Ohio

UNIFORM APPLICATION
FY 2018/2019 - STATE BEHAVIORAL HEALTH ASSESSMENT AND PLAN

SUBSTANCE ABUSE PREVENTION AND TREATMENT
and
COMMUNITY MENTAL HEALTH SERVICES
BLOCK GRANT

OMB - Approved 06/12/2015 - Expires 09/30/2020
(generated on 05/29/2018 3.34.35 PM)

Center for Substance Abuse Prevention
Division of State Programs

Center for Substance Abuse Treatment
Division of State and Community Assistance

and

Center for Mental Health Services
Division of State and Community Systems Development

State Information

State Information

Plan Year

Start Year	2018
End Year	2019

State SAPT DUNS Number

Number	808847669
Expiration Date	

I. State Agency to be the SAPT Grantee for the Block Grant

Agency Name	Ohio Department of Mental Health and Addiction Services
Organizational Unit	Office of Planning, Quality and Research
Mailing Address	OhioMHAS 30 East Broad Street, 8th floor
City	Columbus, OH
Zip Code	43215

II. Contact Person for the SAPT Grantee of the Block Grant

First Name	Elizabeth
Last Name	Gitter
Agency Name	Ohio Department of Mental Health and Addiction Services
Mailing Address	OhioMHAS 30 East Broad Street, 36th floor
City	Columbus, OH
Zip Code	43215
Telephone	614-466-9963
Fax	
Email Address	Elizabeth.Gitter@mha.ohio.gov

State CMHS DUNS Number

Number	808847669
Expiration Date	

I. State Agency to be the CMHS Grantee for the Block Grant

Agency Name	Ohio Department of Mental Health and Addiction Services
Organizational Unit	Office of Planning, Quality and Research
Mailing Address	OhioMHAS 30 East Broad Street, 8th floor
City	Columbus
Zip Code	43215

II. Contact Person for the CMHS Grantee of the Block Grant

First Name	Elizabeth
Last Name	Gitter
Agency Name	Ohio Department of Mental Health and Addiction Services

Mailing Address	30 East Broad Street, 36th Floor
City	Columbus
Zip Code	43215
Telephone	614-466-9963
Fax	
Email Address	Elizabeth.Gitter@mha.ohio.gov

III. Third Party Administrator of Mental Health Services

First Name	Ohio does not have a third party administrator.
Last Name	
Agency Name	
Mailing Address	
City	
Zip Code	
Telephone	
Fax	
Email Address	

IV. State Expenditure Period (Most recent State expenditure period that is closed out)

From	
To	

V. Date Submitted

Submission Date	8/31/2017 3:36:26 PM
Revision Date	5/29/2018 3:33:01 PM

VI. Contact Person Responsible for Application Submission

First Name	Elizabeth
Last Name	Gitter
Telephone	614-466-9963
Fax	
Email Address	Elizabeth.Gitter@mha.ohio.gov

Footnotes:

Alternate Contacts for both grants:
Deputy Director: Sanford Starr, Sanford.Starr@mha.ohio.gov , 614-644-8316
Director: Tracy Plouck, Tracy.Plouck@mha.ohio.gov, 614-466-2337

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Substance Abuse Prevention and Treatment Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
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Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**

Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

ASSURANCES - NON-CONSTRUCTION PROGRAMS

Note: Certain of these assurances may not be applicable to your project or program. If you have questions, please contact the awarding agency. Further, certain Federal awarding agencies may require applicants to certify to additional assurances. If such is the case, you will be notified.

As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
7. Will comply, or has already complied, with the requirements of Title II and III of the Uniform Relocation Assistance and Real Property Acquisition Policies Act of 1970 (P.L. 91-646) which provide for fair and equitable treatment of persons displaced or whose property is acquired as a result of Federal or federally assisted programs. These requirements apply to all interests in real property acquired for project purposes regardless of Federal participation in purchases.
8. Will comply with the provisions of the Hatch Act (5 U.S.C. §§1501-1508 and 7324-7328) which limit the political activities of employees whose principal employment activities are funded in whole or in part with Federal funds.
9. Will comply, as applicable, with the provisions of the Davis-Bacon Act (40 U.S.C. §§276a to 276a-7), the Copeland Act (40 U.S.C. §276c and 18 U.S.C. §874), and the Contract Work Hours and Safety Standards Act (40 U.S.C. §§327- 333), regarding labor standards for federally assisted construction subagreements.
10. Will comply, if applicable, with flood insurance purchase requirements of Section 102(a) of the Flood Disaster Protection Act of 1973 (P.L. 93-234) which requires recipients in a special flood hazard area to participate in the program and to purchase flood insurance if the total cost of insurable construction and acquisition is $10,000 or more.
11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tracy J. Plouck

Signature of CEO or Designee[1]: _____

Title: Director, Ohio Mental Health and Addiction Services

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

JOHN R. KASICH
GOVERNOR
STATE OF OHIO

August 28, 2013

Virginia Simmons
Division of Grants Management
Office of Financial Resources, SAMHSA
1 Choke Cherry Road
Room 7-1109
Rockville, MD 29857

Dear Ms. Simmons:

With this letter, I delegate to the Director of the Ohio Department of Mental Health and Addiction Services the authority to apply for the Community Mental Health Services, Projects for Assistance in Transition from Homelessness, and Substance Abuse Prevention and Treatment grants. I also grant the authority to make the certifications, assurances, agreements and any proper waiver requests required. The authority will remain in effect for the duration of my administration as the Governor of Ohio.

Sincerely,

John R. Kasich
Governor

77 SOUTH HIGH STREET • 30TH FLOOR • COLUMBUS, OHIO 43215-6117 • 614.466.3555

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [SA]

Fiscal Year 2018

U.S. Department of Health and Human Services
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Funding Agreements
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2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
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16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

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2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

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Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

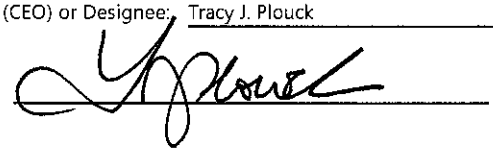
The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tracy J. Plouck

Signature of CEO or Designee[1]: 

Title: Director, Ohio Mental Health and Addiction Services

Date Signed: 8·17·17

mm/dd/yyyy

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State Information

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Fiscal Year 2018

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Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
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As the duly authorized representative of the applicant I certify that the applicant:

1. Has the legal authority to apply for Federal assistance, and the institutional, managerial and financial capability (including funds sufficient to pay the non-Federal share of project costs) to ensure proper planning, management and completion of the project described in this application.
2. Will give the awarding agency, the Comptroller General of the United States, and if appropriate, the State, through any authorized representative, access to and the right to examine all records, books, papers, or documents related to the award; and will establish a proper accounting system in accordance with generally accepted accounting standard or agency directives.
3. Will establish safeguards to prohibit employees from using their positions for a purpose that constitutes or presents the appearance of personal or organizational conflict of interest, or personal gain.
4. Will initiate and complete the work within the applicable time frame after receipt of approval of the awarding agency.
5. Will comply with the Intergovernmental Personnel Act of 1970 (42 U.S.C. §§4728-4763) relating to prescribed standards for merit systems for programs funded under one of the nineteen statutes or regulations specified in Appendix A of OPM's Standard for a Merit System of Personnel Administration (5 C.F.R. 900, Subpart F).
6. Will comply with all Federal statutes relating to nondiscrimination. These include but are not limited to: (a) Title VI of the Civil Rights Act of 1964 (P.L. 88-352) which prohibits discrimination on the basis of race, color or national origin; (b) Title IX of the Education Amendments of 1972, as amended (20 U.S.C. §§1681-1683, and 1685- 1686), which prohibits discrimination on the basis of sex; (c) Section 504 of the Rehabilitation Act of 1973, as amended (29 U.S.C. §§794), which prohibits discrimination on the basis of handicaps; (d) the Age Discrimination Act of 1975, as amended (42 U.S.C. §§6101-6107), which prohibits discrimination on the basis of age; (e) the Drug Abuse Office and Treatment Act of 1972 (P.L. 92-255), as amended, relating to nondiscrimination on the basis of drug abuse; (f) the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment and Rehabilitation Act of 1970 (P.L. 91-616), as amended, relating to nondiscrimination on the basis of alcohol abuse or alcoholism; (g) §§523 and 527 of the Public Health Service Act of 1912 (42 U.S.C. §§290 dd-3 and 290 ee-3), as amended, relating to confidentiality of alcohol and drug abuse patient records; (h) Title VIII of the Civil Rights Act of 1968 (42 U.S.C. §§3601 et seq.), as amended, relating to non- discrimination in the sale, rental or financing of housing; (i) any other nondiscrimination provisions in the specific statute(s) under which application for Federal assistance is being made; and (j) the requirements of any other nondiscrimination statute(s) which may apply to the application.
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11. Will comply with environmental standards which may be prescribed pursuant to the following: (a) institution of environmental quality control measures under the National Environmental Policy Act of 1969 (P.L. 91-190) and Executive Order (EO) 11514; (b) notification of violating facilities pursuant to EO 11738; (c) protection of wetland pursuant to EO 11990; (d) evaluation of flood hazards in floodplains in accordance with EO 11988; (e) assurance of project consistency with the approved State management program developed under the Costal Zone Management Act of 1972 (16 U.S.C. §§1451 et seq.); (f) conformity of Federal actions to State (Clear Air) Implementation Plans under Section 176(c) of the Clear Air Act of 1955, as amended (42 U.S.C. §§7401 et seq.); (g)

protection of underground sources of drinking water under the Safe Drinking Water Act of 1974, as amended, (P.L. 93-523); and (h) protection of endangered species under the Endangered Species Act of 1973, as amended, (P.L. 93-205).

12. Will comply with the Wild and Scenic Rivers Act of 1968 (16 U.S.C. §§1271 et seq.) related to protecting components or potential components of the national wild and scenic rivers system.
13. Will assist the awarding agency in assuring compliance with Section 106 of the National Historic Preservation Act of 1966, as amended (16 U.S.C. §470), EO 11593 (identification and protection of historic properties), and the Archaeological and Historic Preservation Act of 1974 (16 U.S.C. §§ 469a-1 et seq.).
14. Will comply with P.L. 93-348 regarding the protection of human subjects involved in research, development, and related activities supported by this award of assistance.
15. Will comply with the Laboratory Animal Welfare Act of 1966 (P.L. 89-544, as amended, 7 U.S.C. §§2131 et seq.) pertaining to the care, handling, and treatment of warm blooded animals held for research, teaching, or other activities supported by this award of assistance. 16. Will comply with the Lead-Based Paint Poisoning Prevention Act (42 U.S.C. §§4801 et seq.) which prohibits the use of lead based paint in construction or rehabilitation of residence structures.
16. Will cause to be performed the required financial and compliance audits in accordance with the Single Audit Act of 1984.
17. Will comply with all applicable requirements of all other Federal laws, executive orders, regulations and policies governing this program.

LIST of CERTIFICATIONS

1. CERTIFICATION REGARDING LOBBYING

Title 31, United States Code, Section 1352, entitled "Limitation on use of appropriated funds to influence certain Federal contracting and financial transactions," generally prohibits recipients of Federal grants and cooperative agreements from using Federal (appropriated) funds for lobbying the Executive or Legislative Branches of the Federal Government in connection with a SPECIFIC grant or cooperative agreement. Section 1352 also requires that each person who requests or receives a Federal grant or cooperative agreement must disclose lobbying undertaken with non-Federal (non- appropriated) funds. These requirements apply to grants and cooperative agreements EXCEEDING $100,000 in total costs (45 CFR Part 93). By signing and submitting this application, the applicant is providing certification set out in Appendix A to 45 CFR Part 93.

2. CERTIFICATION REGARDING PROGRAM FRAUD CIVIL REMEDIES ACT (PFCRA)

The undersigned (authorized official signing for the applicant organization) certifies that the statements herein are true, complete, and accurate to the best of his or her knowledge, and that he or she is aware that any false, fictitious, or fraudulent statements or claims may subject him or her to criminal, civil, or administrative penalties. The undersigned agrees that the applicant organization will comply with the Department of Health and Human Services terms and conditions of award if a grant is awarded as a result of this application.

3. CERTIFICATION REGARDING ENVIRONMENTAL TOBACCO SMOKE

Public Law 103-227, also known as the Pro-Children Act of 1994 (Act), requires that smoking not be permitted in any portion of any indoor facility owned or leased or contracted for by an entity and used routinely or regularly for the provision of health, day care, early childhood development services, education or library services to children under the age of 18, if the services are funded by Federal programs either directly or through State or local governments, by Federal grant, contract, loan, or loan guarantee. The law also applies to children's services that are provided in indoor facilities that are constructed, operated, or maintained with such Federal funds. The law does not apply to children's services provided in private residence, portions of facilities used for inpatient drug or alcohol treatment, service providers whose sole source of applicable Federal funds is Medicare or Medicaid, or facilities where WIC coupons are redeemed.

Failure to comply with the provisions of the law may result in the imposition of a civil monetary penalty of up to $1,000 for each violation and/or the imposition of an administrative compliance order on the responsible entity.

The authorized official signing for the applicant organization certifies that the applicant organization will comply with the requirements of the Act and will not allow smoking within any portion of any indoor facility used for the provision of services for children as defined by the Act. The applicant organization agrees that it will require that the language of this certification be included in any sub-awards which contain provisions for children's services and that all sub-recipients shall certify accordingly.

The Department of Health and Human Services strongly encourages all grant recipients to provide a smoke-free workplace and promote the non-use of tobacco products. This is consistent with the DHHS mission to protect and advance the physical and mental health of the American people.

I hereby certify that the state or territory will comply with Title XIX, Part B, Subpart II and Subpart III of the Public Health Service (PHS) Act, as amended, and summarized above, except for those sections in the PHS Act that do not apply or for which a waiver has been granted or may be granted by the Secretary for the period covered by this agreement.

I also certify that the state or territory will comply with the Assurances Non-Construction Programs and Certifications summarized above.

Name of Chief Executive Officer (CEO) or Designee: Tracy J. Plouck

Signature of CEO or Designee[1]: _____

Title: Director, Ohio Mental Health and Addiction Services

Date Signed: _____

mm/dd/yyyy

[1]If the agreement is signed by an authorized designee, a copy of the designation must be attached.

Footnotes:

JOHN R. KASICH
GOVERNOR
STATE OF OHIO

August 28, 2013

Virginia Simmons
Division of Grants Management
Office of Financial Resources, SAMHSA
1 Choke Cherry Road
Room 7-1109
Rockville, MD 29857

Dear Ms. Simmons:

With this letter, I delegate to the Director of the Ohio Department of Mental Health and Addiction Services the authority to apply for the Community Mental Health Services, Projects for Assistance in Transition from Homelessness, and Substance Abuse Prevention and Treatment grants. I also grant the authority to make the certifications, assurances, agreements and any proper waiver requests required. The authority will remain in effect for the duration of my administration as the Governor of Ohio.

Sincerely,

John R. Kasich
Governor

77 SOUTH HIGH STREET • 30TH FLOOR • COLUMBUS, OHIO 43215-6117 • 614.466.3555

State Information

Chief Executive Officer's Funding Agreement - Certifications and Assurances / Letter Designating Signatory Authority [MH]

Fiscal Year 2018

U.S. Department of Health and Human Services
Substance Abuse and Mental Health Services Administrations
Funding Agreements
as required by
Community Mental Health Services Block Grant Program
as authorized by
Title XIX, Part B, Subpart II and Subpart III of the Public Health Service Act
and
Tile 42, Chapter 6A, Subchapter XVII of the United States Code

Title XIX, Part B, Subpart II of the Public Health Service Act		
Section	**Title**	**Chapter**
Section 1911	Formula Grants to States	**42 USC § 300x**
Section 1912	State Plan for Comprehensive Community Mental Health Services for Certain Individuals	**42 USC § 300x-1**
Section 1913	Certain Agreements	**42 USC § 300x-2**
Section 1914	State Mental Health Planning Council	**42 USC § 300x-3**
Section 1915	Additional Provisions	**42 USC § 300x-4**
Section 1916	Restrictions on Use of Payments	**42 USC § 300x-5**
Section 1917	Application for Grant	**42 USC § 300x-6**
Title XIX, Part B, Subpart III of the Public Health Service Act		
Section 1941	Opportunity for Public Comment on State Plans	**42 USC § 300x-51**
Section 1942	Requirement of Reports and Audits by States	**42 USC § 300x-52**
Section 1943	Additional Requirements	**42 USC § 300x-53**
Section 1946	Prohibition Regarding Receipt of Funds	**42 USC § 300x-56**
Section 1947	Nondiscrimination	**42 USC § 300x-57**
Section 1953	Continuation of Certain Programs	**42 USC § 300x-63**
Section 1955	Services Provided by Nongovernmental Organizations	**42 USC § 300x-65**
Section 1956	Services for Individuals with Co-Occurring Disorders	**42 USC § 300x-66**

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Name of Chief Executive Officer (CEO) or Designee: Tracy J. Plouck

Signature of CEO or Designee[1]

Title: Director, Ohio Mental Health and Addiction Services

Date Signed: 8·17·17

mm/dd/yyyy

State Information

Disclosure of Lobbying Activities

To View Standard Form LLL, Click the link below (This form is OPTIONAL)

Standard Form LLL (click here)

Name

Not applicable - state does not lobby.

Title

Organization

Signature:

Date:

Footnotes:

Planning Steps

Step 1: Assess the strengths and needs of the service system to address the specific populations.

Narrative Question:

Provide an overview of the state's behavioral health prevention, early identification, treatment, and recovery support systems. Describe how the public behavioral health system is currently organized at the state and local levels, differentiating between child and adult systems. This description should include a discussion of the roles of the SSA, the SMHA, and other state agencies with respect to the delivery of behavioral health services. States should also include a description of regional, county, tribal, and local entities that provide behavioral health services or contribute resources that assist in providing the services. The description should also include how these systems address the needs of diverse racial, ethnic, and sexual gender minorities, as well as American Indian/Alaskan Native populations in the states.

Footnotes:

Substance Abuse/Mental Health Block Grants Plan for 2018 - 2019

Step 1: Assess the strengths and needs of the service system.

(1) Overview of Ohio's Mental Health and Addiction System

Ohio's *Substance Abuse and Mental Health Block Grants Plan* serves as an application for two federal Block Grants awarded to states by the Substance Abuse and Mental Health Services Administration (SAMHSA) for federal fiscal years (FFY) 2018 and 2019. This statewide Block Grant Plan uses a system of care framework to describe Ohio's mental health and addiction services within Ohio's complex human service and health care systems. It also provides information about the diversity among Ohio's 50 Board areas which each have a local system of care. Additionally, the Plan describes the variety of Ohio's providers. The Plan provides a data-driven needs assessment, prioritizes goals with implementation strategies and monitors progress with annual performance indicators. This Plan also addresses specific SAMHSA questions about states' mental health and substance abuse service system in the last section.

Overview of Ohio's Community Behavioral Health System

Ohio has a county-operated, state supervised behavioral health system in a "home rule" state in which local behavioral health tax levies provide additional resources for recovery supports in most communities. Ohio's Block Grant Plan is integrated with Community Plans developed by Ohio's county behavioral health authorities (Alcohol Drug Abuse and Mental Health Services (ADAMH) Boards). These Boards plan, evaluate and fund mental health and addiction services in 50 county and multi-county "Board" areas serving 88 counties. The Boards contract with a wide range of providers for prevention, treatment and recovery support, and are prohibited by state law from providing treatment services with some exceptions. With the expansion of Medicaid in Ohio, community behavioral health treatment providers receive a substantial portion of their revenue from the Ohio Department of Medicaid (ODM), and are licensed or certified by the Ohio Department of Mental Health and Addiction Services (OhioMHAS). Some "Medicaid only" providers do not contract with the county boards, and many of the larger providers have expanded into multiple counties across the state. Mental health and addiction services provided in primary care clinics, community hospital emergency rooms and federally qualified health care centers are part of the behavioral health services available to Ohioans, but are not addressed in this plan, because they are not licensed, certified or operated by OhioMHAS. As a result, Ohio has a very complex behavioral health care system that will continue to evolve in response to changes in federal and state policies.

Number of Ohioans Receiving Services

More than 530,000 of Ohio's 11,600,000 citizens received mental health and SUD services through Ohio's publicly funded system. More than 7,000 persons with SUD incarcerated in Ohio's prisons received SUD treatment services during the past year in the prison-based programs operated by OhioMHAS in collaboration with the Ohio Department of Rehabilitation and Corrections (ODRC). (ODRC continues to provide mental health treatment within state prisons.) Just prior to release, persons with SUD and/or persons with serious mental illness receive community linkage services from OhioMHAS staff to facilitate access to treatment services and recovery supports upon their release. OhioMHAS community linkage services are supported by a partnership between Ohio Department of Medicaid and ODRC' pre-lease program which ensured individuals could apply for Medicaid and enroll with a Managed Care plan before being released from prison. Also, persons in county jails or involved with courts are also receiving mental health and SUD treatment funded through OhioMHAS and Boards.

More than 7,700 adults received inpatient mental health treatment in six state-run regional psychiatric hospitals including some with co-occurring SUD. About 38,000 citizens with Medicaid funding received services in Ohio's private psychiatric hospitals or psychiatric units of community hospitals which includes persons receiving community behavioral health services. Boards also fund some residential treatment and psychiatric hospitalization for persons who are indigent. These numbers do not include the thousands of Ohioans who benefit from prevention programs and services.

Transformation of Ohio's Health Care System

Ohio's Health Care Transformation Initiative

Transformation of Ohio's health care system, a major initiative of Governor Kasich, will continue in Ohio into SFY 2018 – 2019. Governor Kasich utilized the Affordable Care Act option to expanded Medicaid eligibility to more Ohioans; persons with SUD and mental illness benefited from this expansion. The eligibility expansion addresses Ohio's opiate epidemic by increasing access to SUD treatment services and recovery supports. Ohio's mental health and SUD service system transformation builds on a series of gubernatorial health care reforms. In order to understand what is planned for SFY 2018 – 2019, it is important to understand recent changes which are described in the next few paragraphs.

Governor's Office of Health Transformation in partnership with cabinet level staff coordinated three overall healthcare reform initiatives beginning in January 2011 that led and coordinated the work across state agencies, county governments and private health care and insurance partners.

- Modernize Medicaid
- Streamline health and human services
- Pay for value

As a part of the Office of Health Transformation's initiatives, the Ohio Departments of Alcohol and Drug Addiction Services and Mental Health were consolidated and became the Ohio Department of Mental Health and Addiction Services, (OhioMHAS), a single cabinet level agency. OhioMHAS has integrated SUD and mental health ideology in all of its work, and will continue to build on this integration during SFY 2018 – 2019, while also continuing to be mindful that differences still exist between the conditions and the populations.

- OhioMHAS offices are integrated, so that the scope of work includes both SUD and mental health services.
- OhioMHAS' prevention office remains primarily focused on substance use prevention, but includes early childhood and school-based programs that focus on prevention of both mental illness and SUD.
- Early intervention programs such as SBIRT (Screening Brief Intervention, Referral and Treatment) of substance use disorders has been integrated into primary care, hospital emergency departments and mental health treatment programs in some communities.
- Treatment has become more integrated as OhioMHAS developed a single set of licensure and certification rules for both SUD and mental health providers. Additionally, behavioral health billing codes are being aligned with primary care, and to be similar for both treatment of mental illness and SUD, if applicable.
- Recovery supports are being integrated wherever possible for individuals with either SUD and/or mental health needs although providers and ADAMH Boards have the option of developing or maintaining specialized recovery supports for specific populations (e.g. persons with SUD).
    - The housing office integrated housing definitions, and is using capital funds for SUD programs which were formerly available only for mental health programs. Many of the housing programs continue to provide services for either persons with SUD or persons with mental illness.
    - Ohio's peer recovery support certification program uses an integrated mental health and substance abuse curriculum as many peers identify as having co-occurring mental health and SUD disorders and are dually certified. Recovery community organizations and consumer operated services often continue to operate separately, but collaborated well at the peer recovery support conference.
    - Ohio has an integrated Planning Council that advises OhioMHAS on the SAMHSA Block Grant, as well as the 21st Century Cures Act implementation of the Opioid State Targeted Response (STR) grant. Elected officers include persons with both kinds of recovery experiences and their family members. The chair person is an executive director of a new recovery community organization, and has a background of providing peer recovery support to persons in jail with SUD. The leadership also includes long time advocates for mental health services who have been active with NAMI and other mental health advocacy organizations.

- Treatment of SUD within Ohio's prisons became OhioMHAS' responsibility under the state fiscal year (SFY) 2016 – 2017 biennial budget. Ohio will monitor the impact of SUD treatment on recidivism.
- OhioMHAS' community linkage to treatment and recovery resources for persons with serious mental illness being released from prison has been expanded to persons with SUD only. http://www.healthtransformation.ohio.gov/LinkClick.aspx?fileticket=wTsf1ebtLMc%3d&tabid=119

Ohio Mental Health and Addiction Service Standards Consolidated

OhioMHAS replaced two sets of service standard rules with a single set of service standards for mental health and SUD treatment. For General Services, which includes assessment, behavioral health counseling and psychopharmacological management, the same rule applies to both mental health and SUD treatment. For other services, such as buprenorphine and methadone administration, and Assertive Community Treatment, the service is specific to mental health and substance abuse. The rule changes remove some barriers to integrated care. The changes in these standards impact all behavioral health providers licensed and/or certified by OhioMHAS. OhioMHAS standards are applicable to all payor sources. Additionally, as Medicaid is the major source of payment for "medically necessary" clinical services, an additional set of Ohio Department of Medicaid applies to all services eligible for Medicaid funding. These rules are described in the *Behavioral Health Medicaid Benefit Redesign is Ready for SFY 2018 – 2019* starting on page 6.

State Licensure and Certification of Providers

OhioMHAS licenses or certifies individual provider organizations with deeming used for organizations with national accreditation (e.g. JCAHO, CARF, and COA). Most of Ohio's larger providers are nationally accredited. OhioMHAS' six state hospitals are certified by The Joint Commission on Accreditation of Healthcare Organizations (TJC), and received The Joint Commission's Gold Seal of Approval. Ohio has a wide variety of providers ranging from small niche providers with less than 10 employees to major comprehensive community behavioral health providers with fully integrated primary care, some of which have expanded to multiple county ADAMH Board areas. Providers include community behavioral health providers, family service agencies, nationally recognized children's hospitals, recovery community organizations/consumer operated services and a rural community hospital which is also serves as the local community mental health provider. Most larger behavioral health providers have been licensed and/or certified for both mental health and SUD services for many years, however, some became dually credentialed after the state agency consolidation. To provide a more complete description of Ohio's behavioral health system, this document includes a description of service providers for each population. OhioMHAS also operates a consumer-staffed toll-free information and referral line to assist citizens in finding help through Ohio's complex provider system. For a complete list of community behavioral health providers, see: "Where to Get Help" on OhioMHAS' home page http://mha.ohio.gov/ . Following this paragraph is a summary of mental health and SUD services which are licensed or certified or operated by OhioMHAS.

Services Licensed or Certified Ohio Mental Health and Addiction Services (OhioMHAS) June, 2017			
Number of Providers Licensed, Certified or Operated by OhioMHAS	**Addiction Services Only**	**Mental Health Services Only**	**Both Addiction & Mental Health Services**
Prevention providers			194
Driver Intervention Programs	130		
Behavioral Health Providers – Outpatient Services	171	244	188
Consumer Operated and Peer Support Providers		86*	
Adult Care Facilities - Family Home			655
Adult Care Facilities – Group Home			251
Adult Foster Homes			36
Mental Health Residential		146	
SUD Residential	154		
Private psychiatric hospital units			87
Services Operated by OhioMHAS			
State (regionals) psychiatric hospitals		6**	
Therapeutic community programs in state prisons	6**		
State prisons with substance use programs	27		

* Consumer operated and peer support providers provide services to persons with co-occurring substance use disorder, as well as mental illness. Some of Ohio's consumer operated services provide services to persons with SUD only.
**State-operated regional psychiatric hospitals provide SUD services to persons with co-occurring MI/SUD.

Continuum of Care

Ohio's SFY 2016-2017 Biennium Budget Bill required ADAMH Boards to ensure the availability of a continuum of care that includes essential elements for all individuals seeking behavioral health treatment and specific service elements for individuals seeking treatment for opiate or co-occurring drug addiction. The legislation specifies which services must be available within the Boards service area while others can be regional. County boards must demonstrate that all the essential elements of the required continuum are available or shall have funds withheld. In addition, the legislation stipulates the establishment of a waiting list policy and procedures for services and supports for opioid and co-occurring drug addiction. In response to the legislation, OhioMHAS and its stakeholders have undertaken the following steps to prepare for these requirements that are effective July 1, 2017.

1. Identify and assure adequate delivery for required array of services and supports for the continuum.
2. Identify receipts and expenditures available and establish an allocation methodology to support the service array
3. Establish a waiting list policy and procedures for services and supports for opioid and co-occurring drug addiction.

Continuum of Care Required Services Ohio Revised Code		
Opioid Use Disorder (OUD) Treatment		
Services must be available in Board area	**Service must be available to board residents within 30 miles of the board area to receive a limited time waiver**	**Services may be provided in another Board Area**
Non-Intensive Outpatient Services	Ambulatory Detoxification	Sub-Acute Detoxification
Intensive Outpatient Service	Medication Assisted Treatment (MAT)	Residential
Peer Mentoring		
Recovery		
Emergency & Crisis Care		
12 Step Approaches		
Prevention Services (SUD and Mental Health)		
Prevention and Wellness Management		
Locate & Inform Persons Needing Services		
Non-opioid SUD and Mental Health Treatment		
Assessment Services		Residential
Non-Intensive Outpatient Services		Inpatient
Intensive Outpatient Services		
Withdrawal Management		
Emergency & Crisis Services		
Recovery Supports (Mental Health and SUD including Opioid Use Disorder (OUD)		
Recovery Supports, including helping persons in SUD and/or mental health services necessary to: meet basic human needs; care coordination; obtain assistance with social, personal & living skills; obtain multiple paths to recovery, e.g., 12 step approaches, parent advocacy connection, etc.; obtain support, assistance, consultation & education for families, friends & persons receiving SUD & mental health services & supports.		
Participate in peer supports;		
Obtain employment, vocational & educational opportunities		
Obtain housing and support from a wide range of options		

Behavioral Health Medicaid Benefit Redesign is Ready for SFY 2018 - 2019

In addition to the legislature defining a continuum of care, the Kasich administration made transformation of Ohio's health care systems a priority, and included behavioral health redesign in initiatives led by the Governor's Office of Health Transformation. Major initiatives included (1) modernize Medicaid (2) streamline health and human services and (3) pay for value. These

initiatives will continue into SFY 2018 – 2019, and may be impacted by decisions made by Congress on health care.

Ohio's behavioral health system is being redesigned as a part of Ohio's health transformation through the implementation steps in this table. Plans to implement legislative rules for a new Medicaid benefit package for Mental Health and SUD services planned to become effective July 1, 2017 were placed in a "to be refiled status" after the Ohio Council of Behavioral Health & Family Services Providers advocated a delay and to allow for the completion of Ohio's biennial budget process.

Ohio Medicaid Behavioral Health Redesign Initiative	
Implementation Steps:	**Implementation Date:**
Elevation: Financing of Medicaid behavioral health services moved from county administrators to the state	July 1, 2012
Expansion: Ohio implemented Medicaid Expansion to extend Medicaid coverage to more low income Ohioans, including 500,000 residents with behavioral health needs.	January 1, 2014
Modernization: Ohio Department of Medicaid and OhioMHAS are charged with modernizing the behavioral health benefit package to align with national standards and expand services to those most in need.	January 1, 2018
Integration: Post benefit modernization, the Medicaid benefit will fully be integrated into Medicaid managed care.	July 1, 2018

Services Revised to Support Integrated Health and Behavioral Health Medicaid Redesign
OhioMHAS replaced two sets of behavioral health service standard rules with a single set for mental health and SUD treatment after consolidating its state substance abuse and mental health agencies. Where feasible, a single service rule is used for both SUD and mental health treatment with the diagnosis and the scope of practice (of the licensed clinician or non-licensed staff) determining what services may be billed. In some cases, services are also grouped into a single rule. For example, General Services, which includes assessment, behavioral health counseling and psychopharmacological management, the same rule applies to both mental health and SUD treatment. General Services will be billed as either SUD or mental health services depending on the diagnosis being addressed. Additionally, clinicians are required to practice within their scope of practice. For other services, such as Buprenorphine and Methadone Administration, Residential and inpatient substance use disorder services, and Assertive Community Treatment, the service is specific to substance abuse or mental health. OhioMHAS rules apply to all payors. Additional Ohio Department of Medicaid rules define the Medicaid Benefit package, which are the rules for mental health and SUD treatment providers certified and licensed by OhioMHAS.

Medicaid Benefit Changes: Behavioral Health Redesign and Managed Care

Substance Use Disorder Medicaid Benefit Package

In 2017 Ohio's Medicaid Substance Use Disorder Benefit consisted of a single benefit package regardless of a person's level of care. Services included were ambulatory detoxification, assessment, case management, crisis intervention, group counseling, individual counseling, intensive outpatient counseling, laboratory urinalysis, medical/somatic and methadone administration.

Ohio's Substance Use Disorder Benefit was redesigned to align with the American Society of Addiction Medicine (ASAM) Criteria for the outpatient and residential levels of care. With redesign, outpatient and residential SUD treatment are distinguished from each other and services are clearly identified by level of care. Additionally, Peer Recovery Support was added as a service. See the following table for a description of the Medicaid benefits for SUD effective January 1, 2018. http://bh.medicaid.ohio.gov/training

Outpatient Adolescents: Less than 6 hrs/wk Adults: Less than 9 hrs/wk	Intensive Outpatient Adolescents: 6 to 19.9 hrs/wk Adults: 9 to 19.9 hrs/wk	Partial Hospitalization Adolescents: 20 or more hrs/wk Adults: 20 or more hrs/wk	Residential

• Assessment
• Psychiatric Diagnostic Evaluation
• Counseling and Therapy
  • Psychotherapy – Individual, Group, Family, and Crisis
  • Group and Individual (Non-Licensed)
• Medical
• Medications
• Buprenorphine and Methadone Administration
• Urine Drug Screening
• Peer Recovery Support
• Case Management
	• Assessment
	• Psychiatric Diagnostic Evaluation
	• Counseling and Therapy
	  • Psychotherapy – Individual, Group, Family, and Crisis
	  • Group and Individual (Non-Licensed)
	• Medical
	• Medications
	• Buprenorphine and Methadone Administration
	• Urine Drug Screening
	• Peer Recovery Support
	• Case Management
		• Assessment
		• Psychiatric Diagnostic Evaluation
		• Counseling and Therapy
		  • Psychotherapy – Individual, Group, Family, and Crisis
		  • Group and Individual (Non-Licensed)
		• Medical
		• Medications
		• Buprenorphine and Methadone Administration
		• Urine Drug Screening
		• Peer Recovery Support
		• Case Management
			• Per Diems supporting all six residential levels of care including:
			  • clinically managed through medically monitored
			  • two residential levels of care for withdrawal management
			• Medications
			• Buprenorphine and Methadone Administration
			• Medicaid is federally prohibited from covering room and board/housing

• Level 1 Withdrawal Management (billed as a combination of medical services)	• Additional coding for longer duration group counseling/psychotherapy • Level 2 Withdrawal Management (billed as a combination of medical services)	• Additional coding for longer duration group counseling/psychotherapy • Level 2 Withdrawal Management (billed as a combination of medical services)	• Level 2 Withdrawal Management (billed as a combination of medical services OR 23 hour observation bed per diem

Mental Health Medicaid Benefit Package

In 2017 Ohio's Medicaid, Mental Health Benefit package included the following services: psychiatric diagnostic evaluation with medical, mental health assessment, pharmacological management, partial hospitalization, crisis intervention, CPST (case management and supportive

treatment), mental health counseling, respite for children and their families (effective January 2017) and office administered medications.

Effective January 1, 2018, Ohio's Medicaid Mental Health Benefit package will consist of:

- Psychotherapy – individual, group, family and crisis
- Psychiatric Diagnostic Evaluation with and without medical - assessing treatment needs & developing a plan for care
- Medical– medical practitioner service provided
- Assertive Community Treatment (ACT) – evidenced-based, comprehensive team based care for adults with SPMI (seriously and persistently mentally ill)
- Intensive Home Based Treatment (IHBT) – evidence-based, time-limited team based service helping youth with serious emotional disturbances (SED) remain in their homes and the community
- Group Day Treatment
- Crisis Services
- CPST (Community Psychiatric Supportive Treatment – Care Coordination
- Screening, Brief Intervention and Referral to Treatment (SBIRT) for Substance Use Disorders (SUD)
- Therapeutic Behavioral Service (TBS) – provided by paraprofessionals with Master's, Bachelor's or 3 years' experience
- Psychosocial Rehabilitation (PSR) – provided by paraprofessionals with less than Bachelors or less than 3 years' experience.
- Respite for Children and their families – providing short term relief to caregivers
- Office Administered Psychotropic (medications)
- Psychological Testing
- Note: Peer Recovery Support is available for individuals with serious mental illness (SMI) who are enrolled in Assertive Community Treatment, and in the Ohio Specialized Recovery Services (1915(i), and is considered a component of that service.

Specialized Recovery Services

Ohio has a 1915(i)-state plan program for Adults with Severe and Persistent Mental Illness and whose income is above the Medicaid need standard and up to 300 percent of the Federal Benefit Poverty Rate which is $26,388 per year. This program was implemented as a component of Ohio modernizing to a single Medicaid eligibility system. To be eligible, the person must meet Ohio's diagnostic criteria for a severe and persistent mental illness, need help with activities such as medical appointments, social interactions and living skills, not be living in a nursing facility, hospital or similar setting, and have been determined disabled by the Social Security Administration. In addition to all existing mental health services, the new services of Recovery Management, Individual Placement and Support – Supported Employment (IPS-SE) and Peer Recovery Support Services are available to individuals determined eligible via the 1915(i)-state plan program.

MyCare Ohio – Ohio's Dual Eligible Demonstration (Medicare & Medicaid)
MyCare Ohio is a system of managed care plans selected to coordinate the physical, behavioral and long-term care services for individuals over the age of 18 who are dually eligible for both Medicaid and Medicare. Persons receiving community behavioral health services funded by Medicaid in 29 counties receive services through this plan managed for members by the respective MyCare Ohio plan. All available Medicaid services are included, and disability determination continues to be provided by Ohio Department of Job and Family Services. Health care is coordinated through MyOhio.

Institution for Mental Diseases (IMD) Waiver
As of July 1, 2017, Ohio's Medicaid program has implemented the institution for mental diseases (IMD) requirements under the Medicaid managed care regulations (42 CFR 438.6) which allows the State (Ohio) to make a monthly capitation payment to a managed care plan (MCP) for a member age 21 through 64 who is receiving inpatient treatment in an IMD. While this Federal permission is narrowly focused on the MCP capitation payment, Ohio has taken it as an opportunity to 1) increase access to intensive mental health treatment, 2) provide services closer to home by utilizing private sector inpatient psychiatric care capacity rather than the six RPHs, 3) provide community alternatives for services when appropriate, 4) target reducing readmissions for inpatient psychiatric care, 5) expand the private sector network for inpatient psychiatric care and 6) provide for continuity and coordination of care.

OhioMHAS Legislative Budget

OhioMHAS' legislative budget outlines major priorities for the department, as well as many of the major initiatives that widely impact SUD and mental health populations. A major priority for Ohio is addressing the opioid crisis through the 21st Century CURES Opioid State Targeted Response (STR) Grant funded by SAMHSA. Additionally, addressing health disparities, improving access to trauma-informed care, and promoting a recovery oriented system of care are addressed in this section. Other important initiatives such as the First Episode Psychosis and Suicide Prevention are discussed in population specific sections. These populations are prevention, children's mental health treatment, adult mental health treatment, substance abuse treatment and behavioral health services to persons involved with the criminal justice system.

State Legislative Budget Priorities
OhioMHAS has identified and funded some key priorities through the state budget enacted by the legislature. State funds support the following priorities in the SFY 2018 – 2019 operating budget. These priorities include:

- State Psychiatric Hospitals
- Prevention and Wellness
- Community treatment and recovery supports
- Criminal Justice partnership

- Supporting vulnerable families
- Workforce development

OhioMHAS used an "all funds" approach that included General Revenue Funds, state rotaries and federal funds in budgeting. The Ohio legislature approved the funds below:

OhioMHAS Appropriations		
	General Revenue Funds	**All Funds**
FY 2017	$396,852,090 (estimate)	
FY 2018	$407,566,061 (appropriation)	$702,732,759
FY 2019	$416,213,325 (appropriation)	$706,524,023
Medicaid expenditures are appropriated in the Department of Medicaid, and are not included.		

Appropriation Highlights

- Maintain core programs
- Targets additional investments
    - Strong Families/Safe Communities and Criminal Justice Innovation Grants – an additional $1 million/year
    - New Workforce Development programs - $6 million per year
- Authorizes use of 21st Century Cures Act funding to combat opioid epidemic

State Psychiatric Hospitals

- Maintains existing capacity at six state hospitals
- Continues to work with broader hospital community network
- Continues community transition assistance through Access to Success

Changes to Community Recovery Support Funding

- Access to Life Saving Measures: Increases funds to enhance access to Naloxone for first responders to $750,000 per year; funding flows through county health departments
- Allocates an additional $75,000 per year per ADAMH Board, and requires OhioMHAS to use a statutory formula to award any additional funding to Boards.
- Residential State Supplement (RSS): Adds $1 million in each year for annual investment of $16 million, and gives OhioMHAS additional rule making authority for RSS.
- Recovery Housing; allocates $20 million for the expansion of recovery housing as defined in ORC 340.01; funds must be spent on capital investment
- Stabilization Centers; requires Boards to collaboratively establish in each of the six-state psychiatric hospital catchment areas: Substance Abuse Stabilization Centers ($6 million/year appropriated) and Mental Health Crisis Centers ($1.5 million/year)

Prevention and Wellness

- State funding of $2.6 million/year for substance abuse and mental health prevention
- Evidenced based prevention in schools $500,000/year
- Evidence base prevention activities $1.5 million
- Suicide prevention $500,000

Criminal Justice Programs

- Partnership with Department of Corrections; OhioMHAS staff will continue to provide treatment within the state prison system.
- Continues resources for recovery supports and treatment for released inmates
- Continues funding for Care Source (managed care company) for offenders who received SUD treatment within the prisons system. Upon release, these offenders with SUD, will receive enhanced community based services and recovery supports, which provide increased access to housing, vocational and peer supports. The goal is to reduce recidivism through treatment.
- Local Criminal Justice Partnerships
    - Continued Investments:
        - Specialized court docket support at $5 million/year; supports courts that connect non-violent offenders with community supports required to stay in the community rather than serve a sentence in jail or prison.
        - Medication assisted treatment (MAT) drug court programs at $8 million/year
        - Linkage to behavioral health services at prison release (SUD & MH) $4 million/year
    - New investments
        - Pilot program to support Mental Health Courts: $500,000/year in Franklin and Warren Counties
        - Psychotropic drug reimbursement program

Support for Children and Families

- Strong Families/Safe Communities - $4 million/year
- Early Childhood Mental Health - $5 million/year

Workforce Development

- Behavioral health workforce training – one-time funding for behavioral health providers that may be used for training/supervision for licensure, loan repayment program or tuition
- Resident Trainee funding
- Workforce development to support 21st Century Cures grant
- 21st Century Cures workforce initiatives (see details in Step 1, SUD Treatment section)

Outreach – required by legislation

- Creates the All Roads Lead to Home public relations program which must include:

    - A media campaign
    - Development of a website
    - 24-hour consumer hotline
- Creates Opioid Addiction Treatment website and mobile application in partnership with Development Services Agency and Ohio State University

Opioid Crisis

State Targeted Response (STR) to the Opioid Crisis

Ohio ranks second nationally in opioid overdose deaths, surpassed only by the state of California. Unintentional drug overdose continued to be the leading cause of injury-related death in Ohio. In 2015, drug overdoses caused the deaths of 3,050 Ohio residents, which is the highest number on record. Opioids (heroin, fentanyl and prescription) remained the driving factor behind unintentional drug overdoses in Ohio. The sharp increase in overdose deaths coupled with National Survey on Drug Use and Health (NSDUH) prevalence data on individuals needing but not receiving treatment led to the identification of priority target areas to focus project efforts. The targeted strategies outlined in Ohio's Opioid STR which proposal will impact over 8 million Ohioans, which represents 75 percent of the state population, and encompasses 53 percent of counties and board areas. The goals and activities of this work, as well as other work in response to the opioid crisis is included in the Substance Use Disorder section.

Major Initiatives Impacting All Populations

Addressing Health Disparities

Ohio has a plan to address health disparities through a *Cultural and Linguistic Competency Plan, Intro Action: 2020 Strategic Vision OhioMHAS Commitment.* OhioMHAS partnered with external stakeholders to develop a plan to use cultural and linguistic competence strategies to change "one size fits all" approaches in behavioral health care delivery to strategies that offer high-quality, person-centered care. The department has dedicated itself to providing appropriate, accessible services to Ohioans, who encompass a broad range of human differences such as ability and disability, age, educational level, ethnicity, gender, geographic origin, race, religion, sexual orientation, socio-economic status and values. OhioMHAS recognizes that its vision must entail supporting, endorsing and encouraging community system partners – including county and local entities – to identify, initiate and implement cultural and linguistic competence services for all recipients of care. OhioMHAS acknowledges that there is significant evidence of health inequities and disparities disproportionately impacting outcomes experienced by minorities when compared to those experienced by the general population. To address inequities, the *OhioMHAS Cultural and Linguistic Competency Plan* provides state and local systems with the strategies necessary to achieve the following:

- Enhance workforce competency of race, ethnic and cultural groups in Ohio by increasing awareness of cultural and linguistic needs, treatment barriers and service gaps;

- Improve organizational procedures by adopting and promoting policies that enhance communication and community engagement; and
- Improve outcomes by assessing organizational activities and community services.

For goals and activities of this plan, please see the Environmental Factors and Plan section, Health Disparities.

Trauma-Informed Care

Ohio's statewide trauma informed care initiative will expand its trauma-informed care awareness and trauma-responsive services to Ohio's law enforcement agencies. OhioMHAS will assist in the development of a trauma-informed approach curriculum for law enforcement. The Ohio Peace Officer Training Academy, a division of the Ohio Attorney General's Office, has developed a six-hour curriculum entitled Trauma-Informed Policing required of all sworn and commissioned law enforcement officers (30,000+). The course introduces trauma and trauma-informed approaches in policing, describes how prevalence of trauma histories among Ohioans and explains how trauma may impact law enforcement in their jobs and personal lives.

Ohio will continue to use a train-the-trainer model to train providers in trauma-informed approaches which provided 268 trainings to 10,500 providers. Content included understanding trauma, trauma-informed approaches, guidance and implementation, healing and recovery. Additionally, OhioMHAS is also piloting trauma-informed care for residential providers in partnership with Ohio Department of Developmental Disabilities. To support these training efforts, Ohio has developed nine Ohio Voices Videos which feature persons with lived experiences who share their trauma histories and the strategies they employed to support resiliency. The videos focus on the impact of trauma on recovery housing residents, children and older adults, law enforcement staff, young children and their caregivers, and persons in recovery In the coming year, Ohio will:

- Continue to offer Trauma-Informed Approaches: Key Assumptions and Principles training; improve connection with ADAMH Boards with goal of Boards sustaining this trauma-informed training and approaches in their communities
- Implement trauma-informed care principles into crisis response teams and vicarious trauma in first responders
- Roll out of Trauma-Informed Approaches: Responding to Older Adults in partial support of case manager's new trauma informed care standards
- Provide technical assistance to agencies and organizations which desire to become

Recovery Oriented System of Care

Ohio Association of County Behavioral Health Authorities (OACBHA, an association of ADAMH Boards) continues to implement its five-year plan, Recovery is Beautiful: A Blue Print for Ohio's Community Mental Health and Addiction System. This five year-plan as goals and action steps to move Ohio's fifty local mental health and addiction systems toward a Recovery-

Oriented System of Care. A ROSC emphasizes a community-based system of care that includes prevention and wellness, crisis and treatment services, and recovery supports to help individuals with a mental illness and/or addiction achieve recovery. A fundamental value of ROSC is the involvement of people in recovery, their families and their communities to continually improve access to and quality of services. Through the ROSC initiative, local Boards have assessed their community's system of care, and participated in recovery focus groups and trainings to strengthen the recovery orientation of local systems of care. Boards are making changes in their communities that facilitate partnership of persons in recovery with the organizations that plan, provide and fund services.

This initiative also supports Ohio's ***Recovery IS Beautiful*** movement, which is working to provide individuals and families with hope and encouragement while changing the conversation in regards to mental illness and addiction. "We want people to know and understand that:

1. Mental illness and addiction are ***chronic illnesses.***

2. Both mental illness and addiction can be successfully treated: ***Treatment Works and People Recover****.*

3. ***Recovery is to be celebrated****. Individuals in recovery become active and contributing members of their communities.*

Ohio's Mental Health and Addiction Services System

Strengths

- Ohio redesigned its Medicaid benefits for substance use disorder and mental health to align with national standards, and expanded services to those most in need.
- OhioMHAS has strong partnerships with the criminal justice system to operate SUD treatment programs in prisons, and a program in which persons with mental illness and/or SUD being released from prison are linked with treatment and recovery supports.
- OhioMHAS provides $8 million in funding for MAT in drug court programs, and provides $5 million in funding for staff of specialized docket court programs that provide community interventions for non-violent offenders with mental illness or SUD as an alternative to jail or prison sentences.

Needs:

- Ohio ranks second nationally in opioid overdose deaths, surpassed only by the state of California. Unintentional drug overdose continued to be the leading cause of injury-related death in Ohio, and resulted in 3,050 deaths in 2015. Ohio will be implementing targeted strategies to address the opioid crisis.
- Ohio has health disparities among population groups; these are being addressed through a Cultural and Linguistic Competency Plan, Into Action: 2020 Strategic Vision OhioMHAS Commitment.

- Persons with SUD and mental illness continue to have housing needs that are not always met. Ohio's legislature appropriated $20 million for the expansion of recovery housing in capital investment. It also appropriated $16 million for residential state supplement for persons disabled by serious and persistent mental illness, as well as SUD, developmental disabilities or physical disabilities.

(2) Behavioral Health Promotion, Prevention and Early Intervention Services and Supports

Introduction

OhioMHAS supports a continuum of care using a public health model which includes health promotion, prevention, early intervention, treatment and recovery supports. Behavioral health promotion includes supporting wellness, early intervention and prevention of mental health and substance use disorders. Prevention and early intervention is addressed across the lifespan with a focus on children and their families to intervene as early in life as possible. The Governor promotes *Start Talking* to encourage parents and youth to talk about substance use to reduce use. As Ohio transforms its health care system, behavioral health promotion is essential to keep costs down, to improve the quality of care and to increase satisfaction with care. Behavioral health promotion has an important role in preventing or delaying the onset of acute and chronic disorders. Promoting healthy environments, norms and behaviors is an important component of health reform.

Targeted Population

Primary prevention is directed towards Ohio's entire population of about 11.6 million persons in 2016. Ohio is a very diverse state which includes Appalachian counties, major cities (Cleveland, Cincinnati and Columbus), suburban counties, smaller cities, and rural northern communities typical of the upper Midwest. While Ohio's population is 83.2% white, 12.5% black or African American, 0.3% American Indian, 3.4% Latino, and 1.9% Asian, Ohio's individual counties have very different population mixes. Each of these local communities has an ADAMH Board which is responsible for funding, planning and evaluating services for their local communities.

OhioMHAS, ADAMH Boards and providers face challenges in addressing the prevention needs of new, emerging and under-represented populations in culturally competent ways. Ohio has significant African American, Somali, Latino, Asian, Appalachian and Amish population groups. These new immigrant and refugee populations from Asia and North Africa are increasing the number of languages and dialects spoken, stretching current capacity and dramatically boosting the demand for English as a Second Language services. In addition, the demographics of persons served by Ohio's behavioral health system do not necessarily reflect those of persons in need of services, but rather persons who are comfortable accessing services. Most professional conference and training events try to incorporate cultural competency components into all elements of planning and implementation. As Ohio's increasingly diverse population grows, the ongoing need for behavioral health prevention, treatment and recovery providers to be adequately trained remains a priority.

OhioMHAS recognizes the need to be more inclusive in engaging Ohio's culturally diverse populations in prevention planning, coalition participation, and access to services. OhioMHAS is working to better engage Ohio's diverse populations in prevention planning and in coalition work. The goal is to ensure that all components of the Ohio prevention system are providing culturally appropriate prevention services and optimizing inclusion of these disparate populations in the system. In communities with large minority populations and high poverty rates, minority youth have increased vulnerability. It is imperative that communities understand the risk to youth and how to address the issues to decrease the risk. The Urban Minority Alcoholism, Drug Abuse and Outreach Programs (UMADAOPs) are subject matter experts in cultural competence, and are a resource to their communities. As a part of the SPF Ohio has also have developed a Cultural Competency Plan which is in the process of being implemented.

Additionally, the Multiethnic Advocates for Cultural Competence, Inc. (MACC) unveiled a State of Ohio Cultural Competence definition that was developed in 2010 by various state departments including OhioMHAS.

> *"In Ohio, 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."*

This definition begins to lay a foundation for building cultural competence, and the implementation of a Cultural Competency Plan and its recommendations to enhance cultural competency within the prevention system will result in increased prevention workforce capacity in cultural competence and increased participation of under-represented and underserved populations within the prevention system (including community coalitions).

Ohio's Prevention Providers

Ohio has a wide range of prevention providers. As Ohio is a home rule state in which fifty ADAMH Boards plan, evaluate and fund local services with state oversight, Ohio has fifty different behavioral health systems. Each ADAMH Board plans services which meet the needs of the local population, and builds on the institutions, organizations and personal relationships that shape local systems of care. Many Boards use a portion of their local tax levy to support prevention efforts which are tailored to the needs of the population in their communities which can lead to a more culturally sensitive system of care.

OhioMHAS has found that community coalitions are the single most effective means of promoting alcohol, tobacco and other drug prevention among professionals. Ohio has over 100 Drug Free Community Coalitions and more than 80 Suicide Prevention Coalitions. Additionally, OhioMHAS has partnered with ADAMH Boards and other provider systems including schools and health care systems to imbed prevention interventions into other systems such as schools, faith-based organizations, work places and health care systems. As Ohio's behavioral health system is so large and diverse, it is not possible to describe each individual prevention provider. However, OhioMHAS can describe some examples of providers to provide a picture of the state's prevention providers. Some examples of Ohio's prevention providers are:

Urban Minority Programs

- Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP) – UMADAOP provide prevention and treatment to African American and Hispanic communities in urban areas.

  Example: The Cleveland Hispanic UMADAOP serves the Hispanic community with culturally sensitive prevention services and treatment services. Prevention programs include programs for teens at risk for addiction or of dropping out of school, driving while under the influence programs for adults and HIV prevention programs.

Women's Prevention Programs

- Urban Ounce of Prevention- The New Beginnings Project goal focuses on prevention and the following health-related issues: 1) adult female alcohol/ drug use and abuse during pregnancy; 2) infant mortality and low-birth weight; 3) cultivating healthy parent-child relationships; and 4) domestic violence

Drug Free Community Coalition

- Drug Free Community Coalition- Talawanda School District-Coalition for a Healthy Community-Oxford area. The Coalition for a Healthy Community is designed to provide support for the planning and implementation of environmental based strategies to address substance use. Our objective for this year is to focus on the perception of risk and harm

associated with substance use, specifically prescription drugs and marijuana. In addition, we will focus on capacity building and member training.

Opiate Advocacy – Community Prevention

- Prevention Action Alliance- Grief, Advocacy & Prevention seeks to build grassroots coalitions through the Ohio GAP Network that will be linked with the Statewide Prevention Coalition Association (SPCA). This initiative will empower and train family engagement groups, link them to coalitions in their communities, and create a statewide advisory group. Through networking, training and mentoring, a strong emphasis will be placed on grief management, and building on it to offer grief peer coaching. Additionally, members will be trained in advocacy principles to take their zeal, and use it to effectively advocate and promote environmental change, as well as learn to use other evidence-based prevention strategies.

Prevention in Partnership with Schools and Communities

- Deaf Students - Family Services Association - Educating No Drugs uses culture-specific curricula and activities to create awareness and prevent alcohol and other drug use among K-12 Deaf, Hard-of-Hearing and Kids of Deaf Adults youth. Utilizing classroom instruction, campaigns, public service announcements, camping, leadership training and student-led events, 1600 students receive information, resources and activities to increase knowledge, build protective factors and strengthen drug-free peer culture.

Build Prevention Capacity

Prevention and Mental Health Wellness Guidance

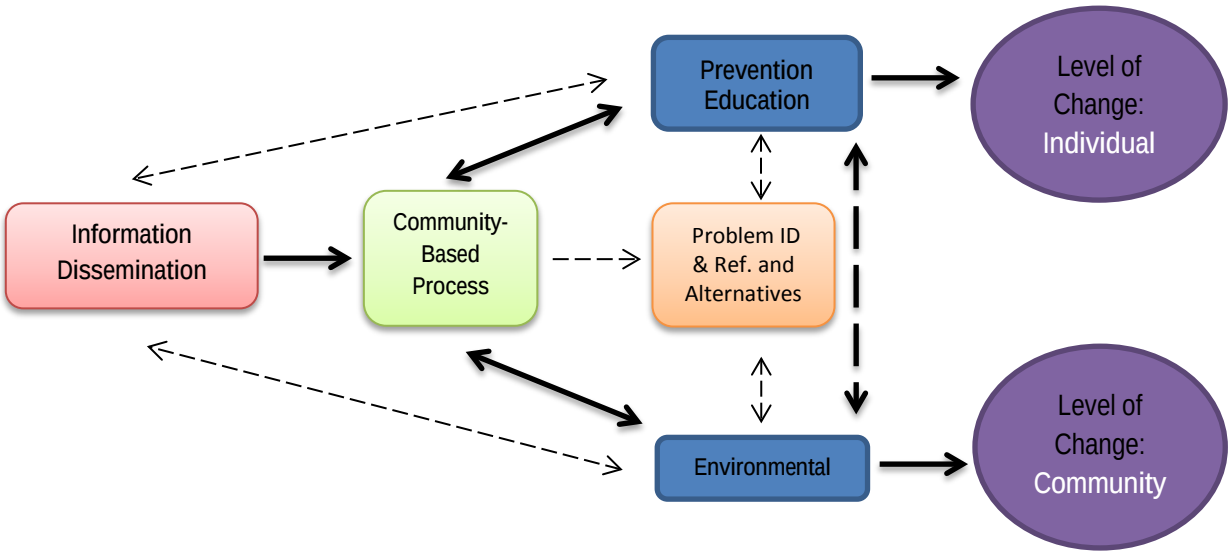
Prevention and wellness focuses on reducing the likelihood of or delaying the onset of behavioral health problems (i.e. substance abuse, mental illness, suicide and problem gambling). Prevention services are a planned sequence of culturally appropriate, evidence-driven strategies intended to facilitate attitude and behavior change for individuals and communities. Ohio supports a public health approach to prevention and mental health wellness to address healthcare and early intervention efforts for all Ohioans.

Following the Public Health model, strategies implemented are based on the assessment of needs, resources and readiness conducted as part of the community planning process to ensure that funded strategies will address community risk and protective factors that either complicate or mitigate mental illness, addiction and other risk behaviors. These community and statewide prevention and wellness efforts benefit all Ohioans.

Behavioral health problems are complex and therefore cannot be adequately addressed without involving multiple systems that impact risk and protective factors. Risk factors are

neurobiological factors, stressful events or psychosocial factors that increase an adolescent's vulnerability to poor outcomes. Protective factors help safeguard youth from poor outcomes. This framework suggests that outcomes grow out of the complex web of interactions of various domains including: genetic/individual, family, peers, school, community and society to prevent or ameliorate severe outcomes.

Ohio has updated its Prevention Guidance based on a model for how the federal Center for Substance Abuse and Prevention's (CSAP) six prevention strategies are to be implemented for the greatest impact in Ohio communities. The following graphic provides a visual representation of how the six CSAP strategies contribute to individual and community-level change. This new model provides a foundation for how substance abuse and mental illness prevention intersect. The focus on intended level of change and a further definition of strategies allows for the work of multiple systems to be integrated into one conceptual model.



Prevention education and environmental strategies are the main prevention strategies which have the strength to influence attitude, behavior and meet outcomes on their own. The other four strategies support the implementation of these two main strategies. All six strategies are needed as part of a comprehensive prevention and wellness approach. **Information dissemination** creates awareness and builds knowledge which provides a foundation for **community-based process** to engage and mobilize communities into action. Although **prevention education** interventions can be implemented without **information dissemination** and **community-based process**, these interventions often lack the benefits resulting from broad-based community support and opportunities for expansion and quality improvement.

Community-based process activities are essential to effectively implement an environmental strategy. The **problem identification and referral** strategy is implemented as an adjunct when an individual enrolled in a direct service is identified as being able to benefit from services which exceed the scope of prevention. Alternative activities are implemented as a celebration of individual or community success. Alternative activities must be activities that will also contribute to addressing risk/protective factors and/or intervening variables identified in initial program development.

Increase Community Capacity

OhioMHAS has a historic process for community and statewide assessment and planning for prevention guided by state and federal law and regulation. State law requires that ADAMH Boards conduct community needs assessments for behavioral health services which are included in a Community Plan submitted to the state. Additionally, Ohio's state substance abuse authority has implemented an assessment as a part of the Ohio Strategic Planning Framework with a series of grants from SAMHSA. In addition to current efforts, the Ohio Strategic Prevention Framework (SPF) Strategic Prevention Enhancement (SPE) Evaluation Team conducted a variety of assessments and inventories to inform the work of the SPE Consortium specifically around data collection. Ohio Community Plans, Ohio Family Health Study, and National Outcome Measures (NOMS) all inform Ohio's prevention planning efforts. This assessment process for all services is in Step 2 of this document.

Increase Community Capacity through Workforce Development (WFD) Plan

OhioMHAS has a goal to create a competent and diverse behavioral health prevention workforce through a structured two-year plan. The objectives for the plan are:

- Define and promote a common language for prevention across systems.
- Continue to educate field on behavioral health, prevention/promotion and population-based strategies.
- Integrate behavioral health in and with Public Health.

The WFD Plan will also include the updating and revision of the E-Based Academy to include the integration of behavioral health in the selection of educational sessions. OhioMHAS will also continue to maintain a connection with the Ohio Chemical Dependency Professionals Board (OCDPB) and ensure all training sessions follow the identified credentials and domains. It is the expectation that there will be a Substance Abuse Specialist Skills Training in each region annually and one statewide opportunity along with opportunities for test/prep study groups for the International Credentialing & Reciprocity Consortium (IC&RC) exam.

Ohio possesses both individual and agency certifications for Prevention. Agency certification is provided by OhioMHAS and has minimum requirements and criteria that agencies must demonstrate to be a prevention certified agency. The agency must show policies and procedures

that meet the requirements, as well as show evidence of culturally appropriate interventions and qualified personnel that are implementing the interventions. Agencies are certified for three-year time periods after which they can participate in a renewal process. (The complete rules document can be found at http://mha.ohio.gov/Portals/0/assets/Regulation/Rules/12082016/OAC-5122-29-20-Prevention-service.pdf .)

Prior to SFY 2013 there were three certification options for an individual to choose: Registered Applicant (RA), Ohio Certified Prevention Specialist I (OCPSI) and Ohio Certified Prevention Specialist II (OCPSII). The purpose of an RA was to enable an individual to begin the process of prevention certification while working in the field. Staff can practice at the RA level for an indefinite amount of time under supervision of an OCPSI I or II.

The OCDPB realized that there were many individuals "parked" in the RA level, and they were not advancing forward to the OCPS I or II. It was decided that the creation of an Ohio Certified Prevention Specialist Assistant (OCPSA) would help individuals who may not have the required educational hours or work experience to move forward and provide an opportunity for them to complete their credential. The committee developed educational criteria and scope for the OCPSA and put a two-year limit on the RA level. This addition of the OCPSA will increase the capacity of the prevention field in Ohio significantly.
Note: The OCDPB changed the credentials to RA, OCPSA, OCPS and OCPC (Ohio Certified Prevention Consultant) in 2017.

Alignment of Prevention Service System with other Systems

Ohio's Strategic Prevention Framework Partnerships for Success (SPF PFS)
Ohio has been awarded $8.13 million for the Strategic Prevention Framework Partnerships for Success Grant for 2014 – 2019 from SAMHSA/CSAP (Center for Substance Abuse Prevention). This grant builds on Ohio's 2009 five-year, Strategic Prevention Framework State Incentive Grant (SPF-SIG) totaling more than $10 million, and a 2011 Strategic Prevention Enhancement (SPE) Grant for $600,000. The SPF-PFS initiative will continue to enhance and strengthen the capacity of the state and local communities to build a sustainable, culturally competent infrastructure focusing on delaying the onset of alcohol and other drug use and reducing substance-related problems. To continue to develop capacity at the community level, Ohio is using training, technical assistance and coaching to provide intensive, ongoing support. These strategies lay a solid foundation for the soon to be funded sub-recipient communities, to work collaboratively with other community entities to address community prevention and needs. The PfS Advisory Committee will oversee the work and will collaborate with the SEOW and representatives of state agencies, foundations, universities, prevention providers and other community members.

Interagency Prevention Partnership

As a part of the SPF grants work, Ohio developed an Interagency Prevention Partnership (IPP) to oversee the grant processes, make policy recommendations, provide input into the development of plans, and to help guide the state substance abuse prevention system. Strengthening working partnerships has allowed the IPP members to explore the opportunities to: a) embed substance abuse prevention within their infrastructure at both the state and community levels; b) share resources and cross train staff; and c) explore cost saving opportunities as Ohio transforms its healthcare delivery system. These efforts increase the mental health and substance abuse prevention system capacity and support for effective prevention services.

The IPP partners include the Ohio Departments of Health, Mental Health and Addiction Services, Education and Youth Services, along with representatives from the Ohio National Guard, the University of Cincinnati, Ohio University, Ohio Children's Trust Fund and the Ohio Suicide Prevention Foundation. Community level stakeholders include the Urban Minority Alcoholism and Drug Abuse Outreach Program (UMADAOP) Federation and the Licking County Juvenile Justice Association. These community stakeholders have strengthened decision making related to community level collaboration. Having multiple disciplines at the table has allowed the creation of comprehensive plans aimed at closing state priority gaps related to capacity building and system enhancement tasks.

The IPP members developed a five-year strategic plan with four main goals and more than 20 actionable objectives. The group continues to discuss how to utilize available and planned resources, key personnel, and stakeholders to address concrete action steps and milestones for completion to meet the goals of the strategic plan. The expertise from all members of the IPP has enabled the plan to include goals, objectives and strategies for integrating a community-based, state supported holistic approach to mental health and substance abuse prevention.

Ohio's Strategic Prevention Framework for Prescription Drugs (SPF-Rx)

Ohio was awarded the Strategic Prevention Framework for Prescription Drugs grant (SPF-Rx) through the Substance Abuse and Mental Health Services Administration's Center for Substance Abuse Prevention (SAMHSA CSAP). This project is a 5-year initiative for a total of $1,858,080. Ohio's SPF-Rx Initiative seeks to raise awareness about the dangers of prescription drug misuse, work with the pharmaceutical and medical communities on the risks of overprescribing, and increase the utilization of the Ohio's Automated Rx Reporting System (OARRS). It will enhance infrastructure and prescription drug prevention throughout Ohio, especially in rural and Appalachian communities.

Ohio's SPF Rx is aligned with the Ohio's SPF-PFS grant and focuses on rural and Appalachian communities in Ohio which are in high need and/or have lower capacity to combat the prescription drug misuse issue. The decision to select Appalachian and rural communities as the

target population for this grant grew out of several years of need, resource and readiness assessment work conducted at the state and local levels. The first year of the grant is being spent on the development of a 5-year plan, working collaboratively with the Ohio SPF-Rx Workgroup.

Drug Free Community Coalitions and the Statewide Prevention Coalition Association
Ohio has found that community coalitions are the single most effective means of promoting grassroots alcohol, tobacco and other drug prevention across disciplines at the local level. Drug Free Community Coalition funding helps communities to address local alcohol and other drug abuse needs and mobilize and promote healthy youth development and healthy communities. Coalitions assist county alcohol and drug boards in determining prevention needs and in developing strategic prevention plans. The Department currently funds 18 coalitions in 16 counties. The Department also supports the Statewide Prevention Coalition Association (SPCA) and the Ohio Center for Coalition Excellence (OCCE) in working with coalitions in over 100 communities. Both SPCA and OCCE provide training, technical assistance and support to communities in their efforts to impact community norms; access and availability of alcohol, tobacco and other drugs; media messages; and policy enforcement issues on the local level.

The Department also supports over 80 Suicide Prevention Coalitions through a grant to the Ohio Suicide Prevention Foundation. Ohio has a rich history of coalition development. Ohio's community coalitions serve geographically and culturally diverse populations; however, there are gaps in that service. Some counties and board areas have very few, if any, community coalitions, while others have many. A few of the 29 federally funded Drug Free Community Coalitions have also received funding for the Sober Truth on Preventing Underage Drinking campaign. The Statewide Prevention Coalition Association is unique in that it is the only statewide association for prevention organizations in Ohio. The statewide perspective enhances and broadens the local and regional perspectives that the members have. The focus of these groups is to help local communities increase capacity, increase use of environmental prevention strategies, and foster healthy communities.

The Ohio Center for Coalition Excellence was conceptualized to assist communities to mobilize substance abuse prevention efforts. Ohio Center for Coalition Excellence (OCCE) assists community groups to build their local collaborative capacity, to plan, implement, evaluate and sustain prevention strategies within communities. The goal continues to be to increase capacity, change community environments and build healthy communities The OCCE works with the Underage Enforcement Training Center, Community Anti-Drug Coalitions of America and national and state experts to provide trainings that assist coalitions in strengthening coalition development and increasing impact within communities.

School Based Prevention

Strong Families, Safe Communities

Governor Kasich and the State of Ohio are committed to improving care coordination and providing support for families with children in crisis who present a risk to themselves, their families, or others because of mental illness or a developmental disability. Many children who are at risk are not engaged in treatment programs and may not be known to the community until a crisis unfolds. Care coordination and targeted crisis intervention services can quickly stabilize a child's health. Support for these families in need will reduce risk of harm and help the family remain together. During spring 2013, the Ohio Departments of Developmental Disabilities (DODD) and OhioMHAS sought collaborative community proposals to establish treatment models of care that focus on crisis stabilization for children with intensive needs. This initiative has engaged local systems to identify community-driven solutions that highlight collaboration across agencies to develop the best possible outcomes for children and families.

In July, 2013, DODD and OhioMHAS announced awards of nearly $3 million out of a $5 million grant to seven community partnerships to implement the Strong Families, Safe Communities project and to provide care coordination and crisis intervention services for youth at risk of harming themselves or others due to a mental illness or developmental disability. In addition to the grant awards, the project will train mental health and developmental disabilities services professionals in crisis intervention.

Good Behavior Game

Ohio supports the **Good Behavior Game (GBG)** because it has shown both proximal and distal outcomes regarding student behavior, mental illness and substance abuse. The research suggests that durable results lasting well into young adulthood can be achieved with only one year of exposure to the GBG in first grade. GBG has been broadly embraced by teachers in Ohio due to more and more children coming to school with problem behaviors and difficulty with self-regulation. Self-regulation of attention is a meta-skill that predicts standardized achievement test scores and school success. GBG used during normal instruction gives teachers a tool to cultivate this essential skill. Ohio communities are using GBG both with and without coaching. The training, coaching, and materials cover all sorts of strategies to make the game more effective; how to increase PAX (good behavior) when not playing the game; and what to do with children who are not responsive or have special needs. The fundamental units of behavioral influence that underlie effective prevention and treatment, or "kernels," introduced to participants have been used with a wide range of ethnic groups and diverse populations. The brain science behind the success of kernels is universally applicable. Ohio is utilizing the STR grant funding to bring PAX GBG to scale across the state.

Infuse Prevention Capacity into Other Systems

Positive Parenting and Screening

Ohio's public service system must seek out ways and means to encourage positive parenting skills and referrals to behavioral health services when identified through screenings. Some models have been used successfully to influence positive parenting outcomes. The **Positive Parenting Program or Triple P** is an evidence-based public health approach for improving parenting practices and child welfare outcomes within a population. It can be implemented in healthcare, child welfare, schools, behavioral health, child care, libraries, military and others.

The principles of Triple P are:

- Ensuring a safe, engaging environment
- Creating a positive learning environment
- Using assertive discipline
- Having realistic expectations
- Taking care of yourself as a parent

Another successful model program supported by the Office of Prevention and Wellness is called **Building "Piece" of Mind and Purposeful Parenting**, and it is being championed in Ohio by the Ohio Academy of Pediatrics. This program provides simple handouts and tools to promote early childhood development from birth to age three, and offers additional tools to help young children grow with self-confidence, health and happiness. The six parts of Purposeful Parenting are being protective, personal, progressive, positive, playful, and purposeful so that parents and caregivers can decrease toxic stress. Decreasing toxic stress releases an in-born drive to grow, to learn, to contribute, and to connect with others. Purposeful Parenting helps children to be all that they can be. To learn more, please visit, http://www.ohioaap.org/building-piece-of-mind/.

OhioMHAS is working in partnership with Wright State University (WSU) in the development of Behavioral Prescriptions. WSU has extracted the active ingredients of many effective behavioral health programs and provided training on these "evidence-based" kernels to "non-usual care providers." This has allowed WSU to expand the breadth of universal prevention outside school-based practices and into the community to include: juvenile courts, parents, foster parents, piano teachers, babysitters, basketball coaches, etc. Fruth, Mayer, Finnegan (2014) have demonstrated that "non-usual are providers match the effectiveness of teachers and behavioral health professionals.

Suicide Prevention

Approximately 1,400 Ohioans die by suicide each year. Males account for about 80 percent of Ohio's suicides, and firearms are used in more than 55 percent of completed suicides. Roughly 90 percent of people who complete suicide experience a mental health and/or substance use

disorder that is untreated or under-treated at the time of death. It is estimated that more than 70 percent of youth who attempt or complete suicide have alcohol or illicit drugs in their systems; suicide is the number 2 cause of death for youth ages 19 to 24.

Substance abuse, addiction and depression are key risk factors in suicide deaths and attempts. To prevent suicides, OhioMHAS funds the Ohio Suicide Prevention Foundation (OSPF) to promote suicide prevention as a public health issue and advance evidence-based awareness, interventions and strategies that will support all Ohio-based suicide prevention efforts to save the lives of hundreds of Ohioans. The audience for the primary prevention efforts of the Foundation is essentially the entire population of the state, while specific at-risk audiences, such as substance abusing populations, may be the target of specific preventative programs. More than 5,000 people benefit from these efforts each year.

Suicide Prevention Community coalitions are committed to reducing stigma, which helps increase people's ability to seek help and ultimately prevent the loss of life from suicide. These coalitions provide training and education on suicide risk factors, warning signs (especially when combined with substance use/abuse), depression, and prevention strategies. Community collaboratives apply for mini-grants to develop and execute combined suicide/substance abuse/depression prevention strategies in their communities. The strategies developed are culturally relevant to the intended audiences and inclusive of local resources.

Additionally, suicide prevention is a public health priority and has support from both the Governor and the Legislature. The OhioMHAS Medical Director's Office and the Office of Prevention and Wellness are working collaboratively on the statewide suicide prevention initiatives. These initiatives complement and enhance the work of the Foundation and other entities addressing this issue. Additionally, OhioMHAS will collaborate with suicide coalitions to identify effective interventions and assist with replication across the state and enhance web-based resources for public awareness.

OhioMHAS will also work toward the development of an advisory group to guide these efforts. This group will assist to leverage other potential funding sources and help to monitor data to assess efficacy and effectiveness of interventions.

Bureau of Workers' Compensation Drug-Free Safety Program and Safety Congress

The Drug-Free Safety Program (DFSP) offers a premium discount through the Ohio Bureau of Workers' Compensation (BWC) to eligible employers for implementing a loss-prevention strategy addressing workplace use and misuse of alcohol and other drugs, especially illegal drugs. In partnership with BWC, OhioMHAS assists in the yearly planning of the Ohio Safety Congress & Expo. The Congress is the largest regional safety and health conference in the nation, bringing in more than 6,000 attendees annually. In addition to the 225 exhibitors

showcasing their latest safety innovations, products and services, there are 170 educational sessions offered on a variety of the hottest topics in the industry. Sessions are led by experts in their respective fields and all sessions offer continuing education credits.

Increase Workforce Capacity

Workforce development is a challenge for the prevention field in Ohio. Recruitment is a significant problem for the substance abuse prevention profession because of a lack of standardized education pathways. Retention is also a concern because of the rate of turnover for substance abuse prevention professionals, due to inequalities in salary and workloads. Young professionals come into the field and gain experience for a few years and move on to better paying positions. This coupled with the aging workforce in substance abuse prevention provides unique circumstances when looking at workforce development issues long-term. While Ohio is fortunate to have a relatively strong infrastructure supporting the prevention, several factors affect advancement of this system. These include periodic state budget reductions in the amount of per capita allocations going to county boards to support prevention services and a reduction in the amount of competitive funding awarded by OhioMHAS.

To address these issues and modernize Ohio's prevention system, the state embraced the findings and recommendations in the 2009 Institute of Medicine (IOM) report on *"Preventing mental, emotional, and behavioral disorders among young people: Progress and possibilities."* The first step to implementing the IOM report recommendations is building awareness through major conferences and meetings. Seven sponsoring organizations held six different events to build awareness in Ohio between September 2012 and May 2014. Sponsoring organizations include Alcohol and Drug Abuse Prevention and Association of Ohio (ADAPAO), Prevention Action Alliance, Ohio Prevention and Wellness Roundtable, Ohio Association of County Behavioral Health Authorities, OhioMHAS, Ohio Prevention Education Conference, and Ohio Early Childhood Conference. Ohio continued to build on these efforts, and hold additional conferences and summits in 2016 and 2017, OPEC conference, Early Childhood Mental Health Conference, Ohio Adult Allies Summit, are just a few. Additionally, the Prevention Action Alliance will continue to provide training, technical assistance and support to communities in their efforts to impact community norms; access and availability of alcohol, tobacco and other drugs; media messages; and policy enforcement issues at the local level.

Empower Pregnant Women to Make Healthy Choices

Pregnant Women and Mothers of Dependent Children

The Department supports programs to address the prevention needs of women with a focus on pregnant women, and women with children and their families. Quarterly meetings bring the programs together to help close the gap between the number of women in need of prevention services and the availability of services designed to address the complex needs of women.

Additional activities are planned for SFY 2016 - 2017 to create statewide interest in the learning community.

Fetal Alcohol Spectrum Disorders (FASD) Initiative

Each year, as many as 40,000 babies are born in the United States with an FASD, costing the nation about $4 billion, and yet, prenatal exposure to alcohol is the leading cause of preventable birth defects in the country. In conjunction with the state's FASD efforts, a public education campaign was developed titled, **Not a Single Drop**. An Ohio website https://notasingledrop.mh.state.oh.us/ redirects visitors to a website packed with information and resources for parent and community education on FASD issues. Radio and television Public Service Announcements (PSAs) are included with the campaign. Since the Department integration, the Not a Single Drop site needs to be updated.

Since 2004, OhioMHAS has served as the key coordinating agency for Ohio's FASD Statewide Committee, a partnership that also includes eight other state agencies, three universities, providers and parents. The Statewide FASD Steering Committee has worked to develop an integrated system for addressing the prevention and identification of fetal alcohol spectrum disorders (FASD).

A project implemented an Alcohol Screening Brief Intervention (ASBI) process in Ohio WIC (Women Infants and Children) in Montgomery County. This initiative allows for the screening of all WIC pregnant women for alcohol use, provision of brief interventions to all who screen positive, follows those receiving brief interventions during pregnancy and refers them to treatment services. The goal is to educate pregnant women about the dangers of drinking alcohol while pregnant and in turn, positively influence their decisions about reducing or completely ceasing drinking.

Maternal Depression

Perinatal Depression encompasses a wide range of mood disorders that can affect a woman during pregnancy and after the birth of her child. It includes prenatal depression, the "baby blues," postpartum depression, and postpartum psychosis. Ohio is 49th in the nation for infant mortality. Although African American babies are dying at double the rate of Caucasian counterparts, Caucasian babies are equally at risk. Of the many risk factors that impact a baby's failure to thrive, maternal depression and stress are significant factors. If the condition is interfering with the woman's ability to do what she needs to do for herself or her child, it can result in serious consequences. Screening is an easy, quick and affordable method of identifying women who may be struggling with depression. Successful efforts to prevent and treat maternal depression require an awareness of how common the disorder is, accurate identification of symptoms, and initiation of treatment as quickly as possible. Since depression occurs across all age, race, ethnic and economic groups, every new mother should be screened and educated about perinatal depression.

Support Families with Children and Youth

Start Talking!

Far too many Ohio families know the heartache of having a loved one deal with the nightmare of drug abuse. When that someone is a child or young adult, the emotional pain can be unbearable. But here is where it gets better: kids are up to 50 percent less likely to use drugs when their parents or other trusted adults talk with them about drug use and abuse. Understanding that this is not an easy discussion to begin, Governor John Kasich and First Lady Karen W. Kasich launched the Start Talking! statewide youth drug prevention initiative to help parents and other adults communicate better with kids. Based on research and what experts say are the best methods to engage kids, Start Talking! offers four ways for parents and other youth leaders to approach children and young adults:

- Know! focuses on the parents of middle school students and provides tips and tools offered by the Drug-Free Action Alliance.
- Parents360Rx is a national program from the Partnership for Drug-Free Kids that is designed to educate adults about the dangers found in their own medicine cabinets.
- 5 Minutes for Life engages student athletes and other young leaders as ambassadors.

The Start Talking Initiative aims to give students the courage to resist drugs and push back on peer pressure. Learn more about this initiative in its entirety at www.StartTalking.ohio.gov.

Parent Engagement Study

OhioMHAS seeks to support the empirical validation of a promising new practice to help families better manage their children's challenging behavior. The role of parents is vital in shaping children's growth, development and future achievements. However, families are often not sufficiently engaged by health care delivery systems around their children's wellness. This program evaluation effort seeks to improve family engagement and effectiveness in managing their children's problem behaviors by equipping them with a novel behavioral change method that can reduce preschool adjustment difficulties, preschool expulsion, emotional and social maladjustment, and subsequent potential problems in learning and behavioral concerns. The goal of this program evaluation effort is to determine that once trained in the **FLIP-IT®** model, the extent to which parents are able to affect decreases in negative behaviors and increases in positive behaviors in their children. The goal is to provide empirical support of the FLIP-IT® model as a promising best practice for use by families to improve the emotional and behavioral functioning of their children.

Increase Access to Youth and Family Prevention Services

The Department funds prevention services primarily through allocations to ADAMH Boards and funding of statewide initiatives. The ADAMH Boards contract with prevention providers to support the development and implementation of a comprehensive array of primary prevention intervention programs to meet the needs of their local communities. The **Ohio Prevention Guidance** document provides the guidelines for the delivery of this service array.

Strategies implemented are based on the assessment of needs, resources and readiness conducted as part of the community planning process. These guidelines s ensure that funded prevention interventions will address community risk and protective factors that either complicate or mitigate substance use and other risk behaviors.

In addition to board prevention allocations, OhioMHAS has a variety of initiatives which form the foundation of the state-level prevention infrastructure and support prevention across the lifespan. Summaries of these initiatives are provided in this section.

Youth Initiatives

Ohio Youth-Led Prevention Network (OYLPN)

Promoting meaningful youth involvement in community prevention efforts is a sound investment in wellness for Ohio. Ohio has a proud history as the birthplace of two of the country's longest-standing and most-widespread youth-led prevention programs: Teen Institute and Youth to Youth. These programs led to the development of the OYLPN. Youth-Led Prevention is based on the prevention theories of Social Emotional Learning, Resiliency, Youth Empowerment and Developmental Assets. These theories, in addition to evidence-based prevention strategies, provide a strong foundation toward supporting Youth-Led Prevention.

The OYLPN consists of youth-led prevention providers and youth throughout the state who are committed to the cornerstones of youth-led prevention, which are peer prevention, positive youth development, and community service. The OYLPN of a Youth Council (YC) that is the driving force behind the prevention initiatives and efforts established by the network to enhance youth-led prevention. Funds provided to Boards foster partnerships that empower youth to participate in community-based processes promoting the health and safety of individuals and communities. Funds are provided to the Prevention Action Alliance to conduct statewide initiatives and coordinate the network of local Youth-Led Prevention groups.

Through a strategic planning process the YC developed a statewide social norming campaign called **We Are the Drug-Free MAJORITY!** This campaign launched with a rally at the Ohio Statehouse in May, 2012, with more than 600 youth participating and has continued with over

1200 attending in 2015. This rally is a celebration to recognize the spark of the drug-free youth movement and to maximize the power of positive peer influence. This celebration is spread throughout the state with satellite events at various locations.

The YC also wants to encourage, inspire, and promote a healthy lifestyle choice for all teens as the various youth-led groups take the message back to their home communities. Over the years, the majority of teens who are drug-free have become a silent majority, allowing the minority to set the "norm." Building awareness that most youth do not use substances communicates healthy expectations about alcohol and other drug-related behaviors.

The OYLPN has developed a Theory of Change for youth led programming in Ohio. Through the development of this theory of change, it became apparent that OYLPN impacted more than just substance abuse, but also impacted mental health promotion and wellness strategies; youth-led prevention takes a behavioral health approach to building resiliency and increasing protective factors in the youth and young adults of Ohio.

The OYLPN continues to build capacity for youth empowerment in local communities and regions through the development of regional youth councils and the implementation of the Holden Model youth empowerment framework across the state. This has been done through the establishment of Adult Allies across the state and intensive training around the SPF process.

Decreasing Youth Access to Tobacco – Synar Compliance

Synar

Section 1926 of the U.S. Public Health Services Act, referred to as the Synar Amendment, requires states to decrease youth access to tobacco. All states are required to have a law making the sale of tobacco products to minors illegal; conduct random, unannounced inspections of tobacco retail outlets in a scientific manner to check the compliance with state law; and report each year on the enforcement of state law activities conducted the previous year, enforcement plans for the coming year, and the extent of success in reducing the availability of tobacco products to minors. The law also requires states to meet established compliance rates (currently 80 percent rate of non-sales to youth) or be subject to up to a 40 percent reduction of Substance Abuse Treatment and Prevention (SAPT) Block Grant dollars for prevention and treatment services. In 2015, Ohio's compliance rate was 73.8 percent which put the state out of Synar compliance.

As an alternative to the 40 per cent SAPT Block Grant reduction, the state of Ohio elected to accept the federally offered alternative penalty. This alternative penalty requires the state of Ohio over the next two federal fiscal years to spend approximately $3.97 million in new state funds on youth tobacco access enforcement and educational programs/activities. The Ohio

Department of Health (ODH), Ohio Department of Public Safety (ODPS) and OhioMHAS have worked together to implement these programs and activities.

Compliance Checks
OhioMHAS works with the Ohio Department of Public Safety's Investigative Unit (OIU) to conduct enforcement activity for the state's Synar program.

Merchant Education
Merchant education is provided by the OIU. The **A.S.K.** (**Alcohol Server Knowledge**) program, formerly known as **H.E.L.P.** (**Hire Education for Liquor Permitted Premises**), provides merchants who sell alcohol with education about Ohio's alcohol and tobacco laws and skill building in checking identification and refusing sale.

Merchants may also choose to receive training through other sources such as the **"We Card"** program. Educational material for employees is available via download from the OIU homepage or by request from the OIU. The pamphlet entitled "Clearing the Air on Ohio's Tobacco Laws" is available in English, Spanish and Somali and was created for distribution through collaboration between OhioMHAS, OIU and the ODH. Merchant education materials are also in the process of being updated and refreshed as a part of our sanction activities.

Community Education: The OIU **"Sober Truth"** program provides information about Ohio's tobacco and alcohol laws throughout the state.

Programs Targeting At-Risk Populations

Urban Minority Alcoholism and Drug Abuse Outreach Programs
The primary purpose of the Urban Minority Alcoholism and Drug Abuse Outreach Programs (UMADAOPs) is to provide culturally appropriate prevention services to African-American and Hispanic/Latino American communities in Ohio. These programs were created by the Ohio legislature in the 1980s, and are supported by state and federal funds. All programming activities are structured to provide a foundation to build healthy communities, positive youth development, violence and substance free lifestyles. UMADAOP provides programming with the belief that substance abuse is best prevented and treated when the cultural dynamics of a group are addressed and included in the process of prevention, treatment, recovery support. The UMADAOPs are located in Akron, Cincinnati, Cleveland, Cleveland Hispanic, Columbus, Dayton, Lima, Lorain, Mansfield, Toledo, and Youngstown. Since their inception, they have been a vital force in meeting the substance abuse education, prevention, treatment and recovery support needs of African and Hispanic/Latino Americans throughout the state of Ohio. The programs will remain central to OhioMHAS' cultural competency goals.

The UMADAOP's embarked on an exciting endeavor in 2016 and engaged in programming for Children of Incarcerated Parents. The UMADAOP's and other partners were trained by Dr. Ted Strader in the Creating Lasting Family Connections program (3 versions) and are currently implementing the program in several of our Department of Rehabilitation and Corrections (ODRC) correctional facilities. This program has enhanced OhioMHAS and ODRC relationships and is helping with the transition of incarcerated individuals from the correctional facility to the community and family. This programming is being implemented in both the male and female correctional facilities.

Ohio National Guard

The Department has a long history of working with the Ohio National Guard (ONG). ONG embeds counter-drug personnel with the Bureau of Prevention to support strong collaborative efforts. The current focus of this work is to build capacity and sustainability in community coalitions, increase the capacity of the workforce and to lead the Department's efforts in developing criteria and a process for designating coalitions as "Ohio Coalitions of Excellence." The Kaizen Event is designed to assist community-based coalitions in understanding how well they are adhering to the principles of the Strategic Prevention Framework through a series of questions, facilitated by a National Guardsman. With the Kaizen Event comes the opportunity for coaching and mentoring to help improve overall processes that will lead to coalition excellence.

To further the partnership with the ONG, OhioMHAS has reached out to the **Ohio 4-H Operation Military Kids (OMK)** project to help support resiliency in military families and children. OMK is a national initiative involving 49 states and the District of Columbia with high levels of National Guard and Reserve deployment. OMK is a partnership of Army Child & Youth Services, the USDA, national and Ohio 4-H educators. Programs are designed for military children to help them find positive ways to cope with the stress of parents' deployment. These efforts align with the Ohio Youth Led Prevention Network initiative; plans are to facilitate the development of youth-led prevention groups specifically for OMK youth.

This is not the entire picture of military families, however, because it does not account for all the branches of the service. By mapping the location of Army and Air National Guard and Army Reserves service members, the Department can use this data to target low capacity areas for youth-led network group expansion.

The ONG has also been participating in the Suicide Prevention Initiatives and is taking the lead on organizing a Mental Health First Aid training for military personnel and law enforcement partners.

Focus on High Need Issues

Marijuana Initiative

With marijuana legalization occurring across the country, Ohio plans to continue to target prevention initiatives on youth at risk for use or abuse of the drug; marijuana is the most frequently abused drug among Ohio's adolescents. Within Ohio, the marijuana consumption rates among young adults between the ages of 18 and 25 remained above that of other ages groups. Marijuana use has been on the rise in this age group since 2007-2008, and current marijuana use is more prevalent than with young adolescents or adults. Between state fiscal years 2008 and 2011, almost 21,000 adolescents (73 percent of all adolescents receiving publicly funded treatment services) reported marijuana as a primary, secondary, tertiary or quaternary drug of choice. Over half of all admissions to publicly funded treatment were associated with marijuana, and the percentage of adolescents reporting this substance as a drug of choice rose from 70 percent in 2008 to 77 percent in 2011. Research shows that the initiation of marijuana use at young ages, especially in pre-adolescence, has been linked to more intense and problematic levels of use of marijuana in adolescents and in adulthood; this also includes physical health problems. There is a need in Ohio for increased prevention efforts among youth and young adults addressing marijuana use as well as medical marijuana.

Opiate Epidemic Related Projects

Family Engagement Groups

Ohio has a public health crisis due to the fast growth in availability of opiate-based prescription painkiller medications and the abuse of these drugs for nonmedical purposes. A dramatic increase in prescribing over the past decade has brought these dangerous medications into the homes of Ohioans, averaging 67 pills for every man, woman, and child in the state. As a result, addiction to prescription pain medications and their chemical lookalike, heroin, is on the rise, and drug overdoses are also at an all-time high, averaging four deaths a day in Ohio.

These overdoses have devastated Ohio families. Many family members personally impacted by the consequences of substance abuse have found a collective voice to issue a public outcry and gain solace from grief in their community. The Family Engagement initiative supports individuals and families affected by addiction through building the capacity of local family engagement groups to bridge the GAP for their families and communities.

The Department, Prevention Action Alliance, the Ohio Attorney General's Office, the Ohio Association of County Behavioral Health Authorities and the Ohio Department of Health teamed up to bring together experts in all areas of Bridging the Gap (moving from grief to taking action for prevention) regarding prescription opiate abuse for a night of celebration followed by a day of education in Fall 2012. The two-day event began with an evening tribute concert by singer/songwriter Edwina Hayes, where people from all over Ohio gathered to honor loved ones lost to prescription drug abuse, remember those currently struggling with addiction, and celebrate

the great strides being made in Ohio communities to combat the issue. The Bridging the Gap conference took place the following day to equip Family Engagement groups with effective strategies for bridging the gap between grief and taking action for prevention, as well as bridging the gap between the prevention field and those affected by substance abuse.

Prevention Action Alliance will continue to build capacity of family engagement groups that are part of the GAP Network and to formalize training in the three focus areas to further assist family members in mobilizing their communities for change.

Opiate Task Forces

The creation of community Opiate Task Forces was seen as one of several strategies to better educate communities, young people, parents, other caring adults and healthcare practitioners about the dangers of opiate abuse and addiction. The Opiate Task Forces:

- Are designed to bring people and resources together from all sectors of the community impacted by the opiate issue and provide a structure for community response to the opiate epidemic.
- Engage communities to develop and pursue a unified goal, coordinate strategies, and pool resources.
- Work with ADAMH Boards to hold local events such as town hall meetings, community summits, prevention days, and lead or participate in drug take-back days.

Drug Take Back Days and Drop-off Boxes

OhioMHAS has partnered with the Drug Enforcement Agency, Ohio Department of Health, Office of the Attorney General, Prevention Action Alliance and dozens of community groups and law enforcement organizations to hold prescription drug take back days throughout Ohio and to purchase hundreds of permanent drug drop-off boxes. These efforts are concrete solutions to getting prescription drugs out of home medicine cabinets where youth and adults can find them and potentially abuse them. All drug drop-off events include education about the importance of using only those medications that have been prescribed for you by a physician and not sharing prescriptions with anyone else.

OhioMHAS is partnering with the Ohio Board of Pharmacy and utilizing STR grant funds to conduct a statewide take back to gather 160,000 pounds of prescription medical waste not covered by the US EPA Resource Conservation and Recovery Act (RCRA) regulations.

Town Hall Meetings

Dozens of town hall meetings have been held throughout the state for discussion of the opiate epidemic and to share valuable tips on how to protect families and the community from opiate addiction and the dangers of overdose. The Town Halls were coordinated and led by Opiate

Task Forces, ADAMH Boards, OhioMHAS, and Ohio Citizen Advocates for Addiction Recovery.

Underage Drinking Initiatives

"Parents Who Host, Lose The Most: Don't be a party to teenage drinking"

Another initiative through Drug-Free Action Alliance that supports the commitment to the reduction of childhood/underage drinking is the public awareness campaign, "Parents Who Host, Lose the Most: Don't be a Party to Teenage Drinking." This program was launched in the spring of 2000.

The campaign objectives are to educate parents about the health and safety risks of serving alcohol at teen house parties and to increase awareness of and compliance with the Ohio Underage Drinking Laws. The campaign is an environmental strategy to change parents' perceptions that drinking alcohol is a "rite of passage." The campaign takes place on a local and statewide level and runs April through early June during prom and graduation season. Since the campaign began, it has been requested for replication in 50 states, Puerto Rico, the Virgin Islands, Guam and Canada. To facilitate local support for the campaign, public awareness kits are disseminated throughout Ohio to local communities. The kits contain a poster, fact sheet, fact card, parent tips, sample press materials, and other information. The intent of the kits is to provide communities with tools that are factual, reproducible, and free.

Ohio College Initiative

OhioMHAS supports the Ohio College Initiative to Reduce High Risk Drinking which began in 1996, and brings together more than 52 college and universities. OhioMHAS provides funding to Prevention Action Alliance, who partners with The Ohio State University Higher Education Center for Alcohol and Drug Misuse Prevention and Recovery (HECAOD) to implement this initiative. The Higher Education Center for Alcohol and Drug Misuse Prevention and Recovery (HECAOD) is the premier alcohol and drug misuse prevention and recovery resource for colleges and universities across the nation. HECAOD is a joint collaboration between The Ohio State University's College of Social Work, College of Pharmacy, Office of Student Life, Generation Rx Initiative and Collegiate Recovery Community. From its beginning, the focus of the Ohio College Initiative has been on forming campus and community coalitions that work to change the alcohol-related culture surrounding college students. To achieve cultural change, campuses initiate a coordinated effort to alter the physical, social, economic and legal environment (including that dimension governed by informal rules in the form of customs, traditions and norms) to influence the decisions that students make about alcohol use.

Higher Education Network

Nine Institutes of Higher Education receive funding to implement prevention and early intervention programs to college students under the age of 21, with special emphasis on

addressing underage access and increasing awareness of the problem of high risk drinking. Higher Education funds also provide an opportunity for universities to form coalitions that work to change the alcohol-related culture surrounding college students and benefit the campus and surrounding community residents. Training and technical assistance is also provided to colleges and universities to address issues of high risk drinking that focus on utilizing environmental strategies.

BUZZKILL

Prevention Action Alliance has developed a program to help colleges educate their students on the responsibilities of social hosting. Based on the nationally-recognized, evidence-based program, Parents Who Host, Lose the Most: Don't be a party to teenage drinking, **BUZZKILL: Serve Under 21 and the Party's Over** is an eye-catching social host campaign that gives colleges the tools to let students understand the consequences when hosting parties with alcohol that underage people attend. A universal prevention program kit is available to provide information to assist communities with implementation planning, ready-to-use reproducible materials, print-ready artwork and materials that can be customized.

Gambling in Prevention

Ohio for Responsible Gambling

With four new casinos and seven upgraded racetracks that now have video lottery terminals (electronic slot machines) in Ohio, four state agencies have joined together to form an initiative to combat problem gambling. The Ohio Lottery Commission (OLC), Ohio State Racing Commission (OSRC), Ohio Casino Control Commission (OCCC) and OhioMHAS have formed an initiative known as Ohio for Responsible Gambling (ORG). As the lead agency, responsible for prevention and treatment of problem gambling, OhioMHAS serves as the behavioral health resource partner for the new organization. The Ohio for Responsible Gambling collaborative is building on existing programs and growing service capacity for Ohio families who may be affected by problem gambling now and in the future. ORG works to provide information and resources to individuals in need of services through the Ohio Problem Gambling Helpline (1-800-589-9966) and ORG website, www.org.ohio.gov.

Prevention Services

A number of actions occurred in SFY 2014 and 2015 and have continued into SFY 2016 and SFY 2017 to ensure that the Ohio behavioral health service system and its partners have the appropriate tools to address prevention of problem gambling in the context of public health.

Prevention Regional Workforce Development

For SFY 2015, OhioMHAS awarded capacity-building grants for problem gambling services in the amount of $1.2 million. These funds currently support development and implementation of evidence-based and promising practice models for prevention and treatment of gambling disorder

and encourage service systems that prioritize data collection toward achievement of effective outcomes. The funded boards and agencies have taken varied approaches to bringing best practices to people in their communities.

Prevention of Problem Gambling

With grant dollars, approximately 120 prevention professionals from across the state were trained as trainers in the prevention model *Stacked Deck*, a curriculum for problem gambling prevention for young people ages 13-17. *Risky Business*, a prevention program developed for the ADAMHS Board of Montgomery County by Wright State University — for youth with criminal justice involvement — is also being piloted at several venues throughout the state and is being evaluated as a future evidence-based practice.

Risky Business

Juvenile justice-involved youth ages 13-17 - 423 participants in Montgomery, Franklin, Cuyahoga, and Mahoning counties; 19 additional youth received the control intervention.

- Risky Business participants showed a large significant improvement in all six curriculum lessons, pre-test to post-test; control group participants showed no improvement on post-test instrument.
- 96.6% of participants reported they liked the program.
- In an anonymous survey, 85.7% said they would recommend the program to friends.

E-based Gambling/Financial Wellness Program: The curriculum was developed in SFY 2015. Arrangements were made for piloting the program in SFY 2016 at Central State University, The Ohio State University, Bowling Green State University, University of Mount Union, and Youngstown State University.

Smart Bet: Prevention Action Alliance is refining *Smart Bet,* a prevention curriculum for 18-25-year-old adults, and creating an online delivery system that will first be utilized at five college/university campuses to study its effectiveness.

Ohio Problem Gambling Resource and Training Center

OhioMHAS has taken steps to develop the Ohio Problem Gambling Resource and Training Center. The Resource Center promotes the recognition of problem/disordered gambling behavior, as well as identified characteristics of low-risk gambling, to this state. The learning module created by the Institute offers the opportunity for training and education services, which can be developed into classes and informational program materials on how to respond to and prevent gambling problems. The Ohio Problem Gambling Resource and Training Center has been moved to PAA web domain, and will continually be updated with resources for the healthcare professional.

Ohio Problem Gambling March Conference
Annually, the OhioMHAS has facilitated a Problem Gambling conference during national Problem Gambling Awareness Week in March. This event has been focused on problem gambling workforce development, bringing the most current evidence-based practices and national experts in the field to Ohio. Since 2002, this Problem Gambling Conference, funded in part by the Ohio Lottery Commission (OLC), has been Ohio's only statewide opportunity to learn the latest in prevention, intervention and treatment for individuals with problem gambling. Opportunities for networking among professionals have always been an important part of this event. The conference became a stand-alone 1.5 days' event that is hosted by the Ohio for Responsible Gambling (ORG) partners. Cost sharing among the ORG partners has allowed for more in-depth workforce capacity expansion sessions with national and internationally known keynote speakers.

Infusing Problem Gambling Prevention within Community Organizations
The Bureau of Problem Gambling Services within the Office of Prevention and Wellness recognizes the need to infuse education and resources through related programming and community partners. According to the ADAMH Board's Problem Gambling Plans, the Boards also see the overwhelming need to apply prevention strategies to problem gambling including information dissemination, education, community based process and environmental strategies. Population-based and environmental prevention strategies are essential to community success in prevention of problem gambling. It is expected that the strategies mentioned above will be particularly effective approaches for problem gambling because of the similarities between gambling and alcohol abuse. Both are illegal for youth; both may cause adverse consequences when frequency and duration increases for adults.

OhioMHAS and its partners take every opportunity to bring education and resources to partners. Activities include current and planned outreach to physicians and other healthcare providers, veterans' services, senior centers, drug-free community coalitions, Job and Family Services offices, clergy/religious groups, and others. Communities across the state are building problem gambling prevention components into existing evidence-based programs for prevention of risky behaviors. An example of this is the Life Skills curriculum.

Statewide and Community Problem Gambling Campaigns
The Ohio for Responsible Gambling partners are committed to ensuring that Ohioans have a constant, consistent message that gambling can be great entertainment, but too much gambling can cause problems for an individual or a family. To ensure that an effective, targeted message of safe and responsible gambling is disseminated, the Ohio Lottery Commission will fund a statewide campaign for SFY 2014-15 on behalf of ORG.

An inter-disciplinary group made up of representatives from ORG and the state's ADAMH Boards and agencies, came together in December, 2012, to make recommendations for the campaign. This group then reviewed the proposed campaign in August 2013 to ensure adherence to evidence-based public health prevention and education practices. *I Lost a Bet* launched in early 2014, targeted toward a prime demographic for awareness of problem gambling – the young adult male. Ohioans reached with prevention messages in SFY 2014 totaled 2.04 million.

Launching in August 2015 is a new public health-focused Problem Gambling Awareness Campaign called "Be the 95%: If you gamble, be the 95% of people who gamble responsibly." This campaign is also being sponsored and funded by the ORG partners. It is targeted to reach influencers of potential problem gamblers.

The behavioral health system of care across the state is primed to take a responsible gambling message into the local communities. In ADAMH board areas where the young adult male has been determined by a needs assessment to be a target demographic, the community organizations will pick-up the new campaign and maximize it with local resources.

Treatment of Problem Gambling

The new Gambling Endorsement for Chemical Dependency Counselors was passed and took effect in March 2015. As of Aug. 1st, 10 CDCs have earned the Endorsement and seven have applications in process. After years of committed work by the behavioral health field, state leaders and the Ohio General Assembly, HB 483 enacted a provision that authorized the OCDPB to create and offer a Gambling Disorder Endorsement for professionals qualified to treat gambling disorder. The Endorsement became effective in March 2015 and is available for individuals who hold an active LCDC II, LCDC III, LICDC or LICDC-CS license.

In SFY 2014, 26,000 Ohioans were screened for gambling disorder and 924 received treatment for a gambling disorder diagnosis. In SFY 2014, 9,727 people called the Ohio Problem Gambling Helpline for assistance.

Problem Gambling Regional Training

The foundational Stage 1 and 2 training sessions for treatment of gambling disorder were offered regionally, along with new seminars to provide hands-on experiential training in treatment, care planning, and continuing care planning. This focus has been requested in the evaluations of gambling treatment trainings over the past year.

Competitive Grant Funding

Through competitive grant funding, seeded development of four new promising practices in Problem Gambling Treatment, including the Rupcich Model. This pilot study was design to

discover the effectiveness of a new group-based facilitated, 12-week treatment curriculum on a sample of Ohio disordered gamblers and whether the curriculum positively influenced self-esteem, gambling cravings, and ultimately reduced gambling behavior among participants.

(3) Children and Youth with Serious Emotional Disturbances (SED) Community Behavioral Health Services

System of Care for Children and Youth with Serious Emotional Disorders (SED)
Ohio's behavioral health system has a public health approach that builds upon established collaboration of state agencies and county ADAMH Boards. At the state level, the OhioMHAS Prevention and Wellness Office; Bureau of Children and Families provides leadership for **treatment services for children and youth with serious emotional disturbances, as well as for mental health and substance abuse promotion and prevention.** Statewide interagency coordination among health agencies is led by Ohio Office of Health Transformation. This office coordinates the activities of the health and human services agencies. Ohio's child serving cabinet-level agencies include: Aging (disability network), OhioMHAS, Developmental Disabilities, Education, Health, Job and Family Services (employment, child welfare, social services/Title XX), Rehabilitation and Corrections (adult justice), and Youth Services (juvenile justice). At the community level, county and multi-county ADAMH Boards plan, evaluate and fund local mental health and addiction services for children and youth with state oversight from OhioMHAS. Boards contract with providers, which provide mental health and/or addiction services, and coordinate services from other systems for individuals. Most Boards develop collaborative relationships with schools and universities, developmental disabilities providers, juvenile justice, child welfare, health departments and county commissioners. Additionally, Boards collaborate with these local child-serving organizations through local Ohio Family and Children First (OFCF).

Family and Children First
Ohio Family and Children First coordinates a single county-level System of Care (SOC) which serves children and youth with SED who receive services through multiple county governmental organizations. County Family and Children First partners include the local government organizations that address mental health and addiction, developmental disabilities, juvenile justice, child welfare, and education. The purpose of the county Family and Children First Councils are to streamline and coordinate existing government services for families seeking services for their children. Each Family and Children First Council is mandated to perform four core functions: Engaging and Empowering Families, Coordinating Systems and Services, Building Community Capacity, all with an eye towards Shared Accountability among their local system partners. Each Family and Children First Council works collaboratively towards a vision that every child and family can thrive and succeed within healthy communities.

Ohio's Children's System of Care Providers	
Services	**Provided by:**
Care coordination for children who need services from multiple service systems	County-level Family and Children First organizations coordinate services for many children with multi-system needs. Additionally, staff employed by community behavioral health providers coordinate care for children with less complex needs who may also be accessing services (crisis intervention, case management, general services, etc.) from multiple organizations
Community behavioral health services and SAMHSA required elements of care	Local treatment providers provide the services. ADAMH Boards coordinate care at system level for their counties, and determine the non-Medicaid supports are available locally in addition, behavioral health Medicaid service array is available statewide.
Social services & employment services	County Job & Family Services provide employment, child welfare and social services/Title XX. Additionally, the Ohio Opportunities for persons with Disabilities provides some additional vocational and employment services.
Education	Schools with oversight from the Ohio Department of Education
Disabilities in education act (IDEA)	Local schools with technical assistance from Ohio Dept. of Education
Developmental Disabilities	Ohio Department of Developmental Disabilities oversees County-level developmental disability boards which may have local tax levies to provide additional services; developmental disabilities providers; local developmental providers offer services and supports to individuals with developmental disabilities and their families
Juvenile justice	Department of Youth Services, County Juvenile Courts, OhioMHAS community linkage social workers provide linkage to community behavioral health services for offenders being released from Department of Youth Services facilities. Ohio's RECLAIM, Targeted RECLAIM and Behavioral Health Juvenile Justice initiatives provide additional community supports for justice involved youth.
Medical & dental	Dental and Medical services are covered for eligible children and youths
Housing/foster care	Ohio Dept. of Job & Family Services; County Job & Family Services; Child welfare agencies; county juvenile court system all may be involved in providing these services. Ohio's new Bridges program extends foster care services for youth to the age of 21.
Behavioral health crisis services	State law requires Boards to assure local availability of crisis services from community behavioral health services; the new BH Medicaid array of services includes funding for crisis services.
Behavioral health crisis Provider Training	Providers and boards contractors
Case management	Providers certified by OhioMHAS to provide CPST (Community Psychiatric Supported Treatment)
Community mental health provider training	Providers, Boards, OhioMHAS, licensure boards, Coordinating Centers of Excellence, trade associations – all offer training.
Partial hospitalization	Partial hospitalization is provided by many larger children's behavioral health providers.
Residential Treatment	Job and Family Services funds residential services which frequently includes partial hospitalization services funded by Medicaid and/or ADAMH Boards
Psychiatric hospitalization	Provided by community, university and children's hospitals, and funded by Medicaid, other insurance and Boards. Ohio does not have public inpatient psychiatric services for persons under age 18.

ENGAGE (System of Care) – Engaging the New Generation to Achieve Their Goals through Empowerment (ENGAGE)

In July 2013, the Ohio Department of Mental Health and Addiction Services (OhioMHAS) received a four-year System of Care Expansion Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA). This grant, called ENGAGE (Engaging the New Generation to Achieve their Goals through Empowerment), follows a SAMHSA System of Care Expansion Planning Grant awarded to the State of Ohio in September 2011, the purpose of which was to develop a cross-system four-year strategic plan focused on expanding the System of Care framework for the target population. ENGAGE's target population is:

> Youth and young adults in transition (YYAT), ages 14 through 21 years, with serious emotional disturbance, who may have co-occurring disorders; and who are: a) at risk for involvement, currently involved, or previously involved with the child welfare or juvenile justice systems; or b) who may be at imminent risk of homelessness.

The purpose of ENGAGE is to reduce expenditures and improve outcomes related to physical and behavioral health, education, employment, and living stability for high risk youth and young adults through statewide System of Care expansion of the evidence-supported, research-based High Fidelity Wraparound practice.

At the end of SFY 2017 (June 2017), the ENGAGE grant has been implemented in 42 counties and enrolled approximately 155 youth into the High Fidelity Wraparound program. Over 350 counties child-serving public employees have been trained in High-Fidelity Wraparound.

Ohio's Children's Mental Health Service Providers

Ohio has a wide-range of providers that offer children's mental health services that are certified by OhioMHAS to provide outpatient services. Providers may have contracts to provide services with one or more ADAMH Boards, or be "Medicaid-only" providers. Some of these providers are also licensed by OhioMHAS to provide residential care, and some are also licensed to provide foster care by Ohio Department of Job and Family Services. Each Ohio community children's system of care is organized differently.

Many providers have evolved over the years to fill a community need, so children's systems of care overlap counties and vary widely among Ohio's Board areas. The service systems also vary widely in how integrated they are with primary health care, child welfare, juvenile justice and developmental disabilities. While many of these children's providers developed from community behavioral health care centers, some evolved from children's hospitals, community hospitals, family service providers, child guidance centers, orphanages and foster care providers to meet the needs of local communities. Most provide SUD treatment services, as well as mental health treatment. Some examples of Ohio's diverse children's providers include:

Community Behavioral Health Centers

- Woodland Centers, Inc. serves persons of all ages in a rural, Appalachian community. Services include out-patient mental health and SUD treatment services and school based services. http://www.woodlandcenters.org/childrens_programs.htm

- Child Adolescent Behavioral Health in Canton provides trauma-informed care, and has Trauma Focused Day Treatment. This agency became one of first five nationally accredited Transitional Age Service Department to provide services to older adolescents and young adults; it also employs young adult peer supporters. It provides Early Childhood Prevention, Consultation and Treatment for children 0 – 6, and as well as an ADHD Program. http://www.childandadolescent.org

Child Guidance Center

- Child Guidance and Family Solutions in Akron which provides mental health services, as well as Integrated Co-occurring Treatment (ICT) for co-occurring mental health, and SUD for children and youth. http://cgfs.org/about/index.php?id=12

Family Service Agencies

- Jewish Family Service Association of Cleveland evolved to provide mental health, intellectual and developmental disability, domestic violence, emergency shelter, older adult, home care and college financial aid services to children and adults of all faiths. Lutheran and Catholic Service Agencies provide similar services in many communities. http://www.jfsa-cleveland.org/

Former Orphanage Evolved into Children's Behavioral Health Provider

- St. Joseph's Orphanage in Cincinnati evolved into providing behavioral health care for children and residential care for children including those with physical and/or developmental disabilities in urban area. Services include crisis stabilization unit, day treatment, outpatient services, education, medication management, therapeutic foster care, CFPT (case management) and Transition to Independence (TIP). http://stjosephorphanage.org/

Foster Care Provider with Mental Health Services

- SAFY (Specialized Alternatives for Families) is a foster care provider in many Ohio communities that expanded into mental health care in multiple states including Alabama, Indiana, Nevada and Oklahoma. http://www.safy.org/

Rural Community Behavioral Health Centers located within Regional Medical Center

- Firelands Regional Medical Center - Outpatient and Recovery Services provides a full range of community behavioral health services to persons of all ages in seven rural counties in multiple Board Areas. Firelands is a hospital and regional health care provider for rural counties in northern Ohio. http://www.firelands.com/services/behavioral-health.aspx

Children's Hospitals

- Nationwide Children's Hospital provides community behavioral health services at multiple sites in the greater Columbus area, and inpatient psychiatric services for children and youth living in central Ohio. As a major pediatric hospital and medical center, it provides a wide range of primary and specialized care for children with cancer and other serious diseases. Nationwide Children's Hospital in Columbus is also one of the largest pediatric research centers in the United States with major grants from National Institute for Health. http://www.nationwidechildrens.org/behavioral-health

As these examples suggest, Ohio has 50 Board areas with diverse children's providers. Each community's system of care has evolved very differently, and has very different levels of integration with primary health care, juvenile justice, developmental disabilities, substance use disorders, schools, and child welfare.

Continuum of Behavioral Health Care for Children with SED

Ohio is beginning a process to redesign its behavioral health continuum of care for persons of all ages. Currently a continuum of care is provided for children with Serious Emotional Disorders (SED) or at-risk for SED is provided in a System of Care framework. Services include mental health and trauma assessment, crisis intervention, behavioral health counseling and therapy service, pharmacological management services, Community Psychiatric Supportive Treatment (CPST), or Partial Hospitalization. Residential services and foster care is available, and funded through County Job & Family Services. Intensive Home Based Treatment (team-based, time limited) home intervention is available in some areas and is now a Medicaid covered treatment. Despite the number of services, Planning Council consumers and family members describe gaps in services for children who need Intensive Home Based Services, High Fidelity Wrap Around, respite care, hospitalization, treatment foster care and/or other intensive services. The department uses the demonstration grants to address the identified gaps.

Community Mental Health Services - Eligible for Ohio Medicaid Reimbursement

Please see the description of Ohio's Behavioral Health Medicaid benefit services earlier in this document. Ohio does not offer state-operated inpatient psychiatric services for persons under 18. The ADAMH Board is responsible to ensure that inpatient services are available for children and youth under age 18. The board offers financial support as needed to the extent that resources are available.

Recovery support services which are not eligible for Medicaid reimbursement are:

- Therapeutic or Treatment Foster Care
- Residential Treatment Facility (RTF)
- Respite care- some respite provided under Medicaid
- Foster care
- Family/Youth peer support
- Information and referral

- Transportation services

Evidence-based and promising treatment services in Ohio include:

- Multi-systemic Therapy
- Intensive Home Based therapy- will be covered under Medicaid redesign
- Integrated Co-occurring Treatment (MH/SA for youth)
- Functional Family Therapy
- High Fidelity Wraparound
- Transition to Independence Process
- First Episode Psychosis (FIRST)
- Incredible Years

Most recovery supports, and some components of evidence-based practices are not eligible for Medicaid funding in Ohio. Block Grant, local tax levies, state General Revenue funds, are used to fund these services which are essential.

Initiatives to Improve Children's Treatment

OhioMHAS has statewide initiatives to improve services for children, youth, and transitional age youth/young adults, as well as many local initiatives to improve care led by Boards and providers. OhioMHAS' initiatives are funded by SAMHSA Block Grants and program specific grants, private non-profit organizations and the state legislature. In addition to funding specific initiatives, OhioMHAS uses Mental Health Block Grant to fund the Center for Innovative Practices (CIP) of Case Western Reserve University. CIP offers technical assistance and training to providers to implement specific evidence based and promising practices including Multisystemic Therapy (MST), Intensive Home Based Therapy, and Integrated Co-occurring Treatment and High Fidelity Wraparound (Funded by ENGAGE) For prevention and early intervention initiatives, please see the previous section of this document. Ohio' statewide initiatives which address treatment for children include:

Promoting Evidence-Based Care

Through direct staff consultation and with the guidance and training resources of the Bureau of Children and Families works with clinicians, agencies, and boards to disseminate therapeutic best practices. These practices are guided by theory, research and practice in the preventive areas of family support, early childhood intervention, and children's mental health treatment. These practices promote and enhance resiliency, improve outcomes/functioning level, and the behavioral health and wellbeing of children, parents, and families. Intensive home and community based treatment practices including but not limited to Multisystemic Therapy,

Trauma-Informed Care, High Fidelity Wraparound, PAX Good Behavior Game, CBT, Incredible Years and Early Childhood Mental Health consultation are emphasized.

Early Childhood Initiatives

Maternal Depression

Perinatal Depression encompasses a wide range of mood disorders that can affect a woman during pregnancy and after the birth of her child. It includes prenatal depression, the "baby blues," postpartum depression, and postpartum psychosis. Of the many risk factors that impact a baby's failure to thrive, maternal depression and stress are significant factors. Please see the Prevention and Wellness section for a more complete description of this work.

Devereux Multi-Tiered Evaluation of the Effectiveness of the FLIP IT Parent Training Model

In response to the Ohio Department of Mental Health & Addiction Services' request for an evaluation, Miami University's Center for School-Based Mental Health Programs (CSBMHP) conducted an empirical evaluation of the FLIP IT parent training program to determine its effectiveness. A total of 321 parents/caregivers (representing a total of 430 children) provided quantitative survey data and qualitative focus group/interview data about the effectiveness of the FLIP IT training model in decreasing negative social, emotional, and behavioral outcomes and increasing positive social, emotional, and behavioral outcomes among participants' children. Data were collected at baseline (before receiving the FLIP IT training) and at three post-training follow-up time points (immediately following training, 3 months later, and 6+ months later). Overall Results.

Based on the results of this evaluation, the FLIP IT parent training model appears to be an effective parenting method for decreasing children's behavior problems, anxiety, depression, withdrawal, somatic complaints, delinquent behavior, aggressive behavior, and developmental problems; and increasing children's abilities to use independent thought and action to meet his/her needs (initiative), to express emotions and manage behaviors in healthy ways (self-regulation), and to promote and maintain mutual, positive connections with other children and adults (attachment/relationships). In addition, the FLIP IT steps appear to be an effective parenting method for decreasing inconsistent or permissive parenting strategies, harsh or punitive parenting strategies, parent/caregiver distress levels, dysfunctional interactions within the parent-child relationship, and parental beliefs that their children are difficult to manage.

In focus groups and interviews, parents/caregivers described being overwhelmingly satisfied with their overall FLIP IT experience, the FLIP IT training session, and the FLIP IT steps/parenting skills that they learned. They described learning new parenting skills that fit with their own personal parenting style and that they are using (either often or sometimes). Although

they identified some challenges with implementing the skills, when asked if they and their families experienced positive outcomes, an overwhelming 100% of comments described positive outcomes. There was also a strong desire from parents/caregivers for follow-up (such as coaching or booster sessions) to further enhance and hone their skills that they have learned.

Dads Matter Program Evaluation Promising Practice:
A Two-Generation Peer Approach to Improved Parenting

OhioMHAS provided funds to pilot and conduct an evaluation of the DADS MATTER curriculum offered at three different locations. Workshop trainers hired to provide this curriculum offered peer support and tools to help fathers become more engaged parents. Early childhood research emphasizes the importance of the parental role as a child's primary educator. Enrolling children in quality preschools and parent involvement have been shown to be key factors supporting kindergarten readiness. The DADS MATTER curriculum supported these outcomes by teaching fathers how to become more involved in early literacy effects that are predictive of children's school success. This curriculum aimed to increase father involvement in at-risk families through workshops that educate fathers on being present and contributing to their child's life by reading, library involvement, playing cards or educational games, engaging in their child's formal education, and knowing what programs their children are watching on TV or through other electronic media sources. This evaluation summarizes the results of the DADS MATTER curriculum by comparing self-reported datasets before the program started and after the program concluded. The DADS MATTER evaluation has two primary purposes:

- To explore the effectiveness of DADS MATTER on participant's behaviors towards their children
- To establish outcomes and impacts for DADS MATTER.

Results suggest that the DADS MATTER program produced motivational improvements for fathers becoming more involved with their children's lives. Specifically, improvements were found for listening to the child read, reading to the child, going to the library to retrieve more books, inter- acting with the school teacher about the child, and playing games (board games and card games) with the child. The findings support the use of this program to enhance parental involvement in their children's lives and provides continued evidence of its effectiveness.

Childhood Trauma and Toxic Stress Demonstration Projects

OhioMHAS Funds Child Sexual Abuse Early Intervention/Prevention Collaboration Demonstration Project implementation has begun! The project is helping to prevent and reduce trauma in children ages 3-8 who are victims of sexual assault/abuse. Five Projects across the

state have completed the Stewards of Children training which is an evidence-based Child Sexual Abuse Prevention training. The program raises awareness of the prevalence and consequences of child sexual abuse by educating adults about the steps they can take to prevent, recognize and respond to appropriately to child sexual abuse. Hopewell staff has implemented Parent Child Interaction Therapy (PCIT) and are training adults on Child-Adult Relationship Enhancement (CARE), a trauma-informed, field initiated training developed by the Trauma Treatment Training Center for general usage by non-clinical adults who interact with children with a history of trauma. Early Childhood Therapists have provided evidence-based Child Sexual Abuse Prevention trainings with a reinforcement activity, for children enrolled in Head Start program through Body Safety Trainings. Adults have been trained using the Stewards of Children Curriculum equipping them to recognize and respond appropriately to Child Sexual Abuse thereby supporting the reduction of trauma in children caused by sexual abuse. The Projects also partners with local CPS' to provide rapid response intervention and treatment to identified victims of substantiated child sexual abuse birth to age 8. The Department seeks to expand these successful projects statewide on the coming years.

Whole Child Matters Early Childhood Program

Following the success of Ohio's role in the Early Learning Challenge Grant - Race to the Top, the efforts OhioMHAS in early childhood mental health rose to national prominence as leader in addressing early childhood social and emotional wellness and reducing preschool expulsion rates. To continue achievements toward a sustainable future for Ohio's families with young children, Ohio's Governor Kasich's Office of Early Learning supported critical programs previous funded by the Early Learning Challenge Grant, including a proposed expansion of the Early Childhood Mental Health (ECMH) workforce his FY 16-17 biennial budget. OhioMHAS was awarded $2.5million dollars in each of the biennium in support of his expansion of publicly funded preschool slots to four-year-old to support and better retain high need children at risk of behavioral destabilization. Based upon the strong response buy the providers to this planned early childhood workforce expansion, the Governor's Office has supported increasing this allocation to $9.1M to assure that all aspects of the program can be implemented to fidelity. The early childhood mental health counselors utilize the evidenced based Georgetown Model (New Ohio/Georgetown Model) to support Early Learning Centers, Head Start and Licensed Child Care Providers with techniques and assessment to improve classroom management, utilizes positive behavior support and positively manage challenging behaviors to support children's success in their early learning environments. The expanded funding will also support a statewide centralized intake component in which parents, preschool and kindergarten teachers can call for an in person ECMH consultation within 48-72 hours.

The expanded funding will support up to 70 ECMH consultants providing consultation and support to 70 counties across Ohio with an emphasis on social foundations of wellness which

serves to support the prevention of episodes of preschool expulsion. New science regarding early brain development, early childhood prevention and early intervention programs and educational technology gained through from the Early Learning Challenge Grant is fully implemented in this expanded new program. [1] [2] [3] [4] (Note: ECMH does not receive Block Grant funds)

Healthy Students & Safe Communities

Strong Families, Safe Communities

Governor Kasich and the State of Ohio are committed to improving care coordination and providing support for families with children in crisis who present a risk to themselves, their families, or others because of mental illness or a developmental disability. Many children who are at risk are not engaged in treatment programs and may not be known to the community until a crisis unfolds. Care coordination and targeted crisis intervention services can quickly stabilize a child's health. Support for these families in need will reduce risk of harm and help the family remain together. During spring 2013, the Ohio Departments of Developmental Disabilities (DODD) and OhioMHAS sought collaborative community proposals to establish treatment models of care that focus on crisis stabilization for children with intensive needs. This initiative has engaged local systems to identify community-driven solutions that highlight collaboration across agencies to develop the best possible outcomes for children and families.

In 2013, DODD and OhioMHAS announced awards of nearly $3 million to seven community partnerships to implement the Strong Families, Safe Communities project and to provide care coordination and crisis intervention services for youth at risk of harming themselves or others due to a mental illness or developmental disability. In addition to the grant awards, the project provided training for mental health and developmental disabilities services professionals in crisis intervention. The Governor's recommended budget for SFY 2018-2019 intends to continue this work with $4 million in state funding. A new competitive Request for Proposals will select new (and returning) collaborative projects across the state.

During FY 2016-2017 the Strong Families, Safe Communities grants were awarded to 14 projects – 7 new and 7 continuing - with cross-system collaborations occurring in 42 counties. Funded projects included a wide range of services and the establishment of a keyword partnership with the National Crisis Text Line organization. Services include early identification of at-risk youth, crisis response, intensive service coordination, crisis and planned respite, therapeutic mentoring, wrap-around services, family support and education, and individual/family treatment using trauma-informed approaches. Additionally, most projects

[1] https://youtu.be/0_FabszsihA
[2] https://youtu.be/wi-VA8uuWsE
[3] https://youtu.be/-yyaCVUsFQI
[4] http://mha.ohio.gov/Default.aspx?tabid=279

included training components intended to support professional development, organizational shifts and system transformation. Training topics included Trauma Informed Care, Strengthening Families, Virginia Student Threat Assessment Guidelines, Integrated Family and Systems Treatment, Youth Mental Health First Aid, Critical Incident Stress Management and safety planning.

Safe Schools/Healthy Students

The goal of Ohio's SS/HS project is to improve access and availability of evidence-based prevention and mental and behavioral health services with school-based and community-wide strategies that prevent violence and promote the healthy development of children and youth. The project is a partnership between OhioMHAS, Ohio Department of Education, other state departments and three local education agencies in rural counties including Greene County Educational Service Center, Northwest Ohio Educational Service Center in Williams County and Harrison Hills City Schools in Harrison County. The partnership has provided community-based models, comprehensive integrated plans which provide effective behavioral health services and prevent youth violence. The focus has been to promote healthy social/emotional development and to build safe and healthy family, school and community environments using the findings of the 2009 Institute of Medicine Report (IOM).

Through collaboration of schools, communities and the state, communities are better able to achieve population level outcomes through the implementation of evidence based programs related to the health and wellbeing of residents. The Ohio SS/HS project provides a forum where local SS/HS partners can review state-of-the-art information, express views on critical policy questions and build an infrastructure to address their community's needs. The project is making progress towards meeting the projects goals and objectives including training SS/HS local communities to build assessment capacity and use data to implement evidenced-based and promising practices. These practices include Early Childhood Social and Emotional Learning and Development; Trauma Informed Care; Youth and Family engagement; Positive Behavioral Interventions and Supports (PBIS) framework; PAX Teacher Training. The project developed a collective impact plan, as well as a public value proposition that connects behavioral health, substance use and violence prevention with academic attendance and disciplinary outcomes. Ohio SS/HS successes can be highlighted as follow:

1) The PAX Good Behavior Game program, an evidenced base practice continues to promote early childhood social and emotional learning.
2) The project fully met its objective to increase the number of students who receive these services, and community referrals increased.
3) The LEAs increased the use of data in making decisions.
4) Participating schools completed the OHYES! student needs assessment which will provide data to schools, local health and human service agencies.

5) Ohio SS/HS developed an infrastructure and capacity for grantee schools and communities to plan and implemented school safety plans and violence-prevention evidenced-based practices.
6) The number of people trained on practices that prevent violence in the schools has increased.
7) The State revised its Behavioral Health Disparities and Impact Statement and Strategies to include its activities and progress in meeting its benchmarks.
8) Local SS/HS communities continue to analyze behavioral health disparities within their schools using benchmarks in consultation with Ohio's Disparities and Cultural Competency (DACC) Advisory Committee.

Mental Health First Aid in Schools

Ohio Department of Education has a Mental Health First Aid capacity building initiative that is funded by a SAMHSA/CMHS grant from 2014 – 2019. Through the "Making Ohio AWARE: Building Statewide Mental Health First Aid Capacity" initiative, Ohio will develop a modern, enhanced infrastructure to raise awareness of mental health needs among school-aged youth and increase statewide and local capacity to develop, implement, and sustain the delivery of integrated, comprehensive, evidence-based mental health and behavioral health services for youth and families. The efforts will occur through collaborative partnerships between the Ohio Department of Education, three partnering Local Education Agencies (Cuyahoga County, Warren County, and Wood County Educational Service Centers), State Management Team, the Center for School-Based Mental Health Programs, the Ohio Mental Health Network for School Success, and other state departments. The project will promote a comprehensive and coordinated system for promoting wellness, safety and resilience built upon foundations of Positive Behavior Interventions and Supports, Safe Schools, and other support programs. Cross-sector assets and resources will be leveraged to build and support an effective interconnected systems workforce by increasing the number of individuals trained to deliver Youth Mental Health First Aid (YMHFA; 3 SEA trainers and 9 LEA trainers), the number of first responders trained in YMHFA (750 trained yearly and 3,750 trained throughout the project), and youth access to mental health services (for at-risk students identified within the 30 districts). The initiative will use data to inform decision making, emphasizing state-wide capacity building for evidence-based innovations. Across the project objectives, a key aspect in the success will be engaging youth, families, and schools as agents of community change. It is anticipated that achievement of project goals will enhance system capacity and strengthen partnerships by providing documented effective community-based models for other communities wishing to adopt comprehensive, integrated mental health promotion.

Suicide Prevention

See Prevention and Early Intervention for a description of Ohio's Suicide Prevention initiative which addresses persons of all ages.

Initiatives to Benefit Youth and Young Adults Receiving Services

First Episode Psychosis

The First Episode Psychosis (FEP) initiative offers evidence-based treatment to youth and young adults ages 15 – 35 who are have experienced their initial episode of psychosis. The treatment approach is team based and includes: specific medication protocols, family education and support, supported employment/education, case management/recovery coach, Cognitive Behavioral Therapy for Psychosis (CBT-P), and may include Peer Support along with other specialized interventions. The teams are person centered, and focus on the goals of the individual client as related to education, work and quality of life. Treatment interventions begin within 18 months of the initial onset of psychosis. OhioMHAS' initiative funds seven programs using the Coordinated Specialty Care model that serve seventeen counties throughout Ohio with a goal of expanding availability to all regions of the state. See the Environmental Factors section of this application for a detailed description of Ohio's FEP programs.

YouthMOVE Ohio

A major service gap in Ohio is youth involvement in the mental health system of care in a way that empowers youth to be able to advocate for themselves and for system change. OhioMHAS is committed to bridging this gap by collaborating with National Alliance on Mental Illness (NAMI) Ohio, which serves as the administrative agent for YouthMOVE Ohio. This program expands, enhances and ultimately sustains the growing voice of youth with lived experience in behavioral health, child welfare, and juvenile justice systems through the development of a YouthMOVE statewide infrastructure which will consist of a network of local YouthMOVE chapters in counties throughout Ohio. By providing recommendations from the youth voice, this program aims to meet young people's needs and ultimately help transition successfully into adulthood with productive, meaningful lives.

YouthMOVE Ohio with support from OhioMHAS will continue to identify agencies/organization to host local YouthMOVE chapters who will receive training and technical assistance on the establishment of a successful chapter. YouthMOVE will continue the youth state leadership council with representation from five regions in the state to provide direction for YouthMOVE Ohio.

NAMI-Ohio

NAMI-Ohio collaborates with YouthMOVE, and has a business agreement with the Ohio Federation for Families of Children with Mental Illness which has a SAMHSA grant to network families of children with serious emotional disturbances. Parent/family education groups are available in many communities throughout Ohio through local NAMI chapters which receive technical assistance and training through NAMI-Ohio. NAMI educational groups include Basics, "*a signature educational program for parents and other caregivers of children and adolescents living with mental illness. The NAMI Basics course is taught by trained teachers who are the*

parents or other caregivers of individuals who developed the symptoms of mental illness prior to the age of 13." http://www.namiohio.org/mental_health_support/basics. Additionally, a similar Family-to-Family is available which focuses on schizophrenia, bipolar disorder and major depression. Additionally, NAMI Family Support groups are available in many communities.

Ohio Adolescent Health Partnership (OAHP)

OhioMHAS is a key partner in the OAHP. The OAHP is a diverse group of agencies, organizations and individuals with expertise in adolescent health and wellness, with the common goal of supporting optimal health and development for all adolescents. By encouraging cooperation, communication and collaboration among the programs, institutions, communities and individuals dedicated to adolescent well-being, the OAHP will be uniquely positioned to provide leadership for local and statewide efforts to make progress in priority areas of adolescent health. OAHP has defined the target age range as 10-24 years.

Behavioral health is a key adolescent health issue area that combines the subjects of mental health and SUD under the umbrella of behavioral health due to their interconnectivity. An adolescent's ability to cope with stressors, be resilient, and practice sound judgment is imperative to supporting good mental health. The development of these skills and attributes can be affected by brain development as well as pre-existing mental health problems and SUD.

Goals identified by the OAHP with leadership from OhioMHAS are:

1. Rates of SUD and abuse of alcohol and other drugs will decrease among adolescents;
2. Behavioral and physical health services for adolescents will be more fully integrated to improve access and quality of care.

Adolescence is a unique developmental time in the lifespan of every individual. It is a time characterized by distinct and dramatic developmental, physical, social, emotional and intellectual changes. The physical and emotional changes that take place in adolescence are second only to the extensive changes that take place in infancy. Many lifestyle behaviors that contribute to or reduce risk for disease and disability in adulthood are developed in adolescence.

Integrating Behavioral Health into Other Systems

Trauma-Informed Care

OhioMHAS continues to support a statewide effort on use of trauma-informed care (TIC) approaches in collaboration with the Department of Developmental Disabilities (DODD). The target audience for this initiative includes individuals in the mental health, addiction and/or development disabilities systems, and the staff that are responsible for their treatment and support. This work is described in the Overview section as a major initiative for multiple populations, as well as the Environmental Factors, (13) Trauma.

Pediatric Psychiatry Network (PPN)
This network addresses the shortage of child psychiatrists by having psychiatrists at Ohio's medical schools provide "curbside clinical psychiatric consultation" to pediatricians, family practice physicians, physician's assistants, advance practice nurses and other prescribing level providers who manage behavioral health conditions in children and youth within their local communities. Benefits include reduced wait times, earlier treatment which reduces morbidity and mortality, improved communication among the child's providers and reduced isolation of rural providers. PPN is a partnership between OhioMHAS and Academic Psychiatry Programs and affiliated Children's Hospitals. Cincinnati Children's Hospital houses and staffs the centralized call center. Nationwide Children's, Akron Children's, University of Toledo, Cincinnati Children's Hospital and Wright State University donate their time to take these calls and/or provide clinical expertise to PPN.) Additionally, Ohio Chapter of the American Academy of Pediatrics and the Ohio Family Practice Association market the program to their members. Ohio Department of Health also promotes the use of PPN and partnership in developmental and behavioral health public health efforts throughout the state which includes NAMI.

Behavioral Health Juvenile Justice Projects
The Behavioral Health Juvenile Justice (BHJJ) initiative, a shared effort of the Ohio Department of Mental Health and Addiction Services (OhioMHAS) and the Ohio Department of Youth Services (DYS), was created to enhance local options for providing services to juvenile offenders with serious behavioral healthcare needs. Pilot projects that started in a few Ohio counties in early 2000 have grown into a statewide initiative with strong support from state and local stakeholders.

The projects are designed to transform child-serving systems by enhancing their assessment, evaluation and treatment of multi-need, multi-system youth and their families. In addition, they provide the Juvenile Court judges an alternative to incarceration, which has been a key to their success. The community projects have shown significant positive impact on youth admissions to DYS facilities and positive outcomes reported at the time of program completion.

The projects serve youth ages 10-18 with a current DSM diagnosis and substantial impairment in behavioral, cognitive and/or affective domains. Most of the youth enter their local program with co-occurring SUD, a history of violence and/or criminal behavior, history of exposure to trauma and/or domestic violence and history of involvement in multiple systems.

The BHJJ projects are required to provide evidence based interventions (e.g. Multi-systemic Therapy, Hi- Fidelity Wraparound) and to engage the youth and their family/support systems in the treatment process. Many of the treatment services are provided in the youth's home and are intensive interventions. Providers are required to address the cultural and ethnic population that

their county has historically admitted to Department of Youth Services (juvenile justice system). Although each program is different and based on local needs and resources, each program offers assessment, evaluation, and coordination of appropriate services and supports for the youth and their family.

The Begun Center for Violence Prevention Research and Education, Mandel School of Applied Social Sciences at Case Western Reserve University has been engaged to evaluate the BHJJ initiative. The staff works very closely with each county to ensure that their project data is collected and is shared in a way that is useful to that community and the state departments.

Summary

Ohio has local, overlapping systems of care serving children (and their families) with serious emotional disturbance, some of whom have co-occurring SUD. Each local system of care has multiple providers; some of these providers also provide primary health care, addiction treatment services, or foster care for the child welfare system. Mental Health Block Grant funds a portion of these services, and programs to improve services. Programs funded under these grant projects are building statewide comprehensive, integrated data-driven strategic plans that will prevent and mitigate the seriousness of behavioral health problems for infants, children, youths and families.

Strengths

- Provider network is strong, diverse and integrated into community systems of health and social services for children and youth in most Ohio communities
- High treated rate of prevalence – top 5 state for treated prevalence of children in Mental Health of America study
- Implementation of evidence based and promising practices in many Board areas including multi-systemic therapy (MST), Intensive Home Based Treatment, Integrated Co-occurring Treatment (ICT), Functional Family Therapy (FFT), Wraparound System of Care, and Transition to Independence Program (TIP)
- Organized mental health youth consumer organizations partner with youth-led drug free coalitions
- Statewide transitional age youth/young adult system of care under development
- Family and youth engagement

Needs

- Specialized services for children with intensive service needs are not sufficiently available. While the Medicaid benefit is being modernized to provide Intensive Home Based Treatment, other intensive services such as. high fidelity wraparound is not eligible for Medicaid reimbursement and are not available in all communities.

- Shortages of child psychiatrists; OhioMHAS is supporting the Pediatric Psychiatry Network to facilitate consultation for pediatricians and family practitioners who are prescribing psychiatric medication.
- Major differences in funding among local systems of care; these include some systems of care in rural and Appalachian areas without some of the specialized services needed by children with high levels of need. OhioMHAS is addressing these differences through the Continuum of Care work described in the first section. Ohio has prioritized rural and Appalachian counties in the State Youth Treatment Planning Effort for youth with SUD and with CURES Act funding.

(4) Mental Health Services for Adults with Serious Mental Illness

System of Care

System of Care for Adults with Serious Mental Illness (SMI)

Ohio's behavioral health system for adults is similar to the children's behavioral health system. It also operates on a public health approach that builds upon established collaboration of state agencies and county ADAMH Boards which plan, coordinate and fund services in 50 local Board areas. Additionally, regional medical centers, university hospitals, nursing facilities and other health care providers are also a part of this system of care. At the state level, the OhioMHAS Medical Director's Office and the Office of Treatment and Recovery provides leadership for **treatment services and recovery supports for adults and older adults with serious mental illnesses.** Statewide interagency coordination among health agencies is led by Ohio Office of Health Transformation which coordinates the activities of the health and human services agencies. The Ohio Department of Medicaid is also a leader, as it funds many of the services regulated by other state health and human service agencies.

Providers and communities also shape service delivery systems in Ohio. Ohio has a diverse network of providers in which providers have evolved to meet community needs. Most communities have multiple providers for less intensive services, which provides choice to persons seeking recovery.

Ohio Adult and Older Adult System of Care Providers	
Adult SMI Services	**Provided by:**
Mental health treatment, and treatment for co-occurring SUD	Community behavioral/mental health care centers with integrated care centers in some parts of the state. Also, includes some Medicaid-only providers, regional medical centers, federally qualified health care centers (FQHC).
Case management	Community behavioral/SUD with some integrated care centers
Behavioral health crisis services	State law requires Boards to assure local availability of crisis services from community behavioral health services; training of workers is the responsibility of the providers and boards.
Peer support	Provided by approximately operated services, as well as by some community mental health service providers
Employment Services	Some community behavioral health services provide Supported Employment which have four OhioMHAS staff to provide regional technical support. Also, provided by Job and Family Services, and Ohio Opportunities for Disabilities
Social Services	Ohio Department of Job and Family Services provides child welfare and social services/Title XX.
Developmental Disabilities	Provided by developmental disability (DD) providers with funding by county DD Boards which may collaborate with ADAMH Boards
Criminal Justice	OhioMHAS provides community linkage to treatment & recovery resources to persons with SMI leaving prison; Ohio Dept. of Rehabilitation and Corrections provides mental health services within prisons. Most communities have specialized dockets which divert offenders into treatment.
Medical & dental	Usually provided by referral; medical services provided by some integrated health care centers and Federally Qualified Health Care Centers (FQHC)
Housing	OhioMHAS licenses serviced enriched housing, group homes and foster homes, crisis care and transitional housing. Availability varies by community.
Psychiatric hospitalization	Provided by community and university hospitals licensed by OhioMHAS, and 6 regional ("state") psychiatric hospitals operated by OhioMHAS
Recovery Requires a Community (also known as "Home Choice")	Provides additional funding and care coordination for persons with disabilities (including mental illness) and older adults who want to move from a nursing facility to home and community-based settings
Older Adult Services	**Providers of Older Adult Specific Services**
Medicare/Medicaid Managed Care	Demonstration program in 29 counties for managed care benefits for dual eligible for Medicare/Medicaid
Twelve Area Agencies on Aging	Respond to the needs of older adults as advocates, planners and funders. Services include in-home care, long term care consultation, PASSPORT (in-home care for persons meeting nursing facility levels of care), residential services and services coordination. See also programs for adults.
Older Adult Behavioral Health	Older adult specific programs available in some communities
Services for Homeless	**Providers in Addition to SMI Providers**
Outreach services	Community mental health centers and housing service providers funded by (SAMHSA funded) PATH program provide outreach services to homeless persons with SMI and co-occurring substance-use disorders funded by SAMHSA grant.
Housing	Ohio Department of Development, Metropolitan Housing Authorities, community shelter board

Community Mental Health and Behavioral Health Service Providers

Ohio has a diverse provider network of organizations. OhioMHAS certifies 188 community providers for mental health services and 244 providers for both mental health and SUD services. A few organizations provide integrated primary care, dental and pharmacy services; most coordinate care with primary care providers. Some consumer housing providers and consumer

operated services are certified for a single service. Providers also include a regional community hospital in a rural area has expanded into community mental health care, as well as a behavioral health care center has become a FQHC and opened a pharmacy. In another community, a family service provider has expanded to provide services to persons with serious mental illness, developmental disabilities and older adults. A representative group of providers is provided to illustrate the diversity of providers certified by OhioMHAS to provide adult community mental health services.

Community Behavioral Health – Appalachian/Rural
Rural SMI in Multi-County Area

- Scioto Paint Valley Mental Health Center is a group of six treatment centers that offer mental health and addiction services to residents of all ages in five rural counties, three of which are in Appalachia. (Ross, Fayette, Highland, Pike and Pickaway Counties). In Pickaway County, it is the only provider certified by OhioMHAS for mental health services, while the other four counties each have two or more providers. Services offered include a full continuum of mental health and substance abuse services. http://www.spvmhc.org/

Regional Medical Center – Community Behavioral Health – Rural
SMI Provider in Rural Area with SAMHSA Supported Employment Grant

- Firelands Regional Medical Center operates community behavioral health services in a seven-county area in northeastern Ohio, and provides a full continuum of care of mental health and substance abuse services; services are offered to Spanish-speakers and deaf and hard-of-hearing persons. Firelands provides Supported Employment, as one of the two sites funded by a SAMHSA Supported Employment Grant to OhioMHAS. http://www.firelands.com/services/behavioral-health.aspx

Behavioral Health – Suburban with Rural Expansion - First Episode Psychosis

- Coleman Professional Services, 5982 Rhodes Road, Kent, OH 44240 is certified by OhioMHAS to provide mental health and SUD services in eight counties across northern Ohio, as well as providing services to developmentally disabled persons and older adults with dementia and physical limitations. In addition to these services, Coleman has diversified into providing employment, social services, rental management, adult day, consultation, data solutions, Bean the Baker, and pregnancy support services. Coleman provides First Episode Psychosis Services, Youth Transitional Services and a Jail Diversion Program for people with mental illness http://www.colemanservices.org/

Integrated Healthcare – Federally Qualified Health Care - Urban & Appalachian
Specialty SMI Services: Homeless, Older Adults, HIV+, Dual Diagnosis (SUD or DD)
SUD Services Includes Medication Assisted Treatment

- Southeast Healthcare Services began as a community mental health center in Columbus that expanded into SUD treatment, medication assisted treatment, employment services and became a Federally Qualified Health Care Center with a pharmacy. Southeast has specialized programs for older adults, sex offenders, perpetrators of domestic violence, and persons with serious mental illness who are HIV+. It also has an art gallery which displays the work of persons with serious mental illness with the goal of decreasing stigma. http://www.southeastinc.com

Family Service Agency/Community Mental Health
Specialty Programs: SMI, Older Adults, Developmental Disabilities, Domestic Violence

- Jewish Family Service Association (JFSA) of Cleveland provides community-based comprehensive services for persons of all ages with intellectual disabilities and mental illness regardless of religious affiliation. Services include housing, clinical services, recreational services and family support services. JFSA also provides specialized services for older adults to maintain independent living, as well as services for teens and families experiencing domestic violence. JFSA also operates a medical clinic to provide integrated health care to the persons it serves. http://www.jfsa-cleveland.org/

Consumer Operated Service (COS) – Mental Health – Urban
Specialty: Peer Services for SMI

- Thomas M. Wernert Center, Toledo, Ohio, certified by the Ohio Department of Mental Health to provide Consumer/Peer Operated Service (and no clinical services) to persons with SMI who may also have co-occurring SUD. Most of the Board and staff are mental health consumers who determine what is offered. Activities and services include Wellness Recovery Action Plan (WRAP), Depression, Bipolar Support Association (DBSA), Diabetes Support, anger management, yoga, Get Fit Club and a variety of peer support, educational and social activities. http://wernertcenter.org/

Housing Provider– Behavioral Health – Urban & Rural – PATH Homeless program

- Neighborhood Properties Inc. (NPI) provides housing services and adult care to persons with mental illness and SUD in greater Toledo with the goal of ending homelessness. It owns 565 apartments in 62 locations in northwest Ohio and expanded into administering an Adult Care Facility Program which serves more than 100 consumers. Programs include permanent supportive housing, homeless outreach (SAMHSA funded PATH program), homeless families, a fresh start for single mothers, young adults, and young adults with criminal justice involvement, homeless veterans, chronically homeless and Road to Recovery for persons with Substance Use Disorders. NPI also operates a service-rich environment program for difficult-to-place persons from rural counties in northwest Ohio which provides staff 24/7. http://www.neighborhoodproperties.org/

Crisis Stabilization/Pre-Screening - Urban

- Netcare Access provides 24-hour emergency services for mental health and SUD, as well as crisis intervention, and assessment for adults, older adults and children. This agency has been designated as the primary intake for SMI in Franklin County and specializes in assessments, crisis services, crisis stabilization, court ordered evaluations. and pre-screening for involuntary hospitalization. Additionally, a crisis stabilization unit provides an alternative to psychiatric hospitalization; persons may stay up to seven days. This provider refers to community behavioral health providers for ongoing care for persons with SMI and/or SUD www.netcareaccess.org

Community Hospitals

OhioMHAS licenses community hospitals with private psychiatric units which provide inpatient psychiatric services to adults. In SFY 2015, about 32,000 persons funded by Medicaid or public funds were admitted to one of Ohio's 87 community hospitals, as compared to 6,000 persons in state hospitals. Many Boards have contracts to fund psychiatric hospitalization for indigent persons, as well as contracts with crisis stabilization units (for up to seven days). Ohio's psychiatric inpatient providers include community hospitals with psychiatric units, free standing psychiatric hospitals and university affiliated psychiatric units. Most Boards reserve OhioMHAS psychiatric hospitals for the difficult-to-know-how-to-treat patients and those on forensic status.

OhioMHAS Operated Regional (state) Psychiatric Hospital (RPH) Care

OhioMHAS operates regional psychiatric hospitals (RPHs) in six locations across the state. Sixty-nine percent of the current patients are receiving court-directed services, and 31% are on voluntary status. Additionally, they provide short-term, intensive mental health and addiction treatment to inpatients, and provide some outpatient care through community support network teams. These hospitals provide evidence-based treatment including trauma-formed care. These hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), and work with county Boards and community providers.

OhioMHAS Operated Services to Reduce Institutionalization

Facilitate State Hospital Discharge: *Access Success*

Access Success funds are one-time, short-term OhioMHAS funding that support a patient at discharge from a state-run psychiatric hospital. They are used to meet the needs of the individual for housing, food, clothing, furnishings and other basic items, allowing for a smooth transition back into his or her community. Funds can also be used to obtain therapeutic services or devices which help the patient maintain stability. The goal of the program is to help the patient address needs between the time of discharge and their eligibility for other benefits.

Reduce Institutionalization: ***Pre-Admission Screening and Resident Review (PASRR)***
PASRR is a federal mandate that requires all states screen applicant seeking admission into, or to remain in a Medicaid-certified nursing facility (NF) for indications of serious mental illness (SMI), and or intellectual disabilities/related conditions (ID/RC). The federal intent is to prevent any inappropriate institutionalization. Implementation of the PASRR-SMI program allows OhioMHAS to advocate that individuals diagnosed with SMI (with or without co-occurring SUD) are provided the choice to access needed services in the most inclusive, least restrictive environment in accordance with the Olmstead decision issued by the US Supreme court in 1999. The state assesses and issues determinations on PASRR-SMI applications seven-days a week in response to an increase in demand. During 2016 OhioMHAS issued 11,296 decisions, completed 6,220 assessments with an average turnaround time of 1.4 business days.

Facilitate Move from Institution to Community: ***Recovery Requires a Community***
Recovery Requires a Community provides flexible funding and care coordination to assist persons who are choosing to move from institutions into the community. It addresses gaps in funding for persons leaving nursing homes, prisons and other institutions and supports Ohio's implementation of the Olmstead court decision. Community behavioral health services provide longer term services with funding for recovery supports from ADAMH Boards. At the state level, this is a financial partnership between the Ohio Department of Medicaid and OhioMHAS which is part of the Money Follows the Person work.

Forensic Monitoring Facilitates Community Living for Persons on Conditional Release
Forensic monitoring assists people who have a severe mental illness and who have been granted conditional release by the court to live successfully in the community and work toward recovery through the provision of behavioral health and risk management services. Forensic Monitors assist SMI patients' discharge to the community from hospitals and support their ongoing treatment in the community. The Forensic Monitors ensure that treatment is being provided in accordance with the conditional release plan. They coordinate with service providers, housing providers, the courts, and hospitals if necessary. They ensure that risk assessments are being conducted and that risk management strategies are being implemented to enhance patient and community safety.

(4 &5) Recovery Support Services for Community Mental Health and Substance Abuse Disorders

Recovery support services are the non-clinical services such as housing, employment, peer support and transportation that are essential to the recovery of many individuals from a serious mental illness. The ADAMH Boards fund recovery supports with local tax levies, as well as state and federal funds from OhioMHAS. ADAMH Boards also promote partnerships with schools, employers, human services, health care providers, courts, law enforcement and other organizations which provide services and supports for persons recovering from SMI and SUD. collaboratives for recovery supports. OhioMHAS awards federal PATH funds to Boards with the highest homeless populations, and funds housing and some employment services.

Peer Recovery Support

Peer Recovery Support (PRS) inspires hope of recovery by sharing lived experiences that foster interpersonal connections between peers. PRS also empathizes with the pain of isolations with other while providing positive person driven support. Peers assist in exploring options and overcoming barriers which may be preventing individuals from moving forward in their recovery.

Peer Run Organizations (PRO) are agencies that promote and implement peer recovery. They are primarily staffed by persons with lived experiences, and provide social support services to individuals of all stages of the recovery process. There are venues in which persons with lived experience with mental illness and/addictions can visit, be a part of and participate on levels in which they are comfortable. PRO are typically "not for profit "and provides advocacy and an array of wellness and recovery based services.

Peer Support Services:

- Reduce symptoms and hospitalizations
- Increase social support and participation in the community
- Decrease lengths of hospital stays and costs of services
- Improve well-being, self-esteem, and social functioning
- Encourage more thorough and longer-lasting recoveries

Peer Recovery Services include:

- Housing
- Employment
- Peer Support
- Peer Mentoring/Coaching
- Crisis Intervention

- Facilitating and Leading Groups
- Providing one-on-one support and education

Employment

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) understands that work contributes greatly to an individual's recovery. Individuals who express a desire to work must have access to quality services and supports to help them obtain and maintain gainful, meaningful employment. Work incentives/benefits planning and career development are an essential part of those supports. OhioMHAS strives to support individuals, providers, and employers in improving the employment outlook for people living with mental illness and substance use disorders.

As part of this effort, OhioMHAS is focused on expanding employment supports to all our behavioral health partners (providers of mental health and substance use treatment) interested in offering employment services in general, and Individual Placement and Support - Supported Employment (IPS - SE) specifically. IPS - SE is an evidence-based practice designed to assist individuals with mental illness or co-occurring mental illness and substance use disorders obtain, maintain, and advance in competitive, integrated employment. Currently, OhioMHAS has 23 qualified IPS providers offering IPS – SE services and supports.

In early 2017, OhioMHAS established an internal employment team. Located in the four quadrants of our state, employment team members will provide training, technical assistance, support, education, and modeling to our behavioral health partners delivering employment services. In addition, the employment team will conduct fidelity reviews for those organizations offering IPS services.

OhioMHAS is committed to ensuring that individuals entering the workforce for the first time or reentering after an interruption, understand the availability of work incentives and how benefits and entitlements will be impacted by employment. To this end, OhioMHAS is aiding with capacity building in work incentives/benefits planning in our state. OhioMHAS has and will continue to fund training to increase the number of work incentive practitioners within behavioral health organizations. Access to quality services will help alleviate and address fears and myths individuals (and practitioners) have regarding employment. OhioMHAS aims to promote employment as an outcome and expectation of service delivery within our behavioral health system.

Housing & Homelessness Policy, Program and Resources
Philosophy Statement

Access to safe, quality, affordable housing and the supports necessary to maintain that housing constitute one of the most basic and powerful social determinants of health and wellness. OhioMHAS believes that housing and housing supports is a cornerstone to recovery for individuals with mental illness and/or SUD, and is dedicated to enhancing supportive community living options for individuals in recovery. Ensuring that housing honors client choice is essential in improving housing outcomes, preventing and reducing homelessness, and reducing institutional recidivism from settings such as jails, prisons, nursing homes, and psychiatric hospitals. Individuals have the right to have safe, decent and affordable housing that facilitates and fosters recovery.

Ohio's behavioral health system has four broad categories of housing and residential services which have several types under each which address the needs of persons with serious mental illness, substance use disorders and co-occurring mental illness. These categories are from Permanent Housing, Residential Care, Time-Limited/ Temporary and Residential Treatment, and may be found on the next page.

To ensure that local behavioral health systems have a full range of housing options and housing supports, OhioMHAS provides funding through federal grants, general revenue funds, state bond dollars and partnerships with other state agencies that address a full continuum of housing options as well as programs to prevent and end homelessness.

Currently, OhioMHAS funds several programs addressing homelessness. It also funds statewide and national housing organizations to provide technical assistance to Ohio providers on building, developing, operating and providing quality housing environments. Ohio has a Housing and Homelessness Collaborative in which all state agencies that work with individuals who need housing and homeless services are developing a state plan to end homelessness. Ohio also has a Projects for Transitions (PATH) homeless outreach program to connect individuals to mental health service in 12 counties and will be expanding to 13 counties in FY 18. OhioMHAS also provides capital funds to build and improve existing housing for persons with serious mental illness and/or in recovery from addiction. These funds are utilized to match Federal Home Loan Bank, Tax Credit and Home funds. Additional housing is funded by ADAMH Boards in most communities throughout Ohio.

Housing Categories and Definitions Crosswalk

July 2014

Categories	Definition	Types of Housing	Examples
Permanent Housing	A housing setting that is voluntary and length of stay is resident-driven, not determined by a program. Housing may be scattered site apartments or single-family homes or a larger housing complex that is in the community of the individual's choice. Services and supports may be available to residents. Supports can be on-site or off-site depending on individual need and specific setting. Participation in supports and services may be voluntary or have some expectation of participation which is agreed to in the lease agreement addendum.	• Permanent supportive housing • Community residence • Recovery residence • Private apartments • Home ownership	• HAP • Housing as housing • Supportive housing • Person with Section 8 — private landlord • Level 1, 2, 3 • Sober house
Time-Limited/ Temporary	A short-term setting that can include room, board and/or personal care. A non-permanent setting that provides support needed for residents to return to previous housing setting; to move into a more permanent housing setting or a break from current housing. Most often treatment and/or services are part of facility rules. NOT intended as a permanent housing environment. Program rules include length of stay. This setting is not subject to tenant landlord law.	• Respite • Foster • Crisis • Temporary • Transitional	• Crisis bed • Crisis intervention • YMCA/YWCA • Boarding home • Respite care • Foster care • Step-down unit
Residential Care	A residential setting that includes room, board and personal care. Depending on resident's level of functioning and care needs, may have staffing 24 hours a day/seven days a week and assistance with activities of daily living. A congregate setting is usually included with this living environment Services are delivered as defined in license. A resident agreement that includes participation in services may be applicable. May or may not be a long term more permanent housing depending on level of care needed for the individual. Residential care is owned and operated by a private owner or provider agency. This type of housing is licensed and is not subject to tenant landlord law.	• Adult care facility (ACF)/ adult group home • Residential care facilities (Health) • Licensed DODD facility • child residential care/ group homes	• ACF • Supervised group living • MH Type II, III • Assisted living
Residential Treatment	A licensed facility staffed 24 hours a day/seven days a week that provides room, board, personal care and clinical services on-site as part of the treatment stay. Entrance into the facility is determined by clinical/medical need. Facility is owned and operated by a certified provider agency for the clinical/medical services provided on-site and may be affiliated with or within an inpatient continuum. This type of housing is licensed and is not subject to tenant landlord law. Reasons for this placement level of care are more clinically driven than environmental.	• Residential treatment • Non-medical community residential treatment (Level II-A) • Medical community residential (Level II-B)	• Level 4 recovery residence • Half-way house (Medical community residential) • MH Type I

Services for SAMHSA's Priority Populations

First Episode Psychosis

Ohio is implementing the Coordinated Specialty Care (CRC) model of treating first episode psychosis using the 10% Mental Health Block Grant set aside to make awards to providers using a competitive Request for Proposal process. Services are available in 17 counties including the three largest urban counties, as well as some rural counties. As required by SAMHSA, this work is more fully described in the Environmental Factors and Plan section.

Homeless

Projects for Assistance in Transition from Homelessness (PATH) is a federally funded program that provides financial assistances through a formula grant to States to help end homelessness among those living with mental illness and co-occurring substance use disorders; PATH is provided in 12 counties and will be expanded to 13 in SFY 2018. PATH is a homeless outreach program that seeks to locate consumers who have a mental illness, not connected with community mental health services, living on the streets, in vehicles and other places that are not designed for human habitation and to link them to supportive services and housing. Individual PATH providers can choose to offer one, two or many services. Services may include outreach, staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where individuals who are homeless require services. It may also include assistance with identifying and securing appropriate housing. PATH services were expanded and enhanced with a three-year Cooperative Agreement to Benefit Homeless Individuals (CABHI) from SAMHSA, and a 2015 CABHI enhancement grant which will end in 2018.

Older Adults

OhioMHAS partners with other state agencies in older adult activities, especially the Ohio Department of Aging which provides leadership for services for this age group. OhioMHAS partnered with Ohio Department of Aging to provide a webinar to the Ohio Council for Home Care and Hospice entitled Older Adult and Mental Health Primer. This membership association supports older adults living in their communities as well as long-term care facilities.

Additionally, OhioMHAS has a long-standing partnership with The Elder Abuse Commission. The Elder Abuse Commission heads up the Aging subcommittee on the Stepping Up initiative which is a jail diversion initiative for older adults. This initiative is in the planning stages of development.

Older adults also benefit from MyCare in which a managed care company coordinates the behavioral health benefit for older adult services in a pilot program in 29 counties that includes most of the urban counties.

Rural

Ohio has some rural Appalachian counties, and some mid-western rural counties which have different cultures that impact service needs. The ADAMH Boards address the needs of rural Ohioans by planning, funding and evaluating services to respond to the needs, culture and preference of each community. Additionally, local county-based tax levies provide much of the funding for recovery supports, which results in differences in availability and organization of services among communities. Some rural counties with poorer residents have not passed county tax levies to fund recovery supports such as housing, employment and peer support, and are especially short on resources. Accessibility to clinical services is more uniform, since Ohioans can use their Medicaid or other insurance across county lines. In response to concerns about differences among community resources, the state legislature allocated $75,000 new funding for each county for ADAMH Boards; this shifted funds to rural areas. Additionally, the legislature enacted a continuum of care that requires specific clinical and recovery resources be available in each Board area. Ohio's 2017 legislature also required Boards to collaboratively establish Substance Abuse Stabilization and Mental Health Crisis Centers in each of the six state hospital catchment areas. This builds on OhioMHAS' strategy of funding Board collaboratives to fund regional service to residents of multiple Board areas. Additionally, some of the larger providers have opened offices in rural counties which has increased access and choice for persons in recovery and their families.

Military and Veteran Cultural Competency

OhioMHAS collaborates with the Ohio Department of Job and Family Services Veteran Managers to reduce barriers to employment by offering education, linkage and referral resources to veterans through their field offices in state; funding is provided by Access to Recovery (ATR), a SAMHSA discretionary grant. In addition, OhioMHAS, the Ohio Department of Veteran Services, the Ohio National Guard received technical assistance from SAMHSA to conduct a mapping project to identify state partners and veteran resources throughout the State of Ohio. This project included peer stories of system navigation through utilizing the community behavioral system, VA, ATR and other partners.

The Ohio Veteran and Military Suicide Prevention and Behavioral Health Collaborative facilitated a statewide initiative to enhance regional coordination of capabilities and outreach among federal, state, and community partners to assist veterans, service members, and their families in preventing suicide through improved access to culturally competent behavioral health services. The work included (1) assess current regional and community collaborations (2) form regional veteran and military suicide prevention collaboratives, and implement a statewide coordinated outreach campaign. In addition to OhioMHAS, partners included NAMI Ohio, Ohio Suicide Prevention Foundation, professional associations and licensing Boards, Managed Care Association, Hospital Association, Drug Free Action Alliance, state agencies, universities,

federal component military organizations, and veteran organizations. Ohio will build on this work.

Program Initiatives to Improve Services

Major initiatives to improve adult mental health services include Medicaid Health Home Implementation, Hot Spot Collaborative Projects, and Coordinating Centers of Excellence. Additionally, the Department has additional new initiatives described under Ohio selected priority populations for recovery supports, housing and forensic services.

Mental Health First Aid

Mental Health First Aid is a public education program that helps the public identify, understand, and respond to signs of mental illnesses and substance use disorders. Mental Health First Aid USA is managed, operated, and disseminated by three national authorities — the National Council for Community Behavioral Healthcare, the Maryland Department of Health and Mental Hygiene, and the Missouri Department of Mental Health. Mental Health First Aid is offered in the form of an interactive 8-hour course that presents an overview of mental illness and substance use disorders. This course introduces participants to risk factors and warning signs of mental health problems, builds understanding of their impact, and reviews common treatments.

Trauma Informed Care

This is described earlier in this document as a major department initiative.

Suicide Prevention

OhioMHAS has partnered with the Suicide Prevention Resources Center to provide intensive training directed toward clinicians working with individuals at risk. Between April 2016 and February 2017, this partnership provided Zero Suicide Academies (a nationally recognized model) in six areas of the state to train more than 300 counselors. Ohio plans to continue these efforts.

Multi-ethnic Advocates for Cultural Competence and Related Activities

OhioMHAS funds MACC to provide cultural competence and diversity training to behavioral health providers. MACC's purpose is to enhance the quality of care in Ohio's behavioral health system and to incorporate cultural competence into systems and organizations that provide care to Ohio's most vulnerable and at-risk populations. MACC supports networking among diversity advocates, conducts needs assessments on under-served populations (e.g. military families), and provides training to behavioral health care staff to increase their cultural competence in providing mental health services. Additionally, MACC hosts an annual conference.

Coordinating Centers of Excellence

OhioMHAS continues to support Coordinating Centers of Excellence (CCOEs) as a means of promoting evidence-based practices and emerging best practices that address critical needs of

adults affected by serious mental illness. CCOEs provide training, consultation, fidelity assessment and evaluation services to provider organizations implementing evidence-based and promising practices. CCOEs are composed of a unique mix of partners which include Ohio universities, consumer or advocacy groups, local mental health boards, private research entities and provider trade associations. Their primary audience is agency-based mental health practitioners, but they also work with consumers, family members, other health practitioners, and key constituents from other local systems, such as education and criminal justice. Each CCOE promotes a specific evidence-based or emerging best practice by providing services such as education, training, consultation, and fidelity and outcomes evaluation. Ohio supports CCOEs that provide technical assistance and training to implement evidence-based treatment practices for adults for

- Assertive Community Treatment)
- Center for Innovative Practices (children's and youth mental illness and SUD)
- Criminal Justice (Sequential Intercept Model)
- Mental Illness/Developmental Disabilities
- Substance Abuse and Mental Illness
- Supported Employment

Ohio's Services and Supports for Adults with Serious Mental Illness

Strengths

- Diverse, well developed provider network providing services to adults with serious mental illness and co-occurring disorders.
- Strong investment in range of housing options for persons recovering from mental illness
- Enhancing recovery supports with SAMHSA grants to improve supported employment and address chronic homelessness and homelessness among veterans.

Needs

- Availability of transportation and housing for persons with serious and persistent mental illness (SPMI/SMI) is limited, especially in some areas of the state. OhioMHAS continues to invest state mental health operating and capital funds in housing, encourages Boards to collaborate to provide these services, and partners with Ohio Department of Development to enhance these services.
- First Episode Psychosis and Supported Employment are available in some areas; expansion of these recovery supports has the potential to increase employment, and reduce the number of persons who rely on Medicaid and disability income from the Social Security Administration.
- Ohio lacks specialized older adult behavioral health services in many communities; Ohio's state agencies are addressing them through a pilot program to address persons with dual Medicare and Medicaid eligibility, as well as partnering with other state agencies to address elder abuse and screening for substance misuse.

(5) Substance Use Disorder Services

System of Care for Adults and Youth with Substance Use Disorders
Ohio's behavioral health system for adults with SUD includes health, medical and recovery support services provided by other systems of care, as well as courts and law enforcement. It also operates on a public health model that builds on established collaboration of state agencies and ADAMH Boards. At the state level, OhioMHAS Medical Director, and the Office of Treatment and Recovery Services provide leadership for treatment services and recovery supports for adults, youth and families impacted by SUD. State agencies collaborating on SUD treatment include Job and Family Services (child welfare, employment, and social services), Ohio Department of Rehabilitation and Corrections, Ohio Supreme Court Ohio Department of Health, Education, Medicaid and regional medical centers. State agency work on health system reform is led by the Governor's Office of Health Transformation. The Health Department takes leadership in smoking cessation initiatives and in data collection. At the local level ADAMH Boards collaborate with courts with specialty dockets for persons with SUD and/or co-occurring SUD and mental illness, as well as county jails. These local and state collaborations provide a system of care for persons with SUD in Ohio.

System of Care for Persons with Intravenous Drug Use and/or Opiate Addiction
Ohio has treatment programs to treat opioid addiction, intravenous drug use and addiction to multiple illicit drugs; this population uses the same system of care as services for all persons with SUD. A major difference is that medication assisted treatment is more likely to be needed than for other treatment groups. Unfortunately, medication assisted treatment is not sufficiently available to meet community needs. Ohio is working to expand its opioid treatment and prevention programs through the Ohio Opioid State Response Project funded by the 21st Century CURES Act which benefitted from coordinated planning by OhioMHAS leadership, as well as state and community partners.

System of Care for Pregnant Women and Women with Dependent Children
ADAMH Boards, as well as providers, prioritize pregnant women and women with dependent children who seek treatment for SUD treatment services. All 50 of the ADAMH Boards prioritized this population in their Community Plans. These Community Plans also include an assurance that ADAMH Boards will work with child welfare programs to address the needs of the parents and children who are impacted by SUD. Certified treatment providers receiving funds are required through SAPT Block Grant Assurances to provide and/or refer pregnant clients to prenatal care as well as offer childcare. Alcohol and other drug treatment services to women of childbearing age, pregnant women, women with dependent children, mature women, and young women continue to be provided as an SAPT Block Grant priority population.

Additionally, OhioMHAS has a designated staff member who may be contacted to insure access to pregnant women who have difficulty accessing needed services in their home community. When needed, she will link pregnant women and women with dependent children to services outside of their ADAMH Board area. Many communities have women's gender specific treatment programs, and some urban communities have gender specific providers that specialize in treating women. In addition to treatment programs, women with dependent children need services for their children which are typically provided by county job and family services, and other social service agencies.

System of Care Providers for Adults and Youth with Substance Use Disorders (SUD)	
Services and Community Supports	**Provided by:**
SUD and outpatient, detoxification and residential services (medical & non-medical)	Includes community behavioral health and SUD treatment providers with integrated care in some communities. Also, includes some Medicaid-only providers, regional medical centers, federally qualified health care centers (FQHC).
Health care	Medical centers, clinics, community and children's hospital, county health departments, Federally Qualified Health Care Centers (FQHC), oversight by Ohio Office of Health Transformation and Medicaid cabinet agencies
Behavioral health crisis services	State law requires Boards to assure local availability of crisis services from community behavioral health services; training of workers is the responsibility of the providers and boards.
Substance abuse outreach, prevention and treatment to urban minorities "UMADAOP"	UMADAOP offers treatment to African American and Hispanic urban populations with targeted services for youth, seniors, women, Spanish speakers and persons involved with criminal justice system.
Drug/behavioral health courts; treatment programs in jails and state prisons; community treatment linkage for offenders	Drug and veterans' courts provide treatment. SUD treatment provided by OhioMHAS within Ohio's state prisons. OhioMHAS community linkage workers meet with offenders with SUD prior to release from prison to link them with community services; Some county jails have SUD treatment services.
Recovery housing	Housing which provides sober environment; may be provided by persons in recovery community or faith-based organization
Time limited housing	May be funded by ADAMH Boards in some communities
Peer support/recovery coaching	Provided by some SUD treatment providers
Employment Services	County Job and Family Services Agencies
Care coordination for adults who need services from multiple service systems	Community behavioral health and SUD treatment providers. ADAMH Boards and/or specialized court dockets may facilitate care coordination for challenging cases. Family and Children First coordinates care for high-need youth involved with multiple systems of care.
Twelve Step Meetings	Self-help groups led by volunteers in community
Other recovery support groups	Support groups which may be a community peer-led group, or may be a support group associated with a treatment setting.
Faith-based programs	Provided by religious organizations & faith-based recovery communities.
Medical & dental care	By referral of SUD treatment staff to area medical centers and clinics; sometimes provided by integrated health care centers, Federally Qualified Health Care Centers (FQHC), or within prisons/jails by medical and dental staff.

Information and referral, and warm lines	211 Lines – provide information to community services for more than 90% of Ohio's population; OhioMHAS maintains consumer-staffed Toll Free Bridge line. Many ADAMH Boards fund this service in their communities which provides information about services and client rights.
Services for Intravenous Drug Users	**Additional Providers for Intravenous Drug Users**
Medication Assisted Treatment	Treatment facilities and physicians who meet DEA/legal requirements
Services for Women with Children	**Additional Providers for Women with Dependent Children**
Gender specific treatment	Women's specific treatment providers or programs who provide specialized tracks for women
Community programs for children	Head Start, Help Me Grow
Food assistance (SNAP), Ohio Works First, foster care, child care	County Job and Family Services
Housing and shelter	Women's recovery housing; battered women's shelters
Communicable diseases	**Additional Providers for Persons with Communicable Diseases**
TB, HIV, Hepatitis C	Treatment by county Departments of Health and behavioral health providers, with some targeted programs for persons who are HIV+

Programs to Engage Persons with Substance Use Disorders

Ohio has programs to engage persons in SUD treatment. Local communities engage persons through specialized dockets for substance use disorders and veteran's courts. Some local jails have clinical treatment and peer recovery support staff. Urban Minority Alcohol and Drug Addiction Programs in eight Ohio communities provide specialized outreach to engage African Americans Hispanics and other urban minority populations. Many SUD and SUD/MH providers have hotlines and crisis services that engage persons seeking recovery in treatment. Others find their way into treatment via the recovery community's twelve step programs or through recovery community organizations.

Screening, Brief Intervention, and Referral to Treatment (SBIRT)

OhioMHAS is in the final years of implementing a five-year, $10 million cooperative agreement from SAMHSA for a statewide Screening, Brief Intervention and Referral for Treatment (SBIRT) initiative. The federally-funded program is designed to reduce morbidity and mortality of alcohol and drug use through early intervention methodologies that rely on the integration of medical and behavioral health approaches. The goal of Ohio SBIRT is to reduce the morbidity and mortality caused by alcohol and illicit or prescription drug use through an integration of SBIRT approaches into medical and behavioral health approaches.

The Ohio SBIRT Project assists healthcare, behavioral health and other organizations to implement alcohol, other drug and depression screening, brief intervention and referral to treatment. Project staff provide trainings to communities, conferences and individual organizations on screening tools and procedures, motivational interviewing skills and brief intervention models to ensure successful implementation. Health care providers across Ohio receive funding through the Ohio SBIRT Project to implement the model. Settings include emergency departments, health departments, primary care and federally qualified health centers,

as well as inpatient hospital settings and urgent cares. Just over 55,500 Ohio patients have been screened in our funded sites, while many more are screened by partners who receive training and technical assistance without funding. The Ohio SBIRT Project will continue partnering with healthcare organizations to sustain the model and expand to new sites in the coming year. Approximately 25,000 patients are expected to be served this year in primary care and other healthcare settings.

Services for Block Grant Priority Populations
Treatment and Recovery Support

Ohio SUD continuum of care and Medicaid-benefit are described in the first part of this section. In addition, recovery supports include housing, employment, education, transportation, child care, spiritual support, and peer support are considered essential services by many persons in recovery. These are described in the Adult Mental Health section, as many of them are for both populations. Ohio's recovery community supports also include Twelve Step groups, as well as individuals, faith-based organizations and other non-profit organizations which offer peer support, spiritual support, employment and sober housing to individuals in recovery and/or seeking recovery. Many important recovery supports including Twelve Step programs are provided outside of the public behavioral health system. Ohio defines as, "*A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.*"

Ohio has a wide variety of SUD treatment providers, community behavioral health providers, integrated health services, regional medical centers and hospitals. OhioMHAS certifies 188 providers for both SUD and mental health services, and 171 providers for SUD only services. Community SUD and behavioral health (MH/SUD) providers have different kinds of programs and services to address the needs of their populations and communities. Many of these providers include same site access to additional health and/or social services. Most providers offer recovery supports consistent with a recovery oriented system of care, or refer consumers to non-medical recovery supports (e.g. recovery housing, employment, peer support, Twelve Step groups). Many also offer programs targeted to specific populations (e.g. Hispanic, youth, and women with young children.) As it is not feasible to describe each of Ohio's 50 ADAMH Board areas overlapping systems of care, a description of a variety of providers is provided in the next few pages. The intent is to provide examples of wide variety of providers to better describe Ohio's provider network.

Behavioral Health Providers in Major Metropolitan Areas

- Talbert House has five service lines which include adult behavioral health, community care, courts and corrections, housing and youth behavioral health services in the greater Cincinnati area. Medication Assisted Treatment (MAT) with Suboxone and Vivatrol is available as part of a comprehensive treatment program for opioid users. Its primary

service area is Hamilton, Brown, Butler Clermont, Clinton, and Warren counties in greater Cincinnati area. Additionally, Talbert House also serves additional counties including Adams, Champaign, Clark, Darke, Fayette, Greene, Highland, Miami, Montgomery and Preble. Services in 25 programs include a full continuum of care of SUD and mental health services as well as many specialized services including School Based Services, Court Treatment, Employment Services, and Teen Parenting. Talbert is accredited by 8 different organizations including CARF, and the three state agencies of Rehabilitation and Corrections, Job and Family Services and Rehabilitation and Corrections. http://www.talberthouse.org/home/

- Maryhaven "*provides integrated behavioral healthcare services with a specialization in addiction recovery care, to help men, women and adolescents restore their lives from addictive and mental illness*." Services are provided in the greater Columbus area with offices in Franklin, Delaware, Union, Marion and Crawford counties. Maryhaven has a full continuum of care including residential services for adolescents and adults with SUD. Services include an outpatient opioid treatment program that includes methadone, Suboxone and Vivatrol, as well as medical, counseling and case management services. Maryhaven has gender specific services for women, including a program specifically for African American women. It also has programs for dual (MH/SUD) treatment, court related services, gambling intervention, homeless services, mental health services. https://www.maryhaven.com/

Behavioral Health Providers Outside Major Metropolitan Areas

- Coleman Professional Services in Allen, Auglaize, Hardin, Portage and Stark Counties in northeastern and northwestern Ohio; Addiction services include SBIRT, diagnostic assessment, individual and group counseling, case management, dual diagnosis and medication assisted treatment in ambulatory detoxification. Coleman also provides a full range of mental health services including Supported Employment and First Episode of Psychosis Services. http://www.colemanservices.org/

- Lake Geauga Recovery Centers (Mentor and Chadron); provides the full continuum of SUD treatment including medication assisted treatment and residential treatment for men and women; it also provides mental health services. A program for women with children includes a range of services including pre-natal care, counseling, group therapy, dual-diagnosis services, parenting skills, workforce participation, integration into 12-step groups, transportation and on-site childcare. http://www.lgrc.us/

- Recovery Council, a CARF accredited agency, provides SUD treatment services at offices in rural Pike and Ross counties. Services include in-patient care to women, out-patient care to men and women, transitional living programming for women, assistance with drug

and alcohol addiction, other substance abuse treatment, mental health services, individual and group counseling, intensive outpatient programs, domestic violence counseling for men and women, life skill coaching, outreach services, educational groups, co-dependency counseling, parenting classes, anger management classes, drug testing, adolescent counseling, substance abuse assessment, substance abuse education, transportation services, and case management. http://therecoverycouncil.org/

Integrated Health Services

- Columbus Area Integrated Health Services in Columbus include residential SUD treatment for men who may have criminal justice issues which use Afrocentric principles, as well as outpatient and intensive outpatient services. Suboxone (medication assisted treatment) is also available for those who qualify. Columbus Area also offers pharmacy services and integrated (primary) care, mental health services, and re-entry programs for persons who are released from prisons. http://www.columbus-area.com/

- Firelands Regional Medical Center provides outpatient SUD treatment services to adults, youth and families in a seven mostly rural county area in northeastern Ohio (Erie, Ottawa, Sandusky, Seneca, Huron, Lorain and Wyandot Counties). Firelands is also providing SBIRT (Substance Abuse, Brief Intervention and Referral to Treatment) in the inpatient hospital and two outpatient physician offices. Firelands includes a community hospital, community mental health services and is also the recipient of a SAMHSA Supported Employment Grant. http://www.firelands.com/services/behavioral-health.aspx

Faith-Based Family Service Organization

- Catholic Charities, Diocese of Cleveland, provides SUD and mental health treatment services in eight counties with the programs varying greatly by county, as well as mental health and other social and spiritual services. In most counties, one or two services are offered, usually non-intensive outpatient services for youth. In Cuyahoga County programs include adult outpatient, intensive outpatient and residential, gender specific programs for adults, Hispanic programs that are bilingual and gender specific, youth (ages 16 – 19) residential program, intensive outpatient for youth through age 21. Catholic Charities provides a wide range of services including mental health, foster care, domestic violence/child neglect, employment and training services, youth services and older adult services. http://ccdocle.org/services

Recovery Community Organization

- The Sandusky Artisans Recovery Community Center has specialized in integrating the arts with recovery from substance abuse, depression and eating disorders since 1996. The Artisans is a peer driven, peer supported, grass roots non-profit Community Center. Thousands battling substance use issues - alcohol, drugs, overeating, depression and such

- have found guidance and support in the East Market Street Building in downtown Sandusky." The center provides free addiction services, offers 12-step meetings overseen by peers, and art based recovery programs. Meetings include a full range of twelve step meetings (AA, NA), NAMI Connections, as well as yoga and some family support. Most activities are scheduled in the evening.

SUD Treatment Providers for Women only

- First Step Home in the Cincinnati area serves women in recovery and their children. This agency provides individual and group SUD counseling, access to medical services, mental health assessments, life skills training, financial counseling, on-site child care, twelve step meetings and connections to job readiness programs. First Step Home also offers a comprehensive child and family development program for children ages 0 – 12 who are living with their mothers at the facility. The children receive daily support and therapy from one of the staff. Transitional housing is also available for families after the mothers complete the residential program. First Step Home received a MOMS grant which includes implementation of medication assisted treatment for opioid dependence for pregnant women. http://www.firststephome.org/

Substance Abuse Prevention and Treatment Providers for Urban Minority Populations
(Urban Minority Alcoholism and Drug Abuse Drug Outreach Programs (UMADAOP) programs funded in eight urban communities by the Ohio Legislature since the 1980s.)

UMADAOP of Cincinnati, Inc. provides programs that cover a broad range of services. These services include but are not limited to Medication Assisted Treatment for Adult and Youth, Professional Intervention Services, Adult Substance Abuse Treatment , Peer Support Services (Recovery Coach),Adult & Youth Prevention & Education Services, Alternative Activities, Alternative Education Placement Services, Community Awareness Outreach Services, Professional Prevention Education Series, Violence Prevention Education Services, and Youth Substance Abuse Treatment, School Based Prevention , Education & Treatment Services.

Recovery Support Services

Please see the consolidated "mental health and substance abuse" description of recovery support services in the previous section on Adult Mental Health Services.

Services for SAMHSA's Priority Populations

Medication Assisted Treatment for Opioid Use Disorders and Intravenous Drug Users

Ohio has promoted Medication Assisted Treatment (MAT) Programs which use buprenorphine, methadone or naltrexone to treat opiate dependence, in combination with counseling and recovery support services. Persons with opiate-dependence are more likely to recover if they receive medication assisted treatment than without it. Data indicates that all MAT improve abstinence rate when provided along with relapse prevention counseling.

Table 1. MAT Effectiveness*

Medication	With MAT (% Opioid Free)	Without MAT (% Opioid Free)
Naltrexone ER	36%	23%
Buprenorphine	20 – 50%	6%
Methadone	60%	30%

*Comparative conclusions cannot be drawn due to lack of head-to-head comparative studies. All medication assisted treatment was provided along with relapse counseling.

Ohio has 26 SAMHSA licensed methadone programs as of June 2016, with multiple sites in Ohio's three most populated counties. Seven of these programs fall outside of regulatory authority of OhioMHAS because they are either federally operated through Veteran's Administration services (3 programs) or only provide buprenorphine (4 programs). OhioMHAS is working to expand the availability of all forms of medication assisted therapy. Ohio Senate Bill 319 allows the significant expansion of opioid treatment programs (OTP) by permitting for-profit organizations to enter the market and removing the two-year service requirement. OhioMHAS has been working closely with nearly 20 vendors who have expressed interest in opening over 60 OTPs over the next two years. The increase in OTPs will dramatically change the access to high quality therapeutic programs with MAT for persons with opioid use disorders.

To prepare for the OTP expansion, OhioMHAS has worked with federal and state partners to update and re-write the Ohio Administrative Code (OAC) concerning OTPs. Representatives from SAMHSA, two Ohio-based offices of the Drug Enforcement Administration (DEA), the State of Ohio Medical Board, the State of Ohio Pharmacy Board, and representatives from four OTPs met several times in December and January to review the current OAC and to propose changes. The resulting documents were shared with the entire OTP community for further refinement, including with the OTPs wishing to enter the Ohio market. The new rules passed legislative review and became effective June 1, 2017.

OhioMHAS has convened a group of state and federal enforcement bodies which include the State of Ohio Medical Board, State of Ohio Pharmacy Board, and the DEA to discuss a protocol

for approving/denying physicians to have the emergency 275 DATA 2000 patient limit waiver. Several physicians have already been approved in the areas hit hardest by Ohio's opioid epidemic. Future planning is also in the works with these organizations to standardize the process when enforcement actions are imminent against OhioMHAS certified providers and non-certified Office-based Opioid Treatment services.

OhioMHAS is poised to make dramatic changes to the behavioral healthcare environment with the 21st Century CURES money. The MAT workforce development strategy involves partnering with the Ohio Hospital Association (OHA), Medicaid managed care plans (MCPs), medical professional training schools, and community planning organizations to promote in-person and live training events. OhioMHAS staff hired through grant funding will interface with these organizations to strategize about physician recruitment and develop promotional materials in communities with the highest overdose rates. Physicians involved in emergency care, primary care and obstetric care will be identified for training efforts to implement the MAT training plan. Emphasis will be placed on physician practices that want to promote MAT as an option for care in emergency settings, for interim treatment while the client is waitlisted for an OBOT or OTP, and for care coordination purposes in obstetric practices. OhioMHAS staff will seek to retain these physicians as buprenorphine prescribers through providing three ECHOS, the first of which will mentor new physician prescribers, the second of which will serve as a hub for ongoing continuing education and case review, and the third of which will mentor new PA and NP prescribers.

Services for Pregnant Women and Mothers

The Ohio Women's Network (OWN) is a group of service providers, funded in part by OhioMHAS, provides leadership in the provision of women's gender specific and gender competent alcohol, tobacco and other drug rehabilitation programming for women; whose mission it is to strengthen collaboration and coordination among the various programs providing services to women and children; to develop and disseminate "best practices" among such programs; to improve identification and referral of substance abusing women by human services agencies; to assure women's access to clinically appropriate prevention and treatment and to increase awareness of women's SUD treatment and effective treatment technologies. OWN is affiliated with OhioMHAS.

OhioMHAS is required by the Family Reunification and Stabilization (FRS) legislation to develop a statewide plan to prioritize SUD services for families involved in the child welfare system in collaboration with the Ohio Department of Job and Family Services. FRS is Ohio's response to the federal Adoption and Safe Families Act. The bill exceeded the federal standards by specifying that child abuse or neglect associated with parental SUD could be grounds for termination of custodial rights. FRS also emphasized the need to provide timely and appropriate treatment necessary to facilitate family reunification. Additionally, FRS included tasks such as improving accessibility and timeliness of alcohol and other drug services for the FRS

populations. Realizing that SUD recovery is vital to family reunification and preservation, ODJFS and OhioMHAS have been working together to meet the multiple needs of children and families. In fact, Ohio Department of Alcohol and Drug Addiction Services (prior to becoming OhioMHAS) were nationally recognized by the Child Welfare League of America for progressively working to address the challenges of SUD among clients in the child welfare system.

Services for Persons with Tuberculosis

OhioMHAS addresses its public health mandate to address TB among person with SUD by requiring that all local funding and auditing Board's require written Assurances that agencies receiving SAPT Block Grant funds for operating a program of SUD treatment *(A) will, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services to each individual receiving treatment for such abuse; and (B) in the case of an individual in need of such treatment who is denied admission to a program on the basis of lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services* [Sec. 1924(a)(1)].

All certified addiction providers are required to have policies and procedures in place for referring or providing counseling and/or client education on exposure to, and the transmission of, tuberculosis, Hepatitis type B and C, and HIV disease for each client admitted. Methadone maintenance programs are required to conduct TB screening and OhioMHAS checks client files on-site annually to verify this activity is being conducted. If the TB test shows a positive result, OhioMHAS verifies that a referral was made for medical treatment. OhioMHAS also requires "counseling on preventing exposure to tuberculosis, hepatitis type B and C, and the transmission of human immunodeficiency virus (HIV) disease." Documentation indicating compliance for this requirement is also reviewed in the client chart. To facilitate compliance, OhioMHAS provides training and technical assistance to providers on client record documentation needed to comply with the rule, as well as for referrals or counseling for TB testing.

Persons with SUD Involved with the Criminal Justice System

See Step 1, (6) Behavioral Health Services for Persons Involved with Criminal Justice System.

Program Initiatives to Improve Services

Governor's Cabinet Opioid Action Team

In January 2011, Governor John R. Kasich announced that his administration would battle the opiate epidemic on all fronts. The Department was tasked with leading and coordinating cross-systems efforts to deal with increased addiction and overdose episodes caused by opiates. As part of this effort, the Governor's Cabinet Opiate Action Team (GCOAT) was established to address the ongoing opiate epidemic, with the goals of decreasing the misuse and abuse of opiates. Many initiatives have been launched under the umbrella of these workgroups and

numerous positive accomplishments have occurred due to this inter-disciplinary work. Over the past year, GCOAT has focused on key initiatives ranging from formalizing a standard of care policy for prescribing opioids for non-terminal, non-cancer chronic pain to increasing access and availability of naloxone. While Ohio has seen major improvements in the fight against opiates, there is still much work to be done.

The Governor's Cabinet Action Team (GCOAT) will continue to develop and review proposed legislation to combat the opioid epidemic during SFY 2018-2019. Policy initiatives include reviewing the current structure for the monitoring of private for-profit businesses that operate as treatment centers for SUD and the determination of whether the state needs to have a greater role in accrediting their practice. Additionally, the GCOAT will be reviewing Ohio Senate Bill 4 and House Bill 62 to provide input on record sealing limits. Over the past six years, GCOAT

The GCOAT has issued a challenge to all state cabinets to review current assets to increase greater awareness about the opioid epidemic. The goal is for each cabinet to develop a strategy based upon the population they serve that will address opioid awareness, prevention, treatment and/or recovery management. In addition, the Deputy Director of GCOAT will work with the Department of Administrative Services will assess the existing state website resources related to addiction and coordinate improvement and cohesion.

GCOAT will work through both the Office of Faith Based Initiatives and Drug Free Action Alliance, to increase partnership with faith communities on topics including stigma reduction, prevention, access to treatment, and recovery supports and identify specific deliverables and measures.

Lastly, the GCOAT will work with communication teams from each GCOAT member agency to develop educational videos that will focus on fentanyl safety precautions for first responders and laypersons when responding to an unintentional overdose, how to identify and address vicarious trauma from helping professionals affected by the opioid epidemic and how to obtain substance use disorder treatment for opioids if you are pregnant and addicted.

Ohio's Opioid State Response (STR) Project funded by 21st Century Cures Act

The projects goals focus on enhancing a community system of care to emphasize service integration between physical health care, emergency health care, behavioral health care, criminal justice, and child welfare. Strategies and activities undertaken for this effort build upon Ohio's on-going efforts to address the opioid epidemic which include SABG funded services. Services and activities are designed to reduce overdose deaths and enhance the ability of individuals with opioid use disorder to receive treatment using evidence-based approaches.

A three-pronged approach is adopted to operationalize the identified strategies and activities. This includes 1) department-directed strategies and activities focusing on counties of the state with highest opioid overdose deaths and treatment need, 2) department-directed strategies and

activities to be deployed statewide, and 3) Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Boards identified projects consistent with the goals and objectives of the Ohio Opioid STR Project.

Ohio's Opioid STR Project emphasizes evidence-based practices throughout the needed continuum of services and interventions: PAX Good Behavior Game and Botvin Lifeskills for primary prevention, Screening, Brief Intervention and Referral to Treatment (SBIRT) for early intervention, and Medication-Assisted Treatment (MAT) for opioid use disorder, using the ECHO model and other training methodologies to expand treatment capacity. Additional evidence-based practices include Sobriety, Treatment and Recovery Teams (START) for child welfare and Trauma Informed Care to address the vicarious trauma experienced by professionals in multiple systems and families who are facing the consequences of Ohio's opioid epidemic.

Workforce training funded by the STR project using the ECHO model is expected to increase the number of physicians, advance nurse practitioners, and physicians' assistants who prescribe MAT for opioid use. The ECHO model mentors primary care physicians to provide specialty care such as MAT. This model is used to increase accessibility to treatment in rural and underserved areas.

Ohio's Services and Supports for Adults with Substance Use Disorders

Strengths

- Large, diverse provider network that benefited from Medicaid expansion.
- Recovery housing expanded by use of capital dollars not available before consolidation of state mental health and substance use agencies
- Medical director, a psychiatrist with a specialty in addiction, is promoting medication assisted treatment which increases credibility with the medical community.
- Culturally-specific and gender –specific programs available in urban communities.

Needs

- Availability of medication assisted treatment does not meet demand; Ohio is using 21st Century CURES grant using an ECHO model to expand the number of prescribers in Ohio.
- Residential services and detoxification has limited availability; implementation of continuum of care legislation described in the first section will address this.
- Recovery supports vary widely depending on local community tax levies and what is provided by recovery community. Resources are being expanded through SAMHSA discretionary grants, state and local tax levy funding.

Behavioral Health Services for Persons Involved with Criminal Justice System

System of Care

Ohio Department of Mental Health and Addiction Services provides funding for SUD and mental health treatment and recovery supports for adults and juveniles with who are under the supervision of courts, are incarcerated in county jails/detention facilities and state correctional facilities, and those in need of reentry services. Federal and state funding for these programs flows through county ADAMH Boards to local behavioral health service providers. Additionally, most ADAMH Boards include them as a priority population in their Community Plans, and many Boards fund some of these services with local tax levies. ADAMH Boards work with courts and law enforcement staff to plan, fund and evaluate treatment and recovery support services for this population. Recovery supports such as housing, transportation, education, employment and peer support are also provided by other local organizations which may or may not be affiliated with the ADAMH Boards. Rather, they may be affiliated with other government entities, faith-based organizations and/or self-help groups (e.g. Alcoholics Anonymous).

Criminal Justice Population Addressed by OhioMHAS – Ohio Department of Rehabilitation and Corrections (ODRC) currently has approximately 50,000 offenders with 4,000 (8%) participating in alcohol and other drug programming offered in Ohio's prisons, and approximately 10% (4,800) being considered SPMI [1] (ODRC). Additionally, many additional offenders with SUD and/or SPMI are incarcerated in local jails, or are on the dockets of municipal and juvenile courts. Most persons with SPMI involved with the criminal justice system have co-occurring substance use disorders. Addressing addiction to alcohol and other drugs upon release is critical to both populations, as well as to provide a range of recovery supports known as "Recovery Oriented System of Care" within the addiction world, and "Community Support System" within the mental health world.

System of Services for Persons with SUD and/or SMI Involved with Criminal Justice System		
Environment	**Services and Supports**	**Provided by:**
Community: Drug Courts	Clinical services, medication assisted treatment, drug and alcohol testing, recovery supports and court supervision. Each participant is managed using a team approach.	Partnership among local courts, local addiction treatment providers, and County Job & Family Services (child welfare) with state support from the Supreme Court of Ohio, and OhioMHAS
Community Courts: Treatment Alternatives to Street Crime (TASC)	TASC provides assessments, case management, drug and alcohol testing and SUD treatment. TASC bridges two distinct systems: courts and SUD treatment.	Partnerships among common pleas, municipal and juvenile court judges, SUD treatment providers and TASC programs
Juvenile Justice Courts to enhance local options for providing behavioral health services	Evidence-based behavioral health interventions including Multisystemic Therapy, Hi-Fidelity Wraparound	Local treatment programs which provide juvenile court judges with an alternative to incarceration
Programs for Offenders with SUD or SMI In Prison		
Prisons operated by ODRC	Treatment of Substance Use Disorders	Treatment staff for SUD are employed by OhioMHAS effective 7/1/15
Prisons operated by ODRC	Treatment of SPMI (severe and persistent mental illness	Clinical staff treating mental illness within the prisons are employed by ODRC.
Prisons operated by ODRC	Cognitive behavioral therapy, life skill classes, client led groups and community meetings	Therapeutic Communities: Six funded by OhioMHAS provide a structured day for offenders who are being released from prison
Prisons operated by ODRC and youth facilities operated by Department of Youth Services (juvenile justice)	For offenders nearing release, community linkage workers make referrals and appointments to community behavioral health providers for treatment of SMI, SUD or co-occurring disorders; assists with Medicaid and Social Security Applications	Community Linkage Workers employed by OhioMHAS
Community Programs		
Community	Treatment for SMI and/or SUD for persons involved with courts and offenders released from prison or jail	Community mental health and addiction providers funded by

		OhioMHAS, ADAMH Boards, Medicaid and SAMHSA
Community	Care coordination, drug free supportive transitional housing, GED Training, substance abuse education, relapse prevention, employment skills, transportation, domestic violence education, HIV/AIDS education, peer mentoring, daily living parenting classes, spiritual support, skills, family engagement, recovery coaching, anger management, self-help, and support groups (not including 12 step groups)	Access to Recovery (ATR) SAMHSA funded grant to OhioMHAS which funds recovery supports for returning offenders with SUD in selected urban counties.
Community	Recovery supports and "gap" needs for offenders returning to the community with SPMI (SMI) or SAMI.	Behavioral Health/Criminal Justice Grants funded by MH Block Grant and state general revenue funds; OhioMHAS awards funds to ADAMH Boards
Urban Communities	Employment/vocational training; GED/education; health education including AIDS/HIV/STD education; relationship; peer support; violence prevention; and crisis intervention services for offenders returning to community with SUD.	Circle for Recovery funded by OhioMHAS with SAPT Block Grant funds

Community Treatment

Drug Courts

Drug courts are a partnership among local courts, County Job & Family Services (child welfare), local addiction treatment providers, the Supreme Court of Ohio, and OhioMHAS. The local courts operate the drug courts and provide supervision for adult and juvenile offenders; the County Job & Family Services provides protective custody and supervision for parents with SUD with dependent children. The local addiction treatment providers provide clinical services and participation on the drug court teams, and the Supreme Court provides certification to allow judges to operate the courts. The goals of these partnerships are to increase abstinence, decrease recidivism, reduce commitments to adult and juvenile corrections facilities, increase protective supervision decisions by the child protection system, decrease protective custody decisions and increase family reunification.

In SFY 2016, OhioMHAS funded drug courts served 1,655 adult offenders and 203 juvenile offenders and parents involved with the child protection system. Ohio's drug courts save the state money through reduced recidivism, reduced commitments to the adult and juvenile prisons, and reduced permanent placements of minor children into the foster care system.

Treatment Alternatives to Street Crime (TASC) for Substance Abusers

TASC was created to address an 800% increase in correctional spending over the past two decades, coupled with the opiate epidemic. TASC's mission is to build a bridge between the criminal justice and treatment systems which have differing philosophies and objectives. The model targets nonviolent alcohol and drug dependent felons and misdemeanants and has enhanced existing correctional supervision programs. TASC identifies chemically dependent offenders, provides assessments and makes referrals for the most appropriate drug treatment. Other key functions include counseling, case management services and drug testing. TASC case managers work closely with judges, probation officers, jail administrators and treatment providers to provide effective and comprehensive programming. Community partners include County Common Pleas Courts, municipal and juvenile courts. These partners refer offenders to TASC and work collaboratively with the programs. The courts' probation departments provide community control supervision to the TASC participants. The goals are to increase abstinence, decrease recidivism, reduce commitments to adult and juvenile correction facilities and increase completion of treatment. In SFY 2016, TASC programs served 7,480 adult and juvenile offenders. TASC programs save the state money through reduced recidivism and reduced commitments to the adult and juvenile prisons.

Addiction Treatment Program

The Addiction Treatment Program (ATP) was legislatively established in the SFY 2016-2017 budget and $11 million was appropriated. The ATP is an expansion of the Addiction Treatment Pilot Program (ATPP), which was implemented in SFY 2014-2015. The program offers funding for treatment services including medication assisted treatment (MAT) as well as recovery supports for eligible clients that are enrolled in selected specialty-docket drug and family dependency courts. Participants receive treatment from a community addiction services provider certified by OhioMHAS. The original pilot program, ATPP, served a total of 366 participants between October 2013 and June 2015 in Allen, Crawford, Franklin, Hardin, Hocking, Mercer and Morrow counties and included an evaluation completed by Case Western Reserve University. In SFY 2016, the ATP expanded to serve 26 courts in the following 13 counties: Allen, Clinton, Cuyahoga, Franklin, Gallia, Hardin, Hocking, Jackson, Marion, Mercer, Montgomery, Summit, and Warren. In SFY 2017, the ATP expanded again to an additional ten courts in the following nine counties: Butler, Clermont, Hamilton, Lake, Lorain, Lucas, Mahoning, Stark, and Trumbull. The ATP has served total of 1,001 participants from January 2016 through March 2017. The program also includes an evaluation component, which is being completed by the Treatment Research Institute (TRI) and will incorporate ATP data through SFY 2017.

Behavioral Health Juvenile Justice Projects

Please see the last two pages of the Treatment – Children with SED section for a description.

SUD Treatment Programs within Prisons

OhioMHAS operated programs within Ohio's 27 prisons provide SUD treatment, as well as linkage to community services for offenders being released. Major goals are to reduce recidivism and treat SUD. In SFY 2017 about 6,200 inmates received formal SUD treatment in Ohio's 27 prisons; some offenders received services in multiple programs. Preliminary SFY 2017 numbers for offenders receiving specific services are:

- Therapeutic Community = 1306
- Treatment Readiness Program = 3248
- Intensive Program Prison = 104
- Brief Intervention Program = 1437
- Treatment Transfer Program = 1099

The program uses the Texas Christian University Drug Screen to identify individuals with a history of drug use or dependency. This instrument is used to determine the Recovery Services level of care, and who is eligible for each of the treatment options. The Recovery Services Level of Care designates the level of need for Alcohol and Other Drug (AOD) Services: R0 = None; R1 = Minimal Need; R2 = Moderate Need; R3 = Considerable Need. A variety of programs is provided.

Alcohol and Other Drug (AOD) Treatment Readiness Program

The AOD Treatment Readiness Program is a 48-hour program delivered daily for a minimum of 12 hours a week. A minimum of ten of the hours must be cognitive behavioral treatment specific. The remaining hours shall consist of Recovery Oriented Supplemental Services. Those institutions designated as control prisons or those institutions with control units may provide restricted treatment hours after consultation with the Bureau of Behavioral Health Services Chief or designee. This program incorporates the stages of change model to focus on participant motivation and readiness that will enhance treatment engagement and retention. This program is offered to Recovery Services Level 2 and 3 inmates.

Brief Intervention Program - Breaking The Cycle

This is a six-week program, 24- hours cognitive behavioral program that uses evidence-based strategies to assist inmates as they work to make positive changes in their criminogenic thoughts and behaviors and patterns of substance use.

Continuing Care Services

Continuing care services are on-going peer support such as Alcoholics Anonymous, Narcotics Anonymous, Big Book Studies, etc.

Family Program

A family program is designed to provide Recovery Services education, program information, improvement of communication skills, and facilitates involvement of both program participants and family members in community reentry. ***This program is available only at London Correctional Institution.

Recovery Services Intensive Outpatient Programs

The Recovery Services Intensive Outpatient Program is a 144-hour program, consisting of the Treatment Readiness Program and Intensive Outpatient Program phases, that provides treatment services delivered daily for a minimum of 12 hours a week. A minimum of ten of the hours must be cognitive behavioral treatment specific. The remaining hours will consist of Recovery-Oriented Supplemental Services. Those institutions designated as control prisons or those institutions with control units may provide restricted treatment hours after consultation with the Bureau of Behavioral Health Services Chief or designee. This program is offered to Recovery Level 2 and 3 inmates.

Outpatient Services

Treatment services are provided less than eight hours per week in regularly scheduled sessions for program participants who reside in general population.

Recovery Oriented Supplemental Services

Those recovery support services that are complementary and supportive of formal Recovery Services treatment activities.

Recovery Maintenance Program

Recovery services are provided following the successful completion of the Recovery Services Intensive Outpatient Program. Services include two 1-hour, or one 2-hour professionally facilitated group meetings per week for a total of 8 weeks (16 sessions). The Recovery Maintenance Program requires an updated treatment plan upon completion of the treatment program and attendance verification. This program is offered to Recovery Level 2 and 3 inmates.

Self-Help/Fellowship/Alcoholic Anonymous (AA)/Narcotics Anonymous (NA) Meetings

An independent support/fellowship group organized by and for drug abusers and alcoholics to help members achieve and maintain abstinence and/or cope with the effects of drugs and alcohol.

Therapeutic Community (TC)

A treatment modality that uses an inmate hierarchy in which treatment stages are used to reflect personal and program growth. This program teaches offenders how to provide peer to peer treatment group sessions and to develop and enhance life skills. The community has a very

structured day that includes clinicians led groups, Cognitive Behavioral Therapy (CBT) classes, client led groups and community meetings. Every member also has a job and role in the therapeutic community. The community members give each other feedback throughout the treatment about one another's behaviors. In this microcosm, the clients can learn and practice pro-social behaviors and responses.

Treatment Transfer Program

The treatment transfer program is a four-week treatment program that is a component of the Treatment Transfer initiative specified in HB64. This four-week treatment program entails providing the Treatment Readiness Program phase of the Intensive Outpatient Program to those eligible inmates identified for this initiative.

Community Linkages (Continuity of Behavioral Health Treatment at Release)

The Community Linkage program links offenders being released from state prisons or juvenile justice youth facilities with SPMI (subgroup of SMI), SED, or with significant SUD treatment needs with community behavioral health appointments or other supports *prior to the offender's release*. Ohio Department of Rehabilitation and Corrections (ODRC) and Ohio Department of Youth Services (ODYS) provide behavioral health treatment for adult and youthful offenders while they are incarcerated; SUD treatment in ODRC prisons is provided by OhioMHAS staff effective July 1, 2015. Both ODRC and ODYS work with Community Linkage staff at each institution across the state to assist with continuity of care for offenders. They provide qualifying offenders with appointments and referrals to supports that promote successful re-integration into the community after discharge, such as housing and health care services. Local ADAMH Boards assist with continuity of care for adult and youthful offenders by contracting with local providers to provide post-release appointments in all 88 counties. Community linkage staff are employed by OhioMHAS and supervised by an independently licensed social worker.

The purpose of the program is to link offenders with SPMI and/or SUD on Ohio Department of Rehabilitation and Correction's (state prisons) health caseload with community mental health appointments and other supports prior to the offender's release date; the goal is to facilitate successful reintegration into the community for offenders. The offenders served are being released from Ohio Department of Rehabilitation and Corrections with SPMI and/or considerable alcohol and drug issues. This program has been working with offenders at ODRC with SMI/ SPMI (including many with co-occurring SUD) for over 20 years. In 2013, the program expanded to providing linkage services to youthful offenders on the mental health caseload at Ohio Department of Youth Services (juvenile justice) in 2013. In 2014, this program was expanded to include linkage services for offenders with considerable SUD treatment needs. The program serves approximately 3,000 offenders each year.
http://mha.ohio.gov/Default.aspx?tabid=197

The Community Linkage Program facilitates continuity of behavioral health care for persons leaving the prison system by assisting in policy development, sharing of information, identifying and addressing needs, monitoring outcomes, and providing problem-solving assistance. The program promotes reduced recidivism rates for persons with behavioral health challenges, and facilitates recovery. Additionally, the Community Linkage program assists eligible offenders in applying for Social Security benefits and Medicaid to improve access to health care including behavioral health treatment. The goals of the Community Linkage Program include;

- Continuity of mental health care for offenders leaving an ODRC prison who are identified with SPMI or SUD or leaving an ODYS facility with SPMI.
- Reduce recidivism of persons with behavioral health needs who are involved in the criminal justice system
- Increase access to health care by assisting with Medicaid application prior to release
- Reduced de-compensation rates of released offenders to increase chances at recovery and successful reintegration
- Reduced relapse rate for persons with SUD
- Facilitate problem solving between the corrections and behavioral health system and offenders related to accessing community behavioral health services
- Enhance public safety by arranging post-release behavioral health services, recovery supports and benefits

Community Behavioral Health Services for Released Offenders

Community Behavioral Health Services

Community providers of SUD and SMI treatment serve offenders. In urban areas, specialized programs for offenders returning to the community are common, and briefly mentioned in some of the descriptions of providers in the previous two sections. Most ADAMH Boards prioritize this population in their community plans and their funding decisions. Additionally, ADAMH Boards, courts and jails collaborate in many communities to address local needs.

Criminal Justice/Behavioral Health Grants

OhioMHAS awarded a total of $3,000,000 in 23 grants from the Mental Health Block Grant state general revenue funds to ADAMH Boards in SFY 2015 to address needs of offenders involved in the local criminal justice system SPMI (a subgroup of SMI) who may also have co-occurring substance abuse and mental illness (SAMI). Each ADAMH Board identified specific needs in their community for their grants, so the specific needs addressed varied. The purpose of the grant was to assist offenders with various needs as they work to become productive members of society. It also allows the providers to help offenders with special requests that may fall outside of their regular resources. The indicators of success are that offenders maintain stay out of jail and prison, work and live independently.

Circle for Recovery (Post-Release SUD Treatment – Urban Minority Programs)
The Circle for Recovery is an OhioMHAS funded program for adult offenders being released from Ohio Department of Rehabilitation and Corrections with a history of SUD who are referred by SUD treatment staff within the prisons; the program also accepts self-referrals. Services provided include employment/vocational training; GED/education; health education including AIDS/HIV/STD education, relationship building, peer support, violence prevention, and crisis intervention services. This program is offered by UMADAOPs (Urban Minority Alcohol, Drug Addiction Outreach Programs) which have been providing prevention services to African Americans, Hispanics and other minorities in Ohio's cities since established by legislation in the 1980s. More recently these programs have been certified to provide SUD treatment services. The goals of the UMADAOP's include reduce recidivism of offenders, increase employment and GED completion, reunite offenders with families, and increase the number of offenders receiving services. The Urban Minority Alcohol and Drug Addiction Outreach Programs (UMADAOP's) Program facilitates continuity of behavioral health care for persons leaving the prison system by assisting in policy development, sharing of information, identifying and addressing needs, monitoring outcomes, and providing problem-solving assistance. The success of this program is a partnership among ADAMH Boards, Ohio Department of Rehabilitation and Corrections, and behavioral health providers.

Access to Recovery
ATR is a federal initiative that provides vouchers to clients for the purchase of treatment and recovery support services for persons with SUD leaving prisons; Ohio's federal funding ends in SFY 2018. The grant focused on men and women with an SUD diagnosis who were re-entering their community following incarceration or other criminal justice system involvement and veterans. Recovery support Services offered included Drug Free Supportive Transitional Housing, GED Training, Substance Abuse Education, Relapse Prevention, Employment Skills Training, Transportation, Domestic Violence Education, HIV/AIDS Education, Peer Mentoring, Parenting Classes, Spiritual Support, Daily Living Skills, Family Engagement, Recovery Coaching, Anger Management, Self Help and Support Groups (Not including 12 step). Recovery Support Services offered for adolescents include: Employment Skills Training, Daily Living Skills, Anger Management Parenting Classes, Peer Mentoring Support Groups and Spiritual Support.

Behavioral Health Services for Persons Involved with Criminal Justice System

Strengths

- OhioMHAS' Community Linkage program links offenders released from Ohio prisons and youth facilities with SUD and/or mental illness with treatment and recovery services in the community; it also assists with Medicaid and Social Security applications.
- Ohio has many courts with specialty dockets for individuals with SUD and SMI including some veterans' court.
- OhioMHAS is partnering with Department of Rehabilitation and Corrections; treatment of SUD within Ohio's prisons is being supervised by OhioMHAS Medical Director effective July 1, 2015. SUD treatment staff was increased about 50%, and the number of offenders receiving SUD treatment was increased.
- Mini grants will be made available for post-release treatment for offenders with SUD and/or SPMI.

Needs

- While funding for SUD treatment within the prisons is being increased, this funding is not sufficient to provide treatment for all offenders with SUD.
- Limited coordination of employment services and job training for SMI offenders being released from prison.
- Lack of coordination between county ADAMH Boards regarding residency issues for SMI and SUD offenders being released from prison.

Planning Steps

Step 2: Identify the unmet service needs and critical gaps within the current system.

Narrative Question:

This step should identify the unmet service needs and critical gaps in the state's current behavioral health system as well as the data sources used to identify the needs and gaps of the required populations relevant to each block grant within the state?s behavioral health system. Especially for those required populations described in this document and other populations identified by the state as a priority. This step should also address how the state plans to meet the unmet service needs and gaps.

The state's priorities and goals must be supported by a data-driven process. This could include data and information that are available through the state?s unique data system (including community-level data), as well as SAMHSA?s data sets including, but not limited to, the **National Survey on Drug Use and Health** (NSDUH), the **Treatment Episode Data Set** (TEDS), the **National Facilities Surveys on Drug Abuse and Mental Health Services**, the annual **State and National Behavioral Health Barometers**, and the **Uniform Reporting System** (URS). Those states that have a State Epidemiological and Outcomes Workgroup (SEOW) should describe its composition and contribution to the process for primary prevention and treatment planning. States should also continue to use the prevalence formulas for adults with SMI and children with SED, as well as the prevalence estimates, epidemiological analyses, and profiles to establish mental health treatment, substance use disorderprevention, and SUD treatment goals at the state level. In addition, states should obtain and include in their data sources information from other state agencies that provide or purchase M/SUD services. This will allow states to have a more comprehensive approach to identifying the number of individuals that are receiving services and the types of services they are receiving.

SAMHSA's Behavioral Health Barometer is intended to provide a snapshot of the state of behavioral health in America. This report presents a set of substance use and mental health indicators measured through two of SAMHSA's populations- and treatment facility-based survey data collection efforts, the NSDUH and the **National Survey of Substance Abuse Treatment Services** (N-SSATS) and other relevant data sets. Collected and reported annually, these indicators uniquely position SAMHSA to offer both an overview reflecting the behavioral health of the nation at a given point in time, as well as a mechanism for tracking change and trends over time. It is hoped that the National and State specific Behavioral Health Barometers will assist states in developing and implementing their block grant programs.

SAMHSA will provide each state with its state-specific data for several indicators from the **Behavioral Health Barometers**. States can use this to compare their data to national data and to focus their efforts and resources on the areas where they need to improve. In addition to in-state data, SAMHSA has identified several other data sets that are available to states through various federal agencies: CMS, the Agency for Healthcare Research and Quality (AHRQ), and others.

Through the **Healthy People Initiative**[1] HHS has identified a broad set of indicators and goals to track and improve the nation's health. By using the indicators included in Healthy People, states can focus their efforts on priority issues, support consistency in measurement, and use indicators that are being tracked at a national level, enabling better comparability. States should consider this resource in their planning.

[1] **http://www.healthypeople.gov/2020/default.aspx**

Footnotes:

Step Two: Identify the Unmet Service Needs and Critical Gaps within the Current System

This section provides an overview of data to identify unmet service needs and critical gaps related to a specific systemic issues and target populations for the Substance Abuse and Mental Health Block Grant. Data sources are identified and quantify contemporary issues within Ohio which align with our agency's mission and the goals of the Block Grants.

Key data from Ohio's **State Epidemiological Outcomes Workgroup (SEOW)** are presented for alcohol, tobacco, and other drug use and related consequences for driving judicious decision-making regarding the state's prevention resources. Ohio's SEOW is a multidisciplinary work group whose members are subject matter experts with vested interest who represent various agencies and organizations across Ohio. This workgroup, funded through a federal grant from SAMHSA/CSAP, was established by OhioMHAS in 2006, to merge epidemiology with data analysis, management, and usage regarding disorders that threaten the health and well-being of Ohioans. Ohio's SEOW is charged with improving prevention assessment, planning, implementation, and monitoring efforts through data collection and analysis to assess factors related to substance use. Other primary data sources include the National Survey on Drug Use and Health (NSDUH), Behavioral Risk Factor Surveillance System (BFSS), Medicaid Information Technology System (MITS) extracts, and peer reviewed journal articles.

Overview of Ohio. According to 2016 Census data, Ohio's population was 11,614,373, ranking it seventh most populous among states. The majority of Ohioans were white (82.4%), blacks or African Americans comprised 12.2 percent, Asians and those identifying two or more races, represented 2.2 percent each, and other races totaled less than half a percent. A total of 3.66 percent of residents identified as Hispanic or Latino. Ohio's poverty rate in 2015 was 14.8 percent. Female households had the highest poverty rate (32.1%) with break-outs showing the impact of poverty for those with children under age 5 (52.6%) and those with children under age 18 (43.1%). The majority of Ohioans had private health insurance (69.7%) while just over a third (36.6%) were publicly-covered and 6.5 percent lacked coverage. The median age was 39.2 years; youth under age 18 comprised nearly a quarter (22.5%), those age 18 to 64 constituted the majority of the population (61.3%) and residents age 65 years and over represented 16.2 percent of the population. [1]

Ohio's has 88 counties, 32 of which are designated as Appalachian. Among those counties, 7 were classified as economically distressed in 2016 by the Appalachian Regional Commission.[2]

The state profile, compiled by the Ohio Secretary of State, provided that Ohio is comprised of 44 percent prime farmland, has the nation's second largest population of Amish, estimated at 60,855 residents in 54 settlements, and the Columbus metropolitan area has one of the highest concentrations of Somali refugees in the nation, with an estimated 45,000 Somali immigrants settling in central Ohio in the past decade. One of Ohio's fastest-growing ethnic groups is the state's Hispanic population; census counts in 2010 showed a 40 percent increase from 2000 data and 2016 census estimates placed this group at 3.65 percent (or 424,625 residents).[3]

Ohio faces many behavioral health challenges, such as poor access to care and high prevalence of depression in youth and young adults, also among the challenges, the upsurge in opioid-related deaths has positioned the state in the top of the nation's opioid-related overdose deaths.

An estimated 26 percent of Ohioans, 3.05 million people, were enrolled in Medicaid during SFY16, for the provision of medically necessary healthcare services. According to Ohio's Legislative Service Commission, in FY16, Medicaid dominated state budget spending (50.6 %), was the largest health insurer in the state, and is the largest single state program, with annual spending of about $25.3 billion across all funds.[4] Medicaid is administered by the Ohio Department of Medicaid (ODM) with assistance from five other state agencies, Developmental Disabilities (DD), Job and Family Services (JFS), Mental Health and Addiction Services (MHAS), Health, and Aging and various local entities. Of total Medicaid expenditures, ODM and DD accounted for 99.0 percent of all funds; the remaining 1.0 percent was accounted for by the other four agencies.[5] In FY 2016, Medicaid expenditures for mental health and SUD services provided by the community behavioral health programs certified and/or licensed by OhioMHAS were $1.05 billion, which is about 4% of Ohio Department of Medicaid's expenditures. The $1.05 billion does not include Medicaid dollars expended for mental health and substance use disorder services provided by community hospitals in their psychiatric units and emergency rooms, primary care clinics and private practices.[6]

In recent years, Medicaid and its sister state agencies have had great success in modernizing and improving the Medicaid program, including vast enhancements to the state's system of mental health and addiction services. The Behavioral Health Redesign continues to expand upon this work by rebuilding Ohio's community behavioral health system capacity. In collaboration with the Governor's Office of Health Transformation (OHT) and OhioMHAS, ODM is implementing a series of reforms aimed at enhancing the quality of care delivered to Ohioans. A key finding of the Medicaid program by Medicaid Director Barbara Sears to the House Finance Subcommittee on Health and Human Services found that 62 percent of Ohioans with depression diagnoses received antidepressants.[7]

With the legalization of medical marijuana in 2016, Ohio is planning to launch its state patient registry in September 2018. Ohio's SEOW has initiated discussions regarding future data opportunities in line with the group's mission.

OhioMHAS utilizes internal as well as external data sources to assess need, demand, and access to substance abuse treatment services. In addition to OhioMHAS' client service data obtained from MITS extracts of Medicaid claims data, the agency began providing a free online youth survey in 2015, the Ohio Healthy Youth Environments Survey (OHYES!) for communities to use in local prevention planning efforts across the state. The total number of students, surveyed electronically by means of convenience sampling, over the 2015-2016 school year was 40,298. While data are not generalizable, results provide action data for use in prevention planning.

Health Status

Several national scorecards, including America's Health Rankings (2015)[8], Commonwealth State Scorecard (2015)[9], and Gallup-Healthways Wellbeing Index (2014)[10], placed Ohio in the bottom quartile of states for health outcomes. Ohio's population health outcomes performance has

steadily declined relative to other states over the last few decades, dropping from a rank of 27 in 1990 to 39 in 2015 according to America's Health Rankings.

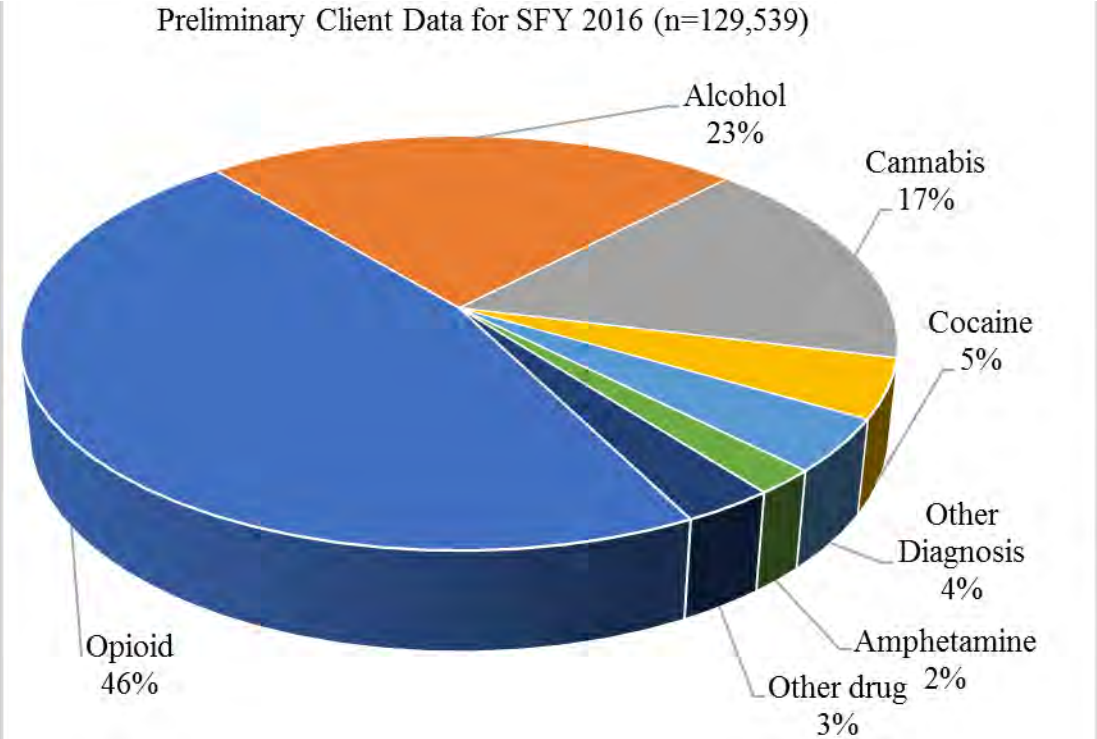
Ohio's 2016 State Health Assessment identified mental health, alcohol and drug abuse, obesity, cardiovascular disease and diabetes as healthcare priorities from a review of 211 local public health department and hospital assessments/plans. A near consensus in these top health issues was identified across regions of the state and across geographical classifications.[11]

Substance Use Disorders (SUDs)

Ohio's publicly-funded behavioral health client data, which are ***preliminary*** for SFY 2016, revealed 58.1 percent of clients had a mental health diagnosis, 11.3 percent had an alcohol or drug diagnosis, 12.2 percent were dually-diagnosed, and 18.5 percent lacked an assessment.[6]

The primary diagnosis for those receiving AoD treatment are presented in Fig. 1. Again, these figures are preliminary and are subject to change pending final data processing.

Figure 1. Primary Diagnosis of Clients in the Public Behavioral Healthcare System, SFY16.



Source: MACSIS/MITS, 2016 Year to Date (*preliminary and subject to change*)

Below Table 1. provides the primary diagnosis breakout by age (*i.e.* adult or youth) and by gender, with the top three categories shown in bold text. Most AoD clients were adults (94.2%); youth age 17 and under comprised 5.8 percent of clients. Opioids were the most diagnosed primary drug for adults (49.2%) while cannabis comprised nearly 75 percent of youth diagnoses. Alcohol was the second most diagnosed for both client populations. Females led in opioid diagnoses (55.5%), while males were diagnosed more for alcohol (27.2%) and cannabis (20.1%).

Table 1. Primary Diagnosis of Clients Receiving Publicly-funded Behavioral Healthcare Treatment, Preliminary Data, SFY 2016.

Primary Diagnosis, by Substance	By Age						By Gender	
	Adults (≥18)	%	Youth (≤17)	%	Total		Male%	Female%
Opioid	59,999	**49.18%**	280	3.72%	60,279		**40.27%**	**55.49%**
Alcohol	29,301	**24.02%**	716	**9.51%**	30,017		**27.17%**	**17.40%**
Cannabis	15,929	**13.06%**	5,604	**74.42%**	21,533		**20.07%**	**11.77%**
Cocaine	5,941	4.87%	33	0.44%	5,974		4.20%	5.20%
Other Diagnosis	4,833	3.96%	542	**7.20%**	5,375		3.86%	4.56%
Amphetamine	2,502	2.05%	56	0.74%	2,558		1.68%	2.38%
Other drug	2,203	1.81%	175	2.32%	2,378		2.26%	2.43%
Sedative	730	0.60%	47	0.62%	777		0.48%	0.77%
Nicotine	333	0.27%	53	0.70%	386			
Hallucinogen	186	0.15%	9	0.12%	195			
Inhalant	52	0.04%	15	0.20%	67			
Total	122,009	100%	7,530	100%	129,539		100%	100%

Source: MACSIS/MITS, 2016 Year to Date (*preliminary and subject to change*)

Prevalence of Substance Use Disorders (SUD)

Recent NSDUH prevalence estimates from 2013 - 2014 indicate approximately 8.55 percent of all Ohioans aged 12 or older are expected to have SUD based upon dependence or abuse criteria for illicit drugs or alcohol in the past year. Prevalence rates were slightly lower than those reported in 2012-2013 for both youth and young adults. The rate for SUDs in youth between the ages of 12 - 17 years was 4.87 percent and 17.27 percent for young adults aged 18 to 25. A slight increase to 7.57 percent was reported for adults aged 26 and older.[12]

U.S. Census estimates reported in July 2015, provided Ohio's estimated total population was 11,613,423 people.[13] Based on the above prevalence rates, it is estimated that of the 917,963 youth ages 12 to 17, 4.9 percent or about 44,704 had a substance use disorder. Young adults, ages of 18 to 25, had a much higher incidence of substance use; accordingly, of those 1,246,786 young adults, approximately 215,320 were expected to have a substance use disorder. Adults age 26 and older had the lowest prevalence rate, with the population being over 7.7 million adults--that translates to roughly 585,779 with a SUD.

According to the CDC, past month heroin use, past year heroin use, and heroin addiction have all increased among 18-25 year olds from 2002 to 2013.[14] In Ohio, past year heroin use from the 2014-2015 NSDUHs indicated the same, with heroin use highest among those in the 18-25 year group (0.92 percent) (Table 2).

Table 2. Past Year Heroin Use in Ohio among Persons 12 or Older

NSDUHs	State	12 or Older Estimate	12-17 Estimate	18-25 Estimate	26 or Older Estimate
2014-2015	U.S.	0.33%	0.10%	0.69%	0.29%
2014-2015	Ohio	0.38%	0.11%	0.92%	0.32%

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014 and 2015.

About 43,000 people, or 0.4 percent of Ohioans, reported past month heroin use based on 2011-2014 NSDUHs (Table 3). Opioid use, including heroin and nonmedical use of prescription pain relievers, during the past year, was reported by 5.2 percent of Ohioans, a total of some 500,000 people. Nonmedical use of prescription pain relievers in the past year was at 5.0 percent, which represents roughly 486,000 people.

Table 3. Past Year Opioid Use in Ohio among Persons 12 or Older

Past Year Use	Numbers in Thousands	% (95% Confidence Interval)
Opioid Use[1]	500	5.2 (4.7, 5.7)
Heroin Use	43	0.4 (0.3, 0.6)
Nonmedical Use of Prescription Pain Relievers	486	5.0 (4.6, 5.5)

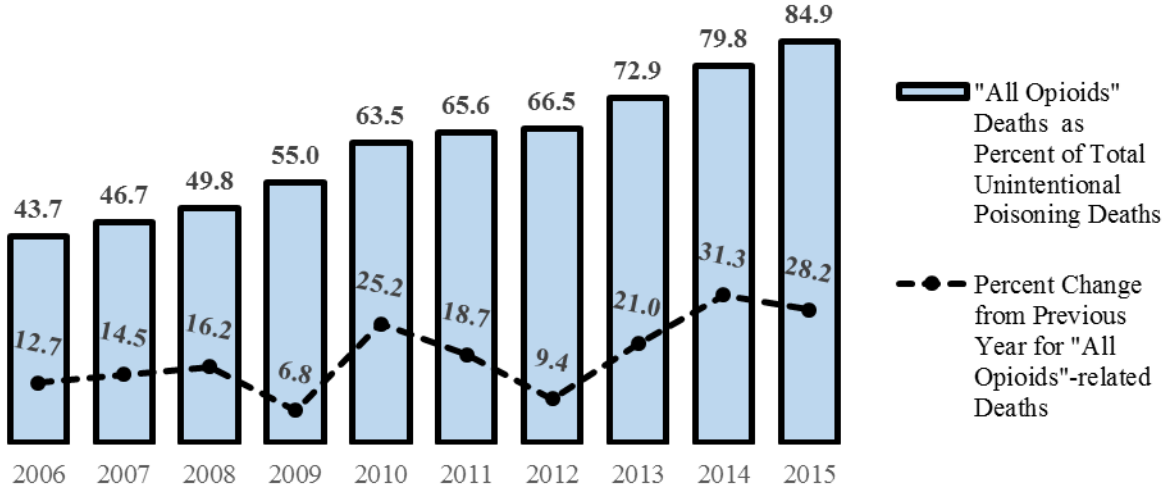
[1] Past year opioid use includes the use of heroin or nonmedical use of prescription pain relievers.

Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2011-2014.

Since 2009, opioids have contributed to an ever increasing proportion of unintentional poisoning deaths in Ohio, as depicted in Figure 2. Ohio Department of Health data for 2015, indicated nearly 85 percent (84.9%) of all deaths were attributed to opioids (*all opioids*) as represented in the graph. The total for that year was 3050 lives, on average eight per day, lost due to unintentional overdose; the annual overdose poisoning death rate leapt to a high of 27.7 per 100,000. Each year, Ohio has seen a positive percent increase in deaths attributed to opioids, with 2014 and 2015 showing the greatest increases over the last ten years.[15] In 2015, unintentional injuries attributed to opioid drug overdoses and lung cancer were the two leading

causes of premature death in Ohio. Recently, the Montgomery County Coroner's Office, which covers one-fifth of Ohio, proejcted the estimated death toll from opioid overdoses at a staggering 10,000 by the end of 2017.[16]

Figure 2. Ohio Deaths Involving Opioids: Percentage of Total Overdoses and of Change



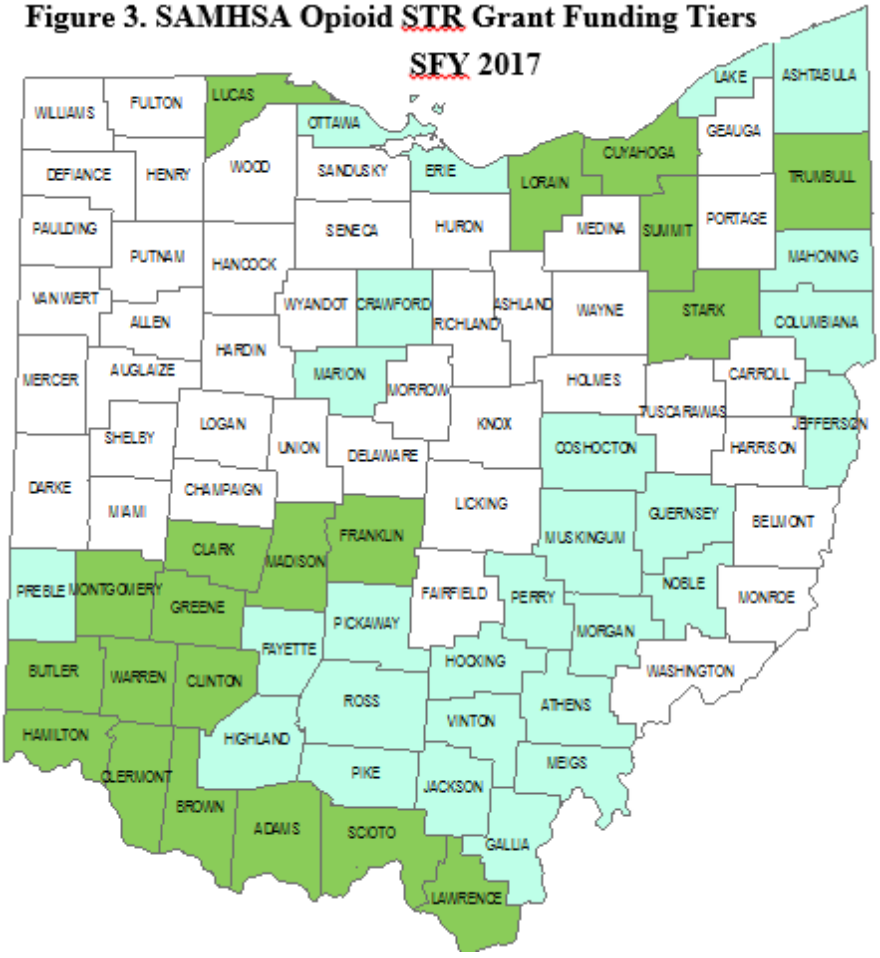
Source: Ohio Department of Health, Bureau of Vital Statistics, Analysis: ODH Injury Prevention Program.

In response to the opioid crisis, OhioMHAS relied on several indicators in determining areas for priority funding for SAMHSA's Opiate State Targeted Response (STR) Grant.

Funding for local projects was allocated to Tier 1 and Tier 2 counties. Tier 3 counties will have access to statewide workforce and training activities. In Figure 3, the three funding tiers are mapped as follows:

- **Tier 1 (Green-shaded):** 20 Counties --15 Board areas with Highest: Overdose

Figure 3. SAMHSA Opioid STR Grant Funding Tiers SFY 2017



Death Counts (2010-15), Overdose Death Rates (2010-15), and Fentanyl Deaths (2015). Total Residents: 7,030,825 (61% of state population)

- **Tier 2 (Blue-shaded):** 27 Counties --12 Board areas, Second Highest: Overdose Death Rates (2010-2015), Need for Treatment (NSDUH 2012-2014), Total Residents 1,678,383 (14% of state population)

- **Tier 3 (White):** 41 Counties with access to statewide prevention and work-force training activities

Current Substance Use

Current substance use, indicated by past 30 day use, revealed statistically significant change across age groups from 2013-2014 to 2014-2015 NSDUHs. Table 4. displays bolded values, representing statistical significance at the .05 or .10 level, as denoted by superscripts "a" or "b", respectively, with blue arrows pointing in the direction of significant change.

Table 4. Past Month Substance Use (Percentages), Ohio, 2013-2014 to 2014-2015.

Age		**Alcohol**		**Cigarette**	**Marijuana**		**Tobacco Product**	
12+	2013-2014	**53.81**[b]		25.93	**6.93**[a]		31.15	
12+	2014-2015	**52.56**	↓	25.26	**7.65**	↑	30.22	
12+	(*P* value)	0.09		0.331	0.023		0.198	
12-17	2013-2014	11.01		6.43	6.04		**9.37**[a]	
12-17	2014-2015	10.33		5.98	6.05		**7.86**	↓
12-17	(*P* value)	0.287		0.334	0.975		0.008	
18-25	2013-2014	61.96		33.42	**17.89**[b]		42.46	
18-25	2014-2015	61.18		33.72	**19.55**	↑	42.54	
18-25	(*P* value)	0.494		0.792	0.072		0.946	
26+	2013-2014	57.71		27.09	**5.24**[b]		31.96	
26+	2014-2015	56.28		26.22	**5.91**	↑	30.93	
26+	(*P* value)	0.116		0.317	0.074		0.252	
18+	2013-2014	**58.31**[b]		27.98	**7.02**[a]		33.44	
18+	2014-2015	**56.97**	↓	27.27	**7.82**	↑	32.55	
18+	(*P* value)	0.095		0.347	0.023		0.263	
Source: SAMHSA, NSDUHs								

Current use of marijuana in Ohio is the highest it has been (7.7%) in the last six years. Notably, marijuana use in the past 30 days, showed statistically significant *increases* across all groups, except for youth (12-17 age group), which showed a negligible increase, and which remained just above 6 percent. Young adults (18 to 25) reported the highest rate of past month marijuana use at 19.6 percent.

SYNAR

Ohio's annual Synar report details trends in tobacco sales to minors and the success of state compliance with the Synar Amendment. In Federal Fiscal Year (FFY) 2015, Ohio's Synar rate of noncompliance was 26.2 percent. This was the first time since Congress enacted the federal requirement that Ohio failed to meet the required noncompliance rate (currently 20.0%). The state's Synar noncompliance rate has improved, and as reported in Ohio's FFY2017 Annual Synar Report (ASR), the state's weighted retailer violation rate was 10.8 percent.

Past 30 day use of tobacco products showed a statistically significant decline to 7.8 percent for youth (12 to 17 age group); percentages varied little for all other age groups but remained high (*i.e*. ranging from 30% to 43%). Past month cigarette use declined for all age groups except for young adults (18 to 25) where a slight increase was observed; despite the declines, no significant differences were found. Cigarette use rates however remained highest for young adults (18 to 25) at 33.8 percent. Youth cigarette use rates were just below 6 percent and other adult groups had past month cigarette use rates from 25 to 28 percent.

According to the U.S. Department of Health and Human Services, e-cigarette use is now a major public health concern and over the past few years, has grown an alarming 900% among youth.[17] From Ohio's 2016 State Health Assessment, preliminary estimates for the 2014 Ohio Youth Tobacco Survey indicated currently more than one out of five (21.7%) high school students use electronic cigarettes and nearly half had ever tried an electronic cigarette.[11]

Alcohol use in the past 30 days decreased across all NSDUH age groups, with statistically significant decreases seen when comparing breakouts for the 12+ and 18+ groups. While values tended to show a decline in past month alcohol use, young adult and adult values remained high (*i.e*. 53% to 62%) and the rate of alcohol use by youth (12 to 17) was just above 10 percent. The rate of underage drinking, defined as past month alcohol use in those age 12 to 20, was 22.09 percent.

For years 2008 to 2015, the CDC's Behavioral Risk Factor Surveillance System (BRFSS) reported over half of Ohioans had at least one drink of alcohol in the past 30 days, with values in the range of 52.9 percent to 55.9 percent. Ohio's current alcohol consumption follows a similar trend as seen for the U.S. The 2015 BRFSS identified 52.9 percent of adults (18 or older) reported they had consumed alcohol (at least one drink) in the past month. More males reported past month alcohol drinking (58.1%) than females (48.1%). Respondents age 25 to 34 had the highest past month percentage (63.1%), followed by those aged 35 to 44 (62.0%). [18]

Data from the 2014-2015 NSDUHs for those 12 and older were similar to the BRFSS for current alcohol use (52.6%) by Ohioans. Those aged 12 to 20, reported current alcohol use of 22.1 percent. Alcohol use was highest in the 18 to 25 year age group (61.2%) followed by the 26 and older group (56.3%) and the 12 to 17 age group (10.3%).

Binge drinking. Over a quarter (27.2%) of Ohioans reported recent binge drinking according to the 2013-2014 NSDUHs. Ohio has exceeded the U.S rate for binge drinking since 2009 and had the highest binge drinking rate among states, with only seven states exceeding Ohio in 2013-2014. Young adults, age 18 to 25, have had the highest rates of binge drinking (41.25 to 44.8%)

in the state since 2009-2010. The BRFSS 2015 data revealed that as age group increased, reported binge drinking decreased with the 18 to 24, 25-34, 35 to 44, 45 to 54, 55 to 64 and 65 and older groups reporting 32.3, 28.4, 21.9, 18.4, 11.9, and 4.5 percent respectively. One consequence of alcohol consumption can be seen in Ohio's alcohol-related crash fatalities. State Highway Patrol data for 2015 showed Ohio had an alcohol-related crash death rate per 100,000 of 3.2[19]

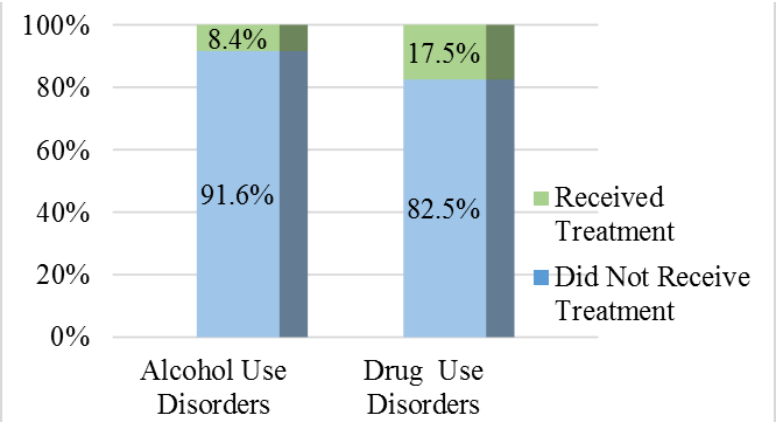
Illicit Drug Use in Past Month. The most recent findings for illicit drug use (including marijuana /hashish, cocaine (including crack, heroin, hallucinogens, inhalants, or prescription-type pychotherapeutics used nonmedically and methamphetamine) in the past month was greatest among those 18 to 25 years of age in Ohio (20.5%), followed by the 12 to 17 age group (8.3%) and those 26 and older (6.9%). The state rate has ranged from 7.9 to 8.8 percent for the same five year period, according to the 2009-2010 to 2013-2014 NSDUHs.

A longer time period was assessed for select drug use including marijuana, cocaine and heroin; NSDUHs for 2014-2015 revealed *past year* use among those in the 18 to 25 age group was highest, with rates of 32.04, 4.24 and .92 percent, respectively. For marijuana, use in the last year was roughly 3 to 5 percent higher than past month use across each age group except for the 18 to 25 year group. Young adults, 18 to 25, reported past year marijuana use that was 12.5 percent above the rate for past month use.

Alcohol Use Disorder. According to 2014-2015 NSDUHs, 6.5 percent of Ohioans 12 or older met the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV) criteria for alcohol dependence or abuse. Respondents aged 18 to 25 had the highest percentage of alcohol disorders meeting DSM-IV criteria (11.7%). A decrease was observed across the 12 to 17 and 18 to 25 NSDUH age groups from 2009-2010 to 2014-2015 for those meeting DSM-IV criteria.

Needing but Not Receiving Treatment. In the year prior to the NSDUH, about 7,000 people (8.4%), age 12 or older received treatment for alcohol dependence or abuse; about 50,000 people (17.5%) received treatment for illicit drug dependence or abuse across each year shown (Fig. 4).

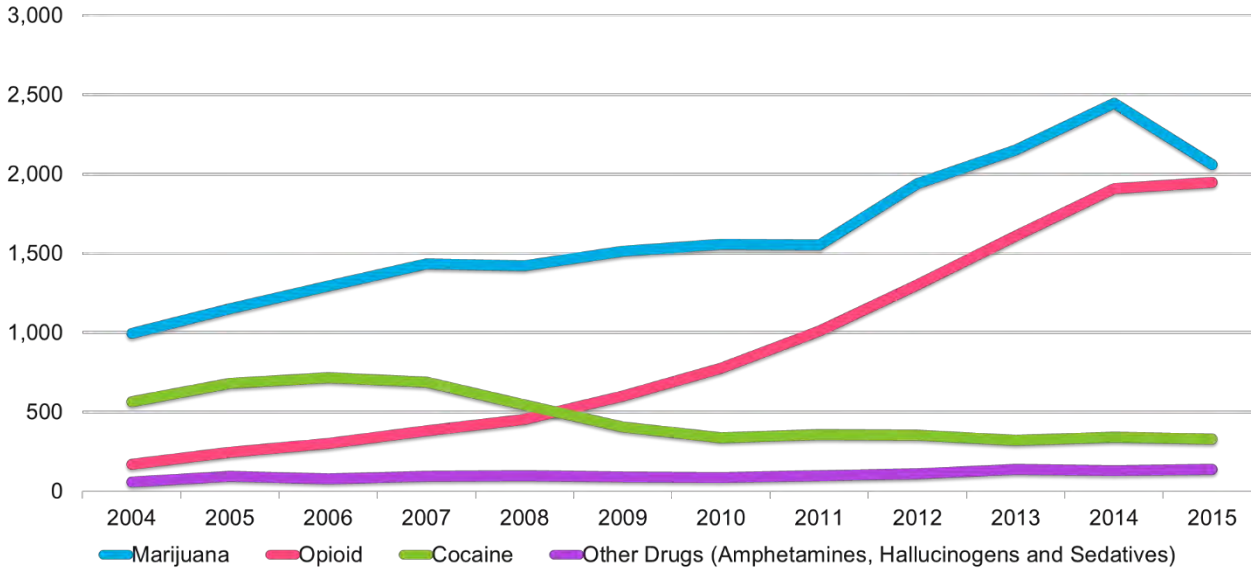
Figure 4. Past Year Treatment, NSDUH Annual Averages 2010-2014, Ohio.



Pregnant Women and Substance Use

In 2014, Ohio's expectant mothers were nearly twice as likely to have smoked during their pregnancy when compared to the U.S. overall according to Ohio's 2016 State Health Assessment.[11] In additional to tobacco use, Ohio's pregnant women are heavily impacted by the opioid crisis. Ohio Hospital Association data presented in Fig. 5 for 2015, revealed 4,013 cases of drug abuse or dependence diagnosed at the time of delivery; the number of cases for opioids (n=1,949) and marijuana (n=2,061) were similar; cocaine (n=332) and other drugs (n=137) were identified in fewer cases. Trend data for 2004-2015 show the number of cases by substance at time of delivery; sharp increases were seen for opioids, and a steady decline was reported for cocaine since 2007.[20]

Figure 5. Drug Abuse or Dependence Diagnosis at Time of Delivery, Number of Cases, Ohio 2004-2015



Source: Ohio Hospital Association

Increasing rates of drug use among delivering women has contributed to babies being born with the drug withdrawal syndrome, Neonatal Abstinence Syndrome (NAS). Health outcomes for NAS infants are significantly worse than for all Ohio infants.

Neonatal Abstinence Syndrome (NAS)

The Ohio Department of Health reported between 2006 and 2015, 11,283 hospitalizations in Ohio resulted from NAS in inpatient settings. In 2015 alone, there were 2,174 admissions (about six admissions per day). The NAS rate grew nearly 8 times from 20 per 10,000 live births in 2006 to 155 per 10,000 live births in 2015.[21] The most common conditions associated with NAS were respiratory complications, low birth weight, feeding difficulties and seizures. Pregnant women in treatment are disclosing opioids and marijuana as their primary drug of choice.

Ohio Substance Abuse Monitoring (OSAM) Network

The Ohio Substance Abuse Monitoring (OSAM) Network has eight regional epidemiologists (REPIs) who conduct focus groups and individual qualitative interviews with active and recovering drug users and community professionals (treatment providers, law enforcement officials, etc.) to obtain epidemiological profiles of local substance abuse trends. Bi-annual qualitative findings are supplemented with available statistical data such as coroner's reports and crime laboratory data to provide accurate epidemiological descriptions that policymakers need for use in planning appropriate prevention and intervention strategies.

Data on current substance availability, collected from July through December 2016, are presented in Table 5.[22] Triangulation was achieved through comparison of participant data to qualitative data collected from 123 community professionals via individual and focus group interviews, as well as to data surveyed from coroner and medical examiner offices, family and juvenile courts, municipal courts, common pleas and drug courts, the Ohio Bureau of Criminal Investigation (BCI), police and county crime labs and OhioMHAS' Screening, Brief Intervention and Referral for Treatment (SBIRT) program which operates in federally qualified health centers. In addition, data were abstracted from the National Forensic Laboratory Information System (NFLIS) which collects results from drug chemistry analyses conducted by state and local forensic laboratories across Ohio. Reports contain in-depth information about drug trends, cost, street names, and methods of use across Ohio's eight OSAM network regions for the following substances as well as several others.

Table 5. Current Substance Availability during the Past 6 Months, Participant Report (n=334) by Region.

Substance	Akron-Canton	Athens	Cincinnati	Cleveland	Columbus	Dayton	Toledo	Youngstown
Crack	High	High	High	High	High	High	High	High
Heroin	High	High	High	High	High	High	High	High
Marijuana	High	High	High	High	High	High	High	High
Methamphetamine	High	High	High	High	High		High	High
Powdered Cocaine	High	High	High	High	ModHi	High	High	ModHi
Prescription Opioids	Mod	High	ModHi	High	ModHi	High	High	ModHi
Prescription Stimulants		High	High	High	ModHi	High	Mod	High
Sedative-hypnotics	High	High	High	High	High	High	High	High
Suboxone®	High	High	ModHi	High	High	High	High	High
Mod= Moderate; ModHi = Moderate to High; Blank =No consensus								

Source: Ohio Substance Abuse Monitoring Network January 2017 Report

During SFY 2017-2018, the OSAM Network will produce three targeted response initiatives to contribute to the evaluation of SAMHSA's State Targeted Response to the Opioid Crisis Grant (CURES) in Ohio.

State Epidemiological Outcomes Workgroup (SEOW)

The purpose of Ohio's federally-funded State Epidemiological Outcomes Workgroup (SEOW) is to provide communities with data needed to improve prevention planning and implementation for alcohol, tobacco, and other drugs (ATOD). The previous federal Strategic Prevention Framework (SPF)/State Incentive Grant (SIG) and new Partnerships for Success (PFS) grant supports the work of the SEOW which is responsible for collecting, analyzing, and reporting substance use incidence, prevalence and consequence data.

The SEOW provides data on the following topic areas:

- Alcohol, tobacco, drugs, gambling, mental health, health and well-being
- Related consequences from substance use/misuse/abuse
    - such as accidental drowning, sexually-transmitted diseases, vehicle crashes, property crime, and unintentional drug deaths
- Measures of use
    - such as age of initial use, current use, lifetime use, current binge use, heavy use, use, and per capita consumption
- School, community and economic data

SEOW Data Sources **Surveys and Federal Government Agencies:**	
Centers for Disease Control (CDC) • Behavioral Risk Factor Surveillance System (BRFSS) • WONDER • Youth Risk Behavior Surveillance Survey (YRBSS) Federal Bureau of Investigation • Criminal Justice Information Services Division • Uniform Crime Report (UCR) National Institutes of Health (NIH) • National Institute on Alcohol Abuse and Alcoholism (NIAAA) SAMHSA • National Survey on Drug Use and Health (NSDUH) US Bankruptcy Courts US Census Bureau • Small Area Health Insurance Estimates (SAHIE) • Small Area Income & Poverty Estimates (SAIPE) US Department of Commerce	
Ohio State Government Agencies:	
• Ohio Department of Commerce, Division of Liquor Control (ODC-LC) • Ohio Department of Education (ODE) • Ohio Department of Health (ODH) • Ohio Department of Job and Family Services (ODJFS) • Ohio Department of Public Safety (ODPS) **Other (non-government):** • Orzechowski and Walker	

SEOW Data Products: Network of Care and ODH Data Warehouse

Ohio's SEOW provides an online data resource for the public on Ohio's Network of Care (NoC) with current and historical data presented in tables, graphs, and maps. Definitions, data caveats, and sources with hyperlinks are provided for each indicator. Visualizations include national, state and county data with various demographic break-outs. Indicators are organized by topic area and by data source. SEOW county profiles are also available with pre-loaded indicators available by year. The main state landing page is displayed (Fig. 6).

Figure 6. Network of Care, State Landing Page

OhioMHAS and ODH partnered to display SEOW-relevant indicators as well as Ohio's youth survey data (OHYES!) in the ODH Data Warehouse (DW). The purpose was to create an integrated, comprehensive, one-stop-shop approach to accessing Ohio's health-related data. OhioMHAS created video tutorials and guides on how to access data in the public and secure areas of the warehouse.

Ohio's NoC is accessible to the general public and co-locates mental health and public-health data to facilitate more integrated planning at the state and local levels. The SEOW's Field Liaison and Data Analyst provide presentations and trainings on access and use of data in the ODH DW and on the NoC.

Ohio Healthy Youth Environments Survey (OHYES!)

OhioMHAS collaborated with the Ohio Departments of Education, Health and other system stakeholders to develop a statewide student survey for providing local and current data on youth. The OHYES! is anonymous, voluntary, and is conducted online in schools across the state; students in grade 7 through 12 are eligible to participate. Items were included for the following:

-Demographics
-Marijuana and Prescription Drugs
-Physical Health & Well-being
-Gambling
-Family and Peer Factors, Community
-Alcohol, Tobacco and Vapor Products
-Bullying, Safety and Violence
-Mental Health
-School Success, Climate and Safety
-Sexual Behavior and Suicide (optional)

Aggregate data, adhering to cell size and agency-directed display rules, are available to all stakeholders in the ODH Data Warehouse; district and school-level results are also available by password for designated school administrators. Data tables and visualizations are in the process of being created for Ohio's Network of Care. Results will be available to the general public in keeping with the previously mentioned suppression rules. The first survey was administered during the 2015-2016 school year; participation is described in Table 6.

Table 6. OHYES! Participation by School Year (SY).

OHYES! Ohio Healthy Youth Environments Survey	**SY 2015-2016**	**SY 2016-2017**
Students participating	40,298	14,797
Counties participating	48	12
Districts participating	90	35
Schools participating	163	49

While results are not generalizable, schools, state and local agencies, organizations and communities can use OHYES! data to assess and monitor the health and safety of Ohio's youth. Survey findings of current and lifetime use of ATOD are presented in Table 7 for each period.

	Table 7. OHYES! Results.	**School Year 2015-2016[2]**	**School Year 2016-2017[3]**
	Total N[1]	40,298	14,797
Past 30-day Use	Alcohol	10.9%	15.1%
	Cigarette	5.3%	6.7%
	Marijuana	6.2%	8.3%
	Tobacco (cigarettes, cigars, chewing tobacco, snuff, or dip)	7.7%	10%
	Electronic Vapor	8.9%	9.3%
Lifetime Use	OTC medications to get high	8.3%	8.5%
	Prescription drug (w/o being prescribed)	2.1%	2.6%
	Prescription pain reliever (w/o being prescribed)	1.2%	1.5%

[1] Valid n differs by individual item
[2] Schools were solicited to participate in SY 2015-2016
[3] OHYES! was available upon request in SY 2016-2017

Survey data provide a snapshot of youth health behaviors in each county across the state and serves as a valuable tool in better understanding the interrelated needs in youth program planning, implementation, and evaluation. The data are essential for strategic planning, prioritizing needs and allocating limited resources.

IV Drug Users and STDs

According to the CDC, injection drug use (IDU) has accounted, either directly and indirectly, for about a third of the HIV infections in the U.S. since the beginning of the HIV epidemic in the early 1980's.[23] Despite the CDC's report that HIV infections in the U.S. attributed to IDU has declined in the most recent five year period (range: 7-10 percent of HIV infections 2009-2013), injecting drugs remains a significant HIV risk factor. Shared and recycled needles create an environment that's ripe for viral infections caused by HIV and Hepatitis C. Over 80 percent of those diagnosed with hepatitis contracted the disease through the use of shared or unsterilized needles.

The "*Syringe Exchange Programs in Ohio, March 2016*" report discusses the impact of the opiate crisis citing the shift from pills to injectable, liquid heroin and the resulting public health safety concerns surrounding IDU and needle-sharing.[24] To combat communicable infections, Ohio established the five syringe exchange programs (SEPs) listed in Table 8.

Table 8. Ohio's SEPs and Year of Establishment.

Syringe Exchange Programs	Cleveland	Portsmout	Cincinnati	Dayton	Columbus
Year Established	1995	2011	2014	2015	2016

Source: The Center for Community Solutions, *Syringe Exchange Programs in Ohio, March 2016*

The Akron Beacon Journal recently reported on two new needle exchange programs aimed at stopping the spread of HIV and hepatitis C by IDU for the following:

- Cincinnati City Council approved funding in the city's 2018 budget
- Stark County, Canton City Health Department, has services now underway

Federal funding restrictions for SEPs are now relaxed in Ohio--as the state continues to face this opioid epidemic with communicable infections associated with IDU and needle sharing.

In 2015, Ohio had an estimated 902 adults and adolescents who were diagnosed with HIV. Data from the Ohio Department of Health identified persons diagnosed with HIV infection and who reported injection drug use (PWID) as follows:

- 5.65 percent of the 902 diagnosed HIV infections were attributed to IDU (including IDU and male-to-male sexual contact with IDU);
- those diagnosed with HIV who reported IDU, comprised 5 percent of all males and 10 percent of all females;
- for PWID, whites accounted for the largest proportion (4.2%), followed by black/African Americans (1.0%) and Hispanic/Latinos (0.22%).[25]

Ohio's State Health Profile reported by the National Center for HIV/AIDS, Viral Hepatitis, STD, and TB Prevention further summarized 2015 data as follows:

- HIV/AIDS:
  - Ohio ranked 13th among states for number of HIV diagnoses
  - Diagnoses for black patients (51.1 %) exceeded those for white patients (39.4%)
- Primary and secondary syphilis:

  - Ohio's rate per 100,000 was 3.8 in 2011 and 4.8 in 2015
  - placed Ohio 25th for primary and secondary syphilis among the states
  - additionally, 82 cases of congenital syphilis (from infected mothers to unborn children) were reported from 2011 to 2015
- Chlamydial infections:
  - Ohio ranked 16th among states with 489.3 per 100,000 persons
  - rates among women (672.8 cases per 100,000) were 2.3 times greater than those among men (297.8 cases per 100,000)
  - among females, age 20-24 had the highest number of cases (15,670)
- Gonorrheal infections:
  - Ohio ranked 12th among states 142.9 per 100,000 persons
  - among females, age 20-24 had the highest number of cases (2,993)
- Tuberculosis (TB)
  - ranked Ohio 41st among states for TB rates (1.2 per 100,000 persons)
  - 62.24% of Ohio's TB cases occurred in foreign-born persons
- Hepatitis:
  - rates of acute hepatitis A did not increase
  - rates of acute hepatitis B increased by 338%
  - rates of acute hepatitis C increased by 1000%.[26]

Substance Involvement in Suicides and Homicides

Ohio Department of Health (ODH), Violent Death Reporting System (VDRS) reported various substances were implicated in suicides and homicides in Ohio; however marijuana and alcohol were detected at the highest rates. Results from 2014 toxicological analyses, conducted on 1,155 homicide victims, indicated decedents tested positive for marijuana (35%) and alcohol (31%); suicide victims (n=512) tested positive for alcohol most often (29%).[27] Decedents may have tested positive for more than one type of substance. Ohio's 2015 age-adjusted suicide death rate was 13.9 per 100,000 residents, up from 12.5 reported for 2014.

Suicide, homelessness and veterans are addressed more fully in the mental health portion of this section.

Mental Health

Substance use has generally declined while depression has steadily increased among Ohio's youth and young adults since the 2012-2013 NSDUHs. An estimated 109,000 youth (11.9 %) and 137,000 (11.2 %) young adults age 18 to 25 reported having at least one major depressive episode (MDE) in the past year according to the 2014-2015 NSDUHs. The state rate of 7.74% equates to roughly 682,000 of Ohioans, age 18 and older, having a MDE in the past year. For major depressive episode in the past year, Ohio ranked 8th highest for adults (18 and older) as well as for young adults (18 to 25) among all the states for 2014-2015.

From the NSDUHs, Ohio had the fourth highest rate among states for serious mental illness (SMI) in the past year *across each age group* and ranked 10th, 13th and 7th for any mental

illness (AMI) in the past year across the 18 and older, 18 to 25, and 26 and older groups, respectively. Rates displayed in Table 9 indicate increasing mental health-related concerns across the majority of Ohio's age groups. Young adults (18 to 25) had the highest rates for both SMI and AMI, and youth age 12 to 17 had the highest percentage change for MDE.

Table 9. NSDUH Mental Health Measures for Ohioans and Percentage Change.

Past Year, Mental Health Measures	Age	2014-2015 Ohio	2013-2014 Ohio	Change
Serious Mental Illness	18+	5.22%	4.95%	↑
	18-25	5.94%	5.43%	↑
	26+	5.10%	4.87%	↑
Any Mental Illness	18+	20.20%	20.26%	
	18-25	22.49%	20.83%	↑
	26+	19.82%	20.17%	
Major Depressive Episode	12-17	11.85%	10.33%	↑
	18+	7.74%	7.33%	↑
	18-25	11.18%	10.27%	↑
	26+	7.19%	6.85%	↑

Source: SAMHSA, NSDUHs

Publicly-Funded Mental Health Services

Ohio's publicly-funded community behavioral healthcare system served mostly adults (61.6%) with services to youth accounting for 38.4 percent. Preliminary data for FY2016 Medicaid eligible services for mental health clients revealed 7.8 million claims were filed, an average of roughly 21 claims per person. Figures for both adults and youth are given in Table 10.

Table 10. FY2016 Medicaid Eligible Services for Publicly-Funded Mental Health Clients

	Patients (count)	Claims (count)	Claims (average)
Adults (≥18)	228,975	3,726,838	16.3
Youth (<18)	142,443	4,029,589	28.3
Total	371,418	7,756,427	20.9

Source: MACSIS/MITS, 2016 Year to Date (*preliminary and subject to change*)[6]

Medicaid. An estimated 26 percent of Ohioans were enrolled in SFY16, or 3.04 million people, for the provision of healthcare services to families and children, pregnant women, related caretakers, childless adults and people with disabilities, with incomes below a specific amount according to the Ohio Department of Medicaid. Medicaid enables treatment of chronic health conditions (including mental health conditions such as addictions), injury, and illness; it also covers preventive care, screenings, and prescription drugs.

Medicaid claims increased roughly by 2 million claims, or 15.8% from SFY14 to SFY15 for services provided to clients matched in the public behavioral healthcare system for alcohol, drug,

and mental health services based on Medicaid Information Technology System (MITS) extracts. During this period, there was a shift in payment of alcohol and drug-related claims from state-only to Medicaid-coverage due to Ohio's participation in the expansion.

Payments for services to clients in the community behavioral healthcare system, showed a 4.7 percent increase in total payments for alcohol and drug-related treatment services from SFY15 to SFY16. For payments covering mental health services only, in the public system, adults comprised 61.6% and youth 38.4% of total payments made, based upon currently available, preliminary data for SFY16. For SFY16, payments for managed care services are not included and data provided are preliminary. Once the claims data are finalized, there may be a larger increase observed for mental health services due to managed care.

Statutory and Historical Reporting of Ohio Statewide Prevalence and Incidence
The Mental Health Block Grant has a statutory requirement to report on prevalence and incidence of serious mental illness (SMI) and serious emotional disorder (SED) in each state. Prevalence is the number of persons with SMI and SED among all Ohioans. Incidence is the number of persons treated for SMI and SED in Ohio's public behavioral health system.

In addition to the reporting of prevalence and incidence in the preceding paragraphs using NSDUH and Medicaid data, Ohio has historically reported data using specific criteria developed by a SAMHSA contractor, National Association of Mental Health Program Directors – National Research Institute (NASMHPD-NRI). These data are used to justify Maintenance of Effort waiver requests if Ohio has a shortfall of state spending on mental health services of 3% or less. SAMHSA has moved these data to the Environmental Factors and Plan, section of this document, 10. Statutory Criterion for Mental Health Block Gant where OhioMHAS included it.

Regional (State-Operated) Psychiatric Hospitals
OhioMHAS provides quality inpatient mental health care at its six regional psychiatric hospitals. Statewide capacity is typically at 95 percent occupancy in the 1,081-bed system. During SFY16, there were 6,563 admissions for inpatient care, averaging $573.80 per patient/bed day. Annual percent change in admissions showed little change for 2009 to 2011 and increased roughly 18 percent, 9 percent, 5 percent for years 2012, 2013 and 2014 respectively. Based on prior year admissions, admissions for SFY15 dipped by 6% and by 10% in SFY16 (Figure 7). [28]

Figure 7. Ohio's Regional Psychiatric Hospital Admissions by Fiscal Year.

Source: Ohio Department of Mental Health and Addiction Services Annual Reports[28]

Youth Suicides

Data from ODH VRDS for 2012 to 2014 provided, on average 187 youth died each year, by means of suicide. Suicide prevalence and patterns differed by age with an annual average for those ages 10 to 14 of 19 compared to 168 for those ages 15- 24. The overall death rate for those age 15-24 years was 10.7 per 100,000.[27]

During this period, the majority of Ohio's suicide victims age 10 to 24 were male (78%), white, non-Hispanics. Investigation yielded surrounding circumstances in 86 percent of cases, including: mental health diagnosis (44%); current treatment for mental illness (27%), depression (25%), alcohol dependency (5%) and substance use problems (19%). From available toxicology reports, more than one substance was often found. Marijuana was most commonly identified in suicide deaths of 15 to 24 year olds.

NSDUHs for 2014-2015 place Ohio 6th highest for suicidal ideation among those 18 and older (4.64%) and 11th highest among young adults age 18 to 25 (8.52%) among states. Responses were based on "yes" when participants were asked if at any time in the past 12 months, "did they seriously think about trying to kill" themselves.

The most recent findings, from the 2013 Youth Risk Behavior Survey (YRBS) revealed the following about Ohio youth:

- 25.8 percent felt sad or hopeless almost every day for 2 or more week in a row;
- 14.3 percent seriously considered attempting suicide during the year prior to the survey;
- 6.2 percent reported attempting suicide during the year prior to the survey.[29]

Older Adults

Older adults, aged 65 and older, comprise more than 12 percent of the current American population, by 2030 they will make up one-fifth of the population (U.S. Census Bureau, 2000).[30] Census estimates for 2016, provided 16.2 percent of Ohioans are age 65 and older; females comprise 56.3 percent of this age group and 66.2 percent of the 85 and older age group.

With the rapid growth in the older adult population, the demand for mental health services is likely to increase. According to SAMHSA, depression affects many older adults. While it can usually can be successfully treated, it is widely under-recognized and under-treated.[30]

Risk factors for depression can include changes in physical health or functioning, mental health; circumstances or social support. According to STEADY U, a comprehensive falls prevention initiative led by the Ohio Department of Aging, falls are the number one cause of injuries leading to ER visits, hospitalizations and deaths for Ohioans age 65 and older.[31] Alzheimer's in Ohioans age 65 and older is projected to increase by 19 percent from 2015 to 2015 according to the 2015 Alzheimer's Disease Facts and Figures from the Alzheimer's Association.[32]

According to SAMHSA's 2015 Behavioral Health Barometer for the United States, in the past year the 65 and older age group had:

- the lowest rate (1.4%) among all age groups for alcohol use disorder, and
- the lowest rate (0.3%) among all age groups for illicit drug use disorder.[33]

In Ohio, Caucasian males over the age of 85 had the highest rate (41.3) of any age group; the age-adjusted suicide rate for 2015 was 16.3 for those ages 55 and above; rates are further broken out by individual age grouping and gender in Table 11.[34]

Table 11. Suicide in Ohio's aging population during 2015.

2015 Suicide Data, Ohio	Age 55-64		Age 65-74		Age 75-84		Age 85+		Total	
Intentional self-harm (suicide) (*U03,X60-X84,Y87.0)	Count	Age Adjusted Rate	Count	Age Adjusted Rate	Count	Age Adjusted Rate	Count	Age Adjusted Rate	Count	Age Adjusted Rate
Females	51	6.2	28	5	15	4.8	7	4.2		
Males	220	28.4	118	24.2	88	38.2	35	41.3		
Total									562	16.3

Source: Ohio Department of Health, Public Health Data Warehouse

According to information on SAMHSA's website, "The prevalence of substance use disorders among older adults remains relatively constant until they reach the age of 60. After that, the rate of those disorders drops to about 6%.

Data for those 65 and older from the 2015 NSDUHs highlights similar findings:

- Only 25.6% had ever used illegal drugs in their lifetime, while lifetime use rates were 53.6% for those ages 60 to 64 and ranged from 50 to 65 percent for each age group from 19 to 59;
- Past month illicit drug use was 1.9 percent, while the national rate was 10.1 percent;
- Past month tobacco product use 10.6 percent, compared to the U.S. rate of 23.9 percent;
- Past month alcohol use was 42.7 percent, compared to 51.7 percent for the national rate;

Across all age groups, those 65 and older had the lowest rate of mental illness (10.6%) and 1.9 percent had serious thoughts of suicide in the past year, while the national average was 4.2%.

Nevertheless, many older adults still experience mental distress associated with limitations, impairments, or an untreated mental illness such as depression. In the 65 and older population depression affects more than 6.5 million people and is closely linked to substance abuse and disability and if left untreated, increases the risks of cognitive decline and suicide.

Nearly, one of every four older adults have some type of mental health problem, such as a mood disorder, not associated with normal aging; those with mental disorders are less likely to be nonsmokers, to eat healthy, or to regularly take part in moderate physical activity.[30]

Serious Mental Illness (SMI) and Homelessness

Ohio's homeless population includes a high proportion of person with serious mental illness and/or SUD. Data for homeless persons are based on annual Point-in-Time Counts (PIT), and occur during one day, during the last ten days of January as required by the U.S. Department of Housing and Urban Development (HUD).[35] Counts of sheltered and unsheltered homeless people are shown below and provide support for local planning efforts by identifying unmet needs and characteristics of homeless populations.

Table 12. Ohio's Homeless, 2017 Point in Time (PIT) Counts.

Ohio, 2017 Point in Time Summary	**Sheltered**			**Unsheltered**	**Total**
	Emergency	Transitional	Safe Haven		
Total Number of Households	1,241	424	10	485	**2,160**
Total Number of Persons	1,860	816	10	623	**3,309**
Adults with SMI	280	92	9	145	**526**
Adults with a SUD	117	65	1	120	**303**
Adults with HIV/AIDS	2	0	0	1	**3**
Victims of Domestic Violence	339	159	1	108	**607**

Source: Coalition on Homelessness and Housing in Ohio, Inventory Count Date 1/24/2017

For the first time since 2012, Ohio Balance of State (BoS) Continuum of Care (CoC) communities that includes the non-metropolitan areas, which receive federal funding, reported an increase in total homelessness. From 2016 to 2017, PIT Count data showed:

- a 9 percent increase in total homelessness in the CoC's 80 counties
  - including a 4% increase in sheltered homelessness and
  - a massive 40% increase in unsheltered homelessness

Ohio BoSCoC PIT Count 2017 data for specific subpopulations are found below:

Sheltered Homelessness

• 2686 homeless in emergency shelter, transitional housing, and safe havens, representing a 4% increase from 2016

Unsheltered Homelessness

• 623 unsheltered homeless, a 40% increase from last year

Chronic Homelessness

• 180 chronically homeless individuals, nearly identical to 2016 (182 reported in 2016)

Veteran Homelessness

• 160 homeless Veterans, which was a 23% decrease from 2016

Youth Homelessness

• 262 total homeless youth (unaccompanied or parenting youth under age 18 or between 18 and 24), which represents a 22% increase from the number reported in 2016.[36]

With federal grant funds from SAMHSA, OhioMHAS funds outreach and engagement to reach persons with SMI and/or SUD and link them to treatment and recovery supports. One of these grants, Project for Assistance in Transition (PATH), is a SAMHSA formulary grant that was authorized by Congress in 1990 to reach persons with SMI. Ohio also received Cooperative Agreement to Benefit Homeless Individuals (CABHI) funds for FFY 2015 – FFY 2017. With CABHI funds, Ohio was able to expand PATH services to persons with SUD.

CABHI funds also included a focused outreach to homeless and chronically homeless veterans and funded the implementation of evidence-based intervention practices with persons with SMI, SUD and/or homeless veterans; Ohio's program data for these populations is shown in Table 13.

Table 13. Projects for Assistance in Transition from Homelessness (PATH) Projections for Numbers to Be Served

	Total	Referral	Attainment
Reengagement/Outreach	4,300		
Enrollment	2,905		
Housing		2,213	745
Community Mental Health Services		2,316	2,022
Substance Use Disorder (SUD) Services		786	406

Source: Permanent Supportive Housing Ohio Department of Development Services Agency Preliminary numbers to be served (final numbers will be available in the Fall)

OhioMHAS has $420,000 available to assist with Permanent Supportive Housing match up to 50% of the match requirement up to the total funding available. This year seven (7) counties requested match funding for a total of $712,600. Funding will be allocated based on the final approval by ODSA and their final allocation as well as on a first come/first served basis in order to spread assistance around the state. These funds are expected to serve 1,387 persons with mental illness and/or SUD related service needs.

Military/Veterans

Ohio ranks sixth in total veteran population and in FY16, had 818,000 veterans, of which roughly 7.5 percent were women according to the Department of Veterans Affairs. The majority of Ohio's veterans were white alone (87.8%); Black or African Americans alone comprised 9.95 percent. Veterans of Hispanic origin (for any race) accounted for 1.99 percent. Ohio's veteran population age 65 and over was 393,000. In FY15, roughly two-thirds (66%) of veteran households were without children and represented 493,351 households. Veteran households with children accounted for 258,480 Ohio households.[37]

Research findings by Cohen *et al*, which are currently in press from a study of 1,582 Ohio Army National Guard soldiers, looked at the relationship between coincident alcohol dependence and depression in determining risk of suicidal ideation. For these soldiers, they found that alcohol dependence and depression interacted statistically (based on risk differences) in shaping risk for suicidal ideation. Their high-risk prevention approach included screening for suicidality in those with alcohol dependence, depression, and both conditions, within military populations.[38]

Veterans Served by CABHI

Below, Table 14 illustrates the percentage of veterans and non-veterans served by the SAMHSA Cooperative Agreement to Benefit Homeless Individuals (CABHI) three-year grant and the CABHI Enhancement (two-yeard grant). Of the 563 individuals connected to permanent supportive housing by Ohio's CABHI program, 60 (10.7%) reported having served in either the Armed Forces, Army Reserve, or National Guard. Of the 157 individuals served by the CABHI Enhancement, 25 (16.6%) reported having served in either the Armed Forces, Army Reserve, or National Guard. Both CABHI grants made clear to prioritize veterans as a special population and set a goal of at least 10% veteran enrollment in the program. By connecting 86 veterans, or 10.8% of the total population connected to permanent supportive housing by both CABHI grants, the program goals are currently being met.

Table 14. CABHI and CABHI Enhancement Grant-funded Services By Military Status.

Military Status of People Served by Grant(s)		Never Served	Served in Armed Forces	Served in Reserves	Served in National Guard	Total
CABHI	Count	503	53	4	3	563
	% within Grant	89.3%	9.4%	0.7%	0.5%	100.0%
CABHI Enhancement	Count	131	25	1	0	157
	% within Grant	83.4%	15.9%	0.6%	0.0%	100.0%
Total	Count	634	78	5	3	720
	% for Grants	88.1%	10.8%	0.7%	0.4%	100.0%

SOURCES:

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Response to Revision Request **February 6, 2018**

Request: *While the narrative comprehensively lays out a picture of current substance use in the state, the application is silent regarding the unmet needs and critical gaps in the state's current behavioral health system for "persons at risk for tuberculosis" and "how the state plans to meet (all) unmet needs and gaps.*

OhioMHAS will annually review the Ohio Department of Health and Center for Disease Control data to monitor the incidence of tuberculosis (TB) to evaluate what kind of planning is required. According to the Center for Disease Control (CDC), Ohio's incidence of tuberculosis is 1.2 persons per 100,000 in 2016 which is lower than the national incidence of 1.9 persons per 100,000. The CDC indicates that persons living or working in congregate settings such as homeless shelters and prisons are at risk, since TB bacteria is transmitted through the air from one person to another.

Ohio Department of Health's website indicates that 140 persons were diagnosed with tuberculosis in Ohio in 2016. Of the 140 persons diagnosed with TB in Ohio, 49 live in Franklin County. The Columbus Public Health Department (Franklin County) website has a January 2017 public health advisory indicating that three active cases of Molecular Genotype Cluster OH_0200 TB have been identified in Franklin County. The persons identified at risk are anyone presenting with symptoms and a recent history of homelessness, incarceration and/or excessive alcohol use. Franklin County Health Department provides information to providers on how to treat TB, and operates a five-day a week clinic to treat TB which offers evening hours. Should OhioMHAS' annual review identify a gap, OhioMHAS will address that gap through partnering with the county ADAMH Board and their partnering county Department of Health.

Planning Steps

Quality and Data Collection Readiness

Narrative Question:

Health surveillance is critical to SAMHSA's ability to develop new models of care to address substance abuse and mental illness. SAMHSA provides decision makers, researchers and the general public with enhanced information about the extent of substance abuse and mental illness, how systems of care are organized and financed, when and how to seek help, and effective models of care, including the outcomes of treatment engagement and recovery. SAMHSA also provides Congress and the nation reports about the use of block grant and other SAMHSA funding to impact outcomes in critical areas, and is moving toward measures for all programs consistent with SAMHSA's **NBHQF**. The effort is part of the congressionally mandated National Quality Strategy to assure health care funds – public and private – are used most effectively and efficiently to create better health, better care, and better value. The overarching goals of this effort are to ensure that services are evidence-based and effective or are appropriately tested as promising or emerging best practices; they are person/family-centered; care is coordinated across systems; services promote healthy living; and, they are safe, accessible, and affordable.

SAMHSA is currently working to harmonize data collection efforts across discretionary programs and match relevant NBHQF and National Quality Strategy (NQS) measures that are already endorsed by the National Quality Forum (NQF) wherever possible. SAMHSA is also working to align these measures with other efforts within HHS and relevant health and social programs and to reflect a mix of outcomes, processes, and costs of services. Finally, consistent with the Affordable Care Act and other HHS priorities, these efforts will seek to understand the impact that disparities have on outcomes.

For the FY 2016-2017 Block Grant Application, SAMHSA has begun a transition to a common substance abuse and mental health client-level data (CLD) system. SAMHSA proposes to build upon existing data systems, namely TEDS and the mental health CLD system developed as part of the Uniform Reporting System. The short-term goal is to coordinate these two systems in a way that focuses on essential data elements and minimizes data collection disruptions. The long-term goal is to develop a more efficient and robust program of data collection about behavioral health services that can be used to evaluate the impact of the block grant program on prevention and treatment services performance and to inform behavioral health services research and policy. This will include some level of direct reporting on client-level data from states on unique prevention and treatment services purchased under the MHBG and SABG and how these services contribute to overall outcomes. It should be noted that SAMHSA itself does not intend to collect or maintain any personal identifying information on individuals served with block grant funding.

This effort will also include some facility-level data collection to understand the overall financing and service delivery process on client-level and systems-level outcomes as individuals receiving services become eligible for services that are covered under fee-for-service or capitation systems, which results in encounter reporting. SAMHSA will continue to work with its partners to look at current facility collection efforts and explore innovative strategies, including survey methods, to gather facility and client level data.

The initial draft set of measures developed for the block grant programs can be found at **http://www.samhsa.gov/data/quality-metrics/block-grant-measures**. These measures are being discussed with states and other stakeholders. To help SAMHSA determine how best to move forward with our partners, each state must identify its current and future capacity to report these measures or measures like them, types of adjustments to current and future state-level data collection efforts necessary to submit the new streamlined performance measures, technical assistance needed to make those adjustments, and perceived or actual barriers to such data collection and reporting.

The key to SAMHSA's success in accomplishing tasks associated with data collection for the block grant will be the collaboration with SAMHSA's centers and offices, the National Association of State Mental Health Program Directors (NASMHPD), the National Association of State Alcohol Drug Abuse Directors (NASADAD), and other state and community partners. SAMHSA recognizes the significant implications of this undertaking for states and for local service providers, and anticipates that the development and implementation process will take several years and will evolve over time.

For the FY 2016-2017 Block Grant Application reporting, achieving these goals will result in a more coordinated behavioral health data collection program that complements other existing systems (e.g., Medicaid administrative and billing data systems; and state mental health and substance abuse data systems), ensures consistency in the use of measures that are aligned across various agencies and reporting systems, and provides a more complete understanding of the delivery of mental health and substance abuse services. Both goals can only be achieved through continuous collaboration with and feedback from SAMHSA's state, provider, and practitioner partners.

SAMHSA anticipates this movement is consistent with the current state authorities' movement toward system integration and will minimize challenges associated with changing operational logistics of data collection and reporting. SAMHSA understands modifications to data collection systems may be necessary to achieve these goals and will work with the states to minimize the impact of these changes.

States must answer the questions below to help assess readiness for CLD collection described above:

1. Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).
2. Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).
3. Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-

identifying information)?

4. If not, what changes will the state need to make to be able to collect and report on these measures?

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Quality and Data Collection Readiness

1. **Briefly describe the state's data collection and reporting system and what level of data is able to be reported currently (e.g., at the client, program, provider, and/or other levels).**

The Ohio Department of Mental Health and Addiction Services collects

a) Medicaid and Non-Medicaid claims data
b) TEDS data for clients payed in whole or in part with public dollars

Medicaid claims data is collected by the Ohio Department of Medicaid and transmitted to the Ohio Department of Mental Health and Addiction Services. Non-Medicaid claims data is collected by county ADAMHS boards and transmitted to the Department. TEDS data (in Ohio, referred to as OHBH) is transmitted to the Department by treatment programs.

2. **Is the state's current data collection and reporting system specific to substance abuse and/or mental health services clients, or is it part of a larger data system? If the latter, please identify what other types of data are collected and for what populations (e.g., Medicaid, child welfare, etc.).**

Medicaid and non-Medicaid claims data is received for by mental health and substance abuse treatment clients. TEDS data (Ohio's OHBH component of the client information system) is required for substance abuse treatment clients and optional for mental health clients. An upgraded OHBH system is being built (to be named Ohio Behavioral Health Information System or OHBIS) that will include AOD TEDs and MH TEDS data. With the implementation of OBHIS, it will be mandatory to report client level data for mental health clients payed in whole or in part with public dollars.

3. **Is the state currently able to collect and report measures at the individual client level (that is, by client served, but not with client-identifying information)?**

Yes. Claims data and OHBH (AOD TEDS) data can be linked and reported in de-identified aggregate reports

4. **If not, what changes will the state need to make to be able to collect and report on these measures?**

Please indicate areas of technical assistance needed related to this section.

None requested.

REVISION RESPONSE February 2018

OhioMHAS is working to expand MAT data though Ohio's Behavioral Health Medicaid Redesign which became effective January 1, 2018. As part of Governor Kasich's Health Transformation initiative, new codes were added to Medicaid claims data to enable us to better track the nature of the service and who is providing that service. Additionally, OhioMHAS is collecting data through the SBIRT, MAT-PDOA and CABHI grants which can be used to improve evidenced based practices. Ohio is partnering with Northeast Ohio Medical University to implement the ECHO model to transfer the knowledge and experience of implementing MAT to more health professionals.

OhioMHAS provides data and technical assistance on using the data to local communities that deliver primary prevention services. County Alcohol and Drug Abuse and Mental Health (ADAMH) Boards are expected to use data for a needs assessment included in community plans that are submitted to OhioMHAS.

Ohio's State Epidemiological Outcomes Workgroup (SEOW), funded by SAMHSA's Strategic Prevention Framework State Incentive Grant (SPF-SIG), examines behavioral health archival data, focusing predominantly on substance abuse prevention with additional focus on mental, emotional and behavioral disorders:
The SEOW:

- Identifies, analyzes, profiles, and shares data from existing national and state sources including NSDUH
- Create data-guided products to inform prevention planning and policies; and
- Trains communities to understand, use, and present data effectively.

Ohio's State Epidemiological Workgroup Ohio's State Epidemiological Outcomes Workgroup (SEOW) website displays both local and national data for the state and communities to use in their Needs Assessments for Strategic Planning purposes. These data are displayed on the Ohio's Network of Care (http://www.ohio.networkofcare.org/splash.aspx?state=ohio), specifically, using the National Survey on Drug Use and Health (NSDUH), the Behavioral Risk Factor Surveillance System (BRFSS), the Wide-ranging Online Data for Epidemiologic Research (WONDER), and the Youth Risk Behavior Survey (YRBS) data where available.

This data will be used by our communities as they re-apply for SABG Prevention funding from OhioMHAS this year. These data have also been utilized at the state-level when applying for grants from SAMHSA CSAP such as the SPF Partnerships for Success grant and the SPF Rx grant. OhioMHAS also uses NSDUH data in setting its Block Grant priorities, goals and performance indicators.

Ohio uses GFMS, Grant Financial Management System which was built by our IT staff working with Prevention & Treatment staff. The FFY 15 award was reported for 2018 using the POPS legacy system on which GFMS was modeled. POPS was built by our agency to report Prevention.

GFMS reports National Outcome Measures, use of prevention strategies, expenditures by strategy, populations served. It requires OhioMHAS staff to set up specific outcome requirements for each prevention program, and then requires applicants to write a plan with goals, objectives and measurable performance indicators. Performance indicators are reported on every six months and vary by the individual program--ie
Youth Led Prevention has its own performance indicators. Budgets & expenditures are built into the system. Numbers served are also required. Fiscal data including awards, NOAs, disbursements and Assurances with SAMHSAs prohibited expenditures are included.

Planning Tables

Table 1 Priority Areas and Annual Performance Indicators

Priority #: 1

Priority Area: Increase access to evidence-based prevention practices

Priority Type: SAP

Population(s): PP

Goal of the priority area:

Increase the number/percentage of funded projects implementing evidence-based practices.

Objective:

Increase the effectiveness of prevention programs

Strategies to attain the objective:

1. Annual conference
2. Statewide and regional trainings
3. Workforce capacity building initiatives
4. Changes in policy
5. Cross system collaboration

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of prevention interventions funded that are evidenced-based

Baseline Measurement: 29.1% SFY 2017 SABG Report; 31.7% SFY 2018 SABG Report

First-year target/outcome measurement: 32%

Second-year target/outcome measurement: 33%

Data Source:

OhioMHAS Grant Financial Management System (GFMS) Prevention provider report

Description of Data:

OhioMHAS Grant Financial Management System (GFMS) Prevention provider report

Data issues/caveats that affect outcome measures::

None

Priority #: 2

Priority Area: Ensure prevention services are available across the lifespan with a focus on families with children and adolescents

Priority Type: SAP

Population(s): PP, Other (Children/Youth at Risk for BH Disorder)

Goal of the priority area:

Participants will perceive substance use as risky and/or harmful

Objective:

1. Participants will be able to identify and engage in pro-social behavior in schools.

2. Youth and adult participants will be able to describe negative consequences of substance abuse, and identify strategies to reduce those behaviors.
3. Participants will build strong, welcoming communities.

Strategies to attain the objective:

1. Support youth initiatives (Good Behavior Game, /PBS, School-Based Prevention Education, Ohio Youth-led Network
2. Promote marijuana and underage drinking initiatives (Higher Ed Network, College Initiative, Parents Who Host, Trace Black)
3. Promote family engagement
4. Fund UMADAOP prevention to reach minority communities
5. Support Military Initiative

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of youth ages 12 - 17 with perceptions of Great Risk from Having Five or more Drinks of an Alcoholic Beverage Once or Twice a Week

Baseline Measurement: 40.30% from 2015 - 2016 NSDUH data

First-year target/outcome measurement: 40.30% (Note data will be same for 2 years;, and 2017-2018 data will not be available in Dec 2018 when report is due)

Second-year target/outcome measurement: 41.%

Data Source:

SAMHSA website NSDUH Population Data: https://www.samhsa.gov/data/

Description of Data:

OhioMHAS staff report the number from SAMHSA NSDUH Population Data for Ohio. For 2015 - 2016, it is from Ohio Table 82 Selected Drug Use, Past Year SUD Disorder and Treatment

Data issues/caveats that affect outcome measures::

Data is reported every 2 years, so outcome will be the same for two consecutive years.

Indicator #: 2

Indicator: Percent of Youth ages 12- 17 with Perception of Great Risk from Smoking One or More Packs of Cigarettes per Day

Baseline Measurement: 66.27% in 2015 - 2016 NSDUH data

First-year target/outcome measurement: 66.27% (Number is the same for 2 years, and 2017 - 2018 will not be available in Dec 2018.)

Second-year target/outcome measurement: 67%

Data Source:

NSDUH data;; see indicator #1 for this priority for specifics

Description of Data:

NSDUH Population Data

Data issues/caveats that affect outcome measures::

Data is reported every two years, so the outcome will be the same for two consecutive years.

Indicator #: 3

Indicator: Percent of Youth Ages 12 - 17 with Perception of Great Risk from Smoking Marijuana Once a Month

Baseline Measurement: 26.15% ini 2015 - 2016 NSDUH data

First-year target/outcome measurement: 26.15% (2017 - 2018 NSDUH data will not be available Dec 2018 when SABG Report is due.)

Second-year target/outcome measurement: 27%

Data Source:

NSDUH data on SAMHSA website. See Indicator #1 of this priority for details.

Description of Data:

NSDUH Population data by state

Data issues/caveats that affect outcome measures::

Measure is reported every 2 years,, so results will be the same for 2 years in a row.

Priority #: 3

Priority Area: Increase availability of medication assisted treatment

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Increase access to medication assisted treatment for persons with opioid use disorders (OUD)including injection users.

Objective:

The number of physicians, physician assistants and advance practice nurses who prescribe medication assisted treatment will increase.

Strategies to attain the objective:

1. OhioMHAS will provide free online training for Ohio physicians to obtain their DATA 2000 waiver, and learn more about ASAM multi-dimensional assessment and levels of care.
2. Encourage physicians to obtain a higher level patient limit.
3. Ohio's Opioid STR project will provide continuing education and case review for all physicians statewide.
4. Continuing education series will be developed to be deployed through the OhioMHAS e-based academy for all professionals statewide with free CE and CME options.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of persons who receive medication assisted treatment (MAT)

Baseline Measurement: SFY 2012 = 4,964; SFY 2013 = 5379, SFY 2014 = 5917; SFY 2015- 6582

First-year target/outcome measurement: 6590

Second-year target/outcome measurement: 6600

Data Source:

Medicaid Information Technology System (MITS) and Ohio Behavioral Health (OHBH). OHBH is being rebuilt, and will become OHBHIS (Ohio Behavioral Health Information System).

Description of Data:

Data issues/caveats that affect outcome measures::

OhioMHAS replaced MACSIS with MITS in SFY 2013, and will soon replace OHBH with OHBIS. As a result, the data may not be comparable with data from prior years.

Priority #: 4

Priority Area: 4 Persons receiving treatment for Opioid Use Disorder (OUD)

Priority Type: SAT

Population(s): PWID

Goal of the priority area:

Improve treatment outcomes for persons receiving treatment for opioid use disorder (OUD), especially women with dependent children.

Objective:

The percentage of persons with OUD who are discharged from treatment with all goals met will increase as compared to the previous two years.

Strategies to attain the objective:

1. Fund provision of culturally competent, gender specific treatment.
2. Collaborate with child welfare system to coordinate services for parents involved with child welfare system.
3. Collaborate with criminal justice system.
4. Fund drug courts
5. Implement strategies from the Opioid STR grant including:

a) Expand the number of physicians, physician assistants and advance nurse practitioners who prescribe MAT by developing and providing continuing education for providers, and incorporate training into university programs.
b) Implement ECHO model that focuses on mentoring 30 physicians every week for 3 months, and expand to physician assistants and advance practice nurses in second year.
c) Encourage Emergency Departments to initiative MAT and link patients with counseling, OUD treatment programs or detoxification centers.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of persons with opioid dependence/abuse who are discharged from treatment with all goals met.

Baseline Measurement: SFY 2013 = 22.1%; SFY 2014 = 22.2%; SFY 2015 = 30.2%

First-year target/outcome measurement: 31%

Second-year target/outcome measurement: 32%

Data Source:

Annual Performance Indicators to measure goal success

Description of Data:

Utilize disposition data of OHBH closure records to determine number of persons with opioid use disorder who were discharged with all goals met.

Data issues/caveats that affect outcome measures::

Priority #: 5

Priority Area: 5 Pregnant Women who have a SUD

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Pregnant women receiving treatment for SUD will meet their treatment goals.

Objective:

The percentage of pregnant women who receive treatment for SUD who meet all of their treatment goals as measured by disposition code at discharge will increase.

Strategies to attain the objective:

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of women who complete treatment wit all goals met as measured by disposition code at discharge

Baseline Measurement: SFY 2014 = 22.2%; SFY 2015 = 31.2%

First-year target/outcome measurement: 31.3%

Second-year target/outcome measurement: 31.4%

Data Source:

MITS/OHBH Icient information system contains disposition data that allows for quantifying the number of women who 1) received assessment only 2) had a "neutral disposition (e.g. transferred to other services); 3) negative outcome (e.g. dropped out of treatment and 4) successful outcome (e.g. completed treatment, all goals met).

Description of Data:

Data issues/caveats that affect outcome measures::

The total number of pregnant women whose outcome is measured is small enough, that data fluctuations are normal.

Indicator #: 2

Indicator: Percent of drug-free births

Baseline Measurement: SFY 2013 = 79.4%, SFY 2014 = 73.1%; SFY 2015 = 61.8%

First-year target/outcome measurement: 62%

Second-year target/outcome measurement: 62.2%

Data Source:

MITS (Medicaid claims data); OHBH (Ohio's behavioral health system data)

Description of Data:

Use MITS/OHBH data systems to capture birth outcomes of pregnant women prior to discharge.

Data issues/caveats that affect outcome measures::

Please see data issues under priority 1, indicator 1.

Priority #: 6

Priority Area: 6 Parents with SUD who have dependent children

Priority Type: SAT

Population(s): PWWDC

Goal of the priority area:

Increase family reunification for parents/caregivers involved in child-welfare system (prevent loss of custody).

Objective:

Increase the numbers of parents with at least one child living at home, who are discharged from SUD treatment as successful per disposition code.

Strategies to attain the objective:

1. Provide culturally competent treatment to parents/caregivers of children involved with the child welfare system.
2. Implement strategies in Opioid STR response grant including:
a) Establish a partnership with Ohio Child Welfare Training Program (OCWTP) to provide training to professionals in behavioral health, child welfare, primary healthcare, and the juvenile justice systems to support an increased understanding of SUD, the importance of MAT and the correlation.
b) Understand and implement the Sobriety Treatment and Recovery Teams (START).
c) Leverage strategic partnerships and current resources that result in a responsive array of cross system training and skill building opportunities

available to child welfare professionals, caregivers, and adoptive parents.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of parents receiving SUD treatment who report having at least one child living at home and who are discharged as successful per disposition code.

Baseline Measurement: SFY 2012 = 39.0%; SFY 2013 = 31.1%, SFY 2015 = 38.9%

First-year target/outcome measurement: 39.5%

Second-year target/outcome measurement: 40.0%

Data Source:

MITS and OHBH. MITS is Medicaid claims data. OHBH is TEDS data collected by county ADAMH boards.

Description of Data:

MITS is Medicaid claims data collected by Ohio Dept. of Medicaid and transmitted to OhioMHAS. OHBH is SUD and MH TEDS data.

Data issues/caveats that affect outcome measures::

OHBH is being rebuilt to be OHBIS.

Priority #: 7

Priority Area: Children with Serious Emotional Disturbances (SED)

Priority Type: MHS

Population(s): SED

Goal of the priority area:

Increase accessibility of services for children with SED and children at risk of SED through a system of care approach

Objective:

The number of children with SED and children with any mental illness will increase each year.

Strategies to attain the objective:

1. Continue to develop and promote state interdepartmental partnerships and county/state collaborations to facilitate children, youth and family access to needed and preferred services.
2. Prioritize and increase services accessibility to young consumers and their families at risk of serious family emotional instability, loss of parental custody, child placement, court involvement, and/or academic failure due to untreated mental illness.
3. Expand system of care for youth/young adults with aid of SAMHSA System of Care Grant (known as ENGAGE in Ohio). ENGAGE increases the availability of high-fidelity wraparound services.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of children served with any mental illness

Baseline Measurement: SFY 2013 = 137740; SFY 2014 = 141,624; SFY 2015 = 146,202; SFY 2016 = 151,830

First-year target/outcome measurement: 153,000

Second-year target/outcome measurement: 154,000

Data Source:

MITS and OHBH

Description of Data:

MITS is Medicaid claims data. Non-Medicaid service data is reported by ADAMH Boards through OHBH.

Data issues/caveats that affect outcome measures::

SED in Ohio is not comparable to SAMHSA's SED definition. Rather, SED is more restrictively defined in Ohio to prioritize children in need of more intensive services. Also, Ohio is replacing MACSIS for non-Medicaid claims with data systems operated by ADAMH Board collaboratives effective SFY 2018. All of these changes make for data that is less comparable from year to year. Changes to state or federal Medicaid rules impacting enrollment will impact these numbers.

Indicator #: 2

Indicator: Number of children ages 9 - 17 with SED as defined by Ohio; Ohio has a more restrictive definition than SAMHSA

Baseline Measurement: SFY 2014 = 66,626, SFY 2015 = 70,337; SFY 2016 = 70,085

First-year target/outcome measurement: 70,086

Second-year target/outcome measurement: 70,100

Data Source:

MITS and OHBH

Description of Data:

MITS/OHBH is a client information system that provides data on the number of persons served, admission and discharge, and some of the National Outcomes Measures (NOMS).

Data issues/caveats that affect outcome measures::

Ohio uses a state-specific definition of SED which is more restrictive than SAMHSA's SED definition. The number treated is a closer approximation for the SAMHSA SED indicator. Additionally, this number does not count children ages 0 - 8, because the prevalence tables used for the MH Block Grant use data from children ages 9 - 17. Ohio had an additional 17,232 children ages 0 - 8 treated for SED in the most recent year reported.

Priority #: 8

Priority Area: Adults with Serious Mental Illness

Priority Type: MHS

Population(s): SMI

Goal of the priority area:

Maintain and expand accessibility to public mental health services for adults with SMI

Objective:

Increase the number of persons receiving services for SMI and other mental illness.

Strategies to attain the objective:

1. Continue to develop and promote state interdepartmental partnerships and county/state collaborations to facilitate consumer access to needed and preferred services.
2. Prioritize and increase services accessibility to adults who are leaving institutions (psychiatric hospitals, prisons, nursing facilities) as well as persons who are homeless or veterans.
3. Promote development of nationally recognized evidenced-based practices and supports to address consumer needs and preferences as reflected in Individualized plans of care.
4. Continue advocacy and innovative initiatives aimed at consumer-guided use of federal, state and local resources in creative, efficient ways to expand the choices and array of care options available.
5. Implement newer behavioral health Medicaid benefits which include ACT services for persons who need more intensive care.
6. Use Mental Health Block Grant to implement First Episode Psychosis treatment using CRC model.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of adults receiving services in Ohio's mental health system for any mental illness

Baseline Measurement: SFY 2013 =244,118; SFY 2014 = 260,218, SFY 2015 = 268,889, SFY 2016 = 277,266

First-year target/outcome measurement: 279,000

Second-year target/outcome measurement: 280,000

Data Source:

MITS, OHBH

Description of Data:

MITS is Medicaid claims data. OHBH is non-Medicaid claims data.

Data issues/caveats that affect outcome measures::

Indicator #: 2

Indicator: Adults with SPMI (severe and persistent mental illness) receiving mental health services using Ohio's more restrictive defintiion

Baseline Measurement: SFY 2013 = 109,034; SFY 2014 = 113,799; SFY 2015 = 118,097; SFY 2016 = 160,291

First-year target/outcome measurement: 161,000

Second-year target/outcome measurement: 162,000

Data Source:

MITS and OHBH

Description of Data:

Number of adults meeting Ohio's restrictive SPMI definition who receive public mental health services each fiscal year.

Data issues/caveats that affect outcome measures::

Priority #: 9

Priority Area: 9

Priority Type: SAT, MHS

Population(s): SMI, PWWDC

Goal of the priority area:

Increase availability of peer support by certified peer support specialists

Objective:

Increase the number of certified peer support specialists trained to meet the need created by rule changes. The new SUD Medicaid benefit will include peer support. ACT teams may include certified peer support specialists, and a 1915i waiver makes peer support available to some persons with SMI who meet specific diagnostic and income requirements.

Strategies to attain the objective:

1. Recruit applicants.
2. Screen training applicants.
3. Provide peer support training manual to trainees.
4. Provide training for supervisors.
5. Provide continuing education opportunities for peer supporters.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Number of peer supporters who are trained and certified

Baseline Measurement: SFY 2014 = 195; SFY 2015 = 269; SFY 2016 = 285

First-year target/outcome measurement: 300

Second-year target/outcome measurement: 315

Data Source:

List of persons who have been trained and certified

Description of Data:

OhioMHAS peer support data

Data issues/caveats that affect outcome measures::

Priority #: 10

Priority Area: Criminal Justice - SUD

Priority Type: SAT

Population(s): PWID, Other (Criminal/Juvenile Justice)

Goal of the priority area:

Improve outcomes in treatment of persons involved with criminal justice system.

Objective:

Increase the percent of criminal justice involved clients who are discharged as successful per disposition code

Strategies to attain the objective:

1. Support evidence-based and promising practices.
2. Maintain collaborative partnership with criminal justice system.
3. Assist offenders treated for SUD to apply for Medicaid just prior to release, and link to treatment services and recovery supports
4. Provide necessary tools and skills to Community Linkage Social Work staff inclusive of motivational interviewing techniques from Substance Abuse/Mental Illness evidenced-based practice.
5. Work cooperatively with community stakeholders to assure quick access to clinical treatment appointments and other supports needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of criminally-involved clients treated for SUD who successfully complete treatment as measured by disposition code

Baseline Measurement: SFY 2013 = 33.9%; SFY 2014 = 30.30%; SFY 2015 = 45.8%

First-year target/outcome measurement: 46%

Second-year target/outcome measurement: 47%

Data Source:

OH BH disposition data for criminal justice clients.

Description of Data:

Uses disposition data of OHBH closure records to determine percent of criminal justice-involved clients who were discharged with all goals met (successful).

Data issues/caveats that affect outcome measures::

Priority #: 11

Priority Area: Criminal Justice - MH

Priority Type: MHS

Population(s): SMI, Other (Criminal/Juvenile Justice)

Goal of the priority area:

Increase the enrollment in treatment of persons with SMI reentering the community from prison.

Objective:

Increase the percentage of persons with SMI who voluntarily enroll in Community Linkage Social Work Service.

Strategies to attain the objective:

1. Support evidence-based and promising practices.
2. Maintain collaborative partnership with criminal justice system.
3. Provide necessary tools and skills to Community Linkage Social Work staff inclusive of motivational interviewing.
4. Work cooperatively with community stakeholders to assure quick access to clinical treatment appointments and other supports needed.

Annual Performance Indicators to measure goal success

Indicator #: 1

Indicator: Percent of eligible offenders with SMI enrolling voluntarily in Community Linkage Social Work Service

Baseline Measurement: SFY 2013 = 87%; SFY 2014 = 91.7%; SFY 2015 = 85.70%; SFY 2016 = 92%

First-year target/outcome measurement: 92.2%

Second-year target/outcome measurement: 92.4%

Data Source:

community linkage program data

Description of Data:

Data collected by Community Linkage social workers. Most of the offenders served have co-occurring SUD.

Data issues/caveats that affect outcome measures::

Priority #: 12

Priority Area: Risk of TB for persons with SUD

Priority Type: SAT

Population(s): TB

Goal of the priority area:

The goal is to monitor the number of Ohioans who are reported to the Ohio Department of Health to have TB. to evaluate if OhioMHAS intervention is needed. In the most recent year reported, (2016), the number of persons with TB. Between 2012 - 2016, an average of 147.2 persons were reported to have TB in Ohio . About 10% of them are estimated be in SUD treatment.----about 15 people.

Objective:

Monitor the number of persons with TB to evaluate if action is needed.

Strategies to attain the objective:

1. Annually review Ohio Department of Health TB data.
2. If TB increases more than 5% in a single year over the average of the previous 5 years, OhioMHAS will partner with the Ohio Department of Health, as well as county public health departments and county alcohol, drug abuse and mental health Boards to address TB.

Annual Performance Indicators to measure goal success

Indicator #:	1
Indicator:	Number of Persons with TB reported to Ohio Department of Health in most recent year reported
Baseline Measurement:	Five year 2012 - 2016 Average = 147.2
First-year target/outcome measurement:	147 or less
Second-year target/outcome measurement:	148 or less

Data Source:

Ohio Department of Health website: Data & Statistics\Infectious Diseases\Tuberculosis. See current weblink below: http://www.odh.ohio.gov/en/healthstats/disease/tb/tb1

Description of Data:

Demographic Breakdown for Ohio and Select Counties: Tables presenting data on tuberculosis disease by age, sex and race for Ohio and four select counties, which are Cuyahoga County, Franklin County, Hamilton County and Montgomery County. Special-interest statistics are also available for pediatric tuberculosis cases, foreign-born tuberculosis cases and drug-resistant tuberculosis cases.

Data issues/caveats that affect outcome measures::

Data is a year or two behind. The number of persons with TB is so small that a small increase may not be significant.

Footnotes:

Ohio is in the process of transition with its data systems that providers use to report services and outcomes of services. Therefore, data changes may reflect differences in reporting rather than differences in outcomes for persons served.

Planning Tables

Table 2 State Agency Planned Expenditures [SA]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention* and Treatment	$91,111,252		$930,424,344	$39,081,704	$99,460,895	$98,448,388	$0
a. Pregnant Women and Women with Dependent Children**	$22,040,794		$0	$0	$0	$0	$0
b. All Other	$69,070,458		$930,424,344	$39,081,704	$99,460,895	$98,448,388	$0
2. Primary Prevention	$31,964,271		$0	$0	$2,237,318	$9,402,844	$0
3. Tuberculosis Services	$0		$0	$0	$0	$0	$0
4. Early Intervention Services for HIV	$0		$0	$0	$0	$0	$0
5. State Hospital							
6. Other 24 Hour Care							
7. Ambulatory/Community Non-24 Hour Care							
8. Mental Health Primary							
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)							
10. Administration (Excluding Program and Provider Level)	$6,009,543		$0	$1,918,296	$42,172,206	$23,619,692	$0
11. SABG Total (Row 1, 2, 3, 4 and 10)	**$129,085,066**	**$0**	**$930,424,344**	**$41,000,000**	**$143,870,419**	**$131,470,924**	**$0**

* Prevention other than primary prevention

** The 20 percent set-aside funds in the SABG must be used for activities designed to prevent substance misuse.

Footnotes:

A. This table is for two STATE fiscal years ending June 30, 2019.

B. Medicaid includes Medicaid expansion in Ohio.

C. Medicaid planned expenditures are from the Ohio Department of Medicaid OAKS Ledger and are budgeted for $415,528,295 in SFY 2018 and $514,896,049 in SFY 2019. Ohio Department of Medicaid is a co-SSA with Ohio Department of Mental Health and Addiction Services.

REVISION RESPONSE Feb 2018

State funds increased because funding for substance use services in Ohio's state prisons in OhioMHAS' budget was included in the expenditures which was not included in the SABG Plan budget. State funding and responsibility for SUD treatment in Ohio's prisons was transferred from Ohio Department of Rehabilitation and Corrections (ODRC) to OhioMHAS a couple years ago.. ODRC 's SUD treatment staff became OhioMHAS staff, and 2 clinical positions were added at each of Ohio's 27 prisons.

The change for local income which is mostly from county tax levies was about $4 million out of $77.5 million which is a 5% change. Some county governments may have allocated additional funds to the Boards to address the opioid crisis. Additionally, we have had some changes in the forms which Boards use to report expenditures which may lead to some differences in what expenditures are reported. Also, local economic and political factors in 50 different Board areas plays a part in determining funding.

D. May 29, 2018 Adjustments to ENACTED 2018 Budget. See footnotes in Table 4 for details.

Planning Tables

Table 2 State Agency Planned Expenditures [MH]

States must project how the SMHA and/or the SSA will use available funds to provide authorized services for the planning period for state fiscal years 2018/2019.

Planning Period Start Date: 7/1/2017 Planning Period End Date: 6/30/2019

Activity (See instructions for using Row 1.)	A.Substance Abuse Block Grant	B.Mental Health Block Grant	C.Medicaid (Federal, State, and Local)	D.Other Federal Funds (e.g., ACF (TANF), CDC, CMS (Medicare) SAMHSA, etc.)	E.State Funds	F.Local Funds (excluding local Medicaid)	G.Other
1. Substance Abuse Prevention and Treatment							
a. Pregnant Women and Women with Dependent Children							
b. All Other							
2. Primary Prevention							
3. Tuberculosis Services							
4. Early Intervention Services for HIV							
5. State Hospital			$29,260,007	$0	$516,818,390	$0	$0
6. Other 24 Hour Care		$9,988,847	$0	$4,590,000	$63,248,204	$143,325,718	$0
7. Ambulatory/Community Non-24 Hour Care		$26,227,329	$1,814,674,045	$32,270,000	$125,759,822	$354,592,760	$0
8. Mental Health Primary*		$0	$0	$0	$18,406,087	$36,702,132	$0
9. Evidence-Based Practices for Early Serious Mental Illness (10 percent of total award MHBG)**		$4,260,727	$0	$0	$0	$0	$0
10. Administration (Excluding Program and Provider Level)		$2,130,363	$0	$3,130,000	$74,659,565	$95,856,326	$0
11. MHBG Total (Row 5, 6, 7, 8, 9 and 10)	**$0**	**$42,607,266**	**$1,843,934,052**	**$39,990,000**	**$798,892,068**	**$630,476,936**	**$0**

* While the state may use state or other funding for these services, the MHBG funds must be directed toward adults with SMI or children with SED

** Column 9B should include Early Serious Mental Illness programs funded through MHBG set aside

Footnotes:

A. OhioMHAS continued its historical practice to budget the FFY 2017 MHBG Award in the next state fiscal (SFY 2018)., since states are allowed to expend the award over two federal fiscal years. As Ohio's MHBG Award is planned to be reduced from $16,793,371 in SFY 2017 to $12,772,348 for SFY 2018 in the President's budget, OhioMHAS will revise Table 2 after Congress has passed the budget and SAMHSA

finalizes allocations.

B. Ohio uses a significant amount of the Mental Health Block Grant to provide Indirect Services which provide infrastructure support, partnerships, outreach, needs assessment, training and education to support Ambulatory and Other 24 hour care. These funds are included as a part of Ambulatory Care and Other 24 hour care with the detail broken out in Table 6.

C. Ohio is a Medicaid expansion state. For Medicaid, the Ambulatory care line includes $1,603,759,351 for community mental health, $123,150,182 for Mycare and $87,755,512 for Health Homes for SPMI (severely and persistently mentally ill). Mycare is managed care for persons who are dual eligible for Medicare and Medicaid.

D. Revised May 29, 2018 using 2018 ENACTED budget for 2018 - 2019. Budgeted 10% set aside, 5% administration, and split the remaining treatment into 24 hour and ambulatory in the same proportion as the originally submitted budget. Original numbers were $7,545,792 Other 24 hour Care; $19,812,694 for Ambulatory Care, $3,358,674 for 10% set aside, and $2,869,582 for Administration. for a total of $33,586,742.

Planning Tables

Table 3 SABG Persons in need/receipt of SUD treatment

	Aggregate Number Estimated In Need	Aggregate Number In Treatment
Pregnant Women	11055	0
Women with Dependent Children	207746	0
Individuals with a co-occurring M/SUD	284400	0
Persons who inject drugs	0	0
Persons experiencing homelessness	1956	0

Please provide an explanation for any data cells for which the stats does not have a data source.

Footnotes:

TABLE IS NOT SAVING DATA CORRECTLY. PLEASE USE THE FOLLOWING DATA

TABLE 3 SABG Persons in need/receipt of SUD Treatment

Aggregate Estimated Need Services/Aggregate Number in Treatment

Pregnant Women
11,055/ 461
Women with Dependent Children
207,746/ 5,985
Individuals with a co-occurring M/SUD
284,400/ 84,105

Persons who inject drugs
43,000/ 8,775
Persons experiencing homelessness
1,956/ 2,356

NOTES FOR AGGREGATE NUMBER IN TREATMENT
All fields, with the exception of Co-occuring M/SUD clients, are from the SFY2015 Ohio Behavioral Health (OHBH) Data. A number of factors has created a situation where Ohio has experienced a decrease in reporting to the OHBH. Because of this decrease, the OHBH data is known to be under-reported. There were only 38,089 unduplicated OHBH admission records available in SFY2015. Ohio actually treated (note: some of these clients were admitted during previous FY) 108,306 unduplicated clients.

Co-occuring M/SUD data was calculated using treatment claims data (MACSIS/MITS). This is part of the reason for the substantially higher number in the field. Please note, some of these clients may have actually been formally admitted to treatment during a previous fiscal year. Total unduplicated treatment clients: 108,306.

NOTES FOR NUMBER ESTIMATED TO BE IN NEED
These numbers are very rough estimates, as NSDUH does not make estimates of these populations. These estimates are based on national prevalence rates applied to Ohio's populations.

Data Sources for Aggregate Number Estimate in Need:
Pregnant Women: 138,192 Number of Resident Live Births x 8 % prevalence = 11,055
Ohio Health Department Resident Live Births for 2016 = 138,192
(2009 – 2010 NSDUH data) estimated number of pregnant women using illicit drugs at 4.4% and binge drinking at 3.7% for a total estimate of a combined prevalence of 8% http://pediatrics.aappublications.org/content/pediatrics/131/3/e1009.full.pdf

Women with Dependent Children:
Estimate of Number of Women in Ohio with dependent children under 18: 1,430,793 Ohio mothers x 14.5% prevalence rate = 207,746
Estimate of SUD prevalence: Epidemiology of Substance Use Disorders, Merikangas, Kathleen and McClair, Vetisha https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4408274/; Twelve month prevalence of SUD in US (about 12% for alcohol and 2 – 3 % for illicit drugs), so estimate about 14.5% of the population.
Estimate of number of Women with Dependent Children in Ohio = 1,430,793; Source: Current Population Annual Social and Economic Supplement, US Census, (using DataFerrett); Ohio has about 1,430,793 women with a child under the age of 18.

Co-Occurring Disorder:
SAMHSA 2014 NSDUH Data; Nationally, SAMHSA estimates that 20.2 million American adults had SUD, and that of those adults 7.9 million had a co-occurring mental illness; https://www.samhsa.gov/disorders/co-occurring
Ohio has 3.6% of US Census per U.S.Census Bureau Quick Facts 2016, so 3.6% X 7.9 million = 284,400

https://www.census.gov/quickfacts/fact/table/OH,US/RHI605210

Persons who Inject Drug; Number of Ohioans estimated at 43,000 (0.4% of Ohioans ages 12 and older using heroin)
Heroin Use is used as a proxy, and estimated at 0.4% of the population age 12+ in Ohio. Past Year Opioid Use in Ohio among Persons 12 or Older: Numbers in Thousands, Percentages, and Confidence Intervals, Annual Averages is estimated at 43,000
Source: SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2014 and 2015.

Homeless: HUD; 2016 Continuum of Care Homeless Populations and Sub Population Reports: Ohio's Report: Homeless with chronic substance abuse 1,956 https://www.hudexchange.info/programs/coc/coc-homeless-populations-and-subpopulations-reports/

Planning Tables

Table 4 SABG Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Expenditure Category	FY 2018 SA Block Grant Award
1 . Substance Abuse Prevention and Treatment	$45,555,626
2 . Primary Substance Abuse Prevention	$15,982,136
3 . Tuberculosis Services	$0
4 . Early Intervention Services for HIV*	$0
5 . Administration (SSA Level Only)	$3,004,771
6. Total	**$64,542,533**

* For the purpose of determining the states and jurisdictions that are considered "designated states" as described in section 1924(b)(2) of Title XIX, Part B, Subpart II of the Public Health Service Act (42 U.S.C. § 300x-24(b)(2)) and section 45 CFR § 96.128(b) of the Substance Abuse Prevention and Treatment Block Grant; Interim Final Rule (45 CFR 96.120-137), SAMHSA relies on the HIV Surveillance Report produced by the Centers for Disease Control and Prevention (CDC,), National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention. The most recent HIV Surveillance Report will be published on or before October 1 of the federal fiscal year for which a state is applying for a grant is used to determine the states and jurisdictions that will be are required to set-aside 5 percent of their respective SABG allotments to establish one or more projects to provide early intervention services for regarding the human immunodeficiency virus (EIS/HIV) at the sites at which individuals are receiving SUD treatment services. In FY 2012, SAMHSA developed and disseminated a policy change applicable to the EIS/HIV which provided any state that was a "designated state" in any of the three years prior to the year for which a state is applying for SABG funds with the flexibility to obligate and expend SABG funds for EIS/HIV even though the state a state's AIDS case rate does not meet the AIDS case rate threshold for the fiscal year involved for which a state is applying for SABG funds. Therefore, any state with an AIDS case rate below 10 or more such cases per 100,000 that meets the criteria described in the 2012 policy guidance would will be allowed to obligate and expend SABG funds for EIS/HIV if they chose to do so.

Footnotes:

A. This table include ONE year of FEDERAL Fiscal Year funding which may be expended over two federal fiscal years. The total must be the exact amount of Ohio's FFY Award for a single year as provided in SAMHSA's annual instructions. Typically OhioMHAS budgets a single FFY Award over 2 state fiscal years. If there has been little change in the award, typically OhioMHAS uses the state fiscal year numbers in Table 2 to budget for Table 4 which is on a federal fiscal year.

B. Adjusted May 29, 2018 to ENACTED SAMHSA 2018 budget. Before adjustment, Sept. 2017 numbers were $45,463,969 for Treatment, $15,949,980 for Prevention and $2,998,726 for Administration.

Planning Tables

Table 5a SABG Primary Prevention Planned Expenditures

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Strategy	IOM Target	FY 2018
		SA Block Grant Award
Information Dissemination	Universal	
	Selective	
	Indicated	
	Unspecified	$1,117,756
	Total	**$1,117,756**
Education	Universal	
	Selective	
	Indicated	
	Unspecified	$8,823,299
	Total	**$8,823,299**
Alternatives	Universal	
	Selective	
	Indicated	
	Unspecified	$911,093
	Total	**$911,093**
Problem Identification and Referral	Universal	
	Selective	
	Indicated	
	Unspecified	$413,045
	Total	**$413,045**

Community-Based Process	Universal	
	Selective	
	Indicated	
	Unspecified	$1,353,166
	Total	**$1,353,166**
Environmental	Universal	
	Selective	
	Indicated	
	Unspecified	$458,508
	Total	**$458,508**
Section 1926 Tobacco	Universal	
	Selective	
	Indicated	
	Unspecified	$282,240
	Total	**$282,240**
Other	Universal	
	Selective	
	Indicated	
	Unspecified	$2,623,029
	Total	**$2,623,029**
Total Prevention Expenditures		**$15,982,136**
Total SABG Award*		**$64,542,533**
Planned Primary Prevention Percentage		**24.76 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:
A. OhioMHAS budgeted $313,979 for Tobacco from (state) General Revenue Funds.

B. The total prevention expenditures in Table 5a and Table 6 combined must equal the total expenditures in Table 4. Actual expenditure data for this table will be reported in GFMS (and was reported in previous years from POPS and PIPAR data systems.)

REVISION Feb 26, 2018:
C. $282,240 added to Section 1926 Tobacco from Fiscal Office's information for Table 2 to correct an error. This amount was also subtracted from the "Other " category to keep the table balanced to the SABG Award.

D., $30,000 was budgeted from State General Revenue Funds (GRF) for enforcement of Section 1926.

E. May 29, 2018 Revised to ENACTED 2018 budget by adjusting Education priority budget. See Table 4 Footnotes for more information.

Planning Tables

Table 5b SABG Primary Prevention Planned Expenditures by IOM Category

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	FY 2018 SA Block Grant Award
Universal Direct	$10,527,044
Universal Indirect	$2,897,274
Selective	$2,049,078
Indicated	$508,740
Column Total	**$15,982,136**
Total SABG Award*	**$64,542,533**
Planned Primary Prevention Percentage	**24.76 %**

*Total SABG Award is populated from Table 4 - SABG Planned Expenditures

Footnotes:
Tuberculosis treatment is provided and funded by county health departments and reported by the county ADAMH Boards to OhioMHAS to meet SAMHSA requirements. Ohio is not an HIV/AIDS state, so that row is not applicable.

May 29, 2018 Adjustment to ENACTED FFY 2018 Budget by adding $32,156 to Universal Direct. See Table 4 for more information.

Planning Tables

Table 5c SABG Planned Primary Prevention Targeted Priorities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Targeted Substances	
Alcohol	☑
Tobacco	☐
Marijuana	☑
Prescription Drugs	☑
Cocaine	☐
Heroin	☑
Inhalants	☐
Methamphetamine	☐
Synthetic Drugs (i.e. Bath salts, Spice, K2)	☐
Targeted Populations	
Students in College	☑
Military Families	☑
LGBT	☐
American Indians/Alaska Natives	☐
African American	☑
Hispanic	☑
Homeless	☐
Native Hawaiian/Other Pacific Islanders	☐
Asian	☐
Rural	☑
Underserved Racial and Ethnic Minorities	☑

Footnotes:
May 29, 2018 Revision - No changes to this table.

Planning Tables

Table 6 Categories for Expenditures for System Development/Non-Direct-Service Activities

Planning Period Start Date: 10/1/2017 Planning Period End Date: 9/30/2019

Activity	A. MHBG	B. SABG Treatment	C. SABG Prevention	D. SABG Combined*
1. Information Systems	$0			
2. Infrastructure Support	$4,336,333			
3. Partnerships, community outreach, and needs assessment	$956,188			
4. Planning Council Activities (MHBG required, SABG optional)	$7,000			$2,000
5. Quality Assurance and Improvement				
6. Research and Evaluation				
7. Training and Education	$5,489,135			
8. Total	**$10,788,656**	**$0**	**$0**	**$2,000**

*Combined refers to non-direct service/system development expenditures that support both treatment and prevention systems.

Footnotes:

A. Ohio uses the Mental Health Block Grant to fund statewide and regional advocacy organizations to provide peer-to-peer and family-to-family education and supports, as well as continuing education for their members. OhioMHAS also awards Block Grant to organizations typically associated with universities to provide technical assistance and training to implement evidence-based practices, as well as support workforce development and suicide prevention activities.

B. Ohio has a Planning Council which includes persons in recovery from SUD, mental health and/or co-occurring. These expenditures are tracked by the Bureau of Recovery Supports and included in a sub-award to the PEER Center operated by persons in recovery. Ohio also uses these funds to provide stipends and travel reimbursement for consumers and family members who participate in policy meetings, trainings and other activities to support a consumer and families voices in our work.

C. The Substance Abuse Block Grant is budgeted for prevention and treatment, rather than infrastructure. Funds were budgeted for Planning Council member's with SUD only who are reimbursed for travel and receive a stipend..

REVISION RESPONSE February 27, 2018
D. The $2000 in SABG for Planning Council is included in Administration. This was budgeted to be included in 5% Administration cap due to the Council's focus being mostly on treatment.

REVISION RESPONSE May 29, 2018
E. No changes were made to this table for SABG.
F. MHBG made changes from numbers submitted Sept. 1, 2017 which were 3,418,274 for Infrastructure, $753,750 for Partnerships, $5,980 for Planning Council and $4,327,012 for Training and Education.

Environmental Factors and Plan

1. The Health Care System, Parity and Integration - Question 1 and 2 are Required

Narrative Question

1. The Health Care System, Parity and Integration

Persons with mental illness and persons with substance use disorders are likely to die earlier than those who do not have these conditions.[25] Early mortality is associated with broader health disparities and health equity issues such as socioeconomic status but "[h]ealth system factors" such as access to care also play an important role in morbidity and mortality among these populations. Persons with mental illness and substance use disorders may benefit from strategies to control weight, encourage exercise, and properly treat such chronic health conditions as diabetes and cardiovascular disease.[26] It has been acknowledged that there is a high rate of co-occurring M/SUD, with appropriate treatment required for both conditions.[27]

Currently, 50 states have organizationally consolidated their mental and substance use disorder authorities in one fashion or another with additional organizational changes under consideration. More broadly, SAMHSA and its federal partners understand that such factors as education, housing, and nutrition strongly affect the overall health and well-being of persons with mental illness and substance use disorders.[28] SMHAs and SSAs may wish to develop and support partnerships and programs to help address social determinants of health and advance overall health equity.[29] For instance, some organizations have established medical-legal partnerships to assist persons with mental and substance use disorders in meeting their housing, employment, and education needs.[30]

Health care professionals and persons who access M/SUD treatment services recognize the need for improved coordination of care and integration of physical and behavioral health with other health care in primary, specialty, emergency and rehabilitative care settings in the community. For instance, the National Alliance for Mental Illness has published materials for members to assist them in coordinating pediatric mental health and primary care.[31] SAMHSA and its partners support integrated care for persons with mental illness and substance use disorders.[32] The state should illustrate movement towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders. The plan should describe attention to management, funding, payment strategies that foster co-occurring capability for services to individuals and families with co-occurring mental and substance use disorders. Strategies supported by SAMHSA to foster integration of physical and behavioral health include: developing models for inclusion of behavioral health treatment in primary care; supporting innovative payment and financing strategies and delivery system reforms such as ACOs, health homes, pay for performance, etc.; promoting workforce recruitment, retention and training efforts; improving understanding of financial sustainability and billing requirements; encouraging collaboration between M/SUD providers, prevention of teen pregnancy, youth violence, Medicaid programs, and primary care providers such as Federally Qualified Health Centers; and sharing with consumers information about the full range of health and wellness programs.

Health information technology, including EHRs and telehealth are examples of important strategies to promote integrated care.[33] Use of EHRs - in full compliance with applicable legal requirements ? may allow providers to share information, coordinate care, and improve billing practices. Telehealth is another important tool that may allow behavioral health prevention, treatment, and recovery to be conveniently provided in a variety of settings, helping to expand access, improve efficiency, save time, and reduce costs. Development and use of models for coordinated, integrated care such as those found in health homes[34] and ACOs[35] may be important strategies used by SMHAs and SSAs to foster integrated care.

Training and assisting behavioral health providers to redesign or implement new provider billing practices, build capacity for third-party contract negotiations, collaborate with health clinics and other organizations and provider networks, and coordinate benefits among multiple funding sources may be important ways to foster integrated care. SAMHSA encourages SMHAs and SSAs to communicate frequently with stakeholders, including policymakers at the state/jurisdictional and local levels, and State Mental Health Planning Council members and consumers, about efforts to foster health care coverage, access and integrate care to ensure beneficial outcomes. SMHAs and SSAs also may work with state Medicaid agencies, state insurance commissioners, and professional organizations to encourage development of innovative demonstration projects, alternative payment methodologies, and waivers/state plan amendments that test approaches to providing integrated care for persons with M/SUD and other vulnerable populations.[36] Ensuring both Medicaid and private insurers provide required preventive benefits also may be an area for collaboration.[37]

One key population of concern is persons who are dually eligible for Medicare and Medicaid.[38] Roughly, 30 percent of persons who are dually eligible have been diagnosed with a mental illness, more than three times the rate among those who are not dually eligible.[39] SMHAs and SSAs also should collaborate with state Medicaid agencies and state insurance commissioners to develop policies to assist those individuals who

experience health insurance coverage eligibility changes due to shifts in income and employment.[40] Moreover, even with expanded health coverage available through the Marketplace and Medicaid and efforts to ensure parity in health care coverage, persons with behavioral health conditions still may experience challenges in some areas in obtaining care for a particular condition or in finding a provider.[41] SMHAs and SSAs should remain cognizant that health disparities may affect access, health care coverage and integrated care of behavioral health conditions and work with partners to mitigate regional and local variations in services that detrimentally affect access to care and integration.

SMHAs and SSAs should work with partners to ensure recruitment of diverse, well-trained staff and promote workforce development and ability to function in an integrated care environment.[42] Psychiatrists, psychologists, social workers, addiction counselors, preventionists, therapists, technicians, peer support specialists, and others will need to understand integrated care models, concepts, and practices.

Parity is vital to ensuring persons with mental health conditions and substance use disorders receive continuous, coordinated, care. Increasing public awareness about MHPAEA could increase access to behavioral health services, provide financial benefits to individuals and families, and lead to reduced confusion and discrimination associated with mental illness and substance use disorders. Block grant recipients should continue to monitor federal parity regulations and guidance and collaborate with state Medicaid authorities, insurance regulators, insurers, employers, providers, consumers and policymakers to ensure effective parity implementation and comprehensive, consistent communication with stakeholders. The SSAs, SMHAs and their partners may wish to pursue strategies to provide information, education, and technical assistance on parity-related issues. Medicaid programs will be a key partner for recipients of MHBG and SABG funds and providers supported by these funds. The SSAs and SMHAs should collaborate with their states? Medicaid authority in ensuring parity within Medicaid programs.

SAMHSA encourages states to take proactive steps to improve consumer knowledge about parity. As one plan of action, states can develop communication plans to provide and address key issues. Another key part of integration will be defining performance and outcome measures. The Department of Health and Human Services (HHS) and partners have developed the National Quality Strategy, which includes information and resources to help promote health, good outcomes, and patient engagement. SAMHSA's National Behavioral Health Quality Framework includes core measures that may be used by providers and payers.[43] SAMHSA recognizes that certain jurisdictions receiving block grant funds ? including U.S. Territories, tribal entities and those jurisdictions that have signed a Compact of Free Association with the United States and are uniquely impacted by certain Medicaid provisions or are ineligible to participate in certain programs.[44] However, these jurisdictions should collaborate with federal agencies and their governmental and non-governmental partners to expand access and coverage. Furthermore, the jurisdiction should ensure integration of prevention, treatment, and recovery support for persons with, or at risk of, mental and substance use disorders.

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[28] Social Determinants of Health, Healthy People 2020, http://www.healthypeople.gov/2020/topicsobjectives2020/overview.aspx?topicid=39; http://www.cdc.gov/socialdeterminants/Index.html

[29] http://www.samhsa.gov/health-disparities/strategic-initiatives

[30] http://medical-legalpartnership.org/mlp-response/how-civil-legal-aid-helps-health-care-address-sdoh/

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[32] Health Care Integration, http:// samhsa.gov/health-reform/health-care-integration; SAMHSA-HRSA Center for Integrated Health Solutions, (http://www.integration.samhsa.gov/)

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[35] New financing models, http://www.samhsa.gov/co-occurring/topics/primary-care/financing_final.aspx

[36] Waivers, http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/Waivers.html; Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders, CMS Informational Bulletin, Dec. 2012, http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

[37] What are my preventive care benefits? https://www.healthcare.gov/what-are-my-preventive-care-benefits/; Interim Final Rules for Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 75 FR 41726 (July 19, 2010); Group Health Plans and Health Insurance Issuers Relating to Coverage of Preventive Services Under the Patient Protection and Affordable Care Act, 76 FR 46621 (Aug. 3, 2011); Preventive services covered under the Affordable Care Act, http://www.hhs.gov/healthcare/facts/factsheets/2010/07/preventive-services-list.html

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[43] About the National Quality Strategy, http://www.ahrq.gov/workingforquality/about.htm; National Behavioral Health Quality Framework, Draft, August 2013, http://samhsa.gov/data/NBHQF

[44] Letter to Governors on Information for Territories Regarding the Affordable Care Act, December 2012, http://www.cms.gov/cciio/resources/letters/index.html; Affordable Care Act, Indian Health Service, http://www.ihs.gov/ACA/

Please respond to the following items in order to provide a description of the healthcare system and integration activities:

1. Describe how the state integrates mental health and primary health care, including services for individuals with co-occurring mental and substance use disorders, in primary care settings or arrangements to provide primary and specialty care services in community -based mental and substance use disorders settings.

The state of Ohio has been promoting the integration of care (physical and behavioral) for many years. Recently, with the merger of the substance use disorder and mental health agencies, one area of focus has been to consolidate the regulatory structure to more appropriately recognize professional status rather than looking at “separate” services by SUD or MH condition. Additionally, through the state led redesign of the behavioral health benefit covered by Ohio Medicaid, a primary objective has been to more appropriately recognize professional practitioners and their respective scope of practice, i.e. medical personnel provide medical services albeit in a behavioral health setting.

2. Describe how the state provide services and supports towards integrated systems of care for individuals and families with co-occurring mental and substance use disorders, including management, funding, payment strategies that foster co-occurring capability.

Through the state led redesign of the behavioral health benefit covered by Ohio Medicaid, a primary objective has been to more appropriately recognize professional practitioners and their respective scope of practice, i.e. medical personnel provide medical services albeit in a behavioral health setting.

3. Is there a plan for monitoring whether individuals and families have access to M/SUD services offered through QHPs? ○ Yes ◉ No

and Medicaid? ◉ Yes ○ No

4. Who is responsible for monitoring access to M/SUD services by the QHP?

Ohio Department of Insurance

5. Is the SSA/SMHA involved in any coordinated care initiatives in the state? ○ Yes ◉ No

6. Do the behavioral health providers screen and refer for:

- **a)** Prevention and wellness education ◉ Yes ○ No
- **b)** Health risks such as
  - **i)** heart disease ◉ Yes ○ No
  - **ii)** hypertension ◉ Yes ○ No
  - **viii)** high cholesterol ◉ Yes ○ No
  - **ix)** diabetes ◉ Yes ○ No
- **c)** Recovery supports ◉ Yes ○ No

7. Is the SSA/SMHA involved in the development of alternative payment methodologies, including risk-based contractual relationships that advance coordination of care? ○ Yes ◉ No

8. Is the SSA and SMHA involved in the implementation and enforcement of parity protections for mental and substance use disorder services? ○ Yes ◉ No

9. What are the issues or problems that your state is facing related to the implementation and enforcement of parity provisions?

OhioMHAS has not been focused on parity provisions.

10. Does the state have any activities related to this section that you would like to highlight?

See Step 1 of the Block Grant Plan.

Please indicate areas of technical assistance needed related to this section

None requested.

Footnotes:

Environmental Factors and Plan

2. Health Disparities - Requested

Narrative Question

In accordance with the **HHS Action Plan to Reduce Racial and Ethnic Health Disparities**[45], **Healthy People, 2020**[46], **National Stakeholder Strategy for Achieving Health Equity**[47], and other HHS and federal policy recommendations, SAMHSA expects block grant dollars to support equity in access, services provided, and behavioral health outcomes among individuals of all cultures, sexual/gender minorities, orientation and ethnicities. Accordingly, grantees should collect and use data to: (1) identify subpopulations (i.e., racial, ethnic, limited English speaking, tribal, sexual/gender minority groups, etc.) vulnerable to health disparities and (2) implement strategies to decrease the disparities in access, service use, and outcomes both within those subpopulations and in comparison to the general population. One strategy for addressing health disparities is use of the recently revised National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (CLAS)[48].

The Action Plan to Reduce Racial and Ethnic Health Disparities, which the HHS Secretary released in April 2011, outlines goals and actions that HHS agencies, including SAMHSA, will take to reduce health disparities among racial and ethnic minorities. Agencies are required to assess the impact of their policies and programs on health disparities.

The HHS Secretary's top priority in the Action Plan is to "assess and heighten the impact of all HHS policies, programs, processes, and resource decisions to reduce health disparities. HHS leadership will assure that program grantees, as applicable, will be required to submit health disparity impact statements as part of their grant applications. Such statements can inform future HHS investments and policy goals, and in some instances, could be used to score grant applications if underlying program authority permits."[49]

Collecting appropriate data is a critical part of efforts to reduce health disparities and promote equity. In October 2011, HHS issued final standards on the collection of race, ethnicity, primary language, and disability status[50]. This guidance conforms to the existing Office of Management and Budget (OMB) directive on racial/ethnic categories with the expansion of intra-group, detailed data for the Latino and the Asian-American/Pacific Islander populations[51]. In addition, SAMHSA and all other HHS agencies have updated their limited English proficiency plans and, accordingly, will expect block grant dollars to support a reduction in disparities related to access, service use, and outcomes that are associated with limited English proficiency. These three departmental initiatives, along with SAMHSA's and HHS's attention to special service needs and disparities within tribal populations, LGBT populations, and women and girls, provide the foundation for addressing health disparities in the service delivery system. States provide behavioral health services to these individuals with state block grant dollars. While the block grant generally requires the use of evidence-based and promising practices, it is important to note that many of these practices have not been normed on various diverse racial and ethnic populations. States should strive to implement evidence-based and promising practices in a manner that meets the needs of the populations they serve.

In the block grant application, states define the populations they intend to serve. Within these populations of focus are subpopulations that may have disparate access to, use of, or outcomes from provided services. These disparities may be the result of differences in insurance coverage, language, beliefs, norms, values, and/or socioeconomic factors specific to that subpopulation. For instance, lack of Spanish primary care services may contribute to a heightened risk for metabolic disorders among Latino adults with SMI; and American Indian/Alaska Native youth may have an increased incidence of underage binge drinking due to coping patterns related to historical trauma within the American Indian/Alaska Native community. While these factors might not be pervasive among the general population served by the block grant, they may be predominant among subpopulations or groups vulnerable to disparities.

To address and ultimately reduce disparities, it is important for states to have a detailed understanding of who is and is not being served within the community, including in what languages, in order to implement appropriate outreach and engagement strategies for diverse populations. The types of services provided, retention in services, and outcomes are critical measures of quality and outcomes of care for diverse groups. For states to address the potentially disparate impact of their block grant funded efforts, they will address access, use, and outcomes for subpopulations.

[45] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[46] **http://www.healthypeople.gov/2020/default.aspx**

[47] **http://minorityhealth.hhs.gov/npa/files/Plans/NSS/NSSExecSum.pdf**

[48] **http://www.thinkculturalhealth.hhs.gov**

[49] **http://www.minorityhealth.hhs.gov/npa/files/Plans/HHS/HHS_Plan_complete.pdf**

[50] **http://minorityhealth.hhs.gov/templates/browse.aspx?lvl=2&lvlid=208**

[51] http://www.whitehouse.gov/omb/fedreg_race-ethnicity

Please respond to the following items:

1. Does the state track access or enrollment in services, types of services received and outcomes of these services by: race, ethnicity, gender, LGBT, and age?

a) Race	◉ Yes	○ No
b) Ethnicity	◉ Yes	○ No
c) Gender	◉ Yes	○ No
d) Sexual orientation	○ Yes	◉ No
e) Gender identity	○ Yes	◉ No
f) Age	◉ Yes	○ No

2. Does the state have a data-driven plan to address and reduce disparities in access, service use and outcomes for the above sub-population? ◉ Yes ○ No

3. Does the state have a plan to identify, address and monitor linguistic disparities/language barriers? ◉ Yes ○ No

4. Does the state have a workforce-training plan to build the capacity of behavioral health providers to identify disparities in access, services received, and outcomes and provide support for improved culturally and linguistically competent outreach, engagement, prevention, treatment, and recovery services for diverse populations? ◉ Yes ○ No

5. If yes, does this plan include the Culturally and Linguistically Appropriate Services(CLAS) standard? ◉ Yes ○ No

6. Does the state have a budget item allocated to identifying and remedialing disparities in behavioral health care? ◉ Yes ○ No

7. Does the state have any activities related to this section that you would like to highlight?

The State agency is working with the Ohio Commission on Hispanic/Latino Affairs to identify gaps in health services to Ohio's expanding Hispanic and Latino community and to ensure that appropriate level behavioral services are provided to address issues of substance use and mental illness. Recent partnerships with the National Hispanic and Latino ATTC, Ohio Latino Commission have brought together Hispanic and Latino experts and thought leaders together in round table discussions in Dayton Ohio and in Lorain County in northeast Ohio to discuss issues of workforce development, cultural sensitivity awareness and cultural competence in service providers. The 2017 Ohio Latino Health Summit, brought together health care advocates, legislators, community providers, state agencies, universities, resident members of the Hispanic/Latino community, law enforcement, judicial courts, employment representatives, educators, students and numerous others together in an annual conference. The focus areas for the conference were Integrate, Educate and Empower. In what was a highlight for the conference was keynote speaker, Dr. Antonia Novella, former Surgeon General of the United States who's message of advocacy and empowerment through education, community engagement and participation captured the spirit of the conference and attendees. The state agency is continuing its collaboration with this fast growing Ohio and national population to assure that barriers and gaps are reduced and services improved.

Please indicate areas of technical assistance needed related to this section

None requested.

Footnotes:

Environmental Factors and Plan

3. Innovation in Purchasing Decisions - Requested

Narrative Question

While there are different ways to define value-based purchasing, the purpose is to identify services, payment arrangements, incentives, and players that can be included in directed strategies using purchasing practices that are aimed at improving the value of health care services. In short, health care value is a function of both cost and quality:

Health Care Value = Quality ? Cost, (V = Q ? C)

SAMHSA anticipates that the movement toward value based purchasing will continue as delivery system reforms continue to shape states systems. The identification and replication of such value-based strategies and structures will be important to the development of behavioral health systems and services.

There is increased interest in having a better understanding of the evidence that supports the delivery of medical and specialty care including M/SUD services. Over the past several years, SAMHSA has collaborated with CMS, HRSA, SMAs, state behavioral health authorities, legislators, and others regarding the evidence of various mental and substance misuse prevention, treatment, and recovery support services. States and other purchasers are requesting information on evidence-based practices or other procedures that result in better health outcomes for individuals and the general population. While the emphasis on evidence-based practices will continue, there is a need to develop and create new interventions and technologies and in turn, to establish the evidence. SAMHSA supports states' use of the block grants for this purpose. The NQF and the IOM recommend that evidence play a critical role in designing health benefits for individuals enrolled in commercial insurance, Medicaid, and Medicare.

To respond to these inquiries and recommendations, SAMHSA has undertaken several activities. NREPP assesses the research evaluating an intervention's impact on outcomes and provides information on available resources to facilitate the effective dissemination and implementation of the program. NREPP ratings take into account the methodological rigor of evaluation studies, the size of a program's impact on an outcome, the degree to which a program was implemented as designed, and the strength of a program's conceptual framework. For each intervention reviewed, NREPP publishes a report called a program profile on this website. You will find research on the effectiveness of programs as reviewed and rated by NREPP certified reviewers. Each profile contains easily understandable ratings for individual outcomes based on solid evidence that indicates whether a program achieved its goals. NREPP is not intended to be an exhaustive listing of all evidence-based practices in existence.

SAMHSA reviewed and analyzed the current evidence for a wide range of interventions for individuals with mental illness and substance use disorders, including youth and adults with chronic addiction disorders, adults with SMI, and children and youth with SED. The evidence builds on the evidence and consensus standards that have been developed in many national reports over the last decade or more. These include reports by the Surgeon General[52], The New Freedom Commission on Mental Health[53], the IOM[54], and the NQF[55]. The activity included a systematic assessment of the current research findings for the effectiveness of the services using a strict set of evidentiary standards. This series of assessments was published in "Psychiatry Online."[56] SAMHSA and other federal partners, the HHS' Administration for Children and Families, Office for Civil Rights, and CMS, have used this information to sponsor technical expert panels that provide specific recommendations to the behavioral health field regarding what the evidence indicates works and for whom, to identify specific strategies for embedding these practices in provider organizations, and to recommend additional service research.

In addition to evidence-based practices, there are also many promising practices in various stages of development. Anecdotal evidence and program data indicate effectiveness for these services. As these practices continue to be evaluated, the evidence is collected to establish their efficacy and to advance the knowledge of the field.

SAMHSA's Treatment Improvement Protocol Series **(TIPS)**[57] are best practice guidelines for the SUD treatment. The CSAT draws on the experience and knowledge of clinical, research, and administrative experts to produce the TIPS, which are distributed to a growing number of facilities and individuals across the country. The audience for the TIPS is expanding beyond public and private SUD treatment facilities as alcohol and other drug disorders are increasingly recognized as a major health problem.

SAMHSA's Evidence-Based Practice Knowledge Informing Transformation **(KIT)**[58] was developed to help move the latest information available on effective behavioral health practices into community-based service delivery. States, communities, administrators, practitioners, consumers of mental health care, and their family members can use KIT to design and implement behavioral health practices that work. KIT, part of SAMHSA's priority initiative on Behavioral Health Workforce in Primary and Specialty Care Settings, covers getting started, building the program, training frontline staff, and evaluating the program. The KITs contain information sheets, introductory videos, practice demonstration videos, and

training manuals. Each KIT outlines the essential components of the evidence-based practice and provides suggestions collected from those who have successfully implemented them.

SAMHSA is interested in whether and how states are using evidence in their purchasing decisions, educating policymakers, or supporting providers to offer high quality services. In addition, SAMHSA is concerned with what additional information is needed by SMHAs and SSAs in their efforts to continue to shape their and other purchasers' decisions regarding M/SUD services.

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[52] United States Public Health Service Office of the Surgeon General (1999). Mental Health: A Report of the Surgeon General. Rockville, MD: Department of Health and Human Services, U.S. Public Health Service

[53] The President's New Freedom Commission on Mental Health (July 2003). Achieving the Promise: Transforming Mental Health Care in America. Rockville, MD: Department of Health and Human Services, Substance Abuse and Mental Health Services Administration.

[54] Institute of Medicine Committee on Crossing the Quality Chasm: Adaptation to Mental Health and Addictive Disorders (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. Washington, DC: National Academies Press.

[55] National Quality Forum (2007). National Voluntary Consensus Standards for the Treatment of Substance Use Conditions: Evidence-Based Treatment Practices. Washington, DC: National Quality Forum.

[56] **http://psychiatryonline.org/**

[57] **http://store.samhsa.gov**

[58] **http://store.samhsa.gov/shin/content//SMA08-4367/HowtoUseEBPKITS-ITC.pdf**

Please respond to the following items:

1. Is information used regarding evidence-based or promising practices in your purchasing or policy decisions? (●) Yes ( ) No

2. Which value based purchasing strategies do you use in your state (check all that apply):

- **a)** [x] Leadership support, including investment of human and financial resources.
- **b)** [x] Use of available and credible data to identify better quality and monitored the impact of quality improvement interventions.
- **c)** [x] Use of financial and non-financial incentives for providers or consumers.
- **d)** [ ] Provider involvement in planning value-based purchasing.
- **e)** [ ] Use of accurate and reliable measures of quality in payment arrangements.
- **f)** [ ] Quality measures focus on consumer outcomes rather than care processes.
- **g)** [ ] Involvement in CMS or commercial insurance value based purchasing programs (health homes, ACO, all payer/global payments, pay for performance (P4P)).
- **h)** [ ] The state has an evaluation plan to assess the impact of its purchasing decisions.

Does the state have any activities related to this section that you would like to highlight?

No.

Please indicate areas of technical assistance needed related to this section.

None requested.

Footnotes:

Environmental Factors and Plan

4. Evidence-Based Practices for Early Interventions to Address Early Serious Mental Illness (ESMI) - 10 percent set aside - Required MHBG

Narrative Question

Much of the mental health treatment and recovery are focused on the later stages of illness, intervening only when things have reached the level of a crisis. While this kind of treatment is critical, it is also costly in terms of increased financial burdens for public mental health systems, lost economic productivity, and the toll taken on individuals and families. There are growing concerns among consumers and family members that the mental health system needs to do more when people first experience these conditions to prevent long-term adverse consequences. Early intervention* is critical to treating mental illness before it can cause tragic results like serious impairment, unemployment, homelessness, poverty, and suicide. The duration of untreated mental illness, defined as the time interval between the onset of a mental disorder and when an individual gets into treatment, has been a predictor of outcome across different mental illnesses. Evidence indicates that a prolonged duration of untreated mental illness may be viewed as a negative prognostic factor for those who are diagnosed with mental illness. Earlier treatment and interventions not only reduce acute symptoms, but may also improve long-term prognosis.

States may implement models that have demonstrated efficacy, including the range of services and principles identified by National Institute of Mental Health (NIMH) via its Recovery After an Initial Schizophrenia Episode **(RAISE)** initiative. Utilizing these principles, regardless of the amount of investment, and by leveraging funds through inclusion of services reimbursed by Medicaid or private insurance, states should move their system to address the needs of individuals with a first episode of psychosis (FEP). NIMH sponsored a set of studies beginning in 2008, focusing on the early identification and provision of evidence-based treatments to persons experiencing FEP the RAISE model). The NIMH RAISE studies, as well as similar early intervention programs tested worldwide, consist of multiple evidence-based treatment components used in tandem as part of a CSC model, and have been shown to improve symptoms, reduce relapse, and improved outcomes.

State shall expend not less than 10 percent of the amount the State receives for carrying out this section for each fiscal year to support evidence-based programs that address the needs of individuals with early serious mental illness, including psychotic disorders, regardless of the age of the individual at onset. In lieu of expending 10 percent of the amount the State receives under this section for a fiscal year as required a state may elect to expend not less than 20 percent of such amount by the end of such succeeding fiscal year.

* MHBG funds cannot be used for primary prevention activities. States cannot use MHBG funds for prodromal symptoms (specific group of symptoms that may precede the onset and diagnosis of a mental illness) and/or those who are not diagnosed with a SMI.

Please respond to the following items:

1. Does the state have policies for addressing early serious mental illness (ESMI)? ○ Yes ◉ No

2. Has the state implemented any evidence based practices (EBPs) for those with ESMI? ◉ Yes ○ No

If yes, please list the EBPs and provide a description of the programs that the state currently funds to implement evidence-based practices for those with ESMI.

OhioMHAS awarded Mental Health funds to providers who are implementing the Coordinated Specialty Care Model for individuals with first episode psychosis. These services are provided by team members, and include medication management, family psychoeducation, cognitive behavior therapy/individual counseling, case management/recovery coach, supported employment and supported education and peer support. We have not required fidelity reviews to date, but this is a goal for projects to achieve in the near future.

3. How does the state promote the use of evidence-based practices for individuals with a ESMI and provide comprehensive individualized treatment or integrated mental and physical health services?

The funded projects were required to respond to a Request for Proposal (RFP) in which they were asked to document various components of their projects. Part of the RFP requirements were to address how the project would provide individualized treatment and their plan to integrate the behavioral health services with their physical health services.

4. Does the state coordinate across public and private sector entities to coordinate treatment and recovery supports for those with a ESMI? ○ Yes ◉ No

5. Does the state collect data specifically related to ESMI? ◉ Yes ○ No

6. Does the state provide trainings to increase capacity of providers to deliver interventions related to ESMI? ◉ Yes ○ No

7. Please provide an updated description of the state's chosen EBPs for the 10 percent set-aside for ESMI.

Ohio is implementing the Coordinated Specialty Care (CSC) model by awarding competitive grants to providers through an RFP process.

8. Please describe the planned activities for FFY 2018 and FFY 2019 for your state's ESMI programs including psychosis?

In FFY '18, through an RFP process we are seeking new projects to provide services to individuals with ESMI in expanded areas of the state. In addition, we have committed to continuation funding (reduced amount) to the current funded seven providers. These programs are available in seventeen counties in Ohio. Our goal is to have more regions/areas with these services to address unmet needs. Also in FFY '18 we will be collecting data directly from the provider and the client which will assist us in monitoring services and outcomes. Our plan for sustainability includes working with a vendor to develop on-line curriculum that will be available to any provider or team who is interested. The projects are contracting with consultants to assist with staff education and training, but with expansion, staff turnover and other transitions this may not be sustainable in the future. We plan to have on-line modules available to supplement the in person training via a Project ECHO model. We will also provide additional technical assistance to the project members. Lastly, in this FFY, we hope to engage with a vendor to assist in developing outreach materials and publications to assist the teams in their recruitment and public relations efforts.
In FFY '19 we will continue to add new FEP providers and also fund the existing providers at a lesser amount. At that time, we hope to have the on-line curriculum developed, and the outreach materials. Additionally, we will have treatment information and outcomes data to assist us in developing future technical assistance events and additional tools in support of the teams.
In collaboration with the Ohio Office of Medicaid, we anticipate that ESMI will be included as an Episode of Care. The goal of having ESMI as an episode of care is that all services in the CSC will be reimbursed by insurance, both private and Medicaid/Medicaid Managed Care. This development will support sustainability for the programs and for needed services.

9. Please explain the state's provision for collecting and reporting data, demonstrating the impact of the 10 percent set-aside for ESMI.

Our Office of Quality, Performance and Research has developed a data collection program that we will be using beginning in July 2017 (SFY 2018). Team members and clients will be asked to enter data at admission to the program, every six months and at termination. This will allow us to identify services provided, client outcomes, client functioning to determine the impact of the programming. At this time, we have a paper collection process that will be replaced with the electronic collection of data.

10. Please list the diagnostic categories identified for your state's ESMI programs.

Brief Psychotic Disorder, Schizophreniform Disorder, Bipolar Disorder with Psychotic Features, Major Depression with Psychotic Features, Schizoaffective Disorder, Delusional Disorder, or Schizophrenia

Does the state have any activities related to this section that you would like to highlight?

11/15/2017 Revision: OhioMHAS was in the planning stage to collect data in SFY 2018 from the ESMI projects at the time the Plan was submitted. In SFY 2017, Ohio had two medical schools (NEOMED-BeST Center and OSU-Epicenter) which were each collecting different data from the projects with which they had contracts to provide technical assistance. For 2018, OhioMHAS will collect data directly from all of the projects using evaluation instruments aligned with the national study of the ESMI projects and with the URS Tables in work by Kraig Knudsen, Ph.D., OhioMHAS Chief of the Office of Research and Evaluation.

Please indicate areas of technical assistance needed related to this section.

Technical assistance in sustainability and financing programs would be helpful. We would like to know more about how to fund a new team (including staff training, building referrals) and how to fund the teams after they have been in place for a few years.

Footnotes:

11/15/2017 Revision: Response changed to yes in question 5 since OhioMHAS recently requested ESMI data for the URS Tables. At the time the Plan was submitted, OhioMHAS had not collected any data. OhioMHAS will implement additional data collection aligned with the national ESMI study in SFY 2018.

Environmental Factors and Plan

5. Person Centered Planning (PCP) - Required MHBG

Narrative Question

States must engage adults with a serious mental illness or children with a serious emotional disturbance and their caregivers where appropriate in making health care decisions, including activities that enhance communication among individuals, families, caregivers, and treatment providers. Person-centered planning is a process through which individuals develop their plan of service. The PCP may include a representative who the person has freely chosen, and/or who is authorized to make personal or health decisions for the person. The PCP may include family members, legal guardians, friends, caregivers and others that the person or his/her representative wishes to include. The PCP should involve the person receiving services and supports to the maximum extent possible, even if the person has a legal representative. The PCP approach identifies the person's strengths, goals, preferences, needs and desired outcome. The role of state and agency workers (for example, options counselors, support brokers, social workers, peer support workers, and others) in the PCP process is to enable and assist people to identify and access a unique mix of paid and unpaid services to meet their needs and provide support during planning. The person's goals and preferences in areas such as recreation, transportation, friendships, therapies, home, employment, family relationships, and treatments are part of a written plan that is consistent with the person's needs and desires.

1. Does your state have policies related to person centered planning? (•) Yes ( ) No

2. If no, describe any action steps planned by the state in developing PCP initiatives in the future.

3. Describe how the state engages consumers and their caregivers in making health care decisions, and enhance communication.

Consumers and their caregivers are engaged through a person centered treatment planning process which is written into Ohio's treatment standards. Providers are required to facilitate consumer participation in treatment planning that is based on the consumer's priorities and preferences, and document it. Caregivers are always included in children's treatment planning, and as appropriate with adult consumers with their consent. Expectations and attitudes toward consumers engaging in making health care decisions are supported by ADAMH Boards promotion of a Recovery Oriented System of Care (ROSC) in their communities.

4. Describe the person-centered planning process in your state.

The development of the person-centered individual treatment plan (ITP) is a collaborative process between the client and service provider based on a diagnostic assessment, a continuing assessment of needs, and the identification of interventions and services appropriate to the individual's diagnosis and other related needs. At minimum, the ITP provides (1) a description of the mental health or addiction services, and supports the needs of the consumer; (2) anticipated treatment goals and objectives based on the needs of the consumer which includes the services being provided, their duration and frequency. Documentation that the ITP has been reviewed with the active participation of the consumer. If the client disagrees with the ITP, refuses to participate in its development, or is unable to participate, that must be documented in the chart. The ITP shall be periodically reviewed at the consumer's request, when clinically indicated when there is a change in level of care, and when a service is added, terminated, denied or no longer available.

Does the state have any activities related to this section that you would like to highlight?

Ohio Association of Community Behavioral Health Boards is promoting a Recovery Oriented System of Care (ROSC) which promotes attitudes among providers and consumers which support person-centered treatment planning. This initiative includes annual recovery conferences, which include key note presentations by consumers on their recovery experiences.

A fundamental principle of a Recovery-Oriented System of Care is that consumers are key. Consumers are the drivers of decisions about service and support needs. Services are built and systems are put in place so that individuals are able to access an array of services and supports when and where they need them.

Please indicate areas of technical assistance needed related to this section.

None requested.

Footnotes:

Environmental Factors and Plan

6. Self-Direction - Requested

Narrative Question

In self-direction - also known as self-directed care - a service user or "participant" controls a flexible budget, purchasing goods and services to achieve personal recovery goals developed through a person-centered planning process. While this is not an allowable use of Block Grant Funds,the practice has shown to provide flexible supports for an individual's service. The self-direction budget may comprise the service dollars that would have been used to reimburse an individual's traditional mental health care, or it may be a smaller fixed amount that supplements a mental health benefit. In self-direction, the participant allocates the budget in a manner of his or her choosing within program guidelines. The participant is encouraged to think creatively about setting goals and is given a significant amount of freedom to work toward those goals. Purchases can range from computers and bicycles to dental care and outpatient mental health treatment.

Typically, a specially trained coach or broker supports the participant to identify resources, chart progress, and think creatively about the planning and budgeting processes. Often a peer specialist who has received additional training in self-direction performs the broker role. The broker or a separate agency assists the participant with financial management details such as budget tracking, holding and disbursing funds, and hiring and payroll logistics. Self-direction arrangements take different forms throughout the United States and are housed and administered in a variety of entities, including county and state behavioral health authorities, managed care companies, social service agencies, and advocacy organizations.

Self-direction is based on the premise that people with disabilities can and should make their own decisions about the supports and services they receive. Hallmarks of self-direction include voluntary participation, individual articulation of preferences and choices, and participant responsibility. In recent years, physical and mental health service systems have placed increasing emphasis on person-centered approaches to service delivery and organization. In this context, self-direction has emerged as a promising practice to support recovery and well-being for persons with mental health conditions. A small but growing evidence base has documented self-direction's impact on quality of life, community tenure, and psychological well-being.

Please respond to the following items:

1. Does your state have policies related to self-direction? (•) Yes ( ) No

2. Are there any concretely planned initiatives in our state specific to self-direction? ( ) Yes (•) No

If yes, describe the currently planned initiatives. In particular, please answer the following questions:

a) How is this initiative financed:

b) What are the eligibility criteria?

c) How are budgets set, and what is the scope of the budget?

d) What role, if any, do peers with lived experience of the mental health system play in the initiative?

e) What, if any, research and evaluation activities are connected to the initiative?

f) If no, describe any action steps planned by the state in developing self-direction initiatives in the future.

Does the state have any activities related to this section that you would like to highlight?

Please indicate areas of technical assistance needed to this section.

Footnotes:

Environmental Factors and Plan

7. Program Integrity - Required

Narrative Question

SAMHSA has placed a strong emphasis on ensuring that block grant funds are expended in a manner consistent with the statutory and regulatory framework. This requires that SAMHSA and the states have a strong approach to assuring program integrity. Currently, the primary goals of SAMHSA program integrity efforts are to promote the proper expenditure of block grant funds, improve block grant program compliance nationally, and demonstrate the effective use of block grant funds. While some states have indicated an interest in using block grant funds for individual co-pays deductibles and other types of co-insurance for behavioral health services, SAMHSA reminds states of restrictions on the use of block grant funds outlined in 42 U.S.C. §§ 300x-5 and 300x-31, including cash payments to intended recipients of health services and providing financial assistance to any entity other than a public or nonprofit private entity. Under 42 U.S.C. § 300x-55(g), SAMHSA periodically conducts site visits to MHBG and SABG grantees to evaluate program and fiscal management. States will need to develop specific policies and procedures for assuring compliance with the funding requirements. Since MHBG funds can only be used for authorized services made available to adults with SMI and children with SED and SABG funds can only be used for individuals with or at risk for SUD. SAMHSA guidance on the use of block grant funding for co-pays, deductibles, and premiums can be found at: **http://www.samhsa.gov/sites/default/files/grants/guidance-for-block-grant-funds-for-cost-sharing-assistance-for-private-health-insurance.pdf**. States are encouraged to review the guidance and request any needed technical assistance to assure the appropriate use of such funds.

The MHBG and SABG resources are to be used to support, not supplant, services that will be covered through the private and public insurance. In addition, SAMHSA will work with CMS and states to identify strategies for sharing data, protocols, and information to assist our program integrity efforts. Data collection, analysis, and reporting will help to ensure that MHBG and SABG funds are allocated to support evidence-based, culturally competent programs, substance use disorder prevention, treatment and recovery programs, and activities for adults with SMI and children with SED.

States traditionally have employed a variety of strategies to procure and pay for behavioral health services funded by the MHBG and SABG. State systems for procurement, contract management, financial reporting, and audit vary significantly. These strategies may include: (1) appropriately directing complaints and appeals requests to ensure that QHPs and Medicaid programs are including essential health benefits (EHBs) as per the state benchmark plan; (2) ensuring that individuals are aware of the covered M/SUD benefits; (3) ensuring that consumers of M/SUD services have full confidence in the confidentiality of their medical information; and (4) monitoring the use of behavioral health benefits in light of utilization review, medical necessity, etc. Consequently, states may have to become more proactive in ensuring that state-funded providers are enrolled in the Medicaid program and have the ability to determine if clients are enrolled or eligible to enroll in Medicaid. Additionally, compliance review and audit protocols may need to be revised to provide for increased tests of client eligibility and enrollment.

Please respond to the following items:

1. Does the state have a specific policy and/or procedure for assuring that the federal program requirements are conveyed to intermediaries and providers? (●) Yes ( ) No

2. Does the state provide technical assistance to providers in adopting practices that promote compliance with programs requirements, including quality and safety standard? (●) Yes ( ) No

3. Does the state have any activites related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed to this section

None requested.

Footnotes:

Environmental Factors and Plan

8. Tribes - Requested

Narrative Question

The federal government has a unique obligation to help improve the health of American Indians and Alaska Natives through the various health and human services programs administered by HHS. Treaties, federal legislation, regulations, executive orders, and Presidential memoranda support and define the relationship of the federal government with federally recognized tribes, which is derived from the political and legal relationship that Indian tribes have with the federal government and is not based upon race. SAMHSA is required by the **2009 Memorandum on Tribal Consultation**[59] to submit plans on how it will engage in regular and meaningful consultation and collaboration with tribal officials in the development of federal policies that have tribal implications.

Improving the health and well-being of tribal nations is contingent upon understanding their specific needs. Tribal consultation is an essential tool in achieving that understanding. Consultation is an enhanced form of communication, which emphasizes trust, respect, and shared responsibility. It is an open and free exchange of information and opinion among parties, which leads to mutual understanding and comprehension. Consultation is integral to a deliberative process that results in effective collaboration and informed decision-making with the ultimate goal of reaching consensus on issues.

In the context of the block grant funds awarded to tribes, SAMHSA views consultation as a government-to-government interaction and should be distinguished from input provided by individual tribal members or services provided for tribal members whether on or off tribal lands. Therefore, the interaction should be attended by elected officials of the tribe or their designees and by the highest possible state officials. As states administer health and human services programs that are supported with federal funding, it is imperative that they consult with tribes to ensure the programs meet the needs of the tribes in the state. In addition to general stakeholder consultation, states should establish, implement, and document a process for consultation with the federally recognized tribal governments located within or governing tribal lands within their borders to solicit their input during the block grant planning process. Evidence that these actions have been performed by the state should be reflected throughout the state's plan. Additionally, it is important to note that approximately 70 percent of American Indians and Alaska Natives do not live on tribal lands. The SMHAs, SSAs and tribes should collaborate to ensure access and culturally competent care for all American Indians and Alaska Natives in the states.

States shall not require any tribe to waive its sovereign immunity in order to receive funds or for services to be provided for tribal members on tribal lands. If a state does not have any federally recognized tribal governments or tribal lands within its borders, the state should make a declarative statement to that effect.

[59] http://www.whitehouse.gov/the-press-office/memorandum-tribal-consultation-signed-president

Please respond to the following items:

1. How many consultation sessions has the state conducted with federally recognized tribes?

Zero; Ohio has no federally recognized tribes, so this section is not applicable.

2. What specific concerns were raised during the consultation session(s) noted above?

Does the state have any activites related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed to this section

None requested.

Footnotes:

Environmental Factors and Plan

9. Primary Prevention - Required SABG

Narrative Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Please respond to the following items

Assessment

1. Does your state have an active State Epidemiological and Outcomes Workgroup(SEOW)? (●) Yes ( ) No

2. Does your state collect the following types of data as part of its primary prevention needs assessment process? (check all that apply) (●) Yes ( ) No

- [x] Data on consequences of substance using behaviors
- [x] Substance-using behaviors
- [x] Intervening variables (including risk and protective factors)
- [ ] Others (please list)

3. Does your state collect needs assesment data that include analysis of primary prevention needs for the following population groups? (check all that apply)

- [ ] Children (under age 12)
- [x] Youth (ages 12-17)
- [x] Young adults/college age (ages 18-26)
- [ ] Adults (ages 27-54)
- [ ] Older adults (age 55 and above)
- [x] Cultural/ethnic minorities
- [ ] Sexual/gender minorities
- [x] Rural communities
- [x] Others (please list)

Department of Education (graduation data)

Department of Health (overdose mortality data, disease prevalence)
Office of Criminal Justice Services (substance use crash/fatality data)
US Census data (children living in poverty, population statistics, etc.)

4. Does your state use data from the following sources in its Primary prevention needs assesment? (check all that apply)

- [x] Archival indicators (Please list)
- [x] National survey on Drug Use and Health (NSDUH)
- [x] Behavioral Risk Factor Surveillance System (BRFSS)
- [x] Youth Risk Behavioral Surveillance System (YRBS)
- [ ] Monitoring the Future
- [ ] Communities that Care
- [x] State - developed survey instrument
- [ ] Others (please list)

5. Does your state use needs assesment data to make decisions about the allocation SABG primary prevention funds? (•) Yes ( ) No

If yes, (please explain)

Ohio uses the needs assessment data to ensure that our statewide initiatives are meeting the needs and ongoing trends occurring in the state. The funded community grants utilize their community needs assessment to plan their evidence based strategies, activities and programs. Communities are also beginning to use the Needs Assessment data provided in the Network of Care and the Ohio Healthy Youth Environments Survey to assist in their federal and state discretionary grant applications and in the Assessment Phase of the Strategic Prevention Framework.

If no, (please explain) how SABG funds are allocated:

Does the state have any activities related to this section that you would like to highlight?

Please see prevention narrative section.

Please indicate areas of technical assistance needed related to this section

None

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Capacity Building

1. Does your state have a statewide licensing or certification program for the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe

Effective April 1, 2016 OhioMHAS updated the Certification Process for all AoD and Mental Health providers. This rule changed Prevention to an AoD and Mental Health service, not a stand-alone program (OAC 3793:5). In order to be a certifiefd Prevention Service provider, agencies must provide one of the six CSAP strategies, with at least one of the strategies being Education or Environmental prevention. Eligible providers are defined in the Appendices for OAC 5122-29-30.

2. Does your state have a formal mechanism to provide training and technical assistance to the substance use disorder prevention workforce? (●) Yes ( ) No

If yes, please describe mechanism used

OPEC: Every summer OhioMHAS sponsors a Prevention Conference that is 2-3 days, at a university to minimize costs (usually $100 registration). There are 6 curriculum tracks: Prevention, Adolescent and Transition-Age Youth, Youth Development, Cultural Competency, Early Childhood Mental Health, and Collective Impact.
E-based Academy: offers classes from Ohio's top educators, professors and professionals from behavioral sciences to the science of addiction. Courses are offered online and at the individual's pace. Continuing education credits are available in a variety of fields including psychology, nursing and social work. Course are available free of charge for everyone, anywhere.
PFS trainings: Through the SPF-PFS grant Ohio is targeting workforce development training to rural and Appalachian areas but is also available to the entire Ohio workforce. Regional Learning Collaboratives (RLC) are designed to offer guidance and support as prevention professionals seek and obtain their OCPS credentials. Coaches assist with eliminating barriers, provide technical assistance and equip area professionals and community members with the necessary skills and knowledge to implement evidence-based prevention. Substance Abuse Skills (SAPST) trainings provide an understanding of the discipline of the prevention of alcohol, tobacco, and other drug abuse as it relates to communities, providers and volunteers, in a fun, creative unique training that begins where people are at, and which includes application. Online pre-work is required to complete the training.

3. Does your state have a formal mechanism to assess community readiness to implement prevention strategies? (●) Yes ( ) No

If yes, please describe mechanism used

Ohio has been working on "SPFing" the state and many of our Boards and providers adopt the SPF process as a part of their work. The SPF-PFS project recently conducted a Community Readiness Assessment of rural and Appalachian counties in Ohio using the Tri-Ethnic model. This created a snapshot of Ohio's rural/Appalachian readiness in order to determine what workforce development and capacity training needs would be most helpful to not only sub-recipient communities, but across the state.

Does the state have any activities related to this section that you would like to highlight?

Additionally, the 9 sub-recipient communities and 6 mini-grantees will be assessing their Community Readiness through the PFS grant. OhioMHAS partnered with Ohio University's Voinovich School of Leadership and Public Affairs and the Pacific Institute for Research and Evaluation to make this training available to all communities in Ohio, regardless of geographical classification. Short videos have been prepared to train community members and are available at http://pfs.ohio.gov/SPF-Phases/Assessment/Community-Readiness

Please indicate areas of technical assistance needed related to this section

None

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
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- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Planning

1. Does your state have a strategic plan that addresses substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

The Plan will be attached.

2. Does your state use the strategic plan to make decisions about use of the primary prevention set-aside of the SABG? (N/A - no prevention strategic plan) (●) Yes ( ) No ( ) N/A

3. Does your state's prevention strategic plan include the following components? (check all that apply):

- **a)** [ ] Based on needs assessment datasets the priorities that guide the allocation of SABG primary prevention funds
- **b)** [ ] Timelines
- **c)** [ ] Roles and responsibilities
- **d)** [ ] Process indicators
- **e)** [ ] Outcome indicators
- **f)** [ ] Cultural competence component
- **g)** [ ] Sustainability component
- **h)** [x] Other (please list):

  Ohio has several plans, not one specific to SABG funding. We have completed strategic plans for the SPF SPE, SPF SIG, SPF -PFS and are working on the plan for our SPF Rx. While all of these plans were for specific grants, Ohio utilizes the information to broader decision making to ensure we are meeting the needs across the state.
- **i)** [ ] Not applicable/no prevention strategic plan

4. Does your state have an Advisory Council that provides input into decisions about the use of SABG primary prevention funds? (●) Yes ( ) No

5. Does your state have an active Evidence-Based Workgroup that makes decisions about appropriate strategies to be implemented with SABG primary prevention funds? (●) Yes ( ) No

If yes, please describe the criteria the Evidence-Based Workgroup uses to determine which programs, policies, and strategies are evidence based

Ohio required that all grantees implement EBPs and we have many providers that have been implementing and can show effectiveness in their programming. Current sub-recipient communities that receive federal discretionary grants (SPF SIG, SPF-PFS,

SPF Rx) submit their Strategic Plans to the Evidence-Based Workgroup (EBP) for review. The EBP Workgroup has received extensive training on the SPF as well as other evidence based practices, and serve as our expert reviewers. They review innovative community programs and practices and state –level processes and guidance documents. A number of useful tools and resources were developed to assist in the review and approval of SPF SIG sub-recipient documents.

Does the state have any activities related to this section that you would like to highlight?

Ohio's EBP has also been involved in other projects and provided feedback and recommendations to Ohio's Youth Led Prevention Network Resource Guide as well as the Ohio Coalition Center for Excellence designation. Currently Ohio's EBP consists of statewide SPF SIG Project team members, state department representatives and local ADAMHS Boards and prevention providers. From the very beginning, Ohio's EBP has been sustained beyond the SPF grant because of the need for a formalized structure and process to increase evidence-based prevention practice in Ohio. The EBP will continue to provide consultation to local communities as well as take a broader role in guiding the future of Ohio behavioral health practice.

Please indicate areas of technical assistance needed related to this section.

None

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Implementation

1. States distribute SABG primary prevention funds in a variety of different ways. Please check all that apply to your state:

- **a)** ☐ SSA staff directly implements primary prevention programs and strategies.
- **b)** ☐ The SSA has statewide contracts (e.g. statewide needs assessment contract, statewide workforce training contract, statewide media campaign contract).
- **c)** ☐ The SSA funds regional entities that are autonomous in that they issue and manage their own sub-contracts.
- **d)** ☐ The SSA funds regional entities that provide training and technical assistance.
- **e)** ☐ The SSA funds regional entities to provide prevention services.
- **f)** ☑ The SSA funds county, city, or tribal governments to provide prevention services.
- **g)** ☑ The SSA funds community coalitions to provide prevention services.
- **h)** ☑ The SSA funds individual programs that are not part of a larger community effort.
- **i)** ☐ The SSA directly funds other state agency prevention programs.
- **j)** ☑ Other (please describe)

Ohio also funds several entities that work on statewide prevention X initiatives.

2. Please list the specific primary prevention programs, practices, and strategies that are funded with SABG primary prevention dollars in each of the six prevention strategies. Please see the introduction above for definitions of the six strategies:

a) Information Dissemination:

Community Coalitions
Higher Education programs
UMADAOP (Urban Minority Alcohol & Drug Addiction) programs
Community Prevention programs
Women's Prevention programs

b) Education:

Community Coalitions
Higher Education programs
UMADAOP programs
Community Prevention programs
Youth Led Programs
Women's Prevention Programs

Statewide Conferences and Summits

c) Alternatives:

UMADAOP programs
Youth Led programs
Community Prevention programs

d) Problem Identification and Referral:

Community Prevention programs
UMADAOP programs

e) Community-Based Processes:

Community Coalitions
Community Prevention programs
Youth Led programs
UMADAOP programs

f) Environmental:

Community Coalitions
UMADAOP programs
Youth Led programs

3. Does your state have a process in place to ensure that SABG dollars are used only to fund primary prevention services not funded through other means? ○ Yes ◉ No

If yes, please describe

Does the state have any activities related to this section that you would like to highlight?

Please see Prevention section in Step 1 of the Plan.

Please indicate areas of technical assistance needed related to this section.

None

Narratve Question

SABG statute requires states to spend not less than 20 percent of their SABG allotment on primary prevention strategies directed at individuals not identified to be in need of treatment. While primary prevention set-aside funds must be used to fund strategies that have a positive impact on the prevention of substance use, it is important to note that many evidence-based substance use disorder prevention strategies also have a positive impact on other health and social outcomes such as education, juvenile justice involvement, violence prevention, and mental health. The SABG statute requires states to develop a comprehensive primary prevention program that includes activities and services provided in a variety of settings. The program must target both the general population and sub-groups that are at high risk for substance misuse. The program must include, but is not limited to, the following strategies:

- ***Information Dissemination*** providing awareness and knowledge of the nature, extent, and effects of alcohol, tobacco, and drug use, abuse, and addiction on individuals families and communities;
- ***Education*** aimed at affecting critical life and social skills, such as decision making, refusal skills, critical analysis, and systematic judgment abilities;
- ***Alternative programs*** that provide for the participation of target populations in activities that exclude alcohol, tobacco, and other drug use;
- ***Problem Identification*** and referral that aims at identification of those who have indulged in illegal/age inappropriate use of tobacco or alcohol, and those individuals who have indulged in first use of illicit drugs, in order to assess if the behavior can be reversed by education to prevent further use;
- ***Community-based Process*** that include organizing, planning, and enhancing effectiveness of program, policy, and practice implementation, interagency collaboration, coalition building, and networking; and
- ***Environmental Strategies*** that establish or change written and unwritten community standards, codes, and attitudes, thereby influencing incidence and prevalence of the abuse of alcohol, tobacco and other drugs used in the general population.

In implementing the comprehensive primary prevention program, states should use a variety of strategies that target populations with different levels of risk, including the IOM classified universal, selective, and indicated strategies.

Evaluation

1. Does your state have an evaluation plan for substance use disorder prevention that was developed within the last five years? (●) Yes ( ) No

If yes, please attach the plan in BGAS by going to the **Attachments Page** and upload the plan

See attached plan.

2. Does your state's prevention evaluation plan include the following components? (check all that apply):

- **a)** [x] Establishes methods for monitoring progress towards outcomes, such as targeted benchmarks
- **b)** [x] Includes evaluation information from sub-recipients
- **c)** [x] Includes SAMHSA National Outcome Measurement (NOMs) requirements
- **d)** [ ] Establishes a process for providing timely evaluation information to stakeholders
- **e)** [x] Formalizes processes for incorporating evaluation findings into resource allocation and decision-making
- **f)** [ ] Other (please list:)
- **g)** [ ] Not applicable/no prevention evaluation plan

3. Please check those process measures listed below that your state collects on its SABG funded prevention services:

- **a)** [x] Numbers served
- **b)** [x] Implementation fidelity
- **c)** [ ] Participant satisfaction
- **d)** [x] Number of evidence based programs/practices/policies implemented
- **e)** [ ] Attendance
- **f)** [x] Demographic information
- **g)** [ ] Other (please describe):

4. Please check those outcome measures listed below that your state collects on its SABG funded prevention services:

- **a)** [ ] 30-day use of alcohol, tobacco, prescription drugs, etc
- **b)** [ ] Heavy use
- [ ] Binge use

- [x] Perception of harm

c) [x] Disapproval of use

d) [ ] Consequences of substance use (e.g. alcohol-related motor vehicle crashes, drug-related mortality)

e) [ ] Other (please describe):

Footnotes:

I. Introduction

A. Federal Grant Overview

The Ohio Department of Alcohol and Drug Addiction Services (ODADAS) sought out federal grant funding to strengthen and enhance the state's prevention infrastructure to support more strategic, comprehensive systems of community-oriented care. Ohio received a $600,000 Strategic Prevention Enhancement (SPE) grant September, 2011 from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) to strengthen and extend the national implementation of the Strategic Prevention Framework (SPF). The SPF process is an integral part of SAMHSA's mission to reduce the impact of substance abuse and mental illness on America's communities.

A cross-system consortium of key stakeholders including state agencies, foundations, universities, prevention providers and other community members worked to develop this five-year strategic plan to foster more responsive, interactive State and local systems to better address and adjust to the complexities of the evolving health care initiative.

II. Prevention Infrastructure Review & Progress

Ohio reviewed the required components of a State/Tribal infrastructure to gauge the extent to which our prevention system measures up to the "ideal" prevention infrastructure. This section provides a detailed discussion of where Ohio is in reaching the goals of each of the key elements and how the SPE grant has assisted us in progressing through the SPF process at the state level.

A. Assessment

In addition to current efforts, the Ohio SPF-SPE Evaluation Team conducted a variety of assessments and inventories to inform the work of the SPE Consortium specifically around data collection. The following provides a summary for each of the three main projects.

Current ODADAS Assessment Efforts ----------

Community Assessment and Planning

ODADAS allocates funds to each of the 50 ADAMHS and ADAS Boards who, in turn contract with and offer support to the alcohol and other drug prevention and treatment programs in their counties. ADAMHS and ADAS Boards are required by Ohio law to prepare and submit to ODADAS a plan for the provision of alcohol, drug addiction and mental health services in the board service area. The community plan, which constitutes the Board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS.

ODADAS develops guidelines for boards in their development of their community plans. The most recent community plan guidelines were developed jointly with the Ohio Department of Mental Health which has similar

statutory authority in order to streamline reporting requirements and eliminate duplication of efforts for county boards who must submit plans to both departments.

National Outcome Measures & Alignment of Federal, State & Community Planning

Central to ODADAS' planning framework is the alignment of federal, state and community planning requirements as reflected in the federal Substance Abuse Prevention and Treatment (SAPT) Block Grant, the comprehensive state plan, and board community plans. The connecting thread of these plans is the National Outcome Measures. The graphic below provides a visual of this alignment. The Government Performance Results and Accountability Act of 1993 requires federal agencies to develop strategic plans with measurable outcomes. The Substance Abuse Mental Health and Services Administration (SAMHSA) operationalized this requirement with National Outcome Measures (NOMS) reported annually in the SAPT Block Grant. SAMHSA's NOMS cover ten domains with associated outcomes and measures for substance abuse treatment and prevention.

Vertical Alignment of Federal, State and County/Community Planning Processes

Level	Entity	Focus	Framework	Reporting Requirements
Federal	CSAT/CSAP (SAMHSA)	Sets national menu of outcomes	National Outcome Measures	SAPT Block Grant
State	ODADAS	Establishes statewide targets that meet NOMS and respond to state needs and priorities. Incorporates Governor's priorities and community issues and priorities identified by county boards	Outcome reporting integrated into Community Plan Guidelines and Department Grant Program	Certification standards/rule** Community plan guidelines Grant applications Assurances
County	County Boards	Establishes county treatment, prevention and capacity targets that meet Community Plan Guideline requirements and respond to local needs and priorities	Local discretion with required targets and roll up in Community Plan	Board-Provider Contracts or related mechanism Assurances
Community	Providers	Propose goals and objectives that contribute directly to ODADAS targets and County requirements	Outcomes and objectives consistent with NOMS as required element in Department Grant Program and board contracts	Interim and year end reports for grant program and board reporting requirements to meet contract specifications

State Epidemiological Outcomes Workgroup (SEOW)

Ohio has a sound, functioning and well-organized community prevention infrastructure that is supported by the Ohio Epidemiological Outcomes Workgroup (SEOW). Since 2006, the SEOW has had the responsibility for the collection, analysis, and reporting of substance use incidence, prevalence and related data and National Outcome Measures (NOMs). The NOMs are a set of domains and measures which SAMHSA uses to meet reporting requirements. Substance abuse NOMs are drawn from many types of data including: substance use incidence and prevalence, related consequence data, and program process and output data.

The SEOW has developed state and county level profiles that are utilized by ODADAS, various state agencies and ADAMHS/ADAS Boards for state and community need assessment. The profiles incorporate all substance abuse related components and indicators, including evidence of associated problems (e.g., school dropouts, delinquency, depression, suicide, and violence). Indicators that met the SEOW inclusion criteria were categorized broadly by ATOD consumption and the consequences associated with alcohol, tobacco, or illicit drug use. Consumption indicators include age of initiation, lifetime use, current use, and high-risk use. Consequences of use include mortality and morbidity data, measures of abuse and addictive disorders, and crime related indicators. Contextual indicators from the RTI study that measure community instability and family-related factors (e.g., teen-birth rate, divorce, and child-abuse or neglect)

comprised another set of measures used for the Ohio epidemiological profile. While the relationship between such indicators and ATOD consumption is at times inconsistent, Sanchez, Dunteman, Kuo, Yu, and Bray (2001) suggested that the above demographic and contextual measures should be monitored closely in an effort to evaluate the impact of ATOD use on Ohio's population.

OSAM

The Ohio Substance Abuse Monitoring (OSAM) Network is a collaborative effort funded by ODADAS in association with key stakeholders in the substance abuse community throughout Ohio. The OSAM Network first began monitoring drug trends in 1999 and has the capacity to respond rapidly to investigate new drugs being used on the streets as well as to monitor drug and alcohol abuse and changes in drug abuse or drug-using populations. The primary mission of OSAM is to provide a dynamic picture of substance abuse trends and newly emerging problems within Ohio's communities every six months. The OSAM Network has grown significantly over the years, through the establishment of working relationships with community professionals and agencies that provide rich and diverse sources of drug trend data. This expansion has allowed the Network to provide coverage in most of the major urban and some rural areas of Ohio.

The OSAM Network collects and analyzes both qualitative (focus groups and individual interviews) and quantitative (statistical) data. This data provides substance abuse professionals and policy makers with the information necessary to plan for alcohol and drug addiction prevention, treatment and recovery services.

Assessment Projects Funded by SPF-SPE----------

National Resource Assessment: Statewide Student AOD Surveys in SAMHSA's Central CAPT Region

The Ohio SPF SPE Evaluation Team conducted a web search to determine what states in SAMHSA's Central CAPT Region (i.e., Illinois, Indiana, Iowa, Kentucky, Michigan, Minnesota, Pennsylvania, West Virginia, and Wisconsin) regularly conduct student surveys that provide either county-level or regional estimates of substance use. For most of these states, information was found on the website of the lead substance abuse agency for the state. The purpose was to obtain information about how common it is for states surrounding Ohio to have student surveys that can provide sub-state estimates of substance use, and to learn more about the implementation of such surveys.

The Evaluation Team also developed a set of additional questions to be used to both verify the information they located through the Internet search, and to address other key points related to implementing statewide student surveys. They did not contact officials (such as the NPNs) in these states to ask them these questions. ODADAS and the Evaluation Team are working with Ms. Kate Buchanan, an AOD Research Analyst at the National Association of State Alcohol/Drug Abuse Directors, to field a survey with the membership of NPN. The survey was deployed to all NPNs in the United States in late July.

The following shows summary results by state. It should be noted that this information was gathered solely from the links noted; information was not verified by representatives of the states.

- **Illinois** conducts the Illinois Youth Survey (grades 6, 8, 10 and 12) every two years (e.g., 2010 and 2012) which is available to all eligible public and private schools. The goals are to provide local data and to provide state estimates through a random sample to represent students in these grades in Illinois public schools. In 2010, 188,882 youth in 1,104 schools participated in the survey. Source: http://iys.cprd.illinois.edu/
- **Indiana** conducts the Survey of Alcohol, Tobacco and Other Drug Use by Indiana Children and Adolescents (or Indiana Survey) annually in grades 6 through 12. In 2011, the survey was administered to 152,678 students in 478 schools throughout the state. The strength of the survey is to describe reported ATOD use at the local level. Source: http://www.drugs.indiana.edu/publications/survey/indianaSurvey_2011.pdf
- **Iowa** conducts the Iowa Youth Survey with students in the 6th, 8th and 11th grades "across the state of Iowa"; surveys were implemented in 1999, 2002, 2005, 2008, and 2010, and will be administered in 2012. The website for the survey included 2010 trend reports at the county level for all 99 counties. Source: http://www.iowayouthsurvey.org/

- **Kentucky** conducts the KIP Student Survey with students in grades 6, 8, 10 and 12 in even-numbered years. A total of 8 of 120 counties (and 21 of 176 school districts in the Commonwealth) had no participants in the survey in 2010. Source: http://www.reachoflouisville.com/kip/index.htm
- **Michigan** conducts the Michigan Profile for Health Youth (MiPHY) every other year as an online student health survey with students in grades 7, 9, and 11. In 2010, 63 counties had surveys implemented in at least two districts, yielding a county level report. There are a total of 83 counties in Michigan. Source: http://www.michigan.gov/mde/0,1607,7-140-28753_38684_29233_44681---,00.html
- **Minnesota** conducts the Minnesota Student Survey (MSS) as a statewide student survey every three years with students in grades 6, 9 and 12. All public school districts are invited to participate. In 2010, 295 of the 335 school districts (88%) agreed to participate. Source: https://edocs.dhs.state.mn.us/lfserver/Public/DHS-6380A-ENG
- **Pennsylvania** conducts the Pennsylvania Youth Survey (PAYS) every three years (most recently in 2011). All schools are encouraged to participate and a random sample of schools is selected through which state level estimates are produced (the schools selected participate at no cost). Source: http://www.portal.state.pa.us/portal/server.pt/community/pennsylvania_youth_survey/5396/2011/775032
- **West Virginia** conducts the YRBS and CDC Tobacco Survey, but does not otherwise conduct a statewide survey. Sources: http://wvde.state.wv.us/healthyschools/YRBS.htm and http://www.wvdhhr.org/bph/hsc/statserv/yts.asp
- **Wisconsin**: No student surveys (except BRFS, YRBS, and NSDUH) were reported in a 2010 state epidemiological profile on alcohol and other drug use, and we did not locate any estimates from survey data at the county level in that profile. Source: http://www.dhs.wisconsin.gov/publications/P4/P45718.pdf

Ohio Resource Assessment: Local-level AOD Prevention Surveys

The Ohio SPF SPE Evaluation Team created a web-based form to gather information about local-level surveys collecting substance use data in Ohio. This resource assessment was conducted between April and August 2012 with DFC-funded coalitions and ADAMHS/ADAS Boards.

The resource assessment sought to collect information on youth or adult surveys being conducted at the local-level throughout Ohio. A web-based instrument was developed to collect the following information about local-level surveys and if possible, to obtain an electronic copy of the survey instrument.

- Survey population
- Administration schedule
- Year of most recent administration
- Geographic area covered by survey
- Cost for most recent survey administration
- Inclusion of National Outcome Measures (NOMs)

The Evaluation Team began the resource assessment process by contacting DFC program directors, as these grantees are required to field a youth survey to collect core measures for the program. This ensured that the potential respondents would have at least one survey to enter into the resource assessment. A list of DFC grantees funded for fiscal year 2011 was downloaded from the Office of National Drug Control Policy (ONDCP) website. This list included the contact information for 27 DFC-funded grantees in Ohio.

Before deploying to all DFC-funded grantees in Ohio, the resource assessment was pilot tested by two DFC program directors. Minor changes were made to incorporate their feedback into the final instrument. On June 1, 2012, an email was sent to remaining 25 DFC program directors requesting their participation in the resource assessment. Periodic email reminders were sent to non-respondents and follow-up requests were made by the Ohio Prevention Program Specialists from ODADAS. The DFC portion of the resource assessment concluded on July 6, 2012 with 16 of the 27 DFC program directors submitting information on local-level surveys.

- Almost all of the DFC coalitions (15 of 16) reported contracting with an outside organization for some part of the survey process for their core measures survey.
- Three of the DFC coalitions reported conducting the required DFC core measures survey every year with middle school and high school surveys implemented in alternating years (e.g., middle school in even years and high

school in odd years). The majority reported conducting their survey every other year while one conducted their survey every three years.

- DFC coalitions were asked to upload an electronic version of local-level surveys collecting substance use data in their areas. A total of 17 surveys were provided by respondents. Among these are 12 youth surveys used to collect the required DFC core measures and five other youth or adult surveys conducted in their area.

To collect information on areas not covered by the DFC-funded coalitions a plan was developed to expand the resource assessment to ADAMHS and ADAS Boards. Due to time constraints, this portion of the resources assessments will be conducted by telephone. Initial emails will be sent to the executive directors of ADAMHS and ADAS Boards requesting their participation in the resource assessment. This email will describe the project and ask for the individual with the most knowledge of local-levels surveys to contact the SPF SPE evaluation team about a brief telephone interview. Follow-up calls will be conducted with boards that do not respond to the initial request. Periodic email and telephone follow-up contacts will be made to schedule interviews until August 17, 2012.

Ohio Resource Assessment: Institution of Higher Education Prevention Data Collection Strategies

The Ohio SPF SPE Evaluation Team collected and compiled data and information on which Ohio institutions of higher education implement student surveys that include measures of alcohol and other drug (AOD) use. The purpose was to obtain information on the availability of data as well as on the overlap between the measures used and the National Outcome Measures (NOMs).

First, the Evaluation Team developed a listing of colleges and universities in Ohio, which included the 25 largest universities by enrollment, as well as 24 two-year community and technical colleges in the state (http://en.wikipedia.org/wiki/List_of_colleges_and_universities_in_Ohio). The smallest enrollment four-year university on the list had an estimated enrollment of just over 3,000 students.

Next, the Evaluation Team searched the websites of the institutions to determine who to contact that would be familiar with AOD surveys implemented by the institution. Third, they developed a script to be used to ask the contacts about any surveys their institution regularly conducts that asks students about AOD use. Fourth, they conducted calls starting in mid-June 2012 to collect and compile the information. They used an Excel spreadsheet to track contacts, and a separate Excel spreadsheet to compile the final information. The Team also attempted to obtain copies of all surveys implemented.

The initial focus was on contacting the universities (starting in mid-June), and then moved to contacting the community and technical colleges (in late June). After contacting the institutions and leaving messages at least two times without success in collecting the needed information, the follow-up strategy was to email the most likely best contact to explain the purpose of the information collection and to request that the person either send the information via email or tell us when they can be called.

The Evaluation Team also gathered from the website of the Higher Education Research Institute at UCLA information on what Ohio colleges and universities implemented two surveys (College Senior Survey, and Your First College Year Survey), as well as in what years since 2008 they implemented these surveys. Finally, they developed a table of the measures in the main surveys (College Senior Survey, Your First College Year Survey, NCHA, and Core) to allow comparison with National Outcome Measures (NOMs).

By July 24, 2012, they had collected and compiled information on surveys conducted in 19 of the 25 universities (76%) and on surveys conducted in eight of the 24 two-year community and technical colleges (33%). However, all colleges and universities on the list had been contacted at least once, and most had been contacted multiple times. In addition, every four-year university that had not responded had been sent an email. Attempts to contact all institutions of higher education in Ohio will continue until mid-August. At that time, data collection will be closed and the Excel spreadsheet will be finalized.

An Excel spreadsheet contains the key information we gathered from the colleges and universities about their AOD surveys of their students. The following summarizes some of the main interim results.

Universities

- The most commonly reported surveys that are used broadly (e.g., with a sample of undergraduates within the university) are: (1) the American College Health Association's National College Health Assessment (NCHA), and (2) the Core Institute's Core Alcohol and Drug Survey.
- Regarding how often these surveys are conducted, the modal responses are either every two years or every three years.
- These surveys seem to be implemented most commonly as web surveys, and somewhat less commonly, as paper and pencil surveys with students in a random sample of classrooms.

Community and Technical Colleges

Due to the smaller number of these institutions with complete information collected to date, these results should be interpreted with caution.

- It appears that a smaller proportion of community and technical colleges (compared to universities) implement surveys that ask about AOD use.

Measures in Four Main College Surveys

- All AOD measures were provided within the following surveys: (1) College Senior Survey, (2) Your First College Year Survey, (3) National College Health Assessment, and (4) Core Alcohol and Drug Survey (long form).

While the Team was primarily interested in those surveys that are implemented broadly within the universities and colleges, they also asked about other surveys that are typically implemented with sub-groups within the institutions. They found that surveys that are part of online prevention programs, such as AlcoholEdu and eChug, are often implemented in four-year universities. Most often, they are implemented with subgroups such as all incoming students, or students who are mandated to take such surveys due to violations, etc.

B. Planning

SPE Consortium Overview

This section provides a detailed discussion of how Ohio used Substance Abuse Mental Health Services Administration (SAMHSA), Strategic Prevention Framework (SPF) Strategic Prevention Enhancement (SPE) grant funds to convene a cross-system, consortium of key stakeholders including state agencies, foundations, universities, prevention providers and other community members to develop a five-year strategic plan to foster more responsive, interactive State and local systems to better address and adjust to the complexities of evolving health care initiatives.

Ohio focused SPE efforts toward achieving the following outcomes:

- Strengthening and enhancing current prevention infrastructure to support more strategic, collaborative and comprehensive systems of community-oriented prevention.
- Assessing the current state of the overall prevention infrastructure, identifying gaps and developing a long-term, data-driven strategic plan to enhance and further strengthen the state prevention system to better meet the emerging needs of all populations across communities.
- Fostering a more responsive, interactive Ohio state prevention system that can better address and adjust to the complexities of evolving health care initiatives and its fiscal implications for the state and communities.
- Through stronger, more strategically aligned prevention infrastructures, Ohio will be better positioned to apply the Strategic Prevention Framework (SPF) process to implement data-driven, evidence-based prevention programs, policies and practices across its communities.

SPE Consortium Structure

The State of Ohio has built a solid foundation, upon which to establish the ideal prevention infrastructure. The SPE Policy Consortium was formed in December, 2011 to provide oversight to the grant and to participate in the development of Ohio's comprehensive five-year Strategic Plan. Ohio has worked across divisions and departments to ensure a representation from State agencies and other entities that are involved in the prevention of substance use and associated problems.

The Ohio SPE Consortium is comprised of the following entities: the Ohio Departments of Alcohol and Drug Addiction Services, Health, Mental Health, Education and Youth Services, the Ohio National Guard, the University of

Cincinnati, the Ohio Suicide Prevention Foundation, the Urban Minority Alcohol and Drug Abuse Outreach Program (UMADAOP) Federation, juvenile court and the Ohio Children's Trust Fund for child abuse prevention.

ODADAS contracted with the Invitation Institute, the Ohio University and the Pacific Institute of Research and Evaluation (PIRE) to support various components of the work of the SPE Consortium. Having the variety of disciplines at the table enhanced the creation of the comprehensive plan aimed at closing service system gaps, building capacity and enhancing and aligning policy and process across systems. Names of current SPE Policy Consortium members are provided below.

Consortium Members	**Staff & Consultants**
Mindy Vance, Ohio Department of Mental Health	SPE Project Evaluation Team- OU/PIRE
Jill Jackson, Ohio Department of Education	Molly Stone, ODADAS
Judi Moseley, Ohio Department of Health	Nicholas Martt, ODADAS
Laura Rooney, Ohio Department of Health	Tammy Collins, Ph.D. ODADAS
Cheryl Holton, Ohio Suicide Prevention Foundation	
Keith King, Ph.D. University of Cincinnati	Tracy Johnson, Invitation Institute
CPT. Matt Toomey, Ohio National Guard	Jacy Seehutter, Ph.D. Invitation Institute
Craig Comedy, Franklin County UMADAOP	Steven Dent, Partnering Intelligence
Kristi Oden, Ohio Department of Youth Services	
David Edelblute, President, Ohio Urban Juvenile Court Administrators Association	
Kristen Rost, Executive Director, Ohio Children's Trust Fund	

Strategic Planning Process

Under the facilitation of the Invitation Institute, the group explored system collaboration needs and was able to formulate the foundation for the plan, including a vision and mission, strategic priorities and action steps. The work of the group also included examining how these efforts could be implemented and sustained across systems.

The discussion included available and planned resources, key personnel and stakeholders and concrete action steps and milestones for completion. Utilizing the expertise from all members of the Consortium will enable the 5-year plan to promote an integrated, community based, holistic approach to substance abuse prevention. This integration will better prepare Ohio's communities for recognition of substance abuse prevention as a part of primary health care.

Strengthening interagency and intersystem working partnerships has allowed the SPE Policy Consortium members to explore the opportunity to: a) embed substance abuse prevention within their infrastructure at both the state and community levels, b) share resources and cross train staff; and c) explore cost saving opportunities as Ohio prepares for the behavioral health role in the evolving health care delivery system. Through these efforts there will be increased substance abuse prevention system capacity and support for effective prevention services.

Invitation Health Institute (formerly the Minnesota Institute of Public Health) and Steven Dent, Principal of Partnering Intelligence, facilitated and recorded the process of engaging key stakeholders in the strategic planning process. The Ohio SPE Consortium strategic planning process included four, face-to-face meetings, teleconferences and email communications between meetings. A structured open-ended participatory evaluation process was used throughout the process asking participants to identify aspects of the process that they liked (pluses) and aspects of the meeting that they might like to change in future meetings (deltas).

Strategic Planning Activities

The following activities and accomplishments of the Ohio SPE Policy Consortium through May 31, 2012 led to development of the SPE Strategic Plan.

State prevention staff initiated the strategic planning process by providing an overview of the grant and explanation of how the SPE Policy Consortium members were chosen to represent different areas of prevention across systems. They also reviewed SPE funding highlights and described how this will allow the partners to more effectively establish benchmarks, demonstrate collaboration, and utilize Evidence Based Practices (EBP's). The introductory

comments also clarified the importance of community-level needs assessment and using a planning process to ensure that community need drive the selection and delivery of prevention programming. The State staff also reviewed the Strategic Prevention Framework (SPF) and demonstrated their support for using the SPF framework in Ohio.

A member of the Invitation Health Institute (IHI) team provided members of the SPE Policy Consortium an overview of the Federal SPE Grant and SAMHSA's Initiatives for FY2012. Currently, the Federal Government is working collectively to identify key areas where all systems can work together, one such example is with SAMHSA in which all three (3) of its Centers, Center for Mental Health Services (CMHS), Center for Substance Abuse Treatment (CSAT) and Center for Substance Abuse Prevention (CSAP) are working on specific strategies called the SAMHSA Strategic Initiatives (SSI). www.samhsa.gov. The eight identified strategic initiatives area as: Prevention of Substance Abuse and Mental Illness, Trauma and Justice, Military Families, Recovery Support, Health Reform, Health Information Technology, Data, Outcomes, and Quality, and Public Awareness and Support.

IHI consultants presented the purpose of the planning process, creation of team norms, clarification of roles and expectations, a description of the collaborative strategic planning process and attaining consensus as initial steps in the planning process. Key outcomes in the process were identified as trust and commitment. Key elements of the planning process included:

- Assessing your needs (what do you need out of this partnership) and identifying your own vision or mission
- Exploring who are the right partners. Natural partners (state agencies, public safety, military) and others.
- Developing a mutual vision. A shared vision was identified as the most important organizational force. You have to have an idea of where you want to go together.
- Initiating actions to build trust and demonstrate commitments

An IHI consultant previewed stages of developing a working partnership. Form, Storm, Norm and Perform were briefly explained. Form is stage in which trust with each other is initiated. Storm is the stage in which members are willing to push boundaries. Norm is the stage in which the group forms boundaries and group members agree how they are going to work with each other. Then the perform stage is when the group produces its intended products and outcomes.

During the first face to face meeting, the Consortium members reviewed the strategic planning framework and were invited to participate in a discussion about other planning initiatives, and share their hopes for the SPE strategic planning process. Members were also asked to identify other essential representatives that may need to be included in the Ohio SPE Consortium. As a result of these processes, Consortium members developed a list of possible areas in which to focus upon in the development of the strategic plan (See Table 1) and a list of additional representatives that should be recruited into the Ohio SPE Consortium (See Table 2).

Table 1
Possible Areas of Focus

Meaningful data that we need and can use	Provide EBP for students and CBE for parents
Improve school climate	Strengthen our community
See beyond our own past practices	RE-DEFINE prevention in education settings
Comprehensive system of learning, as well as collecting data and identifying needs.	Stigma reduction
Greater access to VA resource for non-deployed service members	Larger preventive wellness network, more hippies
Lower cost to assessment/ treatment services=benefit for self- referral for the military	National Guard HAS data to share
Development and/or access to Vet Courts	Increase presence of substance abuse prevention at the state and local level
Increase workforce prevention	Increase funding for prevention
Development of statewide survey for youth/communities	Using data to make evidence based decision at an interagency level
Data system reporting and fidelity	Educating workforce around the current ATOD prevention strategies
Understanding of prevention outside of CSAP/ATOD	Assessing/inventory of community based services

Creative partners	Community level data
Improve and ease data collection between state partners	Development of a strong sustainable active partnerships in Ohio
Data driven decisions- what data do we have/ not have/would like/	Buy-in from community level decision makers
Build on current work	Integration of physical and behavioral health promotion initiatives
Continuum of care—let's not be threatened by everyone's professions.	Increase and enhance mental health wellness initiatives through state, county, community partners
Improve outcomes for children and youth living with mental illness (graduation, workforce)	Children, crisis, housing, and forensics.
Data and information sharing that is easy to understand	Evaluation of program data collection that eliminates duplication and eases dissemination.
Understanding that suicide is a public health problem! Outcome of failure of public health services.	We are too busy protecting our resources and not paying attention to collaboration.
Less silos more collaboration	Identification of data sources that may be applicable to outcomes relevant to SPE team.
Create sustainability and buy-in to SPE related activities.	Inventory of the epi systems

Table 2
Possible additional representatives to the SPE Policy Consortium

Treatment/Recovery Support (community member)	Drug Free Action Alliance
Faith-based community-already invited-	Department of Youth Services
Hospitals /Ohio Hospital Association	Physicians/nurse practitioners
Early childhood center	ODJFS
Legislators and judges	Youth and young adults and other special populations (LGBT)
Colleges and Universities	Customers
Ohio Citizens Advocates/NAMI	Children's Hospital
Crisis hotline	RSC- Susan Pugh
ADAPAO	Boards/Provider representation
MACC-Charlotta Tavares	Pharmacy Board
Public health organizations	ODPS/OCJS
Media Representation	VA
Consumer Operated Service Agency (OSU or OACBHA)	Policy Analyst
Working Partners	Board of Regents
College Student Health Assoc	SOPHE
Local public health departments	Office of the Attorney General
Department of Rehab and Corrections	Governor's Office
SPF Community data people	Area Aging
Higher up/Attorney/Legislative Liaison	FCF (state or community)
State Assoc. of School Superintendents	Dept of Developmental Disabilities

An IHI consultant provided an overview of the planning process including the creation of the following elements.

1. Vision statement (group's ultimate aspirations for the outcome of the strategic planning process and the wellness of the people in their state
2. Mission statement (a description of how the Consortium will achieve its vision)
3. Strategic directions (areas of focus)
4. Tactics (activities that move toward achieving the strategies)

In addition, the Consortium members identified a set of expectations that included:

- Offer professional contributions to the group
- Focus on improving outcomes for all Ohioans
- Identify prevention efforts will satisfy agency specific needs (i.e. soldiers' needs)
- Look at prevention roles of all state agencies in Ohio
- Develop a plan that allows for collaborative process
- Seek buy-in from directors to enable collaboration and sustainability
- Agree upon common and shared definition of prevention

- Develop a plan that actually guides prevention and that eliminates silos
- Is different from other plans so actual movement takes place
- Ensure that all things put into plan should be evidence-based and data-driven

SPE Policy Consortium members and the IHI consultants agreed to create a positive vision, mission and plan that would result in Ohio being recognized for being on the cutting edge. The Consortium members identified potential barriers including the challenge of eliminating silos, sustainability of prevention efforts given time limited funding, and capacity building. The group agreed to consider efforts to reduce barriers as they developed the Ohio plan. The discussion also included emphasis on developing a plan that can positively impact the citizens of Ohio.

Each Consortium member shared his/her vision and mission statements, and through a structured and facilitated process, common words and themes were identified and vision and mission statements were developed using a consensus approach.

Vision Statement: All Ohioans are able to live in a state of physical, social, and emotional wellness.

Mission Statement: The SPE consortium promotes and advances prevention capacity and alignment of state and local agencies to afford Ohioans increased wellness and productivity.

The Ohio SPE Consortium Vision and Mission Statements emerged from comments and discussions among the group members that formed the basis for constructing and agreeing upon the following statements.

A subsequent face-to-face meeting was designed to create strategic priorities or objectives and goals for Ohio prevention efforts. The following definitions were used to guide the SPE Policy Consortium.

Strategic priorities: Broad areas that help to define and focus the plan and related strategies.

Goals: General outcomes the consortium expects the strategic plan to achieve

Activities: Actions that move toward achieving the strategies

The group developed goals for the Consortium using an exercise to identify common words and themes among the individual goals. IHI consultant Stephen Dent facilitated a discussion related to goals, objectives or strategic priorities, and activities or tactics to identify terminology the group was comfortable using for statewide goals. Four broad goal constructs were identified.

1. Broad recognition of prevention as effective and cost saving.
2. To ensure consistently effective outcomes and streamline operations.
3. Working together to ensure the best use of resources to meet identified needs.
4. Programs, practices, and strategies are data-driven and effective.

The Consortium's efforts to condense strategic priorities resulted in the following priorities consistent with the broad goals described above.

1. Champion Prevention
   - Marketing
   - Publications

2. Develop and promote evidence-based, culturally competent, policies and practices that support and integrate prevention at multiple levels across systems.
   - Standardize

3. Promote and support formalized collaboration and systems integration at the local and state level for the sharing of resources and program implementation.
   - Systems integration

- Sharing/Collaboration

4. Use relevant data to access community strengths to select programs, practices, and strategies and help evaluate their effectiveness.

- Data-driven

Feedback from the Prevention Field on Strategic Priorities

The Ohio SPE Evaluation Team (Ohio University and PIRE staff) developed a short survey to collect feedback on the goals and strategic priorities and to solicit ideas for the associated action steps. To facilitate the deployment of the web survey, ODADAS provided a list of individuals registered for the alcohol and other drug prevention and treatment portion of the ODADAS Spring Conference. As such, e-mail invitations were sent to 277 preregistered conference attendees asking for their participation in the web survey. The personalized e-mail described the purpose of the survey and included a link to the web-based survey. The survey was also deployed via a posting on the ODADAS Prevention List-serv. Because the survey link was not unique to the individual respondents and the fact the survey was deployed using a Listserv, it is not possible to calculate a response rate because the total number of individuals exposed to the survey is unknown. By the closing of the survey on May 14, 2012, 156 respondents had completed the survey.

The SPE Evaluation Team prepared an Executive Summary and detailed report of findings. The findings affirmed the importance of the goals and provided concrete action steps for consideration in the final stage of developing the Strategic Plan. Survey participants were asked to list up to five action steps for each of the four goals and their associated strategic priority. Results by goal area follow.

Goal 1 – Broad recognition of prevention as effective and cost saving.

Strategic Priority 1 – Champion Prevention

- When asked to rate the importance of Goal 1, 86.4 percent of survey respondents indicated that it was *very important*, and 9.7 percent indicated that it was *somewhat important*.
- When asked to rate the importance of Strategic Priority 1, 75.7 percent of survey respondents indicated that it *was very important*, and 15.1 percent indicated that it was *somewhat important*.
- The top three themes for the Strategic Priority 1 action steps are as follows:
    - Make more ATOD prevention information available to public / stakeholders including through media / media campaigns
    - Strategic Planning and Related Topics
    - Increase Capacity / Collaboration / Advocacy / Community Involvement

Goal 2 – To ensure consistently effective outcomes and streamline operations.

Strategic Priority 2 – Develop and promote evidence-based, culturally competent policies and practices that support and integrate prevention at multiple levels across systems.

- When asked to rate the importance of Goal 2, 60 percent of survey respondents indicated that it was *very important*, and 30.7 percent indicated that it was *somewhat important*.
- When asked to rate the importance of Strategic Priority 2, 60.9 percent of survey respondents indicated that it was *very important*, and 25.8 percent indicated that it was *somewhat important*.
- The top three themes for the Strategic Priority 2 action steps are as follows:
    - Provide Training and Technical Assistance for the Prevention Workforce
    - Develop a Multi-disciplinary Approach to Prevention
    - Create a Resource Library of EBP and Culturally Competent Practices

Goal 3 – Working together to ensure the best use of resources to meet identified needs.

Strategic Priority 3 – Promote and support formalized collaboration and systems integration at the local and state level for the sharing of resources and program implementation.

- When asked to rate the importance of Goal 3, 72.3 percent of survey respondents indicated that it was *very important*, and 18.2 percent indicated that it was *somewhat important*.
- When asked to rate the importance of Strategic Priority 3, 69.1 percent of survey respondents indicated that it was *very important*, and 16.8 percent indicated that it was *somewhat important*.
- The top three themes for Strategic Priority 3 action steps are as follows:
    - enhance and improve opportunities and support for collaboration at state and local levels
    - Enhance the frequency and effectiveness of communication about prevention at the state and local levels
    - Use Media to Implement Strategic Priority and to Enhance Prevention

Goal 4 – Programs, practices, and strategies are data-driven and effective.
Strategic Priority 4 – Use relevant data to access community strengths to select programs, practices, and strategies and help evaluate their effectiveness.

- When asked to rate the importance of Goal 4, 57.9 percent of survey respondents indicated that it was *very important*, and 34.5 percent indicated that it was *somewhat important*.
- When asked to rate the importance of Strategic Priority 4, 57.5 percent of survey respondents indicated that it was *very important*, and 30.8 percent indicated that it was *somewhat important*.
- The top three themes for Strategic Priority 4 action steps are as follows:
    - Collection of substance use-related data
    - Data access and sharing
    - Technical Assistance and/or Training

C. Capacity

Training/Technical Assistance

Ohio has many workforce development efforts coming up in the remainder of 2012. ODADAS provided SPF-SIG carry over funds to organizations for workforce development efforts this fall. ODADAS and the Prevention and Wellness Roundtable will host a Prevention Policy Summit October 10, 2012. The Summit will focus on building awareness of the field about IOM report recommendations and how to implement environmental strategies and population-based interventions. Anthony Biglan, Ph.D. and Dennis Embry, Ph.D. will be providing the training along with local community groups that have successfully implemented IOM recommendations.

The annual Ohio Prevention Education Conference, "Prevention Without Boundaries" will be December 4-6, 2012. The focus on the conference will be population-based strategies and coalition building for community engagement in prevention.

Ohio Resource Assessment: Workforce Development Survey

The changes in the behavioral healthcare field due to the Affordable Care Act implementation and a new understanding of the science behind behavioral health will require a whole new set of competencies for the prevention in Ohio. Role delineation and minimum standards for various Certified Prevention Specialist levels will be a focus of Ohio's revitalized Workforce Development Workgroup. To inform these efforts, ODADAS staff will look at how other states are changing their services systems and ODADAS has contracted with the SPF SPE Evaluation Team to create a web survey to help understand workforce development needs in Ohio. This survey will be fielded in late July and August 2012 with individuals holding a current prevention or treatment credential. The survey will close mid-August in order to meet reporting requirements. The two key objectives to the survey are the following.

1. To provide data to profile the prevention workforce in Ohio and to inform workforce development efforts with Ohio's prevention workforce, and
2. To understand how Ohio's prevention workforce views the importance of the Essential Public Health Services.

Instrumentation. The 2012 Workforce Development Survey included two modules of questions. Module 1 focuses on training and workforce development needs and was administered with all sampled individuals. Module 2 focuses on the perceived importance of the Essential Public Health Services (EPHS) to prevention in Ohio and was administered with individuals holding an OCPS II credential. The SPE evaluation team used an iterative approach to design the questionnaire used for the 2012 Workforce Development Survey.

The first module on workforce development is designed to provide Ohio with a data-informed profile of the prevention workforce and to inform planning for future workforce development and training efforts. The questions in this module were adapted from a 2008 survey fielded with prevention professionals in Maine by the Edmund Muskie School of Public Service at the University of Southern Maine (Hartley, et al., 2008). Draft versions of the survey were reviewed by the SPE Evaluation Team, prevention services staff at ODADAS, and by Ohio's Prevention and Wellness Roundtable. This review process provided extensive feedback that resulted in a survey instrument that better fit the context of Ohio and the upcoming challenges and changes to the prevention system.

The second module on perceived importance of the ten Essential Public Health Services (EPHSs) was adapted from the State Public Health System Performance Assessment Instrument that was created as part of the National Public Health Performance Standards Program (U.S. Department of Health and Human Services, Centers for Disease Control and Prevention, 2007). The ten Essential Public Health Services represent the spectrum of public health services that should be provided by states and local communities. The SPE evaluation team used the State Public Health System Performance Assessment Instrument to develop 44 questions measuring the perceived importance of Essential Public Health Services 1 to 5 and 8 to 10. EPHSs 6 and 7 were omitted from the instrument because they do not directly relate to the focus of the SPF-SPE grant. As with the first module, the SPE evaluation team used an iterative process to review and refine the questions and used feedback and suggestions from SPE evaluation team members and ODADAS staff to improve the questions and to tailor them to prevention in Ohio. This second module of questions on the EPHS was administered only to respondents who indicated that they held an OCPS II credential. As described below, in order to minimize survey burden, OCPS II respondents were randomly assigned to receive questions on only two of the eight EPHSs included in module 2 of the survey.

Sampling. The target population for the 2012 Workforce Development Survey is prevention practitioners and workers in the state of Ohio who held one of 19 different prevention or treatment credentials or who were Registered Applicants (and working to obtain a prevention credential). Under Ohio Revised Code, the Ohio Chemical Dependency Professionals Board (OCDPB) is required to maintain a database containing the names and contact information of all Registered Applicants and credentialed prevention and treatment professionals. The sampling frame for this survey was drawn from the 6,347 individuals listed in the OCDPB database who either had an active prevention or treatment credential or who were considered active Registered Applicants. Prior to beginning fieldwork for the survey, Evaluation Team members reviewed the information in the sampling frame. In a few cases, there were minor errors in either individual's names or contact information. Evaluation Team members made these minor corrections prior to the start of fieldwork to maximize the accuracy and efficiency of the sampling frame. As noted above, the first module of questions on training and workforce development will be administered to all 6,347 individuals listed in the OCDPB. Module 2, which focuses on the EPHS, will be administered to at least 135 individuals who currently held an OCPS II certification.

Next Steps. Fieldwork for the 2012 Workforce Development Survey will begin in late July 2012 and will be completed in mid-August 2012. The survey will be fielded using Qualtrics and is designed so that personalized survey invitation emails will be sent to each sampled respondent. The personalized e-mail describes the purpose of the survey and includes a link to the web-based survey. In keeping with best practices, we will deploy three reminder emails for the survey.

D. Implementation

Alignment of Ohio's Substance Abuse Prevention Service System with Other Service Systems

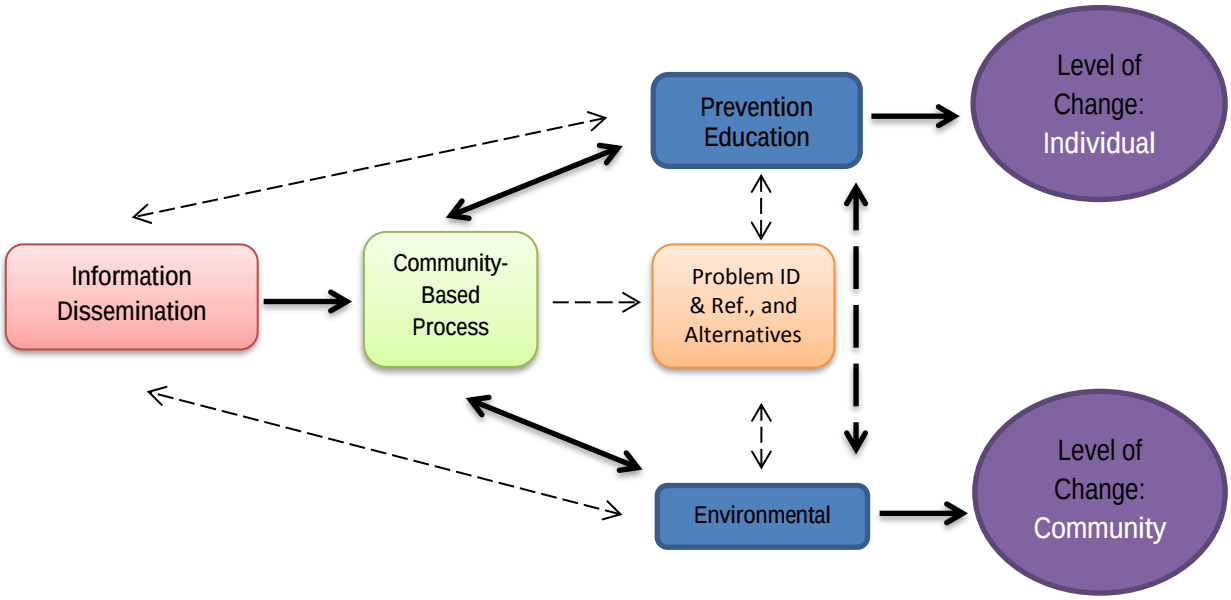
Ohio has updated its Prevention Continuum of Care Taxonomy, and has re-conceptualized the model for how CSAP's six prevention strategies are to be implemented for the greatest impact in Ohio communities. The goal of prevention services in Ohio is to facilitate change in individuals and/or communities. The following graphic provides a visual representation of how the six CSAP Strategies contribute to individual and community-level change. This new model provides a foundation for how substance abuse prevention funded through CSAP intersects with other prevention efforts funded through other federal and state funding streams. The focus on intended level of change and a further definition of strategies allows for the strategies of multiple systems to be integrated into one conceptual model. This will be the focus of one of the projects in the SPE Strategy Action Plan provided in the next section.

Prevention Education and Environmental strategies are seen as the primary prevention strategies and have the strength to influence attitude, behavior and status on their own. The other four strategies support the implementation of these two primary strategies. All six strategies in appropriate proportions are needed as part of a comprehensive prevention approach.

Information dissemination creates awareness and builds knowledge which provides a foundation for Community-Based Processes utilized to engage and mobilize communities into action.

Although Prevention Education interventions can be implemented without the foundational reinforcement of Information Dissemination and Community-Based Process, these interventions tend to lack the benefits resulting from broad-based community support and opportunities for expansion and quality improvement. Community-based processes are essential to effectively implementing an Environmental Strategy.

The Problem ID &Referral Strategy is only implemented as an adjunct when an individual enrolled in a direct service is identified as possibly needing or being able to benefit from services that exceed the scope of prevention.



Alternative Activities are implemented as a celebration of individual or community success and must be an activity that will, through evidence, also contribute to addressing risk/protective factors and/or intervening variables identified in initial program development.

Integrated Prevention Assessment and Planning Infrastructure

The SPE Consortium and the Prevention and Wellness Roundtable suggested a structure for linking standing and ad hoc prevention committees and workgroups to carry out the work of the SPE Strategic Action Plan.

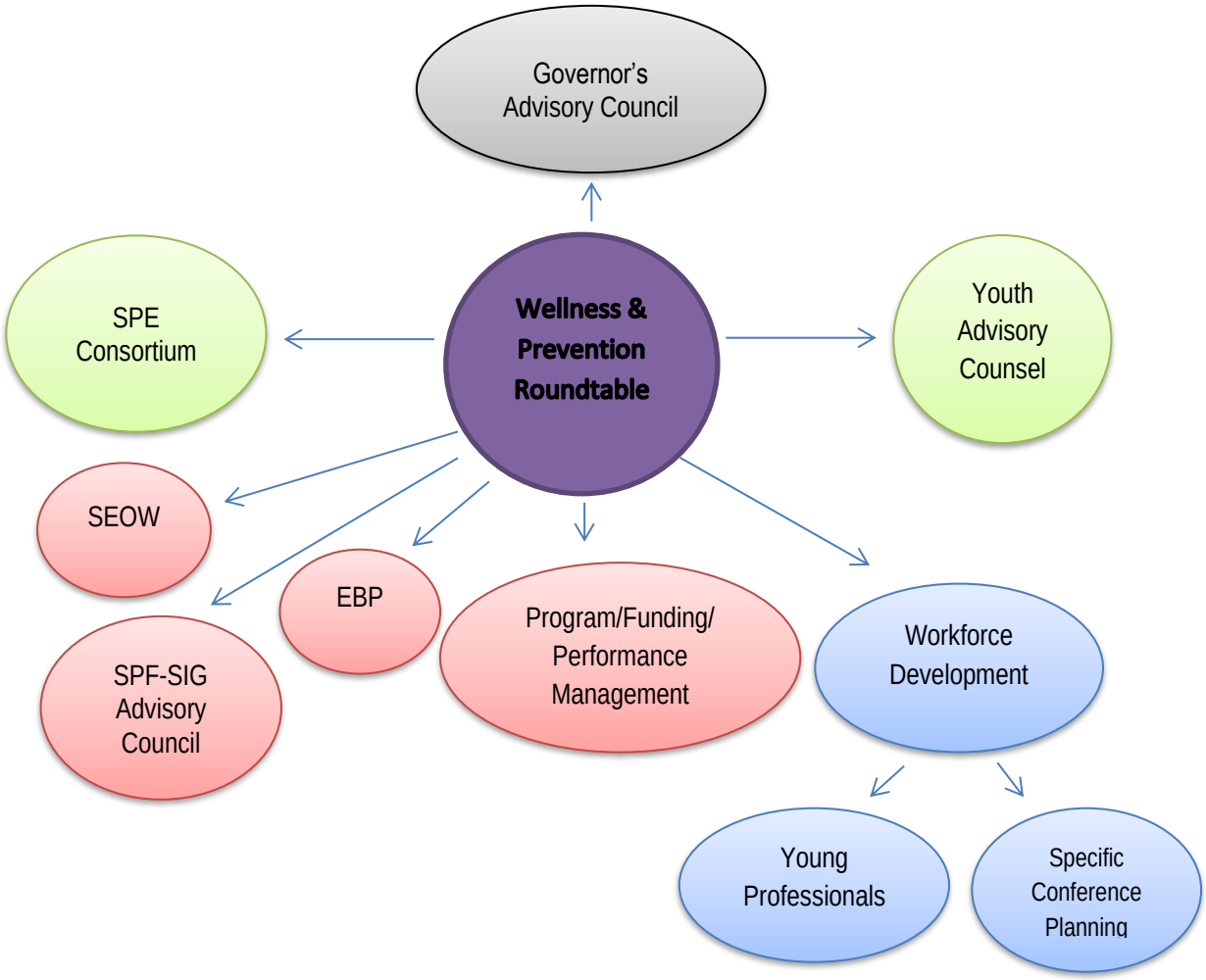
The SPE Consortium will focus on interagency alignment of prevention-related policies and practices. The Prevention and Wellness Roundtable was created in 2012 to assist in addressing the policy concerns and implementation issues related to how AOD prevention services are provided locally across Ohio. This group is a solution-oriented, policy think-tank that discusses and analyzes how state and federal prevention-related matters impact the prevention field and provides feedback to ODADAS and other key stakeholders to help set statewide prevention priorities and address other emerging policy issues. It consists of 15 of the most highly educated, trained and experienced prevention specialists in Ohio.

Among other issues, the Roundtable will address the following.

1. The AOD Prevention Roundtable will ensure that Ohio's Prevention System is prepared for the changes in Behavioral Health related to Health Care Reform.
2. The AOD Prevention Roundtable will investigate standardization of outcomes for prevention related to the National Outcome Measures. They will provide recommended changes necessary to address a changing environment.
3. The AOD Prevention Roundtable will explore ways of eliminating barriers related to the provision of prevention services. These barriers may include but are not limited to: communication, funding, staff development, etc. The AOD Prevention Roundtable will convene Ad Hoc committees when necessary to address specific issues.

The Roundtable agreed to act as the hub of the prevention committee/workgroup organizational structure with the following workgroups being connected through each other through the Roundtable. This structure provides a mechanism for multi-directional information flow (bottom-up, top-down and side-to-side) for all key stakeholder groups. It also provides a forum for the improvement of prevention policy, data and practice by providing a single entry point for input and feedback from all key areas of the field. Information can then be provided to the Governor's Advisory Council.

Other workgroups will inform the policy work of the Roundtable and the SPE Consortium. For example, a sub-set of the Workforce Development Workgroup will focus on Young Professionals and another on specific conference planning such as the annual Ohio Prevention Education Conference. The graphic below provides an illustration of how the prevention infrastructure will be integrated.



As Ohio merges the Departments of Alcohol and Drug Addiction Services and Mental Health, one of the top priorities for consolidation work is to develop a method for allocating prevention service funds that will provide the most value for our citizens. As a first step in this process, Ohio brought in a national speaker on the Ethics of Allocation in an Environment of Scarcity in July 2012 to provide information to the behavioral health leadership at the state and board levels. Dr. Michael Gillette provided an introduction to some of the most interesting and difficult ethical issues in the provision of behavioral health services in an environment of scarce financial resources. He demonstrated a practical approach to ethical reasoning that can be applied to a variety of sub-topics including prioritization and micro-allocation, macro-allocation and budgeting across service areas, along with an overview of a draft budgeting algorithm. This information will be foundational as we select an updated allocation method for funding behavioral health services in Ohio.

F. Evaluation

Performance Management

Ohio is developing a new, web-based system to manage all prevention programmatic, budgeting, billing, performance management and reporting requirements. The new system will fulfill all CSAP Block Grant Reporting requirements and will allow for performance management at both the outcome and process level. The objectives of the new system are to provide the following.

- Establish a secure and centralized online grant and allocation application functionality for prevention that can be utilized by both authorized internal staff and community stakeholders.
- Automate funding to streamline the grant and allocation process and improve efficiency, accountability and service delivery.
- Promote prevention and stakeholder ability to monitor progress and performance.
- Support prevention compliance with state and federal reporting requirements.
- Position ODADAS for emerging health system transformation by adopting a continuous quality improvement grants management partnership that leverages our collective resources and extends our collective capacity.

The new system has each step of the SPF imbedded in various components. A logic model approach taking into account the link between need, target population, intervening variables, strategy selection and prevention intervention selection is being used to gather outcomes. Data will be synthesized using Dr. David Julian's results continuum for categorizing and aggregating varied programmatic outcomes. Dr. Julian is Director of Community Planning and Evaluation at The Ohio State University Center for Learning Excellence. The results continuum includes the following levels.

- Provides a setting
- Provides knowledge
- Changes attitude(s)
- Provides a new skill(s) or increases proficiency in skill
- Changes behavior
- Changes status

The Niatx process improvement model will be used the process evaluation component of the system. ODADAS staff in the Division of Planning, Outcomes and Research have worked with Niatx staff over the last year to modify the process for prevention as well as treatment services. A module of the new system will allow reporting of Niatx project results and learnings.

Evaluation of SPF-SPE Goals

The Ohio SPF SPE Evaluation Team has volunteered graduate students from their respective universities, Ohio University and University of Cincinnati, to assist with the development of an evaluation to measure progress toward the identified SPE Strategic Action Plan goals. Ohio will use results of the State Prevention Enhancement Grants (SPE Grants) Evaluation Activities Survey and the Prevention Workforce Development Survey as baseline data.

Goal 1 – Broad recognition of prevention as effective and cost saving.
Goal 2 – To ensure consistently effective outcomes and streamline operations.
Goal 3 – Working together to ensure the best use of resources to meet identified needs.
Goal 4 – Programs, practices, and strategies are data-driven and effective.

III. Comprehensive Strategic Prevention Action Plan

A. Alignment with SAMHSA Goals

Ohio's SPE plan provides a comprehensive interagency systems integration plan to addresses the four goals listed in SAMHSA Initiative #1: Prevention of Substance Abuse and Mental Illness; and two other SPE-specific goals (i.e., workforce development and policy development) as listed below.

SAMHSA Initiative #1 Goals

Goal 1.1**:** With primary prevention as the focus, build emotional health, prevent or delay onset of, and mitigate symptoms and complications from substance abuse and mental illness.
Goal 1.2**:** Prevent or reduce consequences of underage drinking and adult problem drinking.
Goal 1.3**:** Prevent suicides and attempted suicides among populations at high risk, especially military families, LGBTQ youth, or American Indians and Alaska Natives.
Goal 1.4**:** Reduce prescription drug misuse and abuse.

Additional SPE-Specific Goals

1) Enhance State/Tribal workforce development (e.g., training, support for licensure, credentialing, or accreditation).
2) Enhance State/Tribal Policy development to support needed service system improvements (e.g., rate-setting activities, establishment of standards of care, development/revision of credentialing, licensure, or accreditation requirements).

B. Five-Year Strategic Action Plan

Ohio's SPE strategic plan addresses the items provided in SAMSHA's SPE Strategic Plan Checklist. However, since ODADAS is in the process of merging with the Ohio Department of Mental Health, we chose to prioritize putting systemic processes in place that will serve as the foundation of interagency work on behavioral health under a public health framework.

Action steps are provided for each project under the Strategic Priority Areas. Lead stakeholders are identified for each project and a timeline is provided for each action step. The Consortium also aligned its Strategic Priorities and projects with the **10 Essential Public Health Services** (EPHS) to promote the integration of substance abuse prevention with public health in Ohio and the **EPHS Model Standards** to facilitate future evaluation.

10 Essential Public Health Services List

The Essential Services provide a working definition of public health and a guiding framework for the responsibilities of local public health systems.

1. Monitor health status to identify and solve community health problems.
2. Diagnose and investigate health problems and health hazards in the community.
3. Inform, educate, and empower people about health issues.
4. Mobilize community partnerships and action to identify and solve health problems.
5. Develop policies and plans that support individual and community health efforts.
6. Enforce laws and regulations that protect health and ensure safety.
7. Link people to needed personal health services and assure the provision of health care when otherwise unavailable.
8. Assure competent public and personal health care workforce.
9. Evaluate effectiveness, accessibility, and quality of personal and population-based health services.
10. Research for new insights and innovative solutions to health problems.

Project	Action	Timeframe	Lead	EPHS	EPHS Model Standard
Strategic Priority 1 : Champion Prevention!					
Project 1: Mobilize stakeholders.	a. Use relevant media sources to inform stakeholders.	On-going	SPE	3	
	1. Identify potential media sources.	Sep-12	ODADAS		Planning & Implementation
	2. Develop and maintain a list (including name, agency affiliation and email) of key stakeholders at both the local and state levels as a primary vehicle for integrated communication.	Sep-12	ODADAS		Planning & Implementation
	3. Infuse prevention in behavioral health e-updates with at least one article highlighting prevention quarterly. Agencies will rotate providing state and local information for the spotlight so everyone has an article at least once a year. Agencies will also provide links to calendars and events for inclusion in the e-update.	On-going	SPE		State-Local Relationships
	4. Use results of assessments, cost and reach analyses and evaluation to inform stakeholders.	On-going	SPE		Performance Management & Quality Improvement
	5. Develop a sustainability plan including developing relations with media outlets to keep prime messaging opportunities viable				Planning & Implementation
	b. Define and promote a common language for prevention across systems.	Nov-12	SPE & Roundtable	3	
	c. Identify at least one champion at every level in every system to convey prevention messages.	Sep-12	SPE, ADAPAO	3	
Strategic Priority 2: Promote and support formalized **collaboration and systems integration** at the local and state level for the sharing of resources and program implementation.					
Project 2: Identify existing and needed processes and policies to support prevention at all levels.	a. Assess current policies and processes at state and local levels including ODADAS and ODMH research areas, program management, quality improvement, outcomes and community plan processes.	August - December 2012	SPE	5	
	1. Conduct focus groups/listening sessions to assess policy needs.	August - December 2012	SPE & Roundtable		Planning & Implementation
	2. Identify policy and process improvements that are culturally competent and evidence-based.	August - December 2012	SPE & Roundtable		Performance Management & Quality Improvement
	3. Inform state-level policy makers and field of recommendations. Provide the field with information to inform community policy-makers.	August - December 2012	SPE & Roundtable		State-Local Relationships
	4. Evaluate impact/effectiveness of policy change.	On-going	SPE & Roundtable		Performance Management & Quality Improvement
Project 3: Monitor state and community status to identify and solve behavioral health issues.	a. Facilitate Wellness and Prevention Roundtable as the hub where all the information is routed.	On-going	Roundtable	1, 2	
	b. Continue to collect county level consumption data for all 88 counties, and build on work of SEOW to share data consumption and consequence data with state and communities to utilize as they look at patterns, changes, trends, etc.	On-going	SEOW	1, 2	
	1. Expand the workgroups and the data set by marketing SEOW to all stakeholders by identify partners and a prevention contact with each agency including, ODH, ODE, ODJFS, ODA, ODD, ODRC, ODYS, probation, OCTF, FCFC, ODADAS ODMH.	On-going	SEOW		Planning & Implementation
	2. Take inventory of available data at state and community levels.	Aug-12	SPE Evaluation Team		Planning & Implementation
	3. Identify information needed (target population, domains, NOMs, cost, etc.).	Aug-12	SEOW		Planning & Implementation
	4. Develop a mechanism to collect, analyze and report.	On-going	SEOW		Planning & Implementation
	5. Conduct listening sessions at conferences and meetings and use existing community forums (i.e. FCFCs) for support/assistance.	On-going	SEOW		Planning & Implementation
	6. Develop online surveys to gather information and feedback.	On-going	SEOW		Performance Management & Quality Improvement
	7. Create county level report that summarizes the counties consumption trends and possible influences on community plans	On-going	SEOW		Planning & Implementation
	d. Encourage prevention specialists to assist with identifying and collection county and community data.	On-going	SEOW	1, 2, 4	
	e. Develop an expansion plan for SEOW that will lead to sustainability.	On-going	SEOW	1, 2, 4	
	f. Request federal TA on systems integration from various systems.	On-going	SPE	4	

Strategic Priority 3: Develop & promote **evidence-based,** culturally competent, policies & practices that support & **integrate** prevention at multiple levels across systems.					
Project 4: Encourage use of the Strategic Prevention Framework (SPF).	a. Encourage use of the Strategic Prevention Framework.	On-going	SPF-SIG Advisory	5, 8, 10	
	1. Determine the "What's in it for me" for communities and develop a fact sheet for distribution.	August - December 2012	SPF-SIG Advisory		Planning & Implementation
	2. Identify a SPF champion.	August - December 2012	SPF-SIG Advisory		Public Health Capacity & Resources
	3. Develop and recommend a funding allocation system that support SPF processes.	August - December 2012	SPF-SIG Advisory		Planning & Implementation
	4. Develop a technical assistance/training consortium for SPF.	On-going	SPF-SIG Advisory		Public Health Capacity & Resources
	5. Use SPF SIG Sub-recipients to mentor, train and to disseminate SPF to other areas	On-going	SPF-SIG Advisory		Public Health Capacity & Resources
Project 5: Identify and define multi-faceted prevention services that are cost-effective and feasible for Ohio.	a. Identify and define multi-faceted prevention services that are cost-effective and feasible for Ohio.	On-going	SPF-SIG Advisory	9, 10	
	1. Conduct a literature review to assess expected outcomes versus cost.	August - December 2012	EBP Workgroup		Planning & Implementation
	2. Assess necessary resources to implement recommendations.	August - December 2012	EBP Workgroup		Public Health Capacity & Resources
	3. Recommend best practices and evidenced-based practices for Ohio.	August - December 2012	EBP Workgroup		Planning & Implementation
	4. Provide evidence of outcomes and continue to streamline programs.	On-going	EBP Workgroup		Performance Management & Quality Improvement
Project 6: Review and promote culturally competent policies and practices, using a multi-level approach.	a. Review and promote culturally competent policies and practices, using a multi-level approach.	On-going	EBP Workgroup	5, 8, 9, 10	
	1. Identify, review, revise and promote current culturally competent policies and practices	January - June 2013	EBP Workgroup		Planning & Implementation
	2. Provide information to all stakeholders for review	January - June 2013	EBP Workgroup		State-Local Relationships
	3. Utilize existing or develop training curriculum, and train field.	January - June 2013	EBP Workgroup		Public Health Capacity & Resources
Project 7: Provide workforce development regarding population-based strategies at multiple levels.	a. Provide workforce development regarding population-based strategies at multiple levels.	On-going	Workforce Development Workgroup, OCDB Prevention Committee	5, 8	
	1. Assess current future workforce needs	Aug-12	SPE Evaluation Team		Planning & Implementation
	2. Determine minimum level knowledge level of current state of science for prevention specialists.		Workforce Development Workgroup, OCDB Prevention Committee		Planning & Implementation
	3. Provide standardized prevention education to prevention personnel, and conduct other workforce development efforts.		Workforce Development Workgroup, OCDB Prevention Committee		Public Health Capacity & Resources
Strategic Priority 4: Use relevant **data** to assess community strengths to select programs, practices, and strategies and help evaluate their effectiveness.					
Project 8: Implement a statewide youth survey that provides county-level data.	a. Implement a statewide youth survey that provides county-level data.			1, 2	
	1. Find a champion among all the groups needing data from a statewide youth survey at the state and local levels.	August - December 2012	SPE & SEOW		State-Local Relationships
	2. Examine process across other states and assess their fit for Ohio	Aug-12	SPE Evaluation Team		Planning & Implementation
	3. Find a funding mechanism that is mindful of healthcare reform and political will.	January - June 2013	SPE & SEOW		Planning & Implementation
	4. Involve local level (grassroots)	January - June 2013	Roundtable		State-Local Relationships
Project 9: Seek opportunities to extend existing adult data collection to include prevention.	b. Seek opportunities to extend existing adult data collection to include prevention.			1, 2	
	1. Find a champion among all the groups needing data from a statewide survey at the state and local levels.	August - December 2012	SPE & SEOW		State-Local Relationships
	2. Inventory all adult data collection tools.	Aug-12	SPE Evaluation Team		Planning & Implementation
	3. Inform stakeholders about the importance of collecting prevention data across lifespan.	August - December 2012	SPE & SEOW		Public Health Capacity & Resources
	4. Modify current systems.	January - June 2013	SPE & SEOW		Planning & Implementation
	5. Share data to inform policy	January - June 2013	SPE & SEOW		Planning & Implementation
Project 10: Evaluate action plan.	c. Evaluate action plan.			9	
	1. Develop a system for collecting and analyzing program-related information from the field so good information can go back out to the field for quality improvement.	June - December 2012	ODADAS, PIPAR Workgroup		Planning & Implementation
	2. Use OCPSII survey regarding EPHS as baseline to measure change in knowledge and attitude.	Aug-12	SPE Evaluation Team		Public Health Capacity & Resources

Environmental Factors and Plan

10. Statutory Criterion for MHBG - Required MHBG

Narrative Question

Criterion 1: Comprehensive Community-Based Mental Health Service Systems

Provides for the establishment and implementation of an organized community-based system of care for individuals with mental illness, including those with co-occurring mental and substance use disorders. Describes available services and resources within a comprehensive system of care, provided with federal, state, and other public and private resources, in order to enable such individual to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

Please respond to the following items

Criterion 1

1. Describe available services and resources in order to enable individuals with mental illness, including those with co-occuring mental and substance use disorders to function outside of inpatient or residential institutions to the maximum extent of their capabilities.

OhioMHAS licenses or certifies the following mental health services: 188 mental health (MH)/substance abuse outpatient providers; 244 MH providers, 86 consumer operated services, 655 family home Adult Care Facilities; 251 group home Adult Care Facilities; and 146 MH residential beds. OhioMHAS operates community linkage (referral) services for persons with SMI leaving Ohio's 27 prisons. Medicaid expansion and enrollment in Medicaid prior to leaving prison has increased access to care. Most county Boards have local levies which fund recovery supports in addition to state funds. For more information, please see Step 1 of this document, especially the first (overview) section which describes the new Medicaid benefit, as well as the Continuum of Care. Please also see the children's mental health, adult mental health, and MH/SUD services available within criminal justice system.

2. Does your state provide the following services under comprehensive community-based mental health service systems?

a)	Physical Health	(•) Yes ( ) No
b)	Mental Health	(•) Yes ( ) No
c)	Rehabilitation services	(•) Yes ( ) No
d)	Employment services	(•) Yes ( ) No
e)	Housing services	(•) Yes ( ) No
f)	Educational Services	(•) Yes ( ) No
g)	Substance misuse prevention and SUD treatment services	(•) Yes ( ) No
h)	Medical and dental services	(•) Yes ( ) No
i)	Support services	(•) Yes ( ) No
j)	Services provided by local school systems under the Individuals with Disabilities Education Act (IDEA)	(•) Yes ( ) No
k)	Services for persons with co-occuring M/SUDs	(•) Yes ( ) No

Please describe as needed (for example, best practices, service needs, concerns, etc)

The majority of Ohio providers provide most of these services by referral and care coordination except for mental health, substance abuse, services for persons with co-occurring M/SUD, and support services. Most of Ohio's larger providers are certified to provide both mental health and substance use disorder services, however, Ohio also has providers certified to provide only mental health services. A number of Ohio providers offer rehabilitation, housing, medical and dental services.

3. Describe your state's case management services

Case management services are activities provided to assist and support individuals in gaining access to needed medical, social, educational and other services essential to meeting basic human needs.

4. Describe activities intended to reduce hospitalizations and hospital stays.

The outpatient (community) based services are a major component of reducing hospitalizations and hospital stays. The Ohio Medicaid program has aligned with the institution for mental disease (IMD) requirements for managed care programs and has

taken the opportunity to support the advancement of additional policy goals of 1) increasing access to intensive mental health treatment, 2) providing services closer to home, 3) offering community alternatives to inpatient, 4) focusing on reducing re-admissions and 5) providing for continuity and coordination of care. For persons with substance use disorders (SUDs), the Ohio Medicaid program has developed a per diem payment approach for SUD community residential treatment.

Additionally, Ohio has an Access to Success program. Access to Success funds are used to meet the needs of the individual for suitable housing, food, clothing, furnishings and other basic items, allowing for a smooth transition back into his or her community. Funds can also be used to obtain therapeutic services or devices that have been found to help the patient maintain stability. The goal of the program is to help the patient address any physical, emotional or psychological needs between the time of discharge and their eligibility for other benefits to provide for these needs.

Ohio will also implement Assertive Community Treatment as a bundled service with the new Medicaid benefit scheduled to be implemented January 1, 2018. A 1915(i) waiver expands access to Medicaid for services for persons in 29 counties who meet diagnostic, functional and income criteria for SPMI (serious and persistent mental illness), but who do not meet the financial criteria for Medicaid without the waiver.

Criterion 2: Mental Health System Data Epidemiology

Contains an estimate of the incidence and prevalence in the state of SMI among adults and SED among children; and have quantitative targets to be achieved in the implementation of the system of care described under Criterion 1.

Criterion 2

In order to complete column B of the table, please use the most recent SAMHSA prevalence estimate or other federal/state data that describes the populations of focus.

Column C requires that the state indicate the expected incidence rate of individuals with SMI/SED who may require services in the state's behavioral health system

MHBG Estimate of statewide prevalence and incidence rates of individuals with SMI/SED

Target Population (A)	Statewide prevalence (B)	Statewide incidence (C)
1.Adults with SMI	484,705	161,422
2.Children with SED	136,075	70,085

Describe the process by which your state calculates prevalence and incidence rates and provide an explanation as to how this information is used for planning purposes. If your state does not calculate these rates, but obtains them from another source, please describe. If your state does not use prevalence and incidence rates for planning purposes, indicate how system planning occurs in their absence.

For statewide prevalence, Ohio uses the most recent data available form the National Research Institute, from Uniform Reporting System (URS) Table 1. For adults with SMI, the middle estimate of 5.4% applied to census data is used. For children ages 9 - 17, the lower level limit for a level of functioning of 60 is used to be consistent with Ohio's historical reporting.

Statewide incidence for SMI is from URS Table 14 data. Table 14 can not be used for SED incidence because it lacks the age 9 - 17 breakout. State incidence data for SED is from a special report run by Kwok Tam, OhioMHAS Quality, Planning & Research Office that indicated that 70,085 children ages 9 - 17 with SED were treated, as well as 17,232 children ages 8 and younger with SED.

Ohio has historically used a state-specific algorithm to report SMI and SED data which is more restrictive than SAMHSA's definitions of SMI and SED. Therefore, Ohio has historically reported the number of persons receiving treatment for any mental illness. The number reported by the OhioMHAS Quality, Planning and Research Offices are 45,038 person ages 8 and younger, 106,782 persons ages 9 - 17, and 277,266 persons ages 18 and older as of November 21, 2016. Ohio estimates that the number served in 2018 will be similar.

Criterion 3: Children's Services

Provides for a system of integrated services in order for children to receive care for their multiple needs. Services that should be integrated into a comprehensive system of care include: social services; educational services, including services provided under IDEA; juvenile justice services; substance abuse services; and health and mental health services.

Criterion 3

Does your state integrate the following services into a comprehensive system of care?

a)	Social Services	(●) Yes ( ) No
b)	Educational services, including services provided under IDE	(●) Yes ( ) No
c)	Juvenile justice services	(●) Yes ( ) No
d)	Substance misuse preventiion and SUD treatment services	(●) Yes ( ) No
e)	Health and mental health services	(●) Yes ( ) No
f)	Establishes defined geographic area for the provision of services of such system	(●) Yes ( ) No

Criterion 4: Targeted Services to Rural and Homeless Populations and to Older Adults

Provides outreach to and services for individuals who experience homelessness; community-based services to individuals in rural areas; and community-based services to older adults.

Criterion 4

Describe your state's targeted services to rural and homeless populations and to older adults

Ohio's rural county ADAMH Boards plan, evaluate and fund services to meet the needs of the local community; services are required to meet the minimum continuum of care established by the legislature. Services including emergency & crisis services, assessment, outpatient services, medication management, CPST (case management/care coordination), partial hospitalization/day treatment are available in each Board area. Most rural Board areas also have housing and housing supports and peer support. Inpatient care may be provided out-of board area in community hospitals and regionally-based state hospitals. See Step 1, Adult Mental Health, Services to Rural areas for more details.

OhioMHAS uses SAMHSA PATH grant to fund services to homeless persons in 12 - 13 providers; providers can choose among a menu of services. Services may include outreach, staff training, including the training of individuals who work in shelters, mental health clinics, substance abuse programs, and other sites where individuals who are homeless require services. It may also include assistance with identifying and securing appropriate housing.

Older adults receive the same services listed for rural residents. Ohio's MyCare program coordinates a behavioral health benefit for recipients of both Medicaid and Medicare in 29 counties participating in a pilot program. Some providers offer specialized older adult services which include home visits, enhanced care coordination with primary care, and coordination with older adult services providers.

Criterion 5: Management Systems

States describe their financial resources, staffing, and training for mental health services providers necessary for the plan; provides for training of providers of emergency health services regarding SMI and SED; and how the state intends to expend this grant for the fiscal years involved.

Criterion 5

Describe your state's management systems.

Public mental health treatment services are funded through Medicaid, federal grants, state funds and local tax levies. Most Board areas have local tax levies that fund recovery supports, as well as treatment for persons without Medicaid, Medicare or other insurance. Staffing is determined by providers, as well as meeting OhioMHAS certification and national accreditation standards for the services provided. Providers and ADAMH Boards are responsible for training emergency health service providers regarding SMI and SED. Trauma-informed care training has been provided by regional collaboratives facilitated by OhioMHAS. Training is widely available through web-based programs, as well as in-person training. Providers of crisis services are required to be licensed to provide emergency services, and are required by all state licensing Boards to meet continuing education requirements.

Footnotes:

Ohio's county Boards coordinate services with local health and human services, and legal systems. Ohio also has Family and Children First Councils in most counties that coordinate care for children who are served by multiple service systems (e.g. child welfare, juvenile justice, developmental disabilities). Ohio has a wide variety of providers including large, multi-county community behavioral health providers, community mental health providers, family service providers, children's residential, peer-operated services, and a couple hospitals certified to provide community mental health services. Services provided by other systems of care in Ohio are detailed at the beginning of each section for individual populations (e.g. children, adult, involved with criminal justice system).

Environmental Factors and Plan

11. Substance Use Disorder Treatment - Required SABG

Narrative Question

Criterion 1: Prevention and Treatment Services - Improving Access and Maintaining a Continuum of Services to Meet State Needs

Criterion 1

Improving access to treatment services

1. Does your state provide:

a) A full continuum of services

i)	Screening	◉ Yes ○ No
ii)	Education	◉ Yes ○ No
iii)	Brief Intervention	◉ Yes ○ No
iv)	Assessment	◉ Yes ○ No
v)	Detox (inpatient/social)	◉ Yes ○ No
vi)	Outpatient	◉ Yes ○ No
vii)	Intensive Outpatient	◉ Yes ○ No
viii)	Inpatient/Residential	◉ Yes ○ No
ix)	Aftercare; Recovery support	◉ Yes ○ No

b) Are you considering any of the following:

Targeted services for veterans	○ Yes ◉ No

c) Expansion of services for:

(1)	Adolescents	◉ Yes ○ No
(2)	Other Adults	◉ Yes ○ No
(3)	Medication-Assisted Treatment (MAT)	◉ Yes ○ No

Criterion 2: Improving Access and Addressing Primary Prevention - See Narrative 9. Primary Prevention-Required SABG.

Criterion 2

Criterion 3

1. Does your state meet the performance requirement to establish and/or maintain new programs or expand programs to ensure treatment availability? (●) Yes ( ) No

2. Either directly or through and arrangement with public or private non-profit entities make pernatal care available to PWWDC receiving services? (●) Yes ( ) No

3. Have an agreement to ensure pregnant women are given preference in admission to treatment facilities or make available interim services within 48 hours, including prenatal care? (●) Yes ( ) No

4. Does your state have an arrangement for ensuring the provision of required supportive services? (●) Yes ( ) No

5 Are you considering any of the following:

a) Open assessment and intake scheduling ( ) Yes (●) No

b) Establishment of an electronic system to identify available treatment slots (●) Yes ( ) No

c) Expanded community network for supportive services and healthcare (●) Yes ( ) No

d) Inclusion of recovery support services (●) Yes ( ) No

e) Health navigators to assist clients with community linkages (●) Yes ( ) No

f) Expanded capability for family services, relationship restoration, custody issue ( ) Yes (●) No

g) Providing employment assistance ( ) Yes (●) No

h) Providing transportation to and from services ( ) Yes (●) No

i) Educational assistance ( ) Yes (●) No

6. States are required to monitor program compliance related to activities and services for PWWDC. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The specific strategies to identify compliance lies with the women’s treatment and recovery specialist through mid-year and annual reporting that provides indication whether technical assistance is warranted. OhioMHAS partners with the Ohio Women's Network (OWN) which is a diverse group of professional which provides leadership in the provision of women's gender specific services. OWN promotes collaboration among programs, and disseminates "best practices." It is also encouraged to share lessons learned during the OWN meetings.

Criterion 4,5&6

Persons Who Inject Drugs (PWID)

1. Does your state fulfill the:

- **a)** 90 percent capacity reporting requirement — (•) Yes ( ) No
- **b)** 14-120 day performance requirement with provision of interim services — (•) Yes ( ) No
- **c)** Outreach activities — (•) Yes ( ) No
- **d)** Syringe services programs — (•) Yes ( ) No
- **e)** Monitoring requirements as outlined in the authorizing statute and implementing regulation — (•) Yes ( ) No

2. Are you considering any of the following:

- **a)** Electronic system with alert when 90 percent capacity is reached — ( ) Yes (•) No
- **b)** Automatic reminder system associated with 14-120 day performance requirement — ( ) Yes (•) No
- **c)** Use of peer recovery supports to maintain contact and support — (•) Yes ( ) No
- **d)** Service expansion to specific populations (military families, veterans, adolescents, older adults) — (•) Yes ( ) No

3. States are required to monitor program compliance related to activites and services for PWID. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

The specific strategies to identify compliance lies with the women's treatment and recovery specialist through mid-year and annual reporting that provides indication whether technical assistance is warranted. OhioMHAS partners with the Ohio Women's Network, an organization of providers of women's gender specific services which disseminates evidence-based and best practices. It is also encouraged to share lessons learned during the network meetings.

Tuberculosis (TB)

1. Does your state currently maintain an agreement, either directly or through arrangements with other public and nonprofit private entities to make available tuberculosis services to individuals receiving SUD treatment and to monitor the service delivery? — (•) Yes ( ) No

2. Are you considering any of the following:

- **a)** Business agreement/MOU with primary healthcare providers — ( ) Yes (•) No
- **b)** Cooperative agreement/MOU with public health entity for testing and treatment — ( ) Yes (•) No
- **c)** Established co-located SUD professionals within FQHCs — ( ) Yes (•) No

3. States are required to monitor program compliance related to tuberculosis services made available to individuals receiving SUD treatment. Please provide a detailed description of the specific strategies used by the state to identify compliance issues and corrective actions required to address identified problems.

OhioMHAS addresses its public health mandate to address TB among person with SUD by requiring that all local funding and auditing Board's require written Assurances that agencies receiving SAPT Block Grant funds for operating a program of SUD treatment (A) will, directly or through arrangements with other public or nonprofit private entities, routinely make available tuberculosis services to each individual receiving treatment for such abuse; and (B) in the case of an individual in need of such treatment who is denied admission to a program on the basis of lack of the capacity of the program to admit the individual, will refer the individual to another provider of tuberculosis services [Sec. 1924(a)(1)].

All certified addiction providers are required to have policies and procedures in place for referring or providing counseling and/or client education on exposure to, and the transmission of, tuberculosis, Hepatitis type B and C, and HIV disease for each client admitted. Methadone maintenance programs are required to conduct TB screening and OhioMHAS checks client files on-site annually to verify this activity is being conducted. If the TB test shows a positive result, OhioMHAS verifies that a referral was made for medical treatment. OhioMHAS also requires "counseling on preventing exposure to tuberculosis, hepatitis type B and C, and the transmission of human immunodeficiency virus (HIV) disease." Documentation indicating compliance for this requirement is also reviewed in the client chart. To facilitate compliance, OhioMHAS provides training and technical assistance to providers on client record documentation needed to comply with the rule, as well as for referrals or counseling for TB testing.

Early Intervention Services for HIV (for "Designated States" Only)

1. Does your state currently maintain an agreement to provide treatment for persons with substance use disorders with an emphasis on making available within existing programs early intervention services for HIC in areas that have the greatest need for such services and monitoring the service delivery? ○ Yes ◉ No

2. Are you considering any of the following:

   a) Establishment of EIS-HIV service hubs in rural areas ○ Yes ◉ No

   b) Establishment or expansion of tele-health and social media support services ○ Yes ◉ No

   c) Business agreement/MOU with established community agencies/organizations serving persons with HIV/AIDS ○ Yes ◉ No

Syringe Service Programs

1. Does your state have in place an agreement to ensure that SABG funds are not expended to provide individuals with hypodermic needles or syringes(42 U.S.CÂ§ 300x-31(a)(1)F)? ◉ Yes ○ No

2. Do any of the programs serving PWID have an existing relationship with a Syringe Services (Needle Exchange) Program? ○ Yes ◉ No

3. Do any of the programs use SABG funds to support elements of a Syringe Services Program? ○ Yes ◉ No

   If yes, plese provide a brief description of the elements and the arrangement

Criterion 8,9&10

Service System Needs

1. Does your state have in place an agreement to ensure that the state has conducted a statewide assessment of need, which defines prevention and treatment authorized services available, identified gaps in service, and outlines the state's approach for improvement — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Workforce development efforts to expand service access — (●) Yes ( ) No
- **b)** Establishment of a statewide council to address gaps and formulate a strategic plan to coordinate services — (●) Yes ( ) No
- **c)** Establish a peer recovery support network to assist in filling the gaps — (●) Yes ( ) No
- **d)** Incorporate input from special populations (military families, service memebers, veterans, tribal entities, older adults, sexual and gender minorities) — (●) Yes ( ) No
- **e)** Formulate formal business agreements with other involved entities to coordinate services to fill gaps in the system, i.e. primary healthcare, public health, VA, community organizations — (●) Yes ( ) No
- **f)** Explore expansion of service for:
  - **i)** MAT — (●) Yes ( ) No
  - **ii)** Tele-Health — ( ) Yes (●) No
  - **iii)** Social Media Outreach — ( ) Yes (●) No

Service Coordination

1. Does your state have a current system of coordination and collaboration related to the provision of person-centered and person-directed care? — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Identify MOUs/Business Agreements related to coordinate care for persons receiving SUD treatment and/or recovery services — (●) Yes ( ) No
- **b)** Establish a program to provide trauma-informed care — (●) Yes ( ) No
- **c)** Identify current and perspective partners to be included in building a system of care, e.g. FQHCs, primary healthcare, recovery community organizations, juvenile justice systems, adult criminal justice systems, and education — (●) Yes ( ) No

Charitable Choice

1. Does your state have in place an agreement to ensure the system can comply with the services provided by nongovernment organizations (42 U.S.C.§ 300x-65, 42 CF Part 54 (§54.8(b) and §54.8(c)(4)) and 68 FR 56430-56449) — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Notice to Program Beneficiaries — (●) Yes ( ) No
- **b)** Develop an organized referral system to identify alternative providers — ( ) Yes (●) No
- **a)** Develop a system to maintain a list of referrals made by religious organizations — ( ) Yes (●) No

Referrals

1. Does your state have an agreement to improve the process for referring individuals to the treatment modality that is most appropriate for their needs? — (●) Yes ( ) No

2. Are you considering any of the following:

- **a)** Review and update of screening and assessment instruments — ( ) Yes (●) No
- **b)** Review of current levels of care to determine changes or additions — (●) Yes ( ) No
- **c)** Identify workforce needs to expand service capabilities — (●) Yes ( ) No

d) Conduct cultural awareness training to ensure staff sensitivity to client cultural orientation, environment, and background — (●) Yes ( ) No

Patient Records

1. Does your state have an agreement to ensure the protection of client records? — (●) Yes ( ) No

2. Are you considering any of the following:

a) Training staff and community partners on confidentiality requirements — ( ) Yes (●) No

b) Training on responding to requests asking for acknowledgement of the presence of clients — ( ) Yes (●) No

c) Updating written procedures which regulate and control access to records — ( ) Yes (●) No

d) Review and update of the procedure by which clients are notified of the confidentiality of their records include the exceptions for disclosure — ( ) Yes (●) No

Independent Peer Review

1. Does your state have an agreement to assess and improve, through independent peer review, the quality and appropriateness of treatment services delivered by providers? — (●) Yes ( ) No

2. Section 1943(a) of Title XIX, Part B, Subpart III of the Public Health Service Act (42 U.S.C.§ 300x-52(a)) and 45 § CFR 96.136 require states to conduct independent peer review of not fewer than 5 percent of the block grant sub-recipients providing services under the program involved.

Please provide an estimate of the number of block grant sub-recipients identified to undergo such a review during the fiscal year(s) involved.

OhioMHAS meets the Independent Peer Review requirement by:
(1) Providers which are nationally accredited by Joint Commission (Joint Commission), Council on Accreditation Facilities, CAO) receive Independent Peer Review as a part of their accreditation process
(2) For providers which are not nationally accredited, OhioMHAS contracts for Independent Peer Review with the Ohio Council of Community Behavioral Health Providers for Independent Peer Review of a 5% sample. Most recently, it was 1 or 2 providers since most SUD providers are nationally accredited.

3. Are you considering any of the following:

a) Development of a quality improvement plan — (●) Yes ( ) No

b) Establishment of policies and procedures related to independent peer review — ( ) Yes (●) No

c) Develop long-term planning for service revision and expansion to meet the needs of specific populations — ( ) Yes (●) No

4. Does your state require a block grant sub-recipient to apply for and receive accreditation from an independent accreditation organization, e.g., Commission on the Accreditation of Rehabilitation Facilities (CARF), The Joint Commission, or similar organization as an eligibility criterion for block grant funds? — ( ) Yes (●) No

If YES, please identify the accreditation organization(s)

i) [ ] Commission on the Accreditation of Rehabilitation Facilities

ii) [ ] The Joint Commission

iii) [x] Other (please specify)

Ohio encourages SUD providers of clinical to be nationally accredited. Providers accredited by Commission on Accreditation Facilities, The Joint Commission, or Council on Accreditation are deemed for most OhioMHAS certification requirements. As a result, treatment providers are usually accredited except for niche providers such as Recovery Community Organizations or housing providers,

Criterion 7&11

Group Homes

1. Does your state have an agreement to provide for and encourage the development of group homes for persons in recovery through a revolving loan program? ○ Yes ◉ No

2. Are you considering any of the following:

a) Implementing or expanding the revolving loan fund to support recovery home development as part of the expansion of recovery support service ○ Yes ◉ No

b) Implementing MOUs to facilitate communication between block grant service providers and group homes to assist in placing clients in need of housing ○ Yes ◉ No

Professional Development

1. Does your state have an agreement to ensure that prevention, treatment and recovery personnel operating in the state's substance use disorder prevention, treatment and recovery systems have an opertunity to receive training on an ongoing basis, concerning:

a) Recent trends in substance use disorders in the state ○ Yes ◉ No

b) Improved methods and evidence-based practices for providing substance use disorder prevention and treatment services ○ Yes ◉ No

c) Preformance-based accountability ○ Yes ◉ No

d) Data collection and reporting requirements ○ Yes ◉ No

2. Are you considering any of the following:

a) A comprehensive review of the current training schedule and identification of additional training needs ○ Yes ◉ No

b) Addition of training sessions designed to increase employee understanding of recovery support services ○ Yes ◉ No

c) Collaborative training sessions for employees and community agencies' staff to coordinate and increase integrated services ○ Yes ◉ No

d) State office staff training across departments and divisions to increase staff knowledge of programs and initiatives, which contribute to increased collaboration and decreased duplication of effort ○ Yes ◉ No

Waivers

Upon the request of a state, the Secretary may waive the requirements of all or part of the sections 1922(c), 1923, 1924. and 1928 (42 U.S.C.§ 300x-32 (f)).

1. Is your state considering requesting a waiver of any requirements related to:

a) Allocations regarding women ○ Yes ◉ No

2. Requirements Regarding Tuberculosis Services and Human Immunodeficiency Virus:

a) Tuberculosis ○ Yes ◉ No

b) Early Intervention Services Regarding HIV ○ Yes ◉ No

3. Additional Agreements

a) Improvement of Process for Appropriate Referrals for Treatment ○ Yes ◉ No

b) Professional Development ○ Yes ◉ No

c) Coordination of Various Activities and Services ○ Yes ◉ No

Please provide a link to the state administrative regulations, which govern the Mental Health and Substance Use Disorder Programs.

http://mha.ohio.gov/Default.aspx?tabid=123

Footnotes:

Criterion 1: OhioMHAS plans to expand opioid treatment through the Ohio State Targeted Response grant.

Criterion 7 and 11: Ohio's legislature allocated $20 million in capital funding for recovery homes, so does not need a revolving loan program.

OhioMHAS and its partners provide many opportunities for training on evidence-based practices, but does not use "agreements." OhioMHAS Licensure and Certification requirements of providers require credentialed staff, and state licensing Boards of credentialed clinical staff require continuing education. Ohio has a plan in place to train and credential prevention staff. OhioMHAS partners with the Ohio Association of County Behavioral Health Authorities (ADAMH Board Association) to host annual conferences on opioid treatment and recovery which teach evidence based practices and promotes a Recovery Oriented System of Care. Additionally, Ohio plans additional training as part of its implementation of the CURES (Opioid STR) grant which includes expanding the number of physicians and other prescribers who are trained and credentialed to provide MAT. Ohio also has training for persons with lived experience to become certified as peer recovery specialists. OhioMHAS also offers web-based training on SBIRT and for Certified Peer Support, which provide continuing education credits at no cost to providers. OhioMHAS partners with regional collaboratives to provide training on trauma-informed care. Additionally, OhioMHAS staff provide technical assistance on reporting data and meeting accountability standards, as well as training when new data systems or reporting requirements are implemented.

Environmental Factors and Plan

12. Quality Improvement Plan- Requested

Narrative Question

In previous block grant applications, SAMHSA asked states to base their administrative operations and service delivery on principles of Continuous Quality Improvement/Total Quality Management (CQI/TQM). These CQI processes should identify and track critical outcomes and performance measures, based on valid and reliable data, consistent with the NBHQF, which will describe the health and functioning of the mental health and addiction systems. The CQI processes should continuously measure the effectiveness of services and supports and ensure that they continue to reflect this evidence of effectiveness. The state's CQI process should also track programmatic improvements using stakeholder input, including the general population and individuals in treatment and recovery and their families. In addition, the CQI plan should include a description of the process for responding to emergencies, critical incidents, complaints, and grievances.

Please respond to the following items:

1. Has your state modified its CQI plan from FFY 2016-FFY 2017? (•) Yes ( ) No

Does the state have any activities related to this section that you would like to highlight?

No

Please indicate areas of technical assistance needed related to this section.

None requested.

Footnotes:

Environmental Factors and Plan

13. Trauma - Requested

Narrative Question

Trauma [60] is a widespread, harmful, and costly public health problem. It occurs because of violence, abuse, neglect, loss, disaster, war and other emotionally harmful and/or life threatening experiences. Trauma has no boundaries with regard to age, gender, socioeconomic status, race, ethnicity, geography, or sexual orientation. It is an almost universal experience of people with mental and substance use difficulties. The need to address trauma is increasingly viewed as an important component of effective behavioral health service delivery. Additionally, it has become evident that addressing trauma requires a multi-pronged, multi-agency public health approach inclusive of public education and awareness, prevention and early identification, and effective trauma-specific assessment and treatment. To maximize the impact of these efforts, they need to be provided in an organizational or community context that is trauma-informed.

Individuals with experiences of trauma are found in multiple service sectors, not just in behavioral health. People in the juvenile and criminal justice system have high rates of mental illness and substance use disorders and personal histories of trauma. Children and families in the child welfare system similarly experience high rates of trauma and associated behavioral health problems. Many patients in primary, specialty, emergency and rehabilitative health care similarly have significant trauma histories, which has an impact on their health and their responsiveness to health interventions. Schools are now recognizing that the impact of exposure to trauma and violence among their students makes it difficult to learn and meet academic goals. Communities and neighborhoods experience trauma and violence. For some these are rare events and for others these are daily events that children and families are forced to live with.

These children and families remain especially vulnerable to trauma-related problems, often are in resource poor areas, and rarely seek or receive behavioral health care. States should work with these communities to identify interventions that best meet the needs of these residents. In addition, the public institutions and service systems that are intended to provide services and supports for individuals are often re-traumatizing, making it necessary to rethink doing "business as usual." These public institutions and service settings are increasingly adopting a trauma-informed approach. A trauma-informed approach is distinct from trauma-specific assessments and treatments. Rather, trauma-informed refers to creating an organizational culture or climate that realizes the widespread impact of trauma, recognizes the signs and symptoms of trauma in clients and staff, responds by integrating knowledge about trauma into policies and procedures, and seeks to actively resist re-traumatizing clients and staff. This approach is guided by key principles that promote safety, trustworthiness and transparency, peer support, empowerment, collaboration, and sensitivity to cultural and gender issues. A trauma-informed approach may incorporate trauma-specific screening, assessment, treatment, and recovery practices or refer individuals to these appropriate services.

It is suggested that states refer to SAMHSA's guidance for implementing the trauma-informed approach discussed in the Concept of Trauma[61] paper.

60 Definition of Trauma: *Individual trauma results from an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.*
61 *Ibid*

Please respond to the following items

1. Does the state have a plan or policy for behavioral health providers that guide how they will address individuals with trauma-related issues? ○ Yes ◉ No

2. Does the state provide information on trauma-specific assessment tools and interventions for behavioral health providers? ◉ Yes ○ No

3. Does the state have a plan to build the capacity of behavioral health providers and organizations to implement a trauma-informed approach to care? ◉ Yes ○ No

4. Does the state encourage employment of peers with lived experience of trauma in developing trauma-informed organizations? ◉ Yes ○ No

5. Does the state have any activities related to this section that you would like to highlight.

Ohio has a plan to develop capacity through: (1) Six trauma -informed care (TIC) regional collaboratives will identify strengths and weaknesses for implementation of TIC,. The collaboratives will develop and share resources, as well as strategies for specific target populations (i.e. children, older adults, persons with SUD. (2) Train individuals to serve as trainers to assist in the dissemination of TIC. As of May 2017, over 10,000 persons have been trained in a state developed curriculum entitled "Trauma Informed Approaches: Key Assumptions and Priniciples."

Please indicate areas of technical assistance needed related to this section.

Footnotes:

Question #1

#1 No, the state does not have a plan or policy FOR PROVIDERS that guide how they will address individuals with trauma-related issues. However, Ohio has a plan for a statewide initiative which works with OhioMHAS' state and local partners, as well as providers in local communities.

Ohio's Statewide Trauma Informed Care Initiative goals are:

• Utilize a public health model to support environmental strategies for prevention, identification, intervention and support to advance Trauma-Informed Care in Ohio.

• Adopt Trauma-Informed Care principles that are: based on a public health model; culturally and intellectually sensitive; and, developmentally appropriate

• Expand opportunities for Ohioans to receive trauma-informed intervention be enhancing efforts for practitioners, facilities and agencies to be competent in trauma informed practices

Environmental Factors and Plan

14. Criminal and Juvenile Justice - Requested

Narrative Question

More than half of all prison and jail inmates meet criteria for having mental health problems, six in ten meet criteria for a substance use problem, and more than one-third meet criteria for having co-occurring mental and substance use problems. Youth in the juvenile justice system often display a variety of high-risk characteristics that include inadequate family support, school failure, negative peer associations, and insufficient use of community-based services. Most adjudicated youth released from secure detention do not have community follow-up or supervision; therefore, risk factors remain unaddressed.[62]

Successful diversion of adults and youth from incarceration or re-entering the community from detention is often dependent on engaging in appropriate M/SUD treatment. Some states have implemented such efforts as mental health, veteran and drug courts, Crisis Intervention Training (CIT) and re-entry programs to help reduce arrests, imprisonment and recidivism.[63]

A diversion program places youth in an alternative program, rather than processing them in the juvenile justice system. States should place an emphasis on screening, assessment, and services provided prior to adjudication and/or sentencing to divert persons with M/SUD from correctional settings. States should also examine specific barriers such as a lack of identification needed for enrollment Medicaid and/or Marketplace; loss of eligibility for Medicaid resulting from incarceration; and care coordination for individuals with chronic health conditions, housing instability, and employment challenges. Secure custody rates decline when community agencies are present to advocate for alternatives to detention.

The MHBG and SABG may be especially valuable in supporting care coordination to promote pre-adjudication or pre-sentencing diversion, providing care during gaps in enrollment after incarceration, and supporting other efforts related to enrollment.

[62] Journal of Research in Crime and Delinquency: *Identifying High-Risk Youth: Prevalence and Patterns of Adolescent Drug Victims, Judges, and Juvenile Court Reform Through Restorative Justice.* Dryfoos, Joy G. 1990, Rottman, David, and Pamela Casey, McNiel, Dale E., and Renée L. Binder. **OJJDP Model Programs Guide**

[63] **http://csgjusticecenter.org/mental-health/**

Please respond to the following items

1. Does the state (SMHA and SSA) have a plan for coordinating with the criminal and juvenile justice systems on diversion of individuals with mental and/or substance use disorders from incarceration to community treatment, and for those incarcerated, a plan for re-entry into the community that includes connecting to behavioral health services? — (●) Yes ( ) No

2. Does the state have a plan for working with law enforcement to deploy emerging strategies (e.g. civil citations, mobile crisis intervention, behavioral health provider ride-along, CIT, linkage with treatment services, etc.) to reduce the number of individuals with mental and/or substance use problems in jails and emergency rooms? — (●) Yes ( ) No

3. Does the state provide cross-trainings for behavioral health providers and criminal/juvenile justice personnel to increase capacity for working with individuals with behavioral health issues involved in the justice system? — (●) Yes ( ) No

4. Does the state have an inter-agency coordinating committee or advisory board that addresses criminal and juvenile justice issues and that includes the SMHA, SSA, and other governmental and non-governmental entities to address behavioral health and other essential domains such as employment, education, and finances? — (●) Yes ( ) No

5. Does the state have any activities related to this section that you would like to highlight?

Begining SFY 2016, OhioMHAS assumed responsibility for treatment of SUD within Ohio's 27 prisons with the goal of reducing recidivism. OhioMHAS provides community linkage services for persons who are being released from prison who have serious mental illness and/or SUD which includes referral to treatment and recovery resources. OhioMHAS funds specialty docket courts which divert non-violent offenders with SUD and/or mental illness from jail and/or prison into community treatment programs and link them with recovery resources. Most of Ohio's counties have CIT trained law enforcement. A six-hour training on trauma informed care is being integrated into required law enforcement training. See Step 1 for details.

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Environmental Factors and Plan

15. Medication Assisted Treatment - Requested

Narrative Question

There is a voluminous literature on the efficacy of medication-assisted treatment (MAT); the use of FDA approved medication; counseling; behavioral therapy; and social support services, in the treatment of substance use disorders. However, many treatment programs in the U.S. offer only abstinence-based treatment for these conditions. The evidence base for MAT for SUDs is described in SAMHSA TIPs 40[1], 43[2], 45[3], and 49[4].

SAMHSA strongly encourages that the states require treatment facilities providing clinical care to those with substance use disorders demonstrate that they both have the capacity and staff expertise to use MAT or have collaborative relationships with other providers that can provide the appropriate MAT services clinically needed.

Individuals with substance use disorders who have a disorder for which there is an FDA approved medication treatment should have access to those treatments based upon each individual patient's needs. In addition, SAMHSA also encourages states to require the use of MAT for substance use disorders for opioid use, alcohol use, and tobacco use disorders where clinically appropriate. SAMHSA is asking for input from states to inform SAMHSA's activities.

Please respond to the following items:

1. Has the state implemented a plan to educate and raise awareness within SUD treatment programs regarding MAT for substance use disorders? (●) Yes ( ) No

2. Has the state implemented a plan to educate and raise awareness of the use of MAT within special target audiences, particularly pregnant women? (●) Yes ( ) No

3. Does the state purchase any of the following medication with block grant funds? ( ) Yes (●) No

- **a)** [ ] Methadone
- **b)** [ ] Buprenophine, Buprenorphine/naloxone
- **c)** [ ] Disulfiram
- **d)** [ ] Acamprosate
- **e)** [ ] Naltrexone (oral, IM)
- **f)** [ ] Naloxone

4. Does the state have an implemented education or quality assurance program to assure that evidence-based MAT with the use of FDA-approved medications for treatment of substance abuse use disorders are used appropriately*? ( ) Yes (●) No

5. Does the state have any activities related to this section that you would like to highlight?

Using funds allocated by the state legislature, OhioMHAS funds Naloxone for first responders through county health departments. Additionally, Medicaid expansion funds medication for MAT for eligible individuals.

Ohio Senate Bill 319 allows the significant expansion of opioid programs (OTP) by permitting for-profit organizations to enter the market and removing the two-year service requirement. OhioMHAS has been working closely with nearly 20 vendors who have expressed interest in opening up over 60 OTPs over the next two years. The increase in OTPs will dramatically change the access persons with opioid use disorder have to high quality therapeutic programs with medication assisted treatment.

Please indicate areas of technical assistance needed to this section.

None requested.

**Appropriate use is defined as use of medication for the treatment of a substance use disorder, combining psychological treatments with approved medications, use of peer supports in the recovery process, safeguards against misuse and/or diversion of controlled substances used in treatment of substance use disorders, and advocacy with state payers.*

Footnotes:

Question #3:

Rather than use SABG Block Grant, OhioMHAS uses other funds for medications for MAT:

(1) State legislature funds Ohio MHAS to distribute Naloxone for first responders through county health departments.

(2) Medicaid expansion funds medication for MAT for eligible individuals who meet criteria. On 2016 SAMHSA mini-site visit, Comp Drug which operates a methadone clinic reported that Medicaid expansion allowed them to expand their methadone and other MAT program to

serve residents of 30 counties who were able to travel to Columbus for MAT.

Environmental Factors and Plan

16. Crisis Services - Requested

Narrative Question

In the on-going development of efforts to build an robust system of evidence-based care for persons diagnosed with SMI, SED and SUD and their families via a coordinated continuum of treatments, services and supports, growing attention is being paid across the country to how states and local communities identify and effectively respond to, prevent, manage and help individuals, families, and communities recover from behavioral health crises. SAMHSA has recently released a publication, *Crisis Services Effectiveness, Cost Effectiveness and Funding Strategies* that states may find helpful.[64] SAMHSA has taken a leadership role in deepening the understanding of what it means to be in crisis and how to respond to a crisis experienced by people with behavioral health conditions and their families.

According to SAMHSA's publication, **Practice Guidelines: Core Elements for Responding to Mental Health Crises**[65],

"Adults, children, and older adults with an SMI or emotional disorder often lead lives characterized by recurrent, significant crises. These crises are not the inevitable consequences of mental disability, but rather represent the combined impact of a host of additional factors, including lack of access to essential services and supports, poverty, unstable housing, coexisting substance use, other health problems, discrimination, and victimization."

A crisis response system will have the capacity to prevent, recognize, respond, de-escalate, and follow-up from crises across a continuum, from crisis planning, to early stages of support and respite, to crisis stabilization and intervention, to post-crisis follow-up and support for the individual and their family. SAMHSA expects that states will build on the emerging and growing body of evidence for effective community-based crisis-prevention and response systems. Given the multi-system involvement of many individuals with behavioral health issues, the crisis system approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The following are an array of services and supports used to address crisis response. Please check those that are used in your state:

[64] **http://store.samhsa.gov/product/Crisis-Services-Effective-Cost-Effectiveness-and-Funding-Strategies/SMA14-4848**

[65] Practice Guidelines: Core Elements for Responding to Mental Health Crisis. HHS Pub. No. SMA-09-4427. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2009. **http://store.samhsa.gov/product/Core-Elements-for-Responding-to-Mental-Health-Crises/SMA09-4427**

Please respond to the following items:

1. Crisis Prevention and Early Intervention

- **a)** ☑ Wellness Recovery Action Plan (WRAP) Crisis Planning
- **b)** ☑ Psychiatric Advance Directives
- **c)** ☑ Family Engagement
- **d)** ☑ Safety Planning
- **e)** ☑ Peer-Operated Warm Lines
- **f)** ☑ Peer-Run Crisis Respite Programs
- **g)** ☑ Suicide Prevention

2. Crisis Intervention/Stabilization

- **a)** ☐ Assessment/Triage (Living Room Model)
- **b)** ☐ Open Dialogue
- **c)** ☑ Crisis Residential/Respite
- **d)** ☑ Crisis Intervention Team/Law Enforcement
- **e)** ☑ Mobile Crisis Outreach
- **f)** ☑ Collaboration with Hospital Emergency Departments and Urgent Care Systems

3. Post Crisis Intervention/Support

- **a)** ☑ WRAP Post-Crisis
- **b)** ☑ Peer Support/Peer Bridgers
- **c)** ☑ Follow-up Outreach and Support
- **d)** ☑ Family-to-Family Engagement

e) ☑ Connection to care coordination and follow-up clinical care for individuals in crisis

f) ☑ Follow-up crisis engagement with families and involved community members

g) ☑ Recovery community coaches/peer recovery coaches

h) ☑ Recovery community organization

4. Does the state have any activities related to this section that you would like to highlight?

Ohio launched a statewide Crisis Text Line. The Ohio Department of Mental Health and Addiction Services has entered in to a contract with the national Crisis Text Line to provide Ohioans with this state-specific keyword of "4hope" to access its free, confidential service available 24/7 via text on mobile devices. This resource is intended to broaden the options available through current community crisis hotlines. Other states, cities or communities may have their own keyword. In addition, the word "HELLO" can be texted to 741741 in all area codes in the U.S.

How can I volunteer to become a Crisis Counselor?
You must be over 18, go through a rigorous applications process that includes a background check, and receive 34 hours of web-based training. Apply through crisistextline.org. As of July 2016, there were 1,541 trained Crisis Counselors responding to 50,000 texters per month

Please indicate areas of technical assistance needed to this section.

None requested.

Footnotes:

Environmental Factors and Plan

17. Recovery - Required

Narrative Question

The implementation of recovery supports and services are imperative for providing comprehensive, quality behavioral health care. The expansion in access to and coverage for health care compels SAMHSA to promote the availability, quality, and financing of vital services and support systems that facilitate recovery for individuals.Recovery encompasses the spectrum of individual needs related to those with mental disorders and/or substance use disorders. Recovery is supported through the key components of: health (access to quality health and behavioral health treatment); home (housing with needed supports), purpose (education, employment, and other pursuits); and community (peer, family, and other social supports). The principles of recovery guide the approach to person-centered care that is inclusive of shared decision-making. The continuum of care for these conditions includes psychiatric and psychosocial interventions to address acute episodes or recurrence of symptoms associated with an individual?s mental or substance use disorder. Because mental and substance use disorders are chronic conditions, systems and services are necessary to facilitate the initiation, stabilization, and management of long-term recovery.
SAMHSA has developed the following working definition of recovery from mental and/or substance use disorders:
Recovery is a process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential.
In addition, SAMHSA identified 10 guiding principles of recovery:

- Recovery emerges from hope;
- Recovery is person-driven;
- Recovery occurs via many pathways;
- Recovery is holistic;
- Recovery is supported by peers and allies;
- Recovery is supported through relationship and social networks;
- Recovery is culturally-based and influenced;
- Recovery is supported by addressing trauma;
- Recovery involves individuals, families, community strengths, and responsibility;
- Recovery is based on respect.

Please see **SAMHSA's Working Definition of Recovery from Mental Disorders and Substance Use Disorders**.
States are strongly encouraged to consider ways to incorporate recovery support services, including peer-delivered services, into their continuum of care. Examples of evidence-based and emerging practices in peer recovery support services include, but are not limited to, the following:

- Clubhouses
- Drop-in centers
- Recovery community centers
- Peer specialist
- Peer recovery coaching
- Peer wellness coaching
- Peer health navigators
- Family navigators/parent support partners/providers
- Peer-delivered motivational interviewing
- Peer-run respite services
- Peer-run crisis diversion services
- Telephone recovery checkups
- Warm lines
- Self-directed care
- Supportive housing models
- Evidenced-based supported employment
- Wellness Recovery Action Planning (WRAP)
- Whole Health Action Management (WHAM)
- Shared decision making
- Person-centered planning
- Self-care and wellness approaches
- Peer-run Seeking Safety groups/Wellness-based community campaign
- Room and board when receiving treatment

SAMHSA strongly encourages states to take proactive steps to implement recovery support services. To accomplish this goal and support the wide-scale adoption of recovery supports in the areas of health, home, purpose, and community, SAMHSA has launched Bringing Recovery

Supports to Scale Technical Assistance Center Strategy (BRSS TACS). BRSS TACS assists states and others to promote adoption of recovery-oriented supports, services, and systems for people in recovery from substance use and/or mental disorders.
Because recovery is based on the involvement of consumers/peers/people in recovery, their family members and caregivers, SMHAs and SSAs can engage these individuals, families, and caregivers in developing recovery-oriented systems and services. States should also support existing and create resources for new consumer, family, and youth networks; recovery community organizations and peer-run organizations; and advocacy organizations to ensure a recovery orientation and expand support networks and recovery services. States are strongly encouraged to engage individuals and families in developing, implementing and monitoring the state M/SUD treatment system.

Please respond to the following:

1. Does the state support recovery through any of the following:

a) Training/education on recovery principles and recovery-oriented practice and systems, including the role of peers in care? (●) Yes ( ) No

b) Required peer accreditation or certification? (●) Yes ( ) No

c) Block grant funding of recovery support services. (●) Yes ( ) No

d) Involvement of persons in recovery/peers/family members in planning, implementation, or evaluation of the impact of the state's M/SUD system?

Persons in recovery and their family members are participate in Planning Council. Additionally, local community ADAMH Boards which plan, evaluate and fund mental health and SUD services are required to include a minimum of one person in recovery and family member on the decision making board for the ADAMH Boards. The Ohio Association of Community Behavioral Health Boards (aka "ADAMH Boards) is leading a five year Recovery Oriented System of Care initiative that includes some activities which promote this involvement.

2. Does the state measure the impact of your consumer and recovery community outreach activity? ( ) Yes (●) No

3. Provide a description of recovery and recovery support services for adults with SMI and children with SED in your state.

Ohio has recovery and recovery supports which includes 86 peer operated centers, a range of housing and housing supports, supported employment and other supports. Please see Step 1 for a description. Ohio has Parent Advocacy Connection (PAC) is a grassroots organization of trained parent advocates which is overseen by NAMI Ohio. Peer-to-Peer, Family-to-Family, and BASIC (for parents of children with SED) are widely available.

4. Provide a description of recovery and recovery support services for individuals with substance use disorders in your state.

Ohio has a range of recovery supports provided by the recovery community outside of the public behavioral health system including twelve step groups and recovery housing. Ohio has a variety of housing for persons with SUD which are detailed in Step 1, Ohio Legislature allocated $20 million in expansion of recovery housing which must be spent on capital investment. Ohio's new SUD Medicaid benefit will include Peer Recovery Support. Additionally, Ohio has about 15 recovery community organizations which include some of the 86 peer operated centers (MH) which serve persons in MH and co-occurring recovery. Employment services are also available. Please see Step 1 for a longer description.

5. Does the state have any activities that it would like to highlight?

Ohio developed and implemented an integrated peer recovery supporter training for certification to provide Medicaid-reimbursable services. Individuals in recovery with a direct lived experience of mental health and/or substance use disorders who are interested in taking a 40 hour in-person peer services training, may apply to take the OhioMHAS Peer Services Training. The integrated peer support curriculum was funded through a SAMHSA BRSS TACS grant in an effort to promote the widespread adoption of recovery-oriented supports, services, and systems for people in recovery from mental health and/or substance use disorders. At the time of its development, few states had a curriculum that was designed to train individuals with both mental health and substance use disorders.

OhioMHAS staff review and approve training applications and coordinate trainings for Mental Health and Recovery Boards, Consumer Operated Services, and Behavioral Health Providers. As a part of the training process, individuals must complete 16 hours of E-Based Academy courses and pass the OhioMHAS Peer Supporter Exam. E-Based Academy course may be accessed at http://www.ebasedacademy.org/lms/

Please indicate areas of technical assistance needed related to this section.

None at this time. In SFY 2017 Ohio benefited from Mental Health Block Grant related technical assistance to fund a portion of continuing education training for peer recovery supporters and workforce development for other persons in recovery.

Footnotes:

Environmental Factors and Plan

18. Community Living and the Implementation of Olmstead - Requested

Narrative Question

The integration mandate in Title II of the Americans with Disabilities Act (ADA) and the Supreme Court's decision in **Olmstead v. L.C., 527 U.S. 581 (1999)**, provide legal requirements that are consistent with SAMHSA's mission to reduce the impact of M/SUD on America's communities. Being an active member of a community is an important part of recovery for persons with behavioral health conditions. Title II of the ADA and the regulations promulgated for its enforcement require that states provide services in the most integrated setting appropriate to the individual and prohibit needless institutionalization and segregation in work, living, and other settings. In response to the 10th anniversary of the Supreme Court's Olmstead decision, the Coordinating Council on Community Living was created at HHS. SAMHSA has been a key member of the council and has funded a number of technical assistance opportunities to promote integrated services for people with behavioral health needs, including a policy academy to share effective practices with states.

Community living has been a priority across the federal government with recent changes to section 811 and other housing programs operated by the Department of Housing and Urban Development (HUD). HUD and HHS collaborate to support housing opportunities for persons with disabilities, including persons with behavioral illnesses. The Department of Justice (DOJ) and the HHS Office for Civil Rights **(OCR)** cooperate on enforcement and compliance measures. DOJ and OCR have expressed concern about some aspects of state mental health systems including use of traditional institutions and other settings that have institutional characteristics to serve persons whose needs could be better met in community settings. More recently, there has been litigation regarding certain evidenced-based supported employment services such as sheltered workshops. States should ensure block grant funds are allocated to support prevention, treatment, and recovery services in community settings whenever feasible and remain committed, as SAMHSA is, to ensuring services are implemented in accordance with Olmstead and Title II of the ADA.

Please respond to the following items

1. Does the state's Olmstead plan include :

housing services provided.	(●) Yes	( ) No
home and community based services.	(●) Yes	( ) No
peer support services.	( ) Yes	(●) No
employment services.	( ) Yes	(●) No

2. Does the state have a plan to transition individuals from hospital to community settings? ( ) Yes (●) No

3. What efforts are occurring in the state or being planned to address the ADA community integration mandate required by the Olmstead Decision of 1999?

Ohio has an Access to Success program that provides funds for persons discharged from state hospitals to communities who need recovery supports or housing that is beyond what is normally provided. These mini-grants to providers or Boards are persons-specific and closely managed by OhioMHAS Medical Director's staff. Additionally, PASRR screening of persons with SMI has been expanded to 7 days per week, to avoid unnecessary nursing facility admission.

Does the state have any activities related to this section that you would like to highlight?

Also, Recovery Requires a Community program provides flexible funding to persons with SMI who are leaving institutions (e.g. nursing facilities and prisons) , and need resources (e.g. housing security deposits) to transition from an institution to the community. This is a partnership between OhioMHAS and Ohio Dept. of Medicaid.

Please indicate areas of technical assistance needed related to this section.

None

Footnotes:

Environmental Factors and Plan

19. Children and Adolescents Behavioral Health Services - Required MHBG, Requested SABG

Narrative Question

MHBG funds are intended to support programs and activities for children and adolescents with SED, and SABG funds are available for prevention, treatment, and recovery services for youth and young adults with substance use disorders. Each year, an estimated 20 percent of children in the U.S. have a diagnosable mental health condition and one in 10 suffers from a serious emotional disturbance that contributes to substantial impairment in their functioning at home, at school, or in the community[66]. Most mental disorders have their roots in childhood, with about 50 percent of affected adults manifesting such disorders by age 14, and 75 percent by age 24[67]. For youth between the ages of 10 and 24, suicide is the third leading cause of death and for children between 12 and 17, the second leading cause of death[68].

It is also important to note that 11 percent of high school students have a diagnosable substance use disorder involving nicotine, alcohol, or illicit drugs, and nine out of 10 adults who meet clinical criteria for a substance use disorder started smoking, drinking, or using illicit drugs before the age of 18. Of people who started using before the age of 18, one in four will develop an addiction compared to one in twenty-five who started using substances after age 21[69]. Mental and substance use disorders in children and adolescents are complex, typically involving multiple challenges. These children and youth are frequently involved in more than one specialized system, including mental health, substance abuse, primary health, education, childcare, child welfare, or juvenile justice. This multi-system involvement often results in fragmented and inadequate care, leaving families overwhelmed and children's needs unmet. For youth and young adults who are transitioning into adult responsibilities, negotiating between the child- and adult-serving systems becomes even harder. To address the need for additional coordination, SAMHSA is encouraging states to designate a point person for children to assist schools in assuring identified children are connected with available mental health and/or substance abuse screening, treatment and recovery support services.

Since 1993, SAMHSA has funded the Children's Mental Health Initiative (CMHI) to build the system of care approach in states and communities around the country. This has been an ongoing program with 173 grants awarded to states and communities, and every state has received at least one CMHI grant. Since then SAMHSA has awarded planning and implementation grants to states for adolescent and transition age youth SUD treatment and infrastructure development. This work has included a focus on financing, workforce development and implementing evidence-based treatments.

For the past 25 years, the system of care approach has been the major framework for improving delivery systems, services, and outcomes for children, youth, and young adults with mental and/or SUD and co-occurring M/SUD and their families. This approach is comprised of a spectrum of effective, community-based services and supports that are organized into a coordinated network. This approach helps build meaningful partnerships across systems and addresses cultural and linguistic needs while improving the child, youth and young adult functioning in home, school, and community. The system of care approach provides individualized services, is family driven; youth guided and culturally competent; and builds on the strengths of the child, youth or young adult and their family to promote recovery and resilience. Services are delivered in the least restrictive environment possible, use evidence-based practices, and create effective cross-system collaboration including integrated management of service delivery and costs[70].

According to data from the 2015 Report to Congress[71] on systems of care, services:

1. reach many children and youth typically underserved by the mental health system;
2. improve emotional and behavioral outcomes for children and youth;
3. enhance family outcomes, such as decreased caregiver stress;
4. decrease suicidal ideation and gestures;
5. expand the availability of effective supports and services; and
6. save money by reducing costs in high cost services such as residential settings, inpatient hospitals, and juvenile justice settings.

SAMHSA expects that states will build on the well-documented, effective system of care approach to serving children and youth with serious behavioral health needs. Given the multi- system involvement of these children and youth, the system of care approach provides the infrastructure to improve care coordination and outcomes, manage costs, and better invest resources. The array of services and supports in the system of care approach includes:

- non-residential services (e.g., wraparound service planning, intensive case management, outpatient therapy, intensive home-based services, SUD intensive outpatient services, continuing care, and mobile crisis response);
- supportive services, (e.g., peer youth support, family peer support, respite services, mental health consultation, and supported education and employment); and

- residential services (e.g., like therapeutic foster care, crisis stabilization services, and inpatient medical detoxification).

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[66]Centers for Disease Control and Prevention, (2013). Mental Health Surveillance among Children ? United States, 2005-2011. MMWR 62(2).

[67]Kessler, R.C., Berglund, P., Demler, O., Jin, R., Merikangas, K.R., & Walters, E.E. (2005). Lifetime prevalence and age-of-onset distributions of DSM-IV disorders in the National Comorbidity Survey Replication. Archives of General Psychiatry, 62(6), 593?602.

[68]Centers for Disease Control and Prevention. (2010). National Center for Injury Prevention and Control. Web-based Injury Statistics Query and Reporting System (WISQARS) [online]. (2010). Available from www.cdc.gov/injury/wisqars/index.html.

[69]The National Center on Addiction and Substance Abuse at Columbia University. (June, 2011). Adolescent Substance Abuse: America's #1 Public Health Problem.

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[71] **http://www.samhsa.gov/sites/default/files/programs_campaigns/nitt-ta/2015-report-to-congress.pdf**

Please respond to the following items:

1. Does the state utilize a system of care approach to support:

a) The recovery and resilience of children and youth with SED? (●) Yes ( ) No

b) The recovery and resilience of children and youth with SUD? (●) Yes ( ) No

2. Does the state have an established collaboration plan to work with other child- and youth-serving agencies in the state to address behavioral health needs:

a) Child welfare? (●) Yes ( ) No

b) Juvenile justice? (●) Yes ( ) No

c) Education? (●) Yes ( ) No

3. Does the state monitor its progress and effectiveness, around:

a) Service utilization? ( ) Yes (●) No

b) Costs? (●) Yes ( ) No

c) Outcomes for children and youth services? (●) Yes ( ) No

4. Does the state provide training in evidence-based:

a) Substance misuse prevention, SUD treatment and recovery services for children/adolescents, and their families? (●) Yes ( ) No

b) Mental health treatment and recovery services for children/adolescents and their families? (●) Yes ( ) No

5. Does the state have plans for transitioning children and youth receiving services:

a) to the adult behavioral health system? (●) Yes ( ) No

b) for youth in foster care? (●) Yes ( ) No

6. Describe how the state provide integrated services through the system of care (social services, educational services, child welfare services, juvenile justice services, law enforcement services, substance use disorders, etc.)

System of Care for Children and Youth with Serious Emotional Disorders (SED)
Ohio's behavioral health system has a public health approach that builds upon established collaboration of state agencies and county ADAMH Boards. At the state level, the OhioMHAS Prevention and Wellness Office; Bureau of Children and Families provides leadership for treatment services for children and youth with serious emotional disturbances, as well as for mental health and substance abuse promotion and prevention. Statewide interagency coordination among health agencies is led by Ohio Office of Health Transformation. This office coordinates the activities of the health and human services agencies. Ohio's child serving cabinet-level agencies include: Aging (disability network), OhioMHAS, Developmental Disabilities, Education, Health, Job and Family Services (employment, child welfare, social services/Title XX), Rehabilitation and Corrections (adult justice), and Youth Services (juvenile justice). At the community level, county and multi-county ADAMH Boards plan, evaluate and fund local mental health and addiction services for children and youth with state oversight from OhioMHAS. Boards contract with providers, which provide mental health and/or addiction services, and coordinate services from other systems for individuals. Most Boards develop collaborative relationships with schools and universities, developmental disabilities providers, juvenile justice, child welfare, health departments and county commissioners. Additionally, Boards collaborate with these local child-serving organizations through local Ohio Family and Children First (OFCF).

Family and Children First

Ohio Family and Children First coordinates a single county-level System of Care (SOC) which serves children and youth with SED who receive services through multiple county governmental organizations. County Family and Children First partners include the local government organizations that address mental health and addiction, developmental disabilities, juvenile justice, child welfare, and education. The purpose of the county Family and Children First Councils are to streamline and coordinate existing government services for families seeking services for their children. Each Family and Children First Council is mandated to perform four core functions: Engaging and Empowering Families, Coordinating Systems and Services, Building Community Capacity, all with an eye towards Shared Accountability among their local system partners. Each Family and Children First Council works collaboratively towards a vision that every child and family can thrive and succeed within healthy communities.

7. Does the state have any activities related to this section that you would like to highlight?

Ohio received a four-year System of Care Expansion Grant from SAMHSA for youth and young adults in transition with SED who may have co-occurring disorders; and who are: a) at risk for involvement, currently involved, or previously involved with the child welfare or juvenile justice systems; or b) who may be at imminent risk of homelessness. The purpose of ENGAGE is to reduce expenditures and improve outcomes related to physical and behavioral health, education, employment, and living stability for high risk youth and young adults through statewide System of Care expansion of the evidence-supported, research-based High Fidelity Wraparound practice. At the end of SFY 2017 (June 2017), the ENGAGE grant has been implemented in 42 counties and enrolled approximately 155 youth into the High Fidelity Wraparound program. Over 350 counties child-serving public employees have been trained in High-Fidelity Wraparound.

OhioMHAS also received a SAMHSA FFY 2017 System of Care grant for SUD. The purpose of Ohio's Adolescent and Transitional Aged Youth Treatment Implementation (YT-I) project is to increase the availability and access of substance use disorder (SUD) and co-occurring SUD and Mental Health treatment and recovery supports in Ohio. The focus will be on the disparities in rural and Appalachian counties for adolescents and transition-aged youth 12-25.

Please indicate areas of technical assistance needed related to this section.

None is requested at this time.

Footnotes:

Environmental Factors and Plan

20. Suicide Prevention - Required MHBG

Narrative Question

Suicide is a major public health concern, it is the 10th leading cause of death overall, with over 40,000 people dying by suicide each year in the United States. The causes of suicide are complex and determined by multiple combinations of factors, such as mental illness, substance abuse, painful losses, exposure to violence, and social isolation. Mental illness and substance abuse are possible factors in 90 percent of the deaths from suicide, and alcohol use is a factor in approximately one-third of all suicides. Therefore, SAMHSA urges behavioral health agencies to lead in ways that are suitable to this growing area of concern. SAMHSA is committed to supporting states and territories in providing services to individuals with SMI/SED who are at risk for suicide through the use of MHBG funds to address these risk factors and prevent suicide. SAMHSA encourages the behavioral health agencies play a leadership role on suicide prevention efforts, including shaping, implementing, monitoring, care, and recovery support services among individuals with SMI/SED.

Please respond to the following items:

1. Have you updated your state's suicide prevention plan in the last 2 years? (•) Yes ( ) No

2. Describe activities intended to reduce incidents of suicide in your state.

Attached annual report highlights our activities. Key pieces include sponsoring of five regional Zero Suicide Academy training events resulting in 32 teams and approximately 140 total individuals participating. Teams are also able to participate in a Community of Practice for nine months' post academy to support implementation of the Zero Suicide framework and networking. The CoPs are facilitated by staff from the Suicide Prevention Resource Center; development and distribution of Media Guidelines; and implementation of a statewide Crisis Text Line for all Ohioans.

3. Have you incorporated any strategies supportive of Zero Suicide? (•) Yes ( ) No

4. Do you have any initiatives focused on improving care transitions for suicidal patients being discharged from inpatient units or emergency departments? (•) Yes ( ) No

5. Have you begun any targeted or statewide initiatives since the FFY 2016-FFY 2017 plan was submitted? (•) Yes ( ) No

If so, please describe the population targeted.

This fiscal year we have purchased participation for 250 clinicians in the one day Assessment and Management of Suicide Risk (AMSR) training, we developed a Suicide Prevention Toolkit (packets and electronic link) to distribute to primary care physicians, federally qualified healthcare centers and private hospital staff; and developed a prevention campaign directed toward young adults through local forums.

Does the state have any activities related to this section that you would like to highlight?

See attached Annual Report for the highlights.

Please indicate areas of technical assistance needed related to this section.

Technical assistance regarding how to stage implementation of suicide prevention efforts, how to sustain efforts and how to train staff when this takes away from their clinical work (fiscal balancing).

Footnotes:

1. OhioMHAS has a comprehensive Suicide Prevention Project Plan that is updated annually.

3. Yes, through the Zero Suicide teams this is an area of focus.

4. Yes, we sponsored Assessment and Management of Suicide Risk (AMSR) New Leader training with twelve clinicians completing the training.

Suicide Prevention SFY ’17 Annual Report

OhioMHAS Office of Quality, Planning and Research conducted a series of surveys to gather comprehensive information regarding the strengths of our existing suicide prevention programs and resources and to identify gaps that can inform our work moving forward. The entities surveyed included staff representing the county Alcohol, Drug, Addiction and Mental Health Services boards, community behavioral health providers, behavioral health crisis hotlines, and Suicide Prevention Coalitions. The executive summaries now available.

In collaboration with the Suicide Prevention Resource Center (SPRC), OhioMHAS offered five Zero Suicide Academies for behavioral health and primary care providers in five regions of the state. Thirty - two teams and approximately 140 community representatives participated in these academies that focused on organizational implementation of seven key strategies directed toward assisting persons at risk. The academies represent the department’s commitment to offer engage directly with behavioral health and primary care providers.

All Zero Suicide Academy teams were provided with the opportunity to participate in monthly Communities of Practice (CoP) for nine months after the Academies. These learning community type events support implementation of the key zero suicide strategies, shared learnings and collaboration. The CoPs are facilitated by SPRC staff and feature Ohio representatives and experts in the seven components of Zero Suicide.

OhioMHAS, in collaboration with the Recovery Board of Summit County, is piloting Cognitive Behavior Therapy training with clinical staff and supervisors. CBT is a best practice intervention that assists clinical staff in address patient suicide risk. All six Regional Psychiatric Hospitals (RPH) have staff and supervisors participating in the pilot. In total, eighteen staff are in the process of completing these requirements.

Assessment and Management of Suicide Risk (AMSR) has been identified by SPRC as a best practice for clinicians who may be working with individual at risk of suicide. To support more of this one-day training, the department provided a AMSR New Leader training to increase the number of qualified trainers in Ohio. Twelve clinicians received the new leader training in May. Upon completion of one additional training, they will be qualified as an AMSR trainer in Ohio.

The Research Institute of Nationwide Children’s Hospital is developing online training curriculum for staff and supervisors working at Crisis/Behavioral Health Hotlines. The training curriculum will be published when tested is completed, and will include a reference manual for those individuals who complete the course. The department’s goal is to elevate crisis hotline staff and supervisors’ skill level to offer the best outcomes for individuals in crisis. Our next step will involve collaboration with national accreditation organizations to ensure that all hotlines meet national standards.

The Ohio State University, College of Medicine staff are completing a study about lithium prescribing patterns for Medicaid-covered individuals to determine the benefits of lithium and other anti-depressants in preventing suicide deaths. The results of this study will be used to develop lithium prescribing guidelines. The study and guidelines will be published when completed and distributed to primary health and behavioral health practitioners.

The Research Institute of Nationwide Children's Hospital (RINCH), in conjunction with the Ohio University E.W. Scripps School of Journalism, developed Social Media Guidelines for journalists to utilize when reporting on suicide deaths. As part of this project, RINCHI conducted workshops on six Ohio college campuses to train both journalism students and journalists on the importance of these guidelines in preventing community contagions that can arise from news stories and on how to use these guidelines when reporting on a suicide death. These guidelines will be disseminated to the county Alcohol, Drug, Addiction and Mental Health Services boards to utilize with their communications and for distribution to community media representatives.

OhioMHAS developed a Suicide Prevention Toolkit that is directed to primary care providers. The toolkit is a compilation of existing information but available in hard copy or on our website.

OhioMHAS collaborated with the Ohio Suicide Prevention Foundation, The Department of Veteran Services, Chalmers Wylie VA Ambulatory Care Center to participate in the Ohio State Association of County Veterans Services Commissioners Spring Conference, April 2017. The conference hosted over 400 Commissioners in Ohio. The Conference agenda highlighted Suicide Prevention initiatives in Ohio.

Statewide Crisis Text Line Text 4HOPE to 741 741

National Suicide Prevention Lifeline

Environmental Factors and Plan

21. Support of State Partners - Required MHBG

Narrative Question

The success of a state's MHBG and SABG programs will rely heavily on the strategic partnership that SMHAs and SSAs have or will develop with other health, social services, and education providers, as well as other state, local, and tribal governmental entities. Examples of partnerships may include:

- The SMA agreeing to consult with the SMHA or the SSA in the development and/or oversight of health homes for individuals with chronic health conditions or consultation on the benefits available to any Medicaid populations;
- The state justice system authorities working with the state, local, and tribal judicial systems to develop policies and programs that address the needs of individuals with M/SUD who come in contact with the criminal and juvenile justice systems, promote strategies for appropriate diversion and alternatives to incarceration, provide screening and treatment, and implement transition services for those individuals reentering the community, including efforts focused on enrollment;
- The state education agency examining current regulations, policies, programs, and key data-points in local and tribal school districts to ensure that children are safe, supported in their social/emotional development, exposed to initiatives that target risk and protective factors for mental and substance use disorders, and, for those youth with or at-risk of emotional behavioral and SUDs, to ensure that they have the services and supports needed to succeed in school and improve their graduation rates and reduce out-of-district placements;
- The state child welfare/human services department, in response to state child and family services reviews, working with local and tribal child welfare agencies to address the trauma and mental and substance use disorders in children, youth, and family members that often put children and youth at-risk for maltreatment and subsequent out-of-home placement and involvement with the foster care system, including specific service issues, such as the appropriate use of psychotropic medication for children and youth involved in child welfare;
- The state public housing agencies which can be critical for the implementation of Olmstead;
- The state public health authority that provides epidemiology data and/or provides or leads prevention services and activities; and
- The state's office of homeland security/emergency management agency and other partners actively collaborate with the SMHA/SSA in planning for emergencies that may result in behavioral health needs and/or impact persons with behavioral health conditions and their families and caregivers, providers of behavioral health services, and the state's ability to provide behavioral health services to meet all phases of an emergency (mitigation, preparedness, response and recovery) and including appropriate engagement of volunteers with expertise and interest in behavioral health.

Please respond to the following items:

1. Has your state added any new partners or partnerships since the last planning period? (•) Yes ( ) No

2. Has your state identified the need to develop new partnerships that you did not have in place? ( ) Yes (•) No

If yes, with whom?

Ohio is developing new partnerships with hospitals, clinics and primary care setting in the implementation of the Opioid State Treatment Response grant project. Additionally, Ohio entered into a contract with the National Crisis Line to offer a text option which is accessed using the keyword, 4HOPE.

3. Describe the manner in which your state and local entities will coordinate services to maximize the efficiency, effectiveness, quality and cost-effectiveness of services and programs to produce the best possible outcomes with other agencies to enable consumers to function outside of inpatient or residential institutions, including services to be provided by local school systems under the Individuals with Disabilites Education Act.

OhioMHAS provides oversight to 50 county/multi-county ADAMH Boards which coordinate services to achieve outcomes in local communities. OhioMHAS collaborates ADAMH Boards and Ohio Department of Development to offer a range of housing options described in Step 1. Additionally, OhioMHAS has several programs to reduce inpatient hospitalization which include (1) Access to Success which provides one-time flexible funding for persons being discharged from state hospitals (2) PASRR which screens nursing home admissions of persons with SMI to reduce inappropriate admissions to nursing facilities (3) Recovery Requires a Community that provide flexible funding to assist a person with SMI, SED and/or SUD to voluntarily transition from an institution to the community, (4) Forensic monitoring which facilitates community living for persons on conditional release from the state hospital for forensic patients. For children and youth, Ohio has long funded county Family and Children First Councils which plan and coordinate services for high need children who are being served by multiple agencies (e.g. child welfare, juvenile justice, special education, developmental disabilities, mental health and substance abuse).

Does the state have any activities related to this section that you would like to highlight?

Ohio Stepping Up Initiative to Reduce Jail Incarceration

Stepping Up is a national initiative targeted at reducing the number of people with mental illnesses in jails. Without change, large numbers of people with mental illnesses (many with co-occurring substance use disorders) will continue to cycle through the criminal justice system, often resulting in missed opportunities to link them to treatment, tragic outcomes, inefficient use of funding, and failure to improve public safety.

The Ohio Department of Mental Health and Addiction Services (OhioMHAS) is collaborating with other leading organizations and local experts to support the common goal. The Stepping Up initiative engages a diverse group of organizations, including those representing sheriffs, jail administrators, judges, community corrections professionals, treatment providers, people with mental illnesses and their families, mental health and substance use program directors, and other stakeholders. Through its Community Innovations grants, which began in 2014, OhioMHAS took action to help counties reduce the number of criminal offenders with untreated mental illness and/or substance use disorders who continually cycle through county jails.

Please indicate areas of technical assistance needed related to this section.

None requested.

Footnotes:

Environmental Factors and Plan

22. State Behavioral Health Planning/Advisory Council and Input on the Mental Health/Substance Abuse Block Grant Application - Required MHBG

Narrative Question

Each state is required to establish and maintain a state Mental Health Planning/Advisory Council for adults with SMI or children with SED. To meet the needs of states that are integrating services supported by MHBG and SABG, SAMHSA is recommending that states expand their Mental Health Advisory Council to include substance misuse prevention, SUD treatment, and recovery representation, referred to here as a Behavioral Health Advisory/Planning Council (BHPC). SAMHSA encourages states to expand their required Council's comprehensive approach by designing and implementing regularly scheduled collaborations with an existing substance misuse prevention, SUD treatment, and recovery advisory council to ensure that the council reviews issues and services for persons with, or at risk, for substance misuse and SUDs. To assist with implementing a BHPC, SAMHSA has created **Best Practices for State Behavioral Health Planning Councils: The Road to Planning Council Integration.**[72]

Planning Councils are required by statute to review state plans and implementation reports; and submit any recommended modifications to the state. Planning councils monitor, review, and evaluate, not less than once each year, the allocation and adequacy of mental health services within the state. They also serve as an advocate for individuals with behavioral health problems. SAMHSA requests that any recommendations for modifications to the application or comments to the implementation report that were received from the Planning Council be submitted to SAMHSA, regardless of whether the state has accepted the recommendations. The documentation, preferably a letter signed by the Chair of the Planning Council, should state that the Planning Council reviewed the application and implementation report and should be transmitted as attachments by the state.

[72] **http://beta.samhsa.gov/grants/block-grants/resources**

Please respond to the following items:

1. How was the Council involved in the development and review of the state plan and report? Attach supporting documentation (e.g. meeting minutes, letters of support, etc...)

a) What mechanism does the state use to plan and implement substance misuse prevention, SUD treatment and recovery services?

Ohio has a a combined Substance Abuse and Mental Health Block Grant Plan prepared by an integrated MH/SA state department. The Plan is reviewed by an integrated Planning Council through a Block Grant Committee process. The Block Grant Committee organizes the review, and invites all Planning Council members to participate. Each member volunteers to focus on a population, and provides written comments to the Block Grant Committee. The Block Grant Committee develops recommendations which is attached to a cover letter from the chairperson of Planning Council. The Planning Council reviews, edits and votes on the recommendations at its August meeting. The report, with a focus on performance indicators, is reviewed at the November/December 1 meeting. Additionally, the Council meets three times a year with the Director, as well as an additional three times a year with the Block Grant Coordinator/State Planner, and the Deputy Director of Quality, Planning and Research to hear presentations, provide informal recommendations to staff of OhioMHAS and its partners. For documentation, please see attached letter and recommendations from the Council.

b) Has the Council successfully integrated substance misuse prevention and treatment or co-occurring disorder issues, concerns, and activities into i — (●) Yes ( ) No

2. Is the membership representative of the service area population (e.g. ethnic, cultural, linquistic, rural, suburban, urban, older adults, families of young children)? — (●) Yes ( ) No

3. Please indicate the duties and responsibilities of the Council, including how it gathers meaningful input from people in recovery, families, and other important stakeholders, and how it has advocated for individuals with SMI or SED.

The Council annually reviews the Combined SA/MH Block Grant Application/Plan, and makes recommendations to OhioMHAS. Council members invited presentations on advocacy from NAMI -Ohio and Ohio Citizens for Addiction Recovery. Planning Council members advocated to OhioMHAS' director and other state staff and providers for quality services which meet the needs of its citizens. Additionally, Planning Council members staffed tables at a peer support and trauma training events to gather meaningful input from persons in recovery. OhioMHAS' Planning Council includes representatives of advocacy organizations which facilitates the use of Block Grant information through advocacy organizations (e.g. NAMI- Ohio). Additionally, Planning Council monitors the adequacy and accessibility of services by reviewing Step 2 of the Application/Plan and by reviewing the annual Implementation Report.

Does the state have any activities related to this section that you would like to highlight?

OhioMHAS Planning Council members engaged Advocacy for Human Potential for technical assistance in 2016 - 2017. The Council completed an assessment using a SWOT analysis, and completed a strategic plan. On May 12, 2017, the Council approved the

following priorities for their strategic plan:
1. Improve council effectiveness and sustainability.
2. Monitor and review service delivery system for quality and recovery oriented results.
3. Remain apprised and prepared for action (as appropriate within the Council's scope) in response to state and federal political, legislative, and funding developments that impact behavioral health services and citizens who need those services.

Please indicate areas of technical assistance needed related to this section.

None requested at this time. During calendar 2016 and 2017, Ohio's Planning Council completed a strategic plan with SAMHSA funded technical assistance from John Hudgens of Advocacy for Human Potential (APH) funded by SAMHSA. We also used slides prepared by APH to orient Planning Council members.

Additionally, please complete the Behavioral Health Advisory Council Members and Behavioral Health Advisory Council Composition by Member Type forms.[73]

[73]There are strict state Council membership guidelines. States must demonstrate: (1) the involvement of people in recovery and their family members; (2) the ratio of parents of children with SED to other Council members is sufficient to provide adequate representation of that constituency in deliberations on the Council; and (3) no less than 50 percent of the members of the Council are individuals who are not state employees or providers of mental health services.

Footnotes:

Ohio Community Recovery Support Planning Council

August 26, 2017

Dr. Elinore McCance-Katz
Substance Abuse and Mental Health Services Administration
5600 Fisher Lane
Rockville, MD 20850

Re: Ohio's Substance Abuse and Mental Health Block Grant Application

Dear Dr. McCance-Katz,

The Ohio Community Recovery Support Planning Council reviewed the Ohio Mental Health and Addiction Services' fiscal year 2018 - 2019 application for Substance Abuse and Mental Health Block Grants. After reviewing the application, the Block Grant Committee developed the attached list of recommendations that was reviewed and approved by the Planning Council. These recommendations will be shared with Director Tracy Plouck and other management staff. Additionally, the Council has met with Director Tracy Plouck and other management staff of OhioMHAS to discuss Ohio's mental health and addiction services.

Sincerely,

David Caperton
Chair
Ohio Community Recovery Support Planning Council

Attachment

Cc Tracy Plouck
Angie Bergefurd
James Lapczynski
Jody Lynch
Mark Hurst, MD
Daniel Schreiber
Sanford Starr
Liz Gitter

SFY 2018 Block Grant Plan Recommendations

1. Increase service availability for children with high intensity service needs, and supports for their families, including in rural areas. Services needed include wraparound, Intensive Home Based Treatment, coordination of services, and Family and Children First.

2. Grow early intervention and prevention for children; expand the Good Behavior Game to all school districts.

3. OhioMHAS should address the shortage of child psychiatrists.

4. For transitional-age youth, take what is working, and spread it around the state. Include young adults who provide peer support.

5. For persons involved with the criminal justice system, early assessment provides the best opportunity for treatment.

6. Increase court diversion to divert from jail to substance use disorder (SUD) and mental health treatment.

7. Increase transitional programs for those exiting the criminal justice system with SUD and mental health issues.

8. Put peer supporters into community hospital emergency rooms (ER).

9. Increase peer support training and placement, peer mentoring and recovery supports.

10. *Recovery housing providers should have required professional development, Narcan on site, and require reports of major unusual incidents.*

11. *With attention opioids are receiving, the Council encourages OhioMHAS to continue efforts for all substances of abuse; we've had increase in ER visits for Cocaine and chemically sprayed cannabis. Alcohol related deaths are at an all-time high.*

12. Transportation and housing are needed as a recovery support, especially in rural areas.

13. Expand the number of qualified treatment providers, especially child psychiatrists.

14. Encourage and fund efforts to increase education, cooperation, and inclusion of populations at higher risk for suicide.

Environmental Factors and Plan

Behavioral Health Advisory Council Members

Start Year: 2018 End Year: 2019

Name	Type of Membership	Agency or Organization Represented	Address,Phone, and Fax	Email(if available)
Walter Asbury	Others (Not State employees or providers)	Disability Rights Ohio	Westerville OH,	waltasbury@hotmail.com
Stephen Banks	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Milford OH,	bpd2525@hotmail.com
David Caperton	Others (Not State employees or providers)	Ohio Citizens Advocates for Addiction Recovery	Organizational Representative Medina OH,	autoseller1110@yahoo.com
Lisa Carter	Providers	South Community	1349 E. Stroup St. Kettering OH, 43215 PH: 614-230-6049	Lcarter@southcommunitiy.com
Lisa Clark	Providers	Ohio Guidestone	Ohio Guidestone Columbus OH, 43215	Lisa.Clark@ohioguidestone.org
Greg Collier	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Toledo OH, 43608	gjcollier8@att.net
Craig Commedy	Providers	UMADAOP (Urban Minority Addiction Outreach)	UMADAOP Columbus OH,	columbus@umadaopfc.com
Cheryl Crayden	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Orrville OH, 44667	cherylcrayden@zoominternet.net
Bob Cross	Others (Not State employees or providers)		Columbus OH, 43221	Bcross41@yahoo.com
Karen Dickerson	Parents of children with SED		110 Simms Ave., Apartment C Newark OH, 43055	
Lee Donoho	Others (Not State employees or providers)		352 Fernbank Road Muskingum OH, 43701	
Starla Doty	Others (Not State employees or providers)		Newark OH,	dstarla59@gmail.com
Cynthia Ferran	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)	YouthMove	OH, 43215	Cynthiafernan10@gmail.com
Wayne Ford	Others (Not State employees or providers)	Peer Operated Organization - Focus on Friends	Focus on Friends Findlay OH, 45840	WFord@focusonfriends1.com
Elizabeth Gitter	State Employees	Ohio Department of Mental Health and Addiction Services	OH, 43215	Elizabeth.Gitter@mha.ohio.gov

John Heer	Others (Not State employees or providers)		730 Hearthstone Circle Copley OH, 44320	johnheer@gmail.com
Alaina Herrel	Others (Not State employees or providers)	Ohio Assoc of County Behavioral Health Authorities	Ohio Association of County Behavioral Health Authorities Columbus OH, 43215	aherrel@oacbha.org
Ahmed Hosni	Others (Not State employees or providers)		Westerville OH, 43081	
Emilia Jackson	State Employees	Ohio Department of Aging	Columbus OH,	ejackson@age.com
Lisa Janacovich	Family Members of Individuals in Recovery (to include family members of adults with SMI)		Parma Heights OH, PH: 440-502-8305	
Brian Jones	Others (Not State employees or providers)		623 Williams Street Painesville OH, 44077	wallyjonz123@gmail.com
Sandra Keyes	Others (Not State employees or providers)		Columbus OH, 43221	sandrakeys@columbus.rr.com
Jennifer Koontz	Others (Not State employees or providers)		OH, 43123	KoontzJLK@gmail.com
Diane Mang	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		214 Taggart Ave NE Massillon OH, 44646	dianemang@apsdreamworks.com
Dustin McKee	Family Members of Individuals in Recovery (to include family members of adults with SMI)	NAMI Ohio	NAMI Ohio OH, 43215	dustin@namiohio.org
Tamisha McKenzie	Parents of children with SED		Columbus OH,	mckenzie.tamisha@gmail.com
Kimberly Meals	Providers	Community Support Services	Community Support Services - MH Akron OH, 44311	mealskim@cssbh.org
Barbara Miller	State Employees	OH Dept. of Development - housing	Ohio Dept of Development housing Columbus OH, 43215	barbara.miller@development.ohio.gov
Jennilee Mohler	Individuals in Recovery (to include adults with SMI who are receiving, or have received, mental health services)		Walbridge OH, 43465	JJWBJ1@gmail.com
Alissa Otani-Cole	State Employees	OOD Rehabiliation Services Commission employment		alissa.Otani-Cole@ood.ohio.gov
James Ryan	Providers		ADAPO - Prevention Provider organization P O Box 2394 OH, 43216	mail@adapao.org
Michele Shock	Providers	Miami County Recovery Council	Women's SUD Treatment Troy OH, 45373	dpage@mcrcinc.org
Nichole Small	State Employees	Ohio Department of Medicaid	Columbus OH, 43215	Nichole.Small@medicaid.ohio.gov

Mark Smith	State Employees	Ohio Department of Education	Ohio Department of Education Columbus OH, 43215	Mark.Smith@education.ohio.gov
Donna Thomas	State Employees	Ohio Dept of Rehabiliation and Corrections	Ohio Dept of Rehabilitation and Corrections Columbus OH, 43215	Donna.Thomas@odrc.state.oh.us
Susan Williams	State Employees		Ohio Department of Job and Family Services Columbus OH, 43215	Susan.Williams@jfs.ohio.gov

Footnotes:

Persons listed as "Others (not State Employees or providers) are persons in recovery from addiction and/or family members).

Susan Williams represents Ohio Department of Job and Family Services (ODJF) for Social Services (Block Grant) and child welfare, which are in the same bureau. (BGAS will not save organizational information. We changed bylaws to have one person represent both social services and child welfare, since both are housed in the same bureau within ODJFS.

Environmental Factors and Plan

Behavioral Health Council Composition by Member Type

Start Year: 2018 End Year: 2019

Type of Membership	Number	Percentage
Total Membership	**38**	
Individuals in Recovery* (to include adults with SMI who are receiving, or have received, mental health services)	5	
Family Members of Individuals in Recovery* (to include family members of adults with SMI)	3	
Parents of children with SED*	2	
Vacancies (Individuals and Family Members)	1	
Others (Not State employees or providers)	12	
Total Individuals in Recovery, Family Members & Others	**23**	**60.53%**
State Employees	8	
Providers	6	
Vacancies	1	
Total State Employees & Providers	**15**	**39.47%**
Individuals/Family Members from Diverse Racial, Ethnic, and LGBTQ Populations	5	
Providers from Diverse Racial, Ethnic, and LGBTQ Populations	1	
Total Individuals and Providers from Diverse Racial, Ethnic, and LGBTQ Populations	**6**	
Persons in recovery from or providing treatment for or advocating for substance abuse services	11	
Federally Recognized Tribe Representatives	0	
Youth/adolescent representative (or member from an organization serving young people)	0	

* States are encouraged to select these representatives from state Family/Consumer organizations.

Indicate how the Planning Council was involved in the review of the application. Did the Planning Council make any recommendations to modify the application?

See attachment for Planning Council's 14 recommendations. The Plan is reviewed by an integrated Planning Council through a Block Grant Committee process. The Block Grant Committee organizes the review, and invites all Planning Council members to participate. Each member volunteers to focus on one or more populations, and provides written comments to the Block Grant Committee. Block Grant Committee develops recommendations which is attached to a cover letter from the chairperson of Planning Council. The Planning Council reviews, edits and votes on the recommendations.

Footnotes:

Environmental Factors and Plan

23. Syringe Services (SSP)

Narrative Question:

The Substance Abuse Prevention and Treatment Block Grant (SABG) restriction[1,2] on the use of federal funds for programs distributing sterile needles or syringes (referred to as syringe services programs (SSP)) was modified by the **Consolidated Appropriations Act,** , 2016 (P.L. 114-113) signed by President Obama on December 18, 2015[3].

Section 520. *Notwithstanding any other provisions of this Act, no funds appropriated in this Act shall be used to purchase sterile needles or syringes for the hypodermic injection of any illegal drug: Provided, that such limitation does not apply to the use of funds for elements of a program other than making such purchases if the relevant State or local health department, in consultation with the Centers for Disease Control and Prevention, determines that the State or local jurisdiction, as applicable, is experiencing, or is at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, and such program is operating in accordance with State and local law.*

A state experiencing, or at risk for, a significant increase in hepatitis infections or an HIV outbreak due to injection drug use, (as determined by CDC), may propose to use SABG to fund elements of a SSP other than to purchase sterile needles or syringes. However, directing FY 2016 SABG funds to SSPs will require a modification of the 2016-2017 SABG Behavioral Assessment and Plan (Plan). States interested in directing SABG funds to SSPs must provide the information requested below and receive approval on the modification from the State Project Officer. Please note that the term used in the SABG statute and regulation, *intravenous drug user* (IVDU) is being replaced for the purposes of this discussion by the term now used by the federal government, *persons who inject drugs* (PWID).

States may consider making SABG funds available to either one or more entities to establish elements of a SSP or to establish a relationship with an existing SSP. States should keep in mind the related PWID SABG authorizing legislation and implementing regulation requirements when modifying the Plan, specifically, requirements to provide outreach to PWID, SUD treatment and recovery services for PWID, and to routinely collaborate with other healthcare providers, which may include HIV/STD clinics, public health providers, emergency departments, and mental health centers[4]. SAMHSA funds cannot be supplanted, in other words, used to fund an existing SSP so that state or other non-federal funds can then be used for another program.

In the first half of calendar year 2016 the federal government released three guidance documents regarding SSPs[5]: These documents can be found on the Hiv.gov website: **https://www.hiv.gov/federal-response/policies-issues/syringe-services-programs ,**

1. **Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016** from The US Department of Health and Human Services, Office of HIV/AIDS and Infectious Disease Policy **https://www.hiv.gov/sites/default/files/hhs-ssp-guidance.pdf ,**
2. **Centers for Disease Control and Prevention (CDC)Program Guidance for Implementing Certain Components of Syringe ServicesPrograms,2016** The Centers for Disease Control and Prevention, National Center for HIV/AIDS, Viral Hepatitis, STD and TB Prevention, Division of Hepatitis Prevention **http://www.cdc.gov/hiv/pdf/risk/cdc-hiv-syringe-exchange-services.pdf,**
3. **The Substance Abuse and Mental Health Services Administration (SAMHSA)-specific Guidance for States Requesting Use of Substance Abuse Prevention and Treatment Block Grant Funds to Implement SSPs http://www.samhsa.gov/sites/default/files/grants/ssp-guidance-state-block-grants.pdf ,**

Please refer to the guidance documents above when requesting a modification to the state?s 2016-2017 Behavioral Health Assessment and Plan.

Please follow the steps listed below to modify the Plan:

- Request a Determination of Need from the CDC
- Modify the 2016-2017 Plan to expend FFY 2016 and/or FFY 2017* funds and support an existing SSP or establish a new SSP
- Include proposed protocols, timeline for implementation, and overall budget

- Submit planned expenditures and agency information on **Table A** listed below
- Obtain State Project Officer Approval
- Collect **all** SSP information on **Table B** listed below to be reported in the FFY 2019 SABG report due December 1, 2018

End Notes

[1] Section 1923 (b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-23(b)) and 45 CFR ? 96.126(e) requires entities that receive SABG funds to provide substance use disorder (SUD) treatment services to PWID to also conduct outreach activities to encourage such persons to undergo SUD treatment. Any state or jurisdiction that plans to re-obligate FY 2016 SABG funds previously made available such entities for the purposes of providing substance use disorder treatment services to PWID and outreach to such persons may submit an amendment to its plan to SAMHSA for the purpose of incorporating elements of a SSP in one or more such entities insofar as the plan amendment is applicable to the FY 2016 SABG funds ***only*** and is consistent with guidance issued by SAMHSA.

[2]Section 1931(a(1)(F) of Title XIX, Part B, Subpart II of the Public Health Service (PHS) Act (42 U.S.C.? 300x-31(a)(1)(F)) and 45 CFR ? 96.135(a)(6) explicitly prohibits the use of SABG funds to provide persons who inject drugs (PWID) with hypodermic needles or syringes so that such persons may inject illegal drugs unless the Surgeon General of the United States determines that a demonstration needle exchange program would be effective in reducing injection drug use and the risk of HIV transmission to others. On February 23, 2011, the Secretary of the U.S. Department of Health and Human Services published a notice in the Federal Register (76 FR 10038) indicating that the Surgeon General of the United States had made a determination that syringe services programs, when part of a comprehensive HIV prevention strategy, play a critical role in preventing HIV among PWID, facilitate entry into SUD treatment and primary care, and do not increase the illicit use of drugs.

[3] Division H Departments of Labor, Health and Human Services and Education and Related Agencies, Title V General Provisions, Section 520 of the Consolidated Appropriations Act, 2016 (P.L. 114- 113)

[4] Section 1924(a) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-24(a)) and 45 CFR ? 96.127 requires entities that receives SABG funds to routinely make available, directly or through other public or nonprofit private entities, tuberculosis services as described in section 1924(b)(2) of the PHS Act to each person receiving SUD treatment and recovery services.

Section 1924(b) of Title XIX, Part B, Subpart II of the PHS Act (42 U.S.C. ? 300x-24(b)) and 45 CFR 96.128 requires ?designated states? as defined in Section 1924(b)(2) of the PHS Act to set- aside SABG funds to carry out 1 or more projects to make available early intervention services for HIV as defined in section 1924(b)(7)(B) at the sites at which persons are receiving SUD treatment and recovery services.

Section 1928(a) of Title XXI, Part B, Subpart II of the PHS Act (42 U.S.C. 300x-28(c)) and 45 CFR 96.132(c) requires states to ensure that substance abuse prevention and SUD treatment and recovery services providers coordinate such services with the provision of other services including, but not limited to, health services.

[5]***Department of Health and Human Services Implementation Guidance to Support Certain Components of Syringe Services Programs, 2016*** describes a SSP as a comprehensive prevention program for PWID that includes the provision of sterile needles, syringes and other drug preparation equipment and disposal services, and some or all of the following services:

- Comprehensive HIV risk reduction counseling related to sexual and injection and/or prescription drug misuse;
- HIV, viral hepatitis, sexually transmitted diseases (STD), and tuberculosis (TB) screening;
- Provision of naloxone (Narcan?) to reverse opiate overdoses;
- Referral and linkage to HIV, viral hepatitis, STD, and TB prevention care and treatment services;
- Referral and linkage to hepatitis A virus and hepatitis B virus vaccinations; and
- Referral to SUD treatment and recovery services, primary medical care and mental health services.

Centers for Disease Control and Prevention (CDC) Program Guidance for Implementing Certain Components of Syringe Services Programs, 2016 includes a description of the elements of a SSP that can be supported with federal funds.

- Personnel (e.g., program staff, as well as staff for planning, monitoring, evaluation, and quality assurance);
- Supplies, exclusive of needles/syringes and devices solely used in the preparation of substances for illicit drug injection, e.g., cookers;
- Testing kits for HCV and HIV;
- Syringe disposal services (e.g., contract or other arrangement for disposal of bio- hazardous material);

- Navigation services to ensure linkage to HIV and viral hepatitis prevention, treatment and care services, including antiretroviral therapy for HCV and HIV, pre-exposure prophylaxis, post-exposure prophylaxis, prevention of mother to child transmission and partner services; HAV and HBV vaccination, substance use disorder treatment, recovery support services and medical and mental health services;
- Provision of naloxone to reverse opioid overdoses
- Educational materials, including information about safer injection practices, overdose prevention and reversing a opioid overdose with naloxone, HIV and viral hepatitis prevention, treatment and care services, and mental health and substance use disorder treatment including medication-assisted treatment and recovery support services;
- Condoms to reduce sexual risk of sexual transmission of HIV, viral hepatitis, and other STDs;
- Communication and outreach activities; and
- Planning and non-research evaluation activities.

Footnotes:

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table A

Syringe Services Program SSP Agency Name	Main Address of SSP	Dollar Amount of SABG funds used for SSP	SUD Treatment Provider	Number Of Locations (include mobile if any)	Narcan Provided
No Data Available					

Footnotes:

Environmental Factors and Plan

Syringe Services (SSP) Program Information-Table B

Syringe Service Program Name	# of Unique Individuals Served		*[Please enter total number of individuals served]*				
			HIV Testing	Treatment for Substance Use Conditions	Treatment for Physical Health	STD Testing	Hep C
	0	ONSITE Testing	0	0	0	0	0
		Referral to testing	0	0	0	0	0

Footnotes:

Environmental Factors and Plan

24. Public Comment on the State Plan - Required

Narrative Question

Title XIX, Subpart III, section 1941 of the PHS Act (42 U.S.C. § 300x-51) requires, as a condition of the funding agreement for the grant, states will provide an opportunity for the public to comment on the state block grant plan. States should make the plan public in such a manner as to facilitate comment from any person (including federal, tribal, or other public agencies) both during the development of the plan (including any revisions) and after the submission of the plan to SAMHSA.

Please respond to the following items:

1. Did the state take any of the following steps to make the public aware of the plan and allow for public comment?

a) Public meetings or hearings? ○ Yes ◉ No

b) Posting of the plan on the web for public comment? ◉ Yes ○ No

If yes, provide URL:

http://mha.ohio.gov/Default.aspx?tabid=235

OhioMHAS posts the Block Grant Plan for comment, and notifies major stakeholder organizations to give their members an opportunity to comment. The Plan is also reviewed by a Block Grant Committee that includes representatives of various stakeholder groups including, but not limited to, persons in recovery, family members, providers and state agencies.

c) Other (e.g. public service announcements, print media) ○ Yes ◉ No

Footnotes: