community priorities: Obesity, Mental Health, Chronic Disease Management, Substance Abuse, and Healthy Birth/Sexuality. MHRB staff are active on the Mental Health Task Force and the Substance Abuse Task Force. The Madison County assessment occurred through the Madison County Family Council. Preliminary results will be available in the near future, however, the two top issues in Madison County have been identified as alcohol and drug use for at least the past decade. It is not anticipated that this finding will change.

### INFORMAL

MHRB staff, board members, and contract agencies are an ongoing source of information regarding behavioral health needs in the three counties.

Because of the broad reach of the Family & Children First Councils and their use of a structured but flexible service delivery mechanism, these entities are often the first to spot issues pertaining to access and gaps/disparities in service availability and delivery. This information reaches the MHRB quickly through regular meetings or phone/email contact. Contract agencies also provide information regarding gaps in services for various populations.

A number of coalitions have formed in the MHRB area, addressing suicide and depression awareness and prevention and the use and misuse of alcohol and other drugs. Participation on the coalitions provides access to information from organizations and groups that Boards have not had ready and/or regular access to, e.g., emergency medical technicians, parents who have lost children due to opiate overdose, faith groups working with those in early recovery, etc.

Other groups such as the Springfield Promise Neighborhood and Greene County Educational Service Center have become key resources in understanding more about community and educational issues as they relate to behavioral health.

### ASSESSMENT OF NEED AND IDENTIFICATION OF GAPS AND DISPARITIES (Board Addendum 1/30/2014)

#### Family & Children First Councils (FCFC)

- In Clark County the FCFC, through work with their Family Stability Group, identified the need for representation from the comprehensive alcohol and other drug treatment provider at Family Stability meetings with families. This representative has become a regular participant at Family Stability meetings
- When the governor announced the Strong Families/Safe Communities initiative, the FCFC directors from the three counties identified a critical need: Crisis Respite Care. In conjunction with a child-serving agency in one of the counties, the FCFC directors developed a proposal that has been awarded funding.

## Coalitions

- Suicide Prevention Coalitions have reviewed relevant data and determined target populations (middle-age, white males) and have conducted surveys which showed a knowledge gap in information about the relationship between depression and suicide. As a result these coalitions have engaged in a great deal of awareness and education as well as gatekeeper trainings for school and medical personnel.
- Substance Abuse Coalitions in Madison and Clark Counties have identified gaps in data collection, identified sources of data critical to reducing the impact of substance use, and utilized both the Strategic Prevention Framework and Logic Model work to name the strategies most effective for community engagement. As the coalitions have become more visible, other community initiatives have sought the help of the coalition to accomplish their goals. For instance, Clark County Fatherhood has linked with the coalition for data sharing and recruitment of coaches.

## Other Partners

- Springfield Promise Neighborhood has identified social and emotional learning gaps in elementary age children at three *Closing the Achievement Gap* schools. A major gap has been the lack of academic opportunities throughout the summer. Children in these schools were falling significantly behind every summer. The MHRB is an active supporter of the summer program through a mini-grant to the Springfield Promise Neighborhood.
- Greene County Educational Service Center (GCESC) has been a national leader in implementing the PAX Good Behavior Game® (GBG) in school districts where significant numbers of children are at risk of falling behind because of behavioral and emotional problems. GCESC identified the capacity for self-regulation as one of the top skills/abilities children must develop if they are to have a chance at success. The GBG uses a variety of interventions that teach children to self-regulate, work peacefully and effectively with peers, and function well as students. Classroom teachers learn classroom management skills that provide more time for teaching because of fewer interruptions and greater focus on the part of students.

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

The MHRB would be pleased to engage with others on both the PAX Good Behavior Game® initiative and the Feedback Informed Treatment approach to clinical service delivery.

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*).

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

Current and potential impacts in attempts to address the increase in the use of opiates are grim. There is a dearth of physicians who are qualified through DATA 2000 requirements to provide buprenorphine to consumers. With the requirement of only 30 patients during the initial year of practice, many addicts have great difficulty accessing medication assisted treatment. Without ready access to services, most

addicts will use rather than face unassisted withdrawal. Further, if appropriate services are not available for a long enough period of time, addicts may relapse with a dose that is far too strong and die as a result of a dose for which they no longer have tolerance.

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

The department and boards could explore ways to alter regulations or generate opportunities for structured discussion on more effectively addressing medication assisted treatment and recovery supports.

- 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*).

As the MHRB plans for service delivery, a culturally competent system of care is seen as a dynamic component that moves through all expressions of the system of care. The MHRB will be intentional in the design of the SFY 2014 Agency Allocation Request to contract providers. More detailed information will be requested on the current status of agency competence and the method(s) through which agency competence is monitored/measured/evaluated. Information will also be requested through the same venue on staff development plans for both clinical and administrative staff in this area.

The MHRB will continue to review population data to assess potential linguistic and cultural concerns for the system of care. Attention will be given to the behavioral health data collected by contract agencies. Input from key informants will be sought regarding behavioral health needs within minority communities across the MHRB three county area.

### 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 the Mental Health & Recovery Board of Clark, Greene and Madison Counties**

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

**\*Priorities Consistent OHIO MAS 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)	<i>To provide a continuum of care for persons who are intravenous/injection drug users (ISU)</i>	<p>Continue to provide medication assisted treatment (MAT) in Clark and Greene Counties</p> <p>Develop and provide MAT in Madison County</p> <p>Review Federal Guidelines for Opioid Treatment and explore feasibility of expanding services</p> <p>Review “low dose naltrexone” protocols and explore feasibility of implementation</p>	<p>Number treated, referred and engaging in treatment services</p> <p>Results of reviews of Federal Guidelines for Opioid Treatment</p> <p>Results of reviews of “low dose naltrexone” protocols</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<b>SAPT-BG:</b> Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	<i>To continue to meet the priority through utilization of services of gender-specific treatment programs</i>	<p>Continue allocations to specific agencies</p> <p>Incorporate reporting services into required Program Reports</p>	<p>Allocation recommendations</p> <p>Review of Program Reports</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<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)	<i>To continue to meet the priority through contractual arrangements</i>	<p>Annual consultation with County Commissioners or their designees</p>	<p>Meetings with child protective services throughout the year</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<b>SAPT-BG:</b> Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases	<i>To address the needs of behavioral health clients with tuberculosis and other communicable diseases</i>	<p>Continue tracking</p>	<p>Quarterly reports from agencies</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<b>MH-BG:</b> Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	<i>Continue allocating funds for services for children with Serious Emotional Disturbances (SED) who are not eligible for Medicaid</i>	Agency Allocation Request process	Program Reporting to MHRB	<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)	<i>Continue allocating funds for services for adults with Serious Mental Illness (SMI) who are not eligible for Medicaid</i>	Agency Allocation Request process	Program Reporting to MHRB	<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): Integration of behavioral health and primary care services*	<i>Improve health outcomes through encouraging comprehensive community behavioral health integration activities along the collaboration continuum</i>	Partner with community FQHC in the implementation of SBIRT by: <ul style="list-style-type: none"> <li>• enhancing access to traditional specialty care for those requiring referral to treatment</li> <li>• address and reduce barriers to care</li> <li>• offer staff development training re: a comprehensive referral to treatment/follow-up system</li> </ul>	Track/monitor referrals to treatment Program Reporting to MHRB Explore data collection/sharing options	<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	<i>To develop and implement county specific recovery supports</i>	Engage community partners in using the Strategic Prevention Framework to identify recovery supports that will reduce the risk of relapse and increase factors that protect sobriety	Recommendations from community partners	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

**Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant**

**\*Priorities Consistent OHIOMAS Strategic Plan**

<p><b>Treatment: Veterans</b></p>	<p>Engage contract agencies to connect veterans with benefits through the Veterans Administration</p> <p>Sustain local system of care services for veterans who are ineligible for Veterans Administration benefits</p>	<p>Identify behavioral health strengths and/or needs available for military connected population</p> <p>Increase provider knowledge of unique behavioral health needs of service members and families</p> <p>Collaborative efforts to increase access and reduce barriers to services</p>	<p>Link contract agencies with opportunities for learning (webinars, literature, speakers, etc.)</p> <p>Identify opportunities to share local resource information with the service member community</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<p><b>Treatment: Individuals with disabilities</b></p>	<p>To develop and implement county specific recovery supports</p>	<p>Engage community partners in using the Strategic Prevention Framework to identify recovery supports that will reduce the risk of relapse and increase factors that protect sobriety</p> <p>Incorporate issues related to individuals with disabilities into Feedback Informed Treatment approach to clinical services</p> <p>Identify strengths and needs related to the delivery of interventions for those with physical or cognitive disabilities</p> <p>Continue to monitor facility appropriateness for individuals needing accommodation for a disability</p>	<p>Recommendations from community partners</p> <p>Feedback Informed Treatment Evaluations from March 2014 training</p> <p>Responses to specific questions in Agency Allocation Requests</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>

Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
*Priorities Consistent OHIOMAS Strategic Plan				
<p><b>Treatment:</b> Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*</p>	<p>To provide a continuum of care for persons who are intravenous/injection drug users (ISU), heroin users and/or users of prescription drugs for non-medical purposes</p>	<p>Continue to provide medication assisted treatment (MAT) in Clark and Greene Counties</p> <p>Develop and provide MAT in Madison County</p> <p>Review <u>Federal Guidelines for Opioid Treatment</u> and explore feasibility of expanding services</p> <p>Review “low dose” naltrexone protocols and explore feasibility of implementation</p>	<p>Track/monitor referrals to treatment</p> <p>Program Reporting to MHRB</p> <p>Explore data collection/sharing options</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<p><b>Treatment:</b> Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*</p>	<p>To develop and implement county specific recovery supports</p> <p>Continue to work with community partners to address the housing needs of behavioral health consumers</p>	<p>Engage community partners in using the Strategic Prevention Framework to identify recovery supports that will reduce the risk of relapse and increase factors that protect sobriety</p> <p>To utilize all approaches possible to assure persons with mental illness and/or addiction are appropriately housed</p>	<p>Recommendations from community partners</p> <p>Program Reports from agencies providing housing</p> <p>Participation on housing collaboratives and coalitions</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>
<p><b>Treatment:</b> Underserved racial and ethnic minorities and LGBTQ populations</p>	<p>Ongoing identification of the specific needs of individuals who are racial and ethnic minorities as well as those who identify as LGBTQ</p>	<p>Include information on racial and ethnic minority and LGBTQ populations in SFY 2015 Agency Allocation Request</p> <p>Include agency specific staff development plans in SFY 2015 and SFY 2016 Agency Allocation Request</p>	<p>Inclusion in Agency Allocation Requests</p> <p>Program Reports from agencies</p>	<p><input type="checkbox"/> No assessed local need</p> <p><input type="checkbox"/> Lack of funds</p> <p><input type="checkbox"/> Workforce shortage</p> <p><input type="checkbox"/> Other (describe):</p>

Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
*Priorities Consistent OHIOMAS Strategic Plan				
<b>Treatment:</b> Youth/young adults in transition/adolescents and young adults	Assess service needs for transition age youth	Participate with community stakeholders to identify gaps and areas of strength in systems serving multi-need youth  Support initiatives to Identify and engage youth in this process	Track and monitor Board participation in collaborative team meetings related to high risk needs of transition age youth  Track numbers of youth participating in process of identifying gaps and strengths	<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> Early childhood mental health (ages 0 through 6)*	Provide access to continuum of ECMH services for Clark, Greene and Madison Counties. Increase knowledge, awareness, resources and skills necessary for community to meet the behavioral health needs of at-risk young children and families.	Support for: <ul style="list-style-type: none"> <li>Center and home-based mentoring, coaching and classroom observation</li> <li>Training in educational settings from problem identification, referral and classroom management strategies</li> <li>Community Needs Assessment and Capacity Building for preschool to first grade</li> </ul>	Monitor tracking system for numbers served  Collect/monitor behavioral indicators Satisfaction surveys.  Utilize data from Needs Assessment to establish community readiness and identify service priorities.	<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	Integrate SPF into existing Suicide Prevention Coalitions in Clark, Greene, and Madison Counties.  Integrate SPF utilizing PAX Good Behavior Game and community-based PAX Kernels in Clark, Greene, and Madison Counties	Continue the development of population specific Logic Models for each Coalition to target activities to include: awareness, education, and intervention.  Sustain and expand school-based and community wide initiatives: <ul style="list-style-type: none"> <li>Facilitate the development of a technical assistance model</li> <li>Assess local capacity</li> <li>Engage key stakeholders and community level champions</li> </ul>	Collect and analyze survey data from community awareness events and campaigns  Consistently evaluate feedback from each Gatekeeper Training  Reduction of barriers to LOSS (Local Outreach to Suicide Survivors) Team development and implementation  Recruit and train LOSS Team Volunteers  Collaborate with PAXIS Institute, Wright State University and stakeholders to Collect and analyze training and implementation data in collaboration with PAXIS Institute, Wright State University and stakeholders	<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>Prevention:</b> Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*	<i>Assess current needs and develop a comprehensive approach to prevention</i>	<i>Develop performance indicators for prevention practice</i> <i>Convene stakeholder discussions to identify opportunities to promote and sustain universal prevention strategies</i> <i>Establish a regional clearinghouse for research informed targeted and universal prevention practice across the lifespan</i>	<i>Monitor POPS data and utilize program evaluation data to identify needs and strengths</i> <i>Survey community providers regarding current prevention strategies, areas of strengths and needs</i> <i>Track numbers of attendees from diverse community participants</i> <i>Compile and organize prevention information</i> <i>Explore methods for sharing resources</i>	<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> Empower pregnant women and women of child-bearing age to engage in healthy life choices	<i>Participate in community education regarding behavioral health</i>	<i>Speaking opportunities</i> <i>Social Media</i> <i>Participation on community coalitions</i>	<i>Number of opportunities, postings, etc.</i>	<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> Promote wellness in Ohio's workforce	<i>Participate in community education regarding behavioral health</i>	<i>Speaking opportunities</i> <i>Social Media</i> <i>Participation on community coalitions</i>	<i>Number of opportunities, postings, etc.</i>	<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*	<i>Provide information to Community and Healthcare Organizations on screening tools and referral sources</i>	<i>Produce/distribute information</i> <i>Participate in state-sponsored initiatives</i>	<i>Information distribution locations</i> <i>Quarterly screening reports from agencies</i>	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

**Board Local System Priorities (add as many rows as needed)**



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)	
(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.

The MHRB Partners in Recovery newsletter was initiated in the fall of 2010 as a quarterly communications tool used to engage the community about the behavioral health system of care. Consumer recovery stories, programs, and collaborative partnerships are highlighted to educate stakeholders, partner agencies, and consumers about the nature of services provided. Over the past two years, electronic and printed newsletter distribution has expanded.

Over the past two years, the MHRB has implemented two community awareness educational (i.e. gambling, depression, and addiction) campaigns through billboards and printed media. The Board is also utilizing public awareness opportunities through vendors of and events associated with the local Chambers of Commerce.

Through the three county-wide suicide prevention coalitions, the Board develops printed and electronic literature, attends community events, and holds numerous speaking engagements (i.e. gatekeeper training, depression awareness). The goal of these activities is to reduce stigma about help-seeking for current consumers and future consumers. Survivors of suicide are invited to and actively participate in local suicide prevention efforts. In this vein, Clark County has established a Local Outreach to Suicide Survivor (LOSS) Team Steering Committee with the coroner's office, law enforcement, emergency medical services, survivors, and integral community partners. The Steering Committee is developing policies and procedures for implementation in 2014.

## 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

The interaction between the local system's utilization of the State Hospital, private hospitals and the outpatient services is indicative of a system in flux. Courts, hospitals and various community partners come from varying frames of reference often resulting in discontinuity while well intentioned. While factors such as fragmentation (a lack of a systematized means of doing business) are present, there are many efforts being made to facilitate improved communication between vested parties, particularly to solidify protocols.

Most recently, the MHRB and area partners are adapting to the impact of the recent State Hospital transition from Twin Valley to Summit. This change became effective September 2013 and requires an adjustment for the Board, State Hospital, local systems of care and patients alike to: teach/learn the available resources, develop processes, and build working relationships with key contacts across the delivery system for continuity of care.

While the current emphasis is on establishing consistent processes for communication and decision making with Summit, it remains necessary to continue a collaborative relationship with Twin Valley due to the maximum security level of care unique to their system. Two MHRB area patients remain in the care of Twin Valley as well as the ongoing presentation of residents from our catchment area to Franklin County often in need of State Hospital services.

Variables such as jail transfers, diverse court involvement, and residents in crisis presenting outside the MHRB area that are beyond Board management of care definitely influence the utilization of bed days. Two counties (Clark and Greene) use the Forensic Psychiatric Center for Western Ohio for forensic evaluations and one county (Madison) uses NetCare. This can impede communication related to State Hospital utilization.

Currently, efforts are being made by all parties to facilitate timely decision making in reference to utilization, least restrictive environments, and the priority of meeting the needs of the local population in their local community.

Activities to improve processes include:

- Utilization Review Team: Representatives of the MHRB, Summit Behavioral Healthcare, and local providers meet monthly to discuss discharge planning needs, barriers to access and level of care questions. This meeting is held via teleconference and was initiated November 2013.
- Quarterly Forensic Review: Provider agencies, MHRB staff, court personnel, and the MHRB Forensic Monitor convene for the purpose of being proactive in the area of client needs.
- Occasional Team Meetings: Specially scheduled team meetings to discuss the emergent needs of individual clients and develop plans to address these needs.

In reference to anticipated changes, the following concerns have emerged:

- Increased barriers due to logistics: face-to-face visits with clients will be more difficult for providers, family and other supports, transportation and resource/support linkage difficulties
- A changing landscape due to the closing of psychiatric units
- Artificial limits on forensic bed days with the increased need for forensic patient bed days resulting in less accessibility for civil cases
- Reports of increased number of aggressive/violent incidents, sexual acting out behaviors and increased risk of sexual assault are cause for concern
- Impact of Affordable Care Act may affect resource availability along the continuum of care.

With the changing landscape in mind, opportunities for Regional Forensic Trainings, technical assistance in the creation of systematic processes, learning communities to share best practices, innovative practices and model programming would be welcomed by MHRB staff and collaborative partners.

## 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

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.

### FEEDBACK INFORMED TREATMENT

During the past two years the MHRB has continued its commitment to implement an approach to clinical service delivery known as Feedback Informed Treatment (FIT). FIT is based on research that demonstrates that “treatment effects” such as model/technique; alliance; expectancy, placebo and allegiance; and therapist contribute only about 13 – 20% to overall outcome. The remaining 80 – 87% contribution comes from client/extra-therapeutic factors such as clients’ readiness for change, strengths, resources, level of functioning before treatment, social support systems, socioeconomic status, personal motivations and life events.

Determining the impact of these client and extra-therapeutic factors is accomplished through the use of routine and ongoing client feedback that provides clinicians with a simple, practical and meaningful method for documenting the usefulness of treatment. The American Psychological Association Task Force on Evidence-Based Practice concluded in 2006 the “providing clinicians with real-time patient feedback to benchmark progress in treatment and clinical support tools to adjust treatment as needed” is one of the “most pressing research needs”.

To accomplish this, FIT uses an Outcome Rating Scale to indicate the severity of the client’s distress at intake and inform decisions about the dose and intensity of services. The client is asked to complete an Outcome Rating Scale (ORS) at the beginning of each counseling session and a Session Rating Scale (SRS) at the end of each session. These scales are the measures of outcome and therapeutic alliance used in Feedback Informed Treatment. Both scales contain four items and are client-rated. The ORS measures the client’s experience of well-being in his or her individual, interpersonal and social functioning. When treatment is successful, scores on the ORS should increase over time. The SRS assesses four interacting elements, including the quality of the relational bond, as well as the degree of agreement between the client and therapist on the goals, methods and overall approach of therapy. Both the ORS and the SRS have clinical cutoff points.

While contract agencies have struggled to understand and create a culture of feedback within clinical services, anecdotal information has been received that describes significantly fewer no shows among adults receiving alcohol and other drug services. Some clinicians have reported seeing substantially stronger commitments to therapeutic work when a rating scale is used to generate feedback.

Several Board areas are implementing FIT and finding it helpful to both clinicians and clients. The MHRB is finding the FIT approach to clinical service delivery to be an approach worth continuing to investment.

## PAX GOOD BEHAVIOR GAME®

The PAX Good Behavior Game®, cited in the 2009 Institute of Medicine Report: *Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities*, shows strong evidence for long-term effects on mental health and substance abuse-related outcomes. Analyses of outcomes at ages 19-21 showed that the PAX Good Behavior Game® significantly reduced the risk of alcohol or illicit drug abuse or dependence and use of mental health and drug services.

The MHRB currently provides funding, with other community partners, for the implementation of the PAX Good Behavior Game® in all three counties. The greatest concentration of classrooms is in Greene County through the Educational Service Center. Children are learning to self-regulate as they move through a school day and teachers are gaining both classroom management skills and increased time for instruction. The capacity to self-regulate is vital in making choices, choosing actions and sustaining relationships.

The MHRB also explored how the environment surrounding our children and adolescents impacts their risk for developing mental health problems and using alcohol and other drugs. Parents need a variety of supports to raise healthy children. Businesses need to invest differently to guarantee the workforce necessary for success. Children need the nurture of parents, educators, and community leaders if they are to move forward.

We know that psychological, behavioral and related problems stem largely from the same conditions. We know that when communities increase factors in the environment that protect children and decrease those that place children at risk, the entire community is healthier. In an article in the *American Psychologist* earlier this year, several noted researchers identified key environmental characteristics that affect development. One of these is *increasing the prevalence of nurturing environments* which certainly increases protective factors.

## 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.

The Manager for Outpatient Services at Mental Health Services for Clark and Madison Counties reported the following at a recent meeting of the Feedback Informed Treatment Guiding Group monthly meeting. To understand the story, the reader should be familiar with the response to Question 10. Innovative Approaches Feedback Informed Treatment.

A young, adult male presented for outpatient services for a problem with alcohol and other drugs. The county municipal court had ordered him to receive assessment and follow any recommendations resulting from the assessment. The assessment showed considerable harmful involvement with a mix of legal and illegal drugs. The client had dropped out of outpatient treatment on two previous occasions.

The treating clinician reviewed the assessment results and recommendations for treatment with the client and explained that she would like to work differently with him during his treatment by using rating scales that would help them review his progress and adjust his treatment as warranted. The client agreed.

After several sessions of using the ORS and SRS, the client remarked, “I like these graphs. This is the first time I have ever had a sense of making progress.” This led to clinical work on where he saw improvement in his life and where he needed to focus more attention.

After two more sessions, the client told the clinician that he was not sure she was focusing on areas of importance to him. Together they refined the treatment goals to reflect his concerns about recovery more directly. The client completed a total of twelve weeks of individual counseling (12 sessions) and asked to see his twelve rating scales. He became very excited about the progression of his treatment when he was able to see his progress over time and reflect on the adjustments made to his treatment goals.

## 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.

As with all Boards, the MHRB carefully tracks client numbers and service costs. MHRB staff review information about potential additional enrollment numbers that are likely to occur through Medicaid Expansion. It is the practice of the MHRB to review progress on strategic plan goals annually with a view to major revisions every other year. The MHRB will hold a Board Retreat in April for a review to address major revisions. In preparation for this Retreat, MHRB staff will use time in the third quarter of SFY 2014 to prepare possible scenarios for budgeting with Medicaid Expansion. The MHRB is exploring shifting dollars to provide for more community recovery supports and additional attention to population level change through environmental strategies.

## 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
n/a		

### 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
n/a			

## 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.