Ohio Mental Health and Addiction Services (OhioMHAS)

Community Plan Guidelines SFY 2014

Environmental Context of the Plan/Current Status

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

Factors Influencing Service Delivery

Mental Health Recovery Services of Warren & Clinton Counties (MHRS) is experiencing what I am calling "The Terrible Twos". Warren County is not only the 2nd fastest growth county in the state but is the 2nd lowest state funded Board Area in the state as well. This is making for a terrible scenario and one we cannot afford.

Additionally, with the closure of the DHL hub in Wilmington in November 2008, Wilmington (with a population of 12,000) lost 7,000 jobs (New York Times, 2008), 3,000 were held by residents in Wilmington and Clinton County (CNN, 2008). Clinton County, at the present time, continues to have the 7th highest unemployment rate in the state of Ohio, at 9.8% (Ohio Department of Job and Family Services, 2012).

Of course this larger group of unemployed individuals cuts across several age groups, and specifically includes young adults (Ohio Department of Jobs and Family Services, 2011), but because of the DHL closure, this finding has local significance with regard to older adults and families.

Fortunately, MHRS has not passed on to our provider systems any reductions in funding allocations from the state departments. This has been accomplished through strategic planning improvement initiatives including mergers in order to reduce costs while improving services. It is not my intent to report on these initiatives at this time, although identifying any additional initiatives that will significantly impact further reductions in costs are very unlikely.

MHRS has seen a 75% increase in the number of unduplicated clients served since 2002. Any cost reductions in our system have been reallocated to expansion of services. Based upon outcomes, MHRS is one of the Board Areas that have been the most efficient in reducing state hospital costs as well as producing one of the highest numbers of consumer participants in vocational/employment programs in the state. This has not been without its costs.

In past years, MHRS' percentage of total revenues generated from local tax levies was anywhere between 25% and 32% (fluctuations due to changes in state, federal and grant funding). Today, in FY14, MHRS' local tax levies account for 61% of our total revenues primarily due to insufficient funds from the state. In June 2013 my Board of Directors approved the FY 2014 budget showing a projected loss of $1,007,125. We are estimating the projected loss will be offset by approximately $200,000 with the new funding from FY14 allocation. We are utilizing reserve funding for services and have projected by FY 2016, if additional revenues are not identified, we will be in a major financial deficit.

Simply put, MHRS has been a "team player" but is not getting its "fair share" of state funding allocations. It is undoubtedly a daunting task for the State Department, although the disparities between Board Areas continue to plague our system.

In September 23, 2010 five board areas, including MHRS, met with Angela Dawson to address our concerns with the inconsistencies in the state funding and population shifts. At that time MHRS was funded at $4.16 per capita (ODADAS state funds only) which was the second lowest average in the state. My concerns regarding funding disparity have previously been written in MHRS' "Community Plans" to the State Departments unfortunately the issue of state

funding disparity continues.

Today, SFY 2014 MHRS remains the second lowest state funded board area (combined MH and AoD funds) with an average of $7.99 per capita. The other five board areas referenced above are now either at or near the state averages ($10.16) or exceeding it. I realize the State Department does not want to take funding away from any board and I am glad to see that the 2012 census data was considered in determining FY 2014 state funding allocations. In order to make an equal playing field among the boards the new funds ($50M) could have been allocated in such a manner that greater equity could have been attained. Unfortunately this did not happen.

Now there is a new set of disparity boards in the state, and MHRS continues to be included in the disparity board group. I suppose someone will always be on the top or bottom of the list yet the extreme disparity between the boards (i.e., highest paid board area receives $23.08 per capita and the lowest paid board area receives just $7.82 per capita) is problematic for everyone in the behavioral health care system. I believe many Board Areas would concur that a maximum and minimum amount needs to be considered in order to establish greater equity. This was not done.

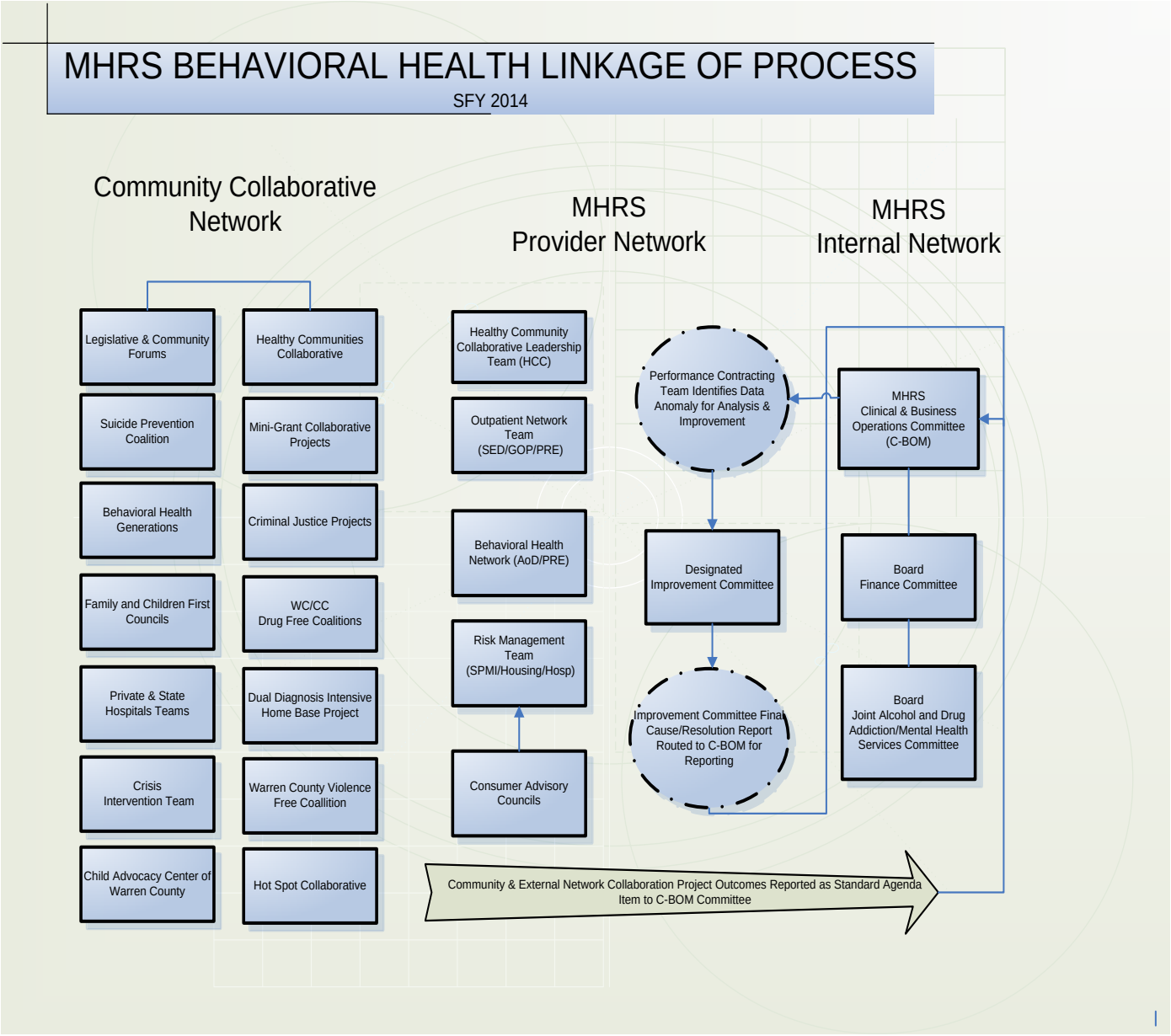
Assessment of Need and Identification of Gaps and Disparities

2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gap issues and disparities, if any. (NOTE: ORC 340.03 requires service needs review of: (1) child service needs resulting from finalized dispute resolution with Family & Children First Councils; and, (2) outpatient service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals)

Methodology

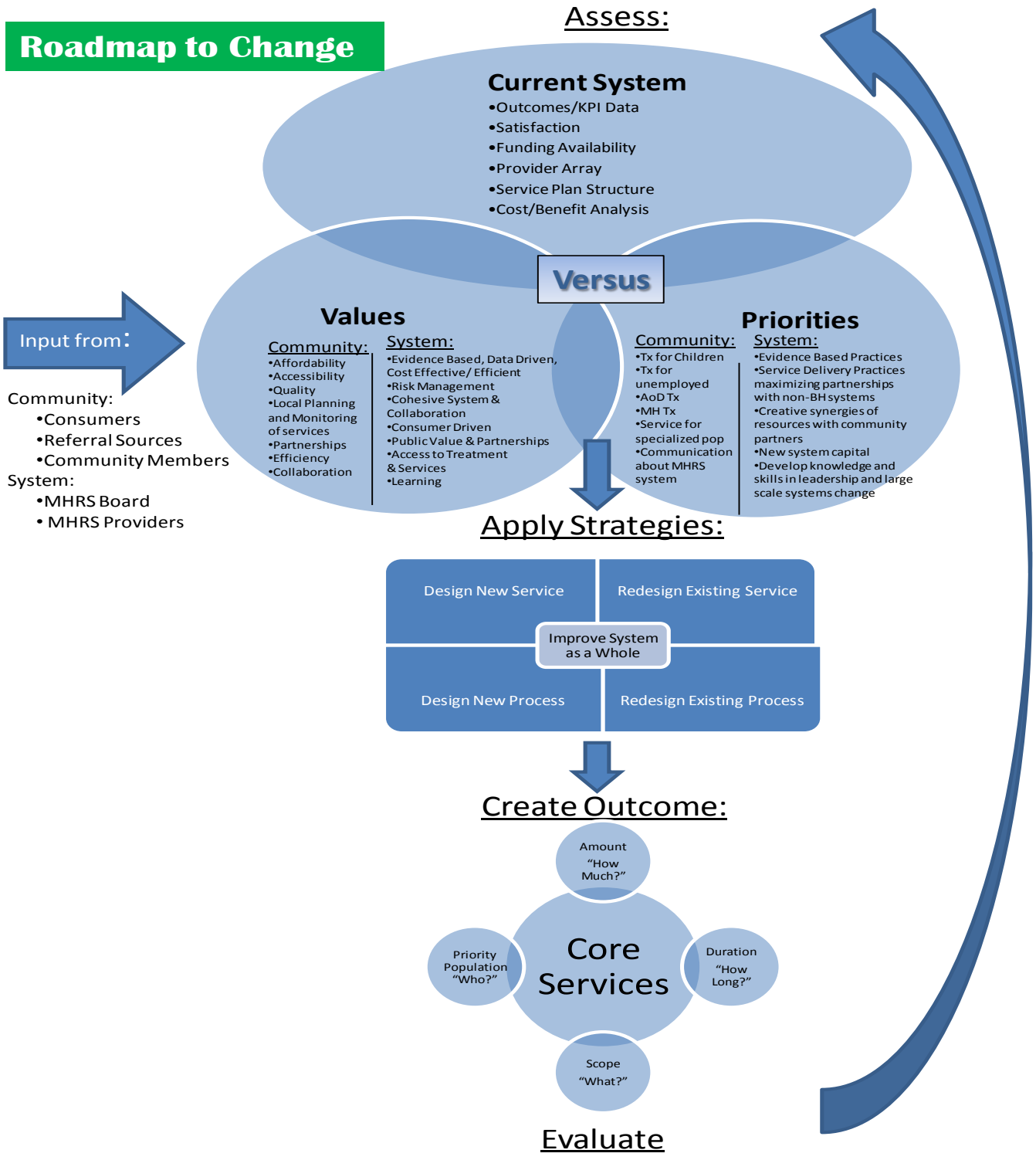
MHRS developed a business model in FY 2005 where attention was given toward identifying processes with concrete measures for determining progress. The business model is considered a living document; therefore, improvement changes to the business model have and will continue to be been made throughout the years.

Underlying the activities are our working principles and values such as accountability measured as idealism, collaboration and learning. The model depicts “how” information is gathered and “what” information is being monitored and evaluated to guide planning, funding and improvement efforts. The “**MHRS Behavioral Health Linkage of Process**” depicts the network linkages between MHRS and with its contract providers. In addition to defining our working relationship with our contract providers, the model incorporates a community linkage with non-behavioral health care organizations (i.e. Courts, Child Advocacy Center, and D.D. Services).



Developing community "partnerships" is a key component of the business plan that has resulted in improvements for both systems. These types of initiatives have reduced duplications in services and reduced costs. Embracing a business model based on clearly defined methodologies; a working relationship with our contract providers centered on accountability, and establishing community partnerships with key constituents has greatly assisted the organization in maintaining a financially sound system.

The inputs received from these specific sources are then utilized by MHRS for the development of improvement strategies leading to the creation of specific core services and outputs and/or outcomes. The "**Roadmap to Change**" depicts the methodology utilized by MHRS for developing improvement strategies and the creation of specific core services.



MHRS collects and reviews annually key performance indicators (KPI) data with its contract providers. Key Performance Indicator data is specific to each Service Plan by Population (i.e., SPMI; SED; AoD; Outpt. and Prevention). In addition to the ongoing inputs as depicted in the "Roadmap to Change" diagram, MHRS collects information from specialized groups and/or populations as deemed appropriate for planning purposes and improvements.

Formal Needs Assessment
Alcohol Drug Addiction Project Needs Assessment Findings

In 2012, MHRS conducted a formal needs assessment process with key-stakeholders in an effort to establish a sustainable coalition. Because of existing stakeholder relationships; a contract was established with the Family and Children's First Council (FCFC) in both Warren and Clinton Counties. The FCFC in both communities developed subgroups to explore and oversee the project.

Subgroups from both FCFC worked collaboratively with consultants to obtain necessary information for the completion of the Assessment. Data was obtained from the following sources: (1) A review of existing sources of information relevant to the drug and alcohol problem in the state of Ohio generally as well as county data specific to existing drug and alcohol use; (2) relevant quantitative data obtained from a variety of local agencies and organizations; (3) a community-wide survey; and (4) Key Stakeholder Interviews.

MHRS recognizes that assessment is an ongoing process, and data collection should be reliable, valid and demonstrate fidelity throughout the collection process. This formal needs assessment utilized existing data, both quantitative and qualitative. There is a clear gap in the lack of youth interviews/input into this assessment process. MHRS recognizes this and has taken steps to assure a more thorough, and consistent data collection is in place for both counties.

Review of Existing Documentation/Relevant Quantitative Data:
Subgroups from both the Warren County and the Clinton County FCFC provided a significant amount of information relevant to the drug and alcohol problems in the state as well as county specific. The Ohio Department of Health created Community Health Profiles for the state of Ohio and for each of the 88 counties in 2008. The following information was detailed in the Community Health Profile for Warren and Clinton County in December of that year (Ohio Department of Health, 2008):

- 4.8% of Warren County adults – as compared to 5.4% of Ohio residents – reported heavy drinking of alcoholic beverages;
- 24.9% of Warren County adults reported smoked cigarettes, as compared to 23.6% of Ohio adults; and
- Between 2004 and 2006, 11% of mothers living in Warren County smoked cigarettes during their pregnancy, as compared to 18.1% percent of pregnant mothers in Ohio.
- Tobacco use among expectant mothers in Clinton County showed relatively high prevalence with a rate of 21.6%, ranking Clinton County the 3rd highest among a total of eight peer counties (2007); significantly higher than the rates observed in Ohio (i.e., 17.9%) and the United States (i.e., 11.2%) overall.
- Clinton County was ranked 64th out of the 88 Ohio counties with regard to health outcomes and morbidity measures and 55th with regard to health factors (2012).
- 40 drug poisoning deaths were observed between 2006 and 2010, at a rate of 18.7 deaths per 100,000, a rate placing Clinton County as the county with the 12th (out of 88 counties) highest rate of drug poisoning deaths, notably higher than the rate observed in the state of Ohio overall (i.e., 12.2 deaths
- per 100,000).
- Seventeen men and women on probation with the Warren County Common Pleas court have overdosed on opiate drugs since 2012.

Community-wide survey & Key Stakeholder Interviews:
Warren and Clinton County residents or individuals who worked in Warren or Clinton County were sought to respond to the FCFC ADAP Needs Assessment Survey, which ran from April 18, 2012 to June 19, 2012. The survey was distributed, in Warren County, electronically through a web based survey link and an introductory email that was sent to members of the subgroup. That group then forwarded a prepared email, which included the survey distribution email and link, to a list of contacts with whom they had been working for the month preceding explaining the need and model of the distribution. That list of contacts was identified by the subgroup as community members/leaders who

would distribute the survey to their e-mail network (e.g., superintendents of the schools would send out the introductory e-mail and survey link to all staff, employees, and parents) or would post the link to the survey where others would access it (e.g., flyers in waiting rooms, on blogs or websites frequented by parents, agencies that could distribute the paper copy to consumers, businesses who would send it out on a company e-mail blast, or to any groups identified as target populations).

In Warren County, 928 individuals responded to the survey. 910 lived or worked in Warren County and of that 910, 676 completed the survey. 720 respondents answered at least 16 out of 22 questions, and 56 individuals indicated they would like to participate in a community effort to increase the available drug and alcohol abuse prevention services, including a banker, education professionals, someone from the treasurer's office, individuals from the health department and a local hospital, members of churches and schools, private business owners, and others who are likely residents as they provided no business affiliation.

65.7% of the respondents were residents of the community, 35.5% of the respondents identified themselves as working as an education or school professional, and all 12 identified sectors were acknowledged by at least four participants. Because there was such a majority of respondents who identified themselves as education or school professionals, that group was examined separately and compared to the group who did not identify as such.

In Clinton County, members of the subgroup carried or mailed paper versions of the survey to meetings and venues where residents, consumers, colleagues, and interested parties might be present. Then those responses were returned to the county's mental health and recovery services board and those surveys (less than 35) were manually entered into the database. Lastly, a story about the survey was run in the Mental Health and Recovery Services of Warren and Clinton Counties' monthly newsletter, including a phone number and address to call to request a survey and a QR code and website link where anyone receiving the newsletter could also take the survey.

331 individuals responded to the survey. 322 lived or worked in Clinton County. The survey was designed so that most questions had to be answered before the respondent could move on, and though most questions were multiple choices or rated using a Likert Scale, there were opportunities to record comments on nearly all questions. Multiple members at a given IP address could respond (e.g., multiple members of the same household, office, or worksite). There was no mechanism to detect if any one person responded to the survey more than once. However, there was no incentive for responding twice, other than being able to provide feedback, so multiple responses from one individual was not likely.

Results were extensive however, the community clearly identifies opiates/heroine and methamphetamines as the most problematic substances. One interesting note about this survey was the low number of respondents who identified marijuana or tobacco as problematic.

As well as combinations of the problems/populations:

- Children being raised by drug-using parents
- Pregnant and young women and drugs/alcohol
- Drug abuse and Employment
    - Eligible unemployed who can't pass drug test
    - Drug related offenses and employment future
- Prescription Drugs
    - Doctor Shopping
    - Elderly (easy access for caregivers, youth, overdose)
    - Youth and experimentation (believed safer than street drugs)

In Warren County it was evident the educators who responded to the survey are concerned about teens and their use of alcohol. The other dynamic evident in the survey results is the community's concern about heroin use. Educators

expressed their concern regarding opiates or heroin at 6% or 7%, yet the general population reports the concern close to 35%.

With regard to specific populations combined with specific drugs, the comments from the teachers were consistent with the previous answers regarding concern about the students and their interaction with alcohol and marijuana and the dangers of that combination for school, sexual activity, and driving. There were some comments about the parents of students, particularly parents of younger children, and the parents using drugs around the children, including methamphetamines, inhalants, and alcohol. The general public comments included young parents of young children using drugs and teens using alcohol; however, they also appeared concerned regarding developmentally-delayed individuals using "any drugs," children in homes where "this drug is processed," caregivers under the influence of, or with access to, drugs, domestic abusers and methamphetamines, teenagers with access to heroin, and a variety of combinations indicating their recognition of the complicating factors of specific populations using a variety of substances.

Respondents to the survey and Key Informant Interviews, and supporting research (Office of Applied Studies, 2010), primarily identify teens (13-18) and young adults (18-25) as two demographics that are particularly in need of prevention services. However, the other age groups were also mentioned in the survey and in the Key Informant Interviews when respondents were describing specific combinations of individuals and addictive substances. While national attention and federal funding is directed towards designing prevention measures, particularly for binge alcohol drinking and opiate use for the 18-25 year olds (Haslum, 2012), there are also indications that 55-59 year olds are increasingly using illicit drugs (Office of Applied Studies, 2010).

Population Specific to Warren County:

There is concern regarding the use of substances, particularly of opiates, in pregnant women and parents of young children. Key Informants reported concerns regarding pregnant mothers, and mothers of young children, using drugs and alcohol and the survey results suggest that the group of people, age notwithstanding, respondents is most concerned about are parents of school-age children.

Further, data obtained from Children Services suggests that not only has the number of cases in which Children Services has become involved due to a concern regarding substance use risen from 2009 to 2011 (i.e., from 32% to 48%, to 68% respectively), the presence of opiates and heroin, within those cases has also risen dramatically (i.e., from 17% to 34%, to 73% respectively).

The misuse or abuse of prescription medications by older adults was also a notable finding from this Needs Assessment. Although this issue did not appear in the survey results, Key Informants mentioned concerns regarding older adults misusing their prescriptions by accident or purposely and also noted the potential for older adults to be at risk of exploitation due to them having a ready supply of addictive substances.

Further, although there were few calls in the 65+ age group in the data obtained from Warren County Emergency Services, almost all of those calls pertained to misuse of prescription medications.

Population Specific to Clinton County:

There is also concern regarding the pregnant women using substances. Key Informants reported concerns regarding the rise in the number of babies born addicted to heroin and opiates. Data obtained from Children Services also suggests that the percentage of substance-involved cases opened with this agency between 2009 and 2011 have increased. Survey respondents also voiced concern regarding pregnant women using substances.

Although studies consistently show that Clinton County has a relatively high percentage of pregnant women using tobacco, their rates of use of other substances appear generally consistent with that observed in the state of Ohio overall.

Substance Specific to Warren County:

Warren County, as is the state of Ohio in general, is seeing a rise in the abuse of heroin and opiates, as well as other prescription medications. Concern regarding these substances was well voiced within responses to the survey and to Key Informant Interviews. Quantitative data gathered during this Needs Assessment also suggests the presence of this problem; specifically:

- A dramatic rise in the number of Children Services cases involving heroin and/or opiates was observed between 2009 and 2011;
- Data from the Coroner's Office suggests that opiates and benzodiazepines were the substances most frequently observed in individuals with a substance-related cause of death;
  and
- An analysis of incoming calls to Warren County Emergency Services (WCES) coded "Overdose" by dispatchers suggests that opiates, heroin, and anti-anxiety medications are most prevalently represented in cases where individuals are suspected of suffering a drug overdose.

In addition, both the 2008-2009 Ohio Youth Survey of Clinton and Warren County youth, and the more recent survey of Ohioans regarding the general population's awareness of the ongoing opiate epidemic, suggested that the use of prescription drugs is of concern. Specifically, the Ohio Youth Survey results suggested that, at that time, 7% of Warren and Clinton County youth reported non- medical use of prescription drugs while the more recent opiate epidemic survey respondents indicated that prescription drugs closely followed alcohol as the most serious drug problem in their communities.

Concerns continue to prevail regarding abuse of alcohol. Key Informants indicated in their interview responses that although alcohol abuse remains a problem it is viewed as more acceptable and less serious than the abuse of other substances. Survey results also suggested that alcohol was the substance about which most respondents were concerned.

Data from the Ohio Youth Survey, conducted during the 2008-2009 school year suggested that alcohol remains a substance of concern for Warren and Clinton County youth, with 2 in 10 reporting having consumed alcohol within the past month, 1 in 10 acknowledging binge drinking, and half of the sample reporting fairly easy access to alcohol.

This observation is consistent with more recent data, gathered in a survey of Ohioans regarding the general population's awareness of the ongoing opiate epidemic; the majority of survey respondents perceived alcohol to be the most serious drug problem in their communities.

Further, data from MHRS suggests that alcohol dependence is the most frequently treated substance- related disorder by contract AOD treatment providers in Warren and Clinton Counties.

Concerns regarding the abuse of synthetic cannabis (e.g., "K2," "spice") and bath salts are also emerging. Several Key Informants mentioned these substances by name although survey results did not suggest these substances were perceived as a significant threat in the county. Beginning in 2011, these substances made a small appearance in data from the Coroner's Office and in the calls coded as "Overdose" by WCES dispatchers, across a wide range of ages.

Substance Specific to Clinton County:

Clinton County, as is the state of Ohio in general, is seeing a rise in the abuse of heroin and opiates. Concern regarding these substances was well voiced within responses to the survey and to Key Informant Interviews and the opiate epidemic in the state is well documented.

Survey and Key Informant responses also voiced significant concern regarding the abuse of methamphetamine in Clinton County although drug abuse trends in the Cincinnati region between, June 2011 through January 2012, suggest that a decrease in methamphetamine is being observed.

Concerns also continue to prevail regarding abuse of alcohol. Key Informants and survey respondents voiced concern regarding the abuse of alcohol.

Although the survey data and responses from Key Informant Interviews suggested that the abuse of prescription medications was less of a concern, statewide data indicates that Clinton County is a community where the highest levels of prescription drug overdose have been reported, placing Clinton County as having the 12th (out of 88 counties) highest rate of drug poisoning deaths. (The Coroner's data examined for this Needs Assessment constituted too small of a sample size to draw any significant conclusions.)

While survey respondents and key informants did not indicate tobacco use as primary concern, the August 2007 Assessment of Youth Development report found that tobacco use in pregnant women in Clinton County was higher than the state average. Further, the number of adults in Clinton County overall who smoke is higher than the state average. The 2012 Health Ratings by the Robert Woods Johnson Foundation found Clinton County to be ranked 64th out of 88 counties in Ohio with respect to health outcomes, a rating contributed to by the high rate of tobacco use in the county.

Further, the majority of youth who tried tobacco (among other potentially addictive substances) did so reportedly for the first time between the ages of 13 and 14, according to 2012 Ohio Youth Survey, with cigarette smoking among teens being correlated with future drug use and delinquent behavior (Myers & Kelly, 2006).

<u>Recommendations:</u>

1. Warren County would benefit from widespread community-based education regarding the following topic areas:
   - the nature, extent, and scope of the drug and alcohol problems present in the county;
   - the difference between prevention and intervention/treatment services; and
   - the need for prevention services to be provided to specific, targeted populations (e.g., unemployed, pregnant women) in addition to youth.

2. There is a significant need for collaboration with a coordinator of prevention services. As noted, strength of this community is the affiliation with a large, well-established, regional drug-free coalition, specifically the Coalition for a Drug-Free Greater Cincinnati, an organization whose mission is to partner with member neighborhood coalitions in their service region to localize efforts to design and implement comprehensive, community-wide substance abuse prevention strategies. It is recommended that efforts be made to utilize the resources this regional coalition may be able to offer to this community with regard to facilitating local community-based efforts to prevent substance abuse.

3. Although, as described, there appears to be a general sense of willingness – and even enthusiasm – for community coordinated efforts to prevent drug and alcohol abuse in the community, there appears to be a lack of clear leadership for such an effort at the present time, with some uncertainty regarding the interest and availability of key parties to participate in – and lead – such an effort. There is also an awareness of a previous drug-free coalition in Warren County that seemed to falter, reportedly due to a lack of leadership.

   It is therefore recommended that a Community Readiness survey be performed. It would be ideal if both key leaders and the public at large could be surveyed; however, if that is unrealistic, it is recommended that at least the key leaders participate in such an effort.

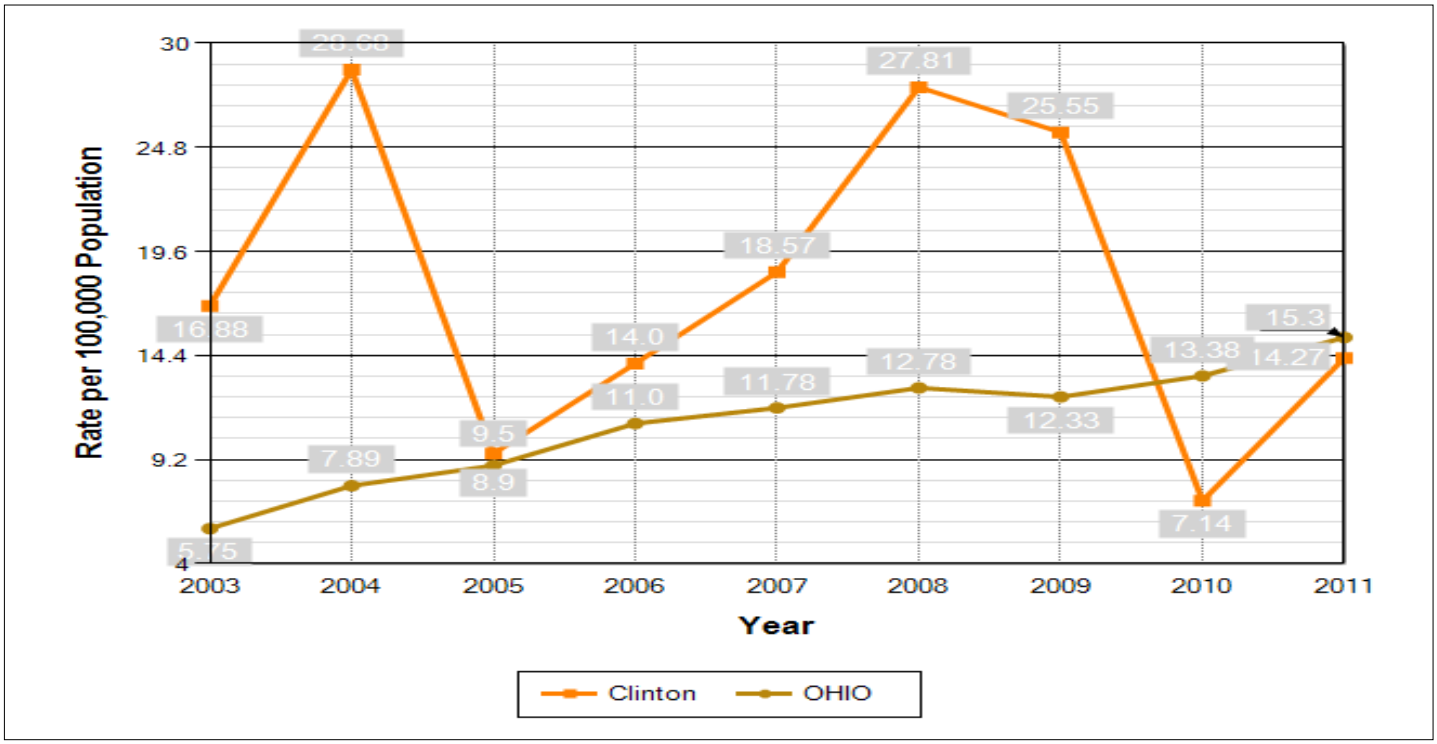
The results of the 2012 AoD Needs Assessment have assisted both the Warren County and Clinton County Coalitions to begin the strategic process of assessing community readiness and establishing the capacity for ongoing data collection. In 2013, all Warren County and Clinton County schools will participate in the PRIDE survey. The Coalition for a Drug-Free Greater Cincinnati has sponsored the administration of the PRIDE survey. This survey is designed to gather information pertaining to prevalence and patterns of drug and alcohol use, violence, gang activity, suicide and gambling behaviors. The survey was administered this year to students in grades 7 through 12th.

FY 2014 Year-To-Date Key Performance Indicator Data
Alcohol and Other Drug Services

Just like other communities across Ohio, both Warren and Clinton County have been impacted significantly by the Heroin/Opiate epidemic. Seventeen probationers from Warren County Common Pleas Court died of a heroin/opiate overdose since January of 2012. The following statistics outline the impact of the Opiate Epidemic in this community:

- Since 2009 there has been a 125% increase in female clients entered into treatment with an Opiate Dependence diagnosis.
- The increase in females with an Opiate Dependence Diagnosis has resulted in a 50% increase in the cost to treat female adult clients in an outpatient setting.
- The number of male clients with an opiate dependence diagnosis has increased by 122% since 2009.
- According to the OARRS Report (Q-3, 2013), the number of Opiates reported being dispensed per capita in Clinton County is 23.17 as compared to Ohio where the number of doses per capita is 16.96.
- The number of Drug Exposed Infants has reached epidemic proportions in both counties. It is difficult to obtain clear data but one hospital reported 5 infants in one week as testing positive at birth for an addictive substance.

Using data from OhioMHAS SEOW, the unintentional Drug Death rate in Clinton County is not only higher than the death rate in Ohio but in most years it is double or triple the rate of unintentional death across Ohio. The following graph depicts these numbers:



	2003	2004	2005	2006	2007	2008	2009	2010	2011
Clinton	16.88	28.68	9.5	14	18.57	27.81	25.55	7.14	14.27
OHIO	5.75	7.89	8.9	11	11.78	12.78	12.33	13.38	15.3

From 2009 until 2012 the number of AOD clients admitted into treatment services dropped by 127 clients. During the same time the overall cost to treat fewer clients increased by approximately 20%.

Access, Retention and Outcomes:

MHRS has aligned the AOD Key performance indicators with Ohio MHAS two treatment measures at four levels to demonstrate the effectiveness of services. These are retention and disposition at discharge. The four levels are provider, board, region and state. The retention indicator uses measures established by the Washington Circle and NIATx. These indicators report that there should be 2 clinical encounters within the first 14 days post assessment. The disposition at discharge reflects whether the client completed treatment successfully.

The goals for AOD services during FY-13 were to reduce the number of unnecessary assessments. This is accomplished by improving screening and referral. Secondly, assuring that timely contact is made once a client completes the assessment and is awaiting treatment. Finally, the third goal is to increase the number of successful treatment completions. These three goals/measures will are being monitored and reported during FY-14. One significant challenge is the data collection system for the treatment providers.

Treatment Access:

Stigma and fear are two primary reasons individuals do not seek assistance for an addictive disorder. Assuring timely access to a counselor can improve the likelihood for positive treatment outcomes. When an individual contacts the treatment facility for services it is imperative they be screened and assessed in a timely manner. The following outlines the baseline data for the AOD treatment system:

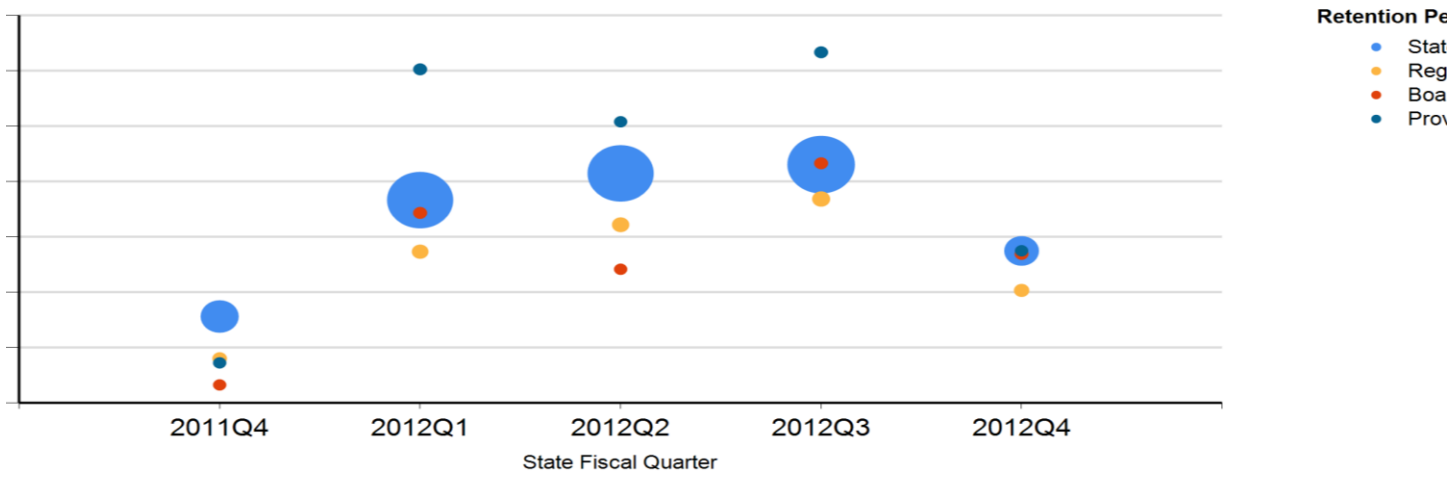
KPI Outcome Measure	Indicator	1st Half Solutions	1st Half WOS
Total number of adult referrals to your agency for AOD assessment	Measured by the first contact to set up an appointment	**851**	**286**
Average number of days from referral to assessment	Calendar days from first contact to first appointment given to client.	**14.5**	**9.7**
Average of days between assessment and first treatment appointment	The first treatment appointment once the assessment and recommendations are given to the client	**9.6**	**14.7**

Treatment Retention:

The single most important indicator for treatment retention is early engagement. This means the practitioner attends, offers accurate empathy and provides stage-wise interventions among other strategies to support the individual in their goal for change**.** These indicators are necessary for establishing the therapeutic relationship. The first chart indicates the provider organization has engaged the client at a rate that matches or exceeds the state, region and board level for four consecutive quarters. The second organization indicates the very opposite. This organization has a significantly larger referral base but is not retaining clients in treatment. The following graphs reflect provider retention rates as they relate to the state, region and board areas:

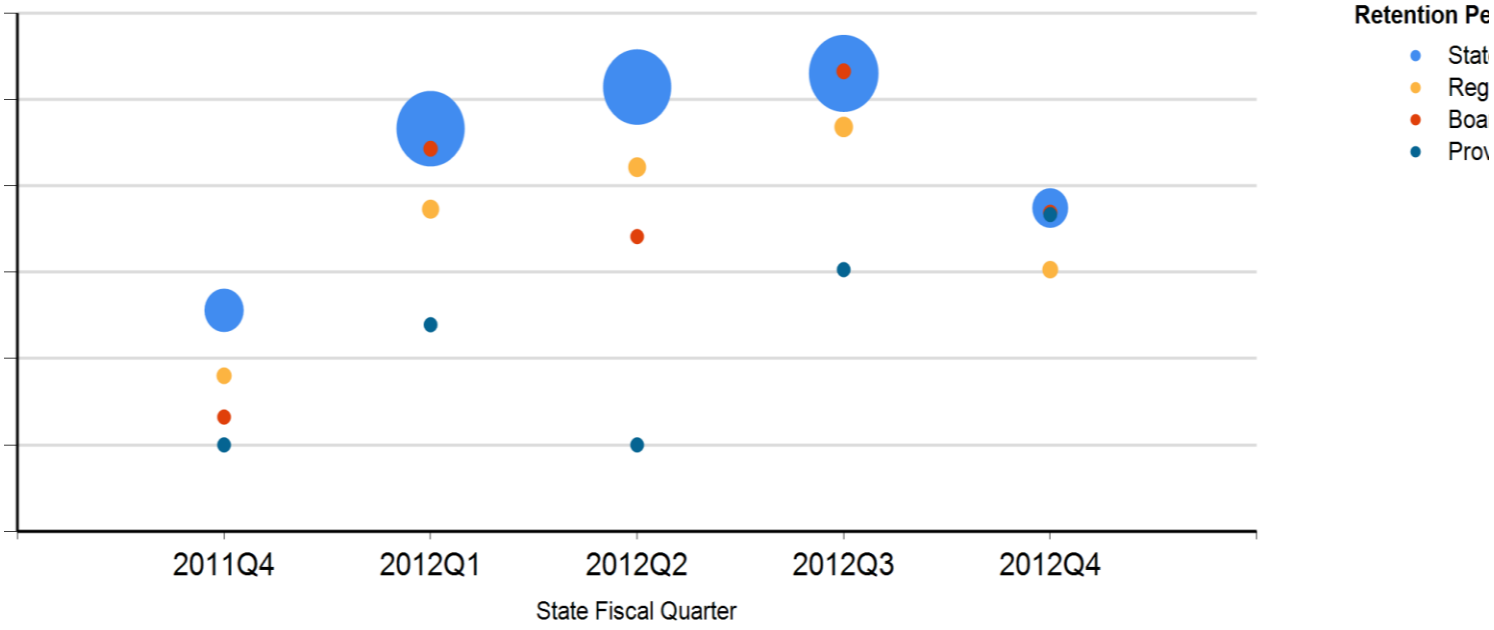
Washington Circle Retention Report 4/1/12 -6/30/12 WOS

Percentages and Changes over the Past Five Quarters
(Bubble size denotes number of retained clients)



Washington Circle Retention Report 4/1/12 -6/30/12 Solutions

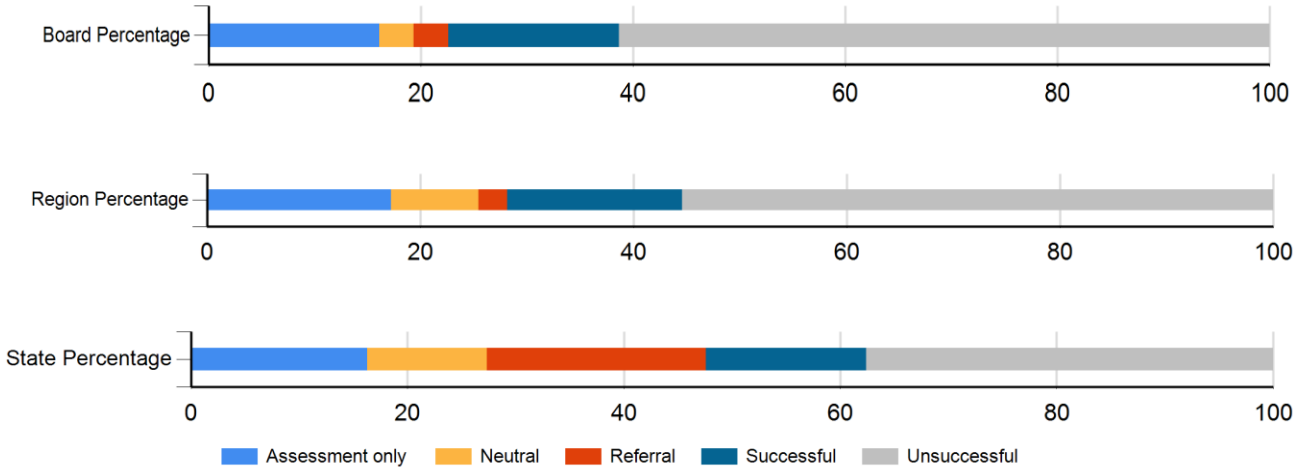
Percentages and Changes over the Past Five Quarters
(Bubble size denotes number of retained clients)



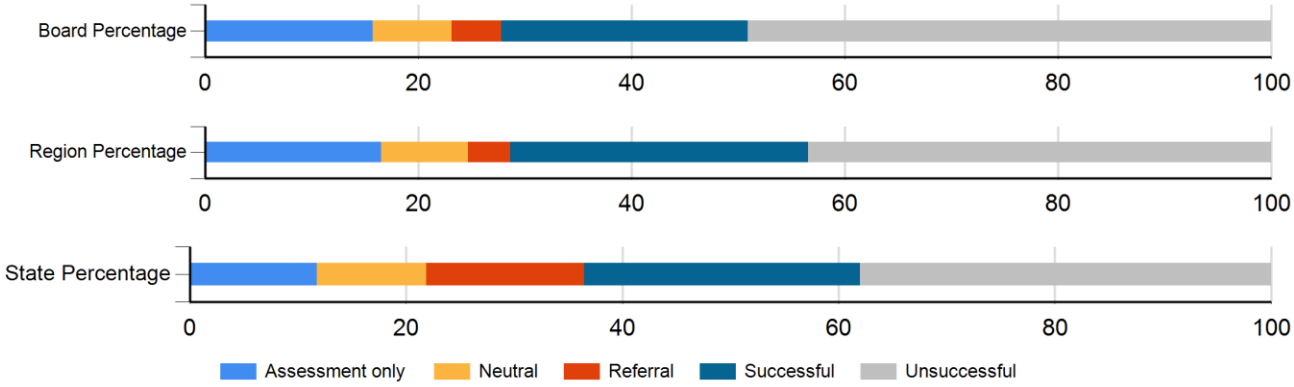
Treatment Effectiveness:

Treatment effectiveness/disposition at discharge reflects the status of the person served at the time their case is closed. Organizations strive to achieve a high level of successful completions but also realize that the disposition at discharge is an important indicator of treatment effectiveness. This allows the organization to make necessary changes. The state department ODADAS has been collecting discharge status reports for many years. The following chart reflects the state, region, board and organizational reflection of the cases that are closed:

Disposition At Discharge Report For 4/1/2012 - 3/31/2013
Solution Community Counseling and Recovery Center
Unsuccessful completion rate 66.67%



Disposition At Discharge Report For 1/1/2012 - 12/31/2012
Talbert House - Warren Outpatient Services
Unsuccessful Completion Rate 48.65%
Solutions Community Counseling and Recovery Centers
Unsuccessful Completion Rate 49.3%

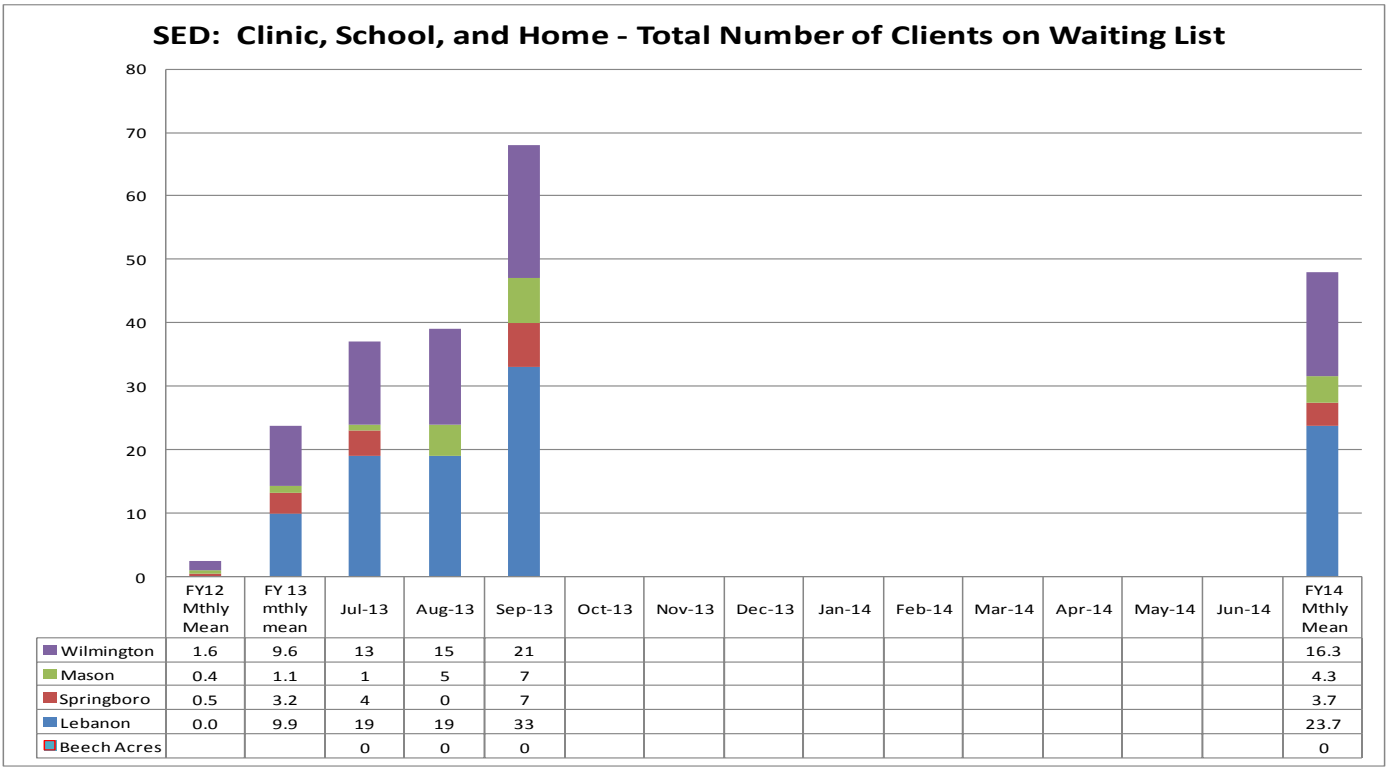


FY 2014 Year-To-Date Key Performance Indicator Data
Seriously Emotionally Disturbed Services

Access and gap issues for this service population are assessed via multiple avenues. Largely these are evaluated using data provided by contract agencies which is reported on a monthly basis. This is augmented with anecdotal information provided by a variety of referral sources. This information is utilized in our annual performance contracting process where MHRS plans services with the contract agencies for the following fiscal year. Overall, it is concluded that access this fiscal year has been readily available. However, a large percentage of SED clients are seen in the school setting which has presented some limitations in past fiscal years. Since much of Quarter 1 is prior to the start of school, this can impact the results. The following are some of the findings:

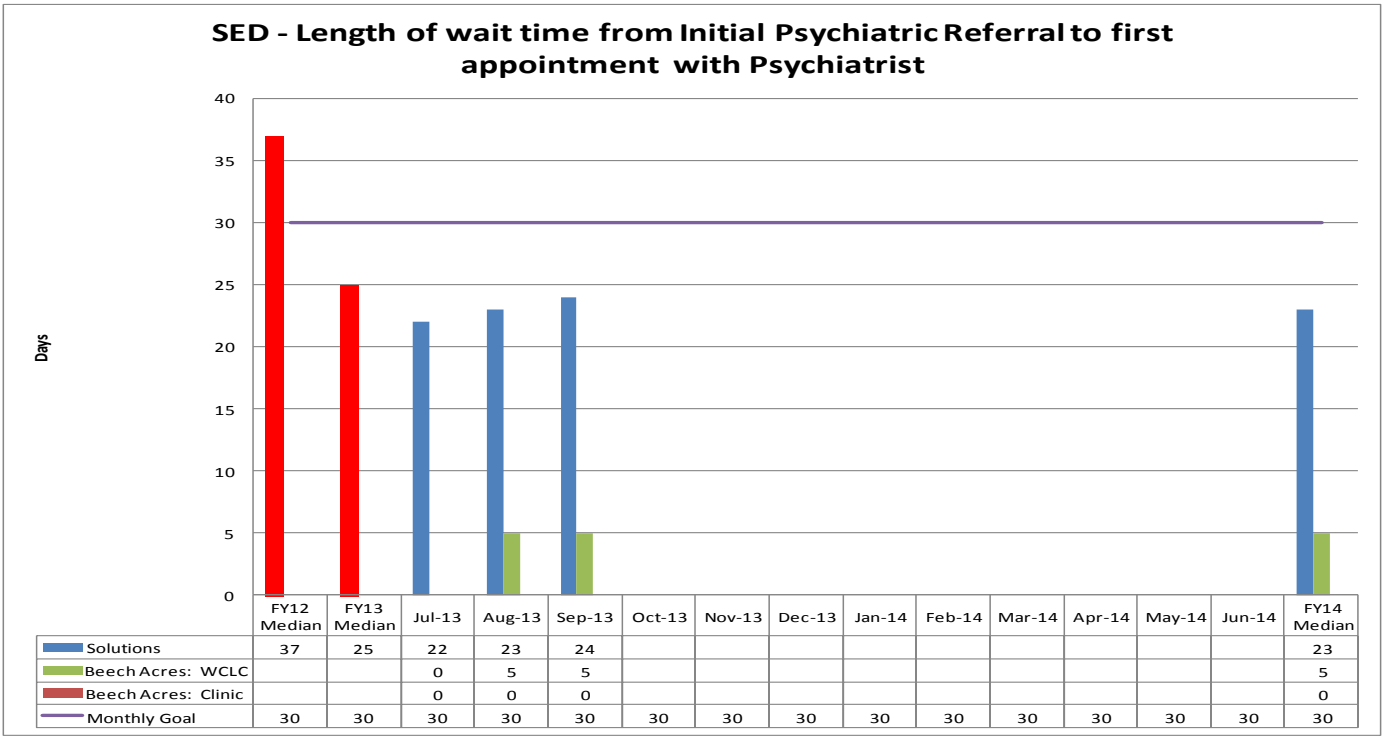
- Mean number of days between request for service and first offered appointment:
  - Standard School-Based/Clinic-Based Service: For Quarter 1, FY14, the monthly mean across agency locations (n=6) was 0-9 days wait. The median was 5 days wait. This is well below our target goal of 21 days. In FY13, this indicator was measured in a slightly different manner. Specifically, it was the mean number of days between request for service and admission. This change was made to control for situations where a family may decline an offered day/time and opt for a later appointment which provides misleading data in terms of access. However, even prior to the change, the median wait time across agency locations (n=4) for all of FY13 ranged from 0-26 days. Only one site exceeded the 21 day goal.
  - Intensive Home Based Service: For Quarter 1, FY14, the monthly mean ranged from 0-29 days. There was only one individual who appeared on the wait list, which resulted in the 29 day wait. This was due to a capacity issue, however other services were intensified until the youth was able to be seen by the team. This is highly unusual as for FY12 and FY13, the median monthly wait was 0 days.

- Number of individuals waiting for service and Number of clients admitted: For Quarter 1, FY14, the number of individuals waiting for service (point in time measurement done monthly) has reached as high as 68 individuals. This occurred in September and is likely due to school being back in session. The two sites which displayed the most consumers waiting were SCCRC Lebanon and Wilmington. Both represent hubs for a large number of school based clinicians. This does, however, represent an increase from the FY12 and FY13 wait list numbers. However, a total of 257 clients were admitted to service during this time. Despite the increase in number waiting, the wait time for an appointment was very low as previously reported.



	FY12 Mthly Mean	FY 13 mthly mean	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	FY14 Mthly Mean
Wilmington	1.6	9.6	13	15	21										16.3
Mason	0.4	1.1	1	5	7										4.3
Springboro	0.5	3.2	4	0	7										3.7
Lebanon	0.0	9.9	19	19	33										23.7
Beech Acres			0	0	0										0

- Psychiatric Access: For Quarter 1, FY14, a monthly average of 24 clients were new referrals to psychiatric services. The mean wait time from referral to first appointment with a psychiatrist is reported by the agencies is well below the established goal of 30 days. This is an improvement from the prior two fiscal years.



	FY12 Median	FY13 Median	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14	FY14 Median
Solutions	37	25	22	23	24										23
Beech Acres: WCLC			0	5	5										5
Beech Acres: Clinic			0	0	0										0
Monthly Goal	30	30	30	30	30	30	30	30	30	30	30	30	30	30	30

- Transitional Age Youth (TAY) Program: In FY12, MHRS contracted with one of our providers to begin a TAY pilot program using the Transition to Independence Process (TIP) model. This decision was based upon a reported need from various referral sources (Juvenile Court, Children's Services, Vocational School, etc). Enrollment has been less than expected (averaging only 5 clients per month), therefore it has continued in the pilot stage. Outreach is being conducted presently to garner more referrals.

- School staff rating of accessibility and satisfaction: At the conclusion of the 2012-2013 school year, area school principals/administrators and guidance counselors were invited to participate in an on-line survey evaluating school-based mental health services. There were two questions measuring value and satisfaction with the school-based services. The results show:
  - 87% reported that "Mental Health services funded by MHRS were of value to the school system"
  - 63% reported that "Yes" or "Sometimes" they are satisfied with the Mental Health Service provided at their school
  - However, only 20% indicated that there was "sufficient staffing to meet needs" (combined response rate of "fully in place" and "partially in place"). This is compared to the provider survey results at the same time frame which resulted in 78%. Clearly there is a difference in opinion with regards to the needed level of school-based staffing. However, it is reported by the agency that the school staff do screen out youth who could benefit from the services in order to help manage the limited caseload capacity of the on-site therapist.

- Kinship Support: In FY13, the Warren County Family and Children First Council subcommittee of Success for School Age Youth explored the need for added support for Kinship providers. A survey was conducted with several kinship providers and a focus group was held to gather more detailed information. It was reported that the common reasons for the kinship care are: parental drug addiction, incarceration and/or domestic violence. The needs were many but included:
  - Support and education for Kinship providers
  - Services to deal with the children's anger and trauma issues
  - Information on how to access mental health treatment
  - Difficulty in managing the behaviors of the children
  - Help with navigating the systems: legal, education, social service

It was clear that the kinship providers were stressed but committed to caring for their relatives. We know that these children, due to their experiences and past traumas, are at a higher risk of developing mental health and/or substance abuse problems. We also know that early intervention is much more cost effective.

As a result of these findings, MHRS contracted with Beech Acres Parenting Center to conduct a monthly Kinship Support Group which also includes education on many topics and referrals to services. This group has been operational since September and has served 11 kinship providers already.

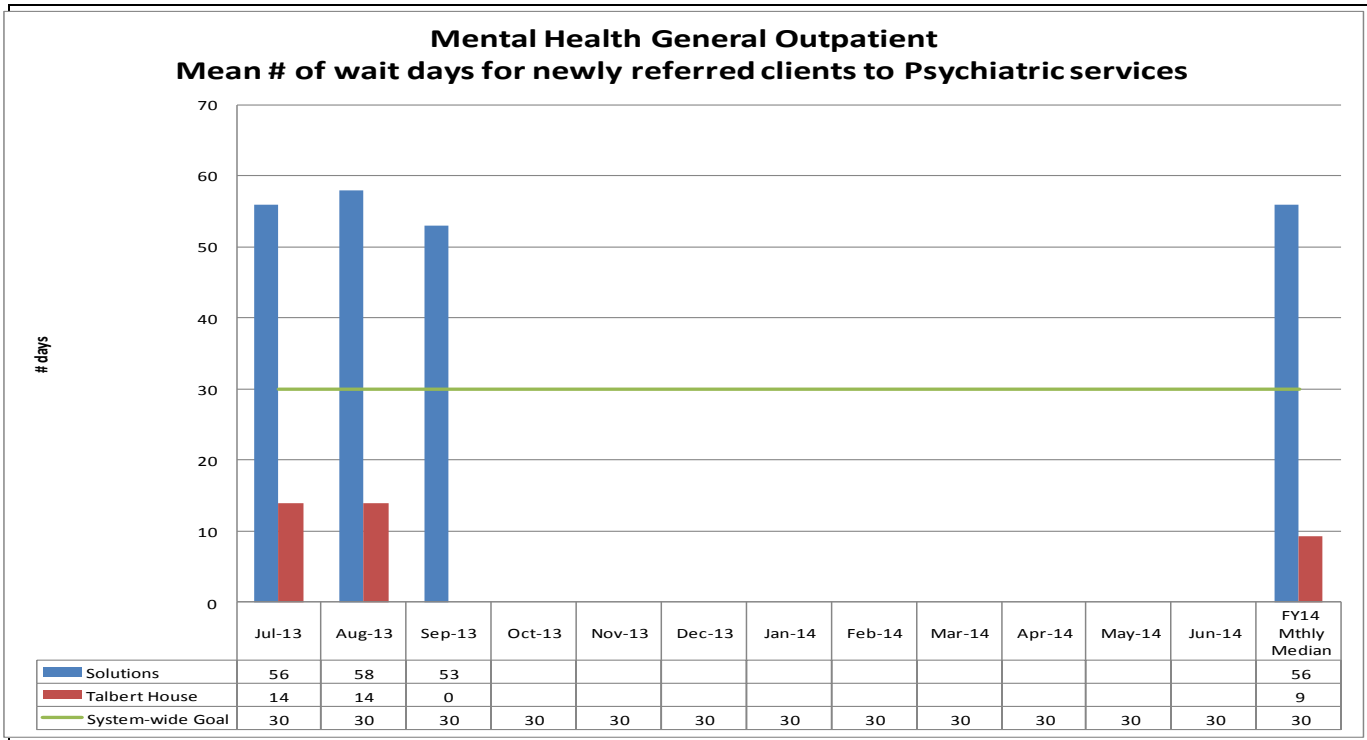
FY 2014 Year-To-Date Key Performance Indicator Data
General Outpatient Mental Health Services

This level of care is provided on a short-term basis or less intense duration/frequency as deemed medically necessary and can include services such as mental health assessment, behavioral counseling & therapy, family counseling, pharmacologic management, and consultation. This is designed for individuals who do not meet the criteria for SED, SMD or SPMI services. Overall, access has improved from last fiscal year. Further work needs to be done to reduce the wait to access psychiatric services. Additionally, with the current demand for services, it will be essential to maximize all potential funding sources such as insurance billing and assisting clients to enroll in Medicaid. Otherwise, this will not be sustainable over the long-term. The following are some of the findings:

- Number of days between request for service and first offered appointment: For Quarter 1, FY14, the monthly mean across agency locations (n=5) was 0-34 days wait. The median was 15 days wait. This is well below our target goal of 30 days. In FY13, this indicator was measured in a slightly different manner. Specifically, it was the mean number of days between request for service and admission. This change was made to control for situations where an individual may decline an offered day/time and opt for a later appointment which provides misleading data in terms of access. However, even prior to the change, the median wait time across agency locations (n=4) for all of FY13 ranged from 24-79 days with the median being 41 days.

- Number of clients admitted: A total of 299 clients were admitted to this service during Quarter 1, FY14. During this same quarter in FY13, a total of 320 clients were admitted. Despite the comparable in number admitted, the wait time for an appointment has been lower.

- Psychiatric Access: For Quarter 1, FY14, a monthly average of 32 clients were new referrals to psychiatric services. The mean wait time from referral to first appointment with a psychiatrist is reported by the agencies is well below the established goal of 30 days. This is a new indicator being measured this fiscal year due to concerns about access. It was revealed that one agency is well below the established goal, however they are serving a very small population (monthly average census of 10). The other agency reports a wait of nearly twice the goal. A plan of action has been put into place by the agency to reduce this during Quarter 2.



FY 2014 Year-To-Date Key Performance Indicator Data
Mental Health Prevention Services

This level of care serves the following individuals: Early Childhood, Elementary, Middle School and High School Age Youth and Their Families as well as Small Businesses, Colleges and Community-at-Large. The population may include a range of persons from infancy to elderly age groups. Special populations which may be seen through this service level include, but are not limited to, older adults, pre-school aged children, dually diagnosed individuals with mental health and mental retardation/development disability diagnoses. The following table provides detail on the number of clients (duplicated) receiving MH Prevention Services by location in FY13. Over **13,000** participants (duplicated) received MH Prevention services this year. The vast majority of these were youth.

		FY11 Mo.Avg.	FY12 Mo. Avg	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Total	Mo.Avg.
School- Based	Partici-pants	745	767	203	243	748	915	981	628	705	561	850	688	574	331	7427	619
	Hours	71	67	68.4	22.9	52.5	77.7	94.8	48.8	51.7	90.05	65.1	76.8	43.1	36.37	728.22	61
Community Based	Partici-pants	206	348	675	262	222	143	128	1034	84	142	81	253	53	53.6	3130.6	261
	Hours	41	48	99.8	49.7	34	27.1	22.8	48.5	18.8	26.8	22.8	22.4	14.2	421	807.9	67
Early Childhood MH Consult	Partici-pants	250	200	148	149	208	274	282	134	249	352	215	258	286	139	2694	225
	Hours	68	90	94.4	95	67.2	76.6	98.3	91.3	120.1	106.2	112.2	126.8	117.2	89.6	1194.9	100
Grand Total	Partici-pants	1201	1315	1026	654	1178	1332	1391	1796	1038	1055	1146	1199	913	523.6	13252	1104
	Hours	179	204	263	168	154	18	216	189	191	223	200	226	175	545	2731	228

The average cost of Mental Health Prevention services during FY 13 was $21.44 per participant contact.

MHRS requires a provider to submit a Mental Health Prevention Plan (MHPP) outlining which Evidence Based Programs will be implemented and how Outcomes will be measured. The MHPP is approved by MHRS prior to the provision of documented programs. Only programs submitted in the MHPP and approved by MHRS are billable to MHRS. This is applicable to:

- Mental Health Prevention – School-Based
- Mental Health Prevention – Community Based
- Mental Health Education – School-Based (multi-week/session programs)
- Mental Health Education – Community-Based (multi-week/session programs)

A total of 18 prevention programs were approved for FY13 and primarily focused on youth and families. Eleven of these are on SAMHSA's National Registry of Evidence-based Programs and Practices. Four others are based in research or appear on other registries of promising practices. In FY14, MHRS contracted with an additional provider agency to further expand the available services.

The Mental Health Prevention Plan also includes the Early Childhood Mental Health (ECMH) Consultation program. Despite the discontinuance of state level funding of this program, MHRS has continued it using local levy dollars. During FY13, the two designated ECMH consultants provided service to 41 classrooms at a total of 11 centers during FY13. This provided intervention to 96 teachers and impacted 779 children. In 37 of these classrooms, a Pre/Post Reflective Checklist for the Environment tool was conducted and analyzed with results provided to center directors. Educational sessions were provided to child care center staff on topics of: Developmental Assets; "Filling Buckets" (providing positive reinforcement); De-escalation techniques; Dealing with parents; and Recognizing mental health symptoms.

Sixty children were referred for individual brief consultation services and 59 followed-through for this assessment. As a result Individualized plans were created for 34. Of these, 88% were 80% or more implemented.

Eighty-five children were referred for more intensive consultative services. These referrals primarily come from Head Start (49%) or a child care center (35%). Of these, 61% were male and 39% were female. Individualized plans were created for 67 of these, with 66% families implementing 80% or more of the plan. Mixed results were displayed on the Devereux Early Childhood Assessment completed by the teacher and the parent for these children. The teachers indicated improvement in all areas except "Self- Control" however the decline was minimal at 0.3%.

The parents reported improvement in 2 ("Initiative" and "Protective Factors") of the 5 areas, with slight decline in "Self-Control" (4%), "Attachment" (1.8%) and "Behavioral Control" (2.8%). Of these children, none were expelled from the early childhood setting, with 79% being maintained in the same early childhood setting. Satisfaction of the child care centers was reported as overwhelmingly positive (all scores at the highest possible level). Satisfaction of family members was also positive with scores averaging 4.67 (5=Strongly agree/highest possible score).

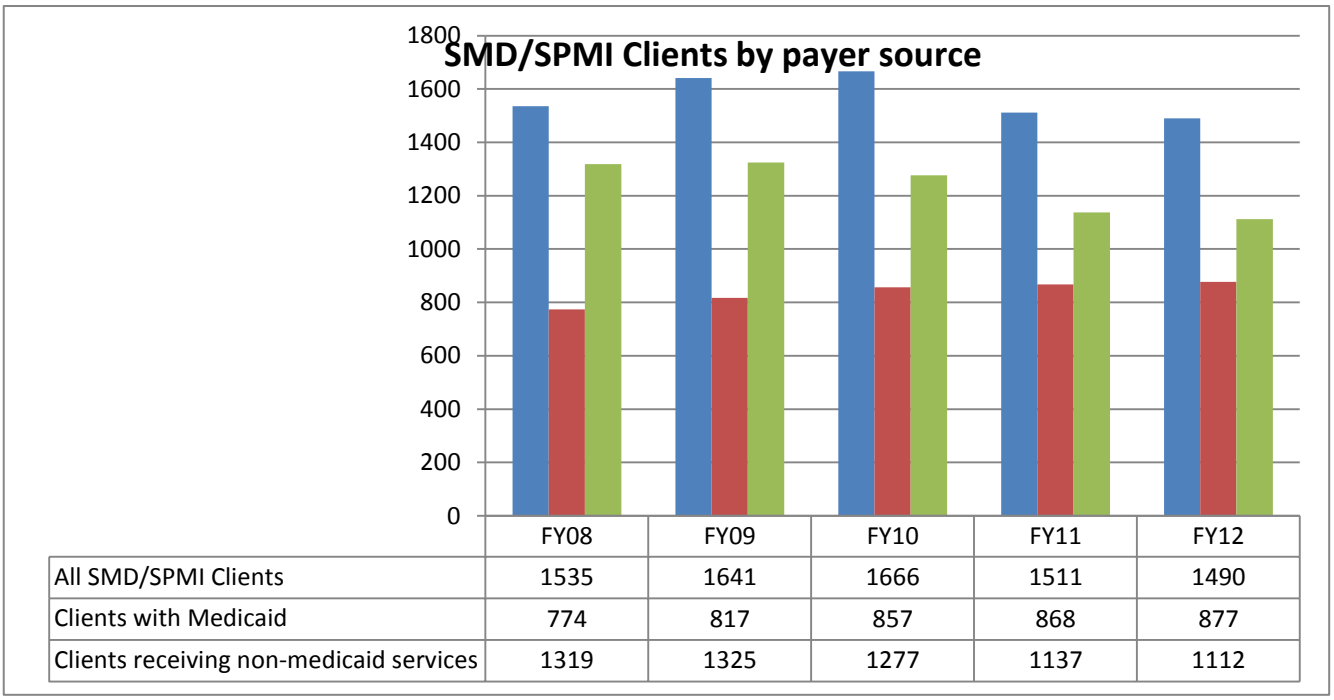
A brief example of a case was supplied by the agency to illustrate the service and its effectiveness:

> "A center requested a consultation for a 3 year old child. The center director stated "no one likes this child including staff." The child's behaviors were out of control, hitting, pushing, biting, yelling, and screaming. A classroom observation was completed and a plan developed. The staff at this location turnover frequently and there was little consistency. Behaviors did not change. The consultant attended a parent teacher conference to meet the parents. As a result a home visit was completed. During the home visit the parent shared with the consultant many issues which were causing great stress in this family. The consultant referred the family for several services in the community for food and some basic needs. It was also suggested the parent seek mental health services. As a result the mother began treatment and trauma issues were discovered that were affecting her ability to care for herself and her children. When mom's issues were identified and addressed, the child's behavior improved at home and at school."

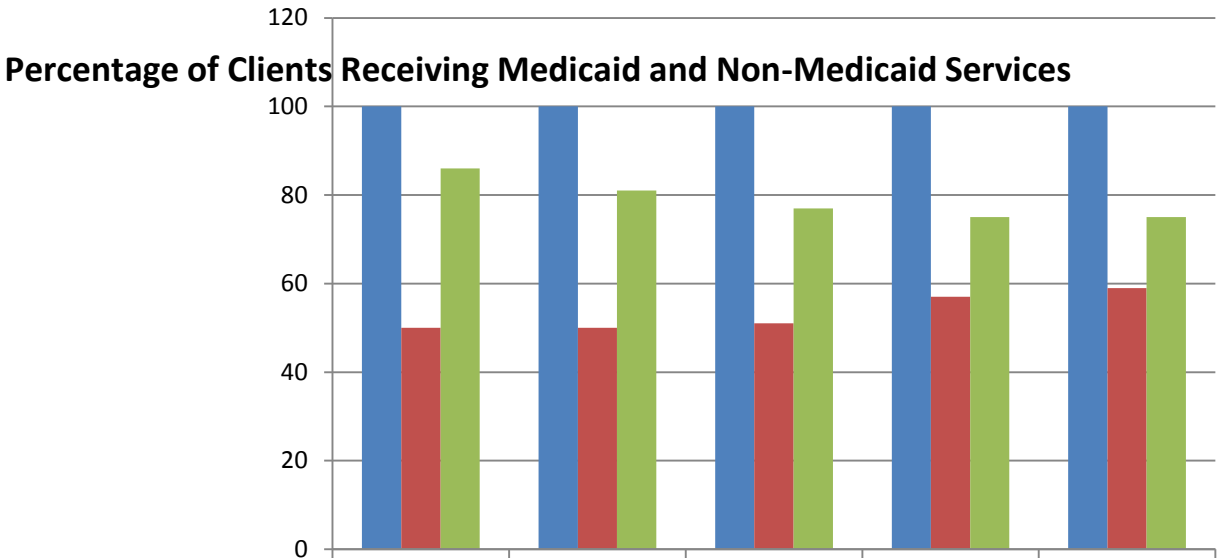
It is clear that many factors impact a child's behavior in the classroom, including: the child's home environment, parenting styles, classroom management and teacher styles. The ECMH consultants can intervene with all these factors, making recommendations and referrals to address each.

FY 2014 Year-To-Date Key Performance Indicator Data
Severely Mentally Disabled and Severely and Persistently Mentally Ill

These populations are defined by OhioMHAS and these definitions are used to identify the served population. In FY12, there were 1490 clients served by MHRS.



	FY08	FY09	FY10	FY11	FY12
All SMD/SPMI Clients	1535	1641	1666	1511	1490
Clients with Medicaid	774	817	857	868	877
Clients receiving non-medicaid services	1319	1325	1277	1137	1112



	FY08	FY09	FY10	FY11	FY12
All SMD/SPMI Clients	100	100	100	100	100
Clients with Medicaid	50	50	51	57	59
Clients receiving non-medicaid services	86	81	77	75	75

The decrease in SPMI/SMD clients may be related to a clearer definition of this population following closely the criteria provided through ODMHAS. Other influencing factors have not been identified.

The charts above are illustrative of the Medicaid penetration rate and the number of non-Medicaid services delivered to both non-Medicaid clients and those with Medicaid for services that are not covered by Medicaid. These non-Medicaid services are essential to clients to support them in community settings by reducing hospitalizations and improving quality of life. Such services are inclusive of, but not limited to peer support groups, adult education, transportation and housing.

MHRS supports the C-POM model (Cluster Based Planning and Outcomes Management) for this population as it is a clinically based approach that allows for the planning and delivery of clinical care in a functional design. The approach matches individual clients need with continuity of care built around a research based clinical subgroup of clients. In addition to C-POM, Wellness Management and Recovery (WMR) is an adult education curriculum designed to enhance areas that increase the quality of life for clients. The incorporation of these two evidence based practices has decreased treatment disparities across this population.

Service gaps do exist in the specific therapies to particular populations such as borderline personality disorder, post traumatic stress disorder for veterans, a trauma informed care system and a more robust ability to engage with criminal justice involved individuals along the sequential intercept continuum. Access issues are most significant around psychiatric service time, even after adding telemedicine and post-incarceration linkage to the service array. MHRS is willing to provide assistance in the development of housing levels of care.

Question 2.1:

ORC 340.03 requires service needs review of: (1) child service needs resulting from finalized dispute resolution with Family & Children First Councils:

During this period of review, there were no cases requiring dispute resolutions with the Family and Children First Councils in either Warren or Clinton Counties.

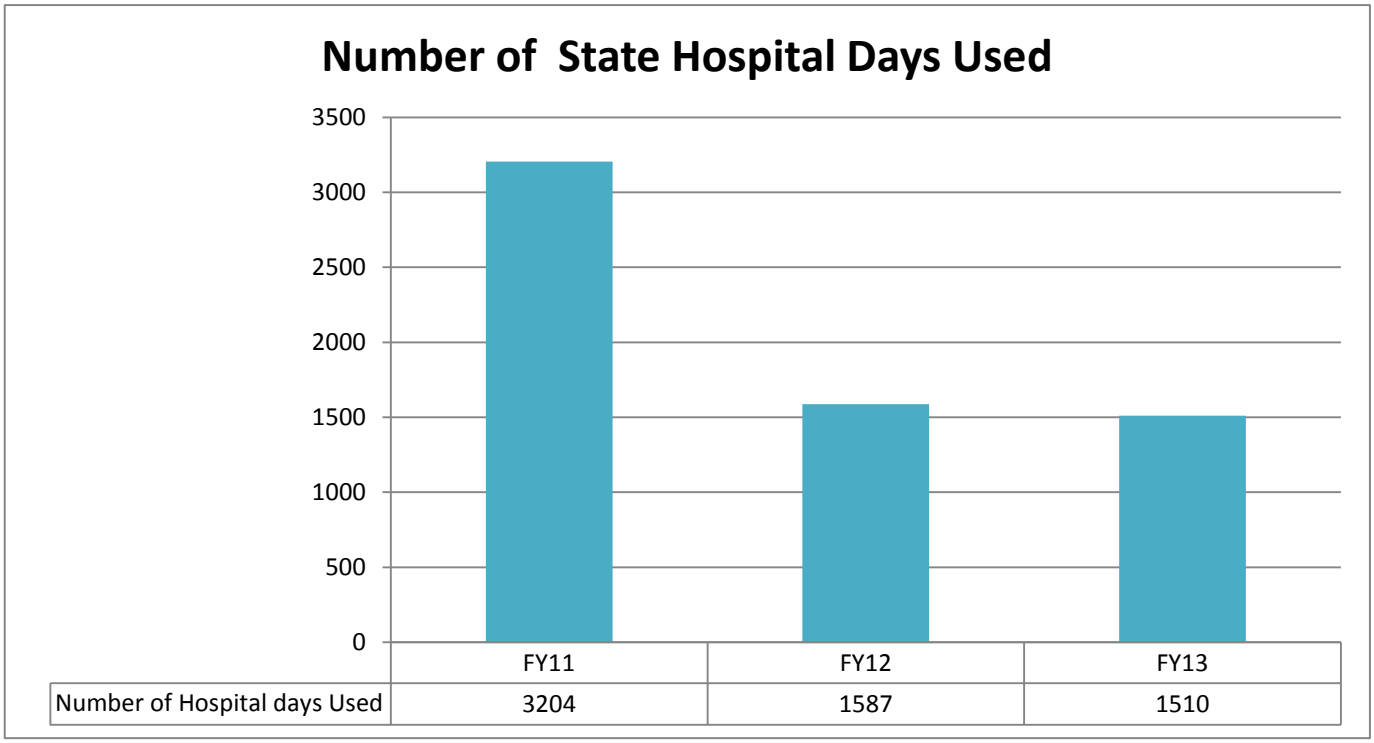
Question 2.2:

ORC 340.03 requires service needs review of: (2) outpatient service needs of persons currently receiving treatment in state Regional Psychiatric Hospitals:

The population in the state hospital is only a small piece of the clients who have psychiatric hospitalizations. MHRS has plan-fully and methodically focused on reducing state hospital use through utilization management and use of community resources whenever possible, therefore the issue of outpatient service needs is much broader than this question's inquiry.

Quick access to psychiatric aftercare is a continuing challenge. Recruitment of new psychiatrists is difficult for the provider system.

Step-down services are a missing element in the continuum of outpatient services. MHRS currently has a plan and facility for step-down, but there is no long term financial feasibility in maintaining it. The use of 24/7 short term residential has allowed for the reduction of hospital days, stabilization before moving directly into the community, and has aided in establishing the client with the provider system.



Housing is an "outpatient" service in high demand. The number of locally support housing units, either with rent subsidy, support or both, is a constant. "If you build it, they will come" is the theme of housing. Establishment of a housing matrix (see below) using the DLA-20 allows for prioritizing the needs. The waiting list for housing is re-evaluated at least monthly to determine any changes in priority status.

Mental Health Recovery Services of Warren & Clinton Counties

SFY 2013 Housing Matrix

7/22/2013

INTENSITY	HOUSING	CITY LOCATION	MINIMUM ON-SITE SUPERVISION or SERVICE	FY 12 SYSTEM CLIENTS / BEDS TARGET					
				A	B	C	D	E	F
Level 3b Long Term Residential Care	Mellon Ridge	Goshen	24 Hrs. Per Day	1	0	0	0	0	15%
	Peebles	Peebles	24 Hrs. Per Day	5	2	0	0	0	15%
	Smith House	Wilmington	24 Hrs. Per Day	8	8	0	0	0	NA
	Eastgate	Batavia	24 Hrs. Per Day	1	0	0	0	0	15%
	Herkin's House	Lebanon	24 Hrs. Per Day	11	10	0	0	0	15%
			Sub Total	**26**	**20**	**0**	**0**	**0**	
Level 3a Time Limited Residential Care	IRR	Lebanon	24 Hrs. Per Day	12		0	0	0	15%
	Bernie's Place	South Lebanon	24 Hrs. Per Day	14	12	0	0	0	N/A
			Sub Total	**26**	**12**	**0**	**0**	**0**	
Level 2c Residential Care	Walnut	Lebanon	20 Hrs. Per Week +	0	0	0	0	0	N/A
			Sub Total	**0**	**0**	**0**	**0**	**0**	
Level 2b Residential Care	Barker House	Wilmington	56 Hrs. Per Week	8	6	0	0	0	NA
			Sub Total	**8**	**6**	**0**	**0**	**0**	
Level 2a Supportive Housing	Connie's Crossing	Lebanon	20 Hrs. Per Week	16	10	0	0	4	N/A
	Harrison	Lebanon	20 Hrs. Per Week	10	2	0	0	4	N/A
	Hunters Run	Lebanon	20 Hrs. Per Week	12	0	0	0	0	N/A
			Sub Total	**38**	**12**	**0**	**0**	**8**	
Level 1 Subsidized Housing	Main	Lebanon	5-8 Hrs. Per Week	6	4	1	0	1	N/A
	Riverdale	Franklin	5-8 Hrs. Per Week	8	2	1	0	1	N/A
	Fairwinds	Lebanon	5-8 Hrs. Per Week	4	0	0	0	3	N/A
	Chillicothe	Lebanon	5-8 Hrs. Per Week	2	2	1	0	0	N/A
	Broadway	Lebanon	5-8 Hrs. Per Week	8	1	1	0	3	N/A
	Mound	Lebanon	5-8 Hrs. Per Week	2	0	0	0	1	N/A
	Grove	Wilmington	5-8 Hrs. Per Week	4	2	0	0	0	N/A
	Cambridge	Lebanon	5-8 Hrs. Per Week	4	2	0	0	2	N/A
	Doan	Wilmington	5-8 Hrs. Per Week	8	4	4	0	0	N/A
			Sub Total	**46**	**17**	**8**	**0**	**11**	
Level 0 Independent Housing w/ HAP Subsidy	Scattered Sites	Warren/Clinton	0 Hrs. Per Week	**32**	**0**	**15**	**0**	**0**	N/A
Level 0 Independent Housing w/ SHAP Subsidy	Scattered Sites	Warren/Clinton	0 Hrs. Per Week	**15**	**0**	**0**	**4**	**0**	N/A
Level 0 Independent Housing w/ S+C Subsidy	NHO only	Warren	0 Hrs. Per Week	**21**	**0**	**0**	**0**	**19**	N/A
TOTAL				**212**	**67**	**23**	**4**	**38**	

A = Total Number of Clients / Beds / Subsidies Available to MHRS
B = Total Number of Clients / Beds Subsidized by MHRS (Direct / Semi-Permanent)
C = Total Number of Clients / Beds Subsidized by MHRS (HAP / Temporary)
D = Total Number of Clients / Beds Subsidized by SHAP (Temporary)
E = Total Number of Clients / Beds Subsidized by S+C (Permanent)
F = Personal Needs Allowance Percentage

Strengths and Challenges in Addressing Needs of the Local System of Care

In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development. (see definitions of "service delivery,"" planning efforts" and "business operations" in Appendix 2).

3. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment? (See definition "local system strengths" in Appendix 2).

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

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

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

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

Answers to Questions 3. and 4. are addressed together below.

Local System Strengths

As previously noted, strength in our local system is the business model developed in FY 2005. In FY 2006 we developed a methodology to assist the Board of Directors for keeping abreast of projects and activities as well as a means for measuring the overall health of MHRS' behavioral health care system. The tool utilized was the implementation of the "Executive Director Balance Scorecard Report". The scorecard serves to give Board members a quick-read of important information. The scorecard indentifies five specific categories with objective measures. The specific categories have not changed, although measures per category do change for each contracting period and are selected based upon changes in programmatic services and identified community needs.

The identified categories are: (1) financial perspective; (2) personnel perspective; (3) internal perspective; (4) external perspective and (5) innovation and learning perspective. Not all measures are applicable throughout the fiscal year. When applicable, measures will be presented with an identifier as either "red" which requires immediate action; "blue" requires monitoring and "green" which indicates we can celebrate. The scorecard is submitted (mailed) to the Board of Directors for review prior to each scheduled Board of Director's meeting (reports are reviewed for discussion). The scorecard implements a variety of methods of reporting data including charts and a written narrative section. The scorecard reduces any uncertainty as it clearly defines for the Board of Directors and MHRS staff what is to be measured and also how it is being identified (I.e., needs either: immediate action, monitored or successful).

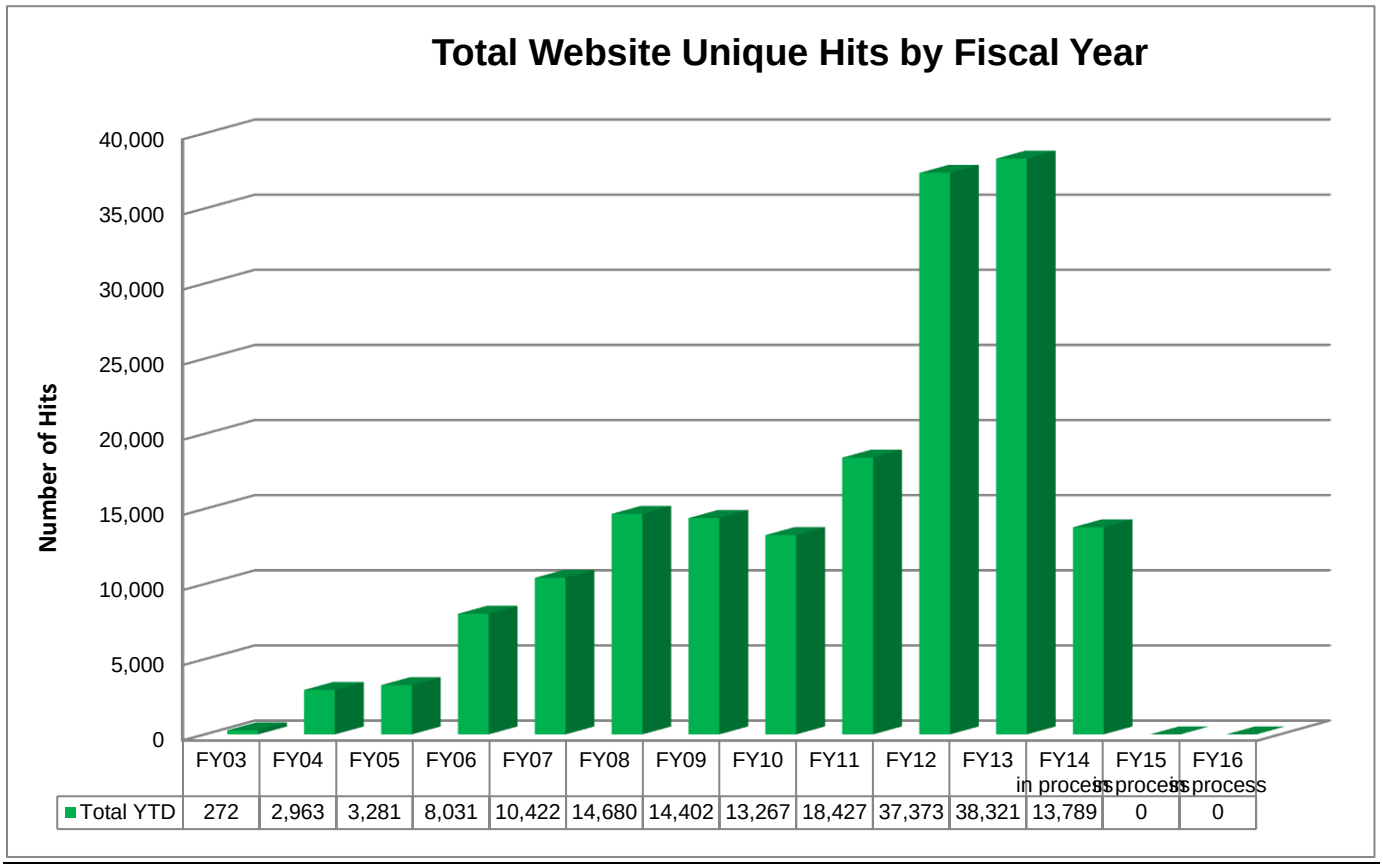
Local System Challenges

Communication Plan

In order to better advertise provided services and to promote the successes of MHRS's endeavors, a communication plan has been developed to address current needs and to bolster current efforts to advertise and promote. Over the next year, MHRS will be implementing several strategies to increase the community's knowledge and awareness of MHRS.

- Website Redevelopment: The MHRS website saw a marked increase in visitors in FY12 and FY13, probably due to a levy campaign in the fall of 2011 and the inception of our eNewsletter. However, in FY 14 y-t-d, we are seeing a decline in the number of visitors to the website. Understanding that the website is the primary access point online for people seeking services and information, it is necessary to redesign the website to make it more user-friendly and to increase the number of visitors to the site. The current website has not had a major redesigned since it was launched. Currently, the website has been described as hard to navigate and outdated.

A new website redesign and relaunch will be aimed at increasing the website navigation, make information easier to find, and make the website a more central location for information regarding the work and efforts of MHRS. It will also allow the website to be brought up to date be removing outdated information and hopefully drive more people to the website for information.



- Social Media: MHRS recognizes that social media, such as FaceBook and Twitter, is an increasing way to communicate with a younger, more connected population. Over the next year, MHRS will be examining ways to establish and or increase its presence on social media sites. MHRS currently has a FaceBook page, but it seems to have little traffic. MHRS will be looking at ways that it can effectively use FaceBook and other social media to both increase its reach and to increase website traffic.

- eNewsletter: MHRS has been distributing an electronic newsletter for the past couple years through Constant Contact. While the newsletter is distributed to over 900 people, the "open rate" (the number of people who open the newsletter) has hovered around 20%. MHRS will be examining changes that can be made to make the newsletter easier to read and more relevant in an effort to increase the number of people signing up for and reading the newsletter. MHRS will also be looking at ways to use the newsletter to drive traffic to the newly designed website.

- Print and Traditional Media: In the past, MHRS has published a yearly printed newsletter that went out to all addresses in Warren and Clinton Counties at a significant cost. Not only is this printing and postage expensive, but the feedback regarding the printed newsletter was mixed. Therefore, MHRS will be examining ways to potentially cut the cost of the printed newsletter dramatically through partnerships with other organizations or will be examining the feasibility of replacing the printed newsletter with the electronic newsletter. Also over the coming year, MHRS will be working to bolster relationships with traditional media outlets (TV, radio, newspapers, etc.) in an effort to increase the promotion of the services and successes of MHRS.

Insurance Panel Enrollment:
MHRS has begun monitoring a new indicator which evaluates the private insurance panels each clinician is enrolled in. This is in preparation for the implementation of mandated insurance under the Affordable Care Act which will begin in January, 2014. Presently, all clinicians meet qualifications to bill Medicaid. Required clinician qualifications for billing to MHRS have historically mirrored that of Medicaid. If a clinician on a given insurance panel is unavailable, this does not mean the individual will go unserved. Rather, a decision process whereby other alternatives are explored. However, the final resort is billing 100% of any balance owed by the client to MHRS even though insurance is another viable payer source. In FY14, a System Policy was implemented indicating that a consumer must apply for Medicaid prior to billing to MHRS if s/he is deemed potentially eligible. Likewise, when more information is available about the insurances on the Health Exchange, a meeting will be convened with the agency directors to create some possible solutions. MHRS' primary agency reports that the vast majority of the direct service clinicians are not independently licensed or are otherwise not qualified to enroll on insurance panels. Because of MHRS' current Benefit Rules paying 100% not covered by a SED client's insurance, this increases the board's cost. Recruitment and retention of independently licensed direct service staff has been difficult for the agencies. When an employee achieves independent licensure, s/he often leaves the agency. Another complicating factor is that insurances have become increasingly complex with the use of health reimbursement plans and health spending plans. This makes it difficult to apply a sliding fee scale to any co-pays or unmet deductibles.

Alcohol and Drug Addiction (AOD) Strengths
As noted throughout the needs assessment both Warren and Clinton Counties have a serious problem with Opiates and Heroin. MHRS contracted with Solutions to evaluate the use of Vivitrol with existing clients. The MOU between the MHRS of Warren and Clinton Counties and Solutions Community Counseling and Recovery Centers dated March 25, 2011, agreed to one-time a one-time funding allocation of $91,550 for the purchase of Vivitrol medication. Solutions agreed to the following:

- Purchase and make arrangements for storage of Vivitrol medications for the duration of the project;
- Select clients for the project who are opioid dependet and reside in the Warren County jail;
- Serve a minimum of 10 clients for the project; and
- Provide clients' monthly injections of Vivitrol in combination with allowable services as specified in the FY12 Solutions Standard out-patient and Intensive out-patients Service Plan Contract Offeror Form

Solutions completed the original pilot project for medication-assisted treatment and has since established a protocol for providing Vivitrol to clients in outpatient services. In the pilot project, 18 potential candidates for MAT were identified. Of those, six did not begin the program for various reasons. The remaining 12 candidates all completed the Jail treatment program and received at least one Vivitrol injection. One client who participated for approximately five months dropped out and was reincarcerated on new charges.

Four candidated did not receive a second injection; three of these were referred to IOP treatment as follow-up and the fourth was reincarcerated on a non-drug charge and dropped from the pilot program. Of the three referred clients, one started but did not complete IOP and the other two did not begin outpatient treatment.

One client received a single follow up Vivitrol Injection, subsequently tested positive for opioids and benzodiazepines and was discontinued from the pilot project. This client continues to receive serves for severe and persistent mental illness. One client received two follow-up Vivitrol injections before droppping out of treatment.

The remaining five clients received eight to 12 Vivitrol injections and are considered treatment successes. None of these clients tested positive for opioids on the course of the pilot project, though one client tested positive for marijuana. All of these clients completed IOP and aftercare. Three of the clients worked at least part-time during half or more of their participation in the pilot project.

The findings from this project indicate about fifty percent success for participants who started the program. This is about a five-fold improvement over counseling alone.

AOD Prevention:
As a result of the statewide trainings on prevention and the Strategic Prevention Framework (SPF), MHRS decided to fund Community-Based and Environmental Prevention Strategies on a grant basis to assure the development of the coalitions and community buy-in regarding prevention activities. Additionally, the division of funds for prevention was adjusted to more closely align with the Institute of Medicine (IOM) report published March, 2009. These changes were implemented to establish a solid framework for using the data from our needs assessment to fund future prevention activities. This transtion in funding only researched-based practices that are culturally appropriate has not been without resistance but provider organizations recognizes the changing prevention dynamic.

Alcohol and Drug Addiction (AOD) Challenges
Eighty to 85% of the clients in AOD treatment are referred by the court/probation system. In Warren County there are 15 different municipalities and 11 different townships. These entities are outside of the Warren County Common Pleas Court, County Court, Domestic Relations Court, and Probate Juvenile Court. As a funding and planning board it can be extremely difficult to plan for services in such a diverse county covering such a wide demographic with multiple layers of problems.

The same problem exists for schools and youth services. Research indicates that intensive home-based services are the most effective AOD treatment modalities. However, it is very difficult to develop the momentum and cover such a large area when considering intensive home-based programs.

One additional challenged faced by the AOD treatment providers is the lack of detox beds or facilities for indigent males. The treatment providers in Warren and Clinton County offer MAT using Vivitrol. The protocols for this medication require 7 to 10 days abstinence from opiates/heroin. This presents as a significant barrier to enrolling clients in the Vivitrol program.

These challenges create obstacles to implement evidenced based or research-based practices. The success of the Vivitrol program with the jail population demonstrates how important MAT is for opiate dependent cleints. Medication along with counseling increases the chances a client will remain abstinent. Waiting for incarceration seems counter-productive for long-term recovery as it exascerbates barriers already in place (child support, employment etc).

Seriously Emotionally Disturbed (SED) Services Strengths
An example of strength in the SED Service Plan is the school-based mental health services provided in Warren and Clinton Counties. As noted in question 2, these have expanded considerably and are very well received. In fact, the schools report satisfaction with the services and find them very valuable. For the first time, there are on-site therapists in all 12 school districts during the 2013-2014 school year. The Warren County Learning Center, operated by the Warren County Educational Service Center (ESC), serves as the SED Unit for the county and draws students from many districts. MHRS collaboratively funds the mental health services provided at this school with the ESC.

MHRS' school based services utilizes two models in determining effective integration: The Ohio Community Collaboration Model for School Improvement (OCCMSI by Anderson-Butcher, et. Al., 2004) and National Assembly on School Based Health Clinic's Mental Health Planning & Evaluation Template (developed in collaboration with the Center for School Mental Health). Both these emphasize the necessity to work collaboratively and to have an explicit understanding of the roles of each entity. Using components of each of these, the services are evaluated annually by the clinicians as well as the school staff. As a result of these findings, adjustments can be made and education/training can be implemented to improve upon the fidelity of the program. MHRS maintains a close relationship with Miami University's Center for School-Based Mental Health and often consults with their staff regarding evidence based programs or best practices in the field.

Seriously Emotionally Disturbed (SED) Services Challenges
The overwhelming success of school-based SED services has caused some concern over the escalating costs of providing the service. Schools would, in fact, like to refer more students if funding and staffing was available. However, access has been reported as good by the provider agencies. Further assessment of this conflicting report led to planning efforts to educate the school primary contacts (those who interface with the mental health provider and manage the referrals) regarding various levels of prevention, early intervention and treatment. The hope is to place a student in the level of care that is most appropriate rather than always recommending individual counseling. If some students can be served by an early intervention group, this will allow more clients to be seen within the school.

MHRS maintains a very liberal benefit rule whereby a SED client is never charged for service. Whatever insurance does not pay, this balance is billed to MHRS. Due to demand, this will become unsustainable and at some point a change in the benefit rule will need to be instituted. The below chart indicates the billing of SED services to MHRS over the last 5 fiscal years.

	FY 09	**FY 10**	**FY 11**	**FY 12**	**FY13***
Billing to MHRS	$651,169	$721,475	$713,124	$921,711	$975,248

*FY13 has not yet been reconciled; there is outstanding billing from services rendered by the provider agency which exceeds the contract amount.

As noted previously, MHRS is currently conducting a pilot project with Transitional Age Youth. This is a much needed service. However there have been so many staff changes within the provider agency, very few of the initially trained are still employed there. In November, 2011 MHRS funded a 2 day training in the use of the Transition to Independence Process (TIP). A total of 17 agency staff members attended, including direct service staff and supervisors. Since this time, only 4 of these staff remain with the agency and they are all supervisors. This has impacted the implementation of the program to fidelity and has lead to limited engagement with consumers and low enrollment numbers. MHRS has received consultation with other ADAMHS boards who have implemented this program but we would also welcome a state-sponsored training in TIP to allow newly hired direct service staff to be trained.

General Outpatient (GOP) Mental Health Services Strengths
An example of a success in the General Outpatient Mental Health Services Plan would be in the area of access. Our contract provider agencies have displayed exceptional performance in this arena. As reported previously, in Quarter 1 FY14, the median wait time from request for service to first offered appointment is 15 days. Some locations even had same day appointments available. Despite nearly 100 new clients being admitted on average per month, ready access has been maintained. Given that this is a non-mandated service which has grown considerably over the last 6 years, this is a remarkable success.

General Outpatient (GOP) Mental Health Services Challenges
This service level is not a mandated one, however MHRS feels as though it is crucial as many are voters who support our local levy. A very large number of non-Medicaid consumers are served in this service plan and funded by MHRS sliding fee scale. In FY13, this represented 1,274 individuals. This is an increase of over 170% since FY07 when only 735 non-Medicaid consumers were served in this service plan. With the Affordable Care Act mandate for all citizens to secure health insurance, the hope is that the cost to MHRS will be reduced, even if the sliding fee scale continues and is applicable to co-pays and deductibles. However, the challenge is ensuring that provider agency staff are on insurance panels and are able to bill. Provider agencies have reported that often master's level direct staff work at the agency until they become independently licensed and then either leave employment or become a supervisor. This impacts the ability to bill services to any funder other than Medicaid and MHRS. As further information becomes available about the insurance policies on the Health Insurance Exchange, a meeting will be convened with the provider agency

directors to develop a strategy to address this issue. However, MHRS would be very interested in assistance from other ADAMHS boards or OhioMHAS in addressing this issue.

Another challenge with General Outpatient Mental Health Services is the wait time to see a psychiatrist. Currently at our largest contract agency, it takes nearly 2 months from referral to first appointment (cases are triaged and urgent cases are seen sooner however). Our goal is to have access within 30 days. However, with the escalating census in this service plan, this goal has yet to be attained. The provider agency will begin using more Advanced Practice Nurses to assist in reducing this wait time as well as attempting to have the Primary Care Physician take over the medication prescribing once a consumer is stabilized.

Mental Health Prevention (MHP) Services Strengths

MHRS began requiring a Mental Health Prevention Plan focusing on the use of evidence-based practices in FY10 and has continued. Providers are required to collect and report outcomes from each approved program on a quarterly basis. These results are evaluated and are considered when determining if a program will continue to be approved in future fiscal years or not. This close monitoring of outcomes has strengthened the quality and fidelity of the programming available. While the array may not be as robust, the effectiveness is deemed more valuable.

MHRS is also expanding our reach in prevention by engaging others outside our contract provider network. This will reduce the cost to the system but also create some key collaboration. Specifically:

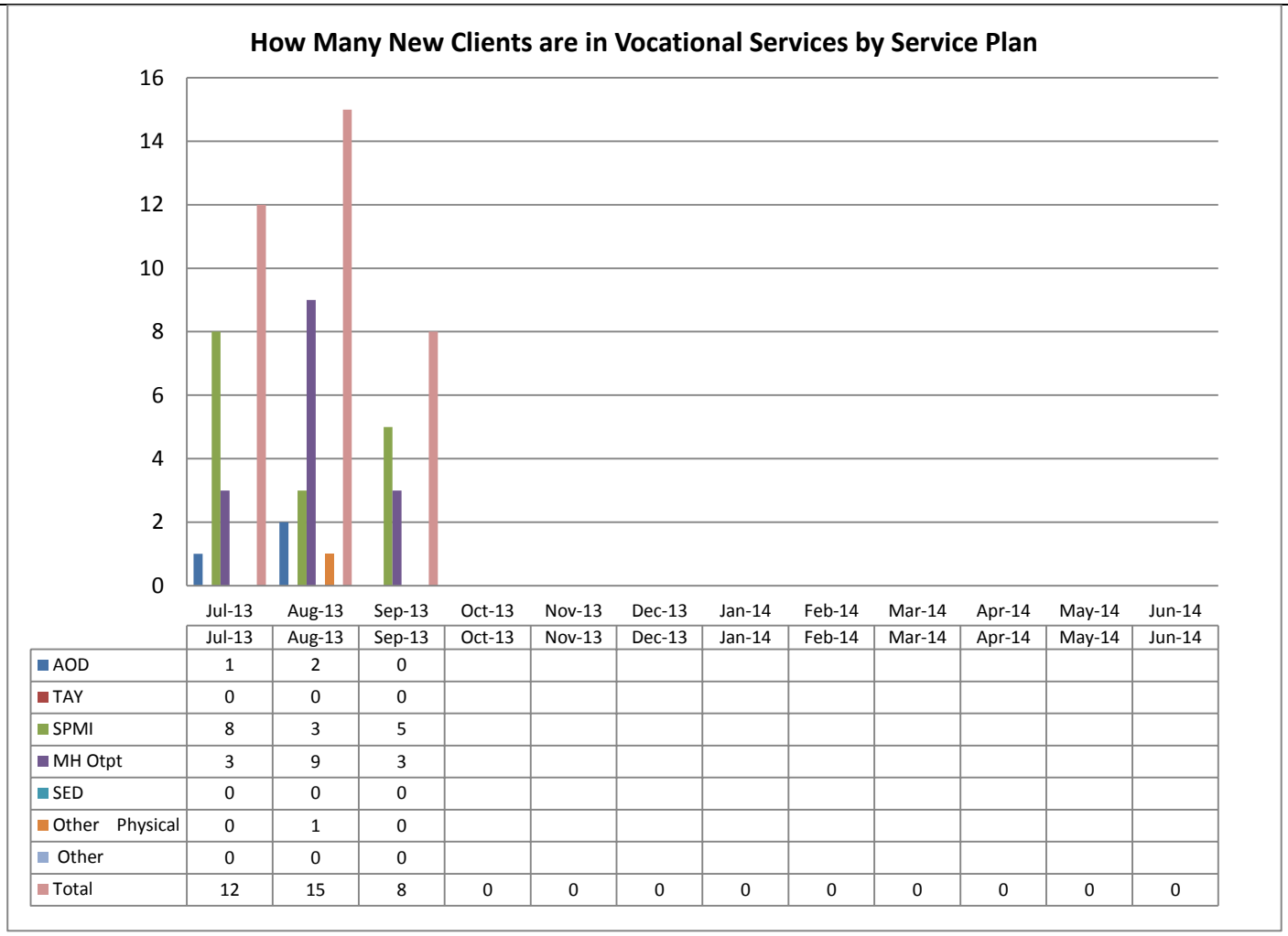
- In FY14, MHRS is partnering with elementary schools to train teachers in the PAX Good Behavior Game. Our first training was conducted on December 2, 2013. MHRS provided this training at no charge to the school districts and will also fund cost of substitute teachers as well as supply kits to the teachers.
- In October, 2013, two MHRS representatives became certified trainers in Mental Health First Aid (a MHRS staff person and a MHRS board member). Six community trainings will be provided in 2014 as a result.

Mental Health Prevention (MHP) Services Challenges

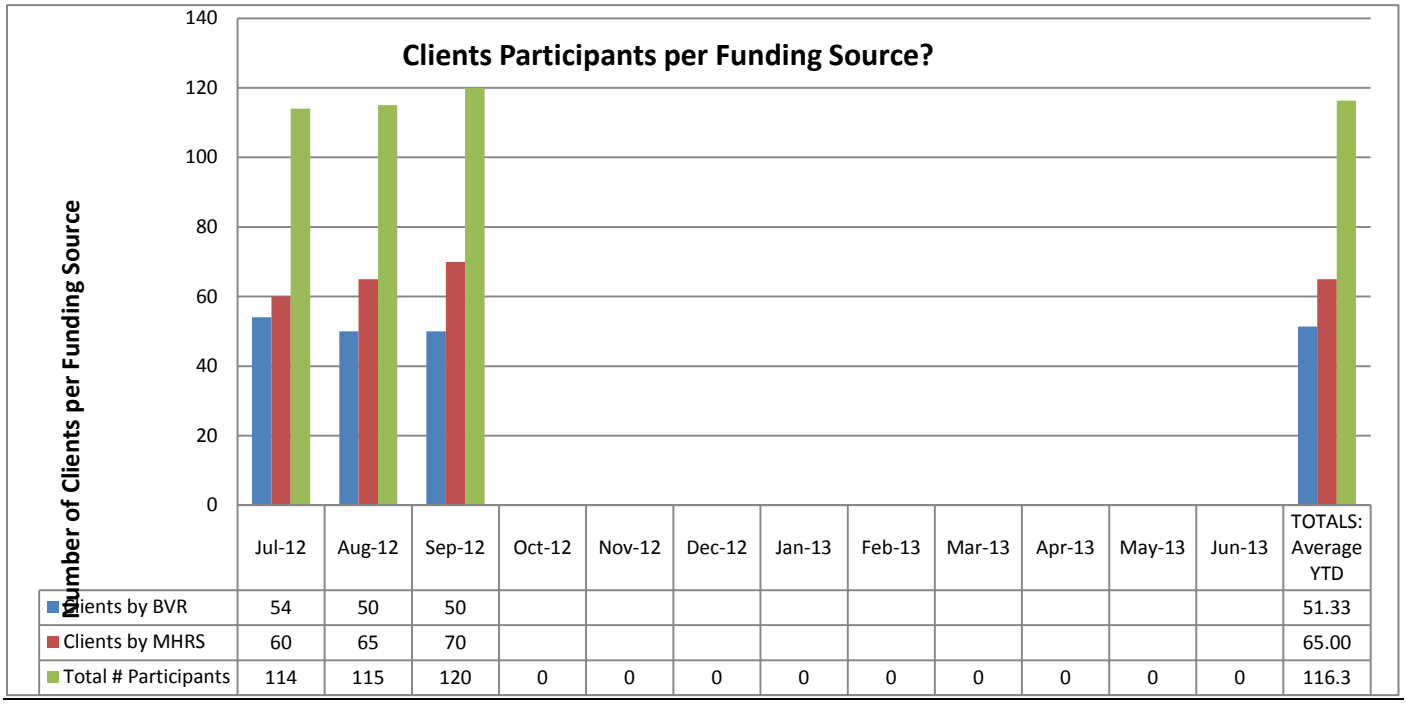
Challenges in providing Mental Health Prevention Services are inter-related and are all associated to the cost of implementing evidence based programs, which at times can be prohibitive. Primarily this is the cost of training staff to conduct the program with fidelity. Often this requires either bringing in a trainer or travel for a staff person to attend a training outside the area. The cost of some of the program kits or curriculum can also be very expensive. Subsequently, if staff members who have been trained in a particular program leave employment with the provider agency, they take this skill with them. Thus, the investment is lost. It has been extremely helpful to have state-sponsored trainings, such as the Ohio Children's Trust Fund's trainings on Incredible Years. This allows for lower training costs and, since these are provided annually, newly employed staff can attend.

Severely Mentally Disabled (SMD) and Severely and Persistently Mentally Ill Service Strengths

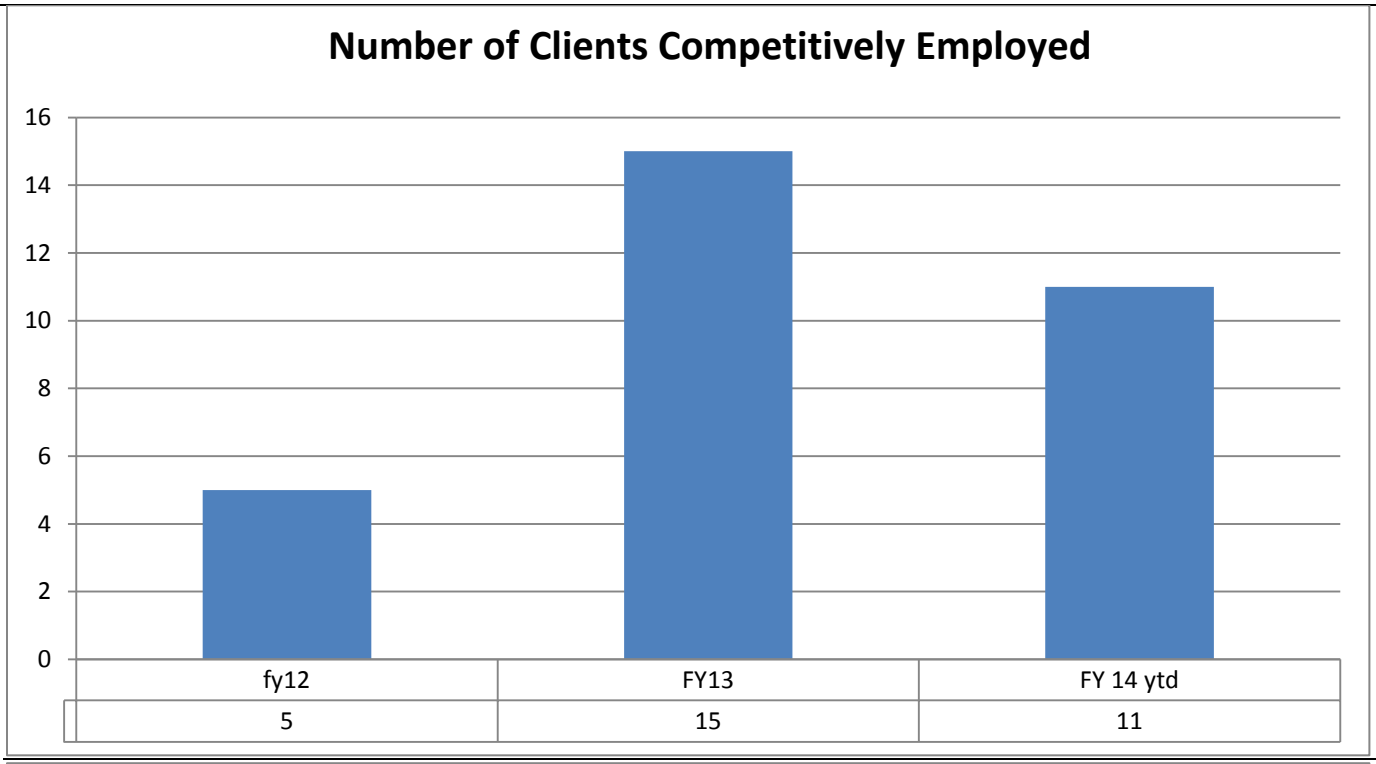
This is the first full year for Pathways to Work since discontinuing the program with Ohio Rehabilitation Services Commission. That decision was made because of the low acceptance of clients, limited by the "most severely disabled" designation required. The MHRS funded program is open to any clients that receive services, regardless of their level of disability or service plan. This program also allows for the maximization of resources in that clients have 2 potential funding streams, MHRS and/or RSC.

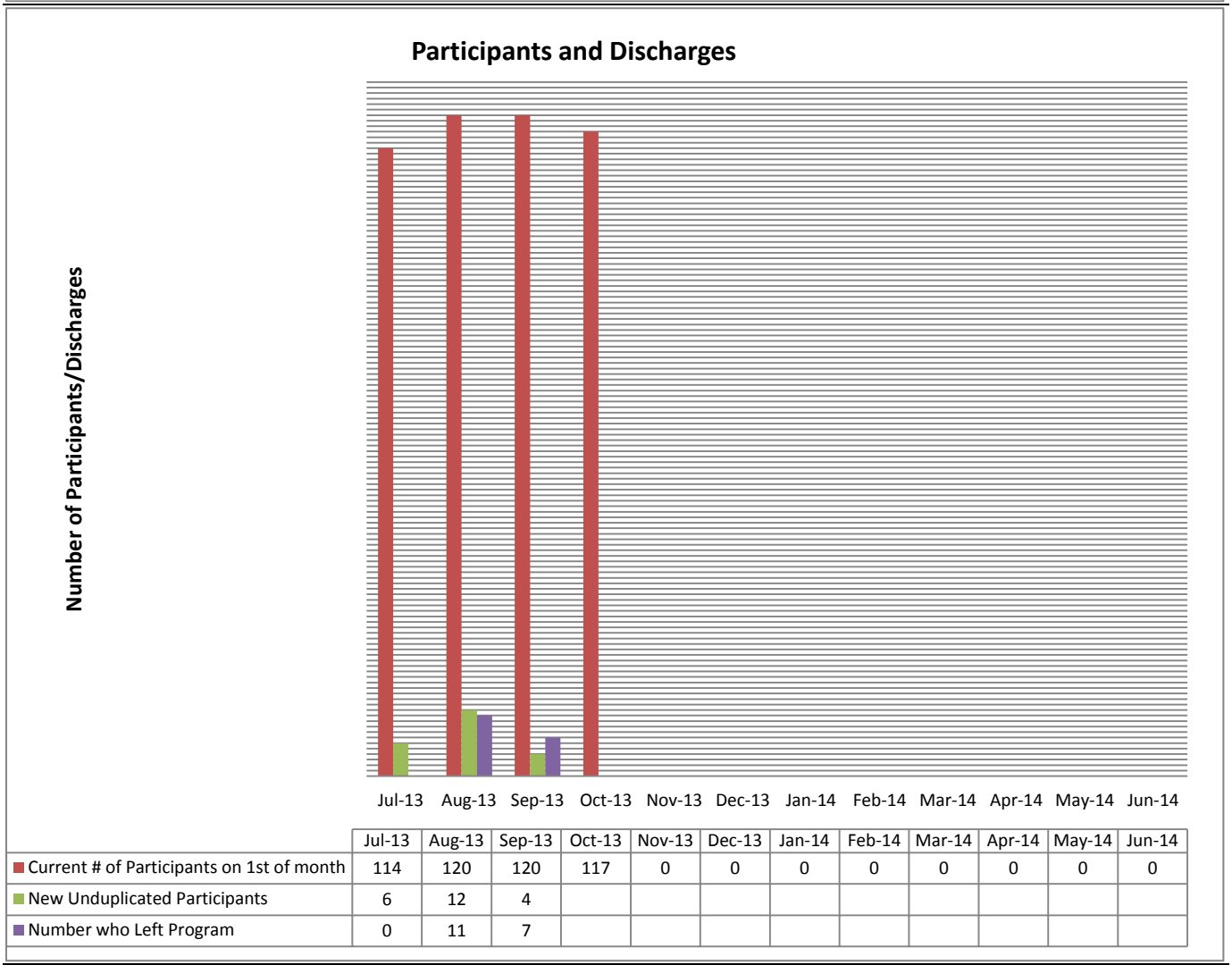


	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
AOD	1	2	0									
TAY	0	0	0									
SPMI	8	3	5									
MH Otpt	3	9	3									
SED	0	0	0									
Other Physical	0	1	0									
Other	0	0	0									
Total	12	15	8	0	0	0	0	0	0	0	0	0



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13	TOTALS: Average YTD
Clients by BVR	54	50	50										51.33
Clients by MHRS	60	65	70										65.00
Total # Participants	114	115	120	0	0	0	0	0	0	0	0	0	116.3





	Jul-13	Aug-13	Sep-13	Oct-13	Nov-13	Dec-13	Jan-14	Feb-14	Mar-14	Apr-14	May-14	Jun-14
Current # of Participants on 1st of month	114	120	120	117	0	0	0	0	0	0	0	0
New Unduplicated Participants	6	12	4									
Number who Left Program	0	11	7									

Implementation of the Crisis Intervention Team (CIT) has been vital in the development of collaboration and communication between mental health services and law enforcement/criminal justice. The CIT project began in FY11 by developing a fidelity model based core curriculum for law enforcement officers. The program has trained 79 sworn officers, and 26 other professionals. In addition, 27 dispatchers have completed a CIT companion course.

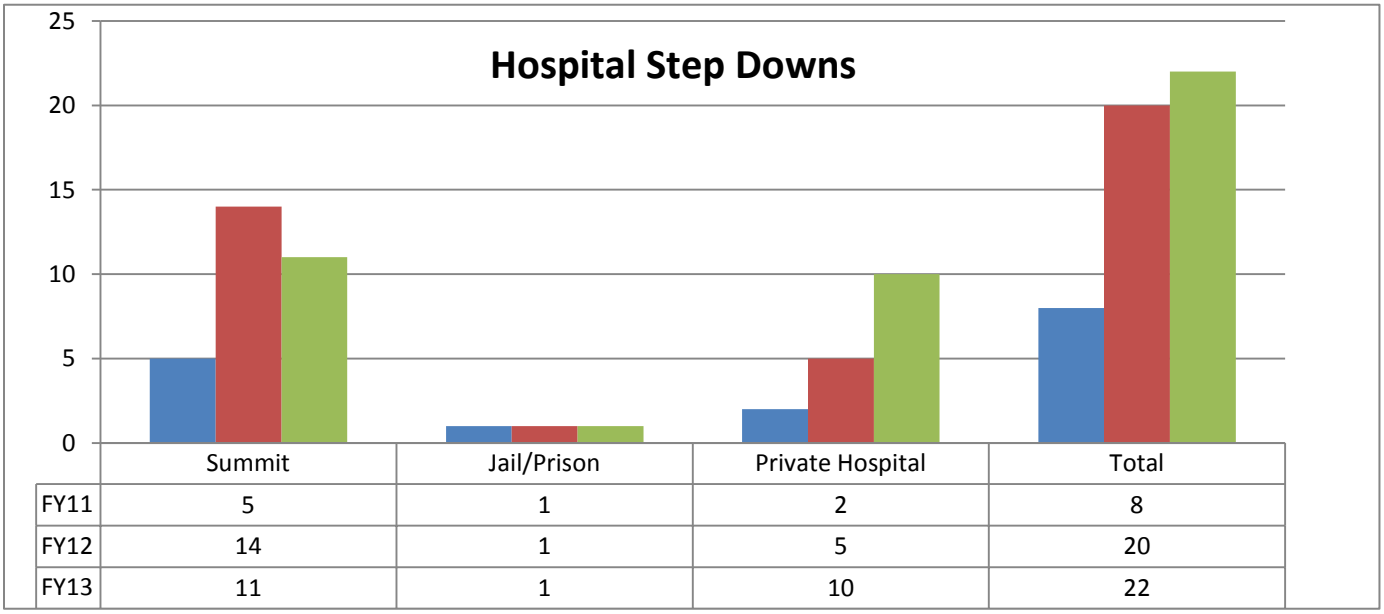
The CIT program is inclusive of a boundary spanner position at the Warren County Jail. This position screens inmates for mental health issues, provides crisis services and provides referral and linkage upon release from jail. (3,364 inmates have been screen since inception). Although referred, the released inmates often do not follow up with appointments in the community. MHRS has funded a Care Linkage case manager for FY14 as a means to increase treatment compliance.

The financial impact of the CIT demonstrates a formula based savings (number of inmates x jail average LOS x jail per idem) shows cost savings compared to baseline costs in FY11 of $61,409. This program can be modified and replicated in both rural and urban communities. The uniqueness of the MHRS program is that it developed the crisis response system and provides services in the jail setting.

Severely Mentally Disabled (SMD) and Severely Persistent Mentally Ill Challenges

Challenges for serving the SPMI population are many. The focus for the purpose of this planning period is the transitional level of care/housing for those clients who are re-entering the community either from jail, civil commitment or forensic commitment. Step-down to a 24/7 supportive environment allows for community integration over a period of time, while re- developing community supports and establishing connections to outpatient treatment services. The availability of transitional beds is quite limited and these beds not eligible for reimbursement by any third party payer.

The chart below demonstrates the use of step down. Averaging four (4) clients in step-down on any given day, the need for an entire facility is not warranted. The "Collaborative" including Clermont, Brown, Warren/Clinton, and Preble counties, is working towards funding a location that all could use for short term transitional clients.



	Summit	Jail/Prison	Private Hospital	Total
FY11	5	1	2	8
FY12	14	1	5	20
FY13	11	1	10	22

Without access to this service, the length of stay and number of clients in the state hospital is likely to increase.

Workforce Development Strengths
MHRS strives to maintain a trained workforce in order to provide the quality services to our consumers. In FY13 and FY14 (to date), MHRS sponsored the following trainings for provider agencies and others in the community:

- DSM-5
- Prevention 101
- Changing the Narrative: Working with People Bereaved by Suicide and Suicide Attempt Survivors
- Evaluating Risk of Harm among Individuals Dually Diagnosed with Mental Illness and Intellectual Disabilities/ Developmental Disabilities
- PAX Good Behavior Game

These trainings were provided either at no cost or at a nominal cost to participants.

Workforce Development Challenges
The last several years have been quite challenging with regards to workforce development at our provider agencies. The following are several situations which have contributed to this:

- Medicaid Reimbursement Rates have remained unchanged for years. During this same time, costs of running a business have escalated including salaries, benefits, rent, mileage reimbursements and supplies, just to name a few. Some of the easiest expenses for agencies to cut are personnel costs. This can lead to the employment of less qualified or less experienced staff.
- Staff turnover results when better compensation and opportunities are offered outside the system. Oftentimes when an agency staff member attains independent licensure or higher credentialing and experience, s/he leaves for private practice or other more lucrative employment.
- OhioMHAS' change in the Health Homes Reimbursement structure has resulted in all our contract provider agencies deciding not to pursue this certification at the present time. This decision was made after many months of agency-level planning and substantial resources spent on developing the necessary structure to implement this service. The reimbursement change rendered this service financially unfeasible for the agencies. Hence, these wasted resources could have been utilized in other arenas which would been more beneficial for our consumers.

5. Describe the Board's vision to establish a culturally competent system of care in the Board area and how the Board is working to achieve that vision (see definitions of "cultural competence" and "culturally competent system of care" in Appendix 2).

Culturally Competent System
The "Contract for Services for FY 2014" between Mental Health Recovery Services of Warren & Clinton Counties with its contract providers clearly specify in Article 4: General Service Requirements, Section 4.4.8 that, "Services shall be culturally competent and shall respond effectively to: (a) the individual's needs and values present in all cultures, including, but not limited to, the African-American, Hispanic, Asian, Appalachian, and Native American cultures, (b) the needs of person with disabilities, including persons who are hearing and/or sight impaired, (c) needs based on each client's gender and sexual orientation, and (d) the needs on each client's age."

Provider treatment agencies may establish their own methodologies as to "how" they show compliance to meeting these standards. All agencies provide either an annual training for all staff or a number of training topics dealing with cultural diversity and most of the specific populations identified above. Talbert House requires all employees to have a minimum of two hours of diversity/competency training annually. Trainings can be obtained online through e-learning, and offered 1-hour trainings every other month on issues related to cultural diversity.

Solutions Community Counseling and Recovery Centers, our primary contract provider has two mental health and alcohol drug addiction professionals and a prevention specialist that are bi-lingual (English and Spanish). Talbert House has a Diversity Committee comprised of a cross section of positions, service lines, roles and disciplines with the agency.

The committee advises the affiliation on practices that will facilitate and support an environment where optimal human relations may flourish. Agencies also have contracts with Cincinnati Speech, Hearing and Vision to assist with consumers as needed.

The fact remains that Warren and Clinton Counties are not racially or ethnically diverse areas. It is therefore critical for the system to look beyond these common cultural factors and delve into other possible aspects which may be at play (i.e., age, language/accent, educational level, income, religion/faith, disability, sexual orientation and physical appearance).

In FY 2012 we developed several new surveys (i.e., community, family, consumer and referral source surveys) that were accessible through our website with Wright State University's Center of Urban and Public Affairs Department. One particular area we desired to explore is if individuals perceive to have been subjected to cultural biases. Unfortunately, as reported in FY 2013 Community Plan (Update), we were very disappointed in the small number of completed web-based surveys therefore the project was terminated. In FY 2014 we are now working to develop a "Board Referral Source" satisfaction survey that will look at including an expanded view of these cultural factors in the survey instrument itself as a means gather additional information beyond that provided by the provider systems.

Priorities

6. ***Considering the Board's understanding of local needs, the strengths and challenges of your local system, what has the Board set as its priorities for service delivery including treatment and prevention and for populations? Below is a table that provides federal and state priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board's priorities, and add the Board's unique priorities in the space provided. For those federal priorities that are mandatory for the OhioMHAS and not selected by the Board, please check one of the reasons provided (e.g., no assessed local need, lack of funds to meet need, lack of necessary professional staff) or briefly describe the applicable reason.***

Board Priorities for Service Delivery

Fiscal Year 2013 was a year in transition. Beginning on September 12, 2012 through January 9, 2013, MHRS' Board of Directors conducted a comprehensive overview and an S.W.O.T. analysis of our behavioral healthcare system. This resulted in the development of 4 new strategic goals that will lead our behavioral healthcare system in FY 2014 through FY 2016. The prior strategic goals developed in 2008 and implemented through FY 2012 are now woven into MHRS's fabric while the new strategic goals with a focus on health and wellness promotion are believed to offset costs and need for traditional behavioral healthcare services. The following is the new strategic goals for FY 2014 through 2016 MHRS Behavioral Healthcare System:

(1) Establish a coalition of community stakeholders to promote wellness across the lifespan;
(2) Raise community awareness of risk factors that impact overall health;
(3) Expand the profile of MHRS' system of care as the premier entity for emotional and mental wellness;
(4) Generate new system capital in order to secure support for reliable and sufficient future funding of services.

Note:
As previously stated, refer to "Environmental Context of the Plan/Current Status" pages 1 through 2, MHRS is utilizing reserve funding for many of the following identified priority services. We have projected by FY 2016, if additional revenues are not identified, we will be in a major financial deficit, and therefore specific priority services may not be sustainable.

Priorities for (Mental Health Recovery Services of Warren and Clinton Counties)				
Substance Abuse & Mental Health Block Grant Priorities ***Priorities Consistent OhioMHAS Strategic Plan**				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)	Prioritize services for IVDU seeking services.	Improve current screening for IVDU by moving screen to initial contact and training screeners on appropriate referrals for IVDU.	Capture the number of positive screens through KPI data in FY-15.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory: Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	Provider organizations must refer pregnant women to another organization when the program has insufficient capacity to provide services to any such pregnant women who seek the services of the program. Provider organizations shall make interim services available within 48 hours to pregnant women who cannot be admitted because of lack of capacity.	Improve current screening for pregnant SUD females by moving screen to initial contact and training screeners on appropriate referrals for pregnant SUD females.	Capture the number of positive screens through KPI data in FY-15.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory: Parents with substance abuse disorders who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Increase the number of screenings for SUD for pregnant women. Decrease barriers for parents with SUD who have dependent children.	Increase the number of screenings for SUD for pregnant females Provide assessments, prior to leaving the hospital for women whose babies have tested positive.	Track the number of completed screenings in the OBGYN clinics Track the number of completed assessments for mothers who are being discharged from the maternity ward at CMH.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases	Education regarding STD, HIV, TB and Hep C shall be provided to all persons seeking services. This information should include how and where to be screened. Additional information may include: 1. Counseling and education about HIV and TB, the risks of needle-sharing, the risks of transmission to sexual	Improve current screening for TB for persons seeking services. Provider organizations are required to link positive screens to appropriate medical services.	Provider organizations will report to MHRS the number of individuals reporting positive for TB.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):

	partners and infants, and steps that can be taken to ensure that, 2. HIV and TB transmission does not occur, 3. Referral for HIV or TB treatment services, if necessary.			
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Manage the increase in demand for services by: 1. Expanding the use of Early Intervention Groups. 2. Enhancing Insurance Billing by providers.	1. Research and implement evidence-based programs to meet the needs of children when symptoms first begin to emerge. 2. Engage provider agency directors in discussions with the goal of increasing the number of staff members enrolled on insurance panels.	1. Expansion on the array of service levels available. 2. Increase in the number of counseling groups provided. 3. Increase in the number of Insurance panels agency staff are enrolled on. 4. Increase in the number of clients served with no increase/reduction in MHRS billing.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Expand treatment integration for SAMI clients.	1. Improve identification of SAMI clients 2. Identify training opportunity to assist providers with integration of SAMI treatment.	Monitor a sample of charts of SPMI clients to ensure that AOD issues are identified and become part of the ISP.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH&SAPT-BG: Mandatory (for OhioMHAS): Integration of behavioral health and primary care services*				__ No assessed local need __Lack of funds __ Workforce shortage _X_ Other (describe): Two contract providers have active projects to address behavioral health/physical health integration. One is developing a Federally Qualified Health Center in northern Warren County. The other provider is developing co-location of physical health providers in their behavioral health centers.

MH&SAPT-BG: Mandatory (for OhioMHAS): Recovery support services for individuals with mental or substance use disorders	Peer Support and Recovery Coaching.	Increase number of Peer support specialists in the system.	Fund training and additional positions.	This initiative cannot be fulfilled as the Medicaid funding for service reimbursement is still not available
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant *Priorities Consistent OhioMHAS Strategic Plan				
Treatment: Veterans	Increase knowledge of available veterans' services with law enforcement, crisis providers and treatment providers.	1. Provide opportunities for training for provider agencies 2. Provide opportunities for training for law enforcement officers.	Number of personnel trained regarding resources and issues.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Treatment: Individuals with disabilities	Continue with the Dual Diagnosis Taskforce and Dual Diagnosis Intervention Team (DDIT) which was developed in 2007. (This references individuals with both intellectual disabilities/developmental disabilities and behavioral health diagnoses.)	1. Pooled Funding for DDIT clients' needs which fall outside other funding mechanisms. 2. Cross-systems training to ensure cohesive service delivery to dually diagnosed clients. 3. Periodic informal needs assessment and gap analysis for service expansion/ variation purposes.	1. Monitor utilization of Pooled Fund and need to replenish. 2. Provide trainings, monitor attendance and post-program evaluations. Solicit input on suggestions for future trainings. 3. Evaluate results of needs assessment/gap analysis and resulting plans.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Treatment: Opiate addicted individuals in the state, including illicit drugs such as heroin and non-medical use of prescription drugs*****				__ No assessed local need __Lack of funds __ Workforce shortage _X_ Other (describe): As previously reported, (refer to "Formal Needs Assessment"), the community clearly identifies opiates/heroine as problematic substances and the misuse or abuse of prescription medications concerns continue to prevail regarding abuse of alcohol and data suggests that alcohol dependence is the most frequently treated substance-related disorder by contract providers in Warren and Clinton Counties. MHRS contracted with Solutions to evaluate the use of

				Vivitrol with existing clients (refer to page 25). The findings from this project indicate about 50% success for participants who started the program. This is a five-fold improvement over counseling alone.
Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing*****	Support of homeless shelters as an interim solution for homeless mentally ill clients.	Continue support of homeless shelters commensurate with percentage of SPMI population served.	Collect data for identified SPMI clients -those referred from providers - those referred to providers - those moved to subsidized housing	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Treatment: Underserved racial and ethnic minorities and LGBTQ populations	No assessed local need.			_X_ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Treatment: Youth/young adults in transition/adolescents and young adults	1. Implement Transition to Independence Process (TIP) Model to fidelity with positive outcomes. 2. Increase the number of consumers enrolled in program.	1. Train direct care staff in the TIP Model. 2. Collect and analyze outcomes data. 3. Increase outreach to referral sources.	1. TIP Fidelity Tool 2. Key Performance Indicators measuring: a. number of arrests b. number of psychiatric hospitalizations c. co-occurring AoD treatment d. number of referrals 3. Results from Ansell-Casey Life Skills Assessment	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Treatment: Early childhood mental health (ages 0 through 6)*****	1. Continue with the Early Childhood Mental Health Consultation services. 2. Expand services to parents through new contract provider as a means to reduce trauma to children and to provide early intervention when problems emerge.	1. MHRS will provide grant funding to Solutions Community Counseling and Recovery Services to continue ECMHC services. 2. MHRS will contract with Beech Acres Parenting Center for Parent Coaching and Parent-Child Interactive Therapy.	Monitor provision of services, outcomes and consumer satisfaction through Key Performance Indicators.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):

Prevention: Adopt a public health approach (SPF) into all levels of the prevention infrastructure	Research methods to reduce the number of suicide deaths in Warren and Clinton Counties by the method of gunshot wound (most used method according to Health Department data).	1. Engage owners of gun shops and target ranges in a discussion regarding potential strategies to reduce the use of guns in suicide deaths. 2. Research prevention methods implemented in other areas.	Development of a viable prevention program supported by stakeholders and key informants based upon collected information.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents*****	1. Continue with Incredible Years prevention programming for children and parents. 2. Continue with a variety of other evidence-based prevention programs as defined by the Mental Health Prevention Plan submitted by each provider and approved by MHRS. 3. Expand services to parents through new contract provider as a means to reduce trauma to children and to provide early intervention when problems emerge. 4. Train school teachers on implementation of PAX Good Behavior Game and support implementation.	1. Continue to contract with Solutions Community Counseling and Recovery Centers for the provision of a variety of prevention programming for those across the lifespan. 2. Continue with the Mental Health Prevention Plan submission process and approval by MHRS. 3. MHRS will contract with Beech Acres Parenting Center for Parent Coaching and Parent Educational seminars on MHRS-approved topics. 4. MHRS offered a training to school teachers on 12/3/13 on PAX Good Behavior Game and will financially support on-going technical assistance through the remainder of the school year to ensure implementation fidelity.	1. Key Performance Indicator measurements evaluating participation in and outcomes of each program provided. 2. Classroom observations of teachers implementing the PAX Good Behavior Game.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Empower pregnant women and women of child-bearing age to engage in healthy life choices				__ No assessed local need __Lack of funds __ Workforce shortage _X_ Other (describe): While this has not been an established priority of MHRS, some services have been provided in this arena. In particular, a contract agency has offered educational seminars and materials to pregnant women on Fetal Alcohol Syndrome and Maternal Depression. Additionally, MHRS continues to

				work collaboratively with the counties' Help Me Grow programs to provide information and linkages to behavioral health services for their consumers. Also reference the mandatory priority on page 34 entitled "Women who are pregnant and have a substance use disorder" for additional strategies.
Prevention: Promote wellness in Ohio's workforce	Provide Mental Health First Aid training to local employers and HR professionals.	Provide six (6) Mental Health First Aid Trainings before October 2014 with at least 10% of participants employers or HR professionals.	Evaluations from Mental Health First Aid Trainings will identify local employers and HR professionals in attendance.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations*****	Screen 100% of individuals who are seeking services at contract organizations.	Provider organizations will integrate an approved screening instrument for problem gambling into the intake process.	Provider organizations will report the number of persons screened to MHRS.	__ No assessed local need __Lack of funds __ Workforce shortage __ Other (describe):

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Insurance Billing	1. Uninsured consumers in the system will become insured either through Medicaid expansion or through the ACA Health Exchange. 2. Contract provider agencies will have a sufficient number of staff enrolled on insurance panels to maximize third party billing.	1. Contract provider agencies will educate consumers on insurance opportunities and assist with enrollment as feasible. 2. Contract provider agencies will enroll staff at each clinic location on insurance plans listed on the ACA Health Exchange for Warren/Clinton Counties.	1. Monitor the number of consumers who remain uninsured after effective date of Medicaid expansion and ACA private insurance mandate. 2. Monitor contract provider agency staff enrollment on insurance panels. 3. Monitor MHRS billing.
Psychiatric access	Access to outpatient psychiatric services will be within 30 calendar days from referral to first appointment (except in urgent situations).	1. Increase the utilization of physician assistants at contract provider agencies. 2. Active caseload review whereby medication	Key Performance Indicator data to monitor number of new clients being referred to psychiatric services and wait

		management is transitioned to regular physician once client is stable.	time.
Decrease waiting time for psychiatric appointments for SPMI clients	1. Ensure access for post-hospitalization clients within 14 days. 2. Ensure access for new SPMI clients within 30 days of assessment and ISP completion.	• Reminder Calls • Repeat No Show Policy • Psychiatric Services Change • Telemedicine	1. Decrease wait times by 10% 2. Decrease waiting list by 10%
Develop an outpatient trauma informed system of care	Increase the awareness of trauma in relationship to care provision as it applies to all elements of the outpatient delivery system.	1. Identify best practices. 2. Provide training opportunities for outpatient contract agencies. 3. Support implementation.	Completion of trauma informed care training for outpatient contract providers.

Priorities (continued)

7. What priority areas would your system have chosen had there not been resource limitations, and why? If you provide multiple priority areas, please prioritize.

Priority if resources were available	Why this priority would be chosen
(4)	
(5)	
(6)	
(7)	
(8)	
(9)	
(10)	
(11)	
(12)	
(13)	
(14)	
(15)	

Collaboration

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

MHRS Boards Accomplishments:
The following is a summary of the types of collaborative relationships and specific achievements for the reporting period between FY 2008 through FY 2012. This timeframe is in reference to the Board's strategic goals established in FY 2007 for FY 2008 through FY 2012 services.

MHRS & Provider System Collaboration Achievements:

A. Seriously Emotionally Disturbed Services
   - Treatment services (includes school-based) increased by 53%.

B. Seriously Emotionally Disturbed Youth Out-of-Home Placements
   - Number of placements and costs decreased by 68%.

C. Severe Mental Disability Services
   - Treatment services costs were decreased by 12.29%;
   - Implemented "cluster-based" and "wellness management & recovery" initiatives;
   - Received the "Community Champion Award" from the WMR Ohio Coordinating Center of Excellence.

D. State and Private Hospital
   - Length of Stays and costs decreased by 52%.

E. Mental Health Prevention
   - Services increased by 45.31%.

F. General Outpatient Services
   - Services (includes home-based) increased by 235.38%.

G. Alcohol and Other Drug Services
   - Treatment services increased by 30.90%;
   - Treatment services expanded to include new provider agency, Talbert House;
   - Developed & implemented, "Vivitrol Pilot Project" w/ Solutions Community Counseling & Centers.

H. Alcohol and Other Drug Prevention
   - Prevention services maintained to actual billings;
   - Prevention services expanded to include a new provider agency, Talbert House;

I. Provider Consolidation Initiative
   - MHRS collaborated with its' two primary provider agencies that agreed to consolidate and combine services;
   - The short term cost savings estimated to be over $400,000 and funding was used for treatment service sustainability and expansion.

J. Intensive Case Coordinator Collaborative Project
   - MHRS established collaborative relationships with Brown and Clermont ADAMHS Boards to address the need for additional case management services in each county through a team concept with will ignore county boundaries.

MHRS & Non-Behavioral Health System Collaboration Achievements:

A. Dual Diagnosis Intervention Team
   - Developed policies for implementation of the "DDIT" with DD Agencies;
   - DDIT awarded the statewide "Clinical Quality Award" by ODMH;
   - DDIT received the "Award of Excellence" by the DD Ohio Coordinating Center of Excellence.

B. Faith Based Collaborative Team
   - Developed the "Faith Based Collaborative Team";
   - Integrated into WC NAMI to enhance consumer connections with local faith based organizations.

C. AOD Screening Collaborative Taskforce
   - Developed with local Courts;
   - Received "Honorable Mention" by the American Society of Quality for the design and implementation of the "Substance Abuse Monitoring Services Online Now" Project;
   - Annual cost savings of over $100,000 were reallocated to provide more AOD treatment.

D. Ohio Youth Survey Project
   - MHRS was only Board Area to actually complete the "Ohio Youth Survey Project";
   - Results published in the Psychiatric Quarterly and the European Psychiatry Journal;
   - Data has been utilized for local planning purposes.

E. Integrate Schools & Mental Health Systems
   - MHRS and the Warren County Educational Service Center submitted joint application and received funding (approximately $300,000) from the U.S. Department of Education to "Integrate Schools and Mental Health Systems". We were one of 17 grantees in the entire nation and only recipient from Ohio.
   - The grant funded two coordinator positions that are assisting schools in Resource Mapping and Gap Analysis regarding the full continuum of behavioral health services.

F. Mini-Grant Projects
   - MHRS developed and implemented the "Mini-Grant" Projects. The goal is to enhance partnerships and creativity in investing in prevention services provided by non-contract agencies in the community;
   - Since its inception, MHRS has awarded 43 grants for a total award amount of approximately $373,000 in FY11 through FY14.

G. Crisis Intervention Team
   - Received a grant from the Health Foundation of Greater Cincinnati to develop and implement a C.I.T. Project in Warren County.

H. Jeremiah Morrow Bridge Community Forum
   - MHRS established a community forum with WC Fire Chiefs, Sheriff, Hwy Patrol, Coroner's and Dispatcher offices and Parks to create widespread ownership for collaborative action in order to lessen the possibilities for increased suicide attempts at the Jeremiah Morrow Bridge. The collaborative suggested viable options for citizens of Warren and/or Clinton County regarding this significant community issue due to the redesign of the bridge.

I. Warren County Transportation Community Forum
   - MHRS established a community forum with Warren County Transit Advisory Council, Developmental Disabilities, United Way, Council of Aging, FCFC, Grants Admin. and Assistant Prosecuting Attorney to address the impact the change in transportation designation will have upon our county.

J. Board Properties Ad-Hoc Committee
   - MHRS worked with City Council and County Commissioners regarding sale of specific properties, rezoning and the transfer of properties resulting in cost reductions from the sale and associated capital expenses reallocated for service sustainability.

K. MHRS Web –Based Surveys
   - MHRS contracted with Wright State University's Center for Urban and Public Affairs to develop web-based survey instruments to be deployed with family, consumers, referral sources and community members affiliated with MHRS.

L. M.E.R.G.E.
   - MHRS established a contractual agreement with Brown County ADAMHS Board for sharing professional resources.
   - Submitted and received grant funding from the Ohio Local Government Innovation Grant to conduct a feasibility study to merge administrative functions of boards in order to offer the most cost effective, high quality contract services to citizens (proposed saving estimated to be $1,010,88. over 3 year period.

M. Horizons Collaborative
   - MHRS entered into a board alliance with 4 ADAMHS Boards (Allen, Auglaize and Hardin; Clark, Green and Madison; Drake, Miami and Shelby; and Clermont Counties) for the purpose to improve efficiency by

encouraging outsourcing of functions where practical, enhancing opportunities for advocacy by representing a larger area with a population exceeding one million residents, and enabling joint applications for funding which would be for the benefit of each ADAMHS Board participating;

- Present initiative is implementing a pilot project, "Good Behavior Game" in each Board area.

N. Strategic Planning with the Community

- The methodology for determining "what is important" includes feedback from the provider system as well as community input from schools, court systems (both adults and juvenile), elderly services, health departments, children services and others who participate in community planning sessions.

As previously stated in the "Priorities Section" of this plan, FY 2013 was a year in transition with the development of 4 new strategic goals that will lead our behavioral healthcare system in FY 2014 through FY 2016. Fiscal Year 2013 will serve as our benchmark for measuring growth and achievements that will focus primarily on health and wellness initiatives to offset costs and need for traditional behavioral healthcare services.

MHRS has continued to increase funding for specific services: SED, GOP, AOD and Prevention Services. Reductions and savings in hospital rates have been reallocated for expansion of needed services. In FY 2014 MHRS established a new contractual relationship with another behavioral health care provider, Beech Acres. In addition, MHRS is developing several innovative programs in FY 2014 that are described in the "Innovative Initiatives Section" that we believe when implemented will have long term positive implications for our future.

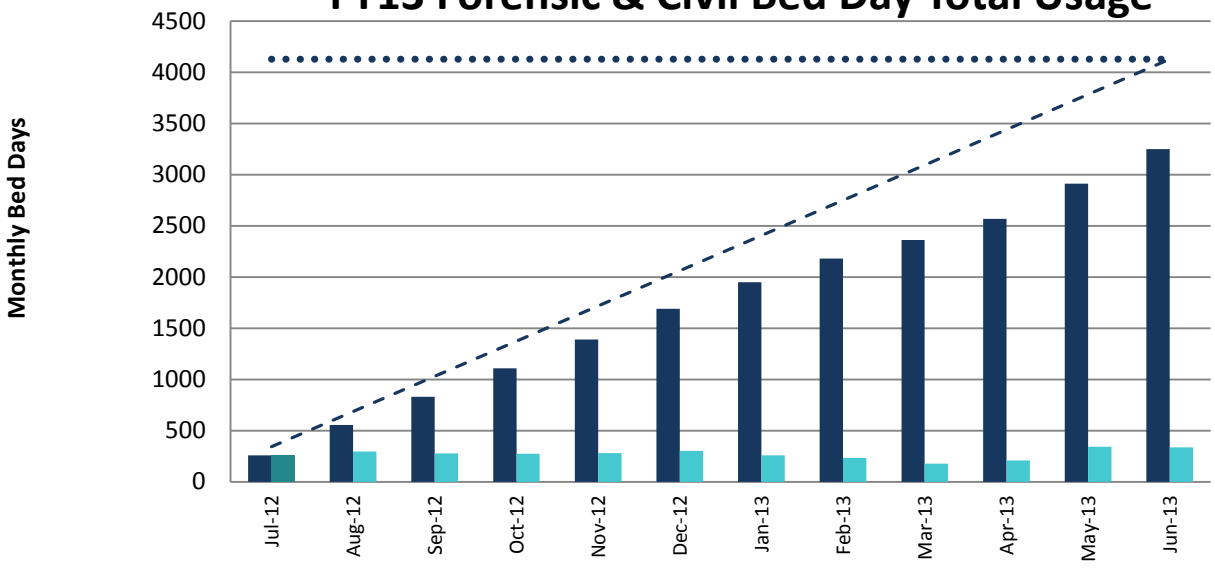
Inpatient Hospital Management

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

Interaction Between State/Private Hospitals and Housing Supports

Measuring and understanding the relationship between these three specific services, state and private hospitals and local housing supports, is paramount. Even a positive change in anyone service (i.e., reduction in state hospital utilization) can easily be offset with increased costs in another service (i.e., private and/or need for more housing and supports).

The following chart shows MHRS' monthly State Hospital Utilization census for FY 2013. Based upon the Ohio Department of Mental Health and Addiction Services daily census reports, MHRS is showing a total reduction of **976** bed days – well below the annual target range. Of the total number of ADAMHS Boards (50) only 18 (36%) are below their averages at close of FY13. Of the 18 boards below their averages, MHRS finished the fiscal year with the 4th highest number of bed days below its average.



	Jul-12	Aug-12	Sep-12	Oct-12	Nov-12	Dec-12	Jan-13	Feb-13	Mar-13	Apr-13	May-13	Jun-13
Total YTD	260	555	832	1108	1389	1691	1949	2182	2361	2570	2913	3251
Total days per Month	260	295	277	276	281	302	258	233	179	209	343	338
Annual Total Day Allocation	4127	4127	4127	4127	4127	4127	4127	4127	4127	4127	4127	4127
Annual target range	344	688	1032	1376	1720	2064	2407	2751	3095	3439	3783	4127

As we all know, the Hospital Services Committee reported that the collective statewide bed target has been eliminated for FY 2014, but Boards that were able to hit individual targets in FY 2013 will and did receive the additional upfront allocation in November 2013. MHRS appreciated the additional upfront allocation although the additional revenues do not come close to covering the need for additional housing services. As board areas hit individual targets in FY 2013 their FY 2014 total annual allocation bed days will presumable reduce and will eventually simply be shifting costs from state hospital expenses to either private and/or housing supports at the local level. Since the OhioMHAS Department is no longer financially penalizing a board area when exceeding its target average and when costs are shifted to the local boards for increased private and/or housing supports there are little to no financial incentives to award boards for improved clinical care.

Issues regarding the state hospital:

1. ACCESS- although MHRS does not utilize its 4 bed civil allotment, there are times when a bed is unavailable die to high census and LACK of adequate physician coverage for the number of licensed beds. This is not acceptable.
2. The forensic process is fragmented and inconsistent. There are delays in processing level movement requests on particular units as the personality of the unit staff refuses to consider requests only after long periods of time pass. (If on another unit, there is consideration in a timelier manner.)
3. The evaluations for forensic movement are very, very slow with certain psychologists.
4. Clients with a combination of medical and mental health issues, such as those with hyponatremia, are difficult to place and there is a lack of appropriate alternatives in the community, thus driving up length of stay.

Innovative Initiatives (Optional)

10. ***Many boards have implemented innovative programs to meet local needs. Please describe strategies, policy, or programs implemented during the past two years that increase efficiency and effectiveness that you believe could benefit other Ohio communities in one or more of the following areas?***
    a. ***Service delivery***
    b. ***Planning efforts***
    c. ***Business operations***
    d. ***Process and/or quality improvement***

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

Healthy Communities Collaborative (HCC) Program

Historically, the primary focus of MHRS has been devoted to treatment. Recently, the MHRS Board of Directors increased the focus to include preventive services in an effort to thwart the need for expanded treatment services in the future. These prevention efforts could include education on appropriate coping skills, drug resistance skills, and by promoting positive youth development, parenting skills, etc. The Warren County Combined Health District (WCCHD) and the Clinton County Health Department (CCHD) strive to promote health and the quality of life by preventing and controlling disease, injury, and disability. A statewide goal of the Association of Ohio Health Commissioners is to "increase awareness and adoption of healthy behaviors".

It became apparent that the missions of our three organizations could be furthered after the dissemination of the National Prevention Strategy in June 2011, which was created by the National Prevention, Health Promotion, and Public Health Council led by Surgeon General Regina M. Benjamin, M.D. The vision of this strategy is "Working together to improve the health and quality of life for individuals, families, and communities by moving the nation from a focus on sickness and disease to one based on prevention and wellness". The goal is to "increase the number of Americans who are healthy at every stage of life". The National Prevention Strategy endorsed seven priorities: (1) Tobacco Free Living, (2) Preventing Drug Abuse and Excessive Alcohol Use, (3) Healthy Eating, (4) Active Living, (5) Injury and Violence Free Living, (6) Reproductive and Sexual Health, and (7) Mental and Emotional Well-Being.

As illustrated in the National Prevention Strategy document, these seven priorities are all inter-related, and a community-wide effort is necessary to promote overall health and wellness. In fact, the Strategy indicates "aligning and coordinating prevention efforts across a wide range of partners is central to the success of the National Prevention Strategy. Engaging partners across disciplines, sectors, and institutions can change the way communities conceptualize and solve problems, enhance implementation of innovative strategies, and improve individual and community well-being".

MHRS, WCCHD, and CCHD have collaborated on various projects in the past, largely in our roles as members of the local Family and Children First Councils. However, a project to enhance the overall health and wellness of our citizens seems most logically to fit under the departments responsible for the behavioral health and physical health of the communities' citizens. MHRS has taken the lead on this project and WCCHD and CCHD are partnering with MHRS in developing the “Healthy Communities Collaborative (HCC)”. The vision of the HCC is to be a coalition of key community stakeholders that will begin working to affect health and wellness issues from a county level by streamlining efforts and resources. Though the project is in its infancy, MHRS is expecting this project to move forward in the 2014 calendar year. The following objectives lay out the process that will be completed in FY14.

1. Establish a Coalition of Community Stakeholders to Promote Wellness Across the Lifespan: Healthy Communities Collaborative (HCC)
    - Develop Charter/MOU Documents
    - Develop Linkage of Process Table
    - Recruit HCC Key Stakeholders/Members
    - Develop Plan to Reach Key Policymakers
2. Raise Community Awareness of Risk Factors that Impact Overall Health:
    - Articulate HCC Community Prevention Vision
    - Conduct HCC Environmental Scan
        - Compile and analyze health data
        - Establish Performance Measures
    - Identify Potential Resources for Plan Implementation
3. Generate New System Capital in Order to Secure Support for Reliable and Sufficient Future Funding of Services:
    - Identify & Submit Grant Opportunities For Sustainability of HCC Program and Projects
    - Participate in OACBHA Week-Long, High-Intensity Grant Training

Advocacy (Optional)

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

A Personal Journey of Living Successfully with Mental Illness through Treatment My name is Gina Lewis, and I was diagnosed with Bipolar when I was 29. Before I tell you what recovery has meant to me, I want to briefly describe what my illness looked like. My mania consisted of days without sleep, shopping sprees of spending hundreds of dollars a day, delusions of grandeur that made me the most famous woman in the world and fits of rage that contributed to the end of my marriage. My depression often meant that getting out of bed was simply not an option. I cried for hours and felt worthless, defeated, ugly, stupid....I felt like I didn't deserve anything good in my life. Sometimes I felt like I didn't deserve life itself. For more than half my life I yelled, I cried, I spent (or even shoplifted), lost jobs and even lost hours to psychotic episodes. I pretty much had to be forced into treatment; but if I hadn't, I don't know if I would be here today. While in treatment I have been successfully employed, I've learned to pay my bills and live on my own, and I have built an incredibly strong relationship with my incredible son. When I stand back and look at my past, I can't believe that was me. It was pure luck that kept me out of the hospital and even out of jail. Now it is treatment that allows me to keep my freedom. But what does treatment look like? At my most successful, treatment looked like four psych meds a day, therapist once a week, psychiatrist once a month and group therapy as often as possible. With that in place I was truly able to become a productive member of society instead of a potential America's most wanted. I had a job for almost three years, I quit my spending habits, stopped believing that my work at the local food pantry was going to earn me a Nobel Prize, and I learned to think before I yelled. In group, I met a lot of different people and heard a lot of different stories--some milder than mine and some a lot worse. The one thing we all had in common is that we all desperately needed treatment! It was also treatment that brought me to the National Alliance on Mental Illness. Through NAMI, I learned to speak out loud about my life without shame. I learned to fight stigma without fear of humiliation. However in my heart, I truly believe that I would not be so confident if my story was littered with hospital stays and incarcerations. Without treatment, it would be. Even worse, without treatment I may not even be alive to tell this story at all. Now, even I consider my story to be one of success, but I know it is far from over. Every Saturday, I fill my med boxes for the following week, and I am reminded that this is my life forever. For me, treatment is forever! I will never wake up one morning and not have this disease. There is no "quick fix". So now I speak for all those who have not been as blessed as I have been, those who have been unable to avoid lengthy hospital stays and unfortunate jail sentences, those who have lost their lives to this illness: No one should have to suffer these fates when treatment is out there! But sometimes the financial means to this treatment is lacking. Each of us reading my story today need to stand up and make our voices

heard to our Ohio legislators to make treatment services available to those without health insurance, to those that "fall between the cracks" like the working poor, so that these individuals can lead productive lives—like me, Gina.

Open Forum (Optional)

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

As previously stated, refer to "Environmental Context of the Plan/Current Status" and "Priorities" Sections, MHRS is utilizing reserve funding for many of the identified priority services. We have projected by FY 2016, if additional revenues are not identified, we will be in a major financial deficit, and therefore specific priority services may not be sustainable.