



**Department of
Mental Health**

**Department of Alcohol
and Drug Addiction Services**

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Ted Strickland, Governor

Community Plan Guidelines for SFY 2012 – 2013

September 29, 2010

Ted Strickland, Governor
Ohio Department of Mental Health
and
Ohio Department of Alcohol and Drug Addiction Services
Community Plan Guidelines for SFY 2012 – 2013

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Introduction and Instructions for Completing the Community Plan Guidelines for SFY 2012 – 2013

INTRODUCTION

Attached please find a copy of the ODMH/ODADAS Community Plan Guidelines and Review Criteria. These guidelines, which will cover SFY 2012 and 2013, represent the Departments' efforts at streamlining statutory requirements and reducing administrative burden. A draft of the guidelines was disseminated to key constituent groups for review and feedback and much of that feedback was incorporated into this version of the guidelines.

Plans will be reviewed by a joint ODMH/ODADAS team. The focus of the Plan reviews will be to ensure that statutory requirements are met and to strengthen the Plan's ability to serve as a marketing tool (utilizing the Plan to leverage shared resources with other systems and enhance collaboration) and blueprint for service provision.

The ODADAS Planning Committee of the Governor's Shareholders Group produced a final report June 17, 2003 that continues to provide guidance to the development of the Community Plan guidelines. The report identified seven priority issues related to Community Planning which have been expanded upon to address both the AOD and mental health system in light of this ODMH/ODADAS Community Plan guidelines effort:

1. The Community Plan should be a living, useful document with widespread applicability and awareness. The Community Plan should be viewed as a management tool for the Board. In this regard, the Plan is best used for marketing, resource development, service identification, delivery and evaluation.
2. Service planning needs to be purposefully connected with other related planning processes in the community. The Plan should address shared community priorities where possible. It should promote solution for priorities established by other entities within the service area.
3. The Planning Committee believed that it was important to identify "best practices" of Community Planning and share these practices with all counties.
4. It is important to identify tangible benefits for local communities that come from doing quality planning.
5. There must be a better connection between local Community Plans and Departmental funding priorities and decisions. This allows local planners to support Departments' initiatives and allow the Departments to promote local initiatives. An improved connection between state and local planning places the field in a position to better advocate for and develop the system. Community Plans and Department priorities should jointly be the basis for the development of state plans.
6. Identify and eliminate activities that are non-productive to the planning process.
7. Recognize that local political process and activity influences Community Planning.

The Governor's Shareholders Group Planning Committee also identified key reasons for engaging in quality planning. These included:

1. Improve the financial position of local behavioral health systems by attracting support from other areas that have a vested interest in assuring that a healthy alcohol and other drug and mental health system exists in the county.
2. Improve the ability of other systems to meet their needs and objectives.
3. A basis for marketing efforts that is needed to attract participation and support (investment) from other systems including the business community.
4. The Community Plan should be product oriented – its operationalization should result in concrete results based upon identified priorities. This should be a *community product* related to mutually shared community priorities.

In summary, the Community Plan Guidelines for SFY 2012-2013 place an emphasis in clarity of outcomes and results within a planning process. Boards are asked to describe Board goals (outcomes) that are consistent with and contribute to Department goals (outcomes) as well as to describe a plan for verifying that results are achieved.

INSTRUCTIONS FOR COMPLETING THE COMMUNITY PLAN GUIDELINES FOR SFY 2012 - 2013

Application and Approval Process

The Community Plan for Alcohol, Drug Addiction and Mental Health Services for SFY 2012 – 2013 is **due by December 30, 2010***. Boards are required to submit their Plan to ODMH and ODADAS by e-mail to [**communplan@ada.ohio.gov**](mailto:communplan@ada.ohio.gov). Plans will not be accepted by fax or hard copy. **All Boards (ADAMHS, ADAS and CMH) must also submit two original hard copies of the completed signature page (page 45 of the Template) to:**

**ATTN: Matthew V. Loncaric
Ohio Department of Mental Health
30 East Broad Street, 8th Floor
Columbus, Ohio 43215-3430**

* The State Departments extended the due date for the Community Plan to September 1, 2011.

ODMH and ODADAS staff will review the completed application within 60 days of receipt and notify each Board of its Plan approval or any required modifications or additions. Complete application approval can occur only after ODMH and ODADAS receive and approve the SFY 2012 – 2013 Community Plan, including:

- ❖ **ODADAS Only:** SAMHSA notifies ODADAS of its final SAPT Block Grant award for FFY 2011;
- ❖ **ODADAS Only:** Boards are informed of their final allocations for SFY 2012 by ODADAS;
- ❖ **ODMH Only:** Approval of State Inpatient Bed Days & CSN Services;
- ❖ **ODMH Only:** Approval of Notification of Election of Distribution;
- ❖ **ODMH Only:** Approval of Agreement and Assurances (*to be sent under separate cover*);
- ❖ **ODMH Only:** Approval of Board Forensic Monitor and Board Community Linkage Contact;
- ❖ **ODMH Only:** Approval of Board Membership Catalog;
- ❖ **ODMH Only:** Approval of Board Budget Template and Narrative.

The Community Plan Guidelines are available on the ODMH and ODADAS websites: <http://mentalhealth.ohio.gov/> and <http://www.odadas.ohio.gov/>. With the exception of the signature page (two original signature pages must be mailed), applications will only be accepted via e-mail submission to communplan@ada.ohio.gov.

Completing the Guidelines

Boards must use the Community Plan Template (see page 42) to complete and submit their Plan. The template includes all of the required headings for each section and each response in the Plan. Instructions for completing the Community Plan Template follow:

Boards must complete responses to each required item in Microsoft Word or other word processor software saved in a format that can be read by **Microsoft Word and Excel VERSIONS 2003 or earlier** using the template included with these guidelines. The Board is expected to provide a response to all items in the Guidelines that are identified.

There are several items that are unique to the needs of ODMH or ODADAS. For items required only by ODADAS, items are marked ADAMHS/ADAS Only. Items required only for ODMH are marked ADAMHS/CMH only. In these instances the CMH or ADAS Board may delete the heading of the item from the Community Plan Template prior to submitting the Plan to the Departments.

Note that in several items the Departments ask Boards to respond, when applicable, to specific populations including deaf and hard of hearing, veterans and criminal justice involved clients or ex-offenders. These are populations with which ODADAS and/or ODMH have a special interest either through federally-funded technical assistance efforts or programs or through statewide, interdepartmental initiatives such as Ohio Cares and the Forensic Strategies Workgroup. Responses in the Community Plan will help to inform these efforts.

Provision of additional information and inclusion of documents in appendices

Boards may attach appendices as needed for the Community Plan; however, Plan reviewers will expect to find complete responses to items under the appropriate heading in the body of the Plan. Appendices should be utilized for supporting documentation.

Example: A Board responds to the methodology and findings questions of the needs assessment by writing “Please see Appendix X: Board Five-Year Strategic Plan.” This is not an acceptable response. An acceptable response would be to summarize, in the needs assessment section of the Community Plan, the methodology and key findings of the needs assessment conducted for the five year strategic plan that have relevance for SFY 2012-2013, then note that the full five year strategic plan can be found in Appendix X.

Regional Webinars

In order to assist Boards in completing the application, regional webinars will be held. Dates and times for the regional forums are:

Tuesday, October 5 from 9:30 AM – 11:30 AM - Central Region:

- ❖ MH & Recovery Board of Ashland County
- ❖ MH & Recovery Board of Clark, Greene, & Madison Counties
- ❖ Crawford-Marion Board of ADAMHS
- ❖ Delaware-Morrow MH & RS Board
- ❖ Fairfield County ADAMH Board
- ❖ ADAMH Board of Franklin County
- ❖ Licking & Knox Counties MHRS Board
- ❖ Logan-Champaign Counties MHDAS Board
- ❖ Paint Valley ADAMH Board
- ❖ MHRS Board of Richland County
- ❖ MH & Recovery Board of Union County

- ❖ MH & Recovery Board of Wayne & Holmes Counties

Tuesday, October 5 from 1:00 PM – 3:00 PM - Southwest Region:

- ❖ ADAMHS Board of Adams, Lawrence & Scioto Counties
- ❖ Brown County Community Board of ADAMHS
- ❖ Butler County ADA Services Board
- ❖ Butler County Mental Health Board
- ❖ Clermont County MH & Recovery Board
- ❖ Gallia-Jackson-Meigs Board of ADAMHS
- ❖ Hamilton County MH & Recovery Services Board
- ❖ ADAMHS Board for Montgomery County
- ❖ Preble County MH & Recovery Board
- ❖ Tri-County Board of Recovery & MH Services
- ❖ MHRHS Board of Warren & Clinton Counties

Wednesday, October 6 from 9:30 AM – 11:30 PM - Southeast Region:

- ❖ Athens-Hocking-Vinton 317 Board
- ❖ Belmont-Harrison-Monroe MH & Recovery Board
- ❖ Jefferson County Prevention & Recovery Board
- ❖ Muskingum Area ADAMH Board
- ❖ Portage County MH & Recovery Board
- ❖ MHRHS Board of Stark County
- ❖ ADAMHS Board of Tuscarawas & Carroll Counties
- ❖ Washington County MH & AR Board

Wednesday, October 6 from 1:00 PM – 3:00 PM - Northwest Region:

- ❖ MHRHS Board of Allen, Auglaize & Hardin Counties
- ❖ MH & Recovery Board of Erie & Ottawa Counties
- ❖ Four County ADAMH Board
- ❖ Hancock County ADAMHS Board
- ❖ Huron County ADAMHS Board
- ❖ MHRHS Board of Lucas County
- ❖ Mercer, Van Wert & Paulding ADAMH Board
- ❖ MH & ADA Recovery Board of Putnam County
- ❖ MHRHS Board of Seneca, Sandusky & Wyandot Counties
- ❖ Wood County ADAMHS Board

Thursday, October 7 from 9:30 AM – 11:30 AM - Northeast Region:

- ❖ Ashtabula County MH & Recovery Board
- ❖ Columbiana County MH & Recovery Board
- ❖ ADAMHS Board of Cuyahoga County
- ❖ Geauga Board of MHRS
- ❖ Lake County ADAMHS Board
- ❖ ADAS Board of Lorain County
- ❖ Lorain County Mental Health Board
- ❖ Mahoning County ADAS Board
- ❖ Mahoning County CMH Board
- ❖ Medina County ADAMH Board
- ❖ County of Summit ADM Board
- ❖ Trumbull County MH & Recovery Board

If you cannot attend the regional webinar at your designated time, you may attend one of the other webinars. The web link and phone number to access the regional webinars will be sent during the week of September 27, 2010.

Weekly Phone Question & Answer/Technical Assistance Sessions

Weekly phone Q&A/TA sessions between Boards and ODMH/ODADAS staff will take place each Wednesday beginning on October 13, 2010 and concluding with a final session on December 22, 2010. Each session will be scheduled from 10:00 AM – 11:00 AM. Questions not unique to a specific Board will be included in a Frequently Asked Questions (FAQ) on the ODMH and ODADAS websites. The phone numbers to access the weekly Q&A/TA sessions will also be posted to the ODMH and ODADAS websites.

Plan Review and Questions

Review criteria are attached in Appendix E and will be reviewed at the regional forums. Questions from Boards regarding the Community Plan Guidelines should be directed to the following e-mail address **communplan@ada.ohio.gov**. Boards will receive a written response via e-mail. An FAQ will be developed and posted as questions are received from Boards.

Changes to the Plan

Consistent with ORC 340.03(A)(1)(c) and 3793.05, if a Board determines that it is necessary to amend a plan that has been approved, the Board is to submit the proposed change to Sanford Starr, Chief of the Division of Planning, Outcomes and Research at ODADAS (SStarr@ada.ohio.gov) and Carrol A. Hernandez, Assistant Deputy Director, Program & Policy Development at ODMH (Carrol.Hernandez@mh.ohio.gov). For ADAMHS/CMH Boards only: If a significant change in budget should occur (i.e. 10 percent or more of the Board's current annual allocation), the proposed change must be submitted to Holly Jones in the Office of Fiscal

Administration at ODMH (Holly.Jones@mh.ohio.gov). If the Departments do not respond within 30 days of the date of receipt, then the revision will be considered approved.

Instructions for Completing the Cover Page:

The Board must insert Board name and submission date where indicated.

Instructions for Completing Mission, Vision and Value Statements:

If the Board has a mission, vision and/or set of value statements, they can be inserted in the spaces indicated. If the Board does not have a mission, vision and/or value statement, the heading of those statements can be removed from the Template.

Instructions for Completing Signature Page:

All Boards (ADAMHS, ADAS and CMH) must submit two original hard copies of the completed signature page (page 45 of the Template) to:

**ATTN: Matthew V. Loncaric
Ohio Department of Mental Health
30 East Broad Street, 8th Floor
Columbus, Ohio 43215-3430**

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.).

Section I: Legislative and Environmental Context of the Community Plan

Background and Instructions for Completing Section I of the Plan

Use the Community Plan Template (see page 42) to respond to each item described below.

I. Legislative Context of the Community Plan

The legislative basis of the Plan defines the statutory “givens” that must be addressed by the Plan. *The Departments have provided the legislative context section fully written in the Community Plan template. The Board does not have to modify this portion of the Plan.*

II. Environmental Context of the Community Plan

The environmental context defines key economic, demographic, and social factors that will have an impact on the service delivery system. A number of different processes or analyses can be used to help define the environmental context of the Plan. For example, SWOT Analysis helps to identify internal factors – The *strengths* and *weaknesses* internal to the local system of care and external factors – The *opportunities* and *threats* presented by the external environment to the local system of behavioral care.

The guidelines do not prescribe a method of environmental analysis but rather ask Boards to address the results of an analysis that include at a minimum two themes of overriding importance that will shape the provision of behavioral health care today and into the future: the economy and healthcare reform. Additionally, Boards are asked to discuss other key factors that will impact the provision of services including trends in clients who seek services. Trend information must include a discussion of forensic clients. Refer to the technical report of the Forensic Strategies Workgroup. Finally, Boards should identify successes or achievements of the previous Plan.

NOTE on description of characteristics of clients who have sought services: There is a number of priority populations mandated by federal or state legislation that Boards incorporate into the Plan. In addition, there are locally derived priority populations that may also be reflected in the Board’s Plan. The response to characteristics of clients served informs the Departments, local systems with which the Board collaborates and the general public of the manner in which the Board is responding to this mix of priority populations. Hence, the focus on characteristics of customers is not about reporting back to ODMH and ODADAS publicly available utilization data, but rather serves as a tool to provide a basis in understanding who is receiving services, and who is not. This is especially important in times of fiscal retrenchment.

Economic Conditions and the Delivery of Behavioral Health Care Services

In response to this item, Boards may discuss their fiscal realities and constraints including Medicaid and Medicare issues that they encounter in providing behavioral health prevention and treatment services.

***Question 1:** Discuss how economic conditions, including employment and poverty levels, are expected to affect local service delivery. Include in this discussion the impact of recent budget cuts and reduced local resources on service delivery. This discussion may include cost-saving measures and operational efficiencies implemented to reduce program costs or other budgetary planning efforts of the Board.*

Implications of Health Care Reform on Behavioral Health Services

***Question 2:** Based upon what is known to date, discuss implications of recently enacted health care reform legislation on the Board's system of care.*

Key Factors that Will Shape the Provision of Behavioral Health Care Services in the Board Area

***Question 3:** Discuss the change in social and demographic factors in the Board area that will influence service delivery. This response should include a description of the characteristics of customers/clients currently served including recent trends such as changes in services (e.g., problem gambling) and populations for behavioral health prevention, treatment and recovery services.*

III. Major Achievements and Significant Unrealized Goals of the SFY 2010-2011 Community Plan

***Question 4:** Describe major achievements.*

***Question 5:** Describe significant unrealized goals and briefly describe the barriers to achieving them.*

Section II: Needs Assessment

Background and Instructions for Completing Section II of the Plan

Use the Community Plan Template (see page 42) to respond to each item described below. This section of the Plan includes a description of process and findings of the Board's needs assessment regarding 1) prevention, 2) treatment and recovery services, and 3) capacity needs for behavioral health care.

Process the Board used to assess behavioral health needs

Question 6: Describe the process the Board utilized to determine its current behavioral healthcare needs including data sources and types, methodology, time frames and stakeholders involved.

Findings of the needs assessment

Question 7: Describe the findings of the needs assessment identified through quantitative and qualitative sources.

In the discussion of findings please be specific to:

- a. Adult residents of the district hospitalized at the Regional Psychiatric Hospitals (**ADAMHS/CMH only**);
- b. Adults with severe mental disability (SPMI) and children and Youths with serious emotional disturbances (SED) living in the community (**ADAMHS/CMH only**);
- c. Individuals receiving general outpatient community mental health services (**ADAMHS/CMH only**);
- d. Availability of crisis services to persons without Medicaid and/or other insurance. (**ADAMH/CMH only**)
- e. Adults, children and adolescents who abuse or are addicted to alcohol or other drugs (**ADAMHS/ADAS only**)
- f. Children and Families receiving services through a Family and Children First Council;
- g. Persons with substance abuse and mental illness (SA/MI); and
- h. Individuals involved in the criminal justice system (both adults and children)
- i. Veterans, including the National Guard, from the Iraq and Afghanistan conflicts

Assessment of Capacity to Provide Behavioral Health Care Services Must Include the Following:

Access to Services

Question 8:

- a) *Identify the major issues or concerns for individuals attempting to access behavioral health prevention and treatment services in the Board area. In this response please include, when applicable, issues that may exist for clients who are deaf or hard of hearing, veterans, ex-offenders, problem gamblers, and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.*
- b) *Please discuss how the Board plans to address any gaps in the crisis care services indicated by OAC 5122-29-10(B). (ADAMHS/CMH only);*
- c) *Please discuss how the Board identified and prioritized training needs for personnel providing crisis intervention services, and how the Board plans to address those needs in SFY 2012-13. (ADAMHS/CMH only);*

Question 9: Workforce Development and Cultural Competence*

- a) *Describe the Board's current role in working with the ODMH, ODADAS and providers to attract, retain and develop qualified direct service staff for the provision of behavioral health services. Does the local service system have sufficient qualified licensed and credentialed staff to meet its service delivery needs for behavioral health services? If "no", identify the areas of concern and workforce development needs.*

Cultural Competence is a set of attitudes, skills, behaviors, and policies that enable organizations (e.g., Boards and Providers) and staff to work effectively in cross-cultural situations (*see Appendix D for State of Ohio definition).

- b) *Describe the Board's current activities, strategies, successes and challenges in building a local system of care that is culturally competent. Please include in this response any workforce development and cultural competence issues, when applicable, related to serving the deaf and hard of hearing population, veterans, ex-offenders, problem gamblers and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.*

Question 10: Capital Improvements:

For the Board's local behavioral health service system, identify the Board's capital (construction and/or renovation) needs.

Section III: Priorities, Goals and Objectives for Capacity, Prevention, Treatment and Recovery Support Services

Background and Instructions for Completing Section III of the Plan

Use the Community Plan Template (see page 42) to respond to each item described below. This section of the Plan requires Boards to describe how priorities were determined, and identify goals and objectives based on the needs assessment. **Priorities, goals, and objectives should be based on the needs assessment and a realistic appraisal of available resources.** Assume a flat budget. Department priorities and goals are identified below for system capacity, prevention, treatment and recovery services.

Boards are expected to align with Department priorities and goals and demonstrate that the Board's efforts are making a contribution to the achievement or success of at least one each of the Department capacity, prevention and treatment and recovery services goals through funding, activities, or outcomes. Boards may also identify additional priorities and goals determined locally.

DEPARTMENT CAPACITY GOALS

Capacity development goals refer to infrastructure development goals that improve the system's efficiency and effectiveness in providing access to services.

Behavioral Health Capacity Goals

- Reduce stigma (e.g., advocacy efforts)
- Mental Illness and Addiction are health care issues with an appropriate and necessary continuum of care that includes prevention/intervention and treatment and recovery services
- An accessible, effective, seamless prevention/intervention, treatment and recovery services continuum from childhood through adulthood
- A highly effective workforce
- Use a diversity of revenue sources to support Ohio's behavioral health system (e.g., apply for foundation and SAMHSA discretionary grants)
- Promote and sustain the use of "evidenced-based" policies, practices, strategies, supportive housing, peer support, and other programs
- Increase the use of data to make informed decisions about planning and investment
- Promote integration of behavioral healthcare and other physical health services
- Maintain access to services to all age, ethnic, racial, and gender categories as well as geographic areas of the state
- Improve cultural competence of behavioral health system
- Maintain access to crisis services for persons with SPMI, and SED regardless of ability to pay
- Decrease nursing facility admissions and increase consumer choice consistent with Olmstead recommendations and the Unified Long Term Care Budget

- Adult and family of youth consumers report that they are satisfied with the quality of their care and participate in treatment planning
- Increase hiring of peers
- Increase access to web-based training systems
- Increase availability of professionals through HPSA in areas with shortages
- Increase the availability of school-based behavioral health services
- Increase availability of trauma-informed and trauma-focused care

DEPARTMENT PREVENTION PRIORITIES AND GOALS

Prevention Goals should address the Board's priorities and project the level of change in condition or behavior for individuals, families, target groups, systems and/or communities. They should be related to the priority populations or initiatives identified below. Both AOD and MH Prevention targets may span the entire life cycle and do not need to be limited to addressing children and youth populations.

Alcohol and Other Drug Prevention Priorities:

Key ODADAS prevention initiatives include:

- Fetal Alcohol Spectrum Disorder
- Childhood/Underage Drinking
- Youth-Led Prevention
- Evidenced-Based Practice
- Stigma Reduction

ODADAS Priority Populations:

- AOD prevention is conceptualized in terms of lifespan. ODADAS is committed to meeting the prevention needs of individuals and families over the lifespan for all populations, and to the promotion of safe and healthy communities.

Mental Health Prevention Priorities:

Key ODMH Prevention, Consultation & Education (PC&E) initiatives include:

- Suicide Prevention
- Depression Screenings, including Maternal Depression Screenings
- Early Intervention programs
- Faith-based and culturally specific initiatives
- School-based mental health services/programs
- Stigma Reduction activities
- Crisis Intervention Training (CIT) and other Jail Diversion Activities

ODMH Priority Populations include:

- Adults with SMI and SPMI, and (see Appendix D)*
- Children/youth with SED (refer also to Appendix D)*
- Youth and Young Adults in Transition
- Older Adults
- Deaf and Hard of Hearing
- Military Personnel/Veterans
- Individuals involved in the criminal justice system including juvenile justice and Forensic clients
- Individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility
- Individuals involved in the child welfare system

*The definition of serious emotional disturbance (SED) for children and youth and severe mental disability (SPMI) for adults, which are based upon a combination of duration of impairment, intensity of impairment and diagnosis, are found in Ohio Administrative Code (OAC), 5122-24-01, "Certification definitions." These definitions historically had been used by ODMH in the distribution of funds to Boards. In SFY 2000 the use of these definitions for funding ended, and the definitions remain in OAC as a guide to Boards to delimit priority populations in the planning and delivery of services. These definitions should not be confused with an algorithm (based on post hoc determinations of intensity of services, age and diagnoses) used within MACSIS for ODMH to satisfy SAMHSA reporting requirements. However, if Boards have not developed an independent means of determining the SPMI/SED status of individual consumers, they may confidently rely upon the aggregate SPMI/SED determinations found within the MACSIS Data Mart. Aggregate SPMI/SED determinations are made within MACSIS by the November following the end of the state fiscal year.

Alcohol and Other Drug Prevention Goals:

- Programs that increase the number of customers who avoid ATOD use and perceive non-use as the norm;
- Programs that increase the number of customers who perceive ATOD use as harmful;
- Programs that increase the number of customers who experience positive family management;
- Programs that increase the number of customers who demonstrate school bonding and educational commitment;
- Programs that increase the number of initiatives that demonstrate an impact on community laws and norms; and
- Programs that reduce the number of customers who misuse prescription and/or over-the-counter medications.

Mental Health Prevention Goals:

The following mental health prevention goals are the new direction set by SAMHSA as cited by Pamela Hyde, Administrator of SAMHSA, in a June 23, 2010 key note address to the National (Mental Health Block) Grantee Conference. These prevention goals are more fully described in "Preventing Mental, Emotional and Behavioral Disorders Among Young People: Brief Report for Policy Makers," Institute of Medicine, March 2009, but in brief include:

- Strengthen families by targeting problems, teaching effective parenting and communication skills, and helping families deal with disruptions (such as divorce) or adversities such as parental mental illness or poverty.
- Strengthen individuals by building resilience and skills and improving cognitive processes and behaviors.
- Prevent specific disorders, such as anxiety or depression, by screening individuals at risk and offering cognitive or other preventative training (e.g. Red Flags).
- Promote mental health in schools by offering support to children encountering serious stresses, modify the school environment to promote pro-social behavior; develop students' skills in decision making, self-awareness, and conducting relationships; and target violence, aggressive behavior and substance use.
- Promote mental health through health care and community programs by promoting and supporting pro-social behavior, and emotional health, such as sleep, diet, activity and physical fitness.
- Programs that promote mental health and wellness for adults, especially for those with occurring chronic health conditions (e.g. cardio-vascular disease, diabetes). Programs that increase the number of persons that receive mental health screenings, brief intervention, referrals and treatment.
- Programs that decrease or eliminate stigma that are barriers to early intervention for emotional problems and mental illness.
- Suicide prevention coalitions that promote development of community resources to reduce suicide attempts.
- Programs that provide screening and early intervention to older adults (e.g. Healthy IDEAS).

DEPARTMENT TREATMENT AND RECOVERY SERVICES PRIORITIES AND GOALS

Alcohol and Other Drug Priority Populations and Key Initiatives

The federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires prioritization of services to several groups of recipients. These include: pregnant women, women, injecting drug users, clients and staff at risk of tuberculosis, and early intervention for individuals with or at risk for HIV disease. ODADAS is involved in several key initiatives directed at deaf and hard of hearing, veterans, and criminal justice involved clients.

Mental Health Priorities

Please refer to Appendix D for the most recent working definitions describing criteria related to SMI, SPMI and SED. **Please note that these definitions are still a work in progress and are not final.**

ODADAS Treatment and Recovery Services Goals

- Increase the number of customers who are abstinent at the completion of the program.
- Increase the number of customers who are gainfully employed at the completion of the program.
- Increase the number of customers who incur no new arrests at the completion of the program.
- Increase the number of customers who live in safe, stable, permanent housing at the completion of the program
- Increase the number of customers who participate in self-help and social support groups at the completion of the program.

ODMH Treatment and Recovery Support Goals

- Increase the number of consumers reporting positively about social connectedness and functioning and client perception of care.
- Increase competitive employment.
- Decrease school suspensions & expulsions.
- Decrease criminal and juvenile justice involvement.
- Increase access to housing, including Supportive Housing
- Decrease homelessness.
- Decrease re-hospitalization at Regional Psychiatric Hospitals in 30 and 180 days.

Process the Board used to determine capacity, prevention, treatment and recovery support services priorities

Identify the Board's process for determining capacity, prevention, treatment and recovery support services.

Question 11: Describe the process utilized by the Board to determine its capacity, prevention, treatment and recovery services priorities for SFY 2012 – 2013. In other words, how did the Board decide the most important areas in which to invest their resources?

Behavioral Health Capacity, Prevention, Treatment and Recovery Support Services Priorities, Goals and Objectives

Identify the Board's priorities for capacity, prevention, treatment and recovery support services.

Question 12: Based upon the Departmental priorities listed in the guidelines (and/or local priorities) and available resources, identify the Board's behavioral health capacity, prevention, treatment and recovery support services priorities, goals and objectives for SFY 2012—2013.

When addressing capacity goals and objectives please address the following:

Access to Services

Question 13: What are the Board's goals and objectives for addressing access issues for behavioral health services identified in the previous section of the Plan?

Workforce Development and Cultural Competence

Question 14: What are the Board's goals and objectives for SFY 2012 and 2013 to foster workforce development and increase cultural competence? Please discuss the areas of most salience or strategic importance to your system. What are the Board's plans for SFY 2012 and 2013 to identify, increase and assess cultural competence in the following areas: Consumer satisfaction with services and staff, staff recruitment (including persons in recovery) staff training, and addressing disparities in access and treatment outcomes? (Please reference Appendix D for State of Ohio definition of cultural competence.)

*When addressing treatment and recovery services goals for **ODADAS**, please address the following:*

ORC 340.033(H) Goals

Question 15: To improve accountability and clarity related to ORC 340.033(H) programming, ADAMHS and ADAS Boards are required to develop a specific goals and objectives related to this allocation.

HIV Early Intervention Goals

Question 16: ADAMHS and ADAS Boards receiving a special allocation for HIV Early Intervention Services need to develop a goal with measurable objective(s) related to this allocation.

*When addressing treatment and recovery services goals for **ODMH**, please address the following:*

Question 17: ADAMHS and CMH Boards only: Address how the Board will meet the needs of civilly and forensically hospitalized adults, including conditional release and discharge planning processes. How will the Board address the increasingly high number of non-violent misdemeanants residing in state hospitals?

Implications of Behavioral Health Priorities to Other Systems

Question 18: What are the implications to other systems of needs that have not been addressed in the Board's prioritization process?

Contingency Plan: Implications for Priorities and Goals in the event of a reduction in state funding

Question 19: Describe how priorities and goals will change in the event of a reduction in state funding of 10 percent of the Board’s current annual allocation (reduction in number of people served, reduction in volume of services, types of services reduced, impact on monitoring and evaluation etc). Please identify how this reduction in services affects specific populations such as minorities, veterans and “high-risk” groups.

Section IV: Collaboration

Background and Instructions for Completing Section IV of the Plan

Use the Community Plan Template (see page 42) to respond to each item described below.

To develop an efficient, comprehensive prevention and treatment service system, maximize resources and improve customer outcomes, it is essential for Boards to interact, coordinate and collaborate with provider agencies and a wide variety of other service systems and community entities some of which are statutorily required (e.g., County Family Planning Committee, Public Children’s Service Agency, Family and Children First Council, criminal and juvenile justice, clients/customers, the general public, and county commissioners.) Description of collaborations and key partnerships should also include alcohol and other drugs/mental health, mental health/mental retardation, mental health and other physical health, schools, and faith-based and other community organizations and community coalitions.

Key collaborations and related benefits and results

Question 20: What systems or entities did the Board collaborate with and what benefits/results were derived from that intersystem collaboration? **ADAMHS and CMH Boards** should include discussion regarding the relationship between the Board and private hospitals.

Involvement of customers and general public in the planning process

Question 21: Beyond regular Board/committee membership, how has the Board involved customers and the general public in the planning process (including needs assessment, prioritization, planning, evaluation and implementation)?

Regional Psychiatric Hospital Continuity of Care Agreements

Question 22: ADAMHS/CMH Boards Only: To ensure a seamless process to access and improve continuity of care in the admissions, treatment and discharge between state hospitals and community mental health providers, describe how Continuity of Care Agreements have been implemented and indicate when and how training was provided to pre-screening agency staff. Please indicate the number of system staff that has received training on the Continuity of Care Agreements.

Consultation with county commissioners regarding services for individuals involved in the child welfare system

***Question 23: ADAMHS/ADAS Boards Only:** Describe the Board's consultation with county commissioners regarding services for individuals involved in the child welfare system and identify monies the Board and county commissioners have available to fund the services jointly as required under Section 340.033(H) of the ORC.*

Section V: Evaluation of the Community Plan

Background and Instructions for Completing Section V of the Plan

Use the Community Plan Template (see page 42) to respond to the following item:

Ensuring an effective and efficient system of care with high quality

***Question 24:** Briefly describe the Board's current evaluation focus in terms of a success and a challenge (other than funding cuts) in meeting the requirements of ORC 340.03(A)(4) and 340.033(H). Please reference evaluation criteria found in Appendix C with regard to your discussion of successes and challenges with measuring quality, effectiveness and efficiency.*

Determining Success of the Community Plan for SFY 2012-2013

***Question 25:** Based upon the Capacity, Prevention Services and Treatment and Recovery Services Goals and Objectives identified in this Plan, how will the Board measure success in achieving those goals and objectives? Identify indicators and/or measures that the Board will report on to demonstrate progress in achieving each of the goals identified in the Plan.*

- a. *How will the Board engage contract agencies and the community in evaluation of the Community Plan for behavioral care prevention and treatment services?*
- b. *What milestones or indicators will be identified to enable the Board and its key stakeholders to track progress toward achieving goals?*
- c. *What methods will the Board employ to communicate progress toward achievement of goals?*

INSTRUCTIONS TO COMPLETE PORTFOLIO OF PROVIDERS:

Table 1: Portfolio of Alcohol and Drug Services Providers Instructions

Identify the Board's current portfolio of providers within its local alcohol and drug service system, including both prevention and treatment providers. Please include all in-county providers with which the Board contracts. Boards are not required to include out-of-county Medicaid providers unless the Boards view it as critical services to meeting the needs of their consumers' needs as specified in the Community Plan. Please include the following specific information within each level of care (the matrix to be completed appears on page 54): a. provider name; b. provider specific program name; c. population served; d. for prevention programs the prevention level of universal, selected or indicated; e. identification of evidence-based practices; f. number of sites; g. whether the program or any of the sites are located outside of the Board area; h. the funding source; and i. MACSIS UPI.

Table 2: Portfolio of Mental Health Services Providers Using EBP Instructions

Identify the Board's current portfolio of providers using EBPs within its local mental health service system. Please include all in-county providers with which the Board contracts. Boards are not required to include out-of-county Medicaid providers unless the Boards view it as critical services to meeting the needs of their consumers' needs as specified in the Community Plan. Please include the following specific information within each level of care (the matrix to be completed appears on page 55): a. provider name; b. MACSIS UPI; c. number of sites; d. program name; e. funding source; f. population served; g. estimated number of clients served in SFY 2012; and h. estimated number of clients served in SFY 2013.

Evidence-Based Programs Defined:

Alcohol and Other Drug Prevention

Alcohol and other drug prevention defines Evidenced-Based Prevention to mean the prevention policies, strategies, programs and practices are consistent with prevention principles found through research to be fundamental in the delivery of prevention services; the prevention policies, strategies, programs and practices have been identified through research to be effective; the service delivery system utilizes evaluation of its policies, strategies, programs and practices to determine effectiveness; and the service delivery system utilizes evaluation results to make appropriate adjustments to service delivery policies, strategies, programs and practices to improve outcomes.

Alcohol and Other Drug and Mental Health Treatment

ODADAS and ODMH have engaged work groups to address definitions and use of promising, best and evidence-based practices. The diligent work of various groups and committees is in various stages of development, including documents in the form of recommendations to one or both Departments. To the extent that these efforts are a work in progress and recommendations may not have been acted upon as of this date, the Departments will use the following SAMHSA definition of EBPs for the purposes of these guidelines:

A program, policy strategy or practice that has met any of the following criteria: a) has appeared in a peer journal and has demonstrated effectiveness, b) is current on at least one federal government approved list of programs (e.g., SAMHSA's National Registry of Evidence-based Programs and Practices, or NREPP), c) data demonstrates that the program, policy, strategy or practice is evidence-based. That is, the implementing organization uses an outcomes system which is data driven and outcomes focused resulting in an ability to demonstrate program impact towards outcomes.

APPENDIX A:

List of Separate Attachments for Submission

The following documents are being provided in Microsoft Word and Excel formats to help facilitate data collection.

Microsoft Word Document:

- ODMH Agreement and Assurances (*to be sent under separate cover*)

Microsoft Excel Documents:

- Table 1: Portfolio of Alcohol and Drug Services Providers
- Table 2: Portfolio of Mental Health Services Providers
- ODMH Service Level Checklist
- ODMH 2012 Adult Housing Categories
- ODMH SFY 2012 Budget Template (*final version to be posted on the ODMH website: <http://mentalhealth.ohio.gov> on December 1, 2010.*)
- ODMH SFY 2013 Budget Template (*final version to be posted on the ODMH website: <http://mentalhealth.ohio.gov> on December 1, 2010.*)

APPENDIX B:

Definitions of Prevention

Prevention Defined—Alcohol and Other Drug Specific

Alcohol and other drug prevention focuses on preventing the onset of AOD use, abuse and addiction. AOD prevention includes addressing problems associated with AOD use and abuse up to, but not including, assessment and treatment for substance abuse and dependence. AOD prevention is a proactive multifaceted, multi-community sector process involving a continuum of culturally appropriate prevention services which empowers individuals, families and communities to meet the challenges of life events and transitions by creating and reinforcing conditions that impact physical, social, emotional, spiritual, and cognitive well-being and promote safe and healthy behaviors and lifestyles. AOD prevention is a comprehensive planned sequence of activities that, through the practice and application of evidence-based prevention principles, policies, practices, strategies and programs, is intended to inform, educate, develop skills, alter risk behaviors, affect environmental factors and/or provide referrals to other services:

- **Universal Prevention Services:** Services target everyone regardless of level of risk before there is an indication of an AOD problem;
- **Selected Prevention Services:** Services target persons or groups that can be identified as "at risk" for developing an AOD problem;
- **Indicated Prevention Services:** Services target individuals identified as experiencing problem behavior related to alcohol and other drug use to prevent the progression of the problem. These services do not include clinical assessment and/or treatment for substance abuse and dependence.

The term Alcohol and Other Drugs (AOD) includes, but is not limited to the following drugs of abuse - alcohol, tobacco, illicit drugs, inhalants, prescription and over-the-counter medications.

Culturally appropriate means the service delivery systems respond to the needs of the community being served as defined by the community and demonstrated through needs assessment activities, capacity development efforts, policy, strategy and prevention practice implementation, program implementation, evaluation, quality improvement and sustainability activities.

Evidenced-based Prevention means the prevention policies, strategies, programs and practices are consistent with prevention principles found through research to be fundamental in the delivery of prevention services; the prevention policies, strategies, programs and practices have been identified through research to be effective; the service delivery system utilizes evaluation of its policies, strategies, programs and practices to determine effectiveness; and the service delivery system utilizes evaluation results to make appropriate adjustments to service delivery policies, strategies, programs and practices to improve outcomes.

Prevention Service Delivery Strategies

Information Dissemination is an AOD prevention strategy that focuses on building awareness and knowledge of the nature and extent of alcohol and other drug use, abuse and addiction and the effects on individuals, families and communities, as well as the dissemination of information about prevention, treatment and recovery support services, programs and resources. This strategy is characterized by one-way communication from source to audience, with limited contact between the two.

Alternatives are AOD prevention strategies that focus on providing opportunities for positive behavior support as a means of reducing risk taking behavior, and reinforcing protective factors. Alternative programs include a wide range of social, recreational, cultural and community service/volunteer activities that appeal to youth and adults.

Education is an AOD prevention strategy that focuses on the delivery of services to target audiences with the intent of affecting knowledge, attitude and/or behavior. Education involves two-way communication and is distinguished from information dissemination by the fact that interaction between educator/facilitator and participants is the basis of the activities. Activities affect critical life and social skills including decision making, refusal skills, critical analysis and systematic judgment abilities.

Community-Based Process is an AOD prevention strategy that focuses on enhancing the ability of the community to provide prevention services through organizing, training, planning, interagency collaboration, coalition building and/or networking.

Environmental prevention is an AOD prevention strategy that represents a broad range of activities geared toward modifying systems in order to mainstream prevention through policy and law. The environmental strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of alcohol and other drug use/abuse in the general population.

Problem Identification and Referral is an AOD prevention strategy that refers to intervention oriented prevention services that primarily targets indicated populations to address the earliest indications of an AOD problem. Services by this strategy focus on preventing the progression of the problem. This strategy does not include clinical assessment and/or treatment for substance abuse and dependence.

Prevention Defined—Mental Health Specific

Mental Health Prevention, Consultation & Education (PC&E) Services:

Mental Health Prevention service means actions oriented either toward reducing the incidence, prevalence, or severity of specific types of mental disabilities or emotional disturbances; or actions oriented toward population groups with multiple service needs and systems that have been identified through recognized needs assessment techniques. Prevention service may include but is not limited to the following: competency skills building, stress management, self-esteem

building, mental health promotion, life-style management and ways in which community systems can meet the needs of their citizens more effectively.

Mental Health Consultation service means a formal and systematic information exchange between an agency and a person other than a client, which is directed towards the development and improvement of individualized service plans and/or techniques involved in the delivery of mental health services. Consultation service can also be delivered to a system (e.g., school or workplace) in order to ameliorate conditions that adversely affect mental health. Consultation services shall be provided according to priorities established to produce the greatest benefit in meeting the mental health needs of the community. Priority systems include schools, law enforcement agencies, jails, courts, human services, hospitals, emergency service providers, and other systems involved concurrently with persons served in the mental health system. Consultation may be focused on the clinical condition of a person served by another system or focused on the functioning and dynamics of another system.

Mental Health Education service means formal educational presentations made to individuals or groups that are designed to increase community knowledge of and to change attitudes and behaviors associated with mental health problems, needs and services. Mental health education service shall:

- Focus on educating the community about the nature and composition of a community support program;
- Be designed to reduce stigma toward persons with severe mental disability or serious emotional disturbances, and may include the use of the media such as newspapers, television, or radio; and
- Focus on issues that affect the population served or populations identified as unserved or underserved by the agency.

Prevention Service Categories by Population Served:

- **Universal Prevention Services:** Services target everyone regardless of level of risk before there is an indication of a mental health problem or mental illness;
- **Selected Prevention Services:** Services target persons or groups that can be identified as "at risk" for developing a mental health problem or mental illness; and
- **Indicated Prevention Services:** Services target individuals identified as experiencing a mental health problem to prevent the progression of the problem. These services do not include clinical assessment and/or treatment for mental health problems or mental illness.

APPENDIX C:

Definitions and Evaluation Criteria for Completing Section V Community Plan Evaluation

A. Definitions

1. Cost Analysis: Measurement and analysis of expenditures incurred by Boards related to the purchase of alcohol, drug addiction and mental health services pursuant to the Community Plan. Can be operationalized by costs accounted through MACSIS.
2. Cost effectiveness: This measure is defined as the ratio of cost to non-monetary units, and is used when both outcomes and costs are expected to vary. Can be operationalized by measuring cost as identified in state or local data systems (MACSIS, PCS, OHBH, etc.).
3. Cost efficiency: This analysis is used when differing services are known to produce the same outcome, and therefore the intent is to find the lowest cost way of producing the outcome. Can be operationalized by measuring cost as identified in state or local data systems (MACSIS, PCS, OHBH, etc). The difference between cost-effectiveness and cost-efficiency is that to use cost-efficiency, the outcomes-equivalence of various programs must be first established.
4. Community acceptance: Primary constituents' assessment of and satisfaction with services offered by the alcohol, drug and/or mental health providers and with the Board planning process. Primary constituents are comprised of consumers, families, other organizations and/or systems (particularly major referral sources such as schools, justice, public welfare, etc). For example, community acceptance may be assessed every two years through a survey of relevant planning and administrative organizations to determine the acceptability of the Board's planning and coordinating efforts among these organizations. Patterns of client referrals to provider organizations from schools, justice, public welfare, etc., may be analyzed on an annual basis to determine level of acceptance.
5. Consumer outcomes: Indicators of health or well-being for an individual or family as measured by statements or observed characteristics of the consumer/family, not characteristics of the system. These measures provide an overall status measure with which to better understand the life situation of a consumer or family.
6. Community Plan: The plan for providing mental health services as developed by a Board and approved by the ODMH in accordance with section 340.03 of the Revised Code and for providing alcohol and other drug prevention and treatment services as developed by a Board and approved by ODADAS in accordance with section 340.033 of the Revised Code.

7. Criterion: A standard upon which a judgment is based. This is currently not used.
8. Cultural relevance: Quality of care that responds effectively to the values present in all cultures.
9. Effectiveness: The extent to which services achieve desired improvements in the health or well being for an individual or family. (See cost-effectiveness.)
10. Efficiency: Accomplishment of a desired result with the least possible exertion/expense/waste. (See cost efficiency.)
11. Evaluation: A set of procedures to appraise the benefits of a program/service /provider/system and to provide information about its goals, expectations, activities, outcomes, community impacts and costs.
12. Patterns of service use: The analysis of relevant characteristics of persons in alcohol, drug addiction or mental health treatment compared with relevant characteristics of services received to determine who is receiving what level of service, and how those levels of service may appropriately differ among agencies. This information, when compared to persons who are not in treatment (e.g., persons on waiting lists, Census data, prevalence/incidence data, etc), is the basis for accurate needs assessment, utilization review and other determinations of appropriate service delivery. A calculation of certified community services by unit of analysis and time period can be conducted via the Claims Data Mart.¹
13. Quality: The degree of conformity with accepted principles and practices (standards), the degree of fitness for the person's needs, and the degree of attainment of achievable outcomes (results), consonant with the appropriate allocation or use of resources.

B. Evaluation Criteria

Boards should utilize the following criteria to assess the quality, effectiveness and efficiency of services paid for by a Board in whole or in part with public funds and provided pursuant to the Community Plan.

1. Measurement and analysis of the patterns of service use in the Board area, including amounts and types of services by important client demographic and diagnostic characteristics and provider agency(ies) of the service district.
2. Measurement and analysis of the cost of services delivered in the service district by unit of service, service pattern, client characteristics and provider agency.

¹ <http://macsisdatamart.mh.state.oh.us/default.html>

3. Measurement and analysis of the levels of consumer outcomes achieved by clients in the service district, by service patterns, client characteristics and provider agency.
4. Measurement and analysis of the cost-effectiveness and cost efficiency of services delivered in the service district, by service pattern, client characteristic and provider agency.
5. Measurement and analysis of the level of community acceptance of services offered by the alcohol and other drug and mental health providers and with the Board planning process.
6. Other measurements and analyses of quality, effectiveness and efficiency of services as agreed upon among ODMH, ODADAS and one or more Boards.

C. Evaluation Data

Data necessary to perform analyses required under these guidelines should include but not be limited to client specific data related to services and costs, characteristics of persons served, and outcomes collected pursuant to ORC 5119.61(G) and (H).

D. Criteria for Data Quality

The measures and analyses employed by a Board to review and evaluate quality, effectiveness and efficiency should comply with generally accepted methodological and analytical standards in the field of program evaluation.

APPENDIX D:

Definition of Cultural Competence and Preliminary Definitions of SMI, SPMI & SED (these definitions are still in the development stage)

❖ Cultural Competence

Cultural competence is a continuous learning process that builds knowledge, awareness, skills and capacity to identify, understand and respect the unique beliefs, values, customs, languages, abilities and traditions of all Ohioans in order to develop policies to promote effective programs and services.

❖ Adult with Serious Mental Illness (SMI) (*working definition*)

- I. Must be eighteen (18) years of age or older; and
- II. Individuals with any DSM-IV-TR diagnosis, with the exception of the following exclusionary diagnoses, unless these conditions co-occur with another diagnosable mental or emotional disorder:
 - Developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders, and communication disorders)
 - Substance-related disorders
 - Conditions or problems classified in DSM-IV-TR as “other conditions that may be a focus of clinical attention” (V codes)
 - Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium sleep disorders; and
- III. Treatment history covers the client’s lifetime treatment for the DSM IV-TR diagnoses other than those listed as “exclusionary diagnoses” specified in Section II and meets one of the following criteria:
 - Continuous treatment of six (6) months or more, or a combination of the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or six (6) months continuous residence in a residential program (e.g. supervised residential treatment program or supervised group home); or
 - Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent twelve (12) month period; or
 - A history of using two or more of the following services over the most recent twelve (12) month period continuously or intermittently (this includes

consideration of a person who received care in a correctional setting):
psychotropic medication management, behavioral health counseling, CPST,
crisis intervention; or

- Previous treatment in an outpatient service for at least six (6) months and a history of at least two (2) mental health psychiatric hospitalizations; or
- In the absence of treatment history, the duration of the mental disorder is expected to be present for at least six (6) months.

IV. Individuals with Global Assessment of Functioning Scale (GAF) ratings between 40 and 60 (mid-range level of care need, tier 2). Clinician discretion may be used in determining into which tier an individual with a GAF rating of 40-50 (either tier 1 or tier 2) should be placed.

❖ **Adult with Serious and Persistent Mental Illness (SPMI) (working definition)**

I. Must be eighteen (18) years of age or older; and

II. Individuals with any DSM-IV-TR diagnosis, with the exception of the following exclusionary diagnoses, unless these conditions co-occur with another diagnosable mental or emotional disorder:

- Developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders, and communication disorders)
- Substance-related disorders
- Conditions or problems classified in DSM-IV-TR as “other conditions that may be a focus of clinical attention” (V codes)
- Dementia, mental disorders associated with known or unknown physical conditions such as hallucinosis, amnesic disorder or delirium sleep disorders; and

III. Treatment history covers the client’s lifetime treatment for the DSM IV-TR diagnoses other than those listed as “exclusionary diagnoses” specified in Section II and meets one of the following criteria:

- Continuous treatment of twelve (12) months or more, or a combination of the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or twelve (12) months continuous residence in a residential program (e.g. supervised residential treatment program or supervised group home); or
- Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent twelve (12) month period; or
- A history of using two or more of the following services over the most recent twelve (12) month period continuously or intermittently (this includes consideration of a person who received care in a correctional setting):
psychotropic medication management, behavioral health counseling, CPST,

- crisis intervention; or
- Previous treatment in an outpatient service for at least twelve (12) months and a history of at least two (2) mental health psychiatric hospitalizations; or
- In the absence of treatment history, the duration of the mental disorder is expected to be present for at least twelve (12) months.

IV. Individuals with Global Assessment of Functioning Scale (GAF) ratings of 50 or below (highest level of care need, tier 1). Clinician discretion may be used in determining into which tier an individual with a GAF rating of 40-50 (either tier 1 or tier 2) should be placed.

❖ **Child or Adolescent with Serious Emotional Disturbance (SED) (*working definition*)**

- I. Zero (0) years of age through seventeen (17) years of age (youth aged 18-21 who are enrolled in high school, in Department of Youth Services or Children Services custody or when it is otherwise developmentally/clinically indicated may be served to assist with transitioning to adult services), and
- II. Individuals with any DSM-IV-TR diagnosis, except developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders), substance-related disorders, or conditions or problems classified in DSM-IV-TR as “other conditions that may be a focus of clinical attention” (V codes) unless these conditions co-occur with another diagnosable mental or emotional disorder, and
- III. Assessment of impaired functioning at age appropriate levels and difficulty with age appropriate role performance with a Global Assessment of Functioning Scale (GAF) score below 60. Clinical discretion may be used to place individuals with GAF scores between 50 and 60 in a lower intensity of services (Mental/Emotional Disorder), and
- IV. Duration of the mental health disorder has persisted or is expected to be present for six (6) months or longer.

❖ **Child, Adolescent, or Adult that does not meet the aforementioned criteria but for whom additional services are medically necessary and documentation contained in the client’s record supports:**

- There is reasonably calculated probability of continued improvement in the client’s condition if the requested healthcare service is extended and there is reasonably calculated probability the client’s condition will worsen if the requested healthcare service is not extended.

APPENDIX E:

COMMUNITY PLAN REVIEW CRITERIA

The following criteria and process will be used to review and evaluate Community Plans that are complete.

The evaluation is divided into seven sections, including Legislative and Environmental Context of the Community Plan, Needs Assessment, Priorities, Goals and Objectives for Capacity, Prevention and Treatment and Recovery Services, Collaboration, Evaluation, ODADAS Service Waivers and Portfolios of Mental Health and Alcohol and Other Drug Services.

Individual Plans will be evaluated through a process of group review. Generalist staff from ODADAS and ODMH will participate in several work groups, each charged with evaluating a portion of the 50 Plans. Individuals in each group will independently read and evaluate the Plans, then come together to discuss the rationale for their evaluation and reach a consensus on a final evaluation. Comments will provide an explanation for the final evaluation in each section.

All sections and subsections of the Plan will need to be evaluated at least "adequate" for the Plan to be recommended for approval. Sections and subsections evaluated as "complete and thorough" will be considered for commendation. Written feedback will be provided to Boards regarding final evaluations and reviewer comments. Evaluations and comments will not be publicized but will be a public document that is available upon request.

A "disapproval" designation will be given to any section or subsection that is not evaluated as "adequate" and the Board will have an opportunity to revise and resubmit the Plan. Since the Plan is considered an application for funds from ODADAS and ODMH, financial consequences may result if the Plan is not approved, since eligibility for state and federal funding is contingent upon an approved Plan or relevant part of a Plan, (See ORC 340.033(A)(3) and 340.03 (A)(1)(c)).

Section: Signature Page

Two Copies of Signature Page Received: _____ Yes (A Plan cannot be approved without completed signature page)

Section I: Legislative and Environmental Context of the Community Plan

Sub-Section II. Environmental Context for the Community Plan

Questions Regarding: Economic Conditions and the Delivery of Behavioral Health Care Services

<p>Question 1: <i>Discuss how economic conditions, including employment and poverty levels, are expected to affect local service delivery. Include in this discussion the impact of recent budget cuts and reduced local resources on service delivery.</i></p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Implications of Health Care Reform on Behavioral Health Services

Question 2: <i>Based upon what is known to date, discuss implications of recently enacted health care reform legislation on the Board's system of care</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Key Factors that Will Shape the Provision of Behavioral Health Care Services in the Board Area

Question 3: <i>Discuss the change in social and demographic factors in the Board area that will influence service delivery. This response should include a description of the characteristics of customers/clients currently served including recent trends such as changes in services and populations for behavioral health prevention, treatment and recovery services.</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Sub-Section III. Major Achievements and Significant Unrealized Goals of the SFY 2010-2011 Community Plan

Question Regarding: Major Achievements

Question 4: <i>Describe major achievements.</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Unrealized Goals

Question 5: <i>Describe significant unrealized goals and briefly describe the barriers to achieving them.</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Section II: Needs Assessment

Sub-Section: Process the Board used to assess behavioral health needs

Question 6: Describe the <u>process</u> the Board utilized to determine its current behavioral healthcare needs including data sources and types, methodology, time frames and stakeholders involved		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Sub-Section: Findings of the needs assessment

Question 7: Describe the <u>findings</u> of the needs assessment identified through quantitative and qualitative sources.		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Sub-Section: Assessment of Capacity to Provide Behavioral Health Care Services Must Include the Following:

Question Regarding: Access to Services

Question 8(a): Identify the major issues or concerns for individuals attempting to access behavioral health prevention and treatment services in the Board area. In this response please include, when applicable, issues that may exist for clients who are deaf or hard of hearing, veterans, ex-offenders, and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Access to Services

Question 8(b): Please discuss how the Board plans to address any gaps in the crisis care services indicated by OAC 5122-29-10(B). (ADAMHS/CMH only)		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Access to Services

<p>Question 8(c): Please discuss how the Board identified and prioritized training needs for personnel providing crisis intervention services, and how the Board plans to address those needs in SFY 2012-13. (ADAMHS/CMH only)</p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Workforce Development and Cultural Competence

<p>Question 9(a): Describe the Board's current role in working with the ODMH, ODADAS and providers to attract, retain and develop qualified direct service staff for the provision of behavioral health services. Does the local service system have sufficient qualified licensed and credentialed staff to meet its service delivery needs for behavioral health services? If "no", identify the areas of concern and workforce development needs.</p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Workforce Development and Cultural Competence

<p>Question 9(b): Describe the Board's current activities, strategies, successes and challenges in building a local system of care that is culturally competent: Please include in this response any workforce development and cultural competence issues, when applicable, related to serving the deaf and hard of hearing population, veterans, ex-offenders and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.</p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Capital Improvements

<p>Question 10: For the Board's local behavioral health service system, identify the Board's capital (construction and/or renovation) needs.</p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Section III: Priorities, Goals and Objectives for Capacity, Prevention, Treatment and Recovery Support Services

Sub-section: Identify the Board’s process for determining capacity, prevention, treatment and recovery support services.

Question 11: Describe the process utilized by the Board to determine its capacity, prevention, treatment and recovery services priorities for SFY 2012 – 2013. In other words, how did the Board decide the most important areas in which to invest their resources?		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Sub-section: Identify the Board’s priorities for capacity, prevention, treatment and recovery support services.

Question 12: Based upon the Departmental priorities listed in the guidelines (and/or local priorities) and available resources, identify the Board’s behavioral health capacity, prevention, treatment and recovery support services priorities, goals and objectives for SFY 2012–2013.		
<input type="checkbox"/> No relationship between Needs Assessment and Goals & Objectives , or <input type="checkbox"/> Discontinuities between Needs Assessment and Goals & Objectives	<input type="checkbox"/> Relevant areas of Needs Assessment are adequately addressed in identifying Goals & Objectives	<input type="checkbox"/> There is an outstanding description of the relationship between Needs Assessment and the identification of Goals & Objectives

Sub-section: When addressing capacity goals and objectives please address the following:

Question Regarding: Access to Services

Question 13: What are the Board’s goals and objectives for addressing access issues for behavioral health services identified in the previous section of the Plan?		
<input type="checkbox"/> No relationship between Needs Assessment and Goals & Objectives , or <input type="checkbox"/> Discontinuities between Needs Assessment and Goals & Objectives	<input type="checkbox"/> Relevant areas of Needs Assessment are adequately addressed in identifying Goals & Objectives	<input type="checkbox"/> There is an outstanding description of the relationship between Needs Assessment and the identification of Goals & Objectives

Question Regarding: Workforce Development and Cultural Competence

Question 14: What are the Board’s goals and objectives for SFY 2012 and 2013 to foster workforce development and increase cultural competence? Please discuss the areas of most salience or strategic importance to your system. What are the Board’s plans for SFY 2012 and 2013 to identify increase and assess cultural competence in the following areas: Consumer satisfaction with services and staff, staff recruitment, staff training, and addressing disparities in access and treatment outcomes? (Please reference Appendix D for State of Ohio definition of cultural competence.)		
<input type="checkbox"/> No relationship between Needs Assessment and Goals & Objectives , or <input type="checkbox"/> Discontinuities between Needs Assessment and Goals & Objectives	<input type="checkbox"/> Relevant areas of Needs Assessment are adequately addressed in identifying Goals & Objectives	<input type="checkbox"/> There is an outstanding description of the relationship between Needs Assessment and the identification of Goals & Objectives

Sub-section: When addressing treatment and recovery services goals for ODADAS, please address the following:

Question Regarding: ORC 340.033(H) Goals (**ADAMHS and ADAS** Boards)

Question 15: <i>To improve accountability and clarity related to ORC 340.033(H) programming, ADAMHS and ADAS Boards are required to develop a specific goals and objectives related to this allocation.</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: HIV Early Intervention Goals (**ADAMHS and ADAS** Boards)

Question 16: <i>ADAMHS and ADAS Boards receiving a special allocation for HIV Early Intervention Services need to develop a goal with measurable objective(s) related to this allocation.</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Sub-section: When addressing treatment and recovery services goals for ODMH, please address the following:

Question 17: <i>Address how the Board will meet the needs of civilly and forensically hospitalized adults, including conditional release and discharge planning processes. How will the Board address the increasingly high number of non-violent misdemeanants residing in state hospitals?</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Implications of Behavioral Health Priorities to Other Systems

Question 18: <i>What are the implications to other systems of needs that have not been addressed in the Board's prioritization process?</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Contingency Plan Implications for Priorities and Goals in the event of a reduction in state funding

<p>Question 19: Describe how priorities and goals will change in the event of a reduction in state funding of 10 percent of the Board's current annual allocation (reduction in number of people served, reduction in volume of services, types of services reduced, impact on monitoring and evaluation etc). Please identify how this reduction in services affects specific populations such as minorities, veterans and "high-risk" groups.</p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Section IV: Collaboration

Question Regarding: Key collaborations and related benefits and results

<p>Question 20: What systems or entities did the Board collaborate with and what benefits/results were derived from that intersystem collaboration? ADAMHS and CMH Boards should include discussion regarding the relationship between the Board and private hospitals.</p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Involvement of customers and general public in the planning process

<p>Question 21: Beyond regular Board/committee membership, how has the Board involved customers and the general public in the planning process (including needs assessment, prioritization, planning, evaluation and implementation)?</p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Regional Psychiatric Hospital Continuity of Care Agreements

<p>Question 22: ADAMHS/CMH Boards Only: <i>To ensure a seamless process to access and improve continuity of care in the admissions, treatment and discharge between state hospitals and community mental health providers, describe how Continuity of Care Agreements have been implemented and indicate when and how training was provided to pre-screening agency staff. Please indicate the number of system staff that has received training on the Continuity of Care Agreements.</i></p>		
<input type="checkbox"/> Did not describe any processes used to implement Continuity of Care Agreements, or <input type="checkbox"/> Partial description of processes used to implement Continuity of Care Agreements, but not well documented.	<input type="checkbox"/> Adequate description of processes used to implement Continuity of Care Agreements, including the training of Provider staff and the number of Provider staff trained	<input type="checkbox"/> A success model for implementing Continuity of Care Agreements.

Question Regarding: Consultation with county commissioners regarding services for individuals involved in the child welfare system

<p>Question 23: ADAMHS/ADAS Boards Only: <i>Describe the Board's consultation with county commissioners regarding services for individuals involved in the child welfare system and identify monies the Board and county commissioners have available to fund the services jointly as required under Section 340.033(H) of the ORC.</i></p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Section V: Evaluation of the Community Plan

Question Regarding: Ensuring an effective and efficient system of care with high quality

<p>Question 24: <i>Briefly describe the Board's current evaluation focus in terms of a success and a challenge (other than funding cuts) in meeting the requirements of ORC 340.03(A)(4) and 340.033(H). Please reference evaluation criteria found in Appendix C with regard to your discussion of successes and challenges with measuring quality, effectiveness and efficiency.</i></p>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Determining Success of the Community Plan for SFY 2012-2013

Question 25: <i>Based upon the Capacity, Prevention Services and Treatment and Recovery Services Goals and Objectives identified in this Plan, how will the Board measure success in achieving those goals and objectives? Identify indicators and/or measures that the Board will report on to demonstrate progress in achieving each of the goals identified in the Plan.</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Determining Success of the Community Plan for SFY 2012-2013

Question 25(a): <i>How will the Board engage contract agencies and the community in evaluation of the Community Plan for behavioral care prevention and treatment services</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Determining Success of the Community Plan for SFY 2012-2013

Question 25(b): <i>What milestones or indicators will be identified to enable the Board and its key stakeholders track progress toward achieving goals?</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Determining Success of the Community Plan for SFY 2012-2013

Question 25(c): <i>What methods will the Board employ to communicate progress toward achievement of goals?</i>		
<input type="checkbox"/> Minimal description, much missing information., or <input type="checkbox"/> Partial description but significant omissions.	<input type="checkbox"/> Adequate description, relevant areas addressed (i.e., complete documentation).	<input type="checkbox"/> An outstanding description (i.e., outstanding clarity, organization and documentation).

Section: ODADAS Waivers

Was an ODADAS Waiver Requested for:

Generic Services _____ Yes _____ No
 Inpatient Hospital Rehab Services _____ Yes _____ No

Section: Template for Submitting the Community Plan

Sub-Section: Table 1: Portfolio of Alcohol and Drug Services Providers Instructions

<p><i>Identify the Board's current portfolio of providers within its local alcohol and drug service system, including both prevention and treatment providers. Please include all in-county providers with which the Board contracts. Boards are not required to include out-of-county Medicaid providers unless the Boards view it as critical services to meeting the needs of their consumers' needs as specified in the Community Plan. Please include the following specific information within each level of care (the matrix to be completed appears on page 54): a. provider name; b. provider specific program name; c. population served; d. for prevention programs the prevention level of universal, selected or indicated; e. identification of evidence-based practices; f. number of sites; g. whether the program or any of the sites are located outside of the Board area; h. the funding source; and i. MACSIS UPI.</i></p>	
<input type="checkbox"/> Not Completed	<input type="checkbox"/> Completed

Sub-Section: Table 2: Portfolio of Mental Health Services Providers Using EBP Instructions

<p><i>Identify the Board's current portfolio of providers using EBPs within its local mental health service system. Please include all in-county providers with which the Board contracts. Boards are not required to include out-of-county Medicaid providers unless the Boards view it as critical services to meeting the needs of their consumers' needs as specified in the Community Plan. Please include the following specific information within each level of care (the matrix to be completed appears on page 55): a. provider name; b. MACSIS UPI; c. number of sites; d. program name; e. funding source; f. population served; g. estimated number of clients served in SFY 2012; and h. estimated number of clients served in SFY 2013.</i></p>	
<input type="checkbox"/> Not Completed	<input type="checkbox"/> Completed

Summary Comments (Including overall strengths of the Plan, aspects of the Plan that could be improved, recommendations for technical assistance):

Review Team Recommendation:

Recommend Plan Approval: _____ Date: _____

Recommend Plan Approval with Corrective Action: _____ Date: _____

Specify Corrective Action Required:

Recommend Plan Disapproval: _____ Date: _____

Specify actions required of the Board in order to resubmit the Plan:

Review Team Members (Name and Department):

TEMPLATE FOR SUBMITTING THE COMMUNITY PLAN

***COUNTY OF SUMMIT ALCOHOL, DRUG ADDICTION & MENTAL
HEALTH SERVICES BOARD***

COMMUNITY PLAN FOR SFY 2012-2013

September 1, 2011

MISSION STATEMENT

In an effort to maintain a safe and healthy community, the Alcohol, Drug Addiction and Mental Health Services Board provides a cost effective, efficient system of prevention and care for persons experiencing addiction and/or mental illness. The Board assures a client driven system of care for residents of Summit County with a priority for those individuals most in need.

VISION STATEMENT

To be a system which acknowledges and respects individual differences and needs, and is recognized by the community for providing quality behavioral health services.

VALUE STATEMENTS

1. We believe that mental illness, drug dependency and alcoholism are treatable diseases.
2. We believe that people must participate in their own care, but that the system shares responsibility.
3. We believe that the community has a responsibility to provide a comprehensive array of mental health and alcohol and other drug services for all who need them.
4. We believe that it is no longer enough to be able to talk about what we do without being able to identify accurately the results of what we do.
5. We believe that cooperation between the ADM Board, the contract agencies, local, state, and federal government, and the community is essential to adequate services for people in need.

SIGNATURE PAGE

Community Plan for the Provision of Alcohol, Drug Addiction and Mental Health Services
SFY 2012-2013

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 Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH) a plan for the provision of alcohol drug addiction and mental health services in its area. The plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS and ODMH. The Community Plan is for State Fiscal Years (SFY) 2012 – 2013 (July 1, 2011 to June 30, 2013).

The undersigned is a duly authorized representative of the ADAMHS/ADAS/CMHS Board. The ADAMHS/ADAS Board hereby acknowledges that the information contained in this application for funding, the Community Plan for SFY 2012 - 2013, has been reviewed for comment and recommendations by the Board's Standing Committee on Alcohol and Drug Addiction Services, and is complete and accurate.

(PREVIOUSLY SIGNED AND SUBMITTED BY MAIL)

County of Summit Alcohol, Drug Addiction & Mental Health Services 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.)].

I. Legislative & Environmental Context of the Community Plan

A. Economic Conditions

B. Implications of Health Care Reform

C. Impact of Social and Demographic Changes

D. Major Achievements

E. Unrealized Goals

SECTION I: LEGISLATIVE AND ENVIRONMENTAL CONTEXT

Legislative Context of the Community Plan

Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards, Alcohol and Drug Addiction Services (ADAS) Boards and Community Mental Health Services (CMH) Boards are required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and/or the Ohio Department of Mental Health (ODMH) a plan for the provision of alcohol, drug addiction and mental health services in its service area. Three ADAS Boards submit plans to ODADAS, three CMH Boards submit plans to ODMH, and 47 ADAMHS Boards submit their community plan to both Departments. The plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS and ODMH. This plan covers state fiscal years (SFY) 2012 – 2013 (July 1, 2011 through June 30, 2013).

The requirements for the community plan are broadly described in state statute. In addition, federal requirements that are attached to state block grant dollars regarding allocations and priority populations also influence community planning.

Ohio Revised Code (ORC) 340.03 and 340.033 – Board Responsibilities

Section 340.03(A) of the Ohio Revised Code (ORC) stipulates the Board's responsibilities as the planning agency for mental health services. Among the responsibilities of the Board described in the legislation are as follows:

- 1) Identify community mental health needs;
- 2) Identify services the Board intends to make available including crisis intervention services;
- 3) Promote, arrange, and implement working agreements with social agencies, both public and private, and with judicial agencies;
- 4) Review and evaluate the quality, effectiveness, and efficiency of services; and
- 5) Recruit and promote local financial support for mental health programs from private and public sources.

Section 340.033(A) of the Ohio Revised Code (ORC) stipulates the Board's responsibilities as the planning agency for alcohol and other drug addiction services. Among the responsibilities of the Board described in the legislation are as follows:

- 1) Assess service needs and evaluate the need for programs;
- 2) Set priorities;
- 3) Develop operational plans in cooperation with other local and regional planning and development bodies;
- 4) Review and evaluate substance abuse programs;
- 5) Promote, arrange and implement working agreements with public and private social agencies and with judicial agencies; and
- 6) Assure effective services that are of high quality.

ORC Section 340.033(H)

Section 340.033(H) of the ORC requires ADAMHS and ADAS Boards to consult with county commissioners in setting priorities and developing plans for services for Public Children Services Agency (PCSA) service recipients referred for alcohol and other drug treatment. The plan must identify monies the Board and County Commissioners have available to fund the services jointly. The legislation prioritizes services, as outlined in Section 340.15 of the ORC, to parents, guardians and care givers of children involved in the child welfare system.

OAC Section 5122-29-10(B)

A section of Ohio Administrative Code (OAC) addresses the requirements of crisis intervention mental health services. According to OAC Section 5122-29-10(B), crisis intervention mental health service shall consist of the following required elements:

- (1) Immediate phone contact capability with individuals, parents, and significant others and timely face-to-face intervention shall be accessible twenty-four hours a day/seven days a week with availability of mobile services and/or a central location site with transportation options. Consultation with a psychiatrist shall also be available twenty-four hours a day/seven days a week. The aforementioned elements shall be provided either directly by the agency or through a written affiliation agreement with an agency certified by ODMH for the crisis intervention mental health service;
- (2) Provision for de-escalation, stabilization and/or resolution of the crisis;
- (3) Prior training of personnel providing crisis intervention mental health services that shall include but not be limited to: risk assessments, de-escalation techniques/suicide prevention, mental status evaluation, available community resources, and procedures for voluntary/involuntary hospitalization. Providers of crisis intervention mental health services shall also have current training and/or certification in first aid and cardio-pulmonary resuscitation (CPR) unless other similarly trained individuals are always present; and
- (4) Policies and procedures that address coordination with and use of other community and emergency systems.

HIV Early Intervention Services

Eleven Board areas receive State General Revenue Funds (GRF) for the provision of HIV Early Intervention Services. Boards that receive these funds are required to develop HIV Early Intervention goals and objectives and include: Butler ADAS, Eastern Miami Valley ADAMHS, Cuyahoga ADAS, Franklin ADAMHS, Hamilton ADAMHS, Lorain ADAS, Lucas ADAMHS, Mahoning ADAS, Montgomery ADAMHS, Summit ADAMHS and Stark ADAMHS Boards.

Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant

The federal Substance Abuse Prevention and Treatment (SAPT) Block Grant requires prioritization of services to several groups of recipients. These include: pregnant women, women, injecting drug users, clients and staff at risk of tuberculosis, and early intervention for individuals with or at risk for HIV disease. The Block Grant requires a minimum of twenty (20) percent of federal funds be used for prevention services to reduce the risk of alcohol and other drug abuse for individuals who do not require treatment for substance abuse.

Federal Mental Health Block Grant

The federal Mental Health Block Grant (MHBG) is awarded to states to establish or expand an organized community-based system for providing mental health services for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED). The MHBG is also a vehicle for transforming the mental health system to support recovery and resiliency of persons with SMI and SED. Funds may also be used to conduct planning, evaluation, administration and educational activities related to the provision of services included in Ohio's MHBG Plan.

Environmental Context of the Community Plan

1. Economic Conditions and the Delivery of Behavioral Health Care Services

Provider Contract - During the past calendar year, the Board began to analyze the unit rates paid to providers for non Medicaid services using the five largest metropolitan boards mean for comparison. During the 2011 budget application process, providers were asked to describe the qualitative difference in their service that would justify a cost greater than the five largest metropolitan boards mean for each service. The Board has met with each of our non Medicaid provider agencies to assist them in positioning themselves operationally and financially for the 2012 contract year.

Medicaid Elevation - In SFY 2012 ODMH and ODADAS will provide funding through a single line item State 501 for all approved Medicaid claims submitted by certified providers with service dates between 7/1/2011 and 6/30/2012. Both departments are responsible for providing Medicaid matching funds and Federal Financial Participation (FFP) through the State 501 line. Boards no longer need to separately identify and account for FFP because it is earned federal revenue to the state. Transferring the Medicaid to the State was part of a broader effort to integrate behavioral and physical health that will allow for a more coordinated approach to ensure better treatment outcomes and lower costs. Medicaid continued to grow within community behavioral health as a cost driver so that was one of the leading reasons why it was important to elevate Medicaid. The Ohio Department

of Job and Family Services (ODJFS) is now the single Medicaid State agency. This move clarifies and aligns responsibility among State agencies and frees up community levy funding that was used for Medicaid match not provided through State funds, allowing county behavioral health boards to focus on developing and managing non-Medicaid community treatment services and supports. In SFY 2013, Medicaid providers will submit claims for services provided to clients on or after 7/1/2012 directly to ODJFS for adjudication and payment. The ADM Board will no longer have any responsibility for Medicaid claiming or payments.

Cost Containment on services - In April 2011 ODMH issued final decisions pertaining to Medicaid cost containment to include annual service limits and tiered rates. The Board is in the process of defining the parameters around establishing the same initiatives to Non-Medicaid services. An additional investment of funds for supportive services not covered by Medicaid and priority populations/programs is under investigation.

Hospital Bed Days - The recent closing of Northcoast Behavioral Health Care psychiatric hospital in Cleveland by ODMH resulted in an increase in the population of the Northfield Campus as it added both civil and forensic patients from Lorain, Cuyahoga, Lake, Geauga and Ashtabula Counties to our Summit County facility. As a result of the Northfield Campus becoming the lone state psychiatric hospital for the region and being located in Summit County, the Summit County ADM Board holds responsibility for not only civil bed days for our own citizens but for any out of state patient bed days who present in the aforementioned counties. This fact weighed heavily on our decision to accept the ODMH “heartburn option” for declaring bed days. This option puts ODMH as the fiscally responsible party. While the Summit County ADM Board will not be fiscally responsible for patient bed days, there is a responsibility to assist in discharge planning in a swift and timely manner, helping move patients out of the hospital and into community services post haste.

Nursing Homes - The State biennium budget includes a provision to adjust the nursing home daily rate to include psychiatric services. This action disallows community based providers from billing Medicaid for services performed in nursing homes that are not related to admission and discharge of the patient.

Levy – Collections from the ADM operating levy will be reduced due to the decrease in the valuation of assessed property of 8.3% and the accelerated phase out of the tangible personal property.

Patient Protection and Affordable Care Act - Should the legislation be enacted, it expands Medicaid eligibility in 2014 to all individuals with income up to 133% of the poverty guideline, including adults without dependent children. This could represent a penetration rate as high as 95% of ADM system clients currently supported by non-Medicaid Board funds, according to penetration data provided by the Urban Institute.

2. Implications of Health Care Reform on Behavioral Health Services

The Ohio Association of County Behavioral Health Authorities (OACBHA), has made the implications clear by stating that: “Behavioral Health Care is Health Care”. They’ve observed that health care reform has leveled the field for behavioral health care and physical health care. Additionally, they have noted that the integration of behavioral health care and health care is imperative. However, while Health Care Reform will make certain medical treatments accessible to most of Ohio residents in three years, there will be a small percentage of working poor who will not be able to afford health insurance coverage, and federal health care reform will not pay for supportive services to live in the community, e.g., housing, education, or a peer support drop-in center services.

Additional observations made by SAMHSA and others include the following implications for Behavioral Health (BH):

- There is an emphasis on prevention with the Affordable Care Act (ACA) which may lead to an expansion of these services for BH. The Affordable Care Act Timeline for January 1, 2013 indicates that states will receive new funding to cover preventative services for Medicaid patients at little or no cost.
- Due to health care reform, SAMHSA is taking a lead role with policies which include integrating primary care and BH, and creating “health homes” to improve health services to individuals with chronic conditions.
- The new provisions will allow Medicaid to reimburse providers for the time they spend on such tasks as coordinating interdisciplinary care, whether in person or virtually, or meeting with family members to help support an individual’s recovery.

At this time, however, there is still much uncertainty as to the specific implications of Health Care Reform on our local county’s behavioral health services system. There are several reasons for this including, 1) many of the major health care coverage reforms are not going to be implemented until 2014, 2) there are several legal challenges involving the constitutionality of the individual mandate as well as questioning the impact on the sovereignty of states. It is our intent to follow the health care reform implications closely as they unfold in order to best address the needs of our system’s clients. The Board planning in the meantime will be consistent with the anticipated implementation of the Affordable Care Act as legislated.

3. Key Factors that Will Shape the Provision of Behavioral Health Care Services in the Board Area

There have been no significant changes observed in social/demographic factors that are likely to influence service delivery outside of a further increase in the area unemployment rate. The rate for Summit County climbed from 6.1% average in CY 2008 to 8.7% in July 2011 (Bureau of Labor Statistics, Ohio Department of Job & Family Services). This along with the economic factors noted in response to question #1 above will further stress the current service system by resulting in more clients to serve with less available resources. One significant trend recently observed has been the increased utilization of AoD treatment services overall, including the rise in the opiate population in Summit County. The newest opiate addicts are young, with some being

below age 18, and in need of detox or medication assisted treatment. Other circumstances impacting the above include a major decrease in state funding for addiction treatment and the impact of prison and sentencing reforms such as HB 86, designed to divert low-level, non violent felons from prison to community alternatives.

4 & 5. Major Achievements and Significant Unrealized Goals of the SFY 2010-2011 Community Plan

Achievements since the previous Plan (SFY 2010-2011) include the following:

New Provider Contracts - during FY 2010, several new Medicaid providers signed contracts with the ADM Board system:

- On the Alcohol and Drug Addiction side, Ignatia Hall at St. Thomas Hospital has been certified by ODADAS for the provision and expansion of AoD Medicaid services to eligible individuals pursuant to Title XIX of the Social Security Act.
- CHOICES Social Center received Ohio Department of Mental Health certification for consumer operated services. This allows us to contract directly with CHOICES, when in the past, this funding was passed through Community Support Services, our lead agency for those with SPMI.
- The Summit County Community Partnership is a coalition that engages more than 180 businesses, municipalities, organizations, and community activists working together to reduce the costly impacts of substance abuse in our community. The Partnership was formed in 1990 with federal funding and guidance in response to the realization that prevention and treatment of substance abuse problems aimed solely at individuals was largely ineffective. The Summit County Community Partnership has grown from a project embedded within the Board to an independent 501(C)(3) (non-profit) organization. In response to federal funding cuts that threatened to close the agency, the Board awarded a one time 2010 budget funding allocation to the Partnership to support its operation, which is recognized for its high value to this community.
- East Akron Community House (EACH) provides drug/alcohol outreach, prevention and educational services to clients that they serve. EACH has received its certification under ODADAS and is now directly funded by the Board.
- Minority Behavioral Health Services, under the direction of Reverend Jeffery Dennis, has achieved certification as a provider of mental health services. The organization, formerly co-located with and operating under the certification of Pastoral Counseling Services, obtained a Medicaid contract with the ADM Board effective January, 2011. The Minority Behavioral Health Services program provides culturally sensitive counseling and educational services.
- Coleman Professional Services opened a branch within St. Thomas Hospital facility to serve persons with behavioral health needs identified in the SUMMA hospital system's

- primary care clinics. Services will include Community Psychiatric Supportive Treatment and Medication/Somatic services.
- Bilocation of Akron General Medical Center behavioral health services with Portage Path Behavioral Health.
 - Catholic Charities Community Services Summit County was certified by the ODMH to provide Behavioral Health Counseling and Therapy, Mental Health Assessment, Pharmacological Management and community psychiatric supportive treatment.
 - Northeast Ohio Applied Health was certified by ODADAS to provide individual and group counseling, case management and intensive outpatient treatment services to youth and adults.

ATR (Access to Recovery) -

- During the grant period there was a total of 33 active providers, 23 community based providers and 10 faith based providers. As of 8/8/11, 554 residents have been served, 266 for treatment services and 547 for recovery support services, with many clients receiving both types of services. To date, ATR has provided an additional \$474,837 funding to benefit our county, with Summit County utilizing the largest share of this grant.
- The grant has resulted in an increase in positive client outcomes related to stable housing, no new re-arrests, employment activities, and an increase in social connectiveness.
- Sent three (3) staff associated with ATR to Connecticut Community for Addiction Recovery (CCAR) to become trainers for Recovery Coaching in Ohio: Paula Rabinowitz, ADM Board; Denny Wilson, FI Community Housing Association; and Eva Moore, Freedom House for Women. There have been two Recovery Coaching trainings held so far (February and June 2011) with the next training scheduled for October 2011.

Policy Governance - Policy Governance is a comprehensive, coherent, principle based operating system model for governing that the Summit County ADM Board of Directors has approved for adoption during the last quarter of this year. The Board of Directors is currently working toward establishing an Ends Policy that will answer three important questions about Board services: What outcomes are to be achieved, and at what level of investment? Who are the primary and intentional party/parties who should be impacted? And did the results justify the resources consumed in creating them? The aim of this strategy is to enable the organization to connect with ownership, meet the needs of its constituents and consumers, and provide comprehensive and rigorous monitoring tools to insure executive director compliance and adherence to its ends and executive limitations policies.

Mental Health/Criminal Justice Forum- This multi-systemic forum convenes quarterly

to address the penetration of persons with mental illnesses and developmental disabilities into the criminal justice system.

Task groups have been assigned to address areas corresponding to a Sequential Intercept Model, which identifies five points of interception at which an intervention can be made to prevent individuals from entering or penetrating deeper into the criminal justice system. Ideally, most people will be intercepted at earlier points, with decreasing numbers at each subsequent point. The interception points are law enforcement and emergency services; initial detention and initial hearings; jail, courts, forensic evaluations, and forensic commitments; reentry from jails, state prisons, and forensic hospitalization; and community corrections and community support. The model provides an organizing tool for a discussion of diversion and linkage alternatives and for systematically addressing criminalization. Using the model, a community can develop targeted strategies that evolve over time to increase diversion of people with mental illness from the criminal justice system and to link them with community treatment. Board staff has also been meeting with the Summit County Sheriff to focus on problem resolution in areas that may be interfering with meeting the specialized needs of inmates with behavioral health needs and the ability of jail staff to work with them. This process has resulted in significant progress including:

- Improved medication adherence for people with mental health problems while incarcerated as well as once discharged. In the first six months of 2011, Board funding for jail medications increased by 36% as well as 38% upon discharge.
- Peer support specialists have been hired and have begun to connect with individuals while in jail to support and help facilitate the transition from incarceration to treatment.
- Enhanced communication and understanding of access to services has been achieved resulting in admissions process from jail to hospital being streamlined and jail release times modified to better enable connections with social services providers.

Request for Information- The Board put out a Request for Information (RFI) in July 2010 for Intensive Treatment Services (ITS) for individuals with severe and persistent mental illnesses who need intensive support to live successfully in a community setting. An innovative and much needed service will be a focus on the specialized needs of adolescents who have intensive additional needs and are in transition into the adult mental health system. These adolescents require support to engage in services and the support needed to live successfully in the community. This team would provide a teaching opportunity to provide daily living skills such as cooking, laundry and travel training. In addition there will be a focus on completing education and work opportunities. A bidder's conference was held in July, 2010 and the deadline for applications closed late in August, 2010. Applications were reviewed by the Board and included presentations by the top two selected applicants. The award was made to Community Support Services in October 2010.

Significant Unrealized Goals have included the inability to expand or in some cases maintain service levels over the 2010-2011 biennium due to past issues of Medicaid match and prior State funding cuts. As a result several major providers (Community Health Center,

Community Plan Guidelines for SFY 2012-2013 September 29, 2010 R.

Child Guidance & Family Solutions and Portage Path Behavioral Health) each implemented a reduction in work force. Additionally, levy priority plans needed to be put on hold, and levy funds were used to backfill the aforementioned funding cuts and increased Medicaid volume to sustain services at a base level.

II. Needs Assessment

A. Needs Assessment Process

B. Needs Assessment Findings

C. Access to Services: Issues of Concern

D. Access to Services: Crisis Care Service Gaps

E. Access to Services: Training Needs

F. Workforce Development & Cultural Competence

G. Capital Improvements

SECTION II: NEEDS ASSESSMENT

6. Process the Board used to assess behavioral health needs

Recent assessments of behavioral health needs

Most recently the Board this past December (2010) sent surveys to all contract provider agencies, Board members and over 75 community stakeholders to provide feedback to staff in regards to the following: MH & AoD behavioral health capacity goals (priority of existing goals and/or additional goals); prevention goals and priorities for MH/AoD; treatment and recovery goals for MH and AoD (priority of existing goals and/or additional goals); and lastly asked “are there other issues you would like the ADM Board to consider in regards to unmet needs, priority populations, planning/evaluation strategies, etc. (See Appendix A for results)

The Summit County ADM Board spearheaded several major planning efforts to assess and make recommendations for our system of care. In December 2009, Jeffrey Geller, MD (University of Massachusetts Medical School) and colleagues began “An Evaluation of Summit County, Ohio’s Care, Treatment and Management of Persons in Psychiatric Crisis”. This report provides an assessment of our current services as well as recommendations for change. Committees of stakeholders will soon begin to use this information to develop a plan for crisis services in the county.

A second planning effort in 2009 involved bringing in a national expert on HIPAA, John Pettila, J.D. (University of South Florida), to discuss ways to legally share information for continuity of care and services with various stakeholders from Summit County and to make recommendations as appropriate. He returned in November 2010 and provided a community presentation, direct consultation around several agency and organizational questions, and assistance in developing action steps to improve system exchange of information in the best interest of persons with behavioral health needs.

Finally, Policy Research Associates (PRA) did a system mapping on the interface between criminal justice and mental health. The above studies were instrumental in leading to our crisis services redesign workgroup. Over the last several months the redesign committee and its subgroups have worked on developing action plans for the following priorities:

1. Development of a Common Assessment
2. Define a One System Wide Release
3. Measuring Our Impact on our Principles
4. Increase/Improve Peer and Family Support
5. Develop a One Access Phone Number
6. Incorporate WRAP and Advance Directives into provider agencies
7. Flowchart Patients/Families through the Crisis Services process

Ongoing process to determine behavioral health needs

A variety of methods, assessment instruments, organizations and groups were used to assess the treatment and prevention needs in the county. Data is regularly collected and analyzed as it relates to system needs and program utilization. Regular forums are convened where service needs and trends are discussed, including a number of Quality Improvement and Coordination groups. The following methodologies are representative, of our process to determine needs:

- Community Stakeholders
- Information on trends derived from the Summit County Community Partnership's Prevention Coalition
- Agency funding requests and rationale for maintaining or increasing prevention/treatment services
- Monitoring of service unit trends provided through MACSIS and the Ohio Department of Mental Health Data Cubes
- Our county's Summit 2010 and recently unveiled 2020 initiative and its goals, objectives and data collected
- Client Satisfaction data primarily from the Behavioral Health Outcome System (BHOS)
- System Coordination Committees (Quality Improvement, Adolescent, Prevention)
- Ongoing collaboration with DD (Developmental Disabilities)
- Mental Health/Criminal Justice Forum (addressing the incarceration of persons with mental illnesses and assisting in developing diversion and linkage alternatives)
- The Ohio Substance Abuse Monitoring Network (OSAM), through an ODADAS contract with Wright State University
- Ohio Family Health Survey (a collaborative effort between the State of Ohio government health and human service agencies and the University System of Ohio)

The overall needs process has historically been determined primarily by collaboration between our agency providers and the Board. In many cases providers and/or the Board are made aware of prevention/treatment needs from "reports from the field" which often come from family members, school teachers/principals/administrators, safety forces and other community organizations. Other organizations which help assess needs include Family and Children First

Council, the Akron Intergroup Office, NAMI, Mental Health America, Summit County Health District, Children's Services Board, local medical providers including area general hospitals and Children's Hospital Medical Center of Akron, local law enforcement and courts, etc. Our own Board of Directors, which includes consumers/family members, is another valuable part of the process. Additional methods include monitoring various indicators such as suicides, suicide attempts, MUI's, crisis calls, etc. More recently, in June 2011, there was a Board Provider Input Forum convened by our Board of Directors which invited agency directors in order to learn about community needs from various system stakeholders (also see Collaboration Section below).

7. Findings of the needs assessment

Below are other findings from the needs assessment process and when pertinent the system's response(s) to those needs or gaps:

- A need for an alternative to the more expensive and out of county residential placements for children and adolescents with SED led to a collaborative partnership between the Board, Children's Services and Juvenile Court to provide Multidimensional Treatment Foster Care (MTFC) to children and adolescents in Summit County, with Village Network providing specialized intensive foster care treatment within the county.
- Continued need for Intensive Treatment Services for individuals with severe and persistent mental illnesses and an emerging need for a new service focused on the specialized needs of adolescents who require intensive services and are in transition into the adult mental health system. This led to a Request for Information (RFI) for the above services and an applicant chosen to implement programming that began serving clients in February 2011.
- Persons receiving services from a local general hospital's primary care outpatient clinics having behavioral health needs (addressed by a local provider offering Community Psychiatric Supportive Treatment and Medication/Somatic services). Moreover, Portage Path Behavioral Health has partnered with Akron General Medical Center to co-locate services at each of their respective locations.
- A recent needs assessment and outcomes study of clients with co-occurring mental health and addictions showed progress in many areas, e.g., those served by the Community Support Services IDDT program demonstrated reduced incarcerations, decreased general/state hospital admissions, improved housing stability etc., but highlighted the need for further improvement in the area of employment opportunities for this population.

8. Access to Services - AoD

There are several challenge areas related to access to AoD treatment and prevention services in

Summit County:

Prevention

Although Summit County provides quality prevention programming to youth of all ages, programming has not had a significant focus on creating a positive impact on family bonding and involvement with education. Especially in the current economic crisis, this is extremely difficult with most low and middle income parents focused on maintaining family income despite many job losses and home foreclosures.

Treatment

Programs providing integrated treatment for adults and adolescents with co-occurring disorders are only able to serve a small number of individuals. There are no adolescent detoxification services. There is also a shortage of safe, decent, and affordable sober housing, although the ATR program has been instrumental in improving on this issue. Finally, there is a shortage of residential treatment for adult males, along with prevention services that have a positive impact on family bonding, as well as involvement with education. Significant progress has been made, however in the area of wait list management and increase access to treatment. In May, 2010, the ADM Board initiated a Recovery Management strategy by creating the AoD Residential Wait List meeting.

In the 15 months of this meeting, much improvement has occurred, not only in the wait time, but also in management of this process to benefit clients. Some of the improvements include:

- Average waiting time is 44 days, with men waiting approximately 8 weeks, and women waiting an average of 2 weeks. This represents a dramatic improvement over the waiting times prior to the improvement strategy where the average male wait was four months, and women had a six week wait for residential treatment.
- Coordination issues were improved with the Summit County jail so that medical information, which often increased waiting time, was received by residential providers on a timely basis.

In most cases, these problematic areas are due to a lack of or insufficient capacity in existing treatment services in Summit County similar to those in many areas in Ohio. In the recent funding environment, the Board is working hard to maintain current capacity and has not been able to find additional funding to initiate new programs to address these issues. Instead, the Board supports its AoD treatment providers in grant writing, cross-system collaborations and other creative “out-of-the-box” approaches to meeting these needs.

A part of the population in need includes adolescents with co-occurring disorders. These youth are often sent to the ADM treatment system through the Crossroads program at the Juvenile Court, after incurring relatively minor offenses. Consequently, extensive underlying issues are often uncovered such as abuse, PTSD, bipolar disorder, chaotic home environments, etc. A traditional mix of treatment services has not been effective in treating this population. As a result, they often fail in outpatient treatment. Many of these youth have been sent to out of county providers to receive specialized co-occurring residential treatment, such as New Directions in Cuyahoga County. The system needs to re-evaluate and revise treatment services for this population to achieve better outcomes in a cost-effective manner.

Another access issue which recently surfaced is access to detoxification services for adolescents. There is a burgeoning population with a combination of opiate, alcohol and benzodiazepine addictions. In the past, youth addiction had not progressed to the point where this was a necessary service. Unfortunately, this is no longer the case. Access is not only an issue in Summit County, but is difficult throughout Northeast Ohio. Complicating this further, on occasion, a few youth have had serious medical issues which required an acute hospital setting, i.e. juvenile diabetes with an insulin pump.

Although Summit County funds a substantial number of residential beds (44) for adult men, there continues to be a waiting list for this service. To facilitate access to this service, the Board created a central access point into residential treatment, through Central Assessment at Oriana Crisis Center. If the assessment and level of care determination indicate residential treatment is needed, and there is not an available bed, the client is placed on a central waiting list. The Board funds a case management position to triage and manage this waiting list, to ensure that clients are offered interim services, and enter residential treatment, as soon as possible. The case manager works with the providers of residential services and clients in this process.

Sober housing is not a treatment service per se; however it is closely related to successful outcomes of clients completing AoD treatment. In many cases, after clients return to a using or non-supportive living environment, they are unable to maintain the sobriety they have worked hard to attain, and they relapse, only to return using or to treatment. Since housing is not a service funded through the AoD system, the Board is seeking increased cross system collaborations, and other creative ventures to support an increased capacity for safe, sober housing. The Choice for Recovery Program is one resource that has shown promise in increasing access to this vital recovery support.

Deaf Services

The Board has access to and pays for deaf interpreters for Board-funded AoD and mental health agencies on a per-request basis. Both the Mental Health and AoD systems have not, until quite recently, been aware of available counseling services from counselors who speak ASL. However, a local provider agency recently began to provide individual/group counseling to several deaf clients remotely by closed circuit television using counselors who speak American Sign Language. In addition many agencies lack bi-lingual counselors. This necessitates the purchase of interpreter services through the International Institute.

Veterans & Ex-Offenders

Veterans and ex-offenders have the same access to services as any other client, with the same access issues related to adult male residential treatment. Additionally, there is a veteran's clinic in Akron and in nearby Canton providing outpatient psychiatry, medical and AoD services. Other resources include the Brecksville and Wade Park Veterans Hospitals in Cuyahoga County providing inpatient and outpatient services. The Brecksville site also has a domiciliary for homeless vets. Lastly, there is a homeless outreach team providing services to a population that includes significant numbers of veterans. The Access to Recovery (ATR) Program provides a mechanism to engage ex-offenders

into treatment, with the hope that they will address treatment and recovery support needs to reduce recidivism. In a similar manner, the Summit County Reentry Network provides resources for those being released back into the community from prison. Resources are made available to assist these individuals with housing, vocational training, job searching, treatment providers, etc.

Access to Services – MH

Prevention

With the current economic conditions, prevention and education programming is the first area of cuts. While the Board has tried to minimize the impact, our designated child-serving agency has seen the need to reduce funding in some targeted areas, including parental education and specialized school-based services. Adult and child-serving agencies are reducing their community and family-based educational programs in order to preserve needed treatment services. Progress, however, has occurred in many prevention areas. These include:

- The FIRST program, a comprehensive early identification and treatment program for individuals with schizophrenia spectrum disorders was initiated earlier this year and is a collaboration between Child Guidance and Family Solutions, Community Support Services and the BeST Center at NEOMED. It provides services to prevent premature penetration into the system while focusing on vocational/educational activities and family psychoeducation.
- The Board's continued mental illness stigma reduction activities which include working with the media as necessary to decrease stigma, as well as activities with local agencies. Also, the Client's Rights Coordinator is involved with helping survivors of suicide around the issues of stigma.
- The Suicide Prevention Coalition, lead by our Client's Rights Coordinator and a staff member from Portage Path Behavioral Health (Barbara Medlock) has provided both high school and campus education to recognize suicide risk. These efforts build on the Red Flags program developed and promoted by Mental Health America.
- Child Guidance and Family Solutions is providing support and training to families and staff of preschool and Head Start Programs to learn how to keep preschool aged problem behaviors from escalating into more significant problems as the child gets older.
- A school based diversion program developed by Judge Teodosio of the Juvenile Court has resulted in diversion of youth with problem behaviors into treatment rather than criminalization for behaviors that may be symptomatic of an emerging mental health problem.
- In an effort to proactively promote good mental health on Ohio's college and university campuses, the Ohio Criminal Justice Coordinating Center of Excellence (CJ/CCoE), which is operated in the Department of Psychiatry at NEOMED, has been engaged in a Campus Safety in a Mental Health Context program for the last several years.
- Most recently, the Board received one time funding from ODADAS to sponsor a variety of local prevention initiatives, including:
 - The Youth to Youth Conference
 - Olweus Bullying Prevention Program
 - Brown Bag Medication Program

- Ongoing Prevention Training

Treatment & Support Services

Major issues of concern regarding treatment and support service access include the following:

- access problems for those released from correctional facilities; extended waiting lists for staff supervised and subsidized housing with decreasing availability of Section 8 housing;
- funding constraints in providing Assertive Community Treatment (ACT) programming (due to Medicaid taxonomy limitations and some needed services not being billable)
- challenges with retention of multi-disciplinary teams due to care coordination expenses not covered by Medicaid.
- lack of adequate funding, particularly at the jail Behavioral Health Unit (BHU)
- recruiting/retaining professional staff, particularly child psychiatrists;
- transitions from incarceration/institutionalization to civilian due to delayed Medicaid coverage.

Intensive CPST is available for high risk individuals with SPMI. However, shortages in funding have resulted in an overall decrease in CPST positions, resulting in higher case loads. Open positions may remain unfilled for long periods of time due to low wages and competition with higher paying employees in the private and public sector. This is primarily due to provider costs exceeding the Medicaid ceilings, which prevent providers from increasing wages. This compromises recruitment and the ability to improve CPST caseload ratios.

There are also serious challenges in the area of medication adherence, side-effect monitoring and overall primary health. These include cognitive deficits in the SPMI population that make complex medication regimens difficult to follow. There are difficulties in accessing medications related to long lapses between appointments, Medicare changes, and the cost of prescriptions. In regards to physical health issues, a weight management group (to help address this common undesired side effect) is led by a nurse weekly at the primary agency in the system that serves SPMI clients, but these services are limited by funding/reimbursement issues and staffing limitations, e.g., the nurse to client ratio is approximately 1:600.

Through all of the funding threats, the Board has tried to maintain critical services and access through the utilization of levy dollars that were earmarked for system expansion. So far, the impact of state budget cuts has been minimal on treatment services for priority populations and services, including individuals who are SPMI, SED, and those with co-occurring disorders. The Board and provider agencies are looking at ways to improve system efficiencies with a minimal impact on services. Specifically, areas of focus will include the system's crisis services, billing, and the exploration of combining administrative costs for further savings by providers. The Board continues back-filling critical services with available levy funding, as long as the services can be maintained without having a detrimental impact on the long range financial health of the Summit County system.

9. Workforce Development and Cultural Competence

a. Workforce Development-

As part of Workforce Development, the system works to maximize local opportunities for students, internships, and mentoring for potential professionals in the behavioral health field.

Locally the workforce is aging and reflects statewide demographics. A majority of the workforce is over age 40, with many agency directors and clinical leaders in their 50's and older. Currently the system has enough counselors and social workers. However nurses and physicians are scarce and current salaries do not attract them to existing vacancies.

Turnover of staff, particularly community psychiatric supportive treatment (CPST) workers in both the adult and child arena, continues to be identified as an issue for agencies. The costs of recruitment, training, and getting staff up to full performance is often identified as a barrier to successfully meeting targeted units of service. There needs to be a focus on improving retention of these vital staff in order to minimize service disruption. One promising endeavor has been the Board's recent wellness initiative implemented on a system wide basis the past year.

Locally, there has already been much discussion about some common training needs for the AoD workforce related to recent events and changing populations. A large percentage of clients presenting for treatment have both co-occurring mental health and substance disorders. The Summit County ADM Board has been involved in moving towards developing a workforce that is competent to assess and treat clients with co-occurring disorders, so this has brought to the surface many training and experiential needs related to this population. In addition, other training needs include: disaster and trauma care, medication-assisted treatment, older adults. Many prevention staff are still in the process of attaining initial prevention credentials and are in need of training hours. Currently, the ADM Board is sponsoring 48 RCH hours, covering all the domains and foundations included in the basic preparation to sit for the Ohio Certified Prevention Specialist (OCPS) exam. This training filled to capacity quickly and has been well received. Additionally, the Board has supported the development of the FIRST program, the implementation of Cognitive Behavioral Therapy for persons with persistent psychotic symptoms (CBT-P), and had an active visiting professor program to provide education to the community and our provider network on evidence-based programs addressing areas such as suicide prevention, motivational interviewing, first episode psychosis, integration of primary and behavioral health.

The Board also assists collaborative stakeholders in the support and provision of mental health and AoD educational offerings. The Board educates police to intervene with mentally ill and intoxicated persons locally (CIT training) and in other parts of Ohio. The Board also sponsors cross system training between treatment providers, Developmental Disabilities (DD) and criminal justice entities to promote better understanding of consumer issues and collaboration between systems. Cross system training for youth in addition to adults will occur in the fall of 2011.

b. Cultural Competence –

A common thread running across all treatment services, whether for individuals using Mental Health or AoD services is providing a family culture of meaningful inclusion. This involves finding ways to include family members in treatment and support of the identified client. Activities to make this culture a reality will occur in partnership with family advocacy organizations that can assist the system in identifying practical and common-sense ways of welcoming and supporting their involvement in treatment and other supports.

The Board currently has a subcontract with The Pastor's Project to assure ready access to culturally appropriate services for individuals who may want services that address unique religious or ethnic issues. The Board also has a contract for interpreter services system-wide. There are internal and external reviews of cultural competence including monitoring of agency staff/board/client ethnic, gender and racial composition. Client rights and grievance documentation is also utilized to assist in this evaluation. Strategies to address disparities include maintaining the above arrangements, monitoring of indicators, tracking culturally competent programs and the number of persons reached. We also have two providers whose primary target population is the African-American community in Akron: Akron-UMADAOP and Urban Ounce of Prevention. Prevention agencies that include culturally specific programming include Akron-UMADAOP, East Akron Community House, Urban Ounce of Prevention and Asian Services in Action (ASIA, Inc.). The Board supports such programs as Kwanzaa Program, Black History Program and Lifeskills Training through participation in such programs, as well as continued monitoring of such programs through the web-based system. Many ADM Board contract agencies also send staff to the *Bridges out of Poverty* trainings where staff can develop accurate mental models of different economic classes, poverty, middle class and wealth, then utilize this understanding to make AoD and mental health services more accessible and culturally appropriate to the many differing populations we serve. Additionally, this allows for the development of new program/treatment strategies to improve relationships and outcomes.

The Board utilizes cross cultural training of staff at provider agencies in order to deliver quality services. It is important that staff is acquainted with the language, history, current events and common practices of local minority communities. Strategies to develop a more culturally competent delivery system are consistent with the move toward more individualized, consumer-oriented services. By the year 2050, the U.S. Census Bureau projects that nearly 1 in 2 Americans will be non-white and/or Latino. New and changing cultural perspectives, emerging cultural groups, and the growing realization that cultural identity contributes in essential ways to mental well-being require new attention to the need for culturally appropriate mental health services.

The AoD Prevention Performance Improvement Committee, which meets every second month, provides an on-going forum for the discussion of needs assessment for alcohol and other drug prevention. Representatives from county agencies meet to discuss how culturally competent services can be consistently available, accessible and effective. This ADM prevention group is currently offering an educational series to prepare providers of prevention services in Summit County and the surrounding area to obtain their Ohio Certified Prevention Specialist I certification (OCPS-I) and sit for the credentialing examination. This series not only provides its participants with the relevant credentialing information but includes sessions geared towards cultural awareness.

Finally, there is a need for culturally competent staff to work with deaf and hard of hearing clients, and agencies need to maintain/increase diversity in their workforce to better reflect the diversity among the client population. There is also a need for more staff trained in trauma informed care, and more dually licensed staff to work with co-occurring clients.

10. Capital Improvements

The Department requested submission of a capital plan to cover three capital biennia, FY13-14, 15-16 and 17-18, with funding to be received only for the SFY 13-14 biennium. While we submitted a capital plan for the FY 11-12 there was not a capital budget for FY 11-12 biennium and no funds were received. We will be resubmitting our plans to provide 50 units independent, supportive housing, replacement, repair and environmental improvements to system properties and residential treatment programs. An additional request will involve the consolidation of several smaller housing units in undesirable areas to one unit in an area that is safe and welcoming for our consumers, with the additional benefit of consolidating supportive services that will be more responsive and cost-effective.

III. Priorities, Goals and Objectives for Capacity, Prevention and Treatment and Recovery Services

- A. Determination Process for Investment and Resource Allocation**
- B. Goals and Objectives: Needs Assessment Findings**
- C. Goals and Objectives: Access and State Hospital Issues**
- D. Goals and Objectives: Workforce Development and Cultural Competence**
- E. Goals and Objectives: ORC 340.033(H) Programming**
- F. HIV Early Intervention Goals**
- G. Civilly and Forensically Hospitalized Adults**
- H. Implications of Behavioral Health Priorities to Other Systems**
- I. Contingency Planning Implications**

Section III: Priorities, Goals and Objectives for Capacity, Prevention, Treatment and Recovery Services

11. Process the Board used to determine prevention, treatment and capacity priorities

The Board utilized the following methods in its determination of priorities:

- Treatment and Prevention Performance Improvement Committees met periodically providing an ongoing forum to discuss priorities. These and other committees e.g., Agency Directors meetings, the Northeast Ohio Children’s Consortium, etc. included provider agency staff, collaborating agency representatives, Board staff and occasionally ODADAS and ODMH departmental staff.
- Implementation of the web-based system for prevention providers also offered a continuing forum in which to discuss prevention priorities. This allowed other prevention providers to interact and share components with other providers, enabling the exchange of ideas and comparisons of what populations are being served. It also allows the Board to review and continually assess the projections and clients served by the various programs.
- Outcome measures and client satisfaction surveys are also utilized in determining priorities.
- Finally, as noted in the sections above, the Board determined its prevention and treatment priorities based on the needs assessment process. This included input from multiple constituents such as consumers, family members, provider agency administration and treatment/prevention staff, city/county officials and data sources, safety forces, medical psychiatric personnel, etc. Specific to the preparation of this Community Plan, the Board held community forums in December and January, sent priority/goal matrices out to stakeholders, agency directors, and Board members, and implemented a short questionnaire utilizing Survey Monkey (see Appendices A and B for a summary of forum and survey

results).

12. Behavioral Health Capacity, Prevention, and Treatment and Recovery Support Goals and Objectives

The Summit County ADM Board is in full alignment with and supports the listed Capacity, Prevention and Treatment Goals and Objectives. However, we realize that we cannot focus on every Goal/Objective with the same level of commitment. Therefore, at the current time we are choosing to focus our efforts on the following Goal/Objectives in the coming biennium period to at least maintain and if at all possibly enhance the following goals:

Behavioral Health Capacity Goals

- Reduce the stigma of seeking care
- A highly effective workforce
- Maintain/increase access to service enriched housing
- Use a diversity of revenue sources to support Ohio's behavioral health system
- Increase the use of data to make informed decisions about planning and investment
- Promote integration of behavioral healthcare and other physical health services
- Maintain access to services to all age, ethnic, racial, and gender categories as well as geographic areas of the state

Prevention Services/Priorities (Alcohol and Other Drug)

- Maintain current levels of programming
- Support programming that builds resiliency and asset development in at-risk youth with global at-risk behaviors such as AToD (alcohol, tobacco and other drug) use, violence/gangs, depression/suicide, etc.
- Family involvement with children/youth in prevention programming.

Prevention Services/Priorities (Mental Health)

- Crisis Intervention Training (CIT)
- Suicide Prevention Education
- School-based mental health services/programs

Alcohol and Other Drug Prevention Goals

The Board endorses and supports all of the AoD Prevention Goals. The goals that are of particular focus are:

- Programs that increase the number of customers who avoid ATOD use and perceived non-use as the norm
- Programs that increase the number of customers who demonstrate school bonding and educational commitment
- Programs that reduce the number of customers who misuse prescription and/or over-the-counter medications (a new goal chosen for this biennium based on demonstrated need by key AoD provider staff and supported by observed local and state trends)

Mental Health Prevention Goals

The Board endorses and supports all of the Mental Health Prevention Goals. The goals that are of particular focus are:

- Strengthen individuals by building resilience and skills and improving cognitive processes and behaviors
- Promote mental health in schools by offering support to children encountering serious stresses, modify the school environment to promote pro-social behavior; develop students' skills in decision making, self-awareness, and conducting relationships; and target violence, aggressive behavior and substance abuse.
- Suicide prevention coalitions that promote development of community resources to reduce suicide attempts.

ODADAS Treatment and Recovery Goals

The Board supports all of the ODADAS Treatment and Recovery Goals listed on p. 16 of the Guidelines. Additionally, the following Summit County specific goals are listed below:

- Additional medication assisted treatment for opiate addicted persons
- AoD intervention services to assist families to engage clients in treatment services at an earlier point in their disease (6-10 sessions) (Unmet need)
- Transitional housing with support after AoD assessment while waiting for AoD residential treatment (Unmet need)
- Additional sober housing

ODMH Treatment and Recovery Support Goals

The Board endorses and supports all of the ODMH Treatment and Recovery Support Goals. The Board recognizes that all the goals are necessary for long term recovery and that programs should address those goals which are most applicable and critical to the customer population they serve. Those in which the Board will put increased emphasis on include:

- Increase Access to Housing, including Supportive Housing
- Decrease criminal and juvenile justice involvement
- Decrease school suspensions & expulsions

13. Access to Services

The Board plans to address several of the critical access issues previously identified. However, due to the decrease in property values levy revenue is not reaching estimated projections. This along with recent state cuts and the uncertainty of future funding means the Board will need to proceed very cautiously in using any new revenue and committing to new projects. Consequently, the top priority will be to maintain critical services which will affect the Board's ability to address current access issues. It is expected that the crisis system redesign project currently being planned will lead to improvements in access issues in the coming years. Also there has been expansion of peer support

in the system, as well as increased attention to reducing penetration into the criminal justice system. Finally, the Board will at the very least work to maintain access for its traditional priority populations/services. These include:

- Persons with Severe and Persistent Mental Illness (SPMI)
- Children who have Serious Emotional Disturbances (SED)
- Emergency Services
- Community Support Programs
- Persons with Medicaid Coverage, especially pregnant women
- Persons with co-occurring disorders
- IV drug users
- Individuals severely medically compromised by their addiction(s) who lack a health support system.
- Poly addicted individuals
- Residential treatment
- Detox
- 23 Hour Observation

Additionally, the Board plans to expand or at the very least maintain the priority populations/services recently identified by provider agencies, identified stakeholders, and the community as identified during our recent community input process for the Community Plan (see Appendices A and B)

14. Workforce Development and Cultural Competence

Please see Workforce Development and Cultural Competence descriptions in Section II above.

15. ORC 340.033(H) Goals

The Summit County ADM Board has been reporting use of H.B. 484 funding for services since the funding' inception, and would find it useful to contribute to a statewide Investor Target specifically designed for the H.B. 484 population. There are two existing Investor targets which seem to be appropriate for this population. Since the original intent of the Adoption and Safe Families (ASFA) act by Congress in 1997 was to remove children from harmful family situations and ensure each child's health and safety, family reunification after parents receive substance use treatment is a prime goal. Following this line of thought, the two (2) Investor Targets that the ADM Board finds critical to behavioral or situational customer changes are:

- Number of customers who are abstinent at the completion of the program.
- Number of customers who live in safe, stable, permanent housing at the completion of the program.

In addition, programs may find the following measures to be applicable, although not to every client, but when used collectively:

- Number of customers who have drug-free babies while in a program or following completion of the program.
- Number of customers who retain custody of their children through completion of the program.
- Number of customers who are re-unified with their children within one year of program completion.

16. HIV Early Intervention Goal/Objectives

No longer applicable due to the loss of funding for this programming.

17. Addressing Needs of Civilly and Forensically Hospitalized Adults

Needs of Civilly and Forensically involved clients are addressed in various ways in our system. Members of this population who present to Psychiatric Emergency Services and who are considered to be unsafe returning home may be voluntarily treated at the Crisis Stabilization Unit (CSU) which is an alternative to hospitalization. The Board receives weekly written reports from Northcoast Northfield on the status and discharge plans of all hospitalized forensic and civil patients. The Board meets monthly via teleconference with Heartland Behavioral staff to review the progress and discharge plans of forensic patients hospitalized there. Discharge planning could include the provision of residential services in the community; beginning the process for guardianship; payeeship; applications for benefits and medication management.

A substantial proportion of clients civilly committed are hospitalized at two of the local community hospitals. Summit County ADM Board has agreements with these hospitals for the provision of inpatient treatment. Board staff meets regularly with hospital and community treatment providers to discuss continuing care at discharge.

Due to the closing of the Northcoast Behavioral Cleveland Hospital in 2011 and the realignment of catchment areas for ODMH hospitals, forensically hospitalized clients are now treated primarily at Heartland Behavioral Healthcare in Massillon, Ohio although patients with certain needs are treated at Northcoast Behavioral Healthcare in Northfield, Northwest Ohio Psychiatric Hospital in Toledo or at the Timothy Moritz Forensic Unit at Twin Valley Behavioral in Columbus. The Forensic Monitor for Summit County ADM Board meets with community treatment staff weekly and with Heartland Behavioral Staff via teleconference at least monthly to plan for the continuity of care in the community at discharge. The Forensic Monitor receives written reports from Northcoast Northfield weekly and communicates with Northwest and Twin Valley staff as necessary to review treatment and discharge plans for Summit County patients in those hospitals. The Forensic Monitor keeps the courts aware of treatment progress and plans for Conditional Release for those clients who have forensic statuses of NGRI or ISTU-CJ (Not Guilty by Reason of Insanity or Incompetent to Stand Trial – Criminal Court Jurisdiction).

All clients, forensic and non-forensic, have similar roadblocks to effective community living. Perhaps the most critical is supported housing. Summit County is fortunate in that we have a range of housing options available for clients. Forensic clients have a particularly difficult time because of restrictions on subsidized housing and/or restriction on location for those who are sex offenders. Summit County ADM Board supports group homes focused on clients of the mental health system. The community agency serving the severely mentally ill in the community has a staff person who acts as an advocate for clients with the Akron Metropolitan Housing Authority. The Board, though contracts with community treatment agencies, partially funds some housing programs.

18. Implications of Behavioral Health Priorities to Other Systems

Treatment Priorities

Unfortunately when system needs are unaddressed or under-addressed there are numerous and varied implications to other systems. Youth in need of AoD services not only present with co-occurring disorders, but usually come to the attention of treatment providers through the juvenile justice system or school system. They do not attend school on a regular basis, have behavioral issues and as a result, have poor grades, and function significantly below grade level.

Consequently, they end up getting into trouble with the law, e.g., curfew violations, assaults, breaking and entering, possession, paraphernalia, etc. and end up in court or detention. The community then spends significant funding on court-related costs, incarceration in the local community or in worst cases in Department of Youth Services (DYS) facilities. Communities need probation officers and local police departments have youth officers to track and assist with these youth. Added to these costs, is the prospect that these youth have set the precedent for future arrests and incarcerations and a lifestyle that preys on the public to support their drug seeking lifestyle. In most cases, without significant treatment intervention, these youth have become “throw away kids”, and have lost the hope of living a rewarding and productive life. In addition the costs of continued treatment recovery support services, possible incarcerations and lost productivity throughout adulthood are overwhelming to consider. Other examples include overcoming Medicaid cost containment for those clients we share with Children’s Services or DD, the challenges of meeting the needs of our clients with SPMI who become incarcerated, e.g., sufficient resources for providing necessary behavioral health treatment, including medications. Additionally, children and adolescents with untreated mental health issues are more likely to enter the juvenile justice system. Much of these risks, however, have been reduced significantly by our systems collaboration with Juvenile Court. One example would be the Behavioral Health Juvenile Justice Program which itself is a collaboration with numerous organizations in addition to the Board, e.g., The Village Network, Child Guidance & Family Solutions, The Center for Innovative Practices of Case Western University (CIP), Mental Health America, etc. Services of this program are directed at a particular population of significantly impaired, serious juvenile offenders in an effort to prevent their commitment to ODYS institutions as well as addressing their behavioral health needs within their home and community.

The program has dramatically reduced DYS commitments.

Another example is the Responder Program (originally known as the McArthur First Responder Program) which is now operated out of the Court’s Family Resource Center. Its purpose is to

identify problem behaviors that may be a signal of mental health issues versus only behavior problems. The goal is diversion into treatment to avoid criminalization. There were sixty-nine youth in the program last year, of which only six youth (8%) were eventually charged with truancy. Seventy-six percent of the youth had increased attendance, decreased tardiness, decreased disruptive behavior in the classroom, improved grades, or a combination of.

Prevention Priorities

Although the Board believes it has addressed many needs of targeted populations and critical areas, it is also aware that resources are limited, particularly in the area of prevention. By necessity, funding in this area is balanced against treatment priorities. It is expected that other collaborators or system providers would be challenged to also do more with less. Some of the systems affected would be the public school and daycare system for early childhood mental health priorities. Child Guidance and Family Solutions has been successful in obtaining support for early childhood mental health program funding from other resources also, e.g., United Way of Summit County and local foundations. Advocacy groups, volunteers, and school teachers/guidance counselors share responsibility for suicide prevention and depression screening for school age youth. In many ways, the entire community, including funders such as United Way and foundations share funding responsibilities for these and other prevention priorities.

One important area that will see significant expansion is CIT-Y (Crisis Intervention Teams for Youth). Similar to adult CIT, it will have a train the trainer component. Through the support of the John and Catherine T. MacArthur Foundation and the Models for Change Mental Health/Juvenile Justice Action Network a free training was sponsored earlier this year. The training curriculum addressed critical youth-specific topics, including youth mental health symptoms and disorders, crisis de-escalation and intervention skills and communication techniques, and local services and resources linkages for youth.

19. Contingency Plan: Implications for Priorities and Goals in the event of a reduction in state funding

Due to other resources it is unlikely that this Board will be faced with a reduction of the magnitude described earlier. In the event that services do need to be reduced, it is our intention to take the steps necessary to maintain services to all priority and “high-risk” populations. There would likely be a reduction in types of services, e.g., some prevention/education programming rather than a reduction in the volume of treatment services or number clients receiving treatment.

IV. Collaboration

A. Key Collaborations

B. Customer and Public Involvement in the Planning Process

C. Regional Psychiatric Hospital Continuity of Care Agreements

D. County Commissioners Consultation Regarding Child Welfare System

SECTION IV: COLLABORATION

20. Key collaborations and related benefits and results

The Board regularly collaborates with other funding/planning entities and other organizations in the county, e.g., Children's Services Board; Cluster (Board staff participate on the Administrative and Executive Cluster as well as Review Council and staffings as needed) ; Child Fatality Review Board Subcommittee; First Things First Initiative (ADM Board Children's Program Coordinator chairs the Behavioral Health Subcommittee and is a member of the Maternal Depression Subcommittee; Juvenile Detention Alternatives Initiative (ADM Board Children's Program Coordinator participates on the following committees: Conditions of Confinement, Detention Alternatives, and Executive Committee); Development Disabilities; the McArthur and Behavioral Health Juvenile Justice (BHJJ) programs through Juvenile Court; Family and Children First Council; NAMI; Multi Dimensional Treatment Foster Care Panel; Summit County Sherriff; Suicide Prevention Coalition; Summit County Mental Health Court; Summit for Kids; various police departments and other safety forces through Crisis Intervention Team (CIT) training; local school systems; universities; and hospitals.

In 2011, the Board also partnered with Summit County Children's Services and the Summit County Juvenile Court to provide Multidimensional Treatment Foster Care (MTFC) provided by the Village Network. This evidence based practice specializes in intensive foster care within the boundaries of the county. There are now six MTFC home in the area.

The above collaborations have resulted in many benefits to each of our systems and to the community at large. Some examples include dramatic reductions in DYS placements due to the successful implementation of the BHJJ program (no DYS placements in the last fiscal year); avoidance of unnecessary system penetration (Cluster, Mental Health Court, etc.); injury risk reduction to mental health clients and safety forces (CIT), and progress within the criminal justice system as the Board and County Sherriff work collaboratively to develop effective and humane practices for providing services for people with mental illness who are incarcerated. Recent accomplishments include improved medication adherence for people with mental illness while incarcerated, and the hiring of peer support specialist to connect with individuals while in jail to support and help facilitate the transition from incarceration to treatment, etc.

National experts were also consulted in late 2009 and 2010. On November 18, 2010, the Board, in collaboration with County Executive Russell M. Pry, sponsored a presentation by Professor John

Petrila, J.D., LL.M., from the University of South Florida. Dr. Petrila's presentation entitled *Cross systems information sharing: Respecting confidentiality while improving care*, focused on sharing information regarding the assessment and treatment of people with serious mental illnesses across service systems. Professor Petrila's *Final Report on Information Sharing in Summit County* contained recommendations for system improvement and was distributed to agencies and other interested parties. Policy Research Associates (PRA) did our system mapping exercise in April 2009 providing a Summit County Action Plan including recommendations for transforming the service system to reduce penetration of those with mental illnesses into the criminal justice system.

In August 2010, Jeffrey Geller, MD, et al, prepared a report for the Board entitled: *An Evaluation of Summit County, Ohio's Care, Treatment and Management of Persons in Psychiatric Crisis.*

The consultants reviewed documents relevant to psychiatric and substance abuse services in Summit County before, during, and after a site visit to Summit County on December 8-9, 2009. During the site visit, the consultants interviewed ADM Board staff; representatives from a range of service providers, criminal justice/law enforcement entities and other county boards; members of NAMI (National Alliance for the Mentally Ill); and individuals with serious mental illness who use county services. The consultants toured the Portage Path Psychiatric Emergency Services (PES); the Oriana House Detox Center; Community Support Services; and Choices Social Center. The above report along with an earlier document prepared in April 2009 by Policy Research Associates (PRA) are part of this Board's Adult Crisis Re-design Inputs.

Additionally, the Board alerted key stakeholders about our community plan process and solicited their input into the needs & priority-setting process by sending out a survey matrix. Information on the community forums and a link to a shorter online survey was also provided.

21. Involvement of customers and general public in the planning process

The Board reached out to involve its customers and the community in the planning process in the following ways:

- Survey matrix to assess priority populations and needs sent to the following:
 - Community Stakeholders
 - Agency Providers
 - ADM Board of Directors
- Online survey for respondents to indicate priority populations and needs.
- A Board Provider Input Forum was held in June, 2011 identifying: changes in populations/trends, unmet service needs and emerging issues.
- Ongoing meetings with community stakeholders as part of the Boards Ends activities
- Community Plan Forums held at public locations to obtain input into the planning process (held in Barberton, West Akron, downtown Akron, Twinsburg, South Akron)

22. Regional Psychiatric Hospital Continuity of Care Agreements

The current Continuity of Care (COC) Agreement with Northcoast Hospital – Northfield Campus is due for renewal. The Board has contacted Northcoast Hospital to begin the process of reviewing the past COC for any necessary modifications and signing the agreement for the next biennium. The Board will also be investigating the need for an additional COC agreement with Heartland Behavioral Health given our utilization of that facility for treatment of our forensic clients. Implementation of the above referenced COC has not been an issue due to the longstanding relationship between the hospital and board which has operated well over an extended period of time since the 1990's with the Department's prior Unified Service Agreements (USA). Although pre-screening agency staff has not received direct training on the Continuity of Care Agreements, the designated pre-screening agency responsibilities are clearly outlined in Appendix B of the Agreement. Additionally, there are signatures from the director of this agency as well as the system's lead SPMI agency. Finally, the operations of the pre-screening agency, including staff training, were recently assessed by consultants (Dr. Jeffery Geller and Professor John Pettila) looking into the feasibility of a system redesign.

23. Consultation with county commissioners regarding services for individuals involved in the child welfare system

This Board service information regarding services for individual involved in the child welfare system is available to county council other parties through its reporting the use of H.B. 484 funding for services which has taken place since the inception of funding. (Also see Section III - E. Goals and Objectives: ORC 340.033H). Board staff are also appointed by the County to the Children's Administrative and Executive Cluster as well as to their Review Council. More recently, the Board's Children's Program Coordinator was appointed this past July to the Summit County Children's Services Citizen's Advisory Committee (CAC). The CAC was established under the authority of the Ohio Revised Code and given three distinct responsibilities:

- To further cooperation between the agency and other child caring agencies in the county
- To carry out studies of the effectiveness and need for particular services in the county; and
- To advise the Summit County Children Services Board of Trustees and Executive Director on policies pertaining to the provision of services to children.

V. Evaluation of the Community Plan

A. Description of Current Evaluation Focus

B. Measuring Success of the Community Plan for SFY 2012-2013

C. Engagement of Contract Agencies and the Community

D. Milestones and Achievement Indicators

E. Communicating Board Progress Toward Goal Achievement

SECTION V: EVALUATION OF THE COMMUNITY PLAN

24. Ensuring an effective and efficient system of care with high quality

The ADM Board has obtained outcome indicators for behavioral healthcare through the BHOS (Behavioral Health Outcome System) outcome initiative for both mental health treatment and alcohol and other drug treatment. The Board is currently collecting the following from its agencies:

- Client Satisfaction
- Family Involvement in Treatment
- Unplanned Discharge Rate
- Role Functioning Reliable Change Ratio: Clinician Rated
- Role Functioning Reliable Change Ratio: Patient Rated

The outcome measurements tracked are consistent with ODMH, ODADAS and County requirements. The system has struggled with integrating the diverse MIS capabilities of provider agencies. Depending on agency size, hardware/software capabilities, human resources and the value attributed to outcome surveillance, the agencies have differed in their ability to adapt to the current outcome measurement requirements recommended by the ADM Board. A challenge to the Board is to anticipate and integrate the collection of outcome data to minimize cost and maximize the possibility of collecting meaningful information to improve quality of care. It should be noted that further work needs to be done by the Board in collaboration with our contract agencies to further improve the monitoring of client outcomes and the evaluation of our services. There are several system-wide indicators that can be measured to address quality of life issues, such as housing stability, employment, incarcerations, crisis visits, and hospitalizations, to name a few.

25. Determining Success of the Community Plan for SFY 2012-2013

The most immediate determination of Community Plan success will be its timely submission, the compliance with various requirements such as obtaining community/agency input and the approval rating assigned by the Departments to the various sections of the Plan (listed in the Community Plan Review Criteria section of the Guidelines).

To help determine the later stage of success of the Plan, the Board will engage contract agencies and the community in evaluation of the Community Plan by utilizing surveys and/or face to face meetings to determine their perception of the success of the goals we have identified within the SFY 2012-2013 Community Plan. This will be done after a sufficient period of time has occurred to allow a proper assessment of progress made or not made, e.g. 18-22 months. Our Board of Directors will be receiving regular updates from Board staff on the success or lack of on various elements of the Plan.

ODADAS Waivers

A. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through ODADAS may not be used to fund inpatient hospital rehabilitation services. Under circumstances where rehabilitation services cannot be adequately or cost-efficiently produced, either to the population at large such as rural settings, or to specific populations, such as those with special needs, a Board may request a waiver from this policy for the use of state funds. Complete this form providing a brief explanation of services to be provided and a justification for this requested waiver. **Medicaid-eligible recipients receiving services from hospital-based programs are exempt from this waiver.**

A. HOSPITAL	ODADAS UPID #	ALLOCATION

B. Request for Generic Services

Generic services such as hotlines, urgent crisis response, referral and information that are not part of a funded alcohol and other drug program may not be funded with ODADAS funds without a waiver from the Department. Each ADAMHS/ADAS Board requesting this waiver must complete this form and provide a brief explanation of the services to be provided

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION

SFY 2012 & 2013 ODMH Budget Templates

The final budget template, narrative template and instructions will be posted on the ODMH website (<http://mentalhealth.ohio.gov>) on December 1, 2010. (ORC Section 340.03)

**Portfolio of Providers, Services Matrix,
and Housing Categories
(see attachments)**

Board Forensic Monitor and Community Linkage Contacts

Community Plan Guidelines for SFY 2012-2013 September 29, 2010 R.

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

Name	Street Address	City	Zip	Phone Number	Email
Christopher Freeman-Clark	100 West Cedar St. - #300	Akron	44307	330-564-4086	freemanclarkc@admboard.org

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

Name	Street Address	City	Zip	Phone Number	Email
Joanne Arndt	100 West Cedar St. - #300	Akron	44307	330-564-4086	arndtj@admboard.org

INSERT ADDITIONAL BOARD APPENDICES AS NEEDED

APPENDIX A

FEEDBACK FROM MATRIX FOR COMMUNITY INPUT

Behavioral Health Capacity Goals, as indicated by respondents:

MH

- Promote “Evidence-Based” policies (2)
- MI and Addiction are health care issues
- Diversity of revenue sources (2)
- Increase hiring of peers
- Reduce stigma (3)
- Strengthen cultural competence of the system
- Maintain access for ethnic and racial populations
- Facilitating treatment and case management for Limited English Proficient clients
- Decrease nursing home admissions
- Increase revenue sources
- Maintain/improve crisis services
- Provide mental health and physical health services in an integrated system (2)
- Maintain access to services to all age, ethnic, racial, gender and all diagnostic categories
- Increase access to housing
- Continuum of care that includes prevention/intervention and treatment and recovery services
- An accessible, effective, seamless prevention/intervention, treatment and recovery services continuum from childhood through adulthood.
- Increase the availability of school-based behavioral health services

Alcohol/Drug Addiction

- Youth led prevention
- Evidence-Based Practice
- Reduce stigma (3)
- Underage drinking
- Fetal alcohol
- Strengthen cultural competence of the system
- Maintain access for ethnic and racial populations
- Facilitating treatment and case management for Limited English Proficient clients
- Older adults
- Decrease nursing home admissions
- Increase revenue sources
- More detox/crisis services

Prevention priorities, as indicated by respondents:

MH

- Stigma reduction (2)
- Suicide prevention (4)
- Early intervention programs (2)
- School mental health (2)
- Youth & Young Adults
- Individuals in Criminal Justice System
- CIT training (2)
- Depression screening
- Early intervention (3)
- Faith-based and culturally specific initiatives

Alcohol/Drug Addiction

- Perceive ATOD use as harmful
- Avoid ATOD use & view nonuse as the norm
- Older adults
- Stigma reduction (2)
- Early intervention
- Evidence based practices (2)
- Underage drinking (2)
- Fetal Alcohol Spectrum Disorder
- Youth-Led Prevention

Prevention goals, as indicated by respondents:

MH

- Stigma reduction (3)
- Strengthen families (2)
- Strengthen individuals
- Prevent specific disorders
- Promote MH in schools (3)
- Suicide prevention coalitions
- Early intervention/screening for older adults
- Mental health and wellness programs (2)
- Programs that train criminal justice system staff to assist mental health service providers prior to “jail”
- Programs that provide screening and early intervention to older adults
- Strengthen individuals by building resilience and skills and improving cognitive processes and behaviors

Alcohol/Drug Addiction

- HIV
- Criminal Justice involved clients
- Pregnant women
- Increase ATOD use as non-norm
- Reduce prescription drug misuse
- Increase perception regarding harmfulness of ATOD use (2)
- Impact community laws and norms (2)
- Increase numbers of early intervention programs for middle and older adults
- Programs that reduce the number of customers who misuse prescription and/or over-the-counter medications
- Programs that increase the number of customers who experience positive family management

Treatment and recovery goals, as indicated by respondents:

MH

- Increase access to housing (2)
- Decrease homelessness (2)
- Consumers reporting positively
- Decrease criminal justice involvement (2)
- Social connectedness
- Decrease rehospitalization

Alcohol/Drug Addiction

- Live in safe, stable housing (3)
- Increase abstinence (3)
- No new arrests (2)
- Additional treatment slots for Methadone treatment (at least 100)
- Medical services to include Hepatitis A & B immunizations
- Treatment slots for individuals that survive Traumatic Brain Injuries (TBI). Both MH and AoD.
- Rehab service for TBI survivors perhaps to include a sheltered workshop environment.
- Housing funds for homeless youth, i.e., Horizon House. This is actually a prevention program.
- Video Therapy, allow agencies to invoice ADM as a third party payer for Mental Health and ODADAS treatment. Once ODADAS video rules clear JCARR.
- New/additional funding for Adolescent AoD therapy. Currently we are using TASC and Medicaid funding and levy to support treatment to these patients.
- Increase social support/recovery support services
- Gainfully employed
- Increased participation in self help

Other issues you would like the ADM Board to consider in regards to the 2012-2013

Community Plan Guidelines for SFY 2012-2013 September 29, 2010 R.

Community Plan, e.g., unmet needs, priority populations outside of those listed in the attached Guidelines, planning and/or evaluation strategies, implementation methods, etc. , as indicated by respondents:

- At PES, the waiting period for an evaluation is too long...
- At CSS, transfer....occur so often leaving many peers confused....
- No support for the former program on homelessness run by CHOICES...
- There should be a mandatory training for staff & providers/Justice Forum on “peer support”
- As an interpreting and translation service provider, BH providers in our system contact us from time to time to provide language access support. It would be very valuable to work with the Board to devise a basic training (e.g. patient navigator) that would enable our interpreters to provide greater help to consumers...
- Third party payment reimbursement issues. Due to the impact of parity laws and healthcare reform, we anticipate needing assistance to implement billing insurance and Medicare and obtaining reimbursement. Assistance with obtaining accreditation (CARF) necessary to obtain certification is another important issue.
- As the baby boom generation continues to age, there will be a huge increase in need for both mental health and substance abuse treatment and prevention services for this population. Trends suggest that this population not only has a higher rate of substance abuse but higher rates of co-occurring mental and physical health problems.
- Grant assistance. As our state and federal dollars become increasingly threatened, it is becoming more important to seek funding in other ways. Agencies, especially smaller ones that may not have a grant writer on staff need assistance with writing competitive grants that in turn benefit the ADM system and client community as a whole.
- Training in additional areas that will be needed are ICD 10 implementation, healthcare reform, crisis intervention and other workforce development issues such as evidenced-based practice and trauma informed care.
- Increase services for opiate-addicted individuals
- Pharmacological management – reimbursement rates do not support the service and given the “shortage” of psychiatrists interested in working with our population (DD & MI) it is a real challenge.
- Individuals with DD and substance abuse have difficulty participating in “typical” treatment programs and are often felt “not appropriate”
- Residential treatment for adolescents with DD and Autism Spectrum Disorders. Parents are told that they need to give up custody to get the service.
- Allowing time for training for staff is difficult given productivity standards.
- There is very little treatment provided in the office given client transportation difficulties.
- Increase capacity for male AoD Residential Treatment Services in Summit County
- Provide Safe Havens or programming for individuals waiting to access residential AoD treatment programs
- Fulfill last levy objectives including funding staff salary adjustments at 100% of initial award amounts

APPENDIX B

FEEDBACK FROM COMMUNITY FORUMS AND ONLINE SURVEYS

Summary of Survey Results of Community Input for the County of Summit ADM Board Community Plan (n=74)

Thank you for your willingness to provide input for the development of the Alcohol, Drug Addiction and Mental Health Services (ADM) Board Community Plan that will be implemented July 1, 2011 through June 30, 2013.

The completed Community Plan will be posted on the ADM Board Web site (www.admboard.org) once approved by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) and the Ohio Department of Mental Health (ODMH).

1. Over the next two years, what THREE types of mental health treatment services should be the highest priority?

RESULTS: Response Count (Response Percentage)

- **Counseling for adults / older adults – 33 (44.6%)**
- **Medications for people with serious mental illness – 31 (41.9%)**
- **Support services that help people with mental illness live in the community – 28 (37.8%)**

Other responses (written in by respondents): Structured/residential adolescent treatment... CIT Officers in the Barberton area...Focus on protocol to ensure that the right services get provided through supportive case management, transportation assistance and provider accountability... Psychiatric services for youth... Marital counseling... Early intervention... No waiting days for evaluation...Utilize private/independent case management oversight to control cost... Monitor providers (for) improved quality of care... Marital/couples counseling...

2. Why did you choose these priorities? (Select comments pertaining to the above results)

The older population is increasing-it would be better to stay ahead of the curve...Medication is important to take...Because some people do not have health insurance...Consumers should have these services...the Board should focus on protocol to ensure that the right services get provided through supportive case management, transportation assistance and provider accountability...These are factors that relate to me personally...Due to the economy and people losing jobs, more and more of this population is needing services...We have an increased demand for counseling services as people face environmental & economic stress. That's a big part of what the ADM tax dollars should support...Because the amount of people with mental illness is increasing and many of the individuals can live in the community with the right help...Personal experience with severe mental illness and benefits

from the selected services.

3. Over the next two years, what THREE types of addiction treatment services should be the highest priority?

- **Intensive Outpatient Treatment – 41 (55.4%)**
- **Detoxification Services – 33 (44.6%)**
- **Crisis Services – 30 (40.5%) – tied for third place**
- **Outpatient Counseling – 30 (40.5%) – tied for third place**

Other responses: Opiate treatment options...Peer support...More expertise on CD agency staffs...
Blended educational and mental health programs that treat all of an individual needs...
Prescription abuse.

4. Why did you choose these priorities?

Need to have these services...I have used detox several times as have many of my friends. I think outpatient is best compared to residential...The need appears to be there...With the frequency & severity of opiate addicted individuals in our community, additional medical detox services & residential treatment options are essential...Living with someone with recovering, detox and residential treatment can be the difference between a person being able to recover or not...I wish I could choose four, including residential. However, detox services are the most difficult for people to afford (person also mentioned IOP& counseling as being crucial in preventing relapses)...Many drug addictions are long term and require multi-levels of support and follow-up...These services can incorporate some of the others mentioned, e.g., Methadone or Suboxone treatment...All are important needs hard to pick top three...I believe many clients could benefit from individual and intensive assistance...Have family member who has benefited from such services for addiction...Because they're all very important.

5. What THREE prevention, education and recovery support services should be highest priority?

- **Community Education about mental health and addictions - 47 (63.5%)**
- **Education for parents to learn how to raise emotionally healthy children - 34 (45.9%)**
- **Suicide prevention education - 33 (44.6%)**

Other responses: Physician education-ER education-social service/nursing/health care professional education. Sad to hear how many individuals know so little about SBIRT (Screening, Brief Intervention, Referral and Treatment) or even basic addiction/mental illness identification, motivation and treatment options...Those that lack resources, e.g., lowest socioeconomic status, homeless, history of legal system involvement...Help for families raising children with severe emotional disturbance – specifically de-escalation techniques...More education in the community at large regarding the extent of mental illness and co-morbid addiction problems...Participation in community events where we can provide education and

screening...ADM Board needs to do a better job educating the general public about its role in the community...

6. What other early intervention services should this Board consider prioritizing in its community plan?

- **Mental health wellness / prevention services targeting youth - 46 (62.2%)**
- **Criminal Justice Diversion Programs for persons with mental health problems (mental health courts) - 44(59.5%)**
- **Criminal Justice Diversion Programs for persons with addictions (drug, DUI courts) - 35 (47.3%)**

Other responses: Helping the schools (where our children spend most of their day) understand children with SED (Severe Emotional Disorder) and how to help them...Mental Health Wellness programs targeting adults (two comments received in this area)...Early prevention and intervention for individuals experiencing or at risk for psychosis...Mental health wellness/prevention services targeting adults in financial and life crisis.

7. Why did you choose these priorities? (Select comments pertaining to the above results)

We can't keep putting people with mental health problems in jail every time they come in contact with law enforcement...There are many people in the jail system that should not be there (and six similar comments to the above)...the education of parents regarding what is and is not abuse, and what are health parenting strategies...most of my counseling caseload have had childhood problems including abuse and neglect...Several suicide attempts – community mental health saved my life...Children are the future...Because prevention costs less than treatment and is better for the community's overall health...Drug Courts and Mental Health Courts work!...Trying to better youth to decrease adult need...Education about addiction is very important for both children, teens and adults...An early detection and understanding provide better prognosis...There are a multitude of individuals who are incarcerated because of drug offences, they get out of prison and usually repeat the same offences...Early prescreening and intervention is the future...In these tough economic times people are falling prey to depression and suicide...

8. What THREE populations should this Board consider prioritizing in its community plan?

- **Adults with serious mental illnesses - 53 (63.5%)**
- **Youth with mental health needs - 48 (64.9%)**
- **People who are incarcerated with mental illness or addictions - 27 (36.5%)**

Other responses: Adults with mental illness who have no other means to get services (two comments)...Addiction and mental health should not be separate categories. Some thought needs to be given to tackling them both at the same time...Outpatient mental health services for those

who are new to the system, have acute crises, and who need general outpatient mental health services...We need to spend our time and money where it will help the most people and provide the greatest benefit back to our communities, i.e., on general mental health services for kids and adults, and addiction services for kids and adults...Young mothers and individuals in abusive relationships.

9. Why did you choose these priorities?

Youth needs early detection (5 similar comments)...Seniors are overlooked (4 similar comments)... Hard to say, all are important but it seems important to address mental health and substance issues to avoid glut in other areas such as criminal justice system...Beginning, middle and end...We need to protect and prioritize society's most vulnerable populations...How can you even suggest just 3 populations?...These are the groups who are least likely to have family or a social support system...There is a shrinking amount of public funding

10. Are there other priorities that the Board should consider that are not addressed above?

- Clubhouse support would be helpful in meeting several of these needs
- Timely access to services
- Sensitivity to different disabilities
- Better, more intensive case management
- Teach clients of all these services that if they are old enough—to go out and vote!
- Take care in allocating taxpayers' money (2 similar comments)
- Option of medically-assisted treatment for opiate dependent individuals
- Funding for mentoring, respite and recreational/pro-social supports
- Detoxification program and referral to inpatient treatment afterwards...
- The ADM Board need to make funding Portage Path more of a priority...
- Constant public education about the role the ADM Board plays in Summit County and the valuable services we offer to residents at low or no cost
- Military personnel with mental health needs
- Can the monthly fee for services be looked at again? Research indicates clients value services more when they have to pay (even a minimal amount) for them...
- Along with increasing funding or making the funding more efficient, the Board really needs to explore capital improvements for some of the ADM supported buildings...
- Working to configure ADM services to fit in with, and not duplicate, the changes coming as a result of the Patient Protection and Affordable Care Act.
- Educating community and educational leaders in understanding that individuals with mental illness have abilities and are capable human beings...
- The underinsured who fall through the cracks because they have insurance not subject to parity..

