

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

Environmental Context of the Plan/Current Status

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.)

Huron County: Geographic Context

Geography, Land Use, Roads

Huron County is rich in history, located in the land tract called the *Firelands*, which was at the western end of the Connecticut Western Reserve. The land was set aside for residents of the Connecticut towns of Danbury, Fairfield, Greenwich, Groton, New London, Norwalk and Ridgefield who had lost their homes in 1779 and 1781 due to fires set by British forces during the American Revolutionary War. It is a half hour's drive south of Lake Erie.

U.S. Census data provide evidence that Huron County is a geographically large rural community in northern Ohio, with a 492.69 square mile land area, similar in geographic size to Delaware County or to Lorain County. It is larger than Cuyahoga County, which has 458 square miles of land area.

Seventy seven percent (77%) of Huron County's 458 square miles, which is 354.69 square miles or 227,000 acres, is dedicated to farms in Huron County. There are 860 farms. Acres per farm average 264.

While much of the U.S. economy has been slow to recover from the recession, that hasn't been true of farmland markets, which have continued to increase in value, a group of Purdue University agricultural economists (Mike Boehlje, Chris Hurt and Brent Gloy) has found. Boehlje, Hurt, Gloy and fellow Purdue agricultural economist Craig Dobbins examined farmland value dynamics in their paper titled *Farmland Values: Current and Future Prospects* (<http://www.agecon.purdue.edu/commercialag/progevents/landvalueswebinar.html>).

Strong crop returns, very low interest rates and a growing expectation that both will continue, have had a positive influence on farmland values, which have risen steadily since 1987 but have shot up in recent years. Between 2000 and 2010 the average price per acre of average farmland nearly doubled in some parts of the eastern Corn Belt. Land values continued to increase even more dramatically during the last half of 2010. Boehlje said, "...we've seen some high prices for farmland in recent months, even exceeding \$10,000 an acre in some extreme cases."

Due to the increase in the property value of farmlands, levies have become significantly more burdensome on farmers. The passage of property tax levies is hence becoming increasingly difficult in rural counties.

An aspect of the infrastructure of rural Ohio that inhibits growth/economic development is the need for public/mass transit as well as the need for highways. As is true for many rural counties, 4-lane highways to urban areas of Ohio and to the state's capital are available only for part of the journey from Huron County. The 2-lane highways available are subject to hazards that include accidents with other vehicles and deer, drifting snow and culverts close to the road. They also are subject to stoppages/slowdowns due to trains and slow-moving farm vehicles. There may no place to stop for vehicle-needs or person-needs for long parts of trips and few places to pull off in bad weather. There are no lights on 2-lane roads so travel at night is hazardous. Improved connectivity to urban areas would assist this county to attract new businesses and professionally trained persons who are desirous of access to specialized health care, higher education and many cultural, shopping and social amenities. It also would assist current residents to access jobs, education, health care and cultural amenities.

Huron County: Demographic Context

Overview

In his groundbreaking work: Boom or Bust: Understanding and Profiting from a Changing Consumer Economy (rev. 2009), financial writer Harry S. Dent Jr. advanced the theory: “Demographics are destiny,” by demonstrating that **demographics are an economic forecasting tool**. This theory is now considered a validated principle and is applied routinely to a myriad of economic issues, many of which directly relate to governments at all levels.

An example of the application of this data-driven principle occurred during the preparation of this Plan when the historic announcement was made by China media officials that China is to loosen its one-child policy, part of major reforms **aimed at securing its economic future** and strengthening policy ties with the US. Although the changes include human rights reforms, they are driven by economics.

Loosening of the family planning laws in China is aimed at preventing an impending crisis caused by an aging population and at ensuring continued manufacturing growth. Analysts believe the one-child policy has shrunk China's labor pool, hurting economic growth. For the first time in decades the working age population fell in 2012. Around 8.5 percent of China's population (114.8 million people) is over 65, and this will rise to 23.9 percent (around 322.9 million people) by 2050, according to United Nations data.

The median age of China's population in **1980 was 22 years**. In **2012, it was 35.9**, not very different from the US. The median age is the age that divides a population into two numerically equal groups; that is, half the people are younger than this age and half are older. It is a single index that summarizes the age distribution of a population. Currently, the median age ranges from a low of about 15 in Uganda and Gaza Strip to 40 or more in several European countries and Japan. (Central Intelligence Agency [CIA] World Fact book, Feb. 2013)

With the “mushroom cloud” of US baby boomers reaching retirement age, the median age in the US has increased from **30.0 years in 1980** (when China's was 22 years) to **37.1 years in 2012**.

Among the most significant of demographic changes that have occurred in the US over the last two decades are **the aging, diversity and urban dwelling of its population**.

Demographic Changes in Huron County: Decreasing Population, Population Density, Aging and Diversity

The demographics of Huron County largely have been determinants (i.e., “destiny”) of the economic, social and health factors influencing the local behavioral health system.

Largely due to the preponderance of the county's land being used for farming, **Huron County has fewer than half the persons per square mile than is average for Ohio**. It has **121.3** persons per square mile, while the state average is **282.3** persons per square mile

Since the 2010 census, the **population of Huron County has decreased** (-0.6%), while Ohio's population showed a slight increase (+0.1%). This is consistent with the trend in the US for the population to reside in urban areas. The US census bureau has found that 79.219 % of the US population lives in urban areas, while 20.781% live in rural areas.

The 2012 US Census data also are indicative that Huron County's **population has aged** (median age in 2000 was 35.66; in 2012 it was 38.0). The median age in Ohio in 2012 also was **38.0 years**. Huron County in 2012 had: 29,371 boys/men (48.9%) and 30,255 girls/women (51.1%), while the average for Ohio in gender distribution was the same.

The 59,280 residents of the county are comprised of 6.4% under 5 years of age (6% for Ohio), 25.4% under 18 years of age (23.1% for Ohio) and 14.5% 65 years of age and older (14.8% for Ohio).

The percentage of youths in the county is slightly greater than the average for Ohio, which may be indicative of the family-friendly nature of this community, with school systems that promote the involvement of students in sports and other extracurricular activities, not always as available in metropolitan schools where there is more competition for such involvements.

While its population is shrinking and aging, it also is **growing in diversity**. Ninety six percent (96%) of the county's population was *White alone* in 2000. In 2012, it was 91.7% *White alone*, a significant change, although it remains significantly less diverse than Ohio as a whole. Nonetheless, Huron County now has a **higher than state average of Hispanic persons**, many of whom came to the county to work on farms.

The 2012 Census presents the following "snapshot" of the diversity of Huron County's population:

- | | | | |
|------------------------------|------------|--------------|----------------------|
| • White Non-Hispanic Alone | US (77.9%) | Ohio (83.4%) | Huron County (91.7%) |
| • Hispanic or Latin | US (16.9%) | Ohio (3.3%) | Huron County (5.6%) |
| • Two or More Races | US (2.4%) | Ohio (2.0%) | Huron County (1.5%) |
| • Black or African Am. Alone | US (13.1%) | Ohio (12.5%) | Huron County (1.2%) |
| • Asian Alone | US (5.1%) | Ohio (1.8%) | Huron County (0.4%) |

Huron County: Social Context

Educational Attainment, Unemployment and Life Expectancy Rates of Huron County's Adult Population

In the 2012 Census, the percentage of *Bachelor's degree or higher percent of persons age 25+* for Huron County was **12.3%**; for Ohio was **24.5%**; and for the US was **28.2%**. In 2010, these percentages were: 12.1% for Huron County; 24.1% for Ohio; and 27.9% for the US, indicative of slight increases, but with **Huron County remaining obdurate at half the average college degree-attainment of adults in Ohio.**

Huron County, thus, has an average adult educational attainment that is **half that of the state and less than half that of the US**. The much lower educational attainment of persons living in this county, compared with state and national averages, has contributed to **limited vocational resiliency** for many who worked in manufacturing jobs that have largely left the area, often going to countries with less costly work forces or to counties not as highly unionized, since unions add cost (although they may add to workforce stability and hence quality of product).

Educational attainment is a critical indicator of the economic, social and health well-being of a population as is demonstrated by the 2012 Census data available for Delaware County. **Delaware County, with 50.0% of its adults who are 25 years of age or older with Bachelor's Degrees or higher degrees, has:**

- **more than 4 times the number of college graduates as are found in Huron County;**
- an unemployment rate (August 2013) of **5.1%**, which is **60% less than the unemployment rate of 8.6% in Huron County** for the same time period;
- a **Median Household Income that is nearly double that of Huron County** (\$90,022 in Delaware County vs. \$48,353 in Huron County); and
- an average **life expectancy** (which is correlated not only to the socioeconomic status of individuals but also to the affluence of their communities) **for men of 78.1 years (ranked #2 highest of 88 counties in Ohio) and for women of 82.2 years (ranked #2 of 88 counties), while Huron County men have an average life expectancy of 74.7 years (ranked #47 out of 88 counties) and Huron County women have a life expectancy of 80.5 years (ranked 25 out of 88 counties).**

(Data from World Health Organization, UNESCO and CIA.)

All counties, but one, that are contiguous to Huron County have higher rates of college graduates. All have lower rates of unemployment:

- Ashland County 18.4% BA or higher; 6.9% unemployment
- Crawford County 11.0% BA or higher; 7.8% unemployment
- Erie County 20.0% BA or higher; 6.2% unemployment
- **Huron County 12.3% BA or higher; 8.6% unemployment**
- Lorain County 21.0% BA or higher; 7.4% unemployment
- Richland County 15.1% BA or higher; 7.6% unemployment
- Sandusky County 13.4% BA or higher; 6.6 % unemployment
- Seneca County 16.0% BA or higher; 6.8% unemployment

The percentage of adults with BA degrees or higher in Huron County (12.3%) is close to that of some of Ohio's southeastern counties. (Interestingly, the rate of prescription drug use in Huron County also is similar with that of Ohio's southeastern counties.)

Although education in Huron County is a key to creating a skilled and versatile work force for the new global economy, **Huron County hosts none of Ohio's large number of postsecondary educational centers.**

Also, as noted under *Geography, Land Use and Roads* above, access to educational institutions in other counties and in metropolitan areas is limited by the roads to those parts of Ohio.

Huron County Residents' Housing and Income

The rate of **home ownership in Huron County is seventy-four percent (74%)**, similar to its closest neighbor, Erie County, which has a 71.4% home ownership rate.

The average home ownership rate for Ohio is 68.7%. In Delaware County it is 82.6%; in Franklin County it is 56.7%.

There are 22,684 households in Huron County. Census Data indicate that the **median household income is \$48,358**, compared with the state average of \$48,071.

The median household income for Delaware County is \$90,022 and for Franklin County is \$50,045 and for counties contiguous with Huron County is:

- Ashland County \$45,641
- Crawford County \$41,336
- Erie County \$47,466
- **Huron County \$48,358**
- Lorain County \$52,194
- Richland County \$43,098
- Sandusky County \$47,277
- Seneca County \$41,761

The median value of owner-occupied housing in Huron County is \$121,400, compared with the state average of \$135,600. In Delaware County, this value is \$253,400 and in Franklin County it is \$155,200.

Poverty Level

Huron County persons below poverty in 2004 were 9.5%, while in 2007-2011 were 15%, up 158% (according to the 2012 Census data).

The state average in 2004 was 11.7%, while in 2007-2011 it increased to 14.8%. In 2007-2011, persons below poverty in Delaware County were 4.5%, in Franklin County were 17.4%.

Huron County has the highest % of persons below the poverty level of the counties contiguous with it:

- Ashland County 14.6%
- Crawford County 14.8%
- Erie County 12.6%
- **Huron County 15.0%**
- Lorain County 13.6%
- Richland County 13.4%
- Sandusky County 13.6%
- Seneca County 14.1%

Persons Without Public or Private Insurances Seeking Board-paid Behavioral Healthcare

Medically indigent persons (who do not have public or private insurance or are under-insured) seeking behavioral healthcare services have increased significantly because:

- there are fewer employed adults in Huron County, indicated by the unemployment data discussed above;
- those with employment less frequently have private insurances, as indicated by data from the Huron County Health Assessment Reports conducted by the Hospital Council of Northwest Ohio, wherein in 2007, 8% of Huron County adults were without health care coverage while in 2011, 12% were without health care coverage, with those most likely to be uninsured being adults under age 30 and those with incomes below \$25,000 ; and
- the stresses created by loss of income have impacted/triggered behavioral health crises, have resulted in families being less economically able to care for persons with behavioral health diagnoses and have resulted in the demise of other community supports that had contributed to the well-being, stability and community tenures of people with behavioral health diagnoses.

Summary

The geography and demographics of Huron County largely have been determinants (i.e., “destiny”) of the economic, social and health factors influencing the local behavioral health system.

Summary of Data-driven Economic, Social and Demographic Factors in the Board Area Influencing Service Delivery

The data-driven summary of economic, social and demographic factors in the Huron Board area influencing service delivery is as follows:

- **its population has decreased from 2010;**
- **its median age has increased;**
- **its racial and ethnic diversity has increased;**
- **its adult attainment of college degrees (12.3%) has remained obdurate at half the average rate for Ohio (24.5%) and only 44% of the average rate for the United States as a whole (28.2%);**
- **its high unemployment rate has remained virtually obdurate;**
- **its infrastructure of roads and transit has not improved;**
- **its farm property value has increased (which may adversely affect levies); and**
- **its proportion of adults without public or private health insurance (i.e., medically indigent) has increased.**

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)

Introduction

The Huron County Board of Mental Health and Addiction Services (MHAS) utilizes a variety of methodologies to determine its needs, which are inclusive of:

- system design/infrastructure needs;
- financial needs;
- treatment, prevention/education and support service needs;
- collaborative needs; and
- imbedded/collocated/referred integrated behavioral health and physical health needs (new).

Some of the methodologies utilized by the Board are conducted quarterly; some annually; and some are conducted periodically or occasionally or are conducted on a one-time basis. Needs assessments conducted in collaboration with community and/or regional partners/stakeholders have become increasingly utilized because of the cost efficiencies achieved as well as the broader and more integrated results that can be achieved.

Methodologies and processes utilized currently by the Board and its stakeholders/collaborative partners to determine needs and then to prioritize these needs include, but are not limited to, the following:

Collaborative Needs Assessment: NW Collaborative “Hot Spot” Regional Needs Assessment

The NW Collaborative, formed to identify and implement regional needs, identified one of the three projects approved for use by its 12 member Boards as the **Waiting List/NOPH Admission Reduction Project**.

The NW Collaborative identified the fact that admissions to the regional state psychiatric hospital used by 11 of the 12 Boards in that Collaborative, Northwest Ohio Psychiatric Hospital (NOPH), had risen significantly after ODMH/MHAS removed Boards’ responsibility to pay for state psychiatric hospital bed days.

Previously, Boards had paid for those bed days from funds available to them to keep persons with SMI/SPMI in the least restrictive environments. The coupling of authority and responsibility for inpatient and outpatient services had resulted in minimal use of the public hospital for the most Boards.

Since admissions to NOPH by Huron County had risen significantly after this change, the Board decided to spend 84% of its NW Hot Spot funds on the NOPH Admission Reduction part of this project **for outpatient service needs of persons currently, or at high risk of, receiving treatment in state Regional Psychiatric Hospitals, a need that must be addressed to fully respond to this section of the 2014 Community Plan.**

It designated these funds for the following projects:

Rescue Crisis \$25,482 spent 18 clients benefited

\$19,950 of Waiting List funds initially were budgeted to be used with Rescue Crisis to access private psychiatric hospital beds in Toledo, but funds for Rescue were increased in June 2013 due to difficulties obtaining admissions to NOPH (Dir. Plouck was met with re: this June 12, 2013). Hot Spot funds for Rescue were increased at the June Board Meeting by up to \$8,500 for a total of up to **\$28,450**, leaving up to **\$17,562** for the remaining programs.

Wellness Programming \$12,480 spent 25 persons benefited

Wellness programs were provided by personal trainers in both individual and group formats, based on research such as that in the article titled *A Fitness Movement* (Behavioral Health February 15, 2012), which found fitness programs to have efficacy in reducing hospitalizations and chronic physical illnesses for persons with SPMI. Planning was challenging and the programs implemented were not always been well attended. However, for those who did become involved, both physical fitness and mental health improvements resulted, with those high service utilizers achieving fewer hospitalizations as well as fewer social problems if they resided in group homes.

Group Home Respite/Step-down \$2,695.00 spent 4 persons benefited

Group home stays (for intervals of 7-14 days) were procured for four clients that either kept them out of NOPH or allowed them to be released sooner from NOPH. As noted by MRU/LLC, the Board's contract QA/UR provider, discharge planning for individuals hospitalized in NOPH often is a barrier to those persons' timely release from that level of care.

Engagement/Outreach \$384.00 spent 1 person benefited

This fund was designed to provide case management to individuals who had multiple prescreens or hospitalizations but had not been willing to be involved with ongoing services. It was successfully used with one individual, preventing a readmission.

Hotel/Transportation \$211.05 spent 4 persons benefited

Hotel stays for four (4) individuals, consisting of one night each, were purchased in SFY13 with this fund, resulting in four diverted inpatient stays.

24-hour on-call CPST \$3,702 spent 10 persons benefited

Implementation of 24-hour CPST availability during crises was made available by this fund for 43 weeks of the fiscal year. This was effective in diverting from NOPH a percentage of those seen by this service, providing the opportunity for a case manager to access alternative resources for a client (albeit that sometimes those alternative resources were in other inpatient/crisis facilities). It also allowed time and staff to deescalate anxieties of the client, of his/her family and of safe-site/hospital ER staff. It also provided opportunities to educate families about mental illnesses at opportune "teachable moments." (This program was so successful, that to proceed without it in the future would be a significant loss.)

Crisis Group \$384.00 spent 0 persons benefited (and this was discontinued)

Four sessions were held open with no attendance. The program was discontinued.

The Huron County Board realized **reductions in NOPH Admissions in SFY 2013** as follows:

Total admissions were cut more than in half (from 64 to 30) so that SFY 2012's admissions were 213% of SFY 2013's;

Civil admissions were cut in half (from 58 to 29) so that SFY 2012's admissions were 200% of SFY 2013's; and

Forensic admissions in SFY 2013 were cut 300% (from 3 to 1).

By targeting the collaboratively identified NOPH Admission Reduction project, Huron County more than cut in half its admissions to NOPH, while also achieving a higher quality of life for persons who otherwise would have been hospitalized by providing those persons with opportunities to increase confidence in their abilities to manage their lives and symptoms.

Collaborative Needs Assessment: *Huron County Health Assessment*

The *Huron County Health Partners Collaborative* retained the **Healthy Communities Foundation of the Hospital Council of Northwest Ohio** to complete a 2nd comprehensive Huron County Community Health Assessment.

With two such surveys, conducted in 2007 and 2011, longitudinal data became available so that a *trajectory of change* could be assessed. This is important because planners often believe that being high or low on a set of variables matters less than the *direction in which the entity measured is trending*.

Huron County is now in the process of planning and recruiting funds not only to complete this survey again in 2014, but to add to it a survey of children 0-11 years of age.

At the writing of this Plan, the number of Ohio counties utilizing this Survey had increased from 16 at the time of the last survey to 26. All of these counties contracted with the Hospital Council of NW Ohio for the completion of their Community Health Assessments. Since the survey instrument used in these counties consists primarily of standardized questions, the findings are comparative across NW Ohio, some of NE Ohio and now Fairfield and Hocking Counties. Counties now utilizing this Healthy Communities Survey are as follows:

- Williams
- Defiance
- Paulding
- Fulton
- Henry
- Mercer
- Allen
- Auglaize
- Lucas
- Wood
- Hancock
- Erie
- Ottawa
- Huron
- Sandusky
- Seneca
- Wyandot
- Marion
- Richland
- Lorain
- Medina
- Cuyahoga
- Geauga
- Ashtabula
- Fairfield
- Hocking

The Huron County Health Partners consists of this county's 3 hospitals (FTMC; Bellevue; Willard Mercy); Firelands Hospital (located in Erie County, but a behavioral health provider in Huron County); the county's Health Department; behavioral health care providers and the MHAS Board; providers of services to the developmentally disabled and the DD Board; mayors, county commissioners and other public officials; school administrators; law enforcement agents; family provider officials from DJFS, FCFC and CAC; and consumers.

While the majority of the adult survey items were taken from the Risk Factor Surveillance System Survey and the majority of the adolescent survey items were taken from the Youth Risk Behavioral Surveillance System Survey, some questions were tailored to this community's specific needs. The Huron County Board's assistance in financing this *Assessment* gave it a "place at the table" to request that specific questions be added such as those that would accommodate the correlation between serious physical health problems and SPMI; those that would solicit why people go out-of-county for behavioral health care treatment; those that would solicit illicit prescription drug use and those that will solicit the prevalence of problem gambling.

A 5% random sample of the population of adults age 19 and over living in Huron County was needed for survey validity and reliability. **A sample size of at least 381 adults was needed** to ensure that the needed level of confidence in the survey. In 2007, there was a 68% return of surveys, with 535 completed. In 2011, there was a 55% return of surveys, with 425 returned.

In both 2007 and 2011, **a sample size of at least 363 youths ages 12-18 was needed** to ensure the needed level of confidence in the survey. In 2007, there was a 96% response rate, with 366 youths participating. In 2011, the response rate was 95%, with 447 youths participating. Schools and grades were randomly selected.

Highlights of the 2011 results follow, indicative of:

Increases in the health problems of:

- adult obesity,
- adult diabetes,
- adult and youth depression,
- adult prescription misuse, and
- youth contemplation of suicide and youth marijuana use.

Decreases in the health problems of:

- adult and youth binge drinking,
- adult marijuana use,
- youth obesity, and
- youth tobacco use.

Responses to one of the questions the MHAS Board had added to the survey pertained to the high percentage of Medicaid-eligible persons going out-of-county to receive behavioral health care treatment services. At the end of SFY 11, Board data indicated:

- 35.5% of MH Medicaid has gone to out-of-county providers, and
- 38.0% of AoD Medicaid has gone to out-of-county providers.

Responses to the Board question about **why people went out of county for behavioral health services** were provided by the 15% of adult survey participants who had indicated that they had gone outside the county for behavioral health services. The responses were as follows:

- There was a better quality program out-of-county (24%)
- Confidentiality/anonymity (14%)
- Did not like the local program (14%)
- The waiting list was too long in Huron County (8%)
- Had insurance restrictions (7%)
- Went to another county because they used to live there (7%)

Another question added to the survey by the Board pertained to **misuse of prescription drugs** by adults, the results of which indicated the following:

- Adults who misused prescription drugs in the past 6 months were 8% in 2011; 7% in 2007

A third question added to the survey instrument by the Board pertained to **parents telling their children that no alcohol/other drug use by them is acceptable, since evidence-based studies have shown that alcohol/other drug use is less prevalent among youth who perceive strong parental disapproval.** The results found that::

- 82% of youths reported their parents would not approve of them drinking alcohol, decreasing to 74% of those 17 years of age and older

A stakeholders meeting about the results were indicative that **parents became less disapproving of youths' use of alcohol at 17, because it had been legal for many of the parents to drink 3.2 beer at age 18.** Until 1984 in Ohio, just 28 years ago, persons age 18-21 legally could purchase beer with 3.2% alcohol. Legal drinking for youths ended when the national effort began to lower fatalities/injuries due to teen-age drunk driving.

The stakeholders decided upon three areas to focus upon for change during the period of time between surveys (i.e., 2011 and 2014), as follows:

- **Wellness-**Seventy one (71%) of Huron County adults identified themselves as overweight (35%) or obese (36%). The obesity rate for Huron county adults had increased since the 2007 survey when it had been 34%. The US average obesity rate in 2011 was 28% and the Ohio rate was 30%. The diabetes rate in Huron County also increased from 12% in 2007 to 15% in 2011, while in the US the average rate was 10% and the Ohio rate was 11%. **Not only are obesity and diabetes increasing in Huron County, but they are significantly higher than is average for the US or Ohio.** Objective: Decrease rates of obesity/overweight by increasing physical activity of persons across the lifespan because of the risk factor that excess weight is for chronic diseases such as diabetes, heart disease, cancer and other serious health problems. Objective to be measured by opportunities for wellness education and for fitness activities.
- **Youth Risky Behaviors-** Fifty six (56%) of Huron County 9-12 graders surveyed reported having had sexual intercourse compared to the state average of 45%. Twenty four percent (24%) of the youths surveyed reported using marijuana compared with the state average of 18%. Objective: Reduce the rate of sexually transmitted diseases/pregnancies in youths (i.e., educational campaigns by the Health Department were to occur and the Health Department was to measure STD/pregnancy rates) and reduce the rate of alcohol/other drug use in youths. **While alcohol use by youths in Huron County had decreased** between 2007 and 2011 (from 65% to 57%), binge drinking had gone down (from 20% to 16%) and tobacco use had gone down (from 40% to 35%), **marijuana use had gone up (from 10% to 15%) and prescription drug use had climbed** sizably (from 12% in 2007 to 21% in 2011). Objective to be measured by 2014 Community Health Assessment; reduction of underage access to alcohol (i.e., training was to be provided to alcohol servers/sellers); reduction of use of addictive prescribed medications not prescribed to youths (i.e., drop boxes were set up for unused medications and PR efforts made to encourage parents to get rid of unused medications); and increase of access to drug test kits for parents to asses drug use by their children.
- **Mental Health- Survey findings for adults** were that 3% thought about attempting suicide; 1% attempted it.

(However, the National Survey on Drug Use and Health [NSDUH] found that while prevalence estimates of suicidal thoughts and behaviors varied by socio-demographic factors, region, and state, during 2008-2009, an estimated 8.3 million US adults per year [aged ≥ 18 years], or 3.7% of the adult U.S. population, reported having suicidal thoughts in the past year. This would place **the % of Huron County adults considering suicide lower than the national average.**) The Huron County survey found that nine (9%) felt sad, blue or depressed nearly every day for two weeks or more increasing to 18% of adults under the age of 30. (Again, according to the National Institute of Mental Health [NIMH], 18.8 million, or 9.5%, American adults suffer from a depressive illness in any given year- so that, again, the finding of 9% of Huron County adults having symptoms of depression in a year is lower than the national average.)

Survey findings for youths were that fifteen percent (15%) of youths reported seriously considering attempting suicide, seven (7%) had attempted suicide and 4% had made more than one attempt. Almost one quarter (26%) of youths reported feeling sad or hopeless almost every day for two weeks or more in a row.

(Again, a nationwide survey of youths in grades 9–12 in public and private schools in **the US found that 16% of students reported seriously considering suicide**, 13% reported creating a plan, and **8% reported trying to take their own life** in the 12 months preceding the survey, so that **Huron County rates of youths considering suicide and attempting suicide were lower than national rates**, according to data from Centers for Disease Control and Prevention, National Center for Injury Prevention and Control, Division of Violence Prevention August 15, 2012.)

While any contemplation of suicide by adults or youths is of concern, the third focus of the community is an example of it not fully employing SAMHSA's *Strategic Planning/Prevention Framework (SPF)*. This focus was less data-driven than panic-driven, representing a sincere concern for any adult or youth who contemplates or attempts suicide, and was decided in the context of a peak year of adult suicides for the county. **If priority choice had been data-driven by the community stakeholders, adult alcohol use and binge drinking may have been selected and may have better assisted to reduce the suicide rate, since substance use and depression are correlates of suicide.**

Highlights of the data from the full Huron County Community Health Needs Assessment Survey were provided in the SFY 2013 Community Plan. Since those data will not be updated until the completion of the 2014 Community Health Needs Assessment, the focus herein shall pertain to comparative data pertinent to the behavioral health care system among the 26 Ohio counties that contracted with the Hospital Council of NW Ohio for Community Health Assessments.

Comparative data pertinent to the behavioral health care system among the 26 Ohio counties that contracted with the Hospital Council of NW Ohio for Community Health Assessments:

- **Adult Risky Behaviors: Binge Drinking and Overeating/Under-exercising Alcohol Consumption**

Alcohol over-consumption and addiction by adults is a much broader problem across NW Ohio, Ohio and the US than is prescription misuse or street drug use.

Most adults, an average of 55% in NW Ohio (with a range from 41% in Paulding County to 68% in Medina County), in these counties define themselves as current drinkers. The rate for Ohio is 56% and for the US is 57%.

In Huron County, the rate of current drinkers decreased from 58% to 50% between 2007 and 2011 (possibly influenced by the severe economic downturn in this county, so that people had less money to spend on alcohol).

Binge drinking (defined as 5 or more drinks in a couple of hours or on an occasion in the past month) was found in 2011 to be **the number one most prevalent substance abuse problem across the 26 counties surveyed, with an average of 21% of the adults in these counties binge drinking in the last month (with a range of 15% in Hancock County to 30% in Erie County).**

In Ohio, an average of 20% of adults binge drink and in the US, an average of 18% of adults binge drink. **In Huron County, 27% of adults were binge drinkers in 2007; this decreased to 19% in the 2011 survey.**

An average 3.78% of NW Ohio adults participating in the survey (with a range of 1% in Geauga, Ashtabula, Lorain, Auglaize, Fulton, and Mercer Counties to 12% in Lucas County) used recreational drugs within a month of the survey.

Although a much smaller segment of the population participates in illegal drug use than in alcohol use, the **attention of law enforcement often goes to drug users because of three matters that demand immediate attention**:

1. Overdoses cause immediate medical crises and occur more commonly due to drugs than to alcohol;
2. Illegal drug users, who must be connected to the criminal subculture- as alcoholics do not need to be to procure their drugs-of-choice, come to the attention of the criminal justice system for property crimes (committed to support their habits) and for activities related to the commerce of the illegal drug industry, so that such persons may have frequent incarcerations; and
3. Heroin drug users in particular, who tend to consider themselves “special” drug addicts (Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy by Theodore Dalrymple, 2006) frequently are from higher socioeconomic backgrounds than other criminals so that their families demand interventions.

Use of the SPF to plan would necessitate a significant focus on alcohol overconsumption/addiction by adults. That the consequences of alcohol addiction may be more **long-term and insidious** (eg., destroying families, destroying the health of the alcoholic, causing accidents, leading to suicide that may be preceded by violence against others) cannot result in the community and in the public behavioral health system ignoring this “elephant in the living room,” the adult risky behavior that **affects 21 in 100 adults who binge drink in a month in NW Ohio, while drugs affect 3.78 (fewer than 4) adults in 100 in a month.**

Overeating/Inactivity

The other predominant adult risky behaviors that permeate a large proportion of the population of NW Ohio are overeating/eating foods that contribute to weight gain and health problems (i.e., too much sugar, fat and salt) and leading inactive life styles that do not contribute to physical fitness.

While 30% of Ohioans are **obese**, that percentage for the US is 28%. In NW Ohio, **obese** persons comprise **32.22%** of the population (with a range of 23% in Medina to 40% in Wyandot County). In Huron County, **obese persons comprise 36% of the population.** Weight issues may lead to many chronic and serious health issues such as hypertension, high blood cholesterol and diabetes.

For example, hypertension in Ohio affects 33% of the population, while in the US, affects 31% of the population. Hypertension in NW Ohio affects 35.5% of the population (with a range from 24% in Hancock County to 44% in Wyandot). In Huron County, it affects 36% of the population.

Diabetes in Ohio affects 11% of the population, while in the US, affects 10% of the population. Diabetes in NW Ohio affects 11% of it (with a range from 5% in Medina County and 15% in Huron County).

Huron County had the highest rate (15%) of diabetes in NW Ohio in 2011. In 2007 it had 12% with diabetes, so the trend is in the unhealthy direction. For persons with SPMI who may be taking psychoactive medications that may contribute to weight gain/diabetes, living in a county with a substantial problem may normalize this health condition, creating less incentive to change.

- **Youth Risky Behaviors: Use of Prescription Medications and Marijuana**

On most indicators of youth risky behaviors, youths in NW Ohio are at or below state and national averages. For example, in response to the question, *Ever had sexual intercourse?* (A question not approved for inclusion in all counties’ surveys), the NW Board-area youths that did answer the question had an average response of 32.85%.

In the US, 47% of youths answered affirmatively. In Huron County, 35% answered affirmatively. Also, NW Board area youths much more often reported condom use (60% in Ohio; 66.5 % in NW Ohio; 74% in Huron County) and birth control use (23% in Ohio, 36.46% in NW Ohio; 41% in Huron County). In response to weight status, Ohio reported 15% obese youths and 15% overweight. Huron County reported 15% obese youths and 13% overweight. The region reported 14.9% obese and 11.11% overweight.

Although marijuana use is less in Huron County (15%) than in Ohio (24%), the trend for Huron County is revealing of more use in 2011 than in 2007, when it was 10%. For NW Ohio in 2011, the rate was 11.88%.

The large jump in drug use by Huron County youths is of prescription medications used to feel high/good, which increased from 12% in 2007 to **21% in 2011**. **Huron County had the highest percentage of youths in NW Ohio indicating use of prescription drugs.** In the region, the rate was 11.89%.

Collaborative Needs Assessment: FCFC Needs Assessment

The Huron County Family and Children First Council (FCFC), which includes parent partners, has been involved in activities that include, but are not limited to: ECMH planning and contracting (i.e., the award of the SFY 2014 Ohio Children's Trust Fund monies was made to Firelands Counseling and Recovery Services (FCRS) to provide *The Incredible Years* in Head Start programs in the county; the implementation of IHBS (i.e., the award of the SFY 2014 contract to provide Integrated Family and Systems Therapy [I-FAST] was made to FCRS; the implementation of *Help Me Grow* (i.e., the award of the SFY 2014 contract to implement this program was made to the DD Board) ; the development and the ongoing collaboration of services for the county's *Alternative School*; and collaboration with the MHAS Board to implement the Search Institute's *40 Developmental Assets Community Change Model*.

The needs of children and families in Huron County have been assessed with the assistance of consultation by the FCFC partners, inclusive of the MHAS Board, through completion of the *Huron County Family and Children First H.B. 289 Biennial Plans*, with the first one facilitated by Brown Consulting, Ltd. and funded with dollars made available to the Board for the completion of that Plans in conjunction with the FCFC (in SFY 2007).

The collaborative decision has been to focus on the goal of children **and youth succeeding in school and engaging in healthy behaviors**. This was to be facilitated by increasing healthy behaviors and activities in Huron County.

To achieve this, the Search Institute was brought to Huron County initially in April 2008 to conduct three asset building training sessions, two with parents and community members and one with community professionals who work with youths and their families. This was funded by the MHAS Board. At those trainings, this community's parents and leaders learned how to create community change by implementing the *Developmental Asset Model*. A later training, *Sharing the Asset Message*, was conducted by the Search Institute in October 2008.

In SFY 2009, the Collaborative partners again conducted this planning process and decided to expand implementation of the *40 Developmental Assets Model* by coordinating the messages conveyed about how the community can optimally nurture its youths and assure their good choices. A program was developed for participating schools, churches, governmental bodies and others to deliver the same monthly message.

For SFY 2014, the FCFC again is planning to bring the Search Institute to Huron County for expansion of the institutions involved in that Institute's *40 Developmental Asset Program*.

Special Formal Board Needs Assessments

The Board conducts or procures special needs assessments as needed. For example, it commissioned a *Service Delivery System Situation Analysis*, completed by Brown Consulting, Ltd., at the end of FY 11 to assist it to address such matters as the reasons persons with Medicaid were seeking out-of-county behavioral health treatment services, how competition in the behavioral health care marketplace could be enhanced to encourage cost effective services.

Ongoing Methodologies of Assessing and Prioritizing Behavioral Healthcare Needs

The formal needs assessments discussed above that are done periodically complement the following **ongoing methodologies** utilized by the MHAS Board to assess and prioritize behavioral health care needs:

- Reviews of Census, Unemployment, Ohio Automated Rx Reporting System data, in comparison with regional, state and national data, in order to identify socio-demographic, economic and cultural characteristics and trends in this service area.
- Reviews of Annual Client Satisfaction Surveys which pertain to treatment and support services received as well as to the quality of, effectiveness of, convenience of (i.e., location and appointment times), attention to cultural sensitivity of and trust/confidence in these services.

The successful completion of one hundred and fifty (150) surveys by clients (adults, youths and parents) served at the Huron County offices (i.e., Norwalk, Willard and Bellevue) occurred in June 2013.

The Huron County survey results were calculated to compare the responses of the forty four (44) participating court-ordered clients with the responses of the one hundred and six (106) clients who had not been court-ordered into treatment. This was done due to the difference involuntary entry into treatment can make in the perception of/satisfaction with it. Involuntary patients often believe (at least initially) that there is nothing wrong with them.

Race/ethnicity by respondents was reported as follows: 89% White/Caucasian, 3% African American, 2% Hispanic/Latino and 2% "Other." Women (83%) replied more frequently than men (17%). *Note: not every respondent answered the demographic questions so totals do not calculate to 100%.*

Since participants had been randomly selected to complete surveys, the length of time they had been in treatment varied significantly so that a range of responses was expected. Those in treatment for a short time, for example, may have responded to the question "How do you feel now?" more negatively than those who had been in treatment longer because they were only beginning to address their symptoms of distress. After several sessions they may have had opportunities to experience positive treatment outcomes.

Conversely, those new to treatment, who may not have received bills, may have answered the question "Are you experiencing difficulty with fees?" more positively than those with bills, although payments are arranged for most people.

Of the non-court ordered clients in treatment, 20% had been in treatment less than one month, 17% had been in treatment 2-6 months and 63% had been in treatment 6 months or more. Of the court-ordered clients in treatment, 15% had been in treatment less than one month, 44% had been in treatment 2-6 months and 41% had been in treatment 6 months or more.

The overview of results for "voluntary" clients (n =106) was as follows:

- 97% of the respondents felt Firelands staff treated them with courtesy/respect and were responsive to their needs "always" or "usually;"
- 100% felt their cultural issues were respected;
- 69% felt better since beginning treatment, 31% felt the same and 0% felt worse;
- 95% indicated that phone calls were always/usually returned within 2 business days;
- 6% reported being unhappy with any service;
- 97% indicated they would choose FCRS even with other options;
- 4% indicated difficulty with appointment time (FCRS is open 3 nights/week);
- 97% of clients surveyed reported they would recommend Firelands to others; and
- 74% reported being "very satisfied," 25% "satisfied" and 1% not satisfied, overall.

The overview of results for court-ordered clients (n =44) was as follows:

- 100% of the respondents felt Firelands staff treated them with courtesy/respect and were responsive to their needs “always” or “usually;”
- 100% felt their cultural issues were respected;
- 57% felt better since beginning treatment, 43% felt the same and 0% felt worse;
- 89% indicated that phone calls were always/usually returned within 2 business days;
- 0% reported being unhappy with any service;
- 92% indicated they would choose FCRS even with other options;
- 7% indicated difficulty with appointment time (FCRS is open 3 nights/week);
- 96% of clients surveyed reported they would recommend Firelands to others; and
- 62% reported being “very satisfied,” 36% “satisfied” and 2% not satisfied, overall.

● **Reviews of Annual Stakeholder and Referral Source Satisfaction Surveys:**

FCRS’ Calendar Year (CY) 2012 *Stakeholder Satisfaction Surveys* were completed by representatives of referral sources including, but not limited to, the county’s courts, law enforcement organizations, probation and parole authorities, schools, consumer group, hospitals, physicians, NAMI/family member organization, Job and Family Services, Developmental Disabilities Board, Family and Children First Council.

FCRS changed its method for collecting these data in CY12. In 2012 it sent the surveys with franked envelopes, instead of handing them out, in order to obtain a larger sample and more open feedback. The number of surveys returned from the 7 counties in which Firelands provides treatment did increase. A total of 214 surveys were returned, an increase of 33 over those submitted in CY11. The county with the most returns was Huron County, with 49 returned (18%).

The questions and responses from the survey of the 7 counties were as follows:

How well do the offered MH services meet the needs of the community?

Excellent	35%
Good	53%
Fair	6%
Poor	6%

How well do the offered AoD services meet the needs of the community?

Excellent	30%
Good	51%
Fair	14%
Poor	5%

How accessible are the agency’s days/hours of operation?

Excellent	50%
Good	44%
Fair	6%
Poor	0%

Rate the ease of the referral process.

Excellent	33%
Good	52%
Fair	11%
Poor	4%

Rate the confidence in the quality of services provided.

Excellent	39%
Good	48%
Fair	8%
Poor	4%

Rate the degree to which staff members return phone calls within 2 business days.

Excellent	55%
Good	33%
Fair	8%
Poor	4%

Rate the quality of feedback from staff (verbal or written).

Excellent	37%
Good	43%
Fair	17%
Poor	3%

Rate the overall satisfaction with services.

Excellent	47%
Good	39%
Fair	12%
Poor	2%

The open-ended survey questions and a sample of replies from Huron County respondents were:

What do you consider Firelands Counseling and Recovery Services strengths?

Good place to go when you are having problems (Consumer Group)

- Friendly (Consumer Group)
- Community access and ability to schedule to meet client needs. Ability to expand services as needed (FCFC)
- Accessibility to students, comfort level with counselors, communication (Schools)
- They are accessible and easy to work with (Schools)
- The staff and resources (Schools)
- Friendly, caring staff (Schools)
- Everything is great (Family Member)
- A great help to the community (Family Member)
- Help children with problem solving (Family Member)
- Employees' dedication to treatment; employees communication with agencies (Court)
- Location, accessibility, GREAT STAFF (Police)
- Staff are very knowledgeable (DJFS)
- Hours of operation (DJFS)

What suggestions do you have for improving our services?

- More counselors to serve high number of referrals in a timely manner (Schools)
- Timeframe for seeing individuals not appropriate for successful MH treatment (Schools)
- Need more programs that involve weekly meetings and supports for families (Schools)
- Wait list times; reaching out to schools more frequently (with) MH services (Schools)
- More alcohol counselors (Family Member)
- Make transportation available for clients in the evening (Court)
- Allow MHP to go to Police Stations to assess suicidal people instead of us transporting them to ER. (Police)

- Reviews of Annual Client Grievance and Major Unusual Incident reviews by Board staff;
- Monthly **Waiting List*** and **Waiting Time**** reviews by Board staff of Firelands Counseling and Recovery Services (FCRS) to assess DA's access for adults and youths by funding source, the triage system and the "spread of resources" being utilized; (Definitions of "Waiting List" and "Waiting Time" operationalized for such monitoring are as follows:

Waiting List* is defined as a list of persons without public or private insurances (i.e., the "medically indigent") who are waiting for initial appointments (i.e., Diagnostic Assessments) due to limited Board-funded treatment capacity.

Appointments for persons on a Waiting List generally become available when:

- Board-funded clients complete therapy, thereby creating capacity for others waiting for initial appointments;
- Board funds are released periodically over the course of a fiscal year (i.e., spread out or stretched) so they will not be diminished early in the fiscal year; or when
- New funds (eg. NW Collaborative funds) are made available.

Waiting Time** is the length of wait a person experiences after a DA appointment has been made.

- Reviews of monthly QA/UR and Risk Management Reports conducted by Managed Recourses Unlimited (MRU), wherein written analyses of a set number of emergency/crisis face-to-face interventions that ended with individuals remaining in the community are provided as well as written analyses of a proportion of emergency interventions that ended in higher levels of care and include NOPH admissions/stays, and reviews of annual aggregated QA/UR and Risk Management Reports by MRU, which identify trends and system needs.

In its *2012 Annual Trend Analysis*, MRU/LLC identified the trend for:

- Those in the 60+ age cohort to utilize crisis services the least (3.3%), although "baby boomers" comprise a significant cohort of the Huron County population;
- Young adults (19-29 years of age), however, to utilize crisis services (36.7%) the most;
- Young men to be high utilizers of crisis and inpatient care, although most are not mentally ill, but lack the supports and/or emotional resilience to manage rejections; and for
- Most persons using crisis services to have mood disorders, versus psychotic or anxiety disorders.

MRU/LLC concluded its *2012 Annual Trend Analysis* by recommending a SFY 2014 contract change. It noted that although releasing persons that present in crisis with voiced suicidal and homicidal ideation is a high risk activity, the Board has contracted with MRU/LLC for years to look at these records and MRU/LLC has been very satisfied that the Board's contract agency, Firelands Counseling & Recovery Services, has performed at above prevailing standards. There have not been any cases to the knowledge of MRU/LLC that have resulted in adverse incidents,

However, since ODMH reconfigured funding for inpatient care so that admissions to state psychiatric hospitals generally have increased, it may be useful to shift some of the Board's funds designated for QA/UR activities from clients utilizing outpatient crisis services to clients utilizing state hospital bed days. This would provide more focus on high resource utilizers. MRU/LLU has a staff member who goes to NOPH every 2 weeks to review clinical records of clients that have been admitted and continue to be hospitalized. The MRU staff member reviews inpatient charts to decide whether clients are still meeting admission/continued stay medical necessity criteria.

- Quarterly and annual reviews of MACSIS data to ascertain changes in patterns of use, durations of use, rates in clinical treatment programs or in education/prevention/consultation programs, particularly pertaining to critical services such as Crises/Emergency Services, which, for example, led to the mid-year SFY 13 addition of funds to Rescue Crisis Stabilization Services when the rate of use of the annually projected public inpatient (i.e. NOPH) bed days had been exceeded;
- Reviews of evaluations of clinical, education/prevention and support services by advisory and collaborative groups that meet regularly and act as focus groups (such as Firelands Counseling & Recovery Services' Advisory Board that meets quarterly and consists of consumers, family members, health care providers, educators, law enforcement representatives and social service providers; such as the FCFC that meets monthly; such as the Suicide Prevention Coalition that meets periodically);
- Targeted focus groups that are convened periodically and that may consist of representatives of behavioral health care consumers in the consumer support group, educators, physicians, law enforcement personnel, court personnel, DJFS personnel and most recently, gas station and convenience store operators to ascertain information about problem gambling regarding the Ohio Lottery;
- Reviews of (or collaboration with) behavioral health care projects undertaken by the county's *Project Leadership Class* that annually provides training to persons who pay tuition to attend this year-long class to learn to be community leaders of service organizations and political offices and who choose projects to complete each year after identifying community needs, which often concern behavioral healthcare matters, that may be done in conjunction with the MHAS Board (eg., the Board was a cosponsor of a Project Leadership effort to bring *Operation Street Smart* to Huron County in 2012);
- Assessment of the findings and recommendations of the *Annual Mental Health Services Field Audit* (conducted initially in SFY 2010 to replace the *Annual Medicaid Medical Necessity Reviews* of mental health treatment services, but with the *Field Audit* record review consisting only of non-Medicaid reimbursed clients/services) and of the *Annual Independent Peer Reviews* of alcohol and other drug treatment services completed on-site at FCRS.

Brown Consulting, Ltd., under contract with the Board, completed the annual Independent Peer Review (IPR) of a statistically significant sample of Firelands' AoD cases and completed the annual Field Audit of a statistically significant sample of Firelands' non-Medicaid Mental Health Cases March 4-5, 2013.

Results showed Firelands clinical records in the sample to be in good organizational order and consistent with best practice clinical record standards and that **71% of clients in the IPR sample were compliant with their Individual Service Plans (ISP) treatment goals, demonstrating "successful" discharge from treatment.** The Brown Consulting AoD auditor called Firelands' AoD case documentation, "masterful." Out of **845 MH closings in 2012, 62.6% had closed positively.** This means some of them were neutral-type closings (i.e., partial goals met) to full goals met. 37.4% were closed with unsatisfactory progress.

- Reviews of emergent information about best practices and evidence-based programs, particularly those new and promising programs from SAMHSA;
- The Board's Annual Budget Reconciliation Review that assists the Board to assess where spending has diverged from projections, leading, thereby, to explorations, or the "drilling down," of financial and clinical data pertaining to particular clinical or education/prevention/consultation services produced below or above expectations;

- :
- Annual reviews of *MyOutcomes*, the only Outcome Evaluation system for behavioral health services that **both measures client outcomes and improves those outcomes** by bringing attention to any process or product concern of the client immediately by measuring both clients' satisfaction with, and progress in, counseling (i.e., both process and product). *MyOutcomes* is more **accurate** and **transparent** than most methods that measure client outcomes since *MyOutcomes* data are **client-generated** and since they **do not exclude those who do not complete treatment**, a flaw in many outcome evaluation systems. For the therapy and therapeutic relationship to be evaluated in *MyOutcomes*, clients need only to have had 2 therapeutic "events" (eg. a Diagnostic Assessment and a therapy session). *MyOutcomes* had been founded on decades of research showing:

- Progress in therapy is very predictable with the majority of change happening early in treatment. Persons who make no progress/deteriorate early in treatment are at risk for poor outcomes.
- The client's rating of the therapeutic relationship predicts treatment success far better than the treatment method, severity of diagnosis or the therapist's training.
- When clients are directly engaged in measuring their own progress and the therapeutic alliance, outcomes improve dramatically.

The client-generated data utilized by *MyOutcomes* is obtained through the use of two instruments administered by behavioral health professionals to their clients. These instruments are as follows:

- **The Outcome Rating Scale (ORS) is a four-item self-report instrument capturing treatment efficacy** that is completed at the beginning of each treatment session. It assesses clients' performance in four areas: personal well-being; family/close relationships; work/school/friendships; and sense of well-being. Since *MyOutcomes* measures distress, not symptoms, it can be used for all populations.

MyOutcomes research shows that adults typically enter treatment with ORS scores of **25** or lower and that young people (under 18) typically enter treatment with scores of **28** or lower. These scores are indicative of substantial distress. For some populations, such as children/adolescents and court-ordered adults, persons usually think they do not need treatment so their initial scores are higher than the clinical cutoff.

Early *MyOutcomes* research indicated that ORS scores that increase by 5 or more points by the end of treatment were indicative of effective treatment. More current data, however, has pointed to ORS scores needing to increase by 6 or more by the end of treatment to be indicative that treatment had been effective. (The initial algorithms were based on 65,000 administrations of the ORS/SRS while the new algorithms are based on 427,000 administrations, greatly enhancing the statistical accuracy.)

- **The Session Rating Scale (SRS) is completed at the end of each session and solicits feedback from the client regarding how well he/she felt understood**, the degree to which the session focused on what he/she wanted to talk about and whether or not he/she felt the therapist's approach was a "good fit."

Use of this instrument eliminates the potential for a therapist to misinterpret a client's experience. It also provides the information/format needed by a therapist to address any problem perceived by the client immediately, so engagement in treatment engagement may be established and sustained.

The scoring on the SRS is done on a continuum from 0 (extremely dissatisfied) to 40 (extremely satisfied). If a therapist scores **below 36, it is a "red flag" that there is a problem** in the session that needs to be discussed (i.e., the client is not happy).

Two populations added for *MyOutcomes* assessment in SFY 2013 were as follows:

- **Adults with Severe Mental Disabilities (SMD) Receiving CPST (Community Psychiatric Support Team) Only Services** began to participate in the *MyOutcomes* methodology in SFY 2013. Individuals with SMD who also are in receipt of counseling are included in the MENTAL HEALTH TREATMENT-ADULT cohort. Since all individuals in this new population have been in receipt of CPST, treatment and/or support services - often for years or decades- the degree of change was expected to be less than if they had just begun treatment since the most change in treatment occurs at the beginning of it.
- **Mental Health Youth Collateral Raters** (i.e., parents/care givers of youths in mental health counseling) also began to participate in the *MyOutcomes* system in SFY13. Of all the counties in which Firelands provides mental health counseling for youths, **Huron County had the highest number (261) of parents participate in this,** a demonstration of how effective the Huron County team of youth counselors is at getting parents involved in the treatment of their children/the children they are responsible for.

The SFY 2013 results are presented below **with the SFY 2012 results in parentheses for comparison.**

OUTCOME RATING SCORES

The *Outcome Rating Scores* (ORS) show the distress of a client at the beginning and end of treatment. A differential of at least 6 points from beginning to end is statistically significant. The lower the score, the greater the distress.

MENTAL HEALTH TREATMENT- ADULT ORS SCORES

- **794 (605) adults in mental health treatment** with at least 2 “measurements” of treatment contacts rated;
- on average, **clients entered treatment with an 18.44 (17.98) score,** (lower score=greater distress), **6.56 (7.02) points** below the clinical cutoff of 25 for adults (i.e., a score above 25 shows adequate coping by adults so treatment is not needed);
- on average (meaning that not every client got better), clients’ **scores after treatment increased to 25.92 (26.34), averaging a 7.48 (8.36) increase,** which is excellent since **a change of 6** (changed from 5 utilized in SFY 11 and 12) **or more points is indicative of statistically significant therapeutic change.**

NEW POPULATION: MH ADULT CPST CLIENTS NOT IN THERAPY

- **82 adult CPST clients** were rated after at least two therapeutic contacts, which were measured quarterly for this population (all other cohorts are rated each session);
- the first measure of distress for these adults was an average of **23.53,** indicative of substantially **less distress than the Adult MH Therapy consumers** who were newly entering treatment at an average distress level of **18.44,** an expected finding since those in this cohort were not new to treatment; and
- the average score after at least 2 measurements was **28.98,** which means the group average increased by **4.75,** indicative that the clients in this cohort trended in a positive direction for achieving less distress, although this differential was not statistically significant (i.e., the differential in initial and ending scores need to be at least 6 to be statistically significant).

MENTAL HEALTH TREATMENT- YOUTH ORS SCORES

- **387 (391) youths in mental health treatment** with at least 2 “measures” were rated;

- on average, these **youths entered treatment with a score of 25.28 (25.24)** (i.e., youths generally rate themselves as having less distress than adults rate themselves as having), 2.72 points below the clinical cut off of 28 for youths (i.e., a score above 28 indicates adequate coping so that treatment is not needed);
- on average, (meaning that not every client got better) their **scores after treatment increased to 33.46 (33.92), averaging an 8.18 increase**, which is excellent since a change of 6 or more is indicative of statistically significant therapeutic change; and
- *Huron County youths achieved the greatest level of change among the counties in which FCRS provides treatment to children/adolescents and measures its effectiveness with MyOutcomes, believed attributable to the experienced and excellent children’s therapists that Firelands has in Huron County.*

NEW POPULATION TO USE MYOUTCOMES: MH YOUTH COLLATERAL RATINGS BY PARENTS/CAREGIVERS

- **261 parents/caregivers** rated the distress, and the change in distress, of the children under their care who were in receipt of mental health treatment;
- the average first measurement of the parent/caregiver perspective of the distress of the child/adolescent entering treatment was **22.82, indicative of an average adult perception of the youth having greater distress than the youth rated him/herself (25.28)**, an expected difference since youths often enter treatment “involuntarily” (i.e., at the direction of parents, schools or court), experiencing less distress than the parent/guardian evaluates there to be; and
- the average score these parents/caregivers gave for the distress of their children after at least 2 treatment sessions attended by their children was **30.53**, for a difference of **7.71**, indicative of statistically significant improvement from the parent/caregiver perspectives.

AoD TREATMENT-ADULT ORS SCORES

- **214 (214) chemically abusing/dependent adults** with at least 2 treatment sessions were rated;
- on average, these **clients entered treatment with a score of 30.26 (30.73)** (i.e., the majority of AoD clients that FCRS treats are court-ordered to treatment and *MyOutcomes* research shows that such clients usually enter treatment in less distress than those seeking mental health services because they think they do not need help; the **30.26** level of distress for this population is significantly less than for the new client seeking mental health treatment, with the average score of **18.44**); and
- on average, (i.e., not every client got better) clients’ scores **after treatment increased to 35.03 (35.38), averaging a 4.77 (4.65) increase**, indicative that progress/change was achieved, although the benchmark for treatment success and statistically significant change (i.e., a 6 point differential) was not achieved.

AoD TREATMENT-YOUTH ORS SCORES

- **31 (71) chemically abusing/dependent youths** with at least 2 “measures” were rated (the 56% reduction, or 40 fewer youths, in treatment in FY13 is notable);
- on average, these **youths entered treatment with a score of 29.92 (29.73)** (i.e., the majority are court-ordered and *MyOutcomes* research shows that such clients usually enter therapy in less distress because they think they do not need help);
- on average, their scores **after treatment increased to 35.95 (34.33), averaging a 6.03 (4.6) increase**, so that statistically significant change is being made.

There were **40 fewer youths** in AoD treatment in SFY 2013 than in SFY 2012, reflective of Juvenile Court's report that AoD-related arrests were down, as were all juvenile arrests, and reflective of the city and county schools reporting that their referrals of youths for AoD issues also were down.

SESSION RATING SCALE

The *Session Rating Scale* (SRS) results for SFY 2013 (**with the SFY 2012 scores in parentheses**), measure clinical alliances on a scale of 0-40, with scores below 36 indicative of problematic alliances, as follows:

- MENTAL HEALTH TREATMENT- ADULT SRS SCORES-on average, adults scored initial sessions at **36.92 (36.36)** and scored follow up sessions at **38.01 (38.02)**.
- NEW POPULATION: MH ADULT CPST SRS SCORES- on average, adults scored initial measurements at **37.71** and their follow up sessions at **37.35, for a slight drop**.
- MENTAL HEALTH TREATMENT- YOUTH SRS SCORES-on average, youths scored initial sessions at **36.32 (36.23)** and scored follow up sessions at **38.54 (38.74)**.
- NEW POPULATION: MH YOUTH COLLATERAL SRS RATINGS-on average, parents/caregivers rated their children's initial sessions at **38.45** and scored follow up sessions at **39.14 (the highest score for a cohort, indicating parents are pleased)**.
- AoD TREATMENT-ADULT SRS SCORES-on average, adults scored initial sessions at the level of **36.94 (36.71)** and scored follow up sessions at the level of **37.87 (38.20)**.
- AoD TREATMENT-YOUTH SRS SCORES-on average, youths scored initial sessions at the level of **37.35 (35.25)** and scored follow up sessions at the level of **38.95 (38.13)**.

A **longitudinal analysis** of consumer outcomes between SFY 2011 (when *MyOutcomes* achieved full implementation) and SFY 2013 indicated the following:

- For MH clients, the ORS change from baseline to follow-up was **7.62** in SFY 11, **8.52** in SFY 12, and **7.03** in SFY 13. (Note: aggregate scores for SFY 13 may have been impacted by the fact that SMD adult consumers who are not in therapy were integrated into the *MyOutcomes* system and they tend to be more vulnerable to periods of decompensation compared to the general MH population.)
- For AoD clients, the ORS score change from baseline to follow-up was **4.10** in SFY 11, **4.63** in SFY 12, and **5.4** in SFY 13. AoD clients showed improvement despite scoring above the clinical cutoff (i.e. not convinced they need help when they enter treatment).

Summary

These methodologies, used to assess gaps in services and optimal mechanisms to fill them, to assess the efficacy of clinical outcomes and mechanisms to improve them, to identify MHAS Board/community/other resources that may be available to fill identified needs, and to assess how reengineered/new/expanded/dropped programs may impact the community, provide the information that then needs to be prioritized for implementation.

To assist the Board to accomplish prioritization of needs, the Board utilizes the schema set forth in Sharing Power-Public Governance and Private Markets by Donald F. Kettl (The Brookings Institution, pages 17-20), which offers the competing goals that government entities need to consider to best promote the public interest, as opposed to private markets that value efficiency above all other goals:

- **Efficiency**-the attainment of a given level of output at the lowest possible price (while this is the single goal of most market-driven businesses, it is not the only goal of government offices that are charged with promoting other goals as well, such as protecting the public interest);
- **Effectiveness**-when the “goal is the goal” regardless of the cost (such as the clean-up of a toxic waste dump or the implementation of programs to achieve the cessation of “copycat” suicides of teens in a community);
- **Capacity**-the need for government to maintain its capacity to manage its contracts, such as by ensuring competition by purposely engaging in inefficient purchasing to keep multiple vendors in business, which may be expensive in the short run but cost effective in the long-run as well as effective in maintaining supplies of goods and services (so that “expensive” is relative);
- **Responsiveness**-the importance of a constituency having a voice in government processes and products; and
- **Trust and Confidence**- wherein government programs- principally those that assure public safety such as fire departments, law enforcement and suicide hot lines- need the trust and confidence of the community, so that the pursuit of efficiency alone, which can bring about delays, complications and adverse publicity, will not suffice.

Weighing these competing goals assists the Huron County Board of Directors to prioritize this community’s needs. The Board values its responsiveness to consumers and other community stakeholders, as well as its desire to be efficient and effective, to maintain a capacity to manage its contracts and to maintain the trust and confidence of the community.

Part of maintaining the trust and confidence of the community and assuring efficiency is the need to be a good steward of tax payers’ dollars. The financing of programs to meet community needs, therefore, is a significant factor in prioritizing needs for program implementation. Even when an “opportunistic fund,” such as a grant, is made available, there needs to be a financial analysis to consider sustainability of a program before such a grant-funded program would be undertaken.

When assessments point to needs for programs for priority populations (such as for children or SMD/SPMI persons or suicidal persons) for which there are resource gaps, for which programs are available for implementation that are best practices or research-validated or research-informed, for which the impact would be cost effective, for which community support exists and for which there are potential providers, funding would be the next consideration.

Whether there would be sustained funds from the Board alone, or with or by partners, to maintain a service would need to be evaluated before a program would be undertaken. For example, when the more expensive MultiSystemic Therapy (MST) strategy of Intensive Home Based Services (IHBS) was replaced in the county by the less expensive Ohio State University (OSU) developed Integrated Family and System Treatment (I-FAST), which accommodates a broader age range of youths than MST does, commitments were made by Huron County DJFS, Juvenile Court and FCFC to fund this approach to IHBS, and by the MHAS Board to include this program in all of its QA/UR reviews to assure quality of services. Changing this program resulted not only in cost savings and sustainability of funding by community partners, but in better treatment outcomes and in greater capacity to provide this IHBS to a broader scope of youths. This had been a need identified by DJFS supervisors, pediatricians and psychiatrists, educators, Huron County Juvenile Court officials and providers of behavioral health services.

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/MHAS.

Local system resources, knowledge and experience (i.e., strengths) that do, and will, assist the Board in addressing the findings of the need assessments discussed above are as follow:

- **Knowledgeable, experienced, accountable, engaged, intelligent and respected Board of Directors**

The most significant strength of this MHAS Board is its Board of Directors, which has a long-standing tradition of its members collectively acting with “good sense, good humor and a good heart.”

Board Members have a history of dedication to this public body, with three Board Members who have served at least two ten-year terms. The tradition of expecting excellence of itself, its Director and its contract providers is passed along seamlessly to new Board Members.

This Board has established a culture of knowledge, leadership, advocacy and stewardship. It is stalwart in conducting itself with the highest of ethical standards.

As the planning and contracting authority for publicly funded behavioral health care services, it is the hub of decision-making for this health care system. Its leadership determines the efficacy of its provider panel, the fit of its benefit package with citizen needs, the success of its planned outcomes and the quality of its collaboration. This Board is:

- comprised of citizen volunteers who collectively represent the values, the geography, the demographic configuration and the occupational composition of the community;
- dedicated to the mission of the Board to advocate for, and with, persons affected by behavioral health disorders to be treated with dignity in all aspects of their lives, best attained when persons with mental illnesses and addictions *become contributors to, as well as beneficiaries of, society*;
- committed to the recruitment of public funds and to the good stewardship of those funds so that the Board may maintain the trust of the public;
- committed to the recruitment of public funds and to the good stewardship of those funds so that persons with mental illnesses and addictions may have access to the treatment and supports that will assist them to achieve optimal self-determination and independence in their lives;
- comprised of Members with the business acumen to engineer/re-engineer this health care system to meet local needs within the resources available;
- knowledgeable of the history and current status of the Board’s Benefit Package and Provider Panel; of federal, state and local public financing mechanisms for behavioral health services; of the involvement of federal, state and local governance bodies in setting public policies and budgets; and of the needs of the community as determined by the Board’s needs assessment methodologies;

- willing and able to advocate at the federal, state and local levels for public policies and budgets that will accommodate the Board to meet local needs; and
- willing and able to value community and regional partners that may assist it to achieve its statutory responsibilities/authority to plan, implement and monitor this community's publicly funded behavioral healthcare benefits.

○ **Experienced, Dedicated Board Staff**

The Board's Director has begun the 26th year in that job. Previous to assuming this position, the Director worked for the Huron County Board as an administrator of a children's program, as an administrator at a Huron County treatment provider, as an Instructor in Social Work and Sociology at BGSU and as a caseworker for Franklin County Children Services. She was one of 2 undergraduates from OSU selected to serve as a Justice Dept. Intern in Washington D.C. and was inducted into Phi Beta Kappa.

As Board resources have been reduced, this person has become the only full-time staff member. With part-time fiscal support, a contract with the Erie/Ottawa Board for CFO and MACSIS services, and use of consultants as needed, this person has assumed not only the CEO duties but also the COO, PR, HR and other duties as needed. Nonetheless, the support staff and consultants utilized also are seasoned and knowledgeable professionals who contribute significantly to the operation of the Board.

○ **Respected, Stable, Professional Provider Panel**

The Board conducts due diligence in contracting with respected, stable and professional provider organizations with staffs that are both competent and compassionate. These organizations are willing and able to modify practices/programs when necessary to meet identified needs and a changing healthcare environment. They strive to continuously embrace research-validated strategies/approaches, to focus on the achievement of successful outcomes, to recruit highly qualified and talented health care professions, to recruit grant funding (having recently received 3-year SAMHSA grant to implement Health Homes for medically indigent persons) and to be active community partners.

The fact that its primary provider is a hospital (Firelands Regional Medical Center) has facilitated the move to integrated health care and "legitimized" for clients the delivery of integrated care.

○ **Valued Community Partners**

The Board works diligently to maintain connectivity with its valued community partners. Since persons with mental illnesses and addictions often interface with multiple systems, working collaboratively on their behalf not only benefits them but assists local organizations to better respond to their needs. Providing education through such mechanisms as the CIT program and Forensic Conferences, the Board, its providers and its community partners work together to implement strategies to meet identified needs.

Community partners also have worked to facilitate funding. Two examples are as follows:

- First, the Intensive Home Based Service of I-FAST is funded through FCFC, by Juvenile Court, DJFS and the County Commissioners. The Board monitors the services provided.
- Second, area courts' IDAT funds have become a major source of funding of the Board's AoD programming. After the funding cuts began in 2008, area Judges became very cooperative with making those funds available so that the valuable AoD treatment could continue for court-referred persons.

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 1).

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

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

The Board’s needs assessments point to the following resources, knowledge and experiences that are not readily available to it and that contribute to the challenges created for its behavioral health system of care::

○ **Challenge: Disadvantageous Environment for Economic, Educational, Social and Somatic Wellness**

As described in the response to Question # 1 of this Plan, Huron County is an **economically depressed** rural county that **has the 11th worst jobless rate** (according to data released by ODJFS December 2, 2013) among the state’s 88 counties for October 2013 (9.4%), that has a **population that is decreasing and aging**, that has **the highest rate of adults with diabetes** and is **among the highest in rates of adult obesity** of the 26 counties that contracted with the Hospital Council of Northwest Ohio for the completion of Community Health Assessments, that has **one of the lowest rates of adults 25 years of age or older with college degrees** (less than half the state’s average), but that has **rising farm land values**.

The impacts of this environment/context are many and include, but not be limited to, the following:

1. The need for integrated Health Homes is greater in this county because of its poor economy and the poor health of many of its citizens, many of whom also are senior citizens.
2. The need for education about behavioral and physical wellness is greater because of the low rate of higher educational attainment of its citizens and the poor health of many of its citizens.
3. The need for integrated vocational rehabilitation and behavioral health treatment services is greater (but made more difficult) because of the county’s poor economy, high unemployment rate, low rate of higher educational attainment of its citizens, and its infrastructure, which lacks public/mass transit and highways.
4. The need for funds for behavioral health treatment, prevention and support services is greater because of the number of adults that are medically indigent, while passage of levies is challenged on two levels:

First, average persons in the county have few economic resources and have educations that do not contribute to their vocational versatility so that they may be unemployed or underemployed and not in support of levies that would erode the resources they do have.

Second, farmers may not support levies because their rising land values have created a disproportionate burden on them when levies are passed, particularly since their assets may be more in land equity than in dollars.

○ **Challenge: Disadvantageous Funding to Control State Psychiatric Hospital Admissions**

Funding challenges involve not only a need for additional dollars, with this system having substantively fewer dollars today than a decade ago, but also a need for a re-coupling a Board’s responsibility for the payment of state psychiatric hospital bed days with the funds available to it to keep persons with SMI/SPMI in the least restrictive environments. That coupling created the tension that resulted in minimal use of the public hospital previous to the change made in the funding of bed days in the last two years.

The competitiveness of the private marketplace made use of private hospitals efficient. For example, the length of stays at NOPH for Huron County residents in SFY 2013 was **28.6 days**. In SFY 2012 it was **23.44 days**.

Contrast this with the average length of stays in the private Toledo hospitals utilized by Rescue for Huron County residents, with average lengths of stay of **7 days**.

Therefore, the 33 admissions to NOPH of Huron County residents in SFY 2013 resulted in approximately 900 bed days, but **if those admissions had been done privately, they would have resulted in approximately 230 bed days, saving the dollar cost of close to 700 bed days** and the client “cost” of substantial interruptions of their lives days, often accompanied by the loss of social competencies.

The change in a Board’s authority and responsibility to pay for the public and private bed days it utilizes has had significant impacts on this system of care that include, but are not limited to, the following:

- more NOPH bed days have been utilized than had been utilized in the past two decades (although the Board did cut in half its admissions to NOPH in SFY 2013 due to the NW Collaborative funds/programs, the bed days used continued to be well above the number used in decades when the Board paid for its private and public beds used);
- the Board’s Benefit Package no longer makes available to its citizens access to private psychiatric bed days at its closest psychiatric unit (Firelands Regional Medical Center in Erie County, contiguous with Huron County, where families could be more involved with inpatients due to reduced drive time) due to the cost of bed days there versus those accessed by Rescue Crisis;
- outpatient treatment services have been reduced in the Board’s Benefit Package available to its citizens without public or private insurances.

○ **Challenge: Few Private Behavioral Healthcare Providers**

The shortage of private behavioral healthcare treatment and support providers in a rural county, and access to those located in other counties limited due to infrastructure issues disused in the response to the first section of the Plan, creates the need for a behavioral health treatment, prevent and support system that can provide services to persons with private insurances, public insurances and with no insurance (i.e., the medically indigent). **Without the public system to support these services, those with private insurances would not have the depth and breadth of behavioral healthcare services available that exist in this rural county.**

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 Huron County MHAS Board strives to have a provider panel and a system of behavioral health care programs and services that may resonate with the attitudes, motivations, social and socioeconomic factors of persons with a range of cultural backgrounds, marginalizing conditions and experiences so that outreach, prevention and treatment services may be engaging, meaningful and life-enhancing to all persons.

A challenge in this ethnically/racially nearly-homogeneous county in rural Ohio is to develop a workforce at the Board and its providers of persons who are culturally competent and who include persons of diverse cultural backgrounds. With a small minority population, it may be even more important to have minority staff members who interface with clients than in more culturally diverse communities, because persons who are minority and have severe/persistent behavioral health disorders may be dually marginalized in a homogeneous population.

Successes that have been achieved include:

- having a behavioral healthcare workforce that is *trending upward* in minority representation, with 5.1% minority representation in SFY 2013, as opposed to 4.86% in SFY 2012 and 4.3% in SFY 2011; and
- having the minority persons who participated in the most recent Client Satisfaction Survey* responding 100% of the time that their cultural issues were respected. As follows:

The overview of results for “voluntary” clients (n =106) was as follows:

- 97% of the respondents felt Firelands staff treated them with courtesy/respect and were responsive to their needs “always” or “usually;”
- 100% felt their cultural issues were respected;

The overview of results for court-ordered clients (n =44) was as follows:

- 100% of the respondents felt Firelands staff treated them with courtesy/respect and were responsive to their needs “always” or “usually;”
- 100% felt their cultural issues were respected;

*The Client Satisfaction Survey is presented under Question #2 of this Plan, Ongoing Methodologies of Assessing and Prioritizing Behavioral Health Needs.

Cultural competence is a set of attitudes, skills, behaviors and policies that enable organizations (e.g., Boards and Providers) and staff members to work effectively in cross-cultural situations.

To achieve cultural competence, leadership needs to be committed to its realization and to the ongoing work that is necessary to retain attention to it and to incorporate more effective strategies as they are developed.

The Huron County Board works to create, improve and implement strategies that will assist it, its providers and community partners to enhance the dignity, the health, the well-being and the community integration of clients with:

- a range of cultural backgrounds;
- marginalizing conditions/circumstances such as being an ex-offender/convict, having mental illness or physical disability;
- LGBTQ orientations; and with
- histories of traumatic experiences that may create challenges for them to carry out everyday tasks and relationships, as may occur with veterans and persons who have who have experienced abuse/disturbing life events.

Accommodations of persons with a range of cultural backgrounds, with marginalizing conditions/circumstances and/or with experiences that may create challenges for them to carry out everyday tasks and to sustain relationships facilitate this healthcare system to be optimally effective in outreach to/treatment of such persons.

The Board and the Board’s treatment provider have policies in place that call for these organizations to evaluate this health care system’s outreach, provision of health care services and cultural attentiveness to persons of all demographic, ethnic and sexual orientation backgrounds.

Staff demographics as well as client demographics are compared annually with county demographics so that discrepancies in representation may be addressed, if possible.

Behavioral Healthcare Staff Demographics

The cultural competency of a provider is enhanced by its workforce of psychiatrists, clinicians, case managers, interpreters and other staff from diverse races, ethnicities and backgrounds. The Board monitors its providers' annually for this expectation.

Current races, ethnicities and genders of Firelands Counseling & Recovery Services of Huron County (the Board's primary provider of AoD and MH services) employees are as follow; with 33.3 total FTE's:

<u>Race/ethnicity</u>	<u>Number of Staff</u>	<u>% of Staff</u>	<u>% 2012 Census Race/Ethnicity/Gender %'s in Huron Co.</u>
White Non-Hispanic Alone	31.6	94.9%	91.7%
Hispanic or Latin	None		5.6%
Two or More Races	None		1.5%
Black or African Am. Alone	0.5	1.5%	1.2%
Asian Alone	1.2	3.6%	0.4%
<u>Gender*</u>			
Male	4.5	13.5%	48.9%
Female	28.8	86.5%	51.1%

(*As the Board has stated in previous Community Plans, having adequate representation of genders on staffs of behavioral health providers also is important in order to achieve optimal balance in understanding cultural/ethnic/social competencies and differences and in order to achieve optimal availability of men and women counselors for situations that are best addressed by a mental health professional of one gender or another. Although there are fewer male employees at this time than in the past, it is a fact that this field is heavily dominated by women so that achieving an even gender distribution is unlikely.)

In addition, Firelands contracts with a bilingual interpreter for Spanish-speaking clients on a regular basis.

Client demographics

On December 10, 2013 the number of active Huron County cases at Firelands Counseling and Recovery Services was as follows:

RACE/ETHNICITY	TOTAL #	Total %	Adult Male	Juvenile Male	Adult Female	Juvenile Female
White Non-Hispanic Alone	921	93.5%	327	76	432	86
Hispanic or Latin	33	3.35%	14	3	8	8
Two or More Races		Don't capture				
Black or African Am. Alone	25	2.54%	11	4	7	3
Asian Alone	1	.1%	0	0	1	0
Unknown	5	.5%	0	1	3	1
TOTAL OPEN CLIENTS:	985		352	84	451	98

A comparison between the race/ethnicity of open cases in Huron County at the Board's treatment provider (Firelands Counseling and Recovery Services) and the race/ethnicity of the Huron County population from the 2012 Census Data is as follows:

Race/ethnicity	% of Cases	% Race/Ethnicity/Gender in Huron County (2012 Census)
White Non-Hispanic Alone	93.5 %	91.7%
Hispanic or Latin	3.35%	5.6%
Two or More Races	Not an MHAS Category*	
Black or African Am. Alone	2.54%	1.5%
Asian Alone	0.1%	0.4%
Unknown	0.5%	Not a US Census Category

***MHAS needs to consider adding the “Two or More Races” category to the choices it provides clients to define their racial and ethnic identities**, as is done in the US Census data, since it would make MHAS-captured data more comparable to the US Census data and- more important- it would make the MHAS forms better align with the racial identities of persons. As it is now, those persons who identify as “Biracial” or of “Mixed Race” must choose one race only for the MHAS forms, making their foray into counseling begin with their provision of information that is less than accurate about their identities.

While in the Black or African American Alone category, Firelands is attracting a higher percentage of persons than is in the county's population, in the Hispanic or Latin category it is lower than the percentage of Hispanic or Latin persons living in the county, believed to be due to the difficulty in engaging persons who may be in America illegally in any health care, except emergency care.

Staff Trainings

Annual trainings in cultural competence by providers are necessitated by providers' credentialing bodies. Such trainings are required for *all* staff, not just clinical staff, as cultural understanding needs to begin at the first contact with a provider, needs to encompass the physical environment the provider creates and needs to encompass not only treatment but all interactions, such as fiscal intakes. Trainings generally last an hour in length. The most recent trainings included the following information:

- Culture and Health Disparity (2013 staff training)
- Increasing Cultural Awareness of Appropriate Communication Techniques for Working with Deaf and Hard of Hearing Populations (2012 staff training)- provided by the Mansfield Counseling Center

Board and agency staffs also participate in cultural competency trainings that may be sponsored by other public authorities in the county, such as County Commissioners or DJFS. Such collaborative trainings help community organizations work in partnership to move to greater levels of cultural understanding and accommodation.

This system's cultural competence was advanced when it adopted *MyOutcomes*, an outcome evaluation program described under **Question #2** of this *Community Plan* (pp. 19-20).

MyOutcomes has created mechanisms that solicit from clients their ratings of each session both for how well they are being understood and how well they are achieving their goals. Therefore, during each session, minority and marginalized persons may express the attentiveness being conveyed pertaining to them and their treatment needs.

This program not only is available in adult and child versions but also in numerous languages to facilitate good communication and cultural competence.

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 Huron County Board of Mental Health and Addiction Services

Substance Abuse & Mental Health Block Grant Priorities

***Priorities Consistent OHIOMAS Strategic Plan**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
<p>SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)</p>	<p>The Board’s goal is to enhance the outreach to, retention in treatment of, and the successful disposition at discharge of persons who are intravenous/injection drug users.</p> <p>The Board’s Benefit Package of AoD services includes comprehensive and effective community-based prevention, treatment and support services for adults and youths with addictions/abuse of substances, <u>with the prioritization of IV drug users.</u></p> <p>As identified by ODADAS, vis-à-vis its <u>State Quality Management System for Treatment Improvement</u>, the two most significant metrics of effective outcomes are measures of :</p> <ul style="list-style-type: none"> • <u>Retention in Treatment</u>; and • <u>Disposition at Discharge.</u> <p><u>Retention in Treatment</u> will continue to be a priority, since the length of stay in treatment is correlated to the completion of successful discharges. Critical <i>sub goals</i> of this for IV drug users include:</p>	<p><u>Retention in Treatment- An Expanded range of approaches</u> shall be targeted for treatment of IV drug users so they may enter treatment that better and more immediately resonates with them and <u>engages them in treatment</u> by meeting them “where they are” on numerous levels that include, but are not limited to, being in or out of jail; having motivation to change or not. This is critical since treatment outcomes are improved by those who are engaged in treatment so that they complete treatment. Strategies to expand the range of approaches shall be as follows:</p> <ul style="list-style-type: none"> • Newly providing treatment services to inmates of 5 county jails in NW Ohio (including the Huron County Jail) as a result of funds awarded to the NW 3-Board Collaborative of Huron, Erie-Ottawa, and Seneca-Sandusky-Wyandot Counties, to pilot a Criminal Justice and Behavioral Health Linkage (CJBHL) grant, intended to improve criminal justice and 	<p><u>Retention in Treatment and Disposition at Discharge</u> will improve in the next biennium and be measured annually by:</p> <ul style="list-style-type: none"> • the dropout rate after DA’s of IV drug users, targeted to be reduced by 10%; • the re-enrollment rate of IV drug users after 30-day treatment non-compliance suspensions, targeted to increase by 10%; • the <i>Disposition at Discharge</i> measure of <i>Goals Met</i> (in the Independent Peer Reviews IPR’s) by IV drug users, which has risen from 42% in 2011 to 71% in 2013, with 75% the goal for SFY 2014; and • The <i>MyOutcomes</i> treatment outcome data (that measure engagement in the treatment process and the extent of goals met will be targeted to meet the threshold for statistical significance in SFY 14 of a 6-point differential between the average level of distress at the beginning of treatment 	<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>

	<ul style="list-style-type: none"> • <u>Improving Outreach to IV Drug Users</u> so that they will be referred to AoD treatment by other systems that include, but are not limited to, health care, criminal justice, education and DJFS; and • <u>Improving Engagement of IV Drug Users in Treatment</u> by assuring the optimal “fit” of persons who are IV drug users with the treatment methodology participated in. <p><u>Dispositions of Completed Goals at Discharge</u> also will continue to be a priority</p> <p>Additional goals for the treatment of IV drug users are:</p> <ul style="list-style-type: none"> • <u>Improved Access to Treatment for IV Drug Users in the Criminal Justice System</u> (eg. treatment to IV drug users who are in jail); and. • <u>Integrated AoD Treatment and Primary Health Care</u>, when needed (i.e., because of the correlation between IV use and such illnesses as HIV, TB. Hepatitis and various vein disorders). 	<p>behavioral health linkages by applying best practices to them. The jail treatment services will include DA’s, individual and group behavioral health treatment services, case management or CPST and psychiatric services. The Board Directors, Sheriffs and treatment providers and are meeting to review group treatment programs that may be offered, such as <i>Thinking for a Change</i> and <i>Seeking Safety</i>, both of which apply to AoD and MH disorders;</p> <ul style="list-style-type: none"> • In addition, a policy was adopted by the Board’s provider of AoD treatment services (Firelands Counseling & Recovery Services) that, whenever possible, a new client coming to the agency for a financial intake was to be introduced to the group facilitator for the group he/she would be attending. If the facilitator were not available, the facilitator would attempt to call the client before the group met to provide a brief overview of the group and to introduce himself. If an individual failed to show-up for a group 	<p>compared with the average level of distress at the end of treatment (i.e., the current average score is 35.03, for a 4.77 increase, indicative that progress/change is being achieved, although the benchmark for statistically significant treatment success of a 6 point differential was not achieved).</p> <p><u>Integrated AoD Treatment and Primary Health Care</u>, when needed (i.e., because of the correlation between IV use and such illnesses as HIV, TB. Hepatitis and various vein disorders) will be measured annually by:</p> <ul style="list-style-type: none"> • The IPR’s <i>Disposition at Discharge</i> measure of <i>Referrals to Other/physical health care providers</i>, (eg. the Health Department) will increase from 79% to 82% in the next biennium; • Involvement of qualifying IV drug users in Firelands’ SAMHSA-funded Health Home physical health care services for medically indigent clients (since there is no base-line data due to the Health Home for medically indigent people beginning in SFY 2014, base-line data will be established as this service 	
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		<p>session, the therapist would attempt to call the individual as an outreach/engagement attempt as well. With the addition of treatment services for inmates of the county jail as a result of receipt of the 3-Board CJBHL grant (discussed in this Plan), this approach to <u>retention</u> that focuses on <u>engagement</u> will be continued, when possible, by having persons released from the jail remain with the same therapist that he/she had seen while in the Jail;</p> <ul style="list-style-type: none"> • Another strategy will be making permanent the piloted <i>Stepping into Recovery</i> therapy group, the gatekeeping modality used for those most resistant to treatment; • Modification of the attendance policy of the Board's AoD treatment provider (Firelands) has been piloted and will be made permanent that changes <u>automatic</u> case closures for 90 days due to absences of individuals who have begun the <i>Stepping into Recovery</i> group <u>to</u> automatic case closures for 30 days for such 	<p>is used with this population); and</p> <ul style="list-style-type: none"> • County Commissioner data pertaining to county funds spent on TB health care will be attained annually as required by the federal Assurances. <p>.</p> <p><u>Improved Access to Treatment for IV Drug Users in the Criminal Justice System</u></p> <p>According to Chapter 19, <i>Treatment of Drug Abuse in the Managed Care Setting</i>, by Richard Caplan, MSW, LICSW, MPH (in <u>Managed Mental Health Care: Administrative and Clinical Issues</u>, (Edited by Judith Feldman, M.D. and Richard Fitzpatrick, Ph.D.), since the procurement of alcohol is legal, the population of alcoholics generally embraces most middle class values. However, <i>When one's drug of choice is illegal, it means time and energy must be spent to develop a network of reliable suppliers...it also means contact with criminal subculture. This subculture represents a departure from typical middle-class values</i> (p. 308). Hence, use of illegal substances is connected with violations of the law, such as property offenses, that come to the attention of the law enforcement community and result in criminal prosecutions and in jail stays.</p>	
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		<p>non-compliance. This change is made after the piloting of it found that a 30-day suspension of treatment due to treatment non-compliance provided as much motivation as the 90-day wait (i.e., a 30-day hiatus from treatment provided the experience of <u>consequences for treatment noncompliance</u> so that individuals were much more likely to be cooperative and attend groups/sessions regularly when their cases were reopened). This change was piloted after Firelands' managers consulted with Sanford Starr about strategies to adopt to improve Dispositions at Discharge. Judges and PO's were kept abreast of this change, as they had been most supportive of instituting consequences for treatment non-compliance. Prior to this attendance policy, addicted persons, and <u>particularly those who are IV drug users</u>, who often believe that they are "special" or the "top of the food chain" of drug users, would participate in DA's but not return to complete</p>	<p>Treatment to such persons (as well as persons with mental illnesses) will be piloted in SFY14 via the Criminal Justice and Behavioral Health Linkage (CJBHL) grant received by the 3-Board Collaborative consisting of the Huron, Erie-Ottawa and S-S-W Boards and will be measured annually by:</p> <ul style="list-style-type: none"> • The number of IV drug users participating in the CJBHL grant-funded treatment to persons <u>in the county jail</u> and the number of IV drug users participating in this treatment while in jail <u>who continue treatment after release</u> from jail with the % of those who continue outpatient treatment <u>with the same counselor seen in jail</u> tracked also (since there is no base-line data for the CJBHL program which began to be operated mid-FY14, base-line data will be set as this service is used with this population); • Annual referrals from the criminal justice system of persons for AoD counselling, with the priority populations of IV Drug Users, Pregnant Women and Parents of Youths in the DJFS System tracked separately, with maintenance of referrals 	
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		<p>the Individualized Treatment Plans. By the time PO's and Judges recognized there had been only a DA for an individual and reentry into treatment was ordered, enough time had lapsed so that another DA was needed and a pattern of "revolving door" DA's began.</p> <p><u>Disposition at Discharge Improvement Strategies</u> will remain a priority. Work on this occurred after results of the 2011 IPR found the sample of Firelands' cases with Goals Met were at a low of 42%. Firelands contacted Sanford Starr, Chief of Planning, Outcomes and Research, to help it increase retention. Consequently, Firelands reviewed its Attendance Policy and engagement processes for AoD clients. While the Board, Courts and Firelands continue to consider client accountability to be part of a sound treatment strategy, the change to a 30-day suspension of treatment has been shown to continue to motivate clients to comply with treatment, while allowing them to more expeditiously continue their recoveries. These policy and procedure changes contributed to Firelands' achievement of IPR results that found the following:</p> <ul style="list-style-type: none"> ○ in 2012, a 12% increase in 	<p>targeted since 95% of AoD clients already are criminal justice system referrals; and</p> <ul style="list-style-type: none"> • Participation by Criminal Justice System representatives in the Annual Regional Forensic Conference, which provides evidence-based practice training and information pertaining to dually diagnosed persons for professionals from organizations that include, but are not limited to, the following: the Criminal Justice System, the Behavioral Health System, DJFS, Education, NAMI and Faces of Hope (the Board's consumer group). A 5% increase in attendance by these representatives is targeted. <p><u>Connectivity with the Board's Recovery to Work Program</u> shall be measured by the number of persons from this population that retain jobs (obtained by one of the program's vocational rehabilitation providers) for at least 90 days (unless the RSC and OOD do not resolve the monitoring issues and the program is forced to cease). This Board's first success in this program was a recovering IV heroin addict.</p>	
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		<p>Discharges with Goals Met (i.e., from 42% in 2011 to 54% in 2012); and</p> <ul style="list-style-type: none"> ○ in 2013, IPR results that found the Discharges with Goals Met to have risen from 54% in 2012 to 71%. Thus, from 2011 to 2013, Discharges with Goals Met increased by 170%. <p><u>Improved connectivity with the criminal justice</u> system will result from treatment services provided in the county jail via the new 3-Board Criminal Justice grant. Integration with the Courts/PO's will continue.</p> <p><u>Improved connectivity of AoD treatment with primary health care</u> (i.e., because of the correlation between IV drug use and exposure to illnesses such as HIV, TB and Hepatitis and disorders that may result such as the collapse of veins.)</p> <p><u>Connectivity with the Board's Recovery to Work Program</u> will continue to be targeted for this population. The first successful person involved in this Board's Recovery to Work program (i.e., who achieved employment for 90 days) was a recovering IV heroin addict.</p>		
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<p>SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)</p>	<p>The Board's goal is to enhance the outreach to, retention in treatment of, and the successful disposition at discharge of women who are pregnant and have a substance use disorder.</p> <p>The Board's Benefit Package of AoD services includes comprehensive and effective community-based prevention, treatment and support services for adults and youths with addictions/abuse of substances, <u>with the prioritization of pregnant women who have substance use disorders.</u></p> <p>As identified by ODADAS, vis-à-vis its <u>State Quality Management System for Treatment Improvement</u>, the two most significant metrics of effective outcomes are measures of :</p> <ul style="list-style-type: none"> • <u>Retention in Treatment</u>; and • <u>Disposition at Discharge.</u> <p><u>Retention in Treatment</u> will continue to be a priority for pregnant women who have substance use disorder, since the length of stay in treatment is correlated to the achievement of successful discharges. Critical <i>sub goals</i> of this for pregnant women who are using substances include:</p> <ul style="list-style-type: none"> • <u>Improving Outreach to Pregnant Women</u> so that 	<p><u>Retention in Treatment</u>, which is correlated with improved treatment outcomes, will be improved by the strategy of attending to the optimal "fit" of such women with the treatment program offered them (which may be individual therapy). That program must result in their <u>engagement in treatment, which is correlated to successful outcomes.</u> Such engagement is to be enhanced by attention to any co-occurring issues such as IV drug use (and potential exposure to diseases that could endanger a fetus such as HIV, Hepatitis and TB) or previous traumas requiring the incorporation of trauma-informed care. Strategies:</p> <ul style="list-style-type: none"> • Newly providing treatment services to inmates of 5 county jails in NW Ohio (including the Huron County Jail) as a result of funds awarded to the NW 3-Board Collaborative of Huron, Erie-Ottawa, and Seneca-Sandusky-Wyandot Counties, to pilot a Criminal Justice and Behavioral Health Linkage (CJBHL) grant, planned to improve criminal justice and behavioral health linkages by applying best practices to them. The jail treatment services will include DA's, individual and group 	<p><u>Retention in Treatment and Disposition at Discharge</u> will be measured annually by:</p> <ul style="list-style-type: none"> • the dropout rate after DA's of pregnant women with substance use disorders, which is targeted to decrease by 25%; • the <i>Disposition at Discharge</i> measure of <i>Goals Met</i> (as measured annually by the annual IPR) by pregnant women with substance use disorders, which is targeted to increase to 75% from the 2012 rate of 71%; and • <i>MyOutcomes</i> treatment outcome data that measure engagement in the treatment process and goals met, which is targeted to <u>improve to a 6-point differential</u> from the beginning to the end of treatment (i.e., the SFY 2013 average score was 35.03, with a +4.77 differential between the beginning and end of treatment, indicative that progress/change is being achieved, although the benchmark for statistically significant treatment success of a 6 point differential was not achieved). <p><u>Integrated AoD Treatment and Primary Health Care</u>, when needed</p>	<ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):
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	<p>pregnant women using substances will be referred for AoD treatment by other systems that include, but are not limited to, health care, criminal justice, education and DJFS; and</p> <ul style="list-style-type: none"> • <u>Improving Engagement of Pregnant Women in Treatment</u> so that there is an optimal “fit” of a pregnant woman with the treatment methodology/program and the therapist. <p><u>Dispositions of Completed Goals at Discharge</u> also will continue to be a priority.</p> <p>Additional goals for the treatment of pregnant women with a substance use disorder are:</p> <ul style="list-style-type: none"> • <u>Improved Access to AoD Treatment for Pregnant Women in the Criminal Justice System</u> (eg. treatment to pregnant women in jail who have been substance users); and. • <u>Improved Rates of Integrated AoD Treatment and Primary Health Care</u>, (i.e., because of the correlation between fetal addiction and impairment when substances are used during pregnancies). 	<p>behavioral health treatment services, case management/CPST and psychiatric services. The 3 Boards, treatment providers and Sheriffs have met to review group treatment programs that may be offered, such as <i>Thinking for a Change</i> and <i>Seeking Safety</i>, both appropriate to dually diagnosed persons.</p> <ul style="list-style-type: none"> • Also, a policy was adopted by the Board provider of AoD treatment services (Firelands Counseling & Recovery Services) that, whenever possible, a new client coming to the agency for a financial intake was to be introduced to the counselor assigned to that client. If the counselor were not available, that person would attempt to call the client before the session to provide a brief overview of counseling and to introduce herself. If a pregnant woman failed to show up for an appointment, the therapist would call her or send case management outreach to her. <p>With the addition of treatment services for inmates of the county jail as</p>	<p>(i.e., because of the correlation between substance use of the mother and resultant life-threatening illnesses for her such as HIV, TB, cirrhosis and Hepatitis and resultant life-altering disorders of the fetus such as Fetal Alcohol Syndrome) will be measured annually by the following:</p> <ul style="list-style-type: none"> • The <i>Disposition at Discharge</i> measure of <i>Referrals to Other/physical health care providers</i> in the annual IPR, inclusive of the Health Department; shall be targeted to improve from the current level of 79% to 82%. • Referral to/collaboration with pre-natal care by pregnant women in AoD treatment who have substance disorders (all of whom would qualify for Medicaid) will be measured for 100% compliance; • Health Department data concerning babies born with addictions or with illnesses/disorders resulting from their mothers’ alcohol or other drug use will be targeted to be reduced by 5%; and • County Commissioner data relating to funds spent on TB treatment for county residents and Health Dept. data 	
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		<p>a result of receipt of the 3-Board CJBHL grant (discussed above), this approach to <u>retention</u> that focuses on <u>engagement</u> will be continued, whenever possible, by having pregnant women with substance use disorders who are released from jails designated to remain with the same therapist seen for treatment while in the County Jail.</p> <ul style="list-style-type: none"> • Another strategy will be making permanent the piloted <i>Stepping into Recovery</i> therapy group, the gatekeeping modality for those resistant to treatment. • The strategy to suspend therapy when there is treatment noncompliance generally will not be used because of the urgency to assist such pregnant women to cease use of subzones so their babies may be born healthy and not addicted. <p><u>Disposition at Discharge</u> also will continue to be a priority. Much work on this occurred, after results of the 2011 IPR found the sample of Firelands' cases with <i>Goals Met</i> were at a low of 42%. Firelands contacted Sanford Starr, ODADAS Chief of Planning, Outcomes &</p>	<p>pertaining to TB treatment provided to Pregnant Women with Substance Disorders will be tracked.</p> <p><u>Improved Access to Treatment for Pregnant Women w/Substance Use Disorders who are involved in the Criminal Justice System</u> (i.e., treatment while they are in jail will be piloted in FY14) to be measured annually by the following (although since there is no base-line data for the CJBHL program which began operation mid-FY14, base-line data will be set as this service is used):</p> <ul style="list-style-type: none"> • The number of pregnant substance using women participating in the CJBHL grant-funded treatment to persons <u>in the county jail</u>; • The number of pregnant drug-involved women participating in this treatment while in jails who continue <u>treatment after release</u> from jail; • The number of pregnant drug-involved women participating in this treatment while in jails with the % of those who continue outpatient treatment <u>with the same counselor seen in jail</u> tracked also; • Referrals from the criminal justice system of persons for AoD counseling, with the priority population of 	
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		<p>Research, to help it increase retention. Consequently, Firelands reviewed its Attendance Policy, engagement processes and programs for AoD clients. The policy and procedure changes made contributed to Firelands' achievement of Independent Peer Review (IPR) results that found:</p> <ul style="list-style-type: none"> ○ in 2012, a 12% increase in <i>Discharges with Goals Met</i> (i.e., from 42% in 2011 to 54% in 2012); and ○ in 2013, IPR results that found the <i>Discharges with Goals Met</i> to have risen from 54% in 2012 to 71%. <p>Thus, from 2011 to 2013, Discharges with Goals Met increase by 170%.</p> <p><u>Improved connectivity with the criminal justice</u> system will result from treatment services provided in the county jail via the new 3-Board Criminal Justice grant. The intensive connectivity with the Courts and PO's will continue.</p> <p><u>Improved connectivity of AoD treatment with primary health care</u> (i.e., because of the correlation between alcohol/other durg use with illnesses a fetus may be exposed to such as HIV, TB and Hepatitis and disorders that may result such as Fetal Alcohol Syndrome.).</p>	<p>Pregnant Women tracked separately, and with the goal of maintenance of the % of referrals from this system targeted (95% of AoD clients already are criminal justice system referrals); and</p> <ul style="list-style-type: none"> ● A 10% increase is targeted in the participation by Criminal Justice System representatives in this Board's SFY 14 Annual Regional Forensic Conference (implemented in collaboration with the Erie-Ottawa and S-S-W Boards), which will provide evidence-based program/treatment information pertaining to persons with behavioral health disorders and criminality for professionals from organizations that include, but are not limited to, the following: the Criminal Justice System, the Behavioral Health System, DJFS, Education, NAMI and Faces of Hope (the Board's consumer group). ● <i>Discharges with Goals Met</i>, as reviewed for the IPR, will be targeted to increase from the 2012 level of 71% to a 2013 level of 75%. 	
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<p>SAPT-BG: 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)</p>	<p>A Board priority goal is to continue to enhance the program developed with the local DJFS and Juvenile Court pertaining to HB 484 to strengthen families involved in those systems by:</p> <ul style="list-style-type: none"> • <u>enhancing referrals from DJFS and Juvenile Courts of parents with substance use disorders and/or mental health disorders who have a child or children decreed Dependent by Juvenile Court;</u> • <u>providing treatment services to parents with substance use disorders and/or mental health disorders who have a child or children decreed Dependent by Juvenile Court and providing any needed family or child therapies, in conjunction with the treatment provided to the referred parents,</u> that may strengthen the families, (such as FCFC-provided or procured Wraparound services or IHBS); • <u>coordinating with DJFS and Juvenile Court services to parents with substance use disorders and/or mental health disorders who have a child or children decreed</u> 	<p>Strategies will be as follows:</p> <ul style="list-style-type: none"> • that DJFS, Juvenile Court and the Board’s treatment provider will continue to use the <u>MOU, referral mechanisms and forms</u> developed to comply with HB 484 when passed in the Ohio Legislature and when reports from the Board were required to be submitted to ODADAS; • that the Board will stipulate in its contract with its treatment provider <u>that this population of parents be prioritized</u> for services, particularly when such parents are medically indigent and when a Waiting List has been instituted for medically indigent persons; • that DJFS, Juvenile Court and the Board’s treatment provider will coordinate services to such parents and such families who enter behavioral healthcare treatment (i.e., family interventions may be needed in addition to AoD treatment for the parent[s], such as Wraparound Services or IHBS provided/coordinated by FCFC) so that they may 	<p>Progress toward goals will be measured annually by:</p> <ul style="list-style-type: none"> • DJFS, Juvenile Court and the Board’s treatment provider <u>tracking the number of referrals made of parents for treatment, with an increase of 10% set as the goal for SFY 14;</u> • the Board’s treatment provider <u>tracking the parents participation in treatment, with the goal under Case Disposition of Goals Met increasing by 10% in SFY 2014;</u> • DJFS, Juvenile Court and the Board’s treatment provider tracking their collaboration on behalf of – and with- the parent(s) in receipt of AoD treatment with the goal of 100% collaboration in such cases; • DJFS, Juvenile Court and the Board’s treatment provider tracking any <u>additional family-centered therapy provided to families of parents referred from Children Services for AoD treatment</u> (such as Wraparound Services, IHBS or treatment for the children), to improve the likelihood of 	<p><input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):</p>
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	<p>Dependent by Juvenile Court; and</p> <ul style="list-style-type: none"> • <u>working collaboratively with the parent to achieve closure of the Dependent Child Court Case.</u> 	<p>work collaboratively to strengthen the family so that the Court Case that designates their child or children to be Dependent be closed and the parents and children be reunited (if the children have been in placement).</p>	<p>Juvenile Court’s Dependency Case terminating successfully on this family, with success in part measured by the <u>number of youths in placement</u> in the county, a critical and meaningful “dashboard” measure for any county. That number has been reduced significantly and currently (12/13) is 18 Huron County youths in placements, which is comparable with the similar-sized contiguous Board of Ashland with 70 children in placement). The goal of the Huron County FCFC partners for SFY 14 is to reduce that number to no more than 15 youths in placements; and</p> <ul style="list-style-type: none"> • DJFS, Juvenile Court and the Board’s treatment provider <u>tracking the referred parents’ progress to have the Dependent Child Court Case closed, with a 10% improved targeted for the biennium.</u> 	
<p>SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases</p>	<p>The Board’s Benefit Package of AoD services includes comprehensive and effective community-based prevention, treatment and support services for adults and youths with addictions/abuse of substances, with the <u>prioritization of special</u></p>	<p>Strategies shall include <u>stipulating in the Board’s contract with its treatment provider</u> the need for <u>signed federal Assurances</u>, which guarantee that the provider will provide/procure annual TB testing of all staff and will conduct the necessary training of staff in when it</p>	<p>While measurements will include annual tracking of the following, the incidence of TB is so infrequent (i.e., it has been over a decade since anyone with TB has been identified) that establishing metrics would be fruitless. One individual in 2012 was sent to the Health Dept. for TB</p>	<p><input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):</p>

	<p><u>populations that include</u>, but are not limited to, IV Drug Users, pregnant women who have substance use disorders, parents of children designated Dependent by Juvenile Court and <u>those with addictions who have TB or other communicable diseases</u>.</p> <p>The goals for this population shall include:</p> <ul style="list-style-type: none"> • <u>Enhancing referrals</u> of this population; • <u>Enhancing the engagement</u> in treatment of persons in this population so that such persons will remain in treatment to achieve successful case closures; • <u>Enhancing the integration of physical and behavioral health services</u> for persons recovering from communicable diseases to improve overall health and to prevent further exposure to life threatening communicable diseases (which not infrequently occurs); • <u>Providing education</u> to all AoD clients about communicable diseases they may be exposed to as a result of risky behavior they may be participating in. 	<p>is necessary to refer persons with suspected/confirmed TB/other communicable diseases to the Health Department for testing/treatment. Clients so referred to the Health Department cannot continue treatment until cleared by the Health Department to do so.</p> <p>Strategies also will include education for all AoD clients in potential exposures to communicable and other diseases/disorders due to risky behaviors. (Although AoD clients with TB have been rare in Huron County, many AoD clients have contracted Hepatitis.)</p>	<p>testing, but the test was negative (although hepatitis is becoming a prevalent problem). Tracked will be:</p> <ul style="list-style-type: none"> • Individuals referred to the Health Department for TB testing or for testing of other communicable diseases; • Individuals cleared by the Health Department to reenter AoD treatment; • Individuals who reenter AoD treatment and are retained in treatment to successfully meet goals; • Individuals who reenter treatment who are enrolled in Firelands Health Home or are involved with another physical health care provider so that education may occur to assist them to prevent any further exposure to potentially life-threatening communicable diseases. 	
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<p>MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)</p>	<p>The Board's Benefit Package includes comprehensive and effective community-based prevention, treatment and support services for the priority population of youths with Serious Emotional Disturbances.</p> <p>Goals include:</p> <ul style="list-style-type: none"> • <u>Access to treatment;</u> • <u>Retention in Treatment to its completion;</u> • <u>Treatment that is collaborative, when appropriate, with schools, Juvenile Court, Children Services, pediatricians and/or others (i.e., the involvement of collateral providers is critical for the successful treatment of youths); and</u> • <u>Dispositions of Completed Goals at Discharge.</u> 	<p>Strategies to meet the Board's goals include the following:</p> <ul style="list-style-type: none"> • <u>Access to treatment</u> will continue to be a priority. The Board will continue to contract with its treatment provider for outreach to schools, area pediatricians, Juvenile Court, Children Services and FCFC to facilitate the referrals of youths who may be experiencing serious emotional problems. The Board also will facilitate access to treatment by <u>guaranteeing no out-of-pocket costs to parents for any mental health or chemical dependency Diagnostic Assessment of a Huron County youth at Firelands Counseling and Recovery Services of Huron County.</u> Huron County is the only Board in the state that offers this in its Benefit Package. Although private insurances are billed, co-payments and deductibles will be covered by the Board, which may save a family up to \$194. The Board also will guarantee to pay at least 10% of the ongoing cost of treatment provided by Firelands for 	<p>Measurement of success will be as follows:</p> <ul style="list-style-type: none"> • <u>Improved Access to Treatment</u> will be measured by the annual tracking of referral sources of youths and by the number of youths entering treatment, with a 10% increase over FY 2013 levels of referrals from pediatricians and educators targeted for FY 14. • <u>Collaborative treatment</u> will be measured by linkages made with FCFC for the involvement of the Diversion Team, by provision of IHBS and Wraparound services; with Juvenile Court and its Intervention Court; with schools; with pediatricians, with Children Services. • <u>Retention in Treatment and Successful Completion of Goals at Discharge</u> will be measured by MACSIS <i>Goals Met</i> data and by <i>MyOutcomes</i> data. <i>MyOutcomes</i> found that, on average in 2013, scores of youths after treatment increased to 33.46, averaging an 8.18 increase, which is excellent since a change of 5 or more points is indicative of statistically significant therapeutic change between intake and discharge. 	<ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):
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		<p>any county resident.</p> <ul style="list-style-type: none"> • <u>Retention in treatment and successful completion of treatment plans</u> will be assisted by use of <i>MyOutcomes</i> (discussed earlier in Plan and below in response to <u>Innovate Programs</u> adopted), which measures progress toward treatment goals and satisfaction with the treatment process. In SFY 13 the Board's primary treatment provider newly <u>began to solicit these measures of the youths' parents as well as the youths,</u> so that feedback is attained from both populations before and after every treatment session, facilitating attention to any issues of concern immediately. This has greatly improved retention in treatment and youths' successful achievement of goals. The Huron County offices of Firelands Counseling & Recovery Services achieved the highest levels of outcomes of any of the Firelands 7-county operation. <p><u>Retention in treatment and successful completion of</u></p>	<p>The Huron County Offices of Firelands achieved the greatest degree of change in youths of all of the 7 counties in which Firelands provides treatment of SED youths. Since this metric was very high, the minimal goal will be to retain this level of change, although exceeding this level to a 9 point differential has been targeted for 2014.</p>	
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		<p><u>treatment plans</u> also will be enhanced by the <u>availability of evidence-based therapies for youths, such as the Intensive Home Based Service of I-FAST</u> (developed by OSU and discussed earlier in the Plan)</p> <p>Such interventions will occur whenever needed to attempt to <i>prevent</i> use of the inpatient and residential levels of care as well as to transition youths back into the community.</p> <p><u>Retention in treatment and successful completion of treatment plans</u> also will be enhanced by collaborating with parents and all systems involved with SED youths</p>		
<p>MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)</p>	<p>The Board has set as a goal the enhancement of its Benefit Package so that SMI adults may more readily enter treatment and access interventions that will assist them to avoid suicides, to avoid NOPH and private inpatient admissions and to avoid the restrictive interventions of other systems such as Jail Admissions, Emergency Room Admissions, Nursing Home Admissions that not only are costly for Boards, OMHAS, public insurances, the criminal justice</p>	<p>To target its SMI population and specifically those subsets wherein the needs of persons are not met due to gaps in the continuum of care, this Board will utilize most of its “Hot Spot” funds toward the NW Hot Spot Collaborative’s <i>Waiting List/NOPH Admission Reduction Project</i>, filling those gaps in its continuum of care as follows:</p> <ul style="list-style-type: none"> • (Private Inpatient) Rescue Crisis (contracted to access all private hospitalizations for adults paid by the 	<p>Utilizing the Hot Spot funds to purchase more private bed days and outpatient programs aimed at filling gaps in services targeted to SMI persons at high risk for inpatient care contributed to the Board realizing reductions in NOPH Admissions in SFY 2013 as follows:</p> <ul style="list-style-type: none"> • Total admissions were <u>cut more than in half</u> (from 64 to 30) so that SFY 2012’s admissions were 213% of SFY 2013’s; 	<p><input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):</p>

<p>system and communities, but also are disadvantageous to the recoveries of adults with SMI.</p> <p>Within the SMI population, subsets (i.e., high risk “hot-spot” populations) have been targeted for new resources to achieve the goal of fewer emergencies and admissions to restrictive levels of care or programing. These subsets include:</p> <ul style="list-style-type: none"> • Difficult to serve populations that are high utilizers of services but not achieving the desired clinical outcomes; • Those with the greatest unmet needs who may be defined as “highest-cost” clients; • The most clinically impaired clients, or a subgroup of those clients, whose treatment/support needs are not met due to a <u>gap</u> in a Board’s Benefit Package (i.e., continuum of care); • Persons in need of essential/special services that would assist to divert those individuals from admissions to more restrictive and typically higher-cost settings (eg., hospitals, prisons, out-of-home placements for children, nursing facilities, etc.); and 	<p>Board)- Hot Spot funds in the amount of up to <u>\$25,450 has been added to the Board’s FY 14 Budget of \$113,000 for Rescue Services</u>, in order to assist to reduce NOPH admission and particularly re-admissions of persons with SMI.</p> <ul style="list-style-type: none"> • (Outpatient) Wellness Programs are being provided to SMI persons by personal trainers in both individual and group formats (most groups have been formed for SMI persons in group homes), based on research (such as in the article titled <i>A Fitness Movement Behavioral Health</i> February 15, 2012), which has found fitness programs to have efficacy in reducing hospitalizations and chronic physical illnesses for persons with SMI; • (Outpatient) Hotel/Transportation availability has been created so that individuals “with no place to go” do not end up in NOPH, a situation that may happen, for example, when persons with SMI are ejected from group homes and alternatives cannot be found immediately. 	<ul style="list-style-type: none"> • Civil admissions were <u>cut in half</u> (from 58 to 29) so that SFY 2012’s admissions were 200% of SFY 2013’s; and • Forensic admissions in SFY 2013 were <u>cut 300%</u> (from 3 to 1). <p>In FY14, the number of NOPH admissions again will be utilized as an important “dashboard measure” of the Board’s accomplishments of its goals with <u>10% improvement set as a goal without increased private admissions</u>; as will the <i>MyOutcomes</i> scores for those in receipt of CPST only, with the scores aimed at reaching a 6 point differential to be statistically significant.</p> <p>It also will continue to work with clinical and administrative staff at NOPH to reduce the lengths of stay of Huron County residents there by 10%. If lengths of stay at NOPH can be reduced as well as the number of admissions (as discussed in response to #4 of this Plan), even more savings could be achieved. (Although <u>NOPH has the authority</u> over lengths of stay and the <u>Board may only influence</u> such lengths in ways including, but not limited to, making available the new services it has created with the Hot Spot funds such as step-down group home stays for high-need SMI persons being discharged from NOPH that staff there do not believe</p>	
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	<ul style="list-style-type: none"> Individuals who are difficult to engage in behavioral health services and who likely are costly to other systems. 	<ul style="list-style-type: none"> (Outpatient) 24-hour on-call CPST has been made available for persons seen in the Emergency System to attempt to divert them from NOPH by providing them with opportunities for case managers to access alternative resources for them (albeit that sometimes those alternative resources may be for other inpatient/crisis facilities). The provision of this service provides the time and staff to de-escalate anxieties of clients evaluated to need inpatient care but waiting for beds, as well as their family members who may be waiting with them, and staff of the safe-site being used for the crises evaluations. It also provided opportunities to educate families about mental illnesses at opportune “teachable moments.” (Outpatient) Engagement/Outreach services have been designed to provide CPST to persons with SMI who have had multiple prescreens or hospitalizations but have not been willing to begin ongoing treatment. If a higher percentage of 	<p>to be ready for community reintegration.)</p> <p>The other “dashboard measure” that will be targeted for improvement is the <i>MyOutcomes</i> average score for persons in receipt of CPST-only on the Outcome Rating Scale (ORS), which was measured for the first time in SFY 13. The ORS score for this population was not expected to show the charge that the other populations did because <u>research shows that most progress is made at the beginning of treatment and persons in receipt of CPST-only have been in treatment often for long periods of time and because this population did not show significant distress at the initial use of the ORS (i.e., since it had been in receipt of services for some time).</u>For SFY 13, the score at the beginning and end of the FY showed an average increase of 4.75, trending in the positive direction of less distress but not reaching the goal of at least a 6-point differential between the beginning and end of treatment that indicates a statistically significant level of improvement.</p> <p>The Board will assess the progress of the NW Collaborative to extend the continuum of care in Ohio by working with MHAS to create secure group homes for the subset of the most-impaired persons with SMI.</p>	
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		<p>persons discharged from inpatient care enter outpatient care, hospital re-admissions are expected to decrease. Therefore, this service is intended to result in lower readmissions.</p> <ul style="list-style-type: none"> • (Outpatient) Group Home Respite/Step-down stays (generally for intervals of 7-14 days) will be procured for SMI clients to either keep them out of NOPH or to allow them to be released sooner from NOPH. As noted by MRU/LLC, the Board's contract QA/UR provider, discharge planning for individuals in NOPH often is a barrier to those persons' timely release from that level of care. This level of care would be utilized primarily for adults with a history of difficulty being stabilized in the community after leaving hospitalizations. For these individuals other strategies previously utilized by/for them have been unsuccessful. Other strategies utilized previously may have included partial hospitalization programs, intensified case management for monitoring and/or the 	<p><u>Connectivity with the Board's Recovery to Work Program</u> shall be measured by the number of persons from this population that retain jobs (obtained by one of the program's vocational rehabilitation providers) for at least 90 days (unless the RSC and OOD do not resolve the monitoring issues and the program is forced to cease).</p>	
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		<p>administration of medication sets or injectable medications to help with medication compliance.</p> <ul style="list-style-type: none"> • <u>(In Planning) Housing in a Secure Facility-</u> will be in the <u>planning stage</u> in FY14 by the NW Collaborative and MHAS, as this is a tool that Boards do not have (i.e., a <u>gap in the continuum of care</u>) that would work to keep high-need SMI persons out of NOPH, nursing homes and other restrictive environments. <p><u>Connectivity with the Board's Recovery to Work program</u> will continue to be targeted for this population. It has been documented that work and treatment create a synergy so that individuals involved in both achieve higher levels of success in both.</p>		
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*	A <u>priority short-term goal</u> for SFY 14 is to be prepared for the implementation of the MHAS Medicaid Health Home initiative, <u>when MHAS enters the next phase of its timeline and awards agreements to more providers to expand this service beyond the initial 5 Board areas.</u>	The Board's treatment provider applied for a 3-year SAMHSA grant to implement <u>Health Homes for Medically Indigent Clients.</u> The Huron County Health Home for Medically Indigent persons opened September 3, 2013, after the facility was remodeled to make available exam rooms, after an agreement was	<p><u>Measurement of short-term goal:</u> The Board will measure:</p> <ul style="list-style-type: none"> • The <i>number</i> of persons entering the SAMHSA-funded Medically Indigent Health Home available at Firelands Counseling & Recovery Services; • The <i>health improvements</i> 	<p>___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):</p>

	<p>The long-term goal (i.e., 10+ years to accomplish) will be to improve the life expectancy of persons with SMI to coincide with that of the non-mentally ill population. The current average life expectancy of SMI's has been found to be 25 years fewer than it is for the general population (source: <i>Morbidity and Mortality in People with Serious Mental Illness</i> –October 2006).</p> <p>The intermediate goal will be <i>The 10 By 10</i> goal adopted by the Wellness Summit hosted by CMHS's Consumer Affairs Program: to reduce the life expectancy disparity by 10 years within the next 10 years (source: <i>The 10 By 10 Goal, Behavioral Health</i>, January 2008, p. 56)</p>	<p>developed with Fisher Titus Hospital for medical oversight, after medical equipment was purchased, after the appropriate staff was retained and trained, after policies and procedures were developed, after letters were sent to the pool of potential clients (150 letters) and after SAMHSA-approval was given.</p> <p>This grant-funded Health Home was intended to supplement the MHAS Medicaid Health Home. The Medicaid Health Home in Huron County, however, has not yet been phased in by MHAS, which has phased in no more Health Homes than the initial five.</p>	<p>achieved by persons treated in this Health Home; and</p> <ul style="list-style-type: none"> • The <i>synergy</i> that is anticipated to be achieved between the physical and behavioral health improvements made. <p>Since there is no base-line data regarding this Health Home due to its opening in 9/13 (i.e., data for FY 14 will be for little more than 2 quarters), the development of base-line data will occur in FY14 and 15. The Health Home population will be targeted for review when the Board has its <i>Annual Field Review</i> of cases completed by Brown Consulting in FY 14. The Board will work with Brown Consulting to determine how the goal: achieving <i>synergy between physical and mental health</i> will be measured.</p> <p>The Board has contracted to pay for a specific dollar amount of medical treatments and tests not covered by the SAMHSA grant for persons in the Health Home for Medically Indigent clients, so will measure use of these FY 14 funds</p> <p>Measurements of the above-bulleted indicators will be expanded when MHAS authorizes this Board's treatment provider to begin a Medicaid Health Home.</p>	
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			<p><u>Measurement of Intermediate and Long-term goals:</u> The intermediate measurement will be to reduce the life expectancy disparity between those with SMI and those without SMI <u>by 10 years within the next 10 years</u>. The long-term measurement will be to eliminate the disparity altogether (in 10+years).</p>	
<p>MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders</p>	<p>The Board’s goal is to assure support services for those with substantial MH and AoD disorders, when needed, when treatment-appropriate and when funds permit. Housing, transportation and jobs are critical so that persons have the stability and means to regularly attend treatment so they may progress in their recoveries to reach optimal independence.</p>	<p>Strategies</p> <p><u>Connectivity with the Board’s Recovery to Work program</u> will continue to be targeted for all appropriate persons entering treatment. It has been documented that work and treatment create a synergy so that individuals involved in both achieve higher levels of success in both.</p> <p><u>Housing deficits</u> (which are measured by the housing needs/goals of clients vs. their current housing situations) are to be addressed in every treatment plan of persons with SMI/SED and/or with chemical dependency. Housing deficits will be met when feasible, with the Board continuing to financially support:</p> <ul style="list-style-type: none"> ○ its Housing Assistance Program (HAP), a program that temporarily assists persons to pay for housing 	<p>Measurements</p> <p>Client housing matches (i.e., agreement between housing needs/goals and current housing) are to increase by 10% in S FY 2014.</p> <p>Clients’ <i>Satisfaction Surveys</i> will convey that clients are very satisfied or satisfied in 99% of cases.</p> <p>Use of interim group home care will be measured and monitored for reducing inpatient days and re-hospitalizations of those who utilize that option. The Board has set the goal (stated in Priority: Adults with SMI) of at least a 10% reduction in NOPH admissions in FY14, without increased private admissions (between FY 2012 and FY 2013 it cut admissions in half- from 64 to 30).</p> <p>Progress of the NW Collaborative toward the creation of the new</p>	<p><input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):</p>

		<p>while they apply for more permanent assistance such as through HUD;</p> <ul style="list-style-type: none"> ○ group homes for the more impaired, to assist them to stay out of the more restrictive housing option of nursing homes; and. ○ temporary group home care to assist those transitioning from inpatient stays or those avoiding such stays. <p><u>The creation of a new level of care, secure group homes,</u> could save nursing home and inpatient stays as well as <u>homelessness</u> and jail stays for the most difficult to stabilize SMI/SPMI adults The NW Collaborative is working with MHAS to explore the feasibility (eg. the laws that would need to change, payment sources, numbers of SMI who could benefit) of this strategy.</p> <p><u>Other support services</u> (such as transportation, wellness/exercise programs, physical health care tests/procedures not covered by the SAMHSA grant for clients in the Medically Indigent Health Home) will be provided as prioritized by need and as funds permit.</p>	<p>“housing tool” of secure group homes will be assessed. This is projected to be a lengthy process since it involves the development of the “political will” to achieve it and then the development of laws, physical facilities and funding.</p> <p><u>Connectivity with the Board’s Recovery to Work Program</u> shall be measured by the number of persons from this population that retain jobs (obtained by one of the program’s vocational rehabilitation providers) for at least 90 days (unless the RSC and OOD do not resolve the monitoring issues and the program is forced to cease).</p> <p><u>Use of other support services</u> will be measured for their enhancement of community retention of clients with high needs who are the recipients of them. Admissions to NOPH are to be reduced by 10% without increased private admissions.</p>	
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Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant

***Priorities Consistent OHIOMAS Strategic Plan**

<p>Treatment: Veterans</p>	<p>A goal will continue to be to target veterans and military personnel for <u>outreach, treatment and support services.</u></p> <p>With delays being experienced by veterans seeking Veterans Administration (VA) health care services, and with veterans' needs for certain behavioral health services not available from the Veterans Administration's behavioral health care service "menu" (such as in-county CPST services, in-county face-to-face emergency services and many support services), outreaching to this population and engaging it in community-based behavioral health treatment and support services can be life-altering and life-saving.</p> <p>(Side Note: Outreach to military personnel and their families has been personalized in Huron County, with the Board Director's son having just returned from deployment to Afghanistan throughout 2013 with the National Guard.)</p>	<p>Strategies</p> <p><u>Collaboration with military organizations</u> (such as the Army National Guard's Co C 612th Engineering Battalion in Norwalk, Ohio, and the county's Office of Veterans Services) to provide veterans with behavioral health prevention, support and treatment service information (via such mechanisms as presentations, meetings brochures, newspaper articles) shall be a strategy utilized to provide outreach to this population and shall concern such topics as these prevention/education, treatment and support services available:</p> <ul style="list-style-type: none"> • behavioral health trainings available (such as QPR Suicide Prevention, PTST information); • the Board's Benefit Package that is available including hotline and emergency services, vocational rehabilitation services, psychiatric services; • meetings of support groups (eg. such as the Huron County Suicide Prevention Coalition, NAMI and Faces of Hope Consumer Group). 	<p><u>Measurement</u></p> <p>Measurement shall include the number of veterans in treatment and in receipt of support services such as housing, <i>Recovery to Work</i> vocational rehabilitation services, and support group services, compared to the number in the previous fiscal year, with the goal of a 10% increase for FY14.</p> <p>Measurement also shall include the number of veterans who complete treatment with <i>Goals Met</i>. This will be baseline for SFY 14 since these data have not be separated out previously.</p> <p>Measurements shall include the number of veterans for whom collaborations are achieved with the VA, when the VA is involved in any other element of veterans' services. (Such collaboration has been difficult in the past but is critical if psychoactive medications are being obtained from the VA but counseling or Partial Hospitalization or <i>Recovery to Work</i> involvement are being obtained locally.)</p> <p>Connectivity with the Board's <i>Recovery to Work</i> program shall be measured by the number of persons</p>	<p>___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):</p>
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		<p><u>Connectivity with the Board's Recovery to Work program</u> will continue to be targeted for all appropriate persons entering treatment. It has been documented that work and treatment create a synergy so that individuals involved in both achieve higher levels of success in both.</p>	<p>from this population that retain jobs (obtained by one of the program's vocational rehabilitation providers) for at least 90 days (unless the RSC and OOD do not resolve the monitoring issues and the program is forced to cease).</p>	
<p>Treatment: Individuals with disabilities</p>	<p>Goals</p> <p><u>Improve Access to Treatment for this Population;</u></p> <p><u>Improve Engagement of this Population in Treatment;</u></p> <p><u>Assure the Application of Evidence-Based Treatment for this Population;</u></p> <p><u>Implement Performance-Based Contracting that Establishes Expectations for Completed Goals at Discharge of this Population;</u> and</p> <p><u>Improve Rates of Integrated Behavioral Health Treatment and Primary Health Care for this population.</u></p>	<p>Strategies</p> <p>Enhance Access by:</p> <ul style="list-style-type: none"> Publicizing the physical accessibility of the facilities that provide Board-contract services; Publicizing sensitivity to this population by showing persons with disabilities in brochures, TV ads; and Targeting organizations that persons in this population may regularly interface for the provision of information about signs and symptoms of mental illnesses, about treatment successes and about providers. <p><u>Enhance Connectivity with the Board's Recovery to Work program</u> since it has been documented that work and treatment create a synergy so that individuals involved in both achieve higher levels of success in</p>	<p>Measurements</p> <p>The goal will be to increase those with disabilities entering treatment by 10% in FY 14.</p> <p>Client Satisfaction Surveys of this population shall be measured for attentiveness to needs.</p> <p><i>MyOutcomes</i> data shall be measured for satisfaction with and progress in treatment.</p> <p>IPR's and Field Reviews shall be targeted to assess the % of those with disabilities that achieved <i>Goals Met</i> as their Treatment Disposition. Baseline data will be gathered in FY14.</p> <p>Connectivity with the Board's <i>Recovery to Work</i> program shall be measured by the number of persons from this population that retain jobs (obtained by one of the program's</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>

		both. Persons with physical disabilities may more readily qualify for the <i>Recovery to Work</i> program, since the <u>disability criteria primarily pertain to physical disabilities</u> (which is why those with mental illnesses and AoD dependencies largely have been excluded from BVR services.)	vocational rehabilitation providers) for at least 90 days (unless the RSC and OOD do not resolve the monitoring issues and the program is forced to cease).	
Treatment: Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*	Addressed under: SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)			<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*	Addressed under: MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)			<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Underserved racial and ethnic minorities and LGBTQ populations	<u>Goals-</u> <u>Improve Access to Treatment for this Population;</u> <u>Improve Engagement of this Population in Treatment;</u> <u>Assure the Application of Evidence-Based Treatment for this Population;</u> <u>Implement Performance-Based Contracting that Establishes Expectations for Goals Met at Discharge of this Population;</u> and	Strategies – Enhance Access by: <ul style="list-style-type: none"> Publicizing sensitivity to diverse populations by showing persons of diversity in brochures, TV ads; and Targeting organizations that persons in this population may regularly interface for the provision of information about signs and symptoms of mental illnesses, about treatment successes and about providers. 	The measurement goal will be to increase those entering treatment that have disabilities by 10% in FY 14. Client Satisfaction Surveys of this population shall be measured for attentiveness to needs. <i>MyOutcomes</i> data shall be measured for satisfaction with and progress in treatment. IPR's and Field Reviews shall be targeted to assess the % of minority persons that achieved <i>Goals Met</i> as	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

	<p><u>Improved Rates of Integrated Behavioral Health Treatment and Primary Health Care for this population.</u></p>	<p><u>Connectivity with the Board’s Recovery to Work program</u> will continue to be targeted for all appropriate persons entering treatment. It has been documented that work and treatment create a synergy so that individuals involved in both achieve higher levels of success in both.</p>	<p>their Treatment Disposition. Baseline data will be gathered in FY14.</p> <p>Connectivity with the Board’s <i>Recovery to Work</i> program shall be measured by the number of persons from this population that retain jobs for at least 90 days (unless the RSC and OOD do not resolve the monitoring issues and the program is forced to cease).</p> <p>Staff recruitment at the Board’s treatment provider will continue to focus on increasing diversity and improving the % of those with diversity in FY 14. This will include the attempt to recruit more male Mental Health Professionals (MHP’s), a critical need discussed BOTH under <u>Local System Priorities</u> and <u>Priorities if Resources Were Not an Object:</u></p> <p>A goal at every level of the public and private behavioral health care system needs to be to educate the public, particularly focusing on men, to no more abandon someone with depression, delusions or other symptoms of mental illness “to fend for himself than a man suffering a stroke.” (Dr. Charles Krauthammer)</p>	
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Priorities	Goals	Strategies	Measurement	Reason for not selecting
<p>Treatment: Youth/young adults in transition/adolescents and young adults</p>	<p>Improve collaboration with FCFC Partners to create optimal plans for adolescents and young adults with mental illnesses/AoD addictions transitioning to adulthood, particularly those transitioning from foster homes or institutions/treatment facilities, so they may be supported to achieve independence whenever possible and reside in the least restrictive environments, with the resources of all appropriate child-serving systems directed to their successful transitions.</p>	<p>Utilize the Diversion Team of FCFC to develop the plans and resources needed for youths with mental illnesses or AoD addictions transiting to adulthood to achieve optimal independence.</p> <p>Target connectivity with the Board’s <i>Recovery to Work</i> program to this population since it has been documented that work and treatment create a <u>synergy</u> so that individuals involved in both achieve higher levels of success in both. Young adults also need to work to support themselves and to develop the adult stance of social and financial reciprocity. (In the research <u>Reciprocity: A Predictor of Mental Health</u> by Live Fyrand the following was found:</p> <p><i>Many studies have demonstrated that social relationships confer mental health benefits. This paper aims to identify whether and how reciprocity in social relationships predicts or is associated with mental health benefits... Reciprocity is regarded as a basis mechanism that creates stable social relationships in a person's life. It has been described generally as the process of “give-and-take”—the degree of balance in social exchange between people.</i></p>	<p>Measurement will be the number of youths in transition for whom FCFC collaborative plans are developed and funded and the progress toward independence of each youth. At least two youths with behavioral health disorders will be so involved in collaborative transition plans in SFY 14.</p>	<p>___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):</p>

		<i>According to the exchange theory, being more dependent on others may cause unbalanced relationships, with associated mental distress and discontinuity as possible negative consequences.)</i>		
Treatment: Early childhood mental health (ages 0 through 6)*	Provide early childhood mental health programs to preschoolers who have the fewest assets so that they may have more opportunity to succeed in school.	Collaborate with FCFC to obtain Ohio Children’s Trust Fund dollars to fund the early childhood mental health program of The Incredible Years and collaborate with FCFC partners that provide Head Start programs in which to operate The Incredible Years program.	Measure success as required by The Incredible Years Program and chart success longitudinally (although this program was suspended for several years until FY 14 due to lack of funds so that longitudinal comparison of success would be with years that are not consecutive).	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Adopt a public health approach (SPF) into all levels of the prevention infrastructure	The Board Director participated in the training in SPF that was provided to assist to prepare this Community Plan. When the Board updates its Strategic Planning it will address SPF as a goal at all levels of prevention infrastructure.			<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): (See Goal column in this grid.
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*	Addressed under the goal: Every level of the public and private behavioral health care system needs to be to educate the public, particularly focusing on men, to no more abandon someone with depression, delusions or other symptoms of mental illness “to fend for himself than a man suffering a stroke.” (Dr. Charles Krauthammer)			<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

<p>Prevention: Empower pregnant women and women of child-bearing age to engage in healthy life choices</p>	<p>Pregnant Women are a priority population and integrated physical/behavioral health care and special wellness programs are priority services available to them, as addressed under the following:</p> <p>SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)</p> <p>MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)</p> <p>MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*</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>Prevention: Promote wellness in Ohio's workforce</p>	<p>Addressed under the Board Priority goal:</p> <p>Reduce crises of residents with mental illnesses and chemical dependencies that result in:</p> <ul style="list-style-type: none"> • use of Behavioral Health Crisis./Emergency Systems; and that result in • personal, family and public tragedies <p>by promoting the early identification and treatment of persons with severe and persistent behavioral health disorders/illnesses.</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>Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*</p>	<p>The prevention goal is to implement an effective problem gambling prevention campaign that builds community awareness that gambling <i>of all forms</i> may become problematic so that it “crowds out” (i.e., becoming the “elephant in the living room” as with all addictions) other activities and relationships and drains financial resources. Focus groups were convened about problem gambling that in this rural community is largely done via the Ohio Lottery at gas stations and convenient stores and at bingo games held in clubs/fraternal organizations. It is a very “silent” and “hidden” compulsion, since unlike substance abuse, substances cannot be smelled on persons and their appearance and physicality may not change. However, gas station and convenience store operators are aware of such behaviors as persons gambling for most of the day and having numerous checking accounts to keep funds hidden from other family members.</p> <p>The goal also is to improve access to treatment so that there are self-referrals as well as to improve access to this treatment by screening all persons entering (and in) treatment for MH and/or AoD issues regarding problem gambling so that</p>	<p>Strategies</p> <p>Contract with the Board’s treatment provider to:</p> <ul style="list-style-type: none"> • with the assistance of MHAS, select a screening instrument to utilize with AoD and MH clients and train staff in the use of that tool; • provide training opportunities to staff re: the treatment of problem gambling; • screen all persons in, and who are entering, treatment with MH and/or AoD issues regarding problem gambling so that treatment plans may be created with clients that may achieve successful outcomes that result in persons no longer being controlled by their problem gambling compulsions; and • convene focus groups to learn community attitudes and behaviors about gambling and how prevention may best be achieved and develop a prevention campaign. 	<p>Measurements</p> <p>The first goal is to raise awareness that problem gambling is not related to the form of gambling participated in (eg. in casinos, buying lottery tickets, playing bingo) but about the activity crowding out (i.e., becoming the “elephant in the living room” as with all addictions) other activities and relationships and draining ones (or the family’s) resources. Progress will be measured by focus group reviews of TV and radio ads developed concerning problem gambling and by the number of self-referrals for problem gambling treatment.</p> <p>In the Annual IPR and MH Field Audits:</p> <ul style="list-style-type: none"> • trainings of staff will be reviewed for staff-preparedness to treat those with gambling addictions; • screening for problem gambling will be reviewed for inclusion in the DA’s of all populations entering treatment and in Treatment Plan Updates; • the number/percentage of the valid and reliable sample of cases reviewed for which persons were found to have problem gambling; • the number/percentage of 	<ul style="list-style-type: none"> ___ No assessed local need ___ Lack of funds ___ Workforce shortage ___ Other (describe):
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	Treatment Plans may be created with clients that may achieve successful outcomes that result in persons no longer being controlled by their problem gambling compulsions.		those with problem gambling for which Treatment Plans were developed to treat this compulsion; and <ul style="list-style-type: none"> the number/percentage of these who archived Goals Met as Treatment Dispositions. 	
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Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
<p>Priority: The data-driven need for prevention, treatment and support services to the population of persons with addiction to alcohol, which is the largest population of substance addicted persons in Huron County, in Ohio and in the US. This is discussed also under #12 of this Plan in response to the following directive: 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)</p>	<p><u>Provide Prevention/Education</u> re: the most prevalent of the substance addictions in Huron County, Ohio and in the US: Alcohol addiction.</p> <p>Although opioid and other illegal substance use are serious problems, they are low-incidence compared with alcohol addiction and abuse (data provided under Question #2 of this Plan, <i>Assessment of Need and Identification of Gaps and Disparities</i>).</p> <p>Since the procurement of alcohol is legal, the population of alcoholics generally embraces most middle class values. However, according to <u>Managed Mental Health Care: Administrative and Clinical Issues</u> (Edited by Judith Feldman, M.D. and Richard Fitzpatrick, Ph.D.) in Chapter 19, <i>Treatment of Drug Abuse in the Managed Care Setting</i>, (by Richard Caplan, MSW, LICSW, MPH): <i>When one's drug of choice is illegal, it means time and energy must be spent to</i></p>	<p>Strategies <u>Prevention and Education</u> Utilize mass media and social media to communicate the extent and consequences of alcohol addiction. An example of this having been done effectively 50 years ago was the media campaign intended to raise Americans awareness about cancer so that when individuals noted symptoms in themselves, they would seek diagnosis and treatment. The “10 Signs of Cancer” could have been recited by most people from that era. It was a simple, straight forward and powerful campaign.</p> <p>However, developing such a media campaign needs to be done carefully since responsible use of alcohol is legal and pervasive and since the alcohol industry is well financed and powerful and could launch a campaign to counter any message it believed to disparage its products, rather than inappropriate use of them.</p>	<p>Prevention and Education The short-term (first two years) goal shall be to provide evidence of an educational campaign and to provide evidence of public exposure to this campaign.</p> <p>The long-term goal shall be to have an educated public about the extent and consequences of alcoholism and to have individuals self-refer for diagnosis in the early stages of this addiction.</p> <p>Outreach The short-term (first two years) goal shall be to provide evidence of a collaborative that has identified the target groups (i.e., gatekeepers) to be provided with education and assessment tools in order to increase referrals of persons in the early stages of alcohol addiction.</p>

	<p><i>develop a network of reliable suppliers...it also means contact with criminal subculture. This subculture represents a departure from typical middle-class values (p.308).</i></p> <p>Hence, use of illegal substances connects persons with the criminal subculture so that those using illegal substances come to the attention of the criminal justice system frequently for such offenses as property crimes and the commerce of making and selling illegal substances.</p> <p>Nonetheless, although the procurement of alcohol is legal, alcohol abuse and addiction contribute significantly more than drug use to violence against self and others (eg. suicides; concurrent suicides/homicides; family violence), to automobile and equipment accidents and to life threatening and/or life-altering health problems for alcoholics and babies born with Fetal Alcohol Syndrome (FAS).</p> <p>The fact that this template from MHAS, with sections for a myriad of behavioral health disorders and populations, some very low-incidence, does not include a section pertaining to those with the addiction and abuse of alcohol is noteworthy, particularly if MHAS is utilizing the Strategic Planning Framework (SPF) so that its questions are to be as data-driven, as the Boards' responses are to be. Only with data-driven questions can information that is important for Ohio to create an effective and efficient public behavioral health care system be solicited.</p>	<p><u>Outreach</u> Create a community collaborative to identify those who may be in positions to refer persons who are alcohol dependent or abusing, particularly those (such as physicians) who may identify persons early in their addictions, the importance of which is explained in the book <u>Managed Mental Health Care: Administrative and Clinical Issues</u> (Edited by Judith Feldman, M.D. and Richard Fitzpatrick, Ph.D.), Chapter 18 (<i>Spectrum of Services for the Alcohol Abusing Patient</i>), written by William R. Zwick, Ph.D. and Maurice Bermon, M.D. :</p> <ul style="list-style-type: none"> • <i>Early case identification is crucial in treating alcohol problems.</i> (p 273) • <i>Prognosis is improved if treatment is initiated prior to the onset of more serious later-stage complication.</i> (pp 273- 274) <p><u>Provide Evidence-based Treatment</u> Provide evidence-based treatment to alcohol-addicted persons, in conjunction with self-help groups and the support of families.</p> <p><u>Provide support</u> groups for, and public education to, family members, significant others and employers so that they may learn the importance of ceasing to enable persons with addictions and learn the necessity for the addict or alcoholic to experience the natural consequences of his or her behavior.</p> <p>Most family members are afraid to stop enabling because of the consequences that will befall their loved one. However, those consequences are the best hope for saving the addict or alcoholic.</p>	<p>The intermediate goal shall be to identify and to provide the training mechanisms for the gatekeepers identified (such as assessment instruments).</p> <p>The long-term (10 year) goal shall be to have the majority of referrals come of persons in the early stages of alcohol abuse addiction instead of the later stages.</p> <p><u>Treatment</u> A review of evidence-based approaches shall take place to assure that effective treatment programs and strategies (eg. should this population be integrated with illegal drug users?) are being utilized specific to this population.</p> <p><u>Family Support</u> The short-term goal is to provide or procure supports to families that focus on <u>enabling consequences</u> instead of <u>enabling use.</u></p> <p>The long-term goal is to have a more knowledgeable public that has learned the necessity of the addict or alcoholic experiencing the natural consequences of his or her substance abuse.</p>
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Provide Outreach through those most likely to identify alcohol-addicted persons and particularly through those most likely to identify alcohol-addicted persons early in their addictions. In the book Managed Mental Health Care: Administrative and Clinical Issues (Edited by Judith Feldman, M.D. and Richard Fitzpatrick, Ph.D.), Chapter 18 (pp 273- 304) is titled: *Spectrum of Services for the Alcohol Abusing Patient*, written by William R. Zwick, Ph.D. and Maurice Bermon, M.D. In that chapter, the authors explain that four major assumptions need to guide the design of a cost-effective managed care program for the treatment of alcohol abuse and dependence. The first is: *Early case identification is crucial in treating alcohol problems.*

The authors further state: *Prognosis is improved if treatment is initiated prior to the onset of more serious later-stage complication. Client characteristics (e.g. age, marital status, social support and psychiatric status) before the start of treatment are better predictors of outcome than are most aspects of the treatment delivered. Capitalizing on positive client characteristics requires the earliest possible case identification”*

Provide Treatment to alcohol-addicted persons, in conjunction with self-help groups and the support of families.

Provide support to family members, significant others and employers so that they may cease enabling, which is the most significant barrier to the recovery of alcohol-addicted persons.

<p>Priority Reduce crises of residents with mental illnesses and chemical dependencies that result in:</p> <ul style="list-style-type: none"> • use of Behavioral Health Crisis./Emergency Systems; and that result in • personal, family and public tragedies <p>by promoting the early identification and treatment of persons with severe and persistent behavioral health disorders/illnesses.</p> <p>This priority was created in response tragedies such as the Virginia Tech massacre that occurred on April 16, 2007; the Chardon High School shooting that occurred in northern Ohio on Feb. 27, 2012; the Sandy Hook Elementary School shooting that occurred in Newtown Connecticut on Dec. 14, 2012; and the Washington Navy Yard shooting that occurred in Washington D.C. on September 16, 2013, all perpetrated by persons with un-diagnosed or un-treated or under-treated severe behavioral health disorders/illnesses.</p> <p>In the newspaper article titled: <i>U.S. Can't Continue to Abandon Mentally Ill</i> (appearing September 22, 2013, in the <u>Columbus Dispatch</u> and written by syndicated columnist and psychiatrist, Dr. Charles Krauthammer), Dr. Krauthammer explained about the September 16, 2013 shooting at the Washington Navy Yard by Aaron Alexis, "...the origin of this crime lies not in any politically expedient</p>	<p>Goal A goal at every level of the public and private behavioral health care system needs to be to educate the public, particularly focusing on men, to no more abandon someone with depression, delusions or other symptoms of mental illness "to fend for himself than a man suffering a stroke." (Dr. Charles Krauthammer)</p> <p>This would result in persons more readily seeking/ being referred for behavioral health care services, resulting in <u>treatment prior to the exacerbation of symptoms.</u></p> <p>Although this goal is to be broadly targeted, men need to be specifically targeted since men have a substantially higher proclivity for violence to selves (i.e., their suicide rate is many times higher than that of women) and to others. As noted under the Needs Assessment section of this Plan, and in national data, the subset of <u>young men</u> experiencing social rejection and those with undiagnosed, untreated or undertreated mental illnesses have shown a vulnerability, often to social rejection, that may result in suicide and suicide/homicide ideation, planning and execution. Targeting men</p> <ul style="list-style-type: none"> • 	<p>Strategy Promote the following (that closely resembles the QPR [Question/Persuade/Refer] suicide prevention approach):</p> <ul style="list-style-type: none"> • recognition by the public, with an emphasis on targeting <u>men</u> (as noted in Needs Assessments), of the signs and symptoms of mental health disorders in individuals, much as previous campaigns have promoted the signs and symptoms of such illnesses as cancer and strokes in individuals; • the expectation that health care be sought urgently so that diagnoses can be made, <u>prior to crises occurring</u>, when signs and symptoms of mental health disorders are recognized in individuals; and • information about health care providers that persons with these signs and symptoms may be referred to. <p>Additionally, the recruitment by universities of more male mental health professionals could influence men to access this health care system that they often now perceive as "touchy-feely," in part due to the predominance of women in this field.</p>	<p>The long-term measurement of this goal shall be evidenced by:</p> <ul style="list-style-type: none"> • The <u>reduction</u> of Board funds contracted for crisis services and the <u>increase</u> of Board funds contracted for DA's and treatment services; and • The reduction of personal, family and public tragedies due to an individual with an undiagnosed or untreated or undertreated severe behavioral health disorder.
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externality *but in the nature of the shooter.*”

Dr. Krauthammer described the delusions, paranoid ideation and hallucinations Aaron Alexis had been having. “So here is this panic-stricken soul, psychotic and in terrible distress,” who called the police from Newport R.I. on August 7, 2013 because he was hearing voices, thought people were following him and sending microwaves through the walls of his third hotel room. He had left two hotel rooms already to try to rid himself of his “pursuers.”

The Newport police told Mr. Alexis to “stay away from the individuals that are following him.”

Aaron Alexis then visited Virginia hospital ER’s twice without “florid symptoms of psychosis and complaining only of sleeplessness.” He was given sleep medication.

According to Dr. Krauthammer, the fact that Aaron Alexis did not receive treatment was not due to lack of funding, but due to criteria that were too narrow for him to be involuntarily treated, largely due to politics that viewed involuntary commitments as paternalism toward mentally ill persons.

Dr. Krauthammer concluded: “...a compassionate society... would no more abandon this man to fend for himself that a man suffering a stroke.”

The prioritization of stigma-reduction toward those with severe behavioral health

<p>illnesses/disorders so their treatments may be perceived to be as urgent, as life-saving and as blameless as provided to those suffering strokes, is needed at the national, state and local public behavioral health care system levels.</p> <p>This priority may be particularly targeted to men since men have a substantially higher proclivity for violence to selves (i.e., their suicide rate is many times higher than that of women) and to others. As noted under the Needs Assessment section of this Plan, and in national data, the subset of young men experiencing social rejection and those with undiagnosed, untreated or undertreated mental illnesses have shown a vulnerability, often to social rejection, that may result in suicide and suicide/homicide ideation, planning and execution.</p>			

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)Public Policy Priorities	<p>In <i>Definitions of Public Policy and the Law</i>, Dean G. Kilpatrick, Ph.D. defines public policy as a system of laws, regulatory measures, courses of action, and funding priorities concerning a given topic promulgated by a governmental entity or its representatives.</p> <p>Public Policies provide boundaries to the authority of entities to fulfill their responsibilities.</p> <p>Two examples <u>of public policies that would enhance MHAS Boards are as follow:</u></p> <ul style="list-style-type: none"> • <u>Advocacy for Continuing Levies</u> <p>Levies for county MHAS Boards generally do not generate nearly the amount of funds that levies for DD Boards generate.</p> <p>Although this is often attributed to the greater vulnerability of, and hence greater public sympathy for, the DD population, it could be argued that the much greater prevalence of those with mental illnesses and chemical dependencies would render broader public support for those populations.</p> <p>The real answer to this differential may be more linked to public policy, however, than to the population served.</p> <p>DD Board are permitted to put <u>continuing (i.e., permanent) levies on ballots, while ADAMHS Boards are not.</u></p> <p>Advocating to the state legislature for a change to permit continuing levies for the public behavioral health care system could substantially change the resources available to this system.</p> <ul style="list-style-type: none"> • <u>Advocacy for a Return to Implementation of the Mental Health Act</u> <p>In response to # 12 of this Plan (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.), the Board responded as follows:</p>

	<p>The Board will continue to advocate for a return to implementation of the Mental Health Act, which was not repealed but was defunded. When Boards purchased both private and public inpatient care for their residents, there were fewer admissions and shorter lengths of stay, which not only saved money but also resulted in persons with mental illnesses developing the skills, resources and confidence needed to address their symptoms in the community.</p>
<p>(2) A Priority at every level of the public and private behavioral health care system needs to be to educate the public, particularly focusing on men, to no more abandon someone with depression, delusions or other symptoms of mental illness “to fend for himself than a man suffering a stroke.”(Dr. Charles Krauthammer)</p>	<p>Priority Reduce crises of residents with mental illnesses and chemical dependencies that result in:</p> <ul style="list-style-type: none"> • use of Behavioral Health Crisis./Emergency Systems; and that result in • personal, family and public tragedies <p>by promoting the early identification and treatment of persons with severe and persistent behavioral health disorders/illnesses.</p> <p>This priority was created in response tragedies such as the. Virginia Tech massacre that occurred on April 16, 2007; the Chardon High School shooting that occurred in northern Ohio on Feb. 27, 2012; the Sandy Hook Elementary School shooting that occurred in Newtown Connecticut on Dec. 14, 2012; and the Washington Navy Yard shooting that occurred in Washington D.C. on September 16, 2013, all perpetrated by persons with un-diagnosed or un-treated or under-treated severe behavioral health disorders/illnesses.</p> <p>In the newspaper article titled: <i>U.S. Can’t Continue to Abandon Mentally Ill</i> (appearing September 22, 2013, in the <u>Columbus Dispatch</u> and written by syndicated columnist and psychiatrist, Dr. Charles Krauthammer), Dr. Krauthammer explained about the September 16, 2013 shooting at the Washington Navy Yard by Aaron Alexis, “...the origin of this crime lies not in any politically expedient externality but in the nature of the shooter.”</p> <p>Dr. Krauthammer described the delusions, paranoid ideation and hallucinations Aaron Alexis had been having. “So here is this panic-stricken soul, psychotic and in terrible distress,” who called the police from Newport R.I. on August 7, 2013 because he was hearing voices, thought people were following him and sending microwaves through the walls of his third hotel room. He had left two hotel rooms already to try to rid himself of his “pursuers.”</p> <p>The Newport police told Mr. Alexis to “stay away from the individuals that are following him.”</p> <p>Aaron Alexis then visited Virginia hospital ER’s twice without “florid symptoms of psychosis and complaining only of sleeplessness.” He was given sleep medication.</p> <p>According to Dr. Krauthammer, the fact that Aaron Alexis did not receive treatment was not due to lack of funding, but due to criteria that were too narrow for him to be involuntarily treated, largely due to politics that viewed involuntary commitments as paternalism toward mentally ill persons. Dr. Krauthammer concluded: <u>“...a compassionate society... would no more abandon this man to fend for himself that a man suffering a stroke.”</u></p>

The prioritization of stigma-reduction toward those with severe behavioral health illnesses/disorders so their **treatments may be perceived to be as urgent, as life-saving and as blameless as provided to those suffering strokes, is needed at the national, state and local public behavioral health care system levels.**

This priority may be particularly targeted to men since men have a substantially higher proclivity for violence to selves (i.e., their suicide rate is many times higher than that of women) and to others. As noted under the Needs Assessment section of this Plan, and in national data, the subset of young men experiencing social rejection and those with undiagnosed, untreated or undertreated mental illnesses have shown a vulnerability, often to social rejection, that may result in suicide and suicide/homicide ideation, planning and execution.

A Priority at every level of the public and private behavioral health care system needs to be to educate the public, particularly focusing on men, to no more abandon someone with depression, delusions or other symptoms of mental illness “to fend for himself than a man suffering a stroke.”(Dr. Charles Krauthammer).

Although this goal is to be broadly targeted, men need to be specifically targeted since men have a substantially higher proclivity for violence to selves (i.e., their suicide rate is many times higher than that of women) and to others. As noted under the Needs Assessment section of this Plan, and in national data, **the subset of young men experiencing social rejection and those with undiagnosed, untreated or undertreated mental illnesses have shown a vulnerability, often to social rejection, that may result in suicide and suicide/homicide ideation, planning and execution.**

To accomplish this the following may be promoted (this closely resembles the QPR [Question/Persuade/Refer] suicide prevention approach):

- **recognition by the public, with an emphasis on targeting men (as noted in Needs Assessments), of the signs and symptoms of mental health disorders** in individuals, much as previous campaigns have promoted the signs and symptoms of such illnesses as cancer and **strokes** in individuals;
- **the expectation that health care be sought urgently so that diagnoses can be made, prior to crises occurring**, when signs and symptoms of mental health disorders are recognized in individuals; and
- **information about health care providers that persons with these signs and symptoms may be referred to.**

Additionally, the recruitment by universities of **more male mental health professionals** could influence men to access this health care system that they often now perceive as “touchy-feely,” in part due to the predominance of women in this field.

The long-term measurement of this goal shall be evidenced by:

- The reduction of Board funds contracted for crisis services and the increase of Board funds contracted for DA’s and treatment services; and
- The reduction of personal, family and public tragedies due to an individual with an undiagnosed or untreated or undertreated severe behavioral health disorder.

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 Board collaborates within its own Board system at both regional and state levels as well as with other systems (on county, state and national bases), consumers, family members and the general public.

Its alliances/collaborations contribute substantially to the attraction of resources (such as state and federal grants), to the efficient implementation of pilot and highly specialized programs, to the development of a comprehensive, high quality and integrated behavioral healthcare system of care, to the maximization of resources, to the optimization of accessibility and responsiveness, and to the improvement of outcomes.

Organizations with which the Huron County MHAS Board collaborates, how it collaborates with each and successes with each include, but are not limited to, the following:

- **Ohio Association of County Behavioral Health Authorities**, with which is works to maximize state and federal funds available; to shape public policy that will facilitate the optimal implementation of treatment, support and prevention services; to bring to Ohio educational opportunities regarding treatment/prevention/support services and administrative approaches that may improve Ohio's behavioral health care systems; and to provide the interface of Boards throughout Ohio so that the sharing of knowledge and experiences may occur to improve systems in all Ohio counties.
- **Collaboratives of Boards of Mental Health and Addiction Services:**
 - The **Northwest (NW) Ohio Board Regional "Hot Spot" Collaborative** (consisting of the 11 Boards that utilize NOPH and the Marion-Crawford Board) formed by Ohio MHAS to provide collaborative funding for the identification of regional needs and for the implementation of regional approaches to address those needs, which in SFY 2013 succeeded in slowing the rise of NOPH admissions (Huron County cut its admissions to NOPH in half in SFY 2013 from the number of admissions it had in SFY 2012, having placed 84% of its "Hot Spot" funds into the NOPH Admission Reduction project), in reducing waiting lists, in enhancing the region's capacity for crisis services to youths, in beginning the implementation of teleconferencing and telemedicine, and in planning for housing needs, particularly for the low incidence but high cost persons in need of a secure environments but not ongoing inpatient or nursing home care.
 - The **NW Ohio 3-Board Collaborative consisting of the contiguous Boards of Huron, Erie-Ottawa and Seneca-Sandusky-Wyandot Counties**, formed to implement regional projects that currently include implementation of:
 - a 3-Board Regional *Recovery to Work* program, which provided the opportunity for these Boards to retain all of their carryover funds, to streamline the operation of their programs and to improve outcomes so that this Collaborative doubled the number set by OOD of persons sustaining employment for 90 days or more;
 - a regional pilot Criminal Justice and Behavioral Health Linkage (CJBHL) grant to improve criminal justice and behavioral health linkages by applying best practices to them, which is being utilized to provide individual and group behavioral health treatment services to persons with mental illnesses and chemical dependencies in this regions' 5 county jails;

- a SFY 2014 Annual Regional Forensic Conference, which will be the 15th Annual Regional Forensic Conference and which will continue to improve the integrated behavioral health and criminal justice services that target the criminogenic risk and need factors of persons in the criminal justice system (including those re-entering from incarcerations) as well as the working relationships of those in the two systems since the Conference's educational opportunities contribute to such persons in the two systems sharing perspectives;
- a regional SAMHSA Health Home Grant for Medically Indigent Persons, received by the primary provider of the three Boards in this Collaborative and supported by the three Boards, which is bringing physical health care and preventive/wellness educational opportunities to persons with SPMI, many of whom have been found to have received no, or minimal, physical health care services for many years so that problems are often serious, with treatments sometimes needed that exceed the grant resources so that the Boards are placing funds in the program for health care services/tests/devices that cannot be obtained gratis. The serious health problems identified have included such conditions as tumors, GI bleeds as well as the nearly pervasive obesity and diabetes condition;
- a contract for "back-office" tasks/responsibilities between the Huron County Board and the Erie-Ottawa Board, an arrangement that has been beneficial to both Boards. For a reasonable cost, the Huron County Board is attaining expertise and experience by contracting with the Erie-Ottawa Board for its CFO and MACSIS functions, while the Erie-Ottawa Board has been able to maintain its full-time staff members during budget cuts. (Nonetheless, while this arrangement saves funds for both Boards and provides a level of expertise that could not be hired on a part-time basis, not having full-time fiscal staff does affect the regular communication between fiscal and program staff that is needed to optimally plan and monitor budgets/programs, does create some issues of timeliness and does create the need for the Huron Board Director to attend to numerous fiscal functions, not an efficient use of that person's time.); and
- the regional application of *MyOutcomes* (discussed in Question #2 of this Plan, under the 14th bullet of *Strengths and Challenges in Addressing Needs of the Local System of Care*). *MyOutcomes* is the only Outcome Evaluation system for behavioral health services that **both measures client outcomes and improves those outcomes** by bringing attention to any process or product concern of the client immediately. It also captures outcomes for more people in treatment since it requires only two contacts (such as a Diagnostic Assessment and a Counseling Session) with a provider for measurement of outcomes to occur. This has been in place for three years in all three Boards in this Collaborative and is applicable to all MH and AoD populations since it is based on levels of distress. The 3-Board application of this provides a much larger sample to assess its usefulness, more peer support of the professionals implementing it, cross-Board comparisons and a lower cost to affiliate with *MyOutcomes*. The comparisons of these Boards' data, for example, have shown that the Huron County office of Firelands has scored the best of the three Boards for the past 2 years in the degree of progress experienced by youths in treatment and in the degree of satisfaction of parents of youths in treatment.

- **Huron County Board of County Commissioners**, with which the Board meets in public session two times a year as well as periodically in conjunction with such county organizations as FCFC, Community Corrections Board and County Department Heads;

- **Huron County Family and Children First Council (FCFC)**, with which the Board has a contract to provide monetary support of the collaborative work of the Council and for which the Board provides leadership of its Planning Committee and QA/UR of its I-FAST IHBS program and of its Ohio Children’s Trust Fund-sponsored Incredible Years- Early Childhood program. In the last two years, it has accomplished collaborative program planning and financing; operated Wraparound services; contracted with the DD Board for *Help Me Grow*, which has operated with high scores on its state evaluations; and operated an effective FCFC Diversion Team, cutting placements to 18 out-of-home youths, the lowest number in over a decade (which can be compared to the similarly sized contiguous county of Ashland, which has approximately 70 youths in placements).
- **Huron County Department of Job and Family Services (DJFS)**, which includes Children’s Services in Huron County, with which the Board collaborates on the FCFC Council and its Diversion Team (accomplishments discussed above); to which it provides QPR staff training due to the frequency of suicide threats of persons applying for benefits; for which the Board’s treatment provider hosts quarterly lunches for the Children Services staff to discuss services available, to trouble-shoot and to discuss joint educational ventures that may be beneficial to improving collaboration and mutually targeted outcomes; and with which it works with companies that close or downsize to prepare people for new employment opportunities.
- **City and County Public Schools, Parochial and Vocational Schools**, to which it provides (in all county high schools) the SAMHSA-designated evidence-based QRP (Question/Persuade/Refer) Suicide Prevention Program; with which it collaborates to provide other services such as Critical Incident Debriefings when traumatic incidents occur and with which it works to plan treatment, prevention and support services for the county’s youths so that schools in SFY 2013 encountered the fewest alcohol and other durg-related behavior problems in a decade, attributing this to the work of these two systems- and particularly to their focus on the research-validated support/education of parents to communicate to their children their disapproval of any alcohol/other drug use, the most effective strategy to reduce the chances of youths’ use of these substances. These two systems have done this in a number of ways, one very successful way consisting of making drug/alcohol test kits available to parents with Board-provided brochures that offer parents with a “crash course” in prevention, suggesting, for example, what to do if test results are positive, or if they are negative, or if a youth refuses to take the test (“You will want to consider a refusal by your child to take this test as a positive result.”). These kits have been donated by area hospitals and businesses so have been provided to parents at no cost.
- **Huron County Board of Developmental Disabilities**, with which it collaborates on the FCFC Council and with which it collaborates to provide specialized Mental Health treatment services for the DD population, particularly psychiatric and CPST(Community Psychiatric Support Team) services;
- **Huron County *Help Me Grow*** is a contract program of the FCFC. FCFC contracts with the DD Board to administer this program. The program involves Board contracted behavioral health services as needed for both the parents and the children in this program. It makes available its *Speakers Bureau* that is used for staff training as needed. The Board provides packets of information that go to each family in the program.
- **Parole and Probation Departments**, with which the Board and its provider work collaboratively on the Community Corrections Board and work collaboratively on behalf of the many clients referred by the PO’s for mental health and/or AoD treatment.

- **Norwalk and Bellevue Municipal Courts**, with which it has contracts to implement IDAT programs. The contacts designate the criteria participants must meet (i.e., medial indigency and alcohol-related crime committed), the processes to be utilized to refer participants, to exchange information, and to pay for treatment provided out of the IDAT accounts, and the Board-designated provider of the AoD treatment. These programs have become major sources of AoD treatment funds, with the Norwalk Municipal Court agreement being for funds up to \$72,000 for SFY 2014.
- **Huron County Common Pleas Court-General Division and Juvenile/Probate Division**, with which the Board funds the treatment for the Drug/Treatment Courts.
- **City/Village Police Departments and the Sheriff Department**, with which the Board and its treatment provider work to provide collaborative education and support through periodic Crisis Intervention Team (CIT) training; Critical Incident Stress Management Team training/support; Annual Forensic conferences; brochures of community resource; and crisis screening of persons as referred. Weekly county “jail adjustment” services are provided to inmates of the county jail and in SFY 2014 the Boards of Huron, Erie-Ottawa and Seneca-Sandusky-Wyandot were awarded a regional pilot Criminal Justice and Behavioral Health Linkage (CJBHL) grant to improve criminal justice and behavioral health linkages by applying best practices to such linkages. This grant is being utilized to provide individual and group behavioral health treatment to persons with mental illnesses/chemical dependencies in the 5 county jails.

Department of Youth Services (DYS), with which the Board works collaboratively on the FCFC; for which the Board provides a counselor to conduct group treatment for county youths in the DYS Northern Ohio Juvenile Correctional Facility* in Sandusky; for which the Board provides counseling in the county’s Alternative School which consists of some students reentering the community from DYS facilities; and for which the Board provides sex offender therapy, begun in DYS facilities.

*There are twelve Community Corrections Facilities (CCFs) established throughout the State of Ohio through the RECLAIM initiative to provide a dispositional alternative to Juvenile and Family Court Judges when committing youth adjudicated of a felony offense. The Northern Ohio Juvenile Community Correctional Facility capacities and programming is as follows:

Bed Capacity:	Bed Capacity: 30 Male
Primary Counties:	Seneca, Sandusky, Erie, Huron, Ashland
Program Length:	5-7 months
Programming and Specialized info: Sex Offender Therapy (typical program lasts 9-12 months), Cognitive Behavioral Therapy, Thinking for a Change, Aggression Replacement Training, Family Counseling, Thinking Errors, Living Skills	

- **Huron County Services for the Aging/Senior Services**, with which the Board has a contract for the *Age Exchange Program*, a program that connects persons of grand-parenting age with elementary aged youths identified to benefit from this once-a-week group mentoring program. Children in the program gain social and educational assets. Senior citizens gain social contracts and a vehicle to provide generativity. The contract also stipulates this provider’s involvement in the county’s Suicide Prevention Coalition, which works to prevent problem behaviors across individual’s life spans and promotes QPR, since *Age Exchange* involves youths, parents, educators and seniors, positioning it well to conduct coalition-building with those cohorts. The county’s Services for the Aging has become more involved with the Suicide Prevention Coalition since persons at the greatest risk of suicides are men as they age.
- **Ministerial Associations** in the county are extended invitations to attend Board-sponsored Forensic, QPR and other conferences, are encouraged to participate in the Suicide Prevention Coalition and the Alcohol/Other Drug Prevention Coalitions, are encourage to respond when AoD Prevention Mini-grants are made available to the community, are provided *Speakers Bureau* information so that their congregations may be provided with educational opportunities and are informed how and when to refer persons for crisis and other behavioral health care services.

- **Community Corrections Board** is a collaborative of representatives of organizations that are providers of services to persons involved with the criminal justice system, including Common Pleas and Municipal Court Judges, the Protector, the Public Defender, the City Law Director, the county Sheriff, Police Chiefs, Probation and Parole Officers, and representatives of the DD Board, the MHAS Board and its treatments contract provider, Firelands Counseling and Recovery Services. The Corrections Board works to improve outcomes for persons who have committed crimes by facilitating coordinated, consistent and comprehensive treatment. The Corrections Board is involved in decisions about such matters as the Drug/Treatment Courts, Forensic Conferences sponsored by the MHAS Board, behavioral health services provided to persons in the jail and after incarcerations and behavioral health services provided to parolees and probationers. The Board's treatment provider hosts periodic lunches with the PO staff to maintain a strong collation with the criminal justice system so that clients of both systems can best be served.
- **Community Hospitals: Fisher-Titus Medical Center; Firelands Regional Medical Center; Bellevue Hospital; and Mercy Willard Hospital:** The Board's relationship with the area's community hospitals is unique since its primary treatment provider is a hospital, Firelands Regional Medical Center, dba Firelands Counseling & Recovery Services (FCRS). Firelands Regional Medical Center (formally known as Firelands Community Hospital) is a 227-bed not-for-profit medical center in Sandusky, Ohio, which is in Erie County, contiguous on the north to Huron County. In 2012 the medical center had 9,678 admissions, 3,162 inpatient procedures, 7,704 outpatient surgeries, and its emergency department had 47,208 visits. Firelands Regional Medical Center is the only hospital in Erie County serving more than 10,000 inpatients and over 45,000 ER patients annually and is the largest year-round employer. The medical center is accredited by the American Osteopathic Association's Healthcare Facilities Accreditation Program.

Today's Firelands Regional Medical Center is the combination of three former Sandusky hospitals into one regional medical center providing state-of-the-art medical care. It began with the laying of the cornerstone for the former Good Samaritan Hospital on June 27, 1876 followed by the Sisters of Charity of St. Augustine based in Cleveland founding Providence Hospital in 1902. In 1985, Good Samaritan Hospital and Sandusky Memorial Hospital merged, becoming Firelands Community Hospital. In 2001 Firelands Community Hospital and Providence Hospital merged to become Firelands Regional Medical Center - the largest health system in the five county area. The Firelands Regional Medical Center School of Nursing is fully accredited and located on hospital property. Firelands has behavioral health offices on the campuses of Fisher Titus Medical Center in Norwalk and Bellevue Hospital in Bellevue.

The close working relationship between the Board and area hospitals began when the Board issued RFP's twenty six years ago to replace its mental health treatment provider, the Linn Center. Firelands Hospital and Fisher Titus Medical Center (FTMC), located in Huron County, jointly submitted a proposal to the Board. The Board authorized entry into a contract with those two entities. However, attorneys for those hospitals concluded that Medicaid/Medicare billings would be problematic if two hospitals entered into a contract with the Board. FTMC asked that the Board contract with Firelands, since Firelands already had inpatient and outpatient behavioral health treatment, prevention and support services in Erie County and already was under contract with the Huron County Board to provide Hotline/Crisis Services. The FTMC CEO and Board remained in an advisory capacity to Firelands' CEO and Board of Directors.

Firelands' main behavioral health care office in Huron County is located on the Norwalk Campus of FTMC. The building utilized by Firelands on that campus was built by FTMC specifically for use by Firelands, a unique arrangement of cooperation between private hospitals. In SFY 2013, Firelands entered into a new agreement with FTMC to collaborate for the development and implementation of a Health Home located within Firelands Counseling and Recovery Services building on the FTMC campus.

This new partnership began with the remodeling of the building rented by Firelands on the FTMC campus to include two examination rooms and a Physician/Nursing station that would include the equipment as specified by SAMHSA in the 3-year grant awarded by it to Firelands to develop a Health Home for persons with behavioral health disorders who were medically indigent. The partnership included FTMC providing a physician to oversee the Health Home.

Firelands also has an behavioral health treatment office in Bellevue located on the campus of the Bellevue Hospital in a building constructed by Firelands, another cooperative arrangement between private hospitals.

Firelands has agreements with FTMC, the Bellevue Hospital and Mercy Willard Hospital to utilize those hospital's ER's as "safe sites" to provide its face-to-face crisis services.

Firelands has available both inpatient and outpatient behavioral healthcare services. However, beginning in SFY 2011, this Board ceased to include Firelands Psychiatric Inpatient as part of its Benefit Package, opting instead to contract with Firelands to arrange private crisis/inpatient beds for adults with Rescue Crisis due to the lower cost of Rescue's Inpatient-accessed care. Rescue Crises arranges with private hospitals in Toledo for inpatient psychiatric care as needed by persons referred to Rescue. The Board contacts with Firelands to arrange as needed inpatient care for youths.

- **Huron County Suicide Prevention Coalition** was formed when the Board first was awarded funds from the Ohio Suicide Prevention Foundation. The Board contracted with Firelands to administer this Coalition, which meets quarterly for luncheons. It was this entity that adopted the QPR suicide prevention strategy.

QPR stands for *Question, Persuade and Refer*: three simple steps that anyone can learn to help save a life from suicide. Just as people trained in CPR help save lives each year, people trained in QPR may also save lives by learning how to recognize the warning signs of a suicide crisis and learn how to question, persuade and refer someone for help.

The QPR Institute applied to the National Registry of Evidence-based Programs and Practices (NREPP), a service of SAMHSA, to have QPR deemed evidence-based. That designation was granted in 2012.

The Huron County Suicide Prevention Coalition has organized several QPR Institute trainings for the community (including members of the Board-sponsored consumer group, Faces of Hope, and the Huron County NAMI) and to "train trainers" and continues to support the teaching of QPR in the community by these mechanisms:

- TV and radio informational campaigns about QPR;
- education about QPR provided in small group formats via the Board's *Speakers Bureau* to community organizations, businesses, church groups and public organizations such as is provided annually to all DJFS staff members after a pattern developed of persons who had lost jobs coming to that agency for benefits and stating that they were thinking of committing suicide; and
- education about QPR provided to all high school students in all high schools in the county.

It is planning for SFY 2014 to expand its trainings in the area's hospitals and businesses.

- **Norwalk Prevention Partners Coalition and the Willard CARE (Community Awareness and Response Effort) Coalition** were developed to bring community organizations together to develop alcohol/other drug prevention activities/strategies to reduce use of substances by youths.

The Board assisted the Norwalk Coalition to develop a model alternative to drug testing students in schools, achieved after community pressure was exerted on the Norwalk City Schools to implement an in-school drug screening program. This community pressure led to the formation of a panel by the school system to review research about the effectiveness of in-school drug testing, particularly the Robert Wood Johnson-sponsored research conducted by the Institute for Social Research at The University of Michigan titled *Drug Testing in the Schools: Policies, Practices, and Association with Student Drug Use*. **That research found that the in-school approach to drug screening not only was ineffective in reducing use by youths but often created problems for students and schools.**

Instead, evidence-based successes in reducing use of substances by youths consistently had been demonstrated when parents clearly demonstrated disapproval of their children's use.

Consequently, the Norwalk Prevention Partners began to make alcohol “sticks” and drug testing kits available to parents at no charge, with kits purchased by community groups/businesses and with MHAS Board-developed and supplied brochures provided with the kits to make available to parents a “crash course” in alcohol/other drug prevention (with suggestions such as that a youth's refusal to take a test be treated as a positive finding). In SFY 2013, the Willard Collation adopted this strategy also, having its initial kits paid for by Mercy Willard Hospital, with the instructions provided by the MHAS Board.

This collaborative project then informed the coalition working on the survey for the 2011 *Huron County Health Assessment*, so that survey included a question pertaining to parents telling their children that no alcohol or other drug use by them is acceptable. The results indicated: **82% of youths reported their parents would not approve of them drinking alcohol, decreasing to 74% of those ages 17 and older.**

As stated under the school coalition bullet above, schools in SFY 2013 encountered the fewest alcohol and other durg-related behavior problems in a decade, attributing this to the work of these two systems- and particularly to their focus on the research-validated support/education of parents to communicate to their children their disapproval of any alcohol/other drug use, the most effective strategy to reduce the chances of youths' use of these substances.

- **Huron County Faces of Hope** (consumer group for persons with mental illnesses) and the Board collaborate in numerous ways. The Board supports *Faces of Hope* financially, provides Firelands' CPST staff support, provides invitations to its Forensic, QPR and other conferences, encourages its members to participate in the Suicide Prevention Coalition and the Alcohol/Other Drug Prevention Coalitions and provides it access to its *Speakers Bureau* presentations for its members. The club provides focus group information to the Board, provides emotional and social support to its members, and provides education to the community about the need for more visibility of those with mental illnesses so that stigma may be reduced via such mechanisms as making members available to speak about the *Faces of Hope* through the Board's *Speakers Bureau*.
- **Huron County NAMI** is the organization that provides education, support and advocacy to, and on behalf of, family members of persons with mental illnesses. The Board invites NAMI members to attend its Forensic, QPR and other conferences, invites its members to participate in the Suicide Prevention Coalition and the Alcohol/Other Drug Prevention Coalitions and provides to NAMI access to its *Speakers Bureau* for educational opportunities. NAMI provides community information about mental illnesses, offers a support group for persons with mental illnesses and offers NAMI-sanctioned courses to its members to increase their knowledge about mental illnesses and treatment strategies available for them. It also participates in providing speakers through the Board's *Speakers Bureau*.

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

Boards in the NW Region of Ohio and NOPH managers have worked together in the NW Regional Board Hot Spot Collaborative to attempt to reduce NOPH bed day admissions as discussed under Question #2 of this Plan (that question, in parentheses, refers to ORC 340.03 that requires Boards to review service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals).

The Huron County Board's response to Question #2 (in the subhead: Collaborative Needs Assessment: NW Collaborative "Hot Spot" Regional Needs Assessment) describes the interaction between this Board's utilization of NOPH, private hospitals (which are accessed through a Rescue Crisis contract) and outpatient services.

Eighty four percent of the Huron County Board's Hot Spot funds were utilized toward the second part of that Collaborative's project called the *Waiting List/NOPH Admission Reduction Project*.

Its Hot Spot-funded projects in Huron County are described as follows, abbreviated from responses provided to Question #2 of this Plan. (Please note that many of the services labeled "Outpatient" might better have been labeled "Intermediate" or between inpatient and outpatient care, as they are provided to persons on the brink of entering or leaving the inpatient level of care.)

- **(Private Inpatient) Rescue Crisis** (contracted to access all private hospitalizations for adults paid by the Board in SFY 2013)- **Hot Spot funds in the amount of up to \$25,450 was added to the Board's June 2012 Budget of \$113,000 for Rescue Services**, in order to assist to reduce NOPH admissions.
- **(Outpatient) Wellness Programs** were provided by personal trainers in both individual and group formats, based on research in the article titled *A Fitness Movement* (Behavioral Health February 15, 2012), which found fitness programs to have efficacy in reducing hospitalizations and chronic physical illnesses for persons with SPMI (**\$12,480 in Hot Spot funds spent on this project**).
- **(Outpatient) Hotel/Transportation** availability was created that resulted in hotel stays for four (4) individuals, consisting of one night each, and resulting in four diverted inpatient stays (**\$211.05 spent in Hot Spot funds were spent on this project**).
- **(Outpatient) 24-hour on-call CPST** was made available for persons in crises by this fund for 43 weeks of SFY 2013. This new service was effective in diverting from NOPH a percentage of those persons seen for Crisis Services, by providing opportunities for case managers to access alternative resources for them (albeit that sometimes those alternative resources were for other inpatient/crisis facilities). It also allowed time and staff to de-escalate anxieties of clients evaluated to need inpatient care but waiting for beds, as well as their family members who may be waiting with them, and staff of the safe-site being used for the crises evaluations. It also provided opportunities to educate families about mental illnesses at opportune "teachable moments" (**\$3,702 in Hot Spot funds were spent on this project**).
- **(Outpatient) Engagement/Outreach** services were designed to provide case management to individuals who had multiple prescreens or hospitalizations but had not been willing to be involved with ongoing services. It was successfully used with one individual, preventing a readmission (**\$384.00 in Hot Spot funds were spent on this project**).

- **(Outpatient) Group Home Respite/Step-down** stays (for intervals of 7-14 days) were procured for four clients that either kept them out of NOPH or allowed them to be released sooner from NOPH. As noted by MRU/LLC, the Board's contract QA/UR provider, discharge planning for individuals hospitalized in NOPH often is a barrier to those persons' timely release from that level of care (**\$2,695.00 Hot Spot funds were spent on this project**).
- **(Outpatient) A Weekly Crisis Group** was created on a set day at a set time so that Crisis MHP's would have a day and time set aside to which to refer persons who had been seen for Crisis services. Four sessions were held open with no attendance. The program was discontinued (**\$384.00 in Hot Spot funds were spent on this project**).

Utilizing the Hot Spot funds to purchase more private bed days and a variety of outpatient programs specifically targeted to persons at high risk for inpatient care contributed to the Huron County Board realizing **reductions in NOPH Admissions in SFY 2013** as follows:

- **Total admissions were cut more than in half (from 64 to 30) so that SFY 2012's admissions were 213% of SFY 2013's;**
- **Civil admissions were cut in half (from 58 to 29) so that SFY 2012's admissions were 200% of SFY 2013's; and**
- **Forensic admissions in SFY 2013 were cut 300% (from 3 to 1).**

By targeting the collaboratively identified NOPH Admission Reduction project, Huron County more than cut in half its admissions to NOPH, while also achieving a higher quality of life for persons who otherwise would have been hospitalized by providing those persons with opportunities to increase confidence in their abilities to manage their lives and symptoms.

If lengths of stay at NOPH also could be reduced (as discussed in response to #4 of this Plan, under the subhead: *Challenge-Disadvantageous Funding to Control State Psychiatric Hospital Admissions*) even more savings could be created for Ohio's public psychiatric hospitals.

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. Innovative Service delivery:

Wellness Programming was discussed in responses to Questions #2 and 9 of this Plan. This innovative programming was based on such findings as those highlighted in the article titled *A Fitness Movement (Behavioral Health February 15, 2012)*, which found **fitness programs to have efficacy in reducing hospitalizations and chronic physical illnesses/conditions for persons with SPMI**. This programming is an excellent fit with Health Homes since Health Homes focus on the interaction between physical and mental well-being. It also is an excellent fit for any Board that has adopted the goal to improve the life expectancy of persons with SPMI, which was shown to be 25 years less than most people in the 2006 research findings reported in the *Morbidity and Mortality in People with Serious Mental Illness*.

Integrated Family and System Treatment (I-FAST), the Intensive Home Based Services (IHBS) approach that was developed at OSU, replaced Huron County’s use of the more expensive MultiSystemic Therapy (MST) strategy when funding cuts threatened to end any IHBS in Huron County. What resulted was a superior approach. Successes improved (i.e., more youths stayed out of placements), this strategy was more versatile (in that it could be used with younger populations, which had been a need identified by this county’s DJFS) and results were attained quicker.

The ***Question/Persuade Refer (QPR) Suicide Prevention Program***, deemed evidence-based by SAMHSA, provides students in every high school in the county as well as social service providers, community groups, businesses and others with knowledge of:

- how to identify persons who may be suicidal by teaching the signs/symptoms of mental illnesses and alcohol/other drug use/addiction, which often correlate with suicidality;
- how to engage persons in wanting to get help; and with
- how to refer them for appropriate intervention.

This is an excellent program utilized for over 5 years in Huron County that can be taught in an hour, that does not attempt to make “counselors” out of the participants and for which there is evidence that participants do use this pragmatic approach. Since it can be taught in an hour, it can reach many more people in the community than the Mental Health First Aid Training program, in which two MHP’s from Firelands also have been trained.

- b. Planning efforts
- c. Business operations

Contracting for “back office” functions with another Board provides both Boards with staff that have high levels of experience and expertise at a lower cost to each Board, as discussed under Question # 8 of this Plan (in the section titled: NW Ohio 3-Board Collaborative consisting of the contiguous Boards of Huron, Erie-Ottawa and Seneca-Sandusky-Wyandot Counties). A contract for such an employee is preferable over two or more Boards actually “sharing staff” so that a staff person has one set of Personnel Policies to abide by and one authority for evaluations, pay and for job retention decisions.

- d. Process and/or quality improvement

MyOutcomes (discussed in Question #2 of this Plan, under the 14th bullet of *Strengths and Challenges in Addressing Needs of the Local System of Care*) **is an infusion of marketplace vigor into behavioral health services.**

***MyOutcomes* is the only Outcome Evaluation system for behavioral health services that both measures client outcomes and improves those outcomes** by bringing attention to any process or product concern of the client immediately. It also captures outcomes for more people in treatment since it requires only two contacts (such as a Diagnostic Assessment and a Counseling Session) with a provider for measurement of outcomes to occur. This has been in place for 3 years for the 3 contiguous Boards of Huron, Erie-Ottawa and S-S-W, and is applicable to all MH and AoD populations since it is based on levels of distress. **Use of *MyOutcomes* has greatly improved client outcomes and satisfaction with services while also assisting providers to reduce lengths of stay in treatment for general population MH clients, thereby enhancing treatment providers’ capacities to treat more medically indigent persons.**

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

Advocacy (Optional)

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

As discussed under the response to Question #3 of this Plan, **the foremost strength of this Board is its Board of Directors, with its orderly process and its proximity to those for whom it is responsible.** An example of how this Board - which is experienced, informed and committed to being both a good steward of taxpayers' dollars and an advocate of treatments/supports that enhance the wellness, the independence and the integrity of persons with severe behavioral health disorders - arrives at reasonable decisions intended to maximize the cost effectiveness of its programs may be evidenced by how it voted with regard to its *Recovery to Work* program.

Although this Board is deeply committed to the power of work, and indeed to the power of the even more fundamental principle of social and economic reciprocity, to transform people's lives, the *Recovery to Work* program has proven to be a difficult program for it to support. This can be evidenced by the fact that in the past twenty-five years the Board has had only three split votes and two have been over the *Recovery To Work* program. (The third split vote was to change AoD providers. One Board member, who had gotten treatment and begun his AoD recovery at a provider that had become "un-auditable", told Board members that he could not vote against the provider that had "saved his life" but that he expected the rest of the Board members "to do the responsible thing" and make the decision to contract with a different provider.)

Nonetheless, working with Opportunities for Ohioans with Disabilities (OOD) Agency, the new name of the Rehabilitation Services Commission (RSC) of Ohio, proved to be difficult, with cumbersome layers of bureaucracy that resulted in clients being processed slowly and in funds flowing slowly, in rules and criteria changing seemingly capriciously and in trainings being required unexpectedly and often. It also proved to be difficult due to OOD administrators lacking responsiveness to Boards and VRP3 providers (eg. one conference call set up with an OOD Deputy Director on August 29, 2012, at her convenience, at 5 PM with the three Directors of the Huron, Erie-Ottawa and the S-S-W Boards and administrators of Firelands Counseling and Recovery Services and The Giving Tree, resulted in the Board and agency administrators waiting on the call for the OOD Deputy Director for nearly an hour- attempting to reach her- to no avail; that administrator never explained or apologized for calling a meeting and failing to attend it).

After the first 18 months of the program, Boards were compelled to form partnerships with other Boards to retain carryover funds that were substantial due to the slow start of the *Recovery to Work* programs throughout Ohio. This Board joined with the Erie-Ottawa and the S-S-W Boards at that time to form a collaborative program.

OOD's administrative complications, nonetheless, continued to contribute to a program with egregious cost effectiveness. The 3-Board RSC FFY 2013 budget (rounded) was \$922,000. Expected successful closures for the program for the year -established by OOD- totaled 15 (for all three Boards), making the cost to these Boards **over \$61,000 per employed individual.** RSC costs were additional and indeterminate.

The original 18-month Recovery-to-Work program for the state was budgeted at \$30M (rounded), although approximately \$19M was spent in that time frame, with the remainder carried over into FFY 2013. With **185 individuals successfully employed in those 18 months, the cost per employed individual was \$102,702.** RSC costs were again additional and indeterminate. (Information from the Ohio Association of County Behavioral Health Providers)

The Board was most concerned about this but did weigh it against the fact that this was a population previously underserved - or not served at all- by the RSC's BVR programs.

OOD administrators then created more concern for the Huron County Board Members when it told the 3-Board Collaborative that OOD would require this program in FFY14 to **reduce the number of part-time supervisors from three to one** and to **replace its two case managers/coordinators** because they no longer met the qualifications to be case managers/coordinators, although they had met the federal criteria to be approved by RSC for those positions in FFY 13. An OOD Deputy Director explained that OOD could **add requirements to federal criteria** in order to increase outcomes and had done so regarding case manager/coordinator staff educational requirements, even though this 3-Board Collaborative had doubled the OOD-targeted number for persons to be employed in FFY 13. The OOD target was fifteen (15) but thirty (30) persons qualified as successful. A September 15 memo was later issued to all OOD Partners with an updated Contract Template, containing language allowing those who currently worked in an OOD contract program and who had, at minimum, a Bachelor's Degree, to continue to work in these VRP3 programs into the FFY14 contract year.

The Board reviewed pro and cons regarding contract continuation of this program for FFY2014 as follow:

Arguments against continuing this program included the following:

- When both federal and local matching dollars are factored in, the program's costs may outweigh its benefits, with relatively few jobs attained at relatively high costs.
- The need to contract with OOD to operate this program is problematic not only because this results in little to no local control over the policies, procedures, costs and perhaps personnel of this program, but also because OOD often has operated, in the two and a half years of Board involvement with it, in an arguably arbitrary and capricious manner, making some decisions without reasonable grounds or adequate consideration of circumstances. It has operated for the most part with rigidity and an unwillingness to negotiate with its partners. It is overly regulated, which contributes to its high costs and inefficiencies, such as the lengthy time frames it takes to process applications and invoices.

Arguments in favor of continuing this program included the following:

- Since there will be carryover from the FFY 13 Recovery to Work program, continuing the program would yield the Board utilization of funds it previously put into the program.
- Local funds used would be relatively small for FFY 14, between **\$22,945.32**, with no carryover yet factored in, and **\$20,455.89** if there is a \$100,000 carryover.
- The trend of the program has been for it to accomplish improved outcomes, with 2 successes achieved during the first 18-month contract and with 6 successes achieved during the second 12-month contract, for a 300% improvement (aided by the OOD requirement for full time case coordinator staffing).
- Continuing the program would provide an opportunity for jobs for people who probably would not get them otherwise since BVR historically has accepted few mentally ill people into its programs and has accepted no addicted persons.
- With the Erie-Ottawa Board acting as the fiscal/administrative agent for the 3-Boards, there has not been a drain on Huron County fiscal staff time to attend OOD information technology trainings and to process Recovery to Work applications and invoices.
- With OOD's agreement to change language in its contract, it demonstrated, if not its willingness to negotiate with partners, its appreciation for the legal acumen of them.

The Implementation Committee of the Board believed the cost inefficiencies of this program could be lessened if its provider of case coordination services (Firelands) for the Recovery to Work program would:

- follow up with successfully employed program participants for up to 6 months, instead of the 3 months required by OOD;
- keep track of the number of persons who find their own jobs while in the *Recovery to Work Program* and of the duration of their job retention; and
- achieve at least 10 program successes, as defined by OOD.

With **those additional deliverables expected** of its provider, the Board voted to continue to support the program with careful reviews of cost effectiveness to occur quarterly. Firelands' administrators were happy to be continuing the program and to be challenged to make it better.

This example shows how well a local Board of Directors, **with its orderly process and its proximity to those for whom it is responsible** works to analyze strengths and non-strengths of programs and providers, provide solutions that may alleviate problems and establish plans to monitor the achievement of expectations. Instead of factions of the Board becoming polarized as to whether to end the program or retain it, the Board acted pragmatically to attempt to fix what is wrong with it so that both the taxpayers and clients may win.

(This Board plan, however, may be made moot now that OOD is in the process of negotiating with the U.S. Department of Education's Rehabilitation Services Administration (RSA) around recommended corrective actions found in RSA's October Draft FFY13 Monitoring Report to OOD. In the draft monitoring report, RSA recommended a corrective action that would require OOD to cease using federal vocational rehabilitation dollars to pay for 3d party cooperative agreements that support activities performed by contracted agencies. This would terminate or change services to over 8,500 disabled Ohioans and negatively impact providers' ability to continue offering employment services to Ohioans recovering from mental illnesses and/or addictions. On 11/22/13, OOD responded to this draft report and requested technical assistance to come into compliance. OOD and RSA representatives will meet in Washington D.C. in the immediate future. It is hoped that OOD and RSA can find a reasonable solution- **as the Huron County Board of Directors did**- that honors federal standards, recognizes Ohio's integrated state-local partnerships, and preserves critical services for thousands of disabled Ohioans.)

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.

First, the Board will continue to advocate for a **return to implementation of the Mental Health Act**, which was not repealed but was defunded. When Boards purchased both private and public inpatient care for their residents, there were fewer admissions and shorter lengths of stay, which not only saved money but also resulted in persons with mental illnesses developing the skills, resources and confidence to manage their symptoms in the community.

Second, the Strategic Prevention/Planning Framework approach to the Plan would be enhanced if the **questions as well as the responses were data-driven**. An example of this is given below.

The Table of Priorities in this Plan's Guidelines do not take into account the data-indicated problem of **alcohol addiction, the most prevalent of addictions and the addiction related to more homicides, suicides, accidents and destroyed families than any other drug**. The priority populations in the Table of Priorities in the Plan are persons who are intravenous/injection durg users, women who are pregnant and have substance use disorders and individuals with TB.

The Table of Priorities, however, would be even more improved if it did not focus on specific substances/delivery mechanisms of those substances (eg., injections), since substances-of-choice vary over time due to availability, cost and impact, but rather **focused on public polices and interventions that lead to successful outcomes (i.e., of sustained recoveries)**.

An analogy may assist to demonstrate the imprudence of focusing on specified substances. If those who work to curb obesity focused on obese persons' foods-of-choice, those foods a few decades ago may have been pies and fried foods that included substances such as lard and butter. Today those foods may be fast foods and processed foods that include substances such as high-fructose corn syrup (a recent invention that largely resulted from public policy that incentivized subsidies to the corn industry). Curbing use of any of those foods/food substances alone can result, however, in obese persons losing weight but not becoming fit or in switching foods that lead to continued weight gain.

Likewise, service providers have seen repeatedly that persons treated for addiction to one substance, such as heroin, who cease to use that substance generally consider themselves to have recovered, regardless of other substances to which they may switch. Recovery involves more than ceasing to use one substance-or all substances. Addiction fosters antisocial/risky life styles, so that addicted persons need to change how-and with whom-they spend their days, and develop purpose in life other than getting and using substances.

Treating this condition with another drug (especially one that continues to harm the brain- such as methadone) or in a residential setting only addresses the most obvious part of addiction- the drug. Residential treatment facilities create environments of deprivation from substances, so that people stay drug-free in them without changing their life styles. When they leave such facilities, however, they will have to depend on themselves to create drug free environments. (Analogy: Anyone living in the food-deprived environment of a concentration camp becomes thin, but life outside such an environment is full of choices. Deprivation works only while imposed.)

Kenneth Minkoff, M.D., a national expert in those with co-occurring mental illnesses and addictions involved in the criminal justice system told the 3-Board audience at the 8th Annual NW Ohio Forensic Conference (May 19, 2005): "Most people get sober in the community where they can practice sobriety over time with therapeutic and peer support." In communities, individuals can learn to avoid the triggers of their use and develop purpose for their lives. Recovery is not contingent upon a place but is a process that begins with a state of mind and a lifestyle that includes purpose of living with pro-social values.

In over 40 years of research about criminal, Dr. Stanton Samenow (The Criminal Personality), also a presenter at a NW Forensic Conference (August 3, 2001) found:

I have arrived at an entirely different understanding of people who use illegal drugs. In the first place, the defendant who says that he would not have been arrested had he not been using drugs may be correct with respect to the particular crime in question. But the fact is that, without exception, every felony offender whom I have interviewed was involved in crime before drug use became a part of his life.

In fact, drugs were initially just a dot on the landscape of many patterns of irresponsibility. Like shoplifting, vandalism and fighting, drugs offered the excitement of doing the forbidden, of being a big shot. Drug use, like other illegal acts, was a choice that the individual made. Eventually, drugs introduced him to another whole world of excitement –the people, the places, the risks to his body and personal safety, and the effects of the substances themselves. No one whom I have met was forced to use drugs. He chose to use them and, increasingly, gravitated to others who did as well. The drug-using criminal rejects the responsible world, for he regards it as dull, boring..." (Understanding the User, Virginia Lawyer, by Dr. Samenow, 1992)

Excerpts from Romancing Opiates: Pharmacological Lies and the Addiction Bureaucracy (2006), by Theodore Dalrymple, M.D., that address myths about beginning and ending the use of heroin, that address the relationship between crime and heroin use and that address problems with the current approaches to heroin treatment are:

Myth: *A person takes a little heroin and is hooked, he is rendered incapable of work, but since withdrawal is such a terrible experience, the addict is virtually forced into criminal activity to fund his habit.* It actually takes some considerable effort to addict oneself to opiates: the average heroin addict has been taking it for a year before he develops an addiction.

Thomas De Quincy in 1822 published a short book romanticizing the use of opiates (The Confessions of an English Opium Eater).

Withdrawal from opium is considered trivial medically, unlike withdrawal from alcohol that can be lethal.

Heroin addicts are confirmed habitual criminals before they ever take heroin.

Methadone can be more lethal than heroin, and there is usually no plan to get off of methadone. It is estimated that 40% of persons on methadone also take heroin.

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.