Additional ODMH Requirements
(Formerly Community Plan – Part B)

Board Membership Catalog for ADAMHS/ADAS/CMHS Boards

Board Name
Community Mental Health & Recovery Board, Serving Licking and Knox Counties

Date Prepared
06/09/11

Board Member
Jesse Marlow

Mailing Address (street, city, state, zip)
First Knox Bank
One South Main Street
P.O. Box 1270
Mount Vernon, OH 43050

Telephone (include area code)
740/399-5319

County of Residence
Knox

Occupation
Finance

Term
Second Term

Year Term Expires
2013

Appointment: Commissioner
Sex: Male
Ethnic Group: White

Officer: Immediate Past President
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name
Community Mental Health & Recovery Board, Serving Licking and Knox Counties

Date Prepared
06/09/11

Board Member
Cara Delcher

Mailing Address (street, city, state, zip)
726 Westwood Drive
Newark, OH 43055

Telephone (include area code)
740/348-0042

County of Residence
Licking

Occupation
Insurance

Term
Second Term

Year Term Expires
2012

Appointment: ODMH
Sex: Female
Ethnic Group: White

Officer: Secretary
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☒ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name
Community Mental Health & Recovery Board, Serving Licking and Knox Counties

Date Prepared
06/09/11

Board Member
Dr. John Adams

Mailing Address (street, city, state, zip)
139 Victoria Drive
Granville, OH 43023

Telephone (include area code)
740/522-2994

County of Residence
Licking

Occupation
Physician

Term
Second Term

Year Term Expires
2013

Appointment: ODMH
Sex: Male
Ethnic Group: White

Officer
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☒ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name	Date Prepared
Community Mental Health & Recovery Board, Serving Licking and Knox Counties	06/09/11

Board Member
Randy Anderson

Mailing Address (street, city, state, zip)
113 Linnridge Drive
Newark, OH 43055

Telephone (include area code): 740/323-1532
County of Residence: Licking

Occupation: Insurance

Term: Second Term
Year Term Expires: 2014

Appointment: Commissioner
Sex: Male
Ethnic Group: White

Officer: Chairperson
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name	Date Prepared
Community Mental Health & Recovery Board, Serving Licking and Knox Counties	06/09/11

Board Member
Tim Durham

Mailing Address (street, city, state, zip)
44 Shady Lane
Granville, OH 43023

Telephone (include area code): 740/587-7247
County of Residence: Licking

Occupation: Mental Health & AoD Counseling

Term: Second Term
Year Term Expires: 2012

Appointment: ODADAS
Sex: Male
Ethnic Group: White

Officer: Public Information Committee Chair
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☒ Professional
- ☐ Advocate

Board Name	Date Prepared
Community Mental Health & Recovery Board, Serving Licking and Knox Counties	06/09/11

Board Member
Dr. Elizabeth Gray

Mailing Address (street, city, street, zip)
111 Briarwood Drive
Granville, OH 43023

Telephone (include area code): 740/587-3279
County of Residence: Licking

Occupation: Retired Educator

Term: First Term
Year Term Expires: 2012

Appointment: Commissioner
Sex: Female
Ethnic Group: White

Officer: Program Committee Chair
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☒ Family Member
- ☐ Professional
- ☐ Advocate

Board Name	Date Prepared
Community Mental Health & Recovery Board, Serving Licking and Knox Counties	06/09/11

Board Member
Mark Gooden

Mailing Address (street, city, state, zip)
951 Fortkort Drive
Reynoldsburg, OH 43068

Telephone (include area code): 614/577-0012
County of Residence: Licking

Occupation: Insurance

Term: First Term
Year Term Expires: 2013

Appointment: Commissioner
Sex: Male
Ethnic Group: African American

Officer: Finance Chair
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name	Date Prepared
Community Mental Health & Recovery Board, Serving Licking and Knox Counties	06/09/11

Board Member
Leonard Hubert

Mailing Address (street, city, state, zip)
3808 Columbus Road
Granville, OH 43023

Telephone (include area code): 740/587-0531
County of Residence: Licking

Occupation: Consultant

Term: First Term
Year Term Expires: 2012

Appointment: Commissioner
Sex: Male
Ethnic Group: African American

Officer: Vice Chairperson
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name	Date Prepared
Community Mental Health & Recovery Board, Serving Licking and Knox Counties	06/09/11

Board Member
Dr. Randie Timpe

Mailing Address (street, city, state, zip)
29 Kester Drive
Mt. Vernon, OH 43050

Telephone (include area code): 740/392-9126
County of Residence: Knox

Occupation: Psychologist

Term: First Term
Year Term Expires: 2014

Appointment: Commissioner
Sex: Male
Ethnic Group: White

Officer: Public Information Committee Chair
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name **Community Mental Health & Recovery Board, Serving Licking and Knox Counties**	Date Prepared 06/09/11

Board Member
Julie McNulty

Mailing Address (street, city, state, zip)
1599 Independence Drive
Newark, OH 43055

Telephone (include area code)
740/366-3907

County of Residence
Licking

Occupation
Nurse

Term
Second Term

Year Term Expires
2013

Appointment: Commissioners
Sex: Female
Ethnic Group: White
Officer
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name **Community Mental Health & Recovery Board, Serving Licking and Knox Counties**	Date Prepared 08/26/11

Board Member
Dr. Robert Cullen

Mailing Address (street, city, state, zip)
1248 Brittany Hills East
Newark, OH 43055

Telephone (include area code)
740/344-9107

County of Residence
Licking

Occupation
Retired

Term
First Term

Year Term Expires
2012

Appointment: Commissioners
Sex: Male
Ethnic Group: White
Officer
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name **Community Mental Health & Recovery Board, Serving Licking and Knox Counties**	Date Prepared 08/26/11

Board Member
Anne Storan

Mailing Address (street, city, state, zip)
11517 Kenyon Road
Mt. Vernon, OH 43050

Telephone (include area code)
740/507-7504

County of Residence
Knox

Occupation
Business Owner

Term
First Term

Year Term Expires
2015

Appointment: ODMH
Sex: Female
Ethnic Group: White
Officer
Hispanic or Latino (of any race)

Representation: select all that apply:

Mental Health
- ☐ Consumer
- ☐ Family Member
- ☐ MH Professional
- ☐ Psychiatrist
- ☐ Other Physician

Alcohol Other Drug Addiction
- ☐ Consumer
- ☐ Family Member
- ☐ Professional
- ☐ Advocate

Board Name **Community Mental Health & Recovery Board, Serving Licking and Knox Counties**	Date Prepared 08/26/11

Board Member Bruce D. White		Appointment Commissioners	Sex Male	Ethnic Group White
Mailing Address (street, city, state, zip) 1008 Newark Road Mt. Vernon, OH 43050		Officer ____	Hispanic or Latino (of any race)	
Telephone (include area code) 740/397-0190	County of Residence Knox	Representation: select all that apply:		
Occupation CEO		Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician	Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate	
Term First Term	Year Term Expires 2015			

Board Name **Community Mental Health & Recovery Board, Serving Licking and Knox Counties**	Date Prepared

Board Member		Appointment	Sex	Ethnic Group
Mailing Address (street, city, state, zip)		Officer ____	Hispanic or Latino (of any race)	
Telephone (include area code)	County of Residence	Representation: select all that apply:		
Occupation		Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician	Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate	
Term	Year Term Expires			

Board Name **Community Mental Health & Recovery Board, Serving Licking and Knox Counties**	Date Prepared

Board Member		Appointment	Sex	Ethnic Group
Mailing Address (street, city, state, zip)		Officer ____	Hispanic or Latino (of any race)	
Telephone (include area code)	County of Residence	Representation: select all that apply:		
Occupation		Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician	Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate	
Term	Year Term Expires			

CMHRB Forensic Monitor and Community Linkage Contacts

a. Please provide the name, address, phone number, and email of the CMHRB's Forensic Monitor:

Name	Street Address	City	Zip	Phone Number	Email
Kay Spergel	1435 West Main Street	Newark	43055	(740) 522-1234	kspergel@bhg.org

b. Please provide the name, address, phone number, and email of the CMHRB's Community Linkage Contact:

Name	Street Address	City	Zip	Phone Number	Email
Kay Spergel	1435 West Main Street	Newark	43055	(740) 522-1234	kspergel@bhg.org

INSERT ADDITIONAL CMHRB APPENDICES AS NEEDED

Attachment A: Criteria for Prioritization of Care Tier Placement

Attachment B: CMHRB Prioritized System of Care by Tier

Attachment C: Summary of Needs Assessments in Licking and Knox Counties: 2006 through 2010

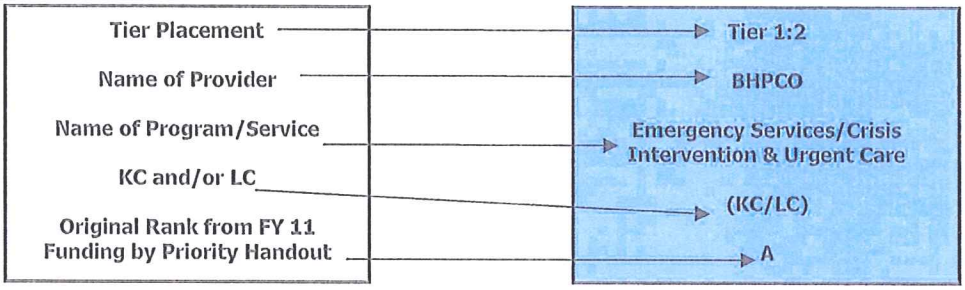
Attachment D: 2011 Needs Assessment and Gaps Analysis

A

Criteria for Prioritized System of Care Tier Placement
(5/27/2011)

System of Care Chart Key:

- ***Box Content:***



- ***Color Coded Lines and Box Outlines:***
  - Red lines or Boxes outlined in red are used to connect and indicate Youth Services or Programs.
  - Green lines or Boxes outlined in green are used to connect and indicate Adult Services or Programs.
  -
  - Black lines or Boxes outlined in **black** are used to connect and indicate **Services or Programs for both Youth and Adults.**

- ***Color Coded Box Funding Information:*** No color indicates that the program/service does not require mandated funding and/or contains a mandated service.

Program contains services with mandated funding – Pass Thru, mandated, or Hospital Bed Days	Statute requires CMHRB to provide 24/7 access to services. Statute does not require how this occurs.	Program contains services mandated by statue. For some mandated services, statue does not require how this occurs.	New Program for SFY 12

Services were ranked and placed into six tiers according to:

1. **Risk:** Potential negative impact if the service was not provided.
   - Risk to public safety
   - Risk to self and/or others
   - Risk of diminished functioning or capacity
   - Risk of medical emergency (access to detox services)
   - Risk of institutionalization
   - Financial risk or high utilization of system resources

2. **Level of Care** required to manage risk and meet **medical necessity** (ORC 5101:3-1-01). **Medically necessary services** are defined as services that are necessary for the diagnosis or treatment of disease, illness, or injury and without which the individual can be expected to suffer prolonged, increased or new morbidity, impairment of function, dysfunction of body organ or part, or significant pain and discomfort. (ODMH May 2010). A medically necessary service must meet generally accepted standards of medical practice, be appropriate to the illness or injury for which it is performed as to the type of service and expected outcome, and to the intensity of the service and level of setting.

- The higher the risk and/or the greater the medical necessity, the higher the level of care required.
- Programs providing higher levels of care were prioritized higher by tier. Programs with higher levels of care generally provided greater intensity and frequency of service.
- Prioritization aligned with ODMH and ODADAS service certification requirements. Service certification requirements address medical necessity and levels of care.
- For AOD programs, prioritization aligned with ODADAS Levels of Care. These levels of care incorporate medical necessity.

Tier placement and prioritization also included:

1. Programs that contain mandated services and/or funding
2. Access to services for children and adolescents and their families
3. Duplication of services:
   - Is there more than one program provided for the same identified population with the same clinical objectives?
   - Are these programs operating at full capacity?
   - What would be the impact to the identified population if one or more of these duplicated services would be decreased or eliminated?
4. Results of April 2010 Stakeholder Surveys (Consumers, Community Stakeholders, and Innovations Committee members)

Criteria for Evaluation Rating

1. Any outcome evaluation conducted in FY10 and FY11	4	▪ Provides evidence of outcome evaluation conducted in FY10 and/or FY11, and/or ▪ Clearly describes how MHSIP/YSS/YSS-F results have been used to guide quality improvement efforts*
	1	▪ Process evaluation only (no outcome evaluation), and/or ▪ No clear evidence that MHSIP/YSS/YSS-F results have been used to guide quality improvement efforts thus far*
	0	No evaluation conducted in FY10 or FY11
2. Local outcome evaluation methods (other than MHSIP/YSS/YSS-F)	4	Rigorous evaluation design, including experimental or quasi-experimental design, valid and reliable measures, minimal attrition or missing data, adequate control of confounding variables, and appropriate analysis and sample size; methods are fully described
	3	Above-average outcome evaluation design, including two or more of the following: comparison/control group or other relevant comparative data; data collected at two or more points in time with same participants (pre/post/follow-up or strong retrospective design); census or random sampling with acceptable attrition (<50%); involvement of an external evaluator; or data tested for statistical significance. And: methods are clearly described, desired outcomes are clearly articulated (preferably in a logic model), and evaluation instrument clearly aligns with desired outcomes.
	2	Adequate outcome evaluation design, including: evaluation instrument that assesses specific outcomes (such as in a logic model); acceptable attrition for at least one method (<50%); and, methods are adequately described
	1	Outcome evaluation methods not clearly described or substantiated, but some outcome evaluation is indicated; above criteria not met
	0	Process evaluation only, no evaluation conducted during FY10 or FY11, or not clear
3. Local outcome evaluation results	4	Provider specifies outcome targets and clearly documents that 75% or more of desired outcomes were achieved
	3	Provider specifies outcome targets and clearly documents that 50% to 75% of desired outcomes were achieved
	3	Provider does not specify outcome targets (thresholds), but clearly documents progress towards several desired outcomes
	1	Minimal outcome results reported, unclear results, negative results (lack of progress on more than half of desired outcomes), or very small sample size (<10)
	0	No outcome results reported

4. Outcome types reported	4	Provider reports positive actual outcomes related to at least one of the following areas: skills/intentions, behavior/actions, decrease in symptoms/increase in functioning, or status/condition
	2	Provider reports positive actual outcomes related to: awareness, knowledge, attitudes, values and/or beliefs
	1	Provider reports positive process evaluation findings only (e.g., participant satisfaction)
	0	No evaluation findings reported

*MHSIP/YSS/YSS-F applies to treatment providers only and is covered in the Quality of Care section #3a in the FY12 BAP, Part 1.

Needs Identified in CMHRB April 2011 *Needs Assessment & Gaps Analysis*

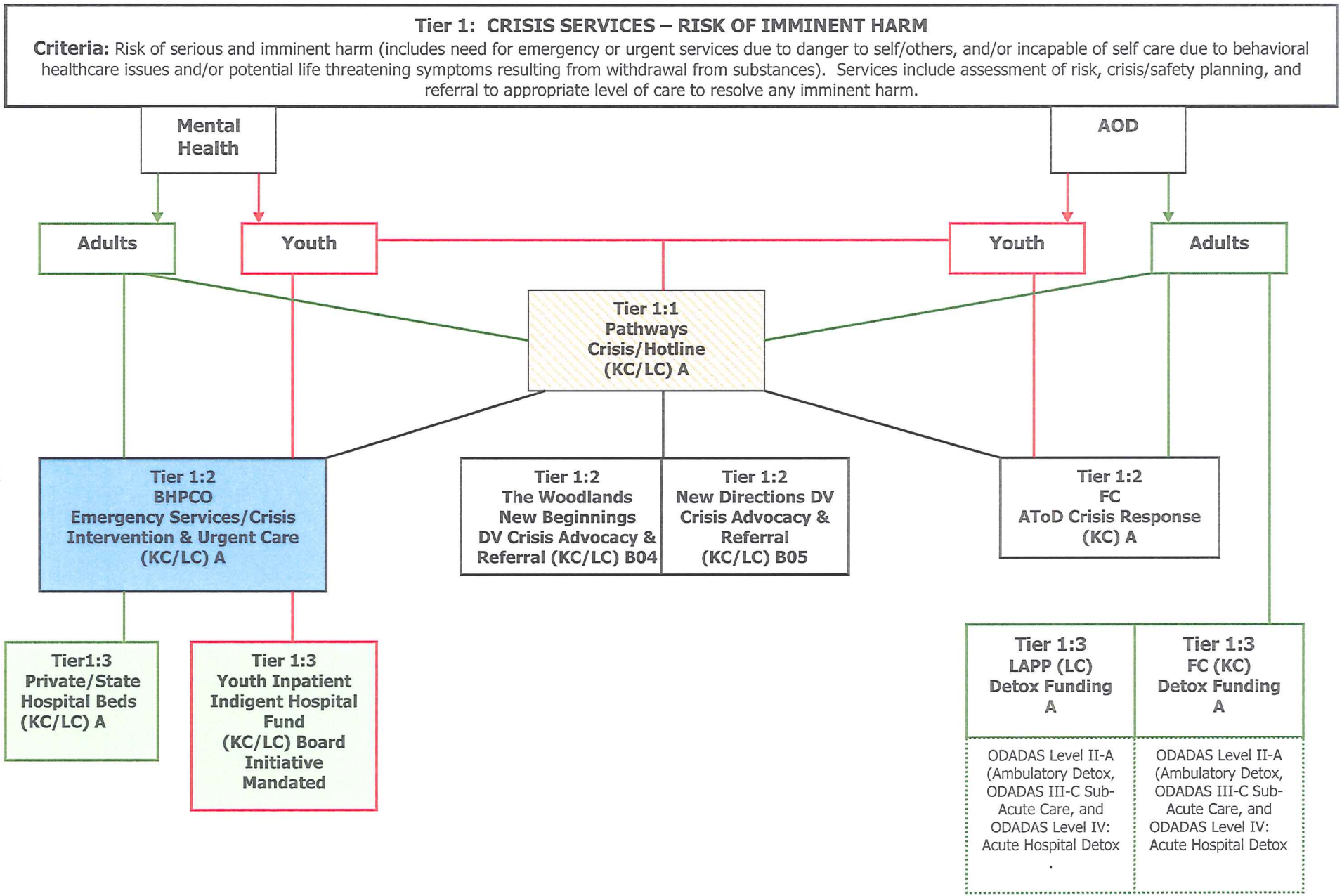
- **Non-SMD:** Decreased ability to serve non-SMD individuals
- **Opiates:** Need comprehensive strategy to address rise in opiate addiction
- **Health Integration:** Lack of integration between behavioral health and physical health to address relationships between BH needs, chronic medical conditions, and obesity
- **Early Childhood:** Need to improve early intervention and services for families with young children
- **Prevention Strategy:** Need comprehensive strategy for investing in effective and efficient prevention activities
- **Potential upcoming challenges**: "spill-over" from state policy changes and budget cuts in related systems (particularly corrections, child protection, long-term care, and schools)

Recommended Change to Prioritization

Starting with the CMHRB *Prioritized System of Care by Tier* approved by the Board in December 2010 as the baseline, recommendations to change the priority level of an existing program or to assign a priority level for a new program, are indicated in **Additional Request Recommendations Attachment D**. Changes in priority level are based on the following criteria:

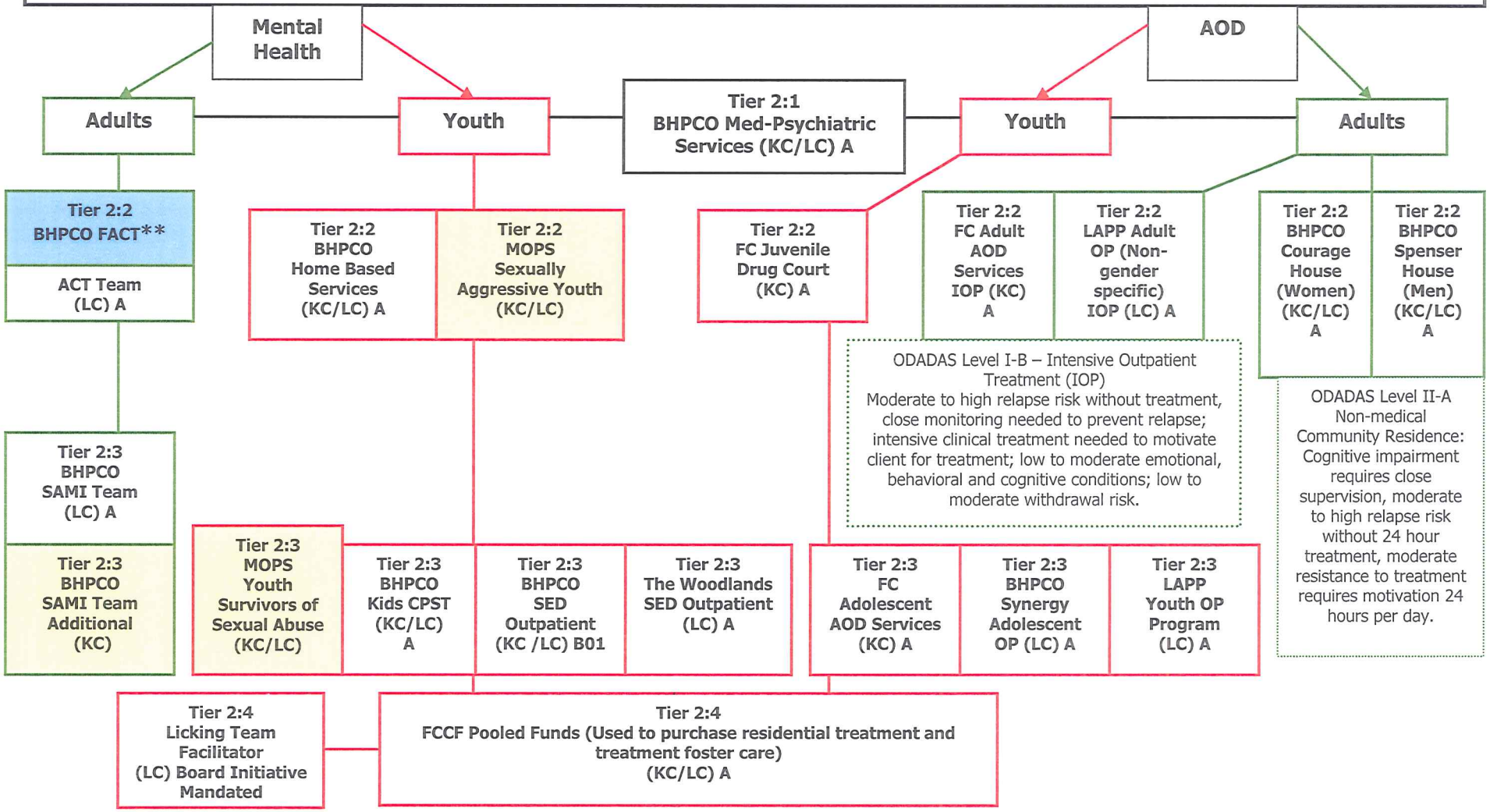
- Services meets a need identified in the gaps analysis
- Particularly strong or weak outcome evaluation methods or results, or an improvement in evaluation results (e.g., evaluation results presented in FY12 BAP were much stronger than were presented in FY11 BAP, or, conversely, no evaluation results presented in FY12 BAP)
  Information gathered during FY12 BAP process (application and/or discussions with providers) caused us to reconsider the level of risk.

CMHRB Prioritized System of Care by Tier (5/27/2011)



Tier 2: TREATMENT SERVICES* – HIGH RISK

Criteria: Court ordered NGRI/IST-U-CJ forensic care, monitoring, and treatment; services to persons of CMHRB priority populations with histories of community violence, treatment non-compliance, and/or criminal justice involvement; services to persons with co-occuring disorders and/or multiple hospitalizations and/or multiple detoxification stays; and services to youth (birth – 17) involved with multi community system involvement and/or in danger of out of home placement. Includes the use of consumer specific plan and must be medically necessary.

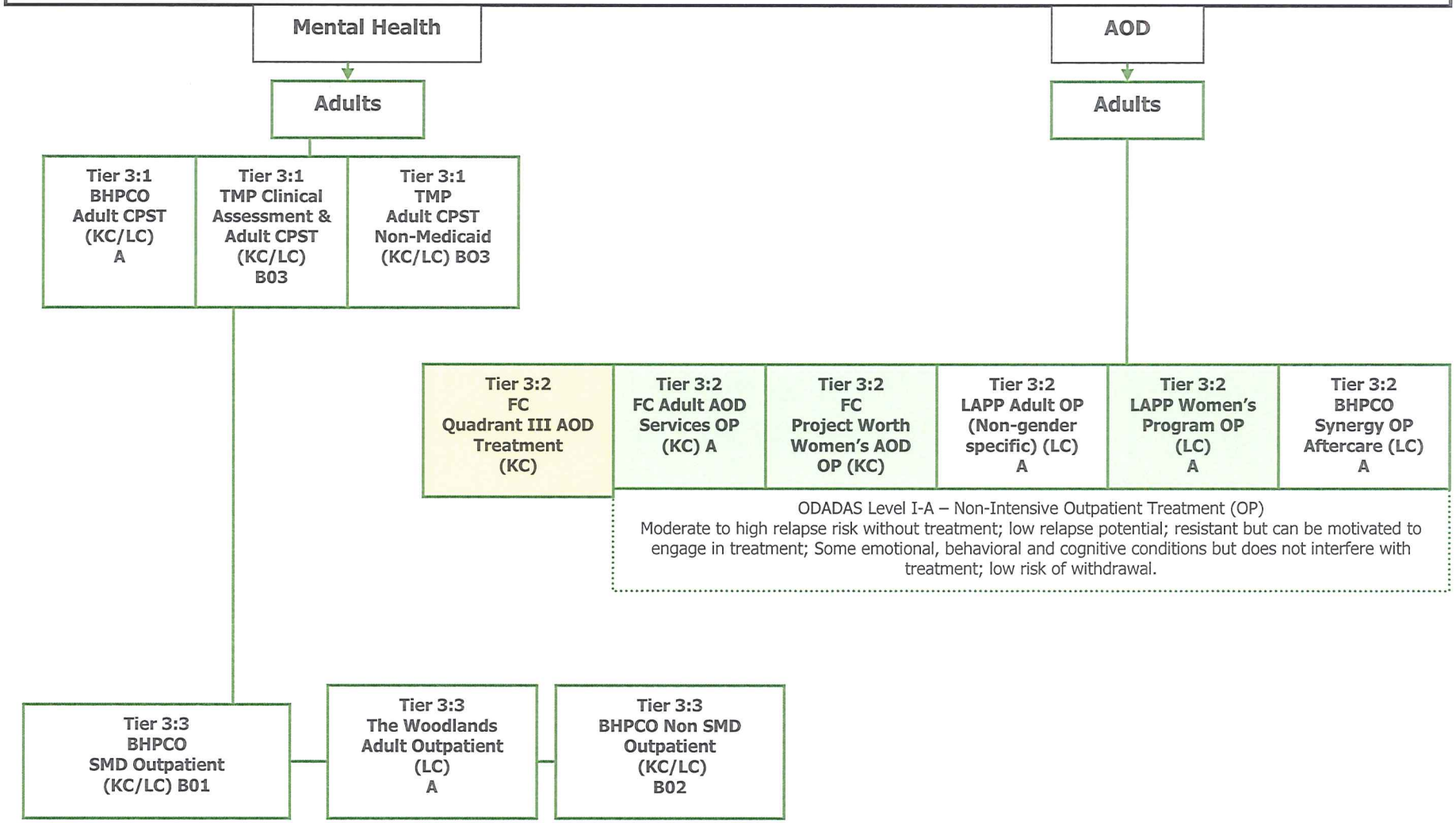


***Assessment included in all treatment services.**

****CMHRB is mandated to provide treatment services for forensic consumers (NGRI/IST-U-CJ) however is not mandated in how to provide services to this population.**

Tier 3: TREATMENT SERVICES* – MODERATE RISK

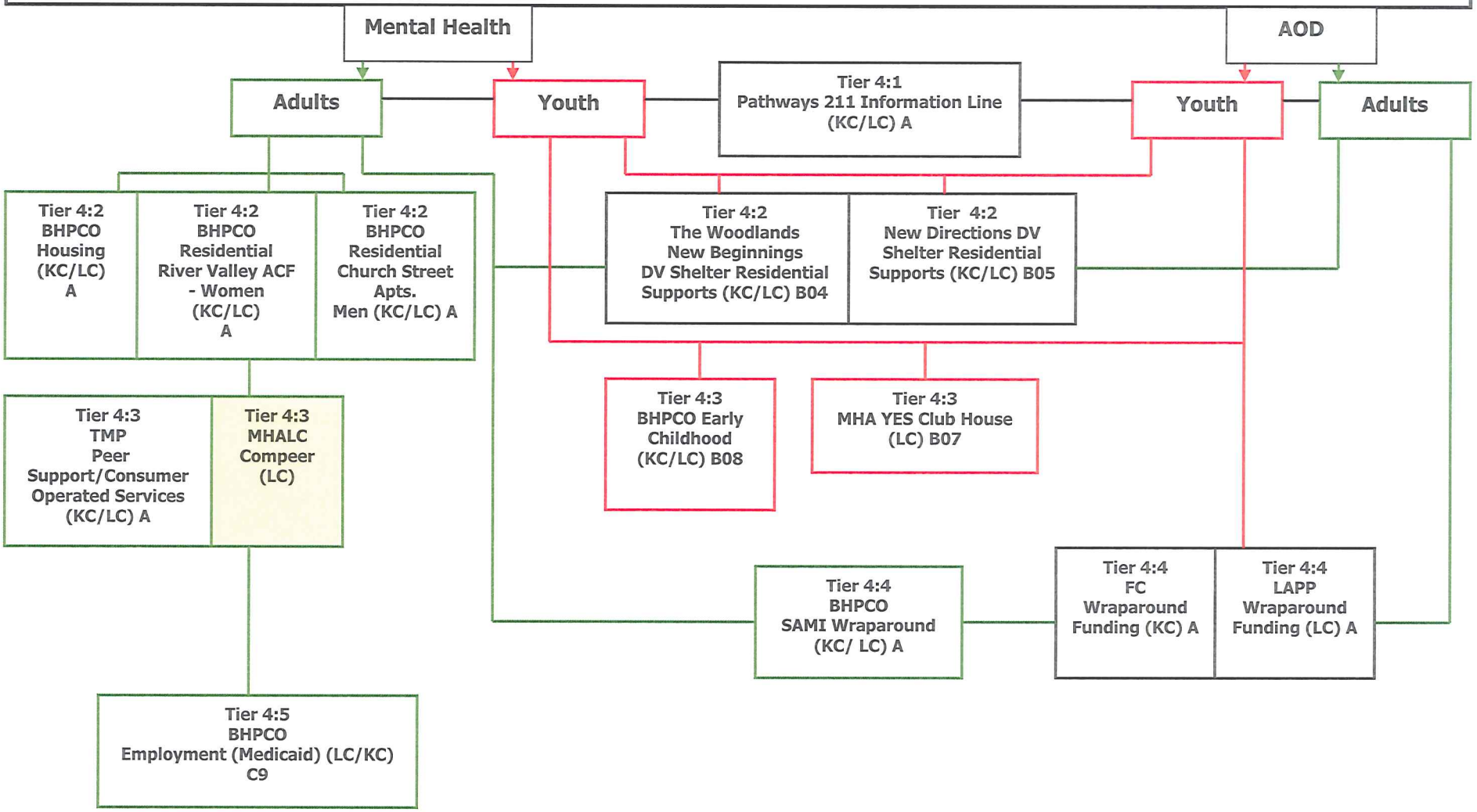
Criteria: Risk of serious negative outcomes, but not imminent harm (includes need for treatment or intervention to persons of CMHRB priority populations that provides structured recovery focused activities leading to stabilization of behavioral healthcare symptoms and/or other safety issues and/or increased functioning). Includes the use of a consumer specific plan and must be medically necessary.



***Assessment included in all treatment services.**

Tier 4: INTERVENTION SERVICES* – POTENTIAL MODERATE RISK

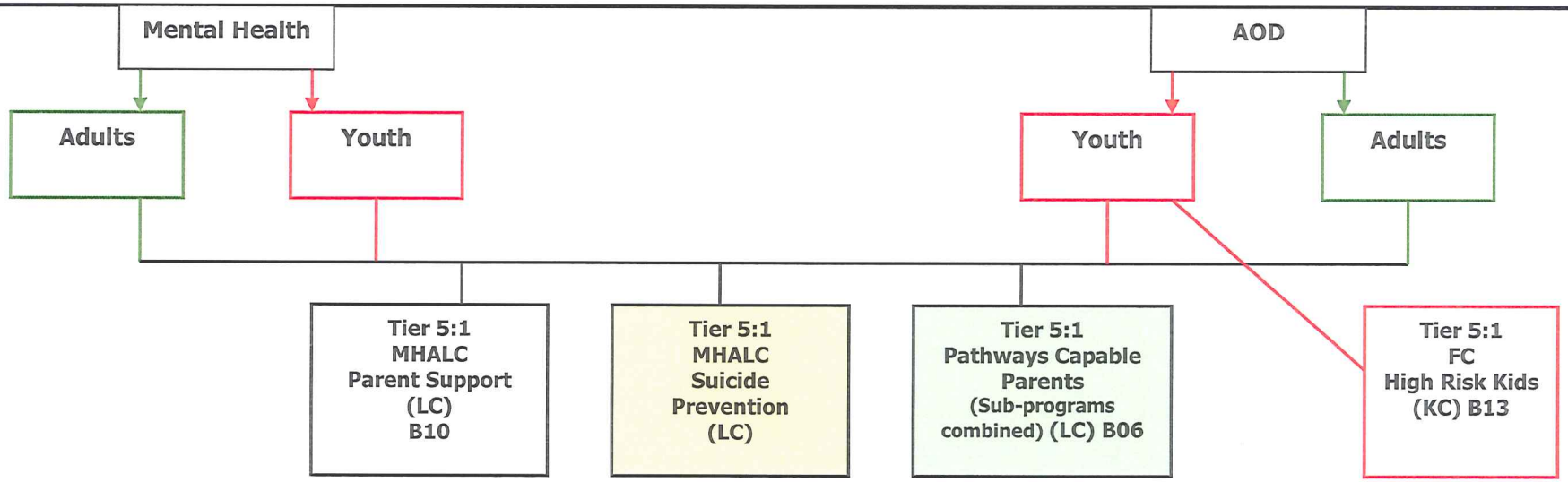
Criteria: Risk of potential negative outcomes in long-term (includes need for intervention that provides structured recovery focused activities and support leading to stabilization of behavioral healthcare symptoms and/or other safety issues, and/or increased functioning OR need for intervention that provides activities that support the recovery process). Typically includes the use of a consumer specific plan and generally are not medically necessary. May or may not include CMHRB Priority populations. Consumers may receive other medically necessary services on other tiers.



***Does not include mental health or drug and alcohol medically necessary treatment services.**

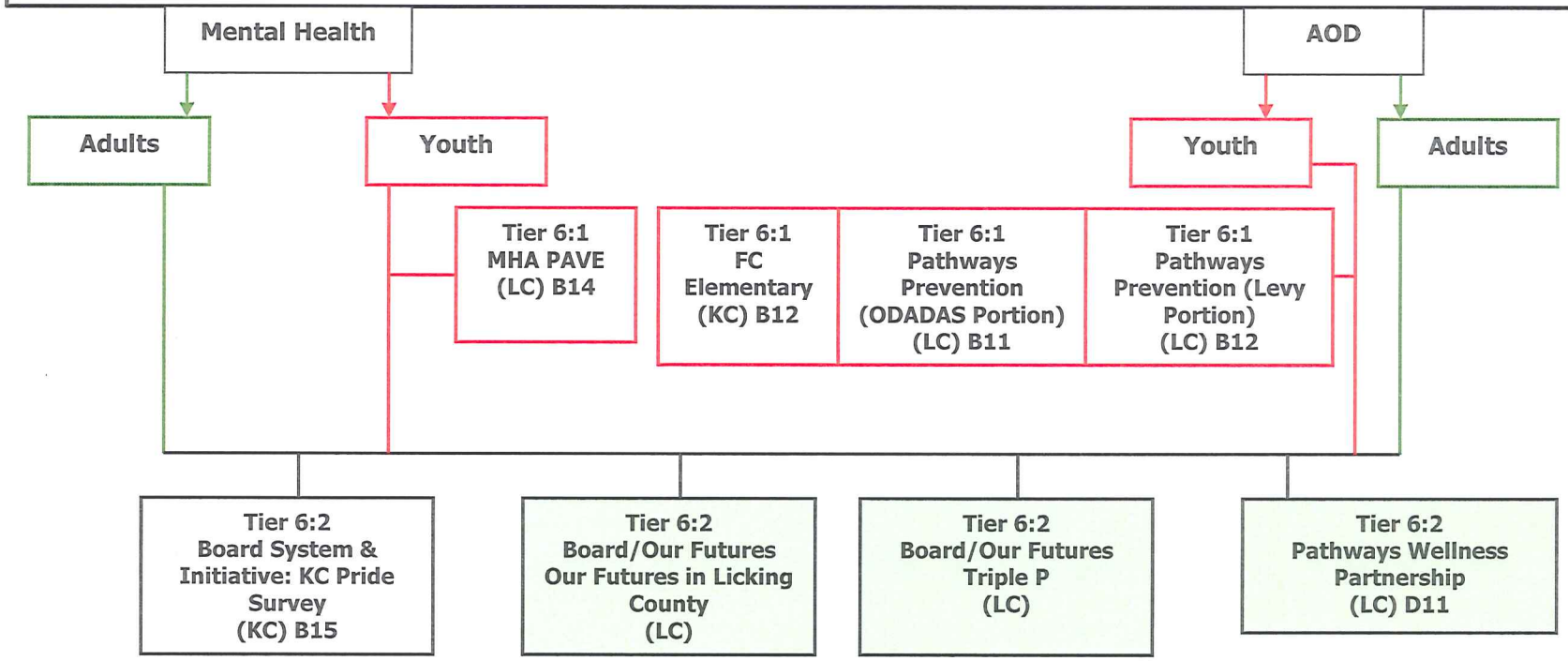
Tier 5: PREVENTION – POTENTIAL MODERATE RISK

Criteria: Potential risk for negative outcomes for many participants in the intermediate to longer-term if services are not provided before more serious problems develop. Early intervention refers to programs delivered to young children and/or their parents and programs delivered to at – risk adolescents before serious problems emerge. Negative outcomes these programs aim to prevent include child abuse and neglect, behavioral and social-emotional problems, school failure, alcohol and other drug abuse, teen pregnancy, delinquency, and violence. Interventions are not considered medically necessary and typically do not include the use of a consumer specific plan. May or may not include CMHRB Priority Populations.



Tier 6: PREVENTION UNIVERSAL PREVENTION WITH YOUTH & THEIR FAMILIES - POTENTIAL LOWER RISK

Criteria: Potential risk for negative outcomes in the long-term for some participants. Negative outcomes these programs aim to prevent include alcohol and other drug use, violence, and sexual assault. Typically serve the general population of children or adolescents and their families, without regard to risk factors. Aims to prevent problems before they arise (primary prevention). Does not include a consumer specific plan and is not medically necessary. May or may not include CMHRB Priority Populations.



Summary of Needs Assessments in Licking and Knox Counties: 2006 through 2010

Community Mental Health and Recovery Board of Licking and Knox Counties (10/26/10)

2006 United Way Community Assessments in Licking and Knox Counties Identify "Behavioral Health" Among Top Community Priorities

2006 Behavioral Health Surveys in Licking and Knox Counties Identify More Specific Concerns

Licking County Behavioral Health Task Force Survey:

- Life skills for families (communication, managing anger, etc.)
- Drug and alcohol prevention for youth
- Stress management, and overall wellness
- Family focused in-home treatment/counseling

Knox County Behavioral Health Needs Prioritization Survey:

- Drug and alcohol prevention for youth
- Services that teach children how to make good choices and manage anger
- Services for victims of domestic violence
- Timely access to therapy and 24-hour crisis hotline

2010 Focus Groups and Surveys with Consumers and Other Stakeholders Identify Most Critical Services in Behavioral Health System

Consumer Focus Groups:

- Adult mental health: case management, housing, peer support, ACT Team, psychiatry
- Child/youth mental health: case management, emergency services, psychiatry, pooled funds
- Adult AOD: group and individual counseling, IOP, links to help with basic needs

Stakeholder Priorities Survey:

- Adult mental health: emergency/crisis services, counseling, treatment for those with both mental health and AOD issues, psychiatry
- Child/youth mental health: early intervention for at-risk children, family therapy, emergency/crisis services, counseling, psychiatry, parenting education
- Adult/youth AOD: detox, outpatient treatment, emergency/crisis services, IOP, AOD prevention

2010: CMHRB Internal Reports Highlight System Challenges and Opportunities

- Need to improve outcomes for mental health consumers
- Community demand for mental health services for children and adults appears to be exceeding capacity; AOD capacity also a concern in some areas
- Need to improve follow-up for consumers exiting state and private hospitals
- Prevention services need to be evidence-based, cost-effective, multi-problem focused, and aimed at behavior change

Recent assessments conducted by CMHRB (SFY 2009 and 2010)		
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
2010 Stakeholder Priorities Survey Results, CMHRB, May 2010	Surveys with 212 consumers, 97 stakeholder organization representatives, and 23 Innovations Committee members identified the following priorities: Top-priority adult mental health services: ▪ 24-hour emergency services/crisis management ▪ Counseling ▪ Treatment for co-occurring disorders (clients with both mental health and addiction issues) ▪ Local outpatient psychiatry Top priority child/youth mental health services: ▪ Early intervention for at-risk children ▪ Family therapy ▪ 24-hour emergency services/crisis management ▪ Counseling ▪ Local child psychiatry ▪ Parenting education Top priority adult and youth alcohol and drug services: ▪ Detoxification ("detox") ▪ Outpatient treatment (assessment, group, individual) ▪ 24-hour emergency services/crisis management ▪ Intensive Outpatient (IOP) ▪ Alcohol and drug prevention	#1, #3, #4, #5, #7
Consumer Focus Group Report, CMHRB, January 2010	Five focus groups with a total of 34 consumers (adults and parents) concluded that: ▪ The MHSIP and YSS-F surveys are feasible and appropriate for consumers in Licking and Knox counties. (focus group included pilot-testing of the surveys) ▪ Adult consumers prioritized the following mental health services: case management, housing assistance, peer support, ACT Team, and psychiatry. ▪ Parents prioritized the following mental health resources for children: case management, emergency services, child psychiatry in county, and pooled funds. ▪ Adult consumers prioritized the following AOD resources: group counseling and IOP, referrals and links to other resources for basic needs, and individual counseling. Consumers identified the following concerns and suggestions for improving services:	#1, #3, #5, #7, #9

	▪ Concerns about access to services at MGC. ▪ Reduce duplication between mental health and AOD providers, and provide better link between inpatient detox and community services. ▪ Increase consumer participation in treatment decisions at MGC. ▪ Improve initial access and support for staying engaged in treatment. ▪ Add or expand specific services, including nutrition education and wellness, medication education, and help paying for medications ▪ Maintain housing assistance (see as critical to recovery)	
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
January and July 2010 Consumer Satisfaction and Outcomes Survey Results, CMHRB, 2010	Analysis of MHSIP, YSS, and YSS-F surveys with current consumers at two points identified the following: System Strengths ▪ The majority of mental health and AOD consumers report they are satisfied with the care they have received, and rate agencies positively regarding several indicators of perceived quality. ▪ The vast majority of adult AOD consumers report that they have achieved meaningful outcomes as a result of the services they have received. ▪ Contact with providers appears to reduce homelessness for mental health and AOD consumers. ▪ AOD treatment appears to be associated with a reduction in encounters with the police. System Challenges ▪ BHPCO-MH, the system's largest provider, did not meet most performance targets related to satisfaction or outcomes, and did not make adequate progress on outcome domains for adults or children. ▪ Regardless of time in treatment and service type, most outcome-related targets for most mental health providers were not met.	#8
SFY10 Year-End Board Performance Target Report, CMHRB, 2010	In addition to identifying several system strengths, this analysis identified the following system challenges: ▪ Community demand for mental health services for adults and children appears to be exceeding capacity, particularly at BHPCO-MH. ▪ Community demand for AOD services is also challenged by provider capacity in some areas. ▪ Seasonal demand patterns may have magnified access "bottlenecks" during SFY10. ▪ Persistent concerns about: access to services, hospital follow-up, domestic violence shelter use, housing vacancy rates (TMP housing), and relatively low use of evidence-based programs among prevention providers.	#1, #3, #9
Prevention Planning and Policy: Changing the Odds in Licking County, PAXIS Institute for CMHRB, 2010	Review of prevention research literature provided the following policy implications for the prevention system: ▪ Multi-problem focus: Prevention strategies that significantly affect several outcomes are to be preferred over strategies that only affect one type of outcome. ▪ Behavior change: Prevention programs or efforts that emphasize knowledge or attitude change in the absence of measurable behavior change should be discontinued. Simple awareness campaigns that do	#2, #4

	not involve clear behavior change topography and tools should not be funded. ▪ Simplicity and cost-effectiveness: Prevention efforts that can be easily applied to intervention and treatment with simple adjustments to dose, supports, or intensity are to be preferred. Prevention efforts that are less expensive in terms of training, supports, and infrastructure and more efficient are to be preferred. ▪ Third party payers: Strategies that can be funded through third-party mechanisms should be pursued.	
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
Pride Survey of Licking County Youth, 2008-09 School Year (baseline), Our Futures, September 2009	Survey of 5,097 students in grades 6, 8, 10, and 12 in 7 Licking county school districts found that: ▪ Alcohol, tobacco, and other drug use (ATOD) was slightly higher in Licking County than in the US overall for 8th, 10th, and 12th graders ▪ ATOD use rates were lower for Licking County 6th graders ▪ Alcohol was the most commonly used drug among youth, followed by marijuana and prescription drugs ▪ Licking County teens reported easier access to alcohol, marijuana, and tobacco compared to the national sample ▪ Most students believe ATOD use is harmful ▪ Most ATOD use occurs at home, not in school ▪ Parental monitoring and supervision drops considerably at the high school level ▪ Most—but not all—parents disapprove of youth ATOD use, and local high school students were less likely than their national counterparts to say their parents disapprove of alcohol use	#4
Community Themes and Strengths Assessment, Licking County Health Department, 2010	*Available by November 2010*	
County Suicide Trends, 2004 to 2009, data compiled by Pathways of Central Ohio, 2010	Total number of suicides in 2009: ▪ 28 in Licking county, up 58% from 2008 ▪ 11 in Knox County, up 55% from 2008 Average age for suicides was 48 years in Licking and 46 years in Knox.	#1, #3

Community assessments led by local United Ways (2006)		
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
Licking County Community Blueprint; collaborative assessment led by United Way; 2006 www.lickingcounty communityblueprint.com	Assessment identified three top-priority issues for follow-up initiatives: • Health care and dental care affordability • Economic and employment issues • Behavioral health	All goals
Moving Toward a Stronger Knox County: 2004-05 Community Assessment; conducted by United Way; 2006 www.uwayknox.org	Broad consensus pointed to four top-priority issues: • Health care affordability, insurance, access, and quality • Jobs, economic issues, and support for self-sufficiency • Recreational and entertainment activities, especially affordable activities for children, families, & teens • Mental health, stress, emotional issues, and substance abuse Other conclusions related to behavioral health: • Not enough providers of mental health and substance abuse treatment • Lower satisfaction with mental health, substance abuse, and employment services compared to other social services	
Collaborative planning group needs assessments on specific topics (2006-2008)		
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
Licking County Behavioral Healthcare Task Force Survey; conducted by the task force in response to Community Blueprint report findings; 2006	Highest behavioral health priorities identified for Licking County: • Life skills for families (communication, managing anger, etc.) • Drug and alcohol prevention for youth • Stress management • Focus on overall wellness for the entire community • Improve how agencies work together • Family focused in-home treatment/counseling services	#1, #3, #4, #5
Knox County Behavioral Health Needs Prioritization Survey; conducted by the task force in response to United Way	Highest behavioral health priorities identified for Knox County: • Drug and alcohol prevention for youth • Services that teach children how to make good choices and manage their anger • Services for victims of domestic violence	

assessment findings; 2006	• Timely access to therapy services & 24-hour crisis hotline	
Report, Responsible Organization(s), & Date	***Key Findings***	**Relevant FY12-13 Community Plan Goals**
Licking and Knox Community Capacity-Building Prevention Plans; result of CMHRB-sponsored planning retreat; 2006	Both counties selected the following strategies to address unmet needs: • Fundraising (seek and write grants) • Strong prevention workforce (skills development, training) • Centralized data collection to inform needs assessment, grant writing, and impact assessment • Effective communication (among partners and with media/public) • Promotion of evidence-based, cost-effective, needs-driven prevention strategies Licking County also specified: Collaboration and comprehensive prevention planning	#2
Licking County Rural Housing Initiative of Southeastern Central Ohio (RHISCO) Plan, Need Assessment section; response to funding from the Osteopathic Heritage Foundation; 2007	2005 point-in-time count identified 126 homeless persons (sheltered and unsheltered). Survey of providers found: • Eight organizations provided emergency, transitional, or permanent housing to an average of 186 homeless persons each month • Unemployment, domestic violence, and mental health issues were the most often-reported reasons for homelessness	#1, #3
Knox County Rural Housing Initiative of Southeastern Central Ohio (RHISCO) Plan, Needs Assessment section; response to funding from the Osteopathic Heritage Foundation; 2007	2005, 2006, and 2007 point-in-time counts identified 21, 22, and 15 homeless persons (sheltered and unsheltered). Survey of stakeholders found: • Substance abuse, "being kicked out by family/friends," and mental illness were perceived as the most important causes of homelessness. • Top three priority areas for ending homelessness: increased jobs/job training/higher-paying jobs, emergency shelter, and mental health services/increased access to mental health facilities.	
Licking County Family and Children First Council Partnerships for Success (2003) and HB289 Annual Plan (2008); collaborative assessment and planning process involving all agencies that serve families and children	Top-priority issue areas identified: • Substance abuse (2003) • Family violence (2003) • Community-Based Prevention (development of a comprehensive approach using evidence-based strategies, with technical assistance from the PAXIS Institute) (2008) Gaps identified (2003): • Prevention and early intervention programs much less common than systems of care (intervention programs) • Most services located in the Newark area • Lack of consistent, centralized data collection needed to track progress.	#2, #4, #5, #7
Licking County Roundtable Discussions; sponsored by United Way, CMHRB, and LC Family and	Identified three strategies needed to address current gaps ("Family Focus Initiative"): • Team service delivery (cross-system collaboration)	#5

Children First Council in response to Community Blueprint findings; 2007	• Family-oriented intervention strategies (family-driven) • Home and community-based interventions	
Report, Responsible Organization(s), & Date	***Key Findings***	**Relevant FY12-13 Community Plan Goals**
Licking County Population-Level Change Stakeholder Interviews; conducted by United Way and CMHRB in response to Community Blueprint findings; 2007	Most important positive change needed for youth: • Reduction or delay in onset of alcohol and other drug (AOD) use • Increased graduation rates and school attendance • Increased literacy	#4
Knox County Family and Children First Council HB289 Annual Plan; collaborative assessment and planning process involving all agencies that serve families and children; 2007	Infants and toddlers were chosen as the top-priority age group with a focus on the following unmet needs: • Improved social-emotional well-being • Improved child care quality • Knowledge of early childhood development Gaps identified for social-emotional wellbeing of young children: • Fewer programs that provide *direct services or treatment* for young children with social-emotional problems, and no play-based therapy services for young children in Knox County. • Fewer programs for infants and toddlers, compared to services for preschool-age children and older.	#5
CMHRB-sponsored needs assessments on specific topics (2006-2009)		
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
Becoming Recovery Focused: General System Readiness; CMHRB-sponsored study conducted by WLT Consulting; 2006	• This baseline assessment concluded that overall the system does not have a major focus on recovery. • Staff respondents were not clear about what kinds of recovery resources were available, and there appeared to be more recovery resources available for staff than for consumers. • Consumers were uncertain about the level of recovery practices and focus. • Collaboration with other organizations and agencies was found to be a system strength, while the availability of flexible resources for consumers (funding for educational activities and stipends for participating in agency planning) was seen as a system weakness.	#8
Western Licking County Needs Assessment; CMHRB-sponsored study conducted by Partners in Performance (consultant) in response to 2006 Board Strategic Planning Retreat; 2006	• Services are most needed in Licking Heights School District and the city of Pataskala. • Licking Heights School District serves the largest proportion of low-income, African American, and Somali immigrant students among county districts, although roughly half or more of these students actually reside in Franklin County. • Estimated CMHRB treatment penetration rates are lower for western Licking County than for comparison areas (Licking County overall, Knox, Franklin). • Many western Licking residents seek services from behavioral health providers in eastern Franklin County.	#4

	• Recommendations included: increase services to Licking Heights and Pataskala; address stigma; increase services for older adults; increase services for youth, especially AOD; and, increase culturally competent prevention services for youth.	
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
State Hospitalization Admission Utilization Review; CMHRB staff analysis; 2006	• Identification of high utilizers of services and bed days • Identification of related hospital diversion activities and alternative interventions (e.g., ACT)	#1, #2, #3
Priority Treatment Populations Assessment; CMHRB staff analysis; 2006	CMHRB determination of priority treatment populations (Administrative Policy #106): *Mental health funding* • SED children • Forensic adults-NGRI • SMD adults • Non SED children • Non SMD adults *AOD funding* • Children with severe AOD abuse/dependency • Adults with severe AOD dependency • Adults with severe AOD abuse • Adults affected by AOD usage	#1, #3

Prevention Resource Assessments (2008)		
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
Licking County Children and Family First Council HB289 Annual Plan (2008): Prevention Resource Assessment, June 2008	Identified the following *strengths* in Licking County prevention resources • Wide variety of prevention programs conducted by several different organizations • Good balance between number of programs for younger and older youth (middle school and high school) • Good balance of programs along the prevention continuum; half are universal prevention approaches for all youth, while the other half are for at-risk youth or families already experiencing problems ▪ Some parent programs exist, particularly for at-risk youth Identified the following *gaps*: • Far fewer programs for parents than for youth, and small proportion of programs promoting parent monitoring and supervision • Need for more prevention resources for the general parent population, not just at-risk families (universal prevention vs. selective and indicated) • Lack information about school climate and programs conducted by school districts	
Report, Responsible Organization(s), & Date	**Key Findings**	**Relevant FY12-13 Community Plan Goals**
Knox County Wellness Coalition Prevention Plan Resource Assessment List & Report, CMHRB and United Way, May 2008	• The report identified 77 behavioral health prevention programs in the county, including 25 substance abuse (33%) and 16 child/teen social-emotional wellbeing and behavior issue programs (21%) (the two largest categories). • 29% of behavioral health programs use universal prevention strategies, while 43% employ indicated prevention. Substance abuse (44%) and violence and abuse (40%) programs were the most likely to implement universal prevention, while only one mental health program did so. Identified the following *strengths* in Knox County's prevention resources (related to behavioral health): • School staff provide many prevention programs to their students, particularly in the area of behavioral health. Schools generally employ universal prevention strategies and reach large numbers of students in the K-12 years. • Health and social service organizations collaborate with each other frequently. Identified the following *gaps*: • Little use of evidence-based programs, particularly in the areas of substance abuse and life skills. • More specifically, only 1 evidence-based substance abuse program and no evidence-based mental health programs provided by community agencies.	

	• Lacking a comprehensive strategy for coordinating prevention resources and tracking outcomes.	

2011 Needs Assessment & Gaps Analysis

Selected Graphs

Prepared for the

April 21, 2011 Board Meeting

Purpose

- Supplement previous community needs assessment results with secondary data on community indicators
- Guided by four questions:
  1. **Community conditions and needs:** What are the key demographic trends and how is the overall health of our communities? What are the most significant needs for behavioral health (BH) treatment and prevention in our counties?
  2. **System overlap:** Which systems overlap most with behavioral health? What are the trends in demand on those related systems and potential policy changes?
  3. **Status of the BH system:** What treatment and prevention services do we currently provide, and how has this changed over the past three years? What are the trends in demand, capacity, and performance in the behavioral health system?
  4. **Alignment and gaps:** How well do our current services align with the needs in our counties? Where are the gaps and potential challenges?

Data sources

- Online compilations of county-level health, economic, and demographic indicators
- Reports from local agencies
- Comparisons to Ohio, and two peer counties with similar demographics (LC=Greene and KC=Darke)

Caution!

- All data sources have some limitations
  - Trends and/or rates not always available
  - Small samples for county-level data for some surveillance surveys
  - "Apples to oranges" for some local agency data

How to read these graphs

- Watch for distinctions between:
  - Rates (e.g., rate per 100,000 population)
  - Percents
  - Number counts
  - Averages
  - Rankings
  - Fiscal vs. calendar years
  - All individuals vs. adults/adults ages 18-64 vs. children ages 0-17

Review of previous needs assessments

- 2010 Consumer Forums (Community Plan goal prioritization)
  - Four groups with 46 consumers
- 2010 Stakeholder Priorities Survey
  - 212 consumers, 97 stakeholder organization representatives, and 23 Innovations Committee members
- 2010 Consumer Focus Groups
  - Five groups with 34 consumers
- Other assessments conducted by United Ways, Our Futures, Licking County Health Department, and Family and Children First Councils, plus CMHRB internal reports

What have past Community Needs Assessments said about behavioral health priorities?

2006 Behavioral Health Prioritization Surveys- Top Priorities	
Licking County: ▪ Life skills for families (communication, managing anger, etc.) ▪ Drug and alcohol prevention for youth ▪ Stress management and overall wellness ▪ Family focused in-home treatment/counseling	Knox County: ▪ Drug and alcohol prevention for youth ▪ Services that teach children how to make good choices and manage anger ▪ Services for victims of domestic violence ▪ Timely access to therapy and 24-hour crisis hotline

Previous Community Needs Assessments, continued

2010 Focus Groups and Surveys with Consumers and Other Stakeholders– Most Critical Services in Behavioral Health System	
Consumer Focus Groups: ▪ Adult mental health: case management, housing, peer support, ACT Team, psychiatry ▪ Child/youth mental health: case management, emergency services, psychiatry, pooled funds ▪ Adult AOD: group and individual counseling, IOP, links to help with basic needs	Stakeholder Priorities Survey: ▪ Adult mental health: emergency/crisis services, counseling, treatment for those with both mental health and AOD issues, psychiatry ▪ Child/youth mental health: early intervention for at-risk children, family therapy, emergency/crisis services, counseling, psychiatry, parenting education ▪ Adult/youth AOD: detox, outpatient treatment, emergency/crisis services, IOP, AOD prevention

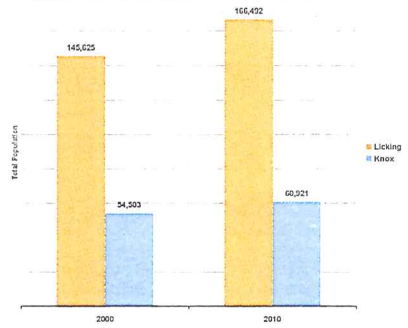
Overall.... Services that emerged as top priorities in two or more previous needs assessments

- **Core MH and AOD services**: counseling, psychiatry, case management, peer support, and emergency/crisis services
- **AOD prevention** for youth
- **Early intervention** for at-risk youth, including social-emotional skill-building for parents and children
- **Basic needs:** housing, employment, survival in poverty (particularly important to consumers)

1. Community Conditions & Needs

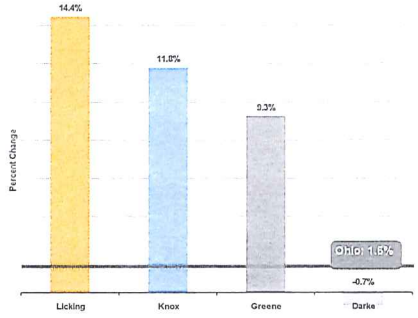
Demographic trends,
overall community health,
and most significant
behavioral health needs

Graph 1. Total population size, 2000 and 2010



Source: U.S. Census Bureau: http://2010.census.gov/2010census/data, and American FactFinder (2000)

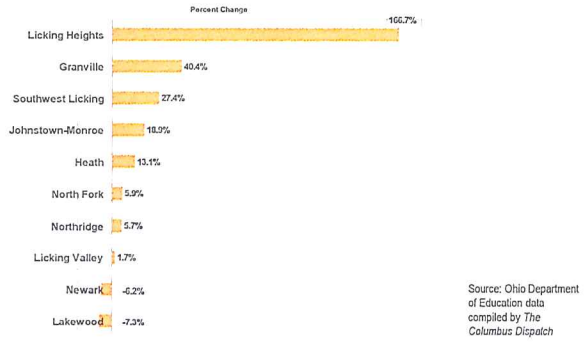
Graph 2. Percent change in total population, 2000 to 2010



Sources: US Census Bureau: http://2010.census.gov/2010census/data, and American FactFinder (2000)

Where is the population growth?

Graph 3. Percent change in enrollment from 1999-00 to 2009-10 school years: Licking County



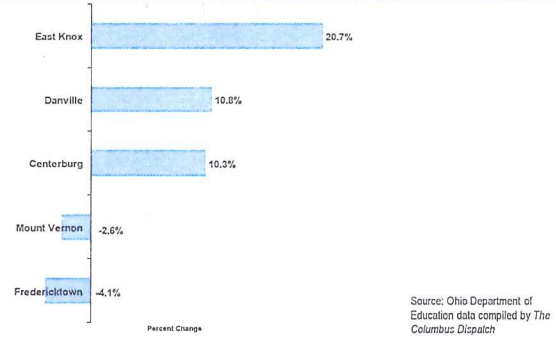
Source: Ohio Department of Education data compiled by *The Columbus Dispatch*

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

13

Where is the population growth?

Graph 4. Percent change in enrollment from 1999-00 to 2009-10 school years: Knox County

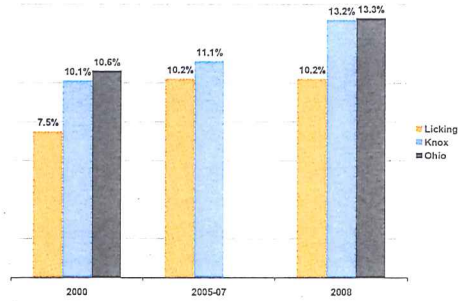


Source: Ohio Department of Education data compiled by *The Columbus Dispatch*

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

14

Graph 5. Percent of individuals in poverty, 2000-2008 (<100% FPL)



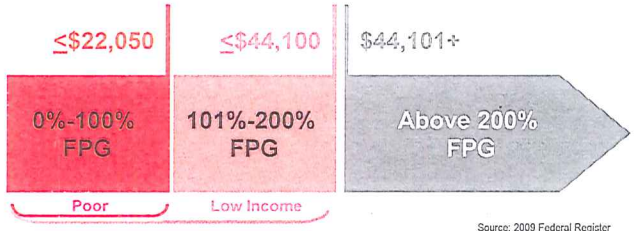
Source: U.S. Census Bureau; 2000 Census and American Community Survey 2005-07 three-year estimates; 2008 Quick Facts

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

15

Federal Poverty Guidelines (FPG), 2009 through January 2011

Annual Income Cut-Offs for FPG Categories: Household of 4

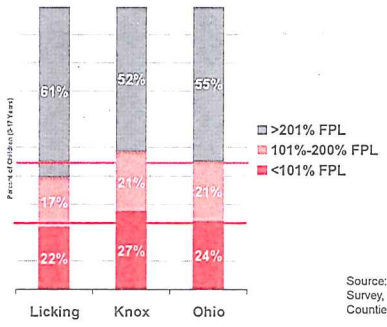


Source: 2009 Federal Register

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

16

Graph 6. Percent of children in poverty (ages <17 at <101%, 101%-200%, and >200% Federal Poverty Line)

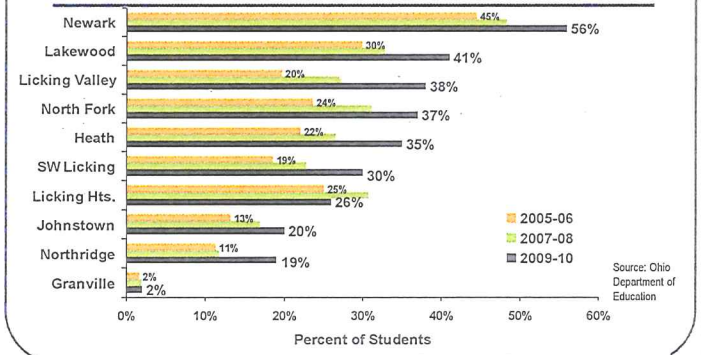


Source: 2008 Ohio Family Health Survey, Table Series 2: Regions and Counties, http://grc.osu.edu/ofhs

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

17

Graph 7. Percent of students who are economically disadvantaged: Licking County, 2005-06 through 2009-10 (selected years)

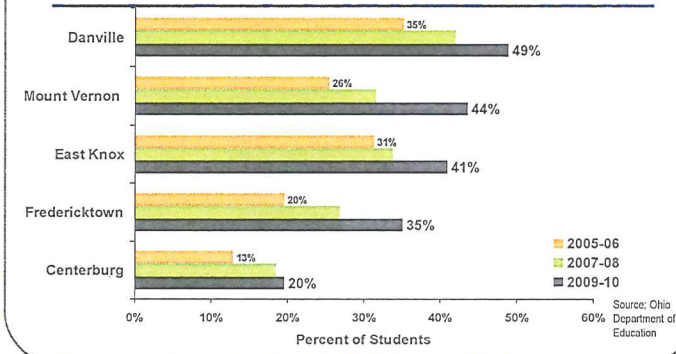


Source: Ohio Department of Education

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

18

Graph 8. Percent of students who are economically disadvantaged: Knox County, 2005-06 through 2009-10 (selected years)



Source: Ohio Department of Education

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

19

County health rankings,

2011, selected counties (1=best, 88=worst)

Health Outcomes Premature death, poor physical and mental health status, low birthweight	Health Factors Health Behaviors, Clinical Care, Social & Economic Factors, Physical Environment
8. Greene	5. Greene
26. Licking	17. Licking
27. Darke	22. Darke
33. Knox	30. Knox

Source: County Health Rankings, 2011 Ohio Health Profile, RWJF

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

20

County health rankings: Health Factor Sub-Categories,

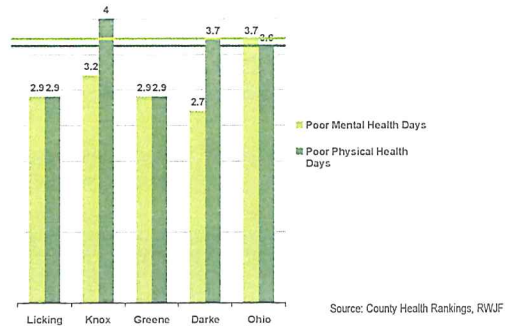
2011, selected counties (1=best, 88=worst)

Health Behaviors Tobacco, obesity, excessive drinking, crash deaths, STIs, teen birth rate	Clinical Care Uninsured adults, primary care provider-to- population ratio, preventable hospital stays, diabetic and mammography screening	Social & Economic Factors Education, Employment, Income, Family & Social Support, Community Safety
8. Darke	4. Greene	8. Greene
9. Greene	13. Licking	19. Licking
58. Licking	37. Darke	24. Knox
61. Knox	41. Knox	35. Darke

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

21

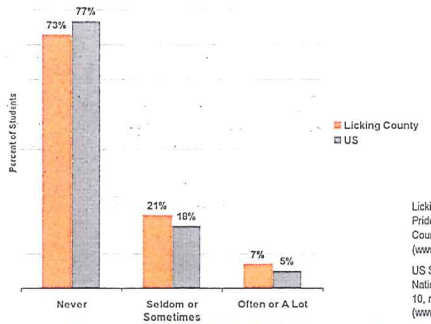
Graph 9. Poor mental and physical health days (average number of days in past 30 days, age adjusted): 2003-09



Community Mental Health & Recovery Board
Serving Licking and Knox Counties

22

Graph 10. "Have you ever thought about committing suicide?", responses among Licking County students in grades 6, 8, 10, and 12



Licking County Source: May 2010 Pride Survey of students in 7 Licking County school districts, n=4,987 (www.ourfutures.org)

US Source: Pride Surveys Report: National Summary Statistics for 2009-10, n=101,721 (www.pridesurveys.com)

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

23

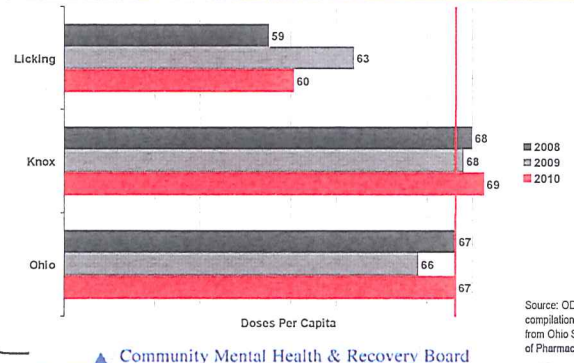
Graph 11. Unintentional drug/medication deaths for selected substances: Death rate per 100,000 population

*X40-X44 poisoning deaths; opioids and "other unspecified drugs" were the most commonly cited drugs
**2009 rate is preliminary and based on a small number of cases at county level (n=10 deaths in Knox, n=20 deaths in Licking)
Source: Ohio Department of Health, Office of Vital Statistics, Analysis by Injury Prevention Program

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

24

Graph 12. Doses per capita of analgesics (pain killers)



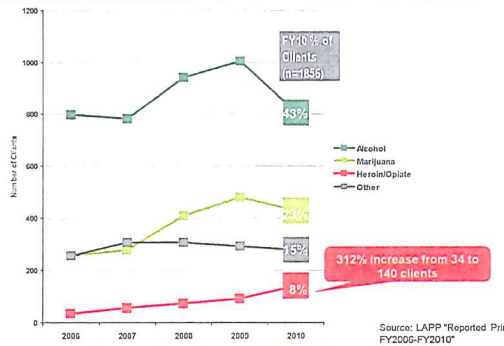
Source: ODADAS compilation of data from Ohio State Board of Pharmacy.

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

25

Graph 13. Primary drug of choice among LAPP clients

(line=number of clients; boxes=percent of clients in SFY 2010)



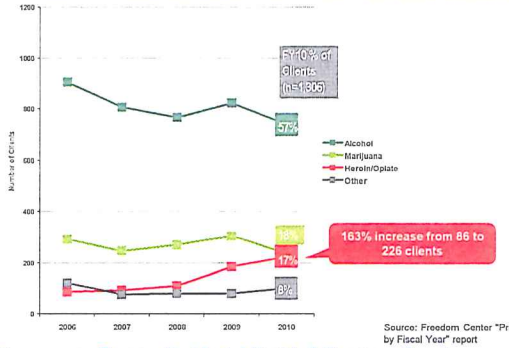
Source: LAPP "Reported Primary Drug of Choice: FY2006-FY2010"

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

26

Graph 14. Primary drug of choice among FREEDOM CENTER clients

(line=number of clients; boxes=percent of clients in SFY 2010)



Source: Freedom Center "Primary Drug of Choice by Fiscal Year" report

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

27

2. System Overlap

Which systems overlap most with behavioral health, and what are the trends in demand on those related systems and potential policy changes?

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

28

Systems that overlap

Reviewed data from:

- Children's services
- Criminal justice
- Domestic violence
- Education
- Physical health/medical
- Nursing homes/long-term care [pending]
- Basic needs (food and housing assistance)

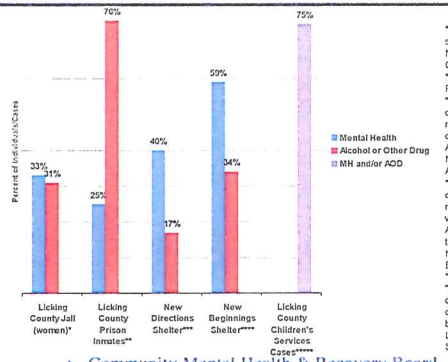
Why is this important?

- Rising demand on related systems indicates increased community needs
- Policy changes and budget cuts to related systems have implications for BH system

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

29

Graph 15. Estimated percent of individuals in related systems with mental health or drug/alcohol problems

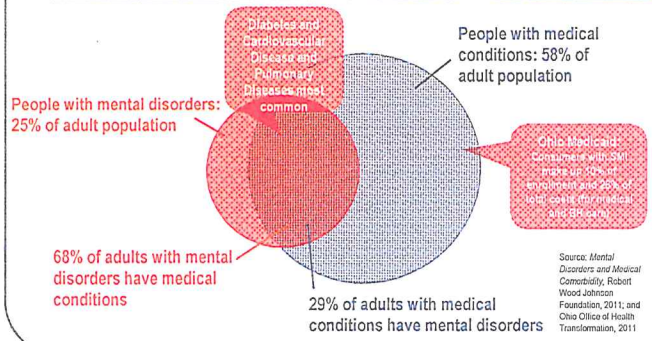


*2009-2010: Estimate based on self-disclosure at intake. N=3,129. Source: Licking County Sheriff's Office.
**Ohio Department of Rehabilitation and Corrections
***2008-2010: Estimate based on the number of shelter residents who were diagnosed or observed to have MH or AOD issues. N=58. Source: New Directions Domestic Abuse Shelter.
****2009-2010: Estimate based on the number of shelter residents who self-identified or were observed to have MH or AOD issues, January 2009 through December 2010. N=129. Source: New Beginnings Shelter.
*****July-Dec. 2010: "Conservative estimate" based on internal review of ongoing cases in which "AOD or MH or both was an issues." Source: Licking County Children Services.

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

30

Graph 16. Percent of adults with mental health and physical health needs, U.S. 2001-2003

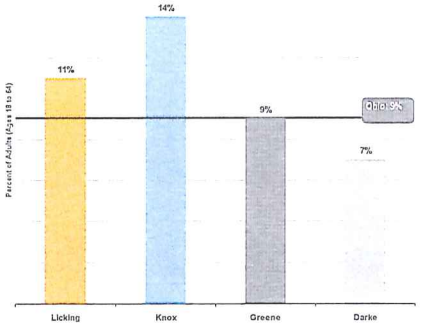


Source: *Mental Disorders and Medical Comorbidity*, Robert Wood Johnson Foundation, 2011; and Ohio Office of Health Transformation, 2011

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

31

Graph 17. Percent of adults ages 18 to 64 who report they have ever been diagnosed with diabetes: 2008

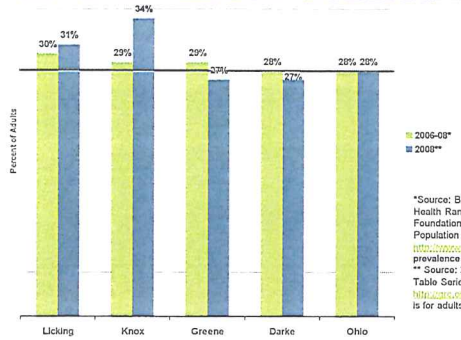


Source: 2008 Ohio Family Health Survey, Table Series 2: Regions and Counties, http://grc.osu.edu/ofhs/

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

32

Graph 18. Adult obesity
(percent of adults who report BMI ≥30)

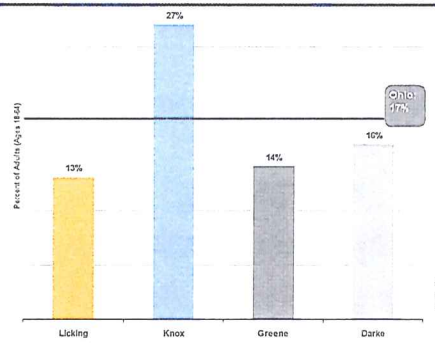


*Source: BRFSS data compiled by County Health Rankings, Robert Wood Johnson Foundation and University of Wisconsin Population Health Institute, http://www.countyhealthrankings.org/; prevalence is for adults ages 18 and older
** Source: 2008 Ohio Family Health Survey, Table Series 2: Regions and Counties, http://grc.osu.edu/ofhs/ ; prevalence is for adults ages 18-64

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

33

Graph 19. Poor or fair health status among adults ages 18 to 64: 2008

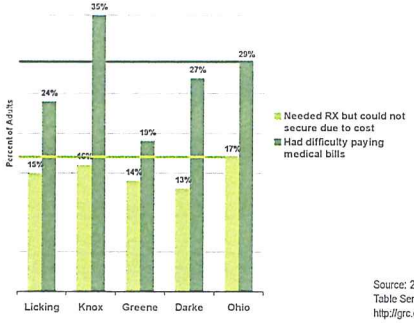


Source: 2008 Ohio Family Health Survey, Table Series 2: Regions and Counties, http://grc.osu.edu/ofhs/

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

34

Graph 20. Percent of adults ages 18-64 who had difficulty paying for health care in past 12 months, 2008-09

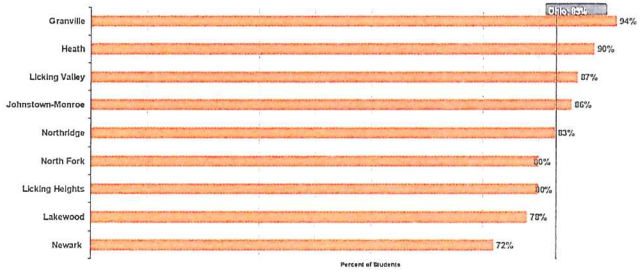


Source: 2008 Ohio Family Health Survey, Table Series 2: Regions and Counties, http://grc.osu.edu/ofhs/

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

35

Graph 21. Percent of students ready for Kindergarten* (KRA-L Scores): Licking County, 2009-10 school year

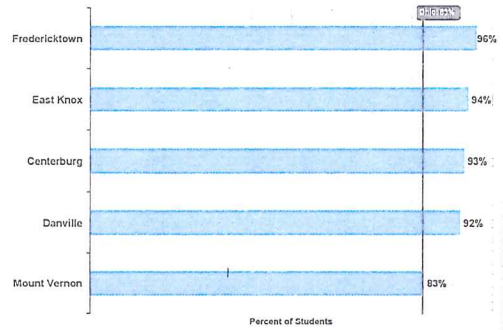


*Percent of Kindergarten students who score within Band 2 ("targeted") or Band 3 ("enriched") on the Kindergarten Readiness Assessment-Literacy (KRA-L).
Source: Ohio Department of Education, Interactive Local Report Card PowerUser Reports, http://ilrc.odo.state.oh.us/

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

36

Graph 22. Percent of students ready for Kindergarten* (KRA-L Scores): Knox County, 2009-10 school year

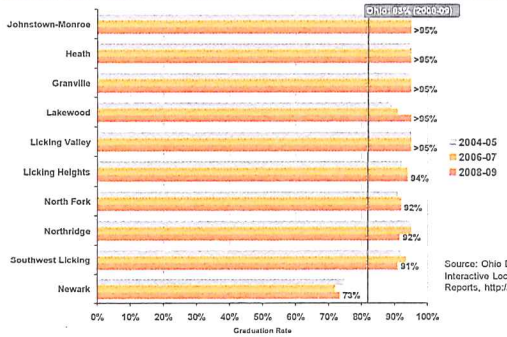


*Percent of Kindergarten students who score within Band 2 ("targeted") or Band 3 ("enriched") on the Kindergarten Readiness Assessment-Literacy (KRA-L). Source: Ohio Department of Education, Interactive Local Report Card PowerUser Reports, http://ilrc.ode.state.oh.us/

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

37

Graph 23. Graduation Rate: Licking County districts, selected school years

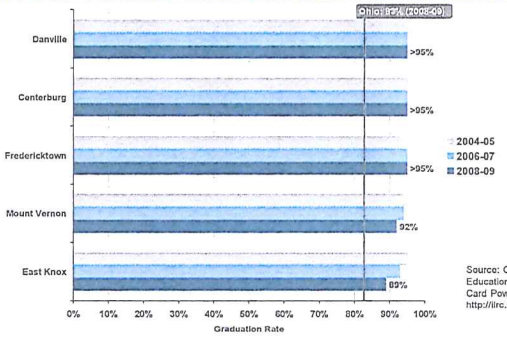


Source: Ohio Department of Education, Interactive Local Report Card PowerUser Reports, http://ilrc.ode.state.oh.us/

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

38

Graph 24. Graduation Rate: Knox County districts, selected school years



Source: Ohio Department of Education, Interactive Local Report Card PowerUser Reports, http://ilrc.ode.state.oh.us/

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

39

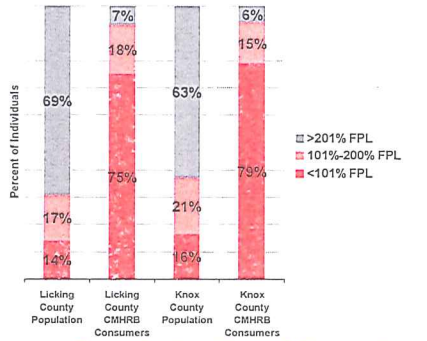
3. Status of the Behavioral Health System

What treatment and prevention services do we currently provide, and how has this changed? What are the trends in demand, capacity, and performance?

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

40

Graph 25. Poverty status of CMHRB treatment consumers compared to poverty status of overall population: 2008

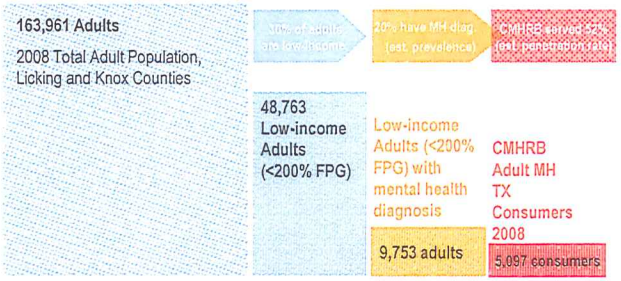


Sources: Population and poverty counts are from 2008 Ohio Family Health Survey, Table Series 2: Regions and Counties, http://grc.osu.edu/ofhs/; CMHRB consumer counts are from FY2010 Individual Providers Report
Note: CMHRB consumer data for 2008 is reported to be comparable with most recently available county-level poverty status data. County population data is for calendar year 2008 and CMHRB consumer data is for state fiscal year 2008. The proportion of CMHRB consumers living in poverty from SFY2008 to SFY2010 has remained constant for Knox County, and increased slightly for Licking County (from 75% to 79%).

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

41

Graph 26. Estimated Adult Mental Health Prevalence and Penetration Rate among Low-Income Population: Licking and Knox Counties, 2008



Population and poverty source: 2008 Ohio Family Health Survey. Mental health prevalence source: SAMHSA, *Results from the 2009 National Survey on Drug Use and Health: Mental Health Findings*, 2010 ("mental illness"). CMHRB consumers source: FY2010 Individual Providers Report, analysis of MACSIS claims for CMHRB of Licking and Knox Counties

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

42

Graph 27. Estimated Adult AOD Prevalence and Penetration Rate among Low-Income Population: Licking and Knox Counties, 2008

Population and poverty source: 2008 Ohio Family Health Survey. AOD prevalence source: National Institute on Alcohol Abuse and Alcoholism, *12-month Prevalence of DSM-IV Alcohol Dependence* (9% estimate includes Abuse and Dependence, alcohol and drugs). CMHRB consumers source: FY2010 Individual Providers Report, analysis of MACSIS claims for CMHRB of Licking and Knox Counties

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

43

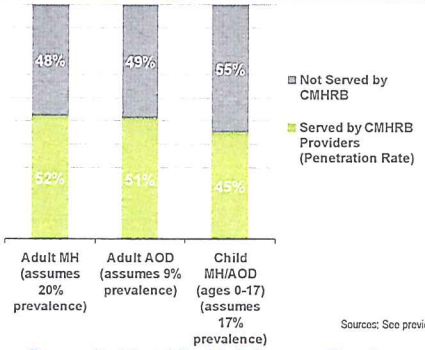
Graph 28. Estimated Child MH/AOD Prevalence and Penetration Rate among Low-Income Population: Licking and Knox Counties, 2008 (ages 0-17)

Population and poverty source: 2008 Ohio Family Health Survey. BH disorder prevalence source: *Preventing Mental, Emotional, and Behavioral Disorders Among Young People*, National Research Council and the Institute of Medicine, 2009 (includes Depression, Anxiety Disorders, ADHD, Conduct Disorder, Oppositional Defiant, Substance Abuse, Alcohol Abuse). CMHRB consumers source: FY2010 Individual Providers Report, analysis of MACSIS claims for CMHRB of Licking and Knox Counties

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

44

Graph 29. CMHRB Treatment Penetration Rates for Adults and Children with BH Needs at <200% FPG, 2008

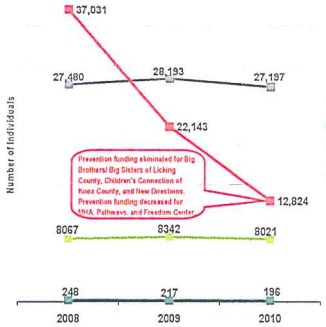


Sources: See previous three slides.

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

45

Graph 30. Number Served by CMHRB-Contracted Providers: Licking and Knox Counties combined, SFY 2008-SFY 2010

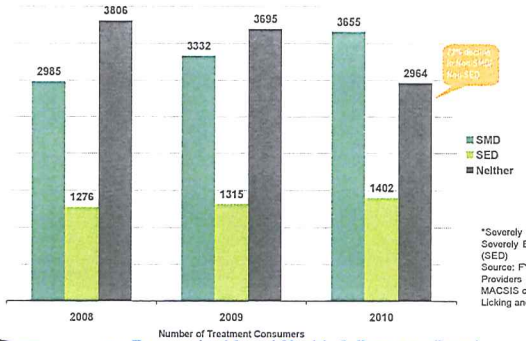


*Total calls from residents of Licking, Knox, and other/unknown counties. **May include some duplicate counts within provider or across provider
Note: Treatment and DV are unduplicated counts of individuals; Hotline and Prevention may include duplicates
Source for Hotline: Monthly hotline reports from Pathways of Central Ohio. Source for Prevention: Semi-Annual Prevention reports from CMHRB-contracted prevention providers. Source for Domestic Violence Shelter: Quarterly DV Shelter reports from New Directions and New Beginnings

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

46

Graph 31. Number of Unduplicated Individual CMHRB MH Treatment Consumers, by SMD/SED* status

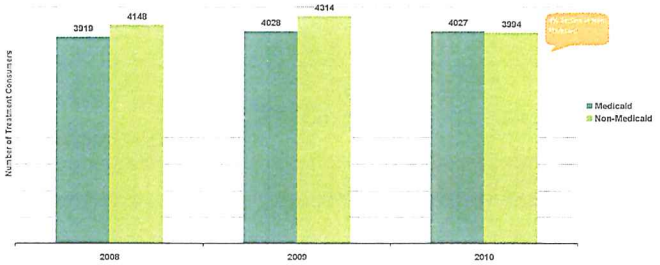


*Severely Mentally Disabled (SMD), Severely Emotionally Disturbed (SED)
Source: FY2010 Individual Providers Report, analysis of MACSIS claims for CMHRB of Licking and Knox Counties

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

47

Graph 32. Number of Unduplicated Individual CMHRB Treatment Consumers, by Medicaid status

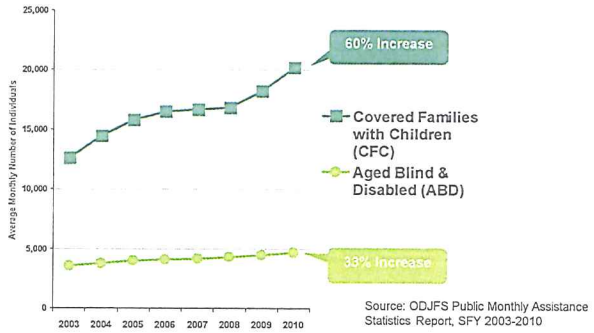


Source: FY2010 Individual Providers Report, analysis of MACSIS claims for CMHRB of Licking and Knox Counties

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

48

Graph 34. Average Number of Individuals Receiving Medicaid Each Month, Licking County, SFY 2003 through

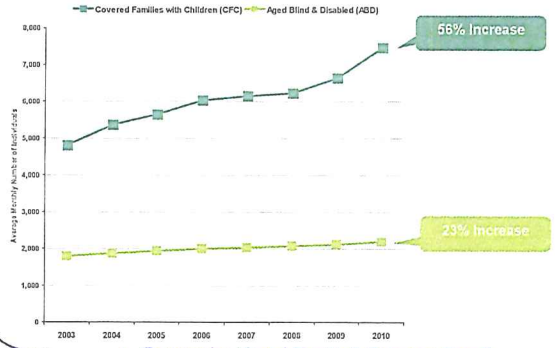


Source: ODJFS Public Monthly Assistance Statistics Report, SFY 2003-2010

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

49

Graph 35. Average Number of Individuals Receiving Medicaid Each Month, Knox County, SFY 2003 through 2010

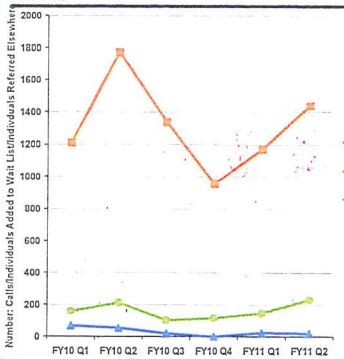


Community Mental Health & Recovery Board
Serving Licking and Knox Counties

50

Graph 36. Volume of Calls, Wait List Additions, and Referred Elsewhere Due to Lack of Capacity:

CMHRB-contracted Providers, by state fiscal quarter, Adults (ages 18+ years)



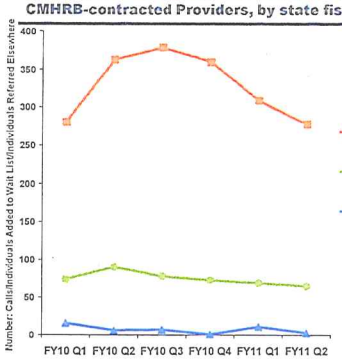
*Number of calls from new/potential clients. Does not include The Main Place. **Number of new clients placed on the waiting list during the quarter. Data are for BHPCO-MH (Moundbuilders) and The Woodlands waiting lists; other providers do not have waiting lists. Source: CMHRB Quarterly Board Performance Target Reports.

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

51

Graph 37. Volume of Calls, Wait List Additions, and Referred Elsewhere Due to Lack of Capacity:

CMHRB-contracted Providers, by state fiscal quarter, Youth (ages 0-17)



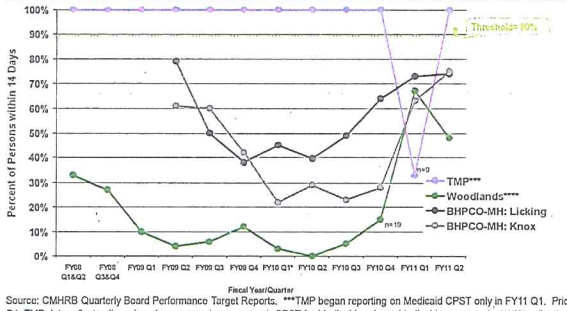
*Number of calls from new/potential clients. Does not include The Main Place. **Number of new clients placed on the waiting list during the quarter. Data are for BHPCO-MH (Moundbuilders) and The Woodlands waiting lists; other providers do not have waiting lists. Source: CMHRB Quarterly Board Performance Target Reports.

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

52

Graph 38. First Appointment Access: Adult Mental Health

(percent of adults scheduled for initial clinical assessment appointment within 14 days of initial call)



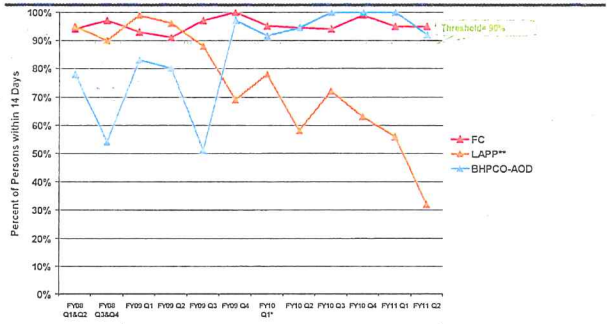
Source: CMHRB Quarterly Board Performance Target Reports. ***TMP began reporting on Medicaid CPST only in FY11 Q1. Prior to FY11 Q1, TMP data reflects all services (peer support, assessment, CPST for Medicaid and non-Medicaid consumers). ****Woodlands corrected its method of reporting data for B2 and C2 in FY11. Data displayed above for FY11 Q1 and Q2 are correct using the appropriate method, while different quarters reflect a consistently different method.

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

53

Graph 39. First Appointment Access: Adult AOD

(percent of adults scheduled for initial clinical assessment appointment within 14 days of initial call)



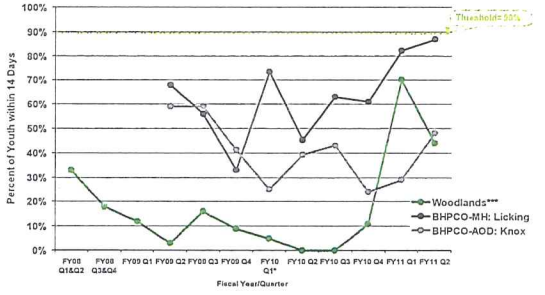
Source: CMHRB Quarterly Board Performance Target Reports. **LAPP changed method in FY09 Q4 from "business days" to "calendar days."

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

54

Graph 40. First Appointment Access: Youth Mental Health

(percent of children/youth scheduled for initial clinical assessment appointment within 14 days of initial call)



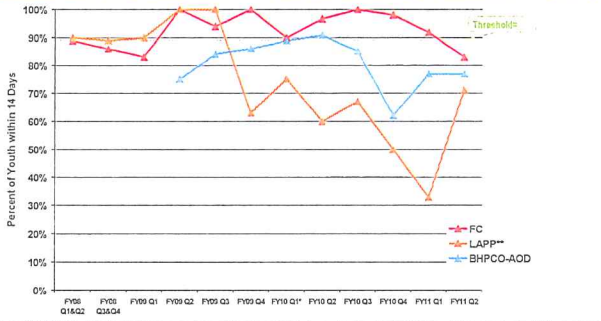
Source: CMHRB Quarterly Board Performance Target Reports. ****Woodlands corrected its method of reporting data for B2 and C2 in FY11. Data displayed above for FY11 Q1 and Q2 are correct using the appropriate method, while different quarters reflect a consistently different method.

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

55

Graph 41. First Appointment Access: Youth AOD

(percent of children/youth scheduled for initial clinical assessment appointment within 14 days of initial call)

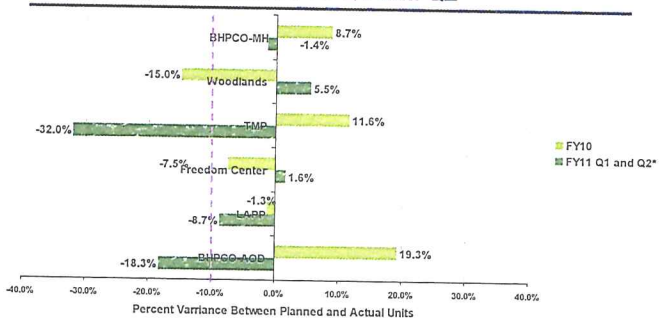


Source: CMHRB Quarterly Board Performance Target Reports. **LAPP changed method in FY09 Q4 from "business days" to "calendar days."

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

56

Graph 42: Treatment Units Produced: Variance between actual and contract amount: Taxonomy A Services*, FY10 and FY11 Q1 and Q2

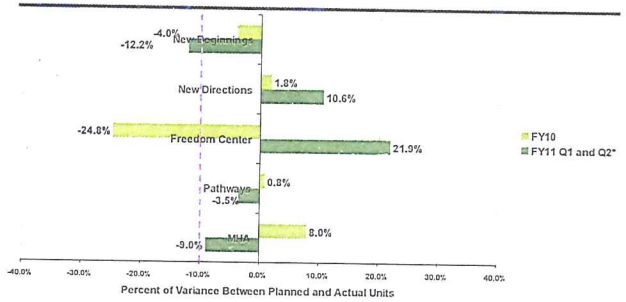


*Taxonomy A includes: Pharm. Mgt., Assessment, Ind. and Grp. Counseling, Crisis Intervention, CPST/Case Management, AOD Intensive Outpatient, Urinalysis. Source: CMHRB provider quarterly financial reports (budgeted vs. actual units, "Dashboard Report")

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

57

Graph 43. Prevention and Domestic Violence Units Produced: Variance between actual and contract amount: Prevention and Residential*, FY11 Q1 and Q2 YTD



*Prevention includes: Education, Prevention, Alternatives, Community-Based Process, Information Dissemination, and Problem Identification. DV shelter includes: Residential Care (NB) and Other MH (ND). Source: CMHRB provider quarterly financial reports (budgeted vs. actual units, "Dashboard Report")

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

58

FY10 and First Half of FY11: System Strengths

- Access to emergency, crisis, and urgent services
- Positive outcomes for AOD consumers (targets related to program completion and abstinence routinely met; positive outcome results on MHSIP/YSS)
- Positive outcomes for ACT Team
- Good use of existing housing resources (low vacancy rates)
- All prevention programs now have moderate or high dose

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

59

FY10 and First Half of FY11: System Challenges

- Despite some improvements in first appointment access to mental health services, timely access remains a concern at some MH and AOD providers
- Analysis of productivity and access indicates that productivity below industry standards and below provider projections may be hampering access for specific providers and product lines, while there appear to be overall system capacity problems for individual mental health counseling

Community Mental Health & Recovery Board
Serving Licking and Knox Counties

60

FY10 and First Half of FY11: System Challenges, continued

- Outcomes for adults, teens, and children (MHSIP/YSS/YSS-F results) are a concern, particularly for mental health
- Hospital follow-up for adults and children
- Need approach to extend reach of evidence-based prevention strategies

4. Alignment and Gaps

How well do our current services align with the needs in our counties? Where are the gaps and potential challenges?

Overall gaps and challenges

- Increase in number of poor individuals in both counties
- Decreased ability to serve non-SMD individuals
- Need comprehensive strategy to address rise in opiate addiction
- Lack of integration between behavioral health and physical health to address relationships between BH needs, chronic medical conditions, and obesity
- Need to improve early intervention and services for families with young children
- Need comprehensive strategy for investing in effective and efficient prevention activities
- Potential upcoming challenges: "spill-over" from state policy changes and budget cuts in related systems

For more information

- Contact Amy Bush Stevens, CMHRB Program Evaluator, stevens@bhg.org