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

Environmental Context of the Plan/Current Status

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

In 2012, Lorain County's population of 301,478 represented a slight growth of 5% from that in year 2000. The economy remains a challenge. The unemployment rate in Lorain County in August 2013 was 7.4%, representing a slightly higher rate than the Ohio rate of 6.9%. As was noted in the last plan, these figures have declined from that of recent years, but unemployment and underemployment are still well above the ideal and remain particularly high in the Latino and African American communities.

Poverty rates in the County continue to be a concern. U.S. Census Bureau 2012 statistics showed poverty increased while household income and home values decreased since the start of the Great Recession in December of 2007. Poverty increased from 12.5 percent in 2008 to 14.4 percent in 2012. The city of Lorain's rate rose from 25.4 percent in 2008 to 27.8 percent. The national poverty rate was 15 percent in 2012. The County Medicaid enrollment as of April 2013 was 56,222, up 2,576 from the previous April. During that time 39.1% of county births were paid by Medicaid. The Projected New Medicaid Enrollment with Medicaid expansion for Lorain County is 13,887 persons.

A major continuous impact of the reduction in local government funds is the lack of adequate public transit services in the county. This hampers citizens' ability to get to behavioral health appointments and other services.

With the elevation of Medicaid to the state, the bulk of the Board's funding to provide mental health services in FY13 came from local levy funds (74%), with 22% coming from state funds and 4% from federal funds.

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)

Methodology:

LCBMH launched a strategic process in the fall of 2013 to develop a plan of action for the time period of January 2014 –June 2016. Board Chair Natalie A. Trachsel and Executive Director Charles Neff directed the strategic planning process. Jacqueline Romer-Sensky of The JRS Group, Ltd. served as a

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consultant/facilitator to the strategic planning process.

The process followed five major planning steps that included discussion at Board meetings and planning team sessions as well as focus groups and individual stakeholder interviews.

1. Exploring the context for LCBMH's planning effort
2. Soliciting input from Board members, service providers, consumers, county partners and LCBMH staff
3. Updating LCBMH's Mission and Vision Statements
4. Determining priorities; adopting goals, objectives and associated performance measures/objectives
5. Establishing a process for drafting and monitoring implementation work plans

As a part of the Board's strategic planning process, information was gathered from two focus groups with consumers, 1 with mental health providers and 1 with public partners. Additionally, the Board continued to utilize the feedback from the Health Survey referenced in the last community plan. A random sample of 1,738 Lorain County students, ranging in age from 12-18 and attending grades six, eight and ten and of 1,465 adults, 19 years or older were included in a Lorain County Health Assessment. The survey was initiated by the local hospitals and the health department, who allowed LCBMH to include multiple questions.

Since the last planning cycle the board has conducted several online surveys to assist in planning related to housing and interest in potential projects. Data is also gathered on the capacity of the system to provide routine services within 14 working days from a weekly waitlist report completed by Network providers and on suicide completions in the county in collaboration with the coroner's office.

Findings

Health Survey

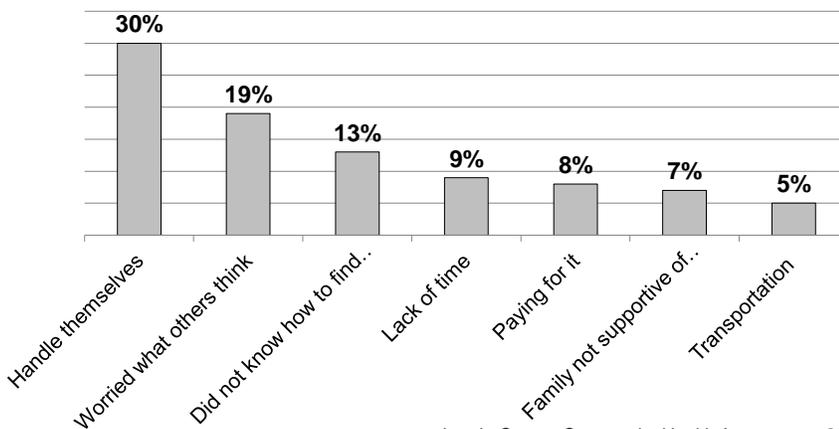
Students—Key findings from the student health assessment indicated that 22.6% of students reported an experience of significant depression that impacted functioning within the last year. 11.6% reported seriously considering suicide, 6.1% reported having made an attempt and 1.6% received medical attention as a result of this attempt. Additionally 5.3% of students reported engaging in self-harming behaviors. This survey, conducted in the late Fall of 2011, was the first local survey to investigate to whom students go when they are depressed. Results suggested that 44.6% of students report that they would not talk to anyone if they were feeling depressed or suicidal. Of those who would talk with someone if they were feeling depressed or suicidal, the greatest number (33%) report that they would speak with a friend or significant other. This suggests the need for peer education regarding depression. It also suggests the need for outreach and early identification of the large percentage of students who will be reluctant to initiate request for help.

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Another question that LCBMH had included in the survey that provided valuable results was one wherein youth were asked, “What would keep you from seeking help if you were dealing with anxiety, stress, depression or thoughts of suicide?” The greatest reasons for not seeking help are provided below in the graph. Three of the obstacles point to a need for better communication of information to the schools since, within Lorain County, there are seven child-serving agencies with sliding scale funds, and one that provides services in the community (eliminating the need for transportation). It appears that many of the students are not aware of the mental health resources available to them. Additionally, the issue related to stigma suggests that students must have options outside of the school as well as school based services.

Barriers to MH assistance - Youth

Reasons for not using MH Programs



Lorain County Community Health Assessment 2011

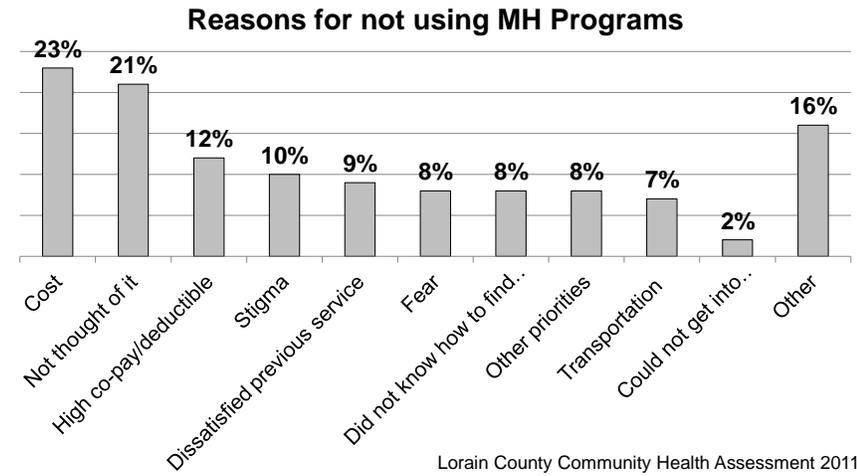
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Adults—Key findings of the assessment included that 4% of the adults responding to the survey considered attempting suicide, with the rate being higher for those under the age of 30 (10%). Less than 1% reported attempting suicide.

Respondents were more likely to report experiencing anxiety and depression. Thirty-six per cent (36%) of the respondents reported not getting enough sleep, 28% reported feeling worried, tense or anxious, and 13% felt sad, blue or depressed nearly every day to the point that they stopped doing usual activities for a period of two weeks or more recently. The reasons most often cited for not using services to assist them or a loved one with depression are included in the Graph below. Again, it is apparent that the board needs to increase efforts to inform the community that assistance is available for those without funds to pay for care. As was the case for students surveyed, it is apparent that many persons are unaware of the resources available, how to access them, and the option to seek other providers when dissatisfied with previous treatment.

Barriers to MH assistance - Adults



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Data collected on completed suicides--Despite a reduction in the number of suicides completed in the county during Calendar Year (CY) 2012, based upon an analysis of data from 1/1/13 to 10/16/13, there have been 45 completions thus far in CY 13, a dramatic increase. From 1998 to 2008, the largest number of completions based upon data gathered from the Coroner's office was 26, with the exception of 30 in 2007. For the past 4 years, there were 34, 28, 41 and 27 completions, respectively for Calendar Years 2009, 2010, 2011 and 2012.

Access issues: In Fiscal Year (FY) 13, 10,500 Lorain County residents received care or support funded by the Lorain County Board of Mental Health (LCBMH). Of those, 53 percent were male, and 47% were female. Adults served represented 66% of the population served; children and youth represented 34%. The major access issues in the system have been for pharmacological management services for adults, supported housing, bilingual counseling staff and IHBT staff. A major challenge to addressing access issues is related to workforce recruitment and retention.

- Intensive Home Based Treatment (IHBT)**—It remains difficult to ensure capacity of Intensive Home Based Treatment Services for youth. Given delays in access to service that were evident in FY2012 and FY2013, LCBMH implemented a plan to incentivize recruitment and retention of IHBT workers with the network of care. A \$2000 per year incentive was offered for each full time IHBT clinician who provided IHBT services for a full year in FY2014. Agencies were given discretion regarding how these funds would be dispersed to their staff. While the wait for IHBT services fell below two weeks shortly after this incentive program was introduced (July 2013), by the fall, the wait for IHBT services was again unacceptably high.

IHBT is utilized as a service to stabilize children in the community and those appropriate for referral can often not manage extended delays in access to treatment. The current wait for IHBT services (as of November 29, 2013) is 45 days. While children who receive crisis

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intervention services at the Nord's Emergency Stabilization Services Unit are linked with a CPST worker who provides support until IHBT services can become available, this is not optimal. Two of the three agencies that provide IHBT have indicated that the program caused the agency to lose funds in FY2014. The Board is considering a pilot project to incentivize outcomes associated with IHBT services, making the provision of this service more cost effective for agencies.

- **Bilingual counseling**—The LCBMH waitlist indicates that as of November 29, 2013, there are no bilingual counseling services available within two weeks for either adults or youth. Bilingual CPST services for adults are available at one agency. Another agency offers bilingual child psychiatry. However, for the most part, the agencies in the network have had to rely on interpretation services to accommodate Non-English speaking clients.
- **Pharmacological management services for adults**—As of November 29, 2013, there is a system-wide wait for routine pharmacological management services for adults, with the shortest wait being 18 days at one agency. For other agencies the wait ranges from 42 to 213 days.
- **Supportive housing**—Currently, there is no wait for supportive housing, but historically this has been an issue. This was also a need identified by multiple focus groups and by providers and consumers completing surveys.

Gap issues:

In addition to the above access issues, other gap issues identified in the assessments include the need to improve community awareness of behavior health services, including availability to receive services with an inability to pay for services. The primary gap issue identified by all focus groups was the lack of adequate public transportation. Another issue identified in the focus groups was insuring that services are available to persons in need within certain geographical areas within the county

Outpatient service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals) –As a result of the Hot Spot funding, a Forensic and Special Project Team was formed that focuses on providing intensive services and supports to frequent utilizers of crisis services and hospital services and/or the county jail that have a severe and persistent mental illness. The Board's Forensic and Special Project Coordinator works with the team in planning for the discharge of forensic patients in the hospital and as the Forensic Monitor, she also works with those on conditional release in the community. The team is able to provide outreach and has access to Wrap Around funds to provide additional support in the community. There are typically weekly calls between Board staff and Nord's Supervisor for the team to discuss the needs of patients at the hospital.

In addition to weekly meetings with hospital staff, the Coordinator meets with the Hospital and Ohio MHAS staff on a monthly basis to participate in planning for discharge of two residents that have been in the hospital for numerous years. As a result of the planning and collaboration with the DD board for one of these clients with multi-system needs that has been in the hospital for seven years during the most recent admission, there is planning for the client to go to a DD facility in FY14.

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A portion of the Hot Spot funding is also being used to address housing issues. As a result, in August 2013, a client who had been in and out of correctional facilities (including Ohio Department of Youth Services and jail), residential facilities, and hospitals was discharged to Hopewell Farms, in collaboration with the DD Board. The client is doing well and there is planning to step her down to another facility. It is anticipated that this resource may be utilized for another client during FY14.

One challenge to reducing the number of patients in the hospital is related to an increase in the number of persons being sent to the hospital for competency evaluations. As for forensic patients, one person was restored in the community after working with a clinician in Cleveland. Subsequently, LCBMH arranged competency restoration training for 1 mental health clinician and 2 Developmental Disabilities (DD) Board staff so that the option is available for appropriate clients charged with a nonviolent offense that are considered safe to be maintained in the community. The Forensic Monitor is working to inform local Judges of this option.

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).

1. 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).

The Board has prioritized the following issues to address within the next two years workforce issues, decreasing suicide, increased prevention and increasing public awareness of behavioral health issues and resources.

Workforce:

- Local levy funds have been used to provide IHBT incentives and psychiatry incentives. The incentive will be considered for Bilingual staff in FY15 if they have the desired impact on recruiting and retaining IHBT clinicians.
- The Board has sponsored trainings for Network staff, training and consultation for supervisors, and is piloting alternative funding models based upon progress towards desired outcomes. Recent trainings have included DSM 5, Applied Suicide Intervention Skills Training (ASIST), Ethics Responsibilities when Clients Threaten Suicide or Harm to Others, CyberEthics, Motivational Interviewing, Self Care for Clinicians and ongoing Trauma Treatment consultation. The Board is in the process of providing monthly telephone consultation opportunities for supervisors following their participating in 4 trainings by Dr. Paula Britton.
- El Centro, a Latino Social Service Agency, opened a new building a couple of years ago and has space available for services to be provided at the site. The agency is currently in discussion with

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two Network clinical agencies about providing services at the El Centro office.

Housing:

- A Capital grant application was submitted for supportive housing and the Hot Spot budget included planning for increasing the number of Adult Care Facilities.
- The Board has continued to set aside funds for temporary rental subsidy assistance for persons with SPMI.
- The Board funds a Housing Retention Specialist (HRS) to work with tenants of New Sunrise Properties who were at risk for losing housing related to the conditions of their apartment. The specialist makes an assessment of the skills of new tenants and provides them with a Welcome basket that consists of household cleaning supplies. Subsequently, none of the tenants have failed their housing inspections related to how the apartment was being maintained. The HRS routinely worked with 42 residents in the first quarter of FY14. An expansion of the services to include a peer specialist is being considered once the certification process is completed.

Increased public awareness of mental illnesses and resources available

- The Board will explore social media resources to increase awareness, particularly targeting adolescents and young adults.
- Mental Health First Aid Trainings will continue to be offered in the community.
- Online Screening Tools are available on the Board website.
- The Board is looking forward to participating in the next Health Survey and analyzing what impact past efforts to increase public awareness of mental illness and awareness have made.

Geographical

To increase the services available to those in certain geographical areas of the county, the Board will explore moving toward more on-site or satellite location options for services (in-home, at-school, etc). Additionally, Network providers are utilizing technology applications, such as telehealth.

Additionally, the Board plans to expand Engagement /outreach services to potentially high risk populations until they are actively involved in treatment.

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

We are willing to share our progress towards developing an alternative funding model based upon outcomes as this project further develops.

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

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

Transportation is a more extensive issue than can be addressed by the MH system, but impacts ability of clients to get to counseling sessions, and to employment and medical appointments.

We will need to develop collaborative relationships to pilot having satellite offices in southern parts of the county and determine if that positively impacts clients from those areas in accessing and benefiting from services.

The Board and the Suicide Prevention Coalition are committed to decreasing the incidents of suicide in the county. However, we are challenged to understand why there has been such a significant increase in the rates, particularly in CY13. We will continue to participate in opportunities offered by the Suicide Prevention Foundation, provide additional training for assessing and managing those at risk for suicide and work to reduce the access to frequent means of completing suicide.

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

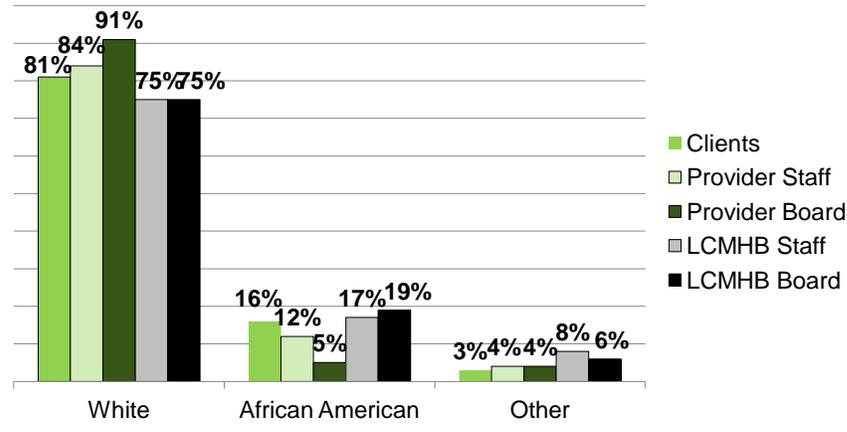
It would be helpful to have more recent data on suicide completions to determine if trends noted in the county are unique to the county or reflect an increase statewide. The most recent data we have been able to obtain was for 2011. Also, any assistance in strategies helping to decrease the number of completions would be appreciated.

Given the flat rates of Medicaid funding over the years, any experiences and lessons learned that other Boards have with performance based funding would be helpful. With the expansion of Medicaid and the implementation of the Affordable Care Act, we will continue discussions with our peers through OCABHA on shifting priorities, including a likely increase in support and prevention services and a reduction in the need for treatment services to be funded by the Board.

3. 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).

LCBMH recognizes the importance of respecting and promoting cultural competence and diversity within the mental health system. LCBMH tracks the diversity of its own Board members and staff and that of its service provider organizations in relation to the diversity of the clients the system serves.

Diversity Across System



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The Board’s vision is that all clients of the county have access to services when they need it and that the services take their culture into account in a way that helps all clients to benefit from treatment. One of the concerns for the system is the small percentage of Latinos represented on the Boards of Directors for Network Agencies. Only 5% of the Agency Board members are African American and 5% are Latino, with 7 of the 18 Latino Board members coming from one agency. In contrast, 13% of the staff in agencies are Latino.

In addition to being willing to explore options with El Centro to have Network agencies offer clinical services at the agency, the Board/agencies are continuing to:

- Implement best practice models
- Work with providers to standardize outcome measures so the benefit to clients can be determined, with the hope of eventually being able to compare effectiveness across cultural groups
- Sponsor cultural competency trainings
- Monitor client satisfaction results with respect for diversity and culture of client. With the Board’s annual client satisfaction survey conducted by independent callers, in FY13, 96% of the 611 clients randomly selected indicated satisfaction with the extent that their lifestyle, culture, values and ethnicity were included in their treatment.
- Participate in the county’s Anti-Hate Task Force
- Advocate for staff and Board member composition reflective of African American and Latino cultures and continuation of the Africancentric and Bilingual teams.

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.

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Priorities for Lorain County Board of Mental Health

**Substance Abuse & Mental Health Block Grant Priorities
*Priorities Consistent OHIO MAS Strategic Plan**

Priorities	Goals	Strategies	Measurement	Reason for not selecting
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 checked="" type="checkbox"/> Other (describe): Not in mission of Mental Health Board
SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): Not in mission of Mental Health Board
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)				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): Not in mission of Mental Health Board
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): Not in mission of Mental Health Board

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<p>MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)</p>	<p>Increase the number of Children with SED with demonstrated benefits from treatment</p>	<p>*Provide incentive to IHBT staff to address workforce issues *Pilot funding IHBT using alternative model based upon demonstrated outcomes Quarter (Q) 3-4 FY14</p>	<p>*# of IHBT staff retained in the system in FY14 *# of children receiving IHBT services with initial and termination outcome measures completed by parents that reflect improvement</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>MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)</p>	<p>Increase the number of Adults with SMI with demonstrated benefits from treatment</p>	<p>*continued funding of a Modified ACT team to work with adults with SMI *Funding housing supports that assist adults with SPMI in their recovery *Continue meetings with local hospitals to discuss planning for high utilizers of crisis and emergency services.</p>	<p>*# adults receiving services on team; # living in community without hospitalization or incarceration, and other measures reflecting improved functioning (cpst outcome measures)</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 align="center">Priorities</p>	<p align="center">Goals</p>	<p align="center">Strategies</p>	<p align="center">Measurement</p>	<p align="center">Reason for not selecting</p>
<p>MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*</p>	<p>Support the integration of primary care and mental health services</p>	<p>*Advocated for Medicaid expansion *Explore the possibility of having MH staff in medical facilities that have expressed interest *Continue funding and supporting health initiatives at Gathering Hope House (GHH) for adults *Explore opportunities with local FQHC</p>	<p>*Decision made about how Board can support the integration of Network agencies into medical facilities *# of GHH members losing weight, lowering blood sugars and blood pressure, exercising in FY 14</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>MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders</p>		<p>*Funding of consumer operated services *Increase number of ACF options *Contract for additional SE</p>	<p># of persons with MI participating in WMR, WRAP and other recovery program # of persons with SMI residing in ACF homes end of FY14</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>

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		services *Provide opportunities for certification of Peer Specialists	*# of additional persons working with SE competitively employed following increased funding *# of Certified Peer Specialists as a result of sponsored trainings	
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant *Priorities Consistent OHIOMAS Strategic Plan				
Treatment: Veterans				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Individuals with disabilities				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input checked="" type="checkbox"/> Other (describe): Not in mission of Mental Health Board
Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*	Assist persons with serious mental illness able to live independently with supports have stable and decent housing	*Provide consultation to shelter staff and outreach/assessment services to residents with mental illness not connected to treatment *Apply for continuation of PATH funds *Provide temporary housing rental housing subsidies *Consider enhancing housing retention specialist(HRS) services by adding certified peer specialist to provide these	*% of persons with serious mental illness assisted in finding permanent housing by the MH shelter staff person *# of persons receiving housing affiliated with PATH *# of persons with SMI receiving board funded housing rental subsidy assistance *# of persons maintaining independent housing that work with HRS	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

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		services		
Treatment: Underserved racial and ethnic minorities and LGBTQ populations	Increase the number of underserved populations benefiting from treatment provided in the Network	*Work with El Centro to enhance services to Latino clients *Continue funding Bilingual and Africancentric Teams at Nord *Provide staff development opportunities related to working with LGBTQ populations *Increase treatment options targeting persons living in the southern part of the county.	*% of Latino and African American persons receiving services; % showing improvement on outcome measures *# of clinicians trained to work with LGBTQ populations *#of residents from southern part of the county receiving services in FY 12-14, tracked by zip codes	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Treatment: Youth/young adults in transition/adolescents and young adults				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Treatment: Early childhood mental health (ages 0 through 6)*	Make accessible effective treatment to those 0-5 who experience difficulties related to mental health and/or trauma issues and their families	Continue to fund services with agency (OhioGuidestone) that has history of demonstrated effectiveness for this population	Matched comparison of pre and post outcome measures completed by parents	<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				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*	Enhance prevention, early awareness and intervention efforts	*Funding of mentoring services *Facilitate Mental Health First Aid (MHFA) trainings *Development of a Loss Team as a Postvention method	*# of youth successfully completing mentoring program *# of participants receiving MHFA training *# of Survivors indicating	<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

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		*Insure consultation and prevention programs remain available in schools	accessing services in Loss Team follow up contacts *# hr of consultation and prevention services provided in schools	
Prevention: Empower pregnant women and women of child-bearing age to engage in healthy life choices				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Promote wellness in Ohio's workforce				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*				<input type="checkbox"/> No assessed local need <input type="checkbox"/> Lack of funds <input type="checkbox"/> Workforce shortage <input type="checkbox"/> Other (describe):

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Ensure quality mental health services are available	Enhance the quality of mental health services	1a. Develop/test alternative clinical services funding model emphasizing positive outcomes. 1b. Develop/test a cross-agency quality assessment process.	<ul style="list-style-type: none"> Plans completed Models tested # trained Diversity of LCMHB and Provider Boards and Staff

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		1c. Support competent MH workforce including EBP/research-based, cultural competency and trauma-informed care knowledge.	
Maintain a trained, stable clinical workforce	Improve access to the continuum of care	2a. Enhance prevention, early awareness and intervention efforts. 2b. Pursue health integration within treatment services. 2c. Develop/Expand client supports. 2d. Decrease geographic barriers to service.	<ul style="list-style-type: none"> • # staff trained • # clients served via integrated health collaboration • # units housing available to SPMI • # SPMI homeless securing housing • Feasibility of foster care respite explored • # served in areas with geographic barriers • # technology clients
Fewer suicides completed by County residents	Decrease the incidence of suicide	3a. Provide supports to persons attempting suicide and connect them to services. 3b. Provide support following suicide for survivors (postvention). 3c. Strengthen support groups. 3d. Provide education and training for providers and partners.	<ul style="list-style-type: none"> • # completed/attempted suicides w connection to service provider • # non-connected who get connected to service provider • # use service after connect • # survivor referrals & access of services by Survivors • # support groups related to suicide and depression • # clinicians trained in assessing suicide risk and managing suicide
Increase public awareness and support for mental health	Maintain adequate financial and public support for the mental health system	4a. Pass the levy to maintain local resources. 4b. Advocate with State and Federal	<ul style="list-style-type: none"> • % levy vote support • # legislative contacts /

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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) Transportation	Because it impacts the ability to access behavioral health, medical, vocational and general social services in the county.
(2)	
(3)	
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
(12)	
(13)	
(14)	
(15)	

Collaboration

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

Integrated Services Partnership (ISP)--a collaboration formed between the Mental Health Board, the Developmental Disabilities Board, Children Services, the Alcohol and Drug Board and the Juvenile Court in Lorain County. All entities pool funds to support treatment recommendations made by the Children's Continuum of Care Committee (4C) regarding youth who have exhausted community based care within Lorain County. The ISP funds and authorizes decisions regarding out of home placements into residential or foster home settings. LCBMH serves as the fiscal agent for the ISP. The total annual FY14 budget is \$2,014,407. The following programs are a part of the ISP:

- **Children's Continuum of Care Committee (4C)**—As referenced above, a committee of representatives meets the 1st and 3rd Wednesdays of each month to make recommendations regarding placement of children in residential settings and to monitor the treatment. In FY13, eleven children were in residential programs and 4 were in therapeutic foster homes.
- **Family Stability Committee**—manages a pooled wraparound fund that agencies of the ISP systems mentioned above can request on behalf of children and families to make it possible for them to meet their goals. In FY13, the program helped 422 youth and 138 families.
- **Mentoring Program**—a program that employs mentors to work with children, typically ages 12 to 17 to expose them to legal recreational activities, increase use of appropriate social skills, and provide opportunities for children to have supervised times apart from their caregivers. In FY13, the program served 112 children and adolescents. Client satisfaction surveys completed as part of the board annual client satisfaction report that was revised to include a few outcome measures indicated a positive satisfaction response at or above 90% for 6 of the 7 questions. Additionally, 87% of the 30 clients surveyed reported an improvement in ability to function well some or most of the time.

Suicide Prevention Coalition—a coalition formed in 2009 to increase awareness and knowledge of risk factors associated with suicides and resources available in the community for those at risk. The coalition currently consists of Survivors, the coroner, health department nurses, school administrators, Hospice staff, the Veterans Administration Suicide Prevention coordinator, ADAS staff, contract Mental Health staff and LCBMH staff. The following has occurred in the past 2 years.

- The Associate Director has been working with the school superintendents to have high school staff trained to utilize *Kognito*. *Kognito* At-Risk for High School Educators is a 1-hour, online, interactive gatekeeper training program that prepares high school teachers and other school personnel to identify, approach, and refer students who are exhibiting signs of psychological distress such as depression, anxiety, substance abuse, and suicidal ideation. Thus far, six of the high schools have committed to full scale implementation.

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- The Lorain County Health District Nurses outreached to 28 pediatric practices where they typically visit for immunizations. They met with office managers who were in a position to share the resources with 182 doctors and nurses. Subsequently, there have been multiple requests to replenish the resources that were originally distributed by the health district.
- After meeting with two sites of the Cleveland clinic to provide one hour training on mental health resources, the hospital is implementing use of behavior health screening tools in Lorain County. Additionally, online behavioral health screening tools have been added to the Board's website.
- As a means of targeting middle aged white males, the Men get Depression DVD was shown and discussed with approximately 130 persons in the community, including staff from the local community college, student nurses at Gathering Hope House (GHH), GHH members, residents at the homeless shelter, and members of a local church. It was also shown as part of the Crisis Intervention Team (CIT) comprehensive training. The general feedback was that it was informative, but too long. A coalition member is in the process of securing access to a shorter video clip. The Suicide Prevention Speaker's Bureau remains available to make presentations to the community, but have not provided any presentations in FY14.
- Six individuals attended the National Loss Conference held in September and now we are in the process of developing a loss team. The Loss Team is an active model of postvention made up of a team of trained survivors and mental health professionals who provide support to Survivors and disseminate information about resources. The primary goal of the model is to let suicide survivors know that resources exist as soon as possible following the death since those who Survive a suicide are at increased risk of suicide themselves. Initially, we will begin having the team work with one police department and then expand to others as the initiative develops. We expect to work with the Suicide Prevention Foundation to provide training to additional members, as well as the Coroner and safety forces.
- Materials from The New Hampshire Firearm Safety Coalition have been modified to include information pertaining to Ohio and staff will be providing training to a gun shop owner and his staff. This initiative is neither strongly pro-gun nor strongly anti-gun, but is meant to reduce access to lethal means for those who are suicidal. Almost half of the suicides completed in the county in CY 13 have been completed with firearms.
- ASIST and RESPONSE Trainings: As a result of an increase in youth suicides in FY2012- FY2013 the Suicide Prevention Coalition determined that new and assertive approaches were necessary to counter the increased risk for youth suicide that is evident in Lorain County. In addition to efforts toward improved outreach and coordination with medical practitioners, it was determined that a different approach was warranted to ensure that suicide prevention programming was implemented within local schools. The coalition determined that efforts to engage schools in the Suicide Prevention Foundation sponsored *Kognito* Program would be continued, and outreach was conducted to groups including the superintendents, the high school principals, the high school guidance counselors and the middle school counselors. In

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addition to promoting *Kognito*, outreach efforts to these groups focused on promoting a Board-Sponsored training focused upon teaching educators and counselors how to implement both teacher in-service and student-focused suicide prevention programs. On November 13, 2013 staff from each of the fourteen school districts, as well as community mental health clinicians participated in training that would arm them with the information they needed to implement suicide prevention programming within their respective schools.

Ninety-five participants learned to provide the RESPONSE in service training, which is appropriate for teachers in middle and high schools. Half of these participants also learned the Red Flags Suicide Prevention Program, which can be implemented with middle school students over four classroom periods. The other half of the participants learned to implement the RESPONSE student program which can be implemented with high school students over four classroom periods. Evaluations of the training were very positive with approximately 60% of participants indicating that they planned to implement the programs that they had learned within three months.

The suicide prevention programs that were provided to the school and clinical staff during the November 13 training focused upon making sure that at risk youth are identified and connected to the necessary supports. To supplement this initiative, the Board is also sponsoring training opportunities for clinicians and counselors. The goal of this training (using the ASIST program) is to increase the comfort and skill level of those tasked with assessing the suicidal intent or plan of youth who are identified by peers or teachers who participate in the aforementioned programs.

- **Steele Screen**—Amherst Schools have continued to screen students in health classes for whom parents give permission. The Board funds counselors to be present to talk with youth who may be at risk and to help connect students to treatment resources. In October, when the first quarterly Screen was implemented, 58 students returned permission forms, 45 were screened, and eight youth were identified as having notable mental health problems. The school is considering expanding the screening to include juniors and seniors.

Criminal Justice— Several initiatives have continued in the past 2 years, including the following:

- A Juvenile Mental Health Court was established in April of 2010. From April 2010 to May 2013, the program has graduated 20 participants, with only a 2% recidivism rate post graduation. During that time, the program received 102 referrals, two of which were duplicate referrals. Of those persons referred, 58 youth were denied acceptance (26 were denied due to the parent/guardians unwillingness or inability to participate in the program, 20 were denied for "other" reasons such as the Prosecutor's Office denying their acceptance or for the youth needing other services within the Court, 12 were denied due to having a diagnosis that did not meet the program criteria), 16 were terminated for non-compliance, new charges, violations of the court orders, etc. after having been accepted into the program. There were 7 active participants at the time of the report, with 1 referral pending review. Sixteen youth were terminated for non-compliance, new charges, violations of court orders, etc. after they were previously accepted into the program.
- The County Jail has a special pod unit. Nord staff provides consultation, mental

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health assessments, and counseling services to persons with SMI while in the jail. The staff person also connects the person to services when released and at times, provides gap services. During FY12, services were provided to 347 persons (includes some duplication), with 89 receiving post release services, and 20 of those released returning to jail.

- Beech Brook provides consultation, informal training and risk assessment within the Detention Home three times per week.
- The Lorain County Board of Mental Health, on behalf of the Lorain County Reentry Coalition, received \$38,616 from the Second Chance Act Adult Offender Reentry Planning grant to strengthen the Coalition's infrastructure and develop a five-year strategic plan. Subsequently, Michelle Riske-Morris has been hired as the Coordinator for the Lorain County Reentry Coalition.
- CIT—Twenty-four (24) first responders participated in the April comprehensive training and 26 participated in the Advanced CIT training presented by Robert Denton, Ph.D. and Ross Santamaria, Ph.D. The participants included police officers, correction officers, park rangers, LifeCare ambulance drivers and state troopers. As of 11/1/13, 128 (30%) full-time sworn Ohio Law Enforcement Officers in the county have been trained in the county. Planning for the FY14 Comprehensive Training began in December 2013.
- For the past 2 years, the Board has shared information about mental health and resources during the Lorain County Ohio Peace Officers Academy "Crisis" training held at the Community College.

NE Regional Public-Private Behavioral Health BH Work Group—The Board participates in the work group and a LCBMH representative is a member of the **Peer Support** in Public and Private Sectors workgroup. In the interim, LCBMH is collaborating with the The Alcohol and Drug Addiction Services Board of Lorain County and the Mental Health & Recovery Board of Erie & Ottawa Counties to have the Ohio Citizens Advocates provide a peer support training to permit 20 individuals become certified in January 2014.

Children's Services and Trauma Initiatives—Since submission of the last plan, the vast majority of LCCS caseworkers and supervisors participated in the two day "Child Welfare Trauma Training," which was co-presented by Beech Brook and LCCS staff. In addition to the provision of the training, Beech Brook provided consultation services to assist caseworkers who were struggling to integrate a trauma informed perspective into case planning decisions. A trauma informed systems workgroup formed following this training effort (approximately one year ago). This group allows for representatives from juvenile court and the Children's Advocacy Center to be included in collaborative efforts with LCCS and LCBMH regarding trauma informed care. The workgroup is currently working with the LCCS Public Relations Consultant to determine messaging that could be most effective for educating the public about trauma in general as well as about trauma informed care in the within specific service delivery sectors (LCCS, Mental Health, Juvenile Court). This group also initiated a pilot project wherein LCCS can make direct referrals to specific trauma informed mental health services or service providers,

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based upon the specific needs of the families whom the caseworkers are serving.

There was continued development of a cross-agency peer supervision to support child serving clinicians who are implementing Trauma Focused Cognitive Behavioral Therapy. Additionally, Dr. Erna Olafson provides monthly telephone consultation services to clinicians within the Network. Twenty (20) clinicians are part of the TF-CBT learning collaborative and ten (10) adult serving clinicians are routinely part of the Adult Trauma learning collaborative. Two of the 6 currently certified TF-CBT clinicians in Ohio are part of the Lorain Learning Collaborative.

LCBMH and Nord Family Foundation have collaborated to sponsor **Mental Health First Aid (MHFA)** trainings in the community. A board staff member who is also the MHFA coordinator was trained in Arizona in March 2013 and then two other trainers participated in the OACBHA training offered this fall. Subsequently, training has been held at the local Job and Family Services office with their staff and one is in process with Gathering Hope House members. Evaluation feedback indicated participants thought the material was helpful and that they would recommend the class to someone else. However, the participants were less confident that they would assist a person who may be dealing with a mental health problem or crisis to seek professional help, but did indicate they would connect them with community, peer, and personal supports.

Housing/Homelessness

- The Board is contracting with Firelands to provide consultation to staff at the local shelters and at a day social service program where the residents of one of the shelters spend a majority of their time during the day. The Firelands staff person also works with the local PATH program. As a result, 37 residents at the designated agencies received mental health assessments, 45 residents were linked to behavioral health services, and 6 trainings were provided to staff.
- The board participates in Housing Task Force and Continuum of Care meetings, as well as the Uninsured Coalition. Currently, the latter is working on sponsoring an ACA event in collaboration with the Ohio Association of Foodbanks.

Girls with Sole--LCBMH received a grant from the Medical Mutual of Ohio Foundation to bring *Girls with Sole* to Lorain County Boys and Girls Clubs. *Girls with Sole* is an approach to building resiliency in girls through a combination of peer support, goal setting and physical fitness. Sessions were implemented with girls from the Boys and Girls Club at various schools in the county until September of 2013 and are currently being implemented with females from the Lorain County Urban League. Groups were led by either Liz Ferro, originator of the Program or two of the mental health clinicians that had learned to co-facilitate the groups early in the grant cycle. The Community Foundation agreed to cover the costs associated with the purchase of sports bras for the participants.

Some of the girls from the groups participated in the LULA 5K run (Lacing Up for a Lifetime of Achievement) on Sunday June 9th and at the Lorain County Voices of Recovery 5K and Family run in September 28, 2013. Seventy-two (72) girls have participated in the Program thus far.

Inpatient Hospital Management

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

Adults--Since 2005 The Board has had a contract with Mercy Hospital, the largest local inpatient facility in the county. An arrangement has been made to pay the hospital for admitting adult indigent patients authorized by the pre-screeners. The maximum amount to be authorized is 1,200 bed days. This collaboration has resulted in more consumers being admitted locally with closer proximity to families and significant others, reduced wait to get admitted to NBH, and reduced transportation costs.

Firelands works with homeless clients being discharged from local hospitals that are not already connected to outpatient services. Nord is currently piloting outreaching and connecting other clients not connected to outpatient services and prioritizing them for treatment. Data will be gathered to determine the effect of these services on clients subsequently following up for services and minimizing missed appointments.

Staffs from the Board, the two local hospitals, and Nord Emergency Services meet monthly to discuss issues pertaining to high utilizers of crisis/intensive services to develop a plan for treating them and addressing barriers. When relevant, DD and ADAS and MH providers are invited to attend the meetings.

As was previously indicated in Question 2 above, Nord and the Forensic Special Project Coordinator are actively involved in treatment planning with NBH staff. The major changes anticipated for current residents of NBH is the discharge of a client who has been in the hospital for an extensive period of time. To decrease admissions to the hospital an increase in outreach/engagement services to high risk populations is planned.

Children and Youth—The Board has continued since FY08 to fund a youth crisis liaison position, currently provided by Beech Brook. The responsibilities of this position include consultation with ESS staff for any youth client whom is assessed, outreach to parents of youth clients that are not hospitalized within 24 hours, and participation in discharge planning for youth who are assessed as in need of a hospitalization but are not connected with local mental health supports. The result of this collaboration has been a more seamless transition to post hospital care for Lorain County youth who are hospitalized. Additionally the Board has a contract with one private inpatient facility to pay for indigents patients for a maximum of 5 days.

Innovative Initiatives (Optional)

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

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

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

Advocacy (Optional)

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

Open Forum (Optional)

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

Determining resource levels for the 2014-16 planning period is difficult. During the planning process, the State approved expanded eligibility for Medicaid to 138% of the federal poverty level for adults. This means Medicaid may pay for some mental health services currently paid for with local resources. At the same time, it may mean that LCBMH will be called upon to provide support services to a larger number of Medicaid recipients in order to ensure treatment outcomes are achieved.

Finally, the roll out of the federal Affordable Care Act (ACA) is just underway. Its staged implementation will greatly impact this planning period. The financial implications are undetermined at this time. LCBMH will vigilantly monitor all Medicaid and ACA developments in order to meet new challenges and seize new opportunities. Amidst all this change, one trend remains clear. The overall reliance on local funding continues to grow.

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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

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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.