Ohio Department of Mental Health and Addiction Services (OhioMHAS)
Community Plan Instructions SFY 2017

Enter Board Name:

Mental Health & Recovery Board of Clark, Greene & Madison Counties

NOTE: OhioMHAS is particularly interested in update or status of the following areas: (1) Trauma informed care; (2) Prevention and/or decrease of opiate overdoses and/or deaths; and/or (3) Suicide prevention.

Environmental Context of the Plan/Current Status

1. Describe the economic, social, and demographic factors in the board area that will influence service delivery.

Demographics
The Mental Health & Recovery Board of Clark, Greene & Madison Counties (MHRB) spans from the outer reaches of Columbus in Franklin County to the outskirts of Dayton in Montgomery County. This entire area is connected by Interstate 70 making it a beltway for transportation that encourages industry as well as drug trafficking. The US Census reports a total population estimate for 2015 of the three counties as 344,480 (Clark 135,959, Greene 164,427, Madison 44,094).

Clark County
Clark County is located in south west central Ohio, between Dayton and Columbus. It is the 21st most populous county in Ohio. The county has a total area of 402.53 square miles, of which 397.47 square miles are land and the remaining 5.05 square miles are water. Clark County is predominately rural with less than one percent of the county’s four hundred square miles consisting of urban areas. The population is 85.1% White; 8.7% African-American; 2.5% Two or More Races; 0.6% Asian; and 0.4% Other. Clark has a growing aging population with 17.9% of its citizens over age 65 raising the need for health education and integration of physical and behavioral healthcare. On the employment front, Clark County reports that while there are manufacturing jobs available, local staffing agencies report 15% fail pre-employment drug testing.

Greene County
Greene County, located in south west central Ohio, beside of Montgomery County, is the 18th most populous county in Ohio. It has a total area of 413.73 square miles. The population is 86.6% White; 7.3% African-American; 2.7% Two or More Races; 3.1% Asian; and 0.3% Other. Greene County is home to portions of the Wright Patterson Airforce Base and more than a dozen colleges and universities including Wright State University. These features have brought more economic growth and development than our other two counties.

Madison County
Madison County, located next to Franklin County, is a community that prides itself in cultivating people, businesses and agriculture. With a central regional location and multiple state highways and interstates, Madison County houses some large employers that take advantage of the hard working labor force that was brought up by an agricultural heritage. The County contains approximately 296,320 land acres of which 91% is farmland and 5.65% Urban uses. Madison County population is a mixture between residential and rural with 33% of the population living in urban settings and 67% in rural areas. The population is 90.9% White; 6.2% African-American; 1.2% Two or More Races; 0.9% Asian; 0.4% Native American; and 0.4% Other.
Key Factors Impacting Demand for and Access to Services

A. Health Care Reform
Healthcare reform both at the national and state level has made the role of the MHRB even more critical in planning, funding and contracting for a local system of care.

**Medicaid Elevation:** With the advent of Medicaid elevation, the role of the Board shifted from being a primary purchaser of clinical services to: 1) filling gaps in needed services that Medicaid and insurance do not reimburse and insuring behavioral health treatment services are accessible to individuals that are under insured; 2) filling gaps at the ends of the continuum of care making prevention services and recovery support services more accessible; and 3) increasing our role as the convener and organizer of services across systems that require connection to behavioral health services. This shift has resulted in a modest increase in the MHRB’s investment in prevention, recovery support services, and other community-based collaborative initiatives. The MHRB has levies in all three counties that facilitate prevention, housing and other recovery support services, and assist in community-based collaborative initiatives that meet community-driven need.

**Medicaid Expansion:** Medicaid has resulted in greater coverage for citizens with substance use disorders. However, there is concern that because the opiate crisis is requiring more and more resources, there has been a shift in resource usage from mental health to substance use resulting in a dearth of access to mental health services when locally, we have seen a need for increased capacity for both mental health and substance use disorder treatment and supportive services (i.e. crisis, suicide, civil hospital beds for youth and adults and state hospital beds for adults).

**New Prevention Service Rules:** MHRB continues to review how prevention services are presented and delivered. With the new prevention service rule going into effect in April 2016, MHRB is working closely with contract prevention providers to ensure that all staff are appropriately credentialed, supervised and that all programming is evidence-based. Three years ago, the Board began its review of the wisdom of investing heavily in expensive evidence-based programs that influence a relatively small number of individuals. As a result, the MHRB has right-sized some of the region’s prevention programs and is focusing on developing Prevention Prepared Communities following the recommendations found in the Institute of Medicine’s 2009 report, Preventing Mental, Emotional and Behavioral Disorders Among Young People: Progress and Possibilities. MHRB now supports the PAX Good Behavior Game (GBG) in elementary schools in all three counties with on-going teacher training and fidelity coaching support using the PAX Partner model. MHRB also is beginning to invest in the Kernels for Life initiative which translate some of the evidence-based kernels used in GBG into a format suitable for distribution to a wide array of community organizations that serve children in various contexts. We are also planning an investment in the Question, Persuade, Refer (QPR) evidence-based suicide prevention program. This approach is a priority due to the MHRB’s commitment to improving access to prevention services (for substance use and mental health disorders; suicide prevention and postvention; community violence and abuse and neglect prevention) as well as supporting trauma-informed care initiatives across the continuum of care.

B. Drug Use Trends
One of the most striking factors that has influenced service delivery is the dramatic increase in both legal and illegal opiate use. The number of prescribed opiate dosages in the local three county region was 18 million in FY2011. Although this number is starting to decline, the number of accidental overdoses continues to increase as does the abuse of heroin and fentanyl. Fentanyl is an opiate that is 30 to 50 times more potent than heroin. According to law enforcement, Fentanyl was a significant contributor to a rise in drug overdose deaths in our area.
Overall, drug overdose deaths in Ohio increased from 2,110 in 2013 to 2,482 in 2014. Clark County had the 14th highest unintentional overdose death rate (22.4% or 38 individuals) in the state in 2014. Greene County’s rate of 17% placed it in the next highest category. Overdose deaths doubled from 2013 to 2014 in Greene County increasing from 21 to 40 individuals. Madison County’s rate was lower (14.3%, 7 individuals) but still higher than many counties in Ohio (ODH, 2015). As illustrated in the figure below from the Ohio Automated Prescription Reporting System, both Clark and Madison Counties are still seeing significantly higher than the state average per capita opioid doses dispensed of 14.17 in the first quarter of 2016.

C. Community Engagement

Another significant result of increasing demand for services and broad changes in service systems is increased community engagement across systems. Engagement has become a double-edged sword for our board area, bringing together new and different partnerships with people ready to implement solutions on one hand, while Boards are dealing with smaller than ever state and federal budgets and staffing to meet the demands and expectations of our new partners on the other hand. As in all times of rapid change, it is both energizing and exhausting. These dramatic changes in the behavioral health landscape are requiring the MHRB to take a different approach to address changing community problems including the use of local coalitions, an increased focus on broad-based prevention efforts, and partnering with other local agencies and organizations such as the recovery and faith communities. MHRB has been a major proponent in establishing multiple collaborative efforts to address the needs of people with substance use and mental health disorders in our community. These efforts have brought together the criminal justice system, local foundations, community residents, social service organizations and government agencies in an unprecedented number and variety of collaborations.
2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gaps in services and disparities, if any.

a. Methods & Findings

MHRB utilizes our relationships with community partners to collect data and conduct on-going need and resource assessment. The Board has engaged in five separate local planning processes in each county collaborating with a diverse array of agencies, organizations, funding bodies, and community advocacy groups to evaluate the needs, strengths and challenges of the behavioral health and connected service systems to form the basis for setting priorities for prevention, early intervention, treatment, and recovery support services.

In addition to the five primary sources of data and feedback described as follows with key findings, MHRB used data from the following sources to determine current behavioral healthcare needs: GOSH, MHRB DataMart, SEOW, Youth Risk Behavior Survey (Clark County), Dayton Area Drug Survey (Greene County), Madison County Family Council Needs Assessment, surveys of eighth and eleventh graders in all school districts in Madison County, information from interagency cluster meetings in all counties, and the MHRB Strategic Planning Process and Plan. Needs are gleaned by MHRB staff from the documents produced from the five planning processes described in the following sections.

The Board’s current strategic plan will be updated in SFY 17 to reflect changing system needs as a result of national and state healthcare reform and community conditions and readiness. The plan will continue to set goals that address communicating the value of the behavioral health system to the community, improving system effectiveness by monitoring outcomes, ensuring access to behavioral health services, and collecting the data necessary to determine the needed services to be purchased with non-Medicaid dollars. The strategic plan is updated every year at a Board Retreat to incorporate decisions involving ongoing conversations with partner agency personnel and stakeholders, including social service agencies, Family Councils, governmental entities, consumers, law enforcement, educational systems, etc.

Annual Partner Agency Need & Resource Assessment
In addition, the MHRB conducts need and resource assessments with partner agencies during the annual allocation process. These interviews include questions on trends, including demand and waiting time for services (access), payment issues; workforce challenges; capacity changes; programmatic changes; and other questions specific to the partner agency.

The table below provides a synthesis of the top needs identified in the state fiscal year 2017 Agency Applications along with the number of agencies identifying that need.

<table>
<thead>
<tr>
<th>Services</th>
<th></th>
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</thead>
<tbody>
<tr>
<td>Housing (including shelter, group homes, transitional)</td>
<td>6</td>
</tr>
<tr>
<td>Prevention interventions</td>
<td>2</td>
</tr>
<tr>
<td>Intensive community-based services for youth</td>
<td>2</td>
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<tr>
<td>Parent engagement</td>
<td>2</td>
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<tr>
<td>Transportation</td>
<td>2</td>
</tr>
<tr>
<td>Behavioral health literacy</td>
<td>1</td>
</tr>
<tr>
<td>Contingency Management</td>
<td>1</td>
</tr>
<tr>
<td>Crisis counseling</td>
<td>1</td>
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<tr>
<td>Early intervention</td>
<td>1</td>
</tr>
<tr>
<td>Legal representation</td>
<td>1</td>
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Community Coalitions
Each county has both an active coalition to address the harmful impact of alcohol and other drug use and a depression and suicide prevention coalition. The coalitions have been a rich source of information and have brought new stakeholders into the conversation about behavioral health needs in each county. Using these sources allowed the MHRB to gather and interpret both quantitative and qualitative data.

- Suicide Prevention Coalitions have reviewed relevant data and determined target populations (middle-age, white males) and have conducted surveys which showed a knowledge gap in information about the relationship between depression and suicide. As a result, these coalitions have engaged in a great deal of awareness and education as well as gatekeeper trainings for school and medical personnel. They have used focus groups to both gather data for program development as well as for pilot testing proposed interventions.
- All three Substance Abuse Coalitions have identified gaps in data collection, identified sources of data critical to reducing the impact of substance use, and utilized both the Strategic Prevention Framework and are completing their updated logic model work to select strategies and intervention that will best meet the needs identified in their community. As the coalitions have become more visible, other community initiatives have sought the help of the coalition to accomplish their goals. For instance, Clark County Fatherhood has linked with the coalition for data sharing and recruitment of coaches. Primarily, the coalitions have selected opiates, alcohol and marijuana as drugs to target with prevention intervention efforts.
- Additionally, an inter-county coalition meeting is being planned for this summer that will bring together all the substance coalitions in Greene and Montgomery counties to share data, priorities and plans to identify possible areas for partnership and gaps in services.
- Adults, children and adolescents who abuse or are addicted to alcohol or other drugs. Findings regarding substance abuse and dependence were remarkably similar across counties: significantly increasing numbers of residents are presenting for treatment that are dependent on opiates, including prescription drugs and street opiates, particularly heroin. The need for medication assisted treatment far outstrips the fiscal resources of the Board area creating a disparity between counties and regions limited by fiscal resources, local capacity, infrastructure and workforce recruitment. Additionally the shortage of physicians who are willing to work with this population creates a lack of availability of this service and although a physician is now practicing in Madison County, keeping up with demand continues to pose significant challenges. This need is so apparent and visible and the data is so alarming that private citizens in all three counties are in various stages of community coalition development to address the problem. Stakeholders indicate that the solution to this problem is much broader than the availability of treatment services. Our community partners are clear in stating that the opiate epidemic is moving deeper into our social structure and will require broad community and professional effort to address the problems.
• **Example of Coalition Data Identifying Early Substance Use & Low Perception of Harm as Needs**

Madison has higher than acceptable alcohol use and binge drinking rates by youth and young adults. The Madison County Middle School Youth Risk Behavior Survey conducted in 2014 demonstrated high rates of alcohol use. 19% of students in middle school reported having ever had at least one drink of alcohol and, 13.4% of students who drank alcohol for the first time before the age of 13 years. The Madison County High School Youth Risk Behavior Survey conducted in 2014 provides data that allows for state and national comparison. Although the percent of Madison County high school students that had at least one drink of alcohol on at least one day in the past 30 days was similar to the national rate of 34.9% at 31.9%, the percent of students who drank alcohol for the first time before the age of 13 years was 40.3% compared to only 18.6% nationally and 12.7% for Ohio. This is particularly concerning due to the correlation of early alcohol use with increased risk of addiction. Madison high school students had lower rates of binge drinking (five or more drinks of alcohol in a row within a couple of hours on at least one day during the past 30 days) than the national average of 20.80% at 17.8% but slightly higher than the Ohio rate of 16.1%. Of serious concern is that students reported not obtaining the alcohol they drank by someone giving it to them (15% compared to 37.9% statewide and 41.8% nationally) which may mean they are either buying it or having someone buy it for them. This provides an opportunity for continued assessment and to make a significant difference in community norms around selling alcohol to underage youth or buying alcohol for youth.

The Madison County Middle School Youth Risk Behavior Survey conducted in 2014 also demonstrated that 6.1% of middle school students reporting ever using marijuana, and 5.5% of these tried marijuana for the first time before age 13 years. More than one quarter (27.2%) of high school students had ever used marijuana compared to 35.7% statewide and 40.7% nationally. However, again Madison youth that are trying substances are trying them much younger than their state or national counterparts with 17.7% of high school students reporting trying marijuana for the first time before age 13 years compared to 5.8% statewide and 8.6% nationally. 14.3% of high school students reported using marijuana one or more times in the past 30 days compared to 20.7% statewide and 23.4% nationally.

41% of 11th graders in Madison County believed there was low to moderate harmfulness of taking other people’s prescriptions drugs. 29% of high school juniors have used other people’s prescription drugs, and 11% use them on a regular basis. Nationally, 1.2% of high schools seniors have used heroin compared to 4% of the juniors in Madison County. 23% of Madison County high school juniors believe that heroin is very easy or somewhat easy to obtain.

3) **Family & Children First Councils (FCFC)**

MHRB participates in all three County Family and Children First Councils assisting with their need assessment, planning and prioritizing process. Priority needs from each Council include the following.

- **When the state announced the Strong Families/Safe Communities initiative,** the FCFC directors from the three counties identified a critical need: Crisis Respite Care. In conjunction with a child-serving agency in one of the counties, the FCFC directors developed a proposal that was awarded funding. When grant dollars ended, the MHRB, lead child-serving agency, FCFC directors, and other partners, such as JFS, continue to fund this collaborative project.
- **Clark County FCFC,** through work with their Family Stability Group
- **Clark County FCFC,** through work with their Family Stability Group, identified the need for representation from the comprehensive alcohol and other drug treatment provider at Family Stability meetings with families. This representative has become a regular participant at Family Stability meetings and coordination of services has improved.
- **Both Greene and Madison County FCFCs have identified community prevention using a public health approach as a key need and have made plans to disseminate the new Kernels for Life across child-serving**
Children and families receiving services through a Family and Children First Council. The Family Councils in all three counties report that behavioral health services are consistently in the top five (5) identified community needs. Each county has a functioning interagency group whose focus is multiple-need children and families. While the desire to keep individuals in their homes and home communities is strong and preferred when possible, the demand for out-of-home placement seems relentless. Clark County has had success with a wrap-around approach and with intensive home-based treatment. These approaches will likely become financially impossible in the future. Both Greene and Madison County have well-functioning interagency groups that regularly review and assess the ongoing need of children, youth and families with multiple needs. All FCFCs actively participate with MHRB-sponsored suicide and substance use coalitions. As such, they are including collaborative effective prevention strategies under their shared plan goals and objectives, including Botvin Life Skills, PAX GBG, QPR, youth-led prevention, and Kernels for Life.

4) ROSC Assessment

Recovery-Oriented System of Care (ROSC) is a way of thinking about service delivery for those with mental illness and/or addiction disorders that focuses on clients and family members. A main goal of ROSC in Ohio is that mental illness and substance use disorders be viewed as the chronic illnesses they are, and can be successfully treated. The Recovery Oriented System of Care Stakeholder Assessment was conducted across Ohio to determine strengths and areas for improvement in the five ROSC principle areas listed below.

- Focusing on clients and families
- Ensuring timely access to care
- Promoting healthy, safe, and drug-free communities
- Prioritizing accountable and outcome-driven financing
- Locally managing systems of care

The survey was administered by the Mental Health & Recovery Board (MHRB) of Clark, Greene & Madison Counties February through April 2016 using both paper and online formats at various meetings and events across the three counties as well as through email, website, and social media. Groups that were asked to complete the stakeholder assessment included the following.

- Family Councils
- MHRB provider agencies/Community Recovery Centers
- Feedback Informed Treatment (FIT) participants
- NAMI Town Hall participants/Substance Abuse Town Hall participants
- Coalition members

Results will be used to set goals and priorities for service system planning. They are provided in Item 2.D.

5) County Health Improvement Plans

MHRB participates in the County Health Improvement Planning process in all three counties serving on various task forces, committees and workgroups on topics that intersect with behavioral health. The Health Departments from each county review a variety of administrative and epidemiological data sources in setting priorities and selecting activities from implementation. One example of MHRB-sponsored partnership with public health is increasing behavioral health literacy and connection to the local system through youth and adult Mental Health First Aid training.

- Adults with severe and persistent mental illness (SPMI) and children and youth with serious emotional disturbances (SED) living in the community. The most pressing need for consumers with severe and persistent mental illness is housing, preferably permanent supportive housing. The approach of “housing first” and the availability of permanent supportive housing have clearly demonstrated that these
individuals can live successfully in the community when these needs are met. The MHRB anticipates having additional information on the needs of consumers with severe and persistent mental illness as the impact of Medicaid reform becomes evident. As a result, MHRB is leading the development of two, 2-unit homes in collaboration with the city of Springfield, a YouthBuild program, an architect, and the mental health agency to create wrap-around services for at-risk adults with SPMI. The health improvement plans have identified crisis-related needs and supports for youth and adults with serious mental illness, especially those at risk for suicide. For youth, the MHRB promotes and supports evidence-based comprehensive school-based frameworks including trauma-informed care and Positive Behavioral Intervention and Supports in all three counties. In addition to a robust Crisis Intervention Team annual training, MHRB has expanded planning, monitoring, and training opportunities with many types of first responders (fire/EMS [i.e. paramedicine], police, emergency management, medical reserve corps) and providers through special housing projects, health improvement workgroups, and specific initiatives to identify and refer individuals to appropriate levels of care who are multi-system involved and at-risk for violence and suicide.

- **Persons with substance abuse and mental illness (SAMI).** The number of consumers with a substance use disorder and a diagnosis of schizophrenia, bipolar disorder and major depression remain consistent at about twenty percent (20%). When all mental health diagnoses are included, the number reaches close to 70%. Effective substance disorder treatment will sometimes decrease symptoms associated with mental illness but it is to be noted that the number of consumers with a substance use disorder and a mental health diagnosis are routinely higher than recognized. Access to medication assisted treatment is quite limited. Adequate and appropriate housing is in short supply for this population. Limits on community psychiatric support services may increase the level of need for these consumers. This population is frequently involved with the legal system. As such, MHRB is participating in several judicial- and jail-based and re-entry linkage initiatives across the region. Such programming has expanded this past year to include assessments, psychotropic and medication assisted treatment, dual-diagnosis and other effective treatments, case management, and peer/recovery support services.

b. Child service needs resulting from finalized dispute resolution with Family and Children First Council [340.03(A)(1)(c)].

Not Relevant

c. **State Regional Psychiatric Hospitals**

*Outpatient service needs of persons currently receiving treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)].*

State regional psychiatric hospital coordination of outpatient services continues to pose unique challenges. A result of the regional re-alignment of hospital catchment areas, providers and family members have difficulty participating in the treatment planning needs of patients admitted to Summit Behavioral Healthcare. Participation in treatment team meetings, transportation and coordinating care needs are costly and time consuming due to the distance from this board region. Often the recommendations of the hospital treatment team are not feasible upon discharge due to a disparity in available resources. An example would be recommending a type of supervised housing (ie group home) that either does not exist in the community of residence or is at capacity. Creative solutions are constantly explored to address the transition needs of those leaving the highly structured, supervised, secure state hospital settings to return to the community. One such solution has been creating board agreements with group homes, residential programs, supervised settings out of
the region to meet the step-down needs of those leaving SBH. While not ideal, it remains necessary to avoid less desirable plans which often include placement in the least supportive, supervised or secure settings (eg, motels, shelters).

Another situation that poses coordination of care concerns are patients who may be transient, homeless, under-resourced or dislocated from supports and in need of an intensive level of psychiatric care. This region, as noted in the Environmental Context, is located on or near several major interstates which is a common denominator for many community challenges. Efforts are made by local contract providers, MHRB and state hospital staff to coordinate outpatient service needs but for those who are not interested or unable to return to a home community situations can be very complex. Transportation alone can be cost prohibitive and for those who agree to a plan to relocate to a county in the board region in order to leave an institutional setting many times do so without intention of staying.

The forensic placements continue to be of concern for many reasons. It has become very difficult to access beds for the civil population due to the increasing demands of the forensically involved patients and limited supply. But, at time of discharge due to legal status, level of care needs (i.e., long-term care recommended for patients who will be on conditional release, undocumented aliens, with limited supports). For those in need of support for dually diagnosed with both developmental disorders and mental health services, as they are often not “restorable” nor respond to the type treatment provided in SBH. An example being a young adult male admitted as NGRI having committed a crime in another county, transition to a civil patient and has severe behaviors which have prohibited successful progression through the level system. He has no informal support, very limited ability to manage ADL’s in a more independent setting and doesn’t meet the criteria to receive services from the local DD system. The coordination of outpatient services on his behalf is very complicated. While state hospitalization is at times necessary it is not optimal. State funds to assist help with supportive services are finite and not available to sustain placements.

The proper support upon discharge either does not exist or is not available causing distress for the consumer, families, and providers. Efforts to address the barriers continue but gaps in outpatient service needs are complex and require creative partnerships across systems and accessible funding/resources. A "One size fits all" approach is not feasible due to the diverse and unique needs of those typically requiring the most intensive level of care.

d. **ROSC Assessment**

*Service and support needs determined by Board Recovery Oriented System of Care (ROSC) assessments.*

Although there were a large percentage of neutral or don’t know responses for many items, the survey instrument did highlight topic areas for celebration of community strengths and areas of obvious need for additional work. These are highlighted in the following summaries.

**Areas of Highest Need**

The areas of high disagreement that services in Clark, Greene and Madison Counties were provided in accordance with the principles of a Recovery Oriented System of Care seemed to be broad system issues of how and when services are accessed as well as community education and support of services throughout the continuum of care.

Following is a list of the areas survey respondents identified as needing the most improvement to come into alignment with ROSC principles.

1) Services provided in person’s natural environment (23)
2) **Early intervention** in childcare settings (17)
3) **Timely** access to services (16)
4) Integration of co-occurring behavioral and physical health (16)
5) **Interim services** for those awaiting treatment or not ready to commit to treatment (16)
6) Acknowledging and **celebrating** the achievements of people in recovery (16)
7) **Stigma reduction** strategy implementation (16)
8) **Community education** about mental illness and addiction (15)
9) **Ordinances** receptive to sober lifestyle communities (14)
10) Participants, alumni, and family members engaged in the **evaluation** of continuing care (14)

**Areas of Strength**
The areas of agreement or strong agreement that services in Clark, Greene and Madison Counties were provided in accordance with the principles of a Recovery Oriented System of Care seemed to be in the areas of service availability and community engagement. Following is a list of the areas that at least half of survey respondents identified as aligning with ROSC principles.

**Timely Access to Care**
- Treatment services are available (44)
- Prevention and wellness services are available (42)
- Partnerships and learning exchanges exist with first responders and others in the community (39)
- Age appropriate services are offered (39)
- Stage-appropriate services are offered (39)
- Prevention, Treatment and Support services are available (39)
- Provide low-intensity care for those who would not benefit from high-intensity treatment at that time (34)

**Focus on Clients & Families**
- Service providers do not use coercion (40)
- Progress towards goals (as defined by the person in recovery) is regularly monitored (39)
- Service providers are trained in recovery, resiliency and trauma (38)
- Staff uses recovery language (e.g., hope, high expectations, respect) in everyday conversations (37)
- Service providers listen to and follow choices and preferences of participants (36)
- Opportunities exist for people to share their stories (31)

**Promoting Healthy, Safe & Drug-Free Communities**
- Public/private partnerships exist (38)
- Recovery supports are available (38)
- Partnerships exist with peer support and recovery programs (38)
- Boards and service providers use people-first language (37)

**Locally Managed Systems of Care**
- Partnerships exist with organizations that provide other resources that may benefit the individuals and the families served (37)
- Service providers offer specific services and programs for individuals with different cultures, life experiences, interests and specific needs (36)
- Every effort is made to involve family members and other natural supports in the planning services (35)
- Workforce programs and supports are available to help individuals get back to work (34)
- Partnerships and learning exchanges exist with first responders (34)
- Connections with key community partners exist for at-risk individuals (32)
- Coordination exists to link people in recovery with other persons in recovery who can serve as role models (32)

**Prioritizing Accountable and Outcome-Driven Financing**
- Intake and engagement strategies use evidence-based practices (34)
- Stages of change models are used in treatment (34)
e. Needs and Gaps

Needs and gaps in facilities, services and supports given the Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03(A)(1)].

Identified “needs and gaps” per the CoC definitions in this Board region include Crisis Management, Recovery Housing, and Workforce/Peer Support. Workforce development, recruitment, training and retention is a common thread related to the needs and service gaps across the continuum of care from prevention through recovery. Demand for psychiatry continues to be a significant problem for Clark and Madison Counties while it seems in Greene County a partnership with a local teaching university has been a means to filling this gap to a degree.

Housing of all types is an identified need. While efforts to shore up the housing inventory are a priority, there remains a housing shortage for those in need of transitional and permanent supportive housing. Housing for women in AOD treatment is being reported as a high demand. This correlates with other sources of feedback to include the ROSC, Agency Allocation Request reports and stakeholder feedback from housing coalitions, re-entry coalitions and the sheer volume of calls received from folks seeking support.

Additionally, although resources are available for crisis response, they are not sufficient to meet the need. There is often a reactive approach to handling crisis rather than having the resources and planning in place to prevent crisis. MHRB receives numerous calls each week from families and individuals seeking a certain level of treatment care due to personal crisis and a lack of understanding of what help is available in the community and how to navigate those resources.

2A. Complete Table 1: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area. (Table 1 is an Excel spreadsheet accompanying this document)

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.

3. Strengths:
   a. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment?

   A primary strength of our local prevention system is that our communities are highly engaged in collaborative efforts and are highly motivated to increase access to prevention services. This is leading to many creative ways that evidence-based prevention is being imbedded into services that are already serving youth and families in natural environments such as home, school, daycare/after school, libraries, pools, churches, etc. Examples of this is having our own Early Childhood Mental Health Consultant; supporting PAX GBG in schools and in community settings such as PAX at the Pool through local organization such as Family and Children First Councils and Educational Service Centers, as well as capacity building efforts for other evidence-based practices that are underway and will start in next fiscal year such as: Youth-Led Prevention and Youth MOVE using the Youth Empowerment Framework; Kernels for Life; Question, Persuade, Refer (QPR); Alcohol literacy Challenge; Life Skills; Stacked Deck, Smart Bet and Risky Business problem gambling prevention programs. Our area is also working toward having seasoned prevention professionals trained as trainers in the Center for Applied Prevention Technology’s Substance Abuse Prevention Skills Training (SAPST) to increase our ability to keep up with the demand for prevention training for professionals already working with youth and families through other systems or on a volunteer basis.
The dramatic changes in the behavioral health landscape have led MHRB to make a greater commitment to involvement and support of local coalitions as a way to increase focus on broad-based prevention efforts in partnership with other agencies and organizations. MHRB supports both a depression and suicide prevention coalition and substance use prevention coalition in all three counties. These coalitions plan and implement various activities and programs through their member organizations and members.

In SFY 2016, eight agencies and two contractors provided prevention services representing a total investment of $579,193 in prevention from all funding sources. Six of the eight reported providing evidence-based practices and both contractors provided evidence-based services. The two other agencies have already received training in prevention and will begin use of evidence-based practices in SFY 2017. Evidence-based practices used include: Strengthening Families, PAX GBG, Georgetown Early Childhood Consulting Model, Strategic Prevention Framework, Prime for Life and Project Alert.

An additional strength of our board region is the strong collaborative relationships with community partners. One benefit is a collective effort to integrate Trauma Informed Care practices to improve treatment outcomes. The local system partners and the MHRB are influencing TIC practices across service sectors and the lifespan as demonstrated by a recent community discussion led by those representing the TIC Taskforce (ie FCFC, Mental Health, MHRB, Education, DJFS) that to date has had a youth focus. With a statewide emphasis on TIC, regional meetings to share lessons learned and partnering on regional training efforts, momentum across service sectors like: first responders, learning communities in the region for therapists, efforts to address needs of professionals exposed to secondary trauma, and a desire to create nurturing environments to enhance healing and reduce unintended traumatic experiences the time was right to convene interested parties. More than forty representatives from partner organizations met to explore opportunities to create a comprehensive community-wide approach to TIC. Creating a unified vision and a community strategic plan were just a couple of the concepts on the table for discussion. The group provided feedback that included the importance of having an over-arching vision for the community that would align efforts and resources.

Our three county board region has a robust constellation of services that provide a comprehensive and high level of care. Under the current landscape, agencies, partners and invested others are working to anticipate the impact of impending changes to the behavioral health system, Medicaid rate changes, Medicaid redesign and the mandated opiate legislation. Although the above are notable challenges, this board region is remaining engaged and flexible keeping in mind the client at the heart of these transitions. Due to the active coalition efforts, community engagement activities and intentional work to keep stakeholders informed the communities served by MHRB partners are engaged and supportive. Alignment and participation in the CHIP processes related to behavioral health needs the MHRB and partners are working to build capacity. An example previously noted would be an effort to increase awareness of suicide risk for school aged youth and empowering gatekeepers to link to appropriate professional services as warranted.

4. Challenges:
   a. Challenges & Impact
      The primary challenge to our prevention and early intervention system is lack of funding for prevention services. The demand for prevention keeps growing as communities become educated on viable solutions to the substance use problems occurring in their neighborhoods. The success of our coalitions and collaborative partnerships such as with the Health Districts in their Health Improvement Planning efforts is driving the demand for data-driven, prevention interventions that have visible results and promote the overall health and safety of communities. The better connected and educated our community organizations and citizens become, the more requests for prevention that we receive and help support as organizations apply for funding for prevention to a variety of local, state and national sources. Prevention for behavioral health
disorders is of equal importance to the prevention of physical disease, yet there is no insurance that provides for access to prevention interventions that are critically needed at key developmental life phases. Preventative medicine for the brain must become as widely available as preventative medicine for the body.

Another challenge to our prevention service system was the new Prevention Service Rule effective date and lack of prior notification of the effective date. Although MHRB reviews how prevention services are presented and delivered on a regular basis, having new rules go into effect at the end of a fiscal year made it very difficult to get the information out to all the providers, ensure they understand the impact of the new rules on their organization and staff and set aside the necessary funding and other resources to come into compliance with the new rules in a very short timeframe. MHRB has worked closely with our contract prevention providers to ensure that starting in SFY17 all staff will be appropriately credentialed, supervised and that all programming is evidence-based. We also had to provide additional resources through various methods because some budgets did not allow for unforeseen training expenses. In SFY16, 24 individuals were involved in providing preventions services across our three counties with five holding a prevention credential and nine holding a treatment or teaching credential with prevention in their scope of practice. At the effective date of the new prevention rule in April, ten of our 24 prevention providers had no valid credential to provide prevention services according to the new rules. By the end of August, all 10 of these will hold valid prevention credentials after intensive technical assistance, MHRB investment in prevention training, and assisting with the development of individual workforce development plans and credentialing applications.

Considering the changing landscape in behavioral health, a common challenge across both AOD and MH systems reportedly is workforce recruitment, development and retention. With rendering provider standards changing, Medicaid rate changes and the need increased investment in recruitment and training all have significant impact on a trained professional workforce. Psychiatry is in high demand but there is limited supply resulting in difficulty with recruitment. Agencies are struggling to sustain a trained workforce due to the influence of private providers and their ability to pay much higher wages and often a less crisis oriented work environment than found in the non-profit or public career options. One contract agency from this board region documented the loss of eight highly trained providers to a for-profit organization in one year. Another is finding it difficult to fill positions for primary care and psychiatry. In response to rendering provider changes, training up current staff has become imminent resulting in training time away from direct practice duties, additional training/travel expenditures. Staffing concerns are also reflected in the crisis oriented nature of current practice. Emergency service workers are needed for crisis assessment and coordination of care 24/7. In many cases, therapists providing crisis assessments are on call and maintain full caseloads during typical work days. The strain on the work force can be daunting and often results in high turnover amidst other challenges.

Another significant challenge which affects our ability to plan, monitor and evaluate effectively, is collaborating closely with healthcare providers. Within our region, there are 3 distinct hospital health care systems, two separate FQHCs within Clark County with one of these recently opening an office in Madison County. Finally, Greene County Public Health, with our support, is submitting a request to bring a satellite office of a third FQHC to Greene County from outside of our region. While access to primary care is a high priority for our MH/AOD population, the level of partnership with MHRB/provider agencies and healthcare varies widely across the continuum of care. The impact of Medicaid expansion, BH Redesign, and concomitant opiate epidemic/significant mental health needs of persons with health problems, has created a perfect storm. While there is greater awareness of the scope and severity of the MH/AOD problem among healthcare
providers, there are well intended but uncoordinated and often inexperienced responses (i.e. stigma, lack of competency in treating SPMI, comorbid MH/AOD, and severe AOD issues) across these healthcare systems. As a result, all of the healthcare providers are expanding into behavioral healthcare. Without close collaboration among providers and funders, services within these systems of care are likely to become more fragmented at the expense of vulnerable clients and families. Unfortunately, with one exception, all of these health systems are choosing to bring in new behavioral health providers (or recruiting from our system workforce) rather than partnering with existing, experienced established providers from our system of care.

5. Cultural Competencies

*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.*

A culturally competent system of care is seen as a dynamic component that moves through all expressions of the MHRB system of care. Examples of these expressions are evident in the MHRB strategic plan, in best practices utilized to accomplish the strategic plan, and through the annual agency allocation review process. The MHRB has adopted a strategic plan which explicitly names two approaches which aid in establishing a culturally competent system of care. The first evidence-based approach is Feedback Informed Treatment which involves routinely and formally soliciting feedback from clients to strengthen the therapeutic alliance and treatment outcomes. This client-centered approach values the client’s unique theory of change and creates a culture of feedback. The second framework described in the strategic plan is implementation of a Recovery Oriented System of Care (ROSC). Services and supports which are culturally responsive, incorporate personal belief systems, and involve people in recovery and their families are three essential elements of a ROSC which relate to cultural competence. Recruiting, supporting, and training diverse peer support specialists and establishing county-specific recovery support centers provide evidence of progress in this area.

Examples of other culturally competent best practice strategies include the Strategic Prevention Framework and PAX Good Behavior Game. The Strategic Prevention Framework has been applied to the substance abuse and prevention Coalitions supported by the Board in all three counties. This framework outlines a process that communities can use to prevent and reduce suicidality and the use and abuse of alcohol, tobacco, and drugs. At the heart of this framework is cultural competence and sustainability. All of the planning, implementation, and evaluation steps incorporate local conditions and risk/protective factors of populations which impact the identified problems. Another robust evidence-based practice supported by the MHRB promotes population-level health in children, PAX Good Behavior Game. This strategy is both culturally responsive and trauma-informed; PAX GBG is utilized by teachers with children to enhance their self-regulation, learning and reduce negative, disruptive behavior. Moreover, MHRB has been instrumental in calling together representatives from multiple sectors to develop a unified vision for trauma-informed care across the lifespan in Clark County. As individuals from minority backgrounds are exposed to disproportionately high levels of trauma, this strategy aims to improve continuity between providers (e.g., reduce re-traumatization, create common language) and increase access to culturally responsive, quality, and effective therapeutic services to residents experiencing traumatic events.

As the MHRB plans for service delivery, the agencies annually describe how they address cultural competency organizationally. For example, agencies have established Cultural Diversity Committees, workforce development training schedules, and policies reflective of racial, religious, gender, LGBTQ, and other special population diversity. The MHRB will continue to review population-level data to assess potential linguistic and cultural concerns for the
system of care identified by contract agencies, persons in recovery, and stakeholders. Input from key informants will be sought regarding behavioral health needs within minority communities across the MHRB three county area. In SFY2017, the MHRB will continue to develop a vision for cultural competency during the review and update of bylaws, policies and procedures, strategic planning, and revision of mission and vision statements. The MHRB will demonstrate efficient, effective, consistent and accountable processes in these areas during the Culture of Quality re-accreditation process in November 2017.

**Priorities**

6. **Considering the board’s understanding of local needs, the strengths and challenges of the local system, what has the board set as its priorities for service delivery including treatment and prevention and for populations?**

Priorities are driven by state mandate often taking precedence over local needs and shifting the focus and already limited resources from one population to another. The Continuum of Care priorities are one such example. There are a number of new services, such as Peer Mentoring, which are not yet clearly defined. For example, the certification process has recently changed for Certified Peer Recovery Supporters and the scope of Medicaid reimbursement for some peer support services is also unknown. Recovery support center services or “club house” services have yet to be operationalized and the MHRB may choose to fund certain peer services to identify and engage underserved populations beyond those affected by opiates. Another MHRB priority would be to develop ongoing coaching and training support models for peers and host agencies to minimize risk of relapse, build self-efficacy, and improve organizational culture (i.e. reduce stigma). While not a locally determined need, Ambulatory Detox services are now mandated without additional dollars. This will likely shift current dollars from an already comprehensive continuum from detox-to-medication assisted treatment, to create a newly billed service category. That is, this shift is not expected to expand access to services. Local providers express greater desire to expand in other areas, such as Recovery and Transitional housing for men and women (including children).

Overall, increasing the development of a continuum of MH and AOD housing opportunities and supports and MH and AOD crisis management across the lifespan are two Board priorities identified by residents, stakeholders and partner agencies alike. Finally, pursue strategies to collaborate with healthcare systems within the MHRB region to maximize efficient and effective use of resources and enhance quality of care for residents.
<table>
<thead>
<tr>
<th>Priorities</th>
<th>Goals</th>
<th>Strategies</th>
<th>Measurement</th>
<th>Reason for not selecting</th>
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</table>
| **SAPT-BG:** Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU) | To provide a continuum of care for persons who are intravenous/injections drug users (ISU) | -Medication Assisted Treatment (MAT) in all three counties across the board region.  
-Support the application of best practices for opioid treatment.  
-Continue to provide access through fiscal support and referral protocols for Nova Behavioral Health Detox when appropriate  
-identify gaps in the continuum of care and address as warranted | -monitor and evaluate MAT services provided by contract agencies | __ No assessed local need  
__ Lack of funds  
__ Workforce shortage  
__ Other (describe): |
| **SAPT-BG:** Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE: ORC 5119.17 required priority) | Continue to meet the priority through utilization of services of gender-specific treatment programs | Use Agency Allocation Request process to identify trends, gaps, and needs (i.e. family-friendly recovery housing, peer support)  
-Expand innovative Partnering for Healthy Pregnancies Program | Quarterly reporting by agencies | __ No assessed local need  
__ Lack of funds  
__ Workforce shortage  
__ Other (describe): |
| **SAPT-BG:** Mandatory (for boards): Parents with SUDs 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) | Continue to meet the priority through contractual arrangements with contract providers | Annual consultation with County Commissioners or their designees | __ No assessed local need  
__ Lack of funds  
__ Workforce shortage  
__ Other (describe): |
| **SAPT-BG:** Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS, HIV, | Identify behavioral health clients with tuberculosis and other communicable diseases | -Track and monitor the provision of services  
-address the identified needs, reduce | Quarterly reporting by agencies | __ No assessed local need  
__ Lack of funds  
__ Workforce shortage |
<table>
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<tr>
<th>Priorities</th>
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<th>Strategies</th>
<th>Measurement</th>
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<tbody>
<tr>
<td>MH/SUD Treatment in Criminal Justice system—in jails, prisons, courts, assisted outpatient treatment</td>
<td>Increase services linked to incarcerated population and improve linkage to community based services upon release.</td>
<td>-Continue to develop agreements and arrangements for services with local jails, prisons, courts, assisted outpatient treatment -Co-located providers to engage inmates into treatment</td>
<td>-# of partnerships between contract agencies and jails/prisons -# of co-located or linked service providers -Re-entry reports # of assessments and those engaged in treatment upon</td>
<td>-No assessed local need -Lack of funds -Workforce shortage -Other (describe):</td>
</tr>
<tr>
<td>Integration of behavioral health and primary care services</td>
<td>Increase partnerships between behavioral health and healthcare</td>
<td>Build a minimum of one integration project into each substance abuse coalition and suicide prevention coalition strategic plan</td>
<td># of partnerships</td>
<td># of collaborative projects</td>
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<tr>
<td>Recovery support services for individuals with mental or substance use disorders; (e.g. housing, employment, peer support, transportation)</td>
<td>Increase availability of recovery support services</td>
<td>Recovery coach training and positions</td>
<td># of persons attending training</td>
<td># of positions filled</td>
</tr>
<tr>
<td>Promote health equity and reduce disparities across populations (e.g. racial, ethnic &amp; linguistic minorities, LGBTQ)</td>
<td>Increase awareness and knowledge of health disparities among racial, ethnic, linguistic minorities, LGBTQ, disability, economic and others, within a ROSC</td>
<td>Promote EBP competency to address special populations</td>
<td># of persons attending training</td>
<td># of positions filled/retained</td>
</tr>
<tr>
<td>Prevention and/or decrease of opiate overdoses and/or deaths</td>
<td>Increase awareness of an availability of Narcan</td>
<td>Continue to support the awareness projects through each county coalition</td>
<td># of Narcan purchased</td>
<td># of Narcan used</td>
</tr>
<tr>
<td>Promote Trauma Informed Care approach</td>
<td>Prefer the adoption of evidence-based practices that are trauma-informed</td>
<td>Support expansion of PAX GBG in elementary schools</td>
<td># of teachers trained</td>
<td># of community members trained</td>
</tr>
<tr>
<td>Prevention Priorities</td>
<td>Goals</td>
<td>Strategies</td>
<td>Measurement</td>
<td>Reason for not selecting</td>
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| **Prevention:** Ensure prevention services are available across the lifespan with a focus on families with children/adolescents | -Utilize evidence-based prevention environmental approaches that work for universal populations | -Continue support of current effective, evidence-based practices  
-Explore new, sustainable funding sources for prevention services that would allow for expansion of prevention services beyond demonstration projects (for example: Clark Senior Services conducts a depression prevention program for seniors referred due to social isolation. They always have a waiting list, and funding is not available to implement in other counties.) | -Amount brought in by new funding sources for prevention such as: increased, sustainable state funding, new federal funds, and prevention services that are reimbursable as preventative medicine for high-risk indicated populations | __ No assessed local need  
X Lack of funds  
__ Workforce shortage  
__ Other (describe): |
| **Prevention:** Increase access to evidence-based prevention | -Integrate SPF into all coalition work  
-Introduce Kernels for Life (community PAX) into community settings  
-Transition any prevention program funded through MHRB into an EBP in SFY 2017  
-Increase access to prevention workforce development | -Continue the development of population specific Logic Models for each Coalition  
-Sustain and expand school-based and community wide initiatives:  
- Facilitate the development of a technical assistance model  
- Engage key stakeholders and community-level champions  
-Recruit prevention specialists to attend state-level training and provide funding for registration  
-Provide prevention training within the Board area including holding a SAPST TOT to increase regional prevention capacity | -Completion of logic models  
-# of Kernel trainings provided  
-# of community members trained in Kernels  
-% of MHRB prevention that is Evidence-based  
-# of individuals receiving prevention training support  
-# of prevention trainings provided  
-# of certified prevention specialists in MHRB area | __ No assessed local need  
__ Lack of funds  
__ Workforce shortage  
__ Other (describe): |
| **Prevention:** Suicide prevention | -Increase access to evidence-based practice services for suicide prevention, intervention and postvention | -Integrate SPF into all suicide prevention coalition work  
-Launch awareness campaign  
-Support the development of an additional LOSS Team for area  
-Provide training to non-clinical | -Completed logic models  
-Increased awareness of availability of community resources and supports  
-# LOSS Team members recruited and trained  
-# of individuals receiving prevention | __ No assessed local need  
__ Lack of funds  
__ Workforce shortage  
__ Other (describe): |
individuals that regularly come into contact with individuals at-risk of suicide
- Promote and utilize Media Guidelines with press and local journalism schools

- Integrated screening for problem gambling into regular assessment for mental health and substance use disorder
- Integrated problem gambling prevention into recovery supports

- Support providers to screen
- Support recovery community to promote the Be the 95% campaign in all events and at drop-in centers

- # of media guidelines provided
- # individuals screened
- # individuals reached with 95% campaign

<table>
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<tr>
<th>Prevention: Integrate Problem Gambling Prevention &amp; Screening Strategies in Community and Healthcare Organizations</th>
<th>Integrated screening for problem gambling into regular assessment for mental health and substance use disorder</th>
<th>Support providers to screen</th>
<th># of media guidelines provided</th>
<th># individuals screened</th>
<th># individuals reached with 95% campaign</th>
<th>__ No assessed local need</th>
<th>__ Lack of funds</th>
<th>__ Workforce shortage</th>
<th>__ Other (describe):</th>
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<th>Measurement</th>
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</table>

| 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.

<table>
<thead>
<tr>
<th>Priority if resources were available</th>
<th>Why this priority would be chosen</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. A dose of prevention for every citizen at every developmental stage</td>
<td>A public health approach to prevention is vital if we expect to see less individuals with diagnosable mental health and substance use disorders. Funding is needed to make effective prevention services available at key developmental milestones just as preventative medicine interventions are provided at key physical development milestones in physical healthcare. If prevention is not made a priority, disorder rates and accompanying community problems will continue to climb.</td>
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<tr>
<td><strong>(2)</strong> Availability of early intervention services for individuals that are beginning to have problems but do not yet meet diagnostic criteria</td>
<td>Early intervention is key to reducing the severity and course of both internalizing and externalizing disorders. It is also key to interrupting cycles of trauma.</td>
</tr>
<tr>
<td><strong>(3)</strong> Universal annual screening for anxiety/depression and substance use for youth people</td>
<td>Early identification allows for early intervention which can prevent many internalizing and externalizing disorders and can also reduce the lifetime impact of childhood trauma.</td>
</tr>
</tbody>
</table>
8. Describe the board’s accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years. (Note: Highlight collaborative undertakings that support a full continuum of care. Are there formal or informal arrangements regarding access to services, information sharing, and facilitating continuity of care at a systems level?)

The MHRB of Clark, Greene, and Madison Counties has established many collaborative relationships locally, regionally and statewide to the benefit of the region stakeholders. Leadership efforts to explore and apply Collective Impact approaches and other efficiency skills for convening partners. Just a few examples include:

- The Jonathan Alder School Project- a collective effort which includes partnering with the school district, the establishment of a unique Board partnership across counties (Union and Madison Counties), partnership with The Ohio State University, local business and faith based representation, parent, student and teacher input. This project was established following tragic events that made major impact on the entire community.
- Cedar Street Supportive Permanent Housing – a pilot project with collaborative partners which include MHRB, City of Springfield, OIC and Youth Build, OMHAS capital monies, Mental Health Services of Clark & Madison Counties.
- Trauma Informed Care- in collaboration with the local taskforce, efforts to influence a community wide strategic plan/approach for a trauma informed community are underway.
- Community Health Improvement Plan (CHIP)- participate on MH and AOD committees to influence infusion of the ACE study questions into two of three county adult surveillance studies, contributing to the development of goals related to both youth and adult mental health outcomes.
- Prevention Workforce Development- in response to the changes in prevention credentialing, there has been more resources dedicated to building on the collaborative relationships with local prevention providers to train the workforce. Local universities and educational service centers have been key in this effort.
- ROSC-community assessment was enhanced by the establishment of a relationship with another university partner, Wright State University. This has resulted increased training and awareness, informed efforts to increase recovery supports. Collaboration with local system.
- Town Hall forums, extensive treatment and prevention training related to Opiate Forums held across the region requiring partnerships with public, private partners.
- Crisis Intervention Training- MHRB sponsors and organizes the 40-hour training for law enforcement officers which requires collaboration with NAMI, consumers and providers of Behavioral Health services, numerous recruiters from local law enforcement agencies, and subject matter expert presenters. The 2015 class was the largest yet with forty officers trained.

Inpatient Hospital Management

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

MHRB is instrumental in utilization related to the local system of care, SBH, private hospitals and community supports. MHRB convenes local providers across the three counties and State Hospitals monthly for a UR conference call to review all admission, progress and discharge plans. All civil admissions require MHRB approval which has led to strong relationships with local providers, patients and families to evaluate options for care. In an effort to be good stewards of the resources the effort to meet the appropriate level of care needs is intentional and planful. MHRB staff is available 24/7 on call to assist with these efforts as needed, explore alternatives to the most restrictive level of care and as needed track trends to plan for resources as informed by local needs.

The forensic population continues to consume the limited state hospital bed stock prohibiting access for many who require a civil inpatient hospitalization. The inpatient bed inventory continues to be a barrier and for those presenting in crisis this may result in: a lengthy stay in the emergency room while providers try to locate inpatient beds, placement far from home and supports, and less than therapeutic length of stay.
### 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 is believed to 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.

**NOTE:** The Board may describe Hot Spot or Community Collaborative Resources (CCR) initiatives in this section, especially those that have been sustained.

### 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 is believed to be important for the local system to share with the department or other relevant Ohio communities.
Community Plan 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.

To request a waiver, please complete this form providing a brief explanation of services to be provided and a justification. 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.

<table>
<thead>
<tr>
<th>A. HOSPITAL</th>
<th>UPID #</th>
<th>ALLOCATION</th>
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</thead>
</table>

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.

<table>
<thead>
<tr>
<th>B.AGENCY</th>
<th>UPID #</th>
<th>SERVICE</th>
<th>ALLOCATION</th>
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</thead>
</table>
Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Alcohol and Drug Addiction Services (ADAS) Board and Community Mental Health Services (CMHS) Board is required by Ohio law to prepare and submit to the Ohio Mental Health and Addiction Services (OhioMHAS) department a community mental health and addiction services plan for its service area. The plan is prepared in accordance with guidelines established by OhioMHAS in consultation with Board representatives. A Community Plan approved in whole or in part by OhioMHAS is a necessary component in establishing Board eligibility to receive State and Federal funds, and is in effect until OhioMHAS approves a subsequent Community Plan.

The undersigned are duly authorized representatives of the ADAMHS/ADAS/CMHS Board.

ADAMHS, ADAS or CMH Board Name  (Please print or type)

ADAMHS, ADAS or CMH Board Executive Director  Date

ADAMHS, ADAS or CMH Board Chair  Date

[Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.).]
Attached are the SFY 17 Community Plan (ComPlan) Essential Services Inventory and some supporting files to enable the Inventory’s completion.

Various service inventories have been included in the ComPlan in the past. The current Essential Services Inventory included with the 2017 ComPlan requires a new element: the listing of services for which the board does not contract. This new element is necessary due to recent changes in the Ohio Revised Code to detail the behavioral health (BH) continuum of care in each board area. The department and constituent workgroups, in pilot studies, have found this information necessary for boards to meet the Ohio Revised Code CoC requirements.

Some additional CoC information resources have been provided (Section VI) to assist in this process, but board knowledge is vitally important given the limitations of these included CoC resources. For example, the attached resources will not address BH services provided by Children Service Boards and other key providers within the local behavioral healthcare system.

Instructions for the Essential Services Inventory

The 1st file is the Services Inventory. The goal is to provide a complete listing of all BH providers in the board area. To be able to proceed, please click on the “Enable Editing” and/or the “Enable Content” buttons, if they occur on top of the spreadsheet, and enter the name of the board in the 1st row.

The spreadsheet lists the ORC required Essential Service Categories in each row. Also in each row are cells to collect information about how each category requirement can be met. The information requested includes:

- Provider Name. Also included in some Provider Name cells are prompts for descriptions of services for which there are no FIS-040 or MACSIS definitions. The prompts request that descriptions of how the Board provides for these services be put in the last column, “Board Notes”. The prompts can be deleted to make room for a Provider Name.
- Mandatory individual service(s) that satisfy the ORC Essential Service Category
- Services related to the required category, but are needed to meet local BH needs, rather than the CoC mandate.
- “Yes” or “No” response indicating that the board contracts with the provider providing the service.
- Counties within the board where the provider provides the required “must be in the board area” service; or, out-of-board location when the required service is allowed to be provided outside the board area.
- Populations for which the service is intended to serve; or, for Prevention/Wellness services, the IOM Category.

Except for "Provider Name” and “Board Notes” cells, in which information is manually entered, all the other cells have a drop down menu from which services are chosen, and typed data entry cannot occur.

To use the drop down menu, click on a cell and a downward pointing arrow will appear. Click on the arrow and a drop-down list of services will appear. Click on a service and it will appear in the cell. Click on the service a 2nd time and it will erase the service entry in the cell; or highlight the unwanted service entry and click “Clear Content” from the right mouse button menu. Click on as many services as are needed for each provider cell in the row. Use the slide-bar on the right side of the drop down menu to see all available items in the list.

To add additional providers in a particular Essential Service row, highlight all cells in the row below the needed Essential Service, and click “Insert” from the right mouse button menu. All of the instructions and drop down menus for that Essential Service will be included in the “Inserted” rows.
Additional Sources of CoC Information

1. MACSIS Data Mart Client Counts by AOD and MH services for 2015.
   Explanation: If a required service or support is not found in a Board’s budget, there may be a number of possible explanations, e.g.:
   a. Variation in how Boards account for services and supports in the budgeting process. A check of the MACSIS Data Mart may reveal budgeted services or supports that haven’t been directly captured in the current budget.
   b. Required service or support is delivered by Providers serving Medicaid only clients. The Data Mart will show that the Medicaid paid service or support is being provided within the Board service area even though the Board has no contract with that Provider.

2. OhioMHAS 2015 Housing Survey.
   Explanation: Certain required housing categories may not be budgeted, e.g., Recovery Housing, or there may be lack of clarity between required housing categories and 040 reporting categories or specified in the Community Plan. The OhioMHAS Housing Survey brings greater clarity to classifications of housing services and environments and better track provision of those Continuum of Care (CoC) elements in Board service areas.

3. SAMHSA 2014 National Survey of Substance Abuse treatment Services (N-SSATS), and the

4. SAMHSA 2014 National Mental Health Services Survey (N-MHSS).
   Explanation: SAMHSA annually surveys AOD and MH Providers irrespective of their OhioMHAS certification status. The surveys provide a broad spectrum of information, including the existence of some AOD or MH services or supports within a Board’s service district that are required essential CoC elements, which are not found within the public behavioral health service taxonomy, or are not captured within the Board’s budget. These surveys should be reviewed for existing required CoC elements delivered by Providers that are OhioMHAS certified (in network) and those Providers that are not (out of network).

Service Crosswalks between ORC Required Essential Service Category Elements and the Additional Information Sources

<table>
<thead>
<tr>
<th>Essential Service Category Elements</th>
<th>2015 OhioMHAS Housing Survey</th>
<th>2014 National Survey of Substance Abuse Treatment Services (N-SSATS)</th>
<th>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-Ambulatory Detox ‡</td>
<td>OP Detox ASAM Level I.D &amp; II.D</td>
<td>Residential Detox ASAM Level III.2-D</td>
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</tr>
<tr>
<td>A-Sub-Acute Detox ‡</td>
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<td></td>
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<tr>
<td>A-Acute Hospital Detox</td>
<td>Inpatient Detox</td>
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<tr>
<td>Intensive Outpatient Services:</td>
<td></td>
<td>Intensive OP ASAM Level II.1 (9+ HRS/WK)</td>
<td>• Assertive Community Treatment (ACT)</td>
</tr>
<tr>
<td>• A-IOP ‡</td>
<td></td>
<td></td>
<td>• Primary Physical Healthcare</td>
</tr>
<tr>
<td>• M-Assertive Community Treatment</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• M-Health Homes</td>
<td></td>
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</table>

<table>
<thead>
<tr>
<th>Essential Service Category Elements</th>
<th>2015 OhioMHAS Housing Survey</th>
<th>2014 National Survey of Substance Abuse Treatment Services (N-SSATS)</th>
<th>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</th>
</tr>
</thead>
<tbody>
<tr>
<td>A-Medically Assisted Treatment ‡</td>
<td></td>
<td>• Naltrexone</td>
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<tr>
<td></td>
<td></td>
<td>• Vivitrol</td>
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<td>• Methadone</td>
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<td></td>
<td></td>
<td>• Suboxone</td>
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<tr>
<td>12 Step Approaches ‡</td>
<td></td>
<td>• Buprenorphine (No Naltrexone)</td>
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<tr>
<td>Residential Treatment:</td>
<td></td>
<td>12 step facilitation</td>
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<tr>
<td>A-MCR-Hospital</td>
<td></td>
<td>Hospital IP Treatment ASAM IV &amp; III.7</td>
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<tr>
<td>A-BHMCR-Hospital</td>
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<tr>
<td>Residential Treatment ‡:</td>
<td>Residential Treatment</td>
<td>Residential Short-Term ASAM</td>
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</tr>
<tr>
<td>Essential Service Category Elements (‡ = ORC 340.033 Required)</td>
<td>2015 OhioMHAS Housing Survey</td>
<td>2014 National Survey of Substance Abuse Treatment Services (N-SSATs)</td>
<td>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</td>
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<tr>
<td>---------------------------------------------------------------</td>
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<tr>
<td>Residential Treatment †: A-NMR-Non-Acute A-BH-Non-Medical-Non-Acute</td>
<td>Residential Treatment Medical Community Residence</td>
<td>Residential Long-Term ASAM Level III.3 (Low Intensity)</td>
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<tr>
<td>Recovery Housing ‡</td>
<td>Recovery Housing</td>
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<tr>
<td>M-Residential Treatment</td>
<td>Residential Treatment-MH</td>
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<td>24 Hour Residential (Non-Hospital)</td>
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<tr>
<td>Locate &amp; Inform:</td>
<td>• M-Information and Referral</td>
<td></td>
<td>MH Referral, including emergency services</td>
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<tr>
<td>M-Partial Hospitalization</td>
<td></td>
<td></td>
<td>Setting: Day Treatment/Partial Hospitalization</td>
</tr>
<tr>
<td>M-Inpatient Psychiatric Services (Private Hospital Only)</td>
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<td></td>
<td>Inpatient Services</td>
</tr>
<tr>
<td>Recovery Supports:</td>
<td>• M-Self-Help/Peer Support</td>
<td></td>
<td>MH Consumer Operated (Peer Support)</td>
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<tr>
<td>• M-Consumer Operated Service</td>
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<tr>
<td>Recovery Supports:</td>
<td>• M-Employment/Vocational Services</td>
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<td>Supported Employment Services</td>
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<tr>
<td>• M-Social Recreational Services</td>
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<td></td>
<td>MH Vocational Rehabilitation Services</td>
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<tr>
<td>Essential Service Category Elements (‡ = ORC 340.033 Required)</td>
<td>2015 OhioMHAS Housing Survey</td>
<td>2014 National Survey of Substance Abuse Treatment Services (N-SSATs)</td>
<td>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</td>
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<tr>
<td>Recovery Supports:</td>
<td>• M-Social Recreational Services</td>
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<td>Activities Therapy</td>
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<tr>
<td>M-Crisis Intervention</td>
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<td>MH Psychiatric Emergency (walk-in)</td>
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<tr>
<td>Wide Range of Housing Provision &amp; Supports:</td>
<td>• M-Residential Care</td>
<td></td>
<td>MH Supported Housing Services</td>
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<tr>
<td>• M-Residential Care</td>
<td>Residential Care:</td>
<td>• Adult Care Facility/Group Home</td>
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<tr>
<td></td>
<td>• Residential Care Facility (Health)</td>
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<tr>
<td></td>
<td>• Child Residential Care/Group Home</td>
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<tr>
<td>Essential Service Category Elements (‡ = ORC 340.033 Required)</td>
<td>2015 OhioMHAS Housing Survey</td>
<td>2014 National Survey of Substance Abuse Treatment Services (N-SSATs)</td>
<td>2014 Nation Survey of Mental Health Services Survey (N-NHSS)</td>
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<tr>
<td>Wide Range of Housing Provision &amp; Supports:</td>
<td>• M-Community Residential</td>
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<td>MH Housing Services</td>
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<tr>
<td>• M-Housing Subsidy</td>
<td>Permanent Housing:</td>
<td>• Permanent Supportive Housing</td>
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<td></td>
<td>• Community Residence</td>
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<td></td>
<td>• Private Apartments</td>
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<tr>
<td>Wide Range of Housing Provision &amp; Supports:</td>
<td>• M-Crisis Bed</td>
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<tr>
<td>• M-Respite Bed</td>
<td>Time Limited/ Temporary:</td>
<td>• Crisis</td>
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<tr>
<td>• Temporary Housing</td>
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<td>• Respite</td>
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<td>• Transitional</td>
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<td>Transitional</td>
<td>Time Limited/ Temporary:</td>
<td>Therapeutic Foster Care</td>
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<tr>
<td>Wide Range of Housing Provision &amp; Supports:</td>
<td>• Foster</td>
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<td>• M-Foster Care</td>
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<tr>
<td>Wide Range of Housing Provision &amp; Supports:</td>
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<td>See Residential Treatment, above</td>
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<tr>
<td>• AOD</td>
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