Question 1: "Describe the community needs assessment process that led to the identification of the local priorities the Board will address. Describe how the Board engaged local and regional planning and funding bodies, relevant ethnic organizations, providers and people living with or recovering from mental illness and addiction in evaluating needs, evaluating strengths and challenges and setting priorities for treatment and prevention for SFY 2021-2022."

Limited and unsustainable funding, growing mental health and substance use concerns, the opioid crisis, rising suicide rates, and workforce trends like the psychiatrist shortage were daunting before the Covid-19 pandemic. With the new environment, these trends have been accentuated by increased feelings of loneliness and isolation, service challenges during the transition to telehealth, and financial pressures on providers that, in some cases, led to layoffs within an already taxed workforce.

In addition to offering crisis support to contract care providers during this time, MHRB remains focused on building access and capacity in our communities. We know that this is the only way to address growing mental health and substance use concerns now and in the future. Our foci are malleable, but they consistently stem from our strategic plan. Two underlying strategies that support all our objectives are using a data-driven approach and increasing communication efforts. We continue to make strides in both areas.

Through communication efforts, we aim to help all community members understand what to do when mental health or substance use concerns surface and to easily find pathways to care. To help achieve this objective, we invested in communication strategies including redesigning our website, improving media relationships, and developing consistent messaging about who MHRB is and what we do. Shortly, we will begin leveraging Google Analytics to track website effectiveness and adjust our efforts accordingly. Media relationships and mentions have improved significantly over the last year. At the end of August, MHRB media mentions in 2020 were up 148 percent compared to all last year's coverage.

An important aspect of consistent messaging is the development of preferred language. We have done initial training to educate our staff, Board, and the public about using person-first, non-stigmatizing language through comprehensive educational communication strategies and hope to formally adopt them within the next year. We employ person-first language not only on our website, social media, and press releases, but also integrate it into community-wide campaigns. Another key tenant of our communication strategy is to reduce stigma that sometimes is tied to seeking treatment. This year, we are investing in a multi-county anti-stigma campaign with other Regional

Affiliate Boards (RAB). It is hoped that consistent messaging across five board areas who share media markets will yield a powerful stigma reduction return in our communities.

We aim to use data collection and analysis to assess current capacity, monitor outcomes, and prioritize investments to enhance our local continuum of care. This summer, Board members are spearheading an Ad hoc Data Strategy Committee. The committee is defining attributes needed to make more data-driven decisions and to more easily see the gaps in the local continuum of care. Key performance indicators related to quality, effectiveness, and efficiency as defined by Board members will be carefully considered while making funding decisions, allowing the board to have a higher degree of confidence in financial investments we extend to contract care providers. Now more than ever, with uncertain economic conditions ahead and concomitant behavioral health fallout from the pandemic, it's critical to consider ethical allocation of resources; that is, not simply distributing resources equally but rather helping those who most need it first and then extending benefits to others. This includes examining racial and other inequities and providing additional resources to minority populations or other groups that are at larger disadvantages.

MHRB also invests in evaluation by collaborating with other Boards to continually identify effective strategies. A certified Culture of Quality Board, two MHRB directors are trained as peer review surveyors and regularly conduct surveys for other Board areas (although Covid-19 temporarily has paused surveying). This process is mutually beneficial: our staff share their expertise with other Board staff and simultaneously learn about other Boards' best practices and policies. Together, these internal investments build capacity and internal infrastructure in order to better position us to evaluate services and increase access for residents.

MHRB knows that identifying people who are experiencing mental health or substance use concerns and engaging them with services as quickly as possible will reduce the chance of crisis situations, and therefore can help reduce burden on our already overwhelmed systems. Recognizing that we cannot feasibly do this alone, our Board is focused on constructive collaboration with system partners. We aim to encourage long-lasting wellness and successful recovery for all populations by approaching mental illness and substance use concerns as chronic illnesses and by connecting people with healthy recovery supports or care whenever a recurrence happens.

We intentionally collaborate with community stakeholders, including local health districts; local, regional, and state planning and funding bodies; contract care providers; and individuals from all racial, ethnic, faith, and age groups—especially those with

lived experience. MHRB approaches this not as a single event, but as an ongoing process to establish and sustain relationships. We build capacity, partnerships, and lead change in our communities through key partnerships within the following sectors: 1) business and employers; 2) criminal justice; 3) education; 4) emergency services; 5) healthcare; 6) family, community, and peers; 7) faith community; and 8) policy and government.

Needs Assessment Methodology: Describe how the Board engaged local and regional planning and funding bodies, relevant ethnic organizations, providers and people living with or recovering from mental illness and addiction in assessing needs, evaluating strengths and challenges and setting priorities for treatment and prevention in SFY 2019. [ORC 340.03 (A)(1)(a)]. Describe the board's plan for on-going needs assessment in SFY 2020 if they differ from this current fiscal year.

Historically, the Board has worked most closely with Clark County Combined Health District (CCCHD) because of longevity with the Clark County Health Commissioner, value placed on effective communication, and growing understanding about how public health is inclusive of behavioral health. While that relationship remains strong, MHRB continues to develop and maintain even closer relationships with public health entities in all three counties. Covid-19 has deepened MHRB's partnership with each public health commissioner through regular connection, resource sharing, and consultation to support one another's mission.

While some parts of our relationships with health commissioners and districts are public—such as advocating together with legislators on common policy issues or issuing joint press releases—much of the work we do together is less visible. For example, multiple MHRB staff serve on the Community Health Assessment (CHA) and Community Health Improvement Plan (CHIP) planning committees, which are further discussed in the following section. MHRB staff and health district employees communicate and work regularly to advance priorities outlined in the CHA and CHIP. For instance, Clark County's 2016-2019 CHA identified high non-emergency utilization of 911 as a concern. In response CCCHD, MHRB, and community partners, including representatives from Springfield City and Clark County government, created a taskforce to develop a Business Associate Agreement to aid in data sharing. Covid-19 has hampered further development, but we intend to continue the work once all partners are able to re-engage.

MHRB partners closely with other funders in all three counties. During Covid-19, we partnered with United Way to distribute information about local resources—including crisis lines and warmlines—in food boxes. We also regularly share updated hours and

service information of our contract care providers with United Way to reduce misinformation and increase pathways to care through 211. As similar regional funding bodies who address complex community issues and who are concerned with achieving measurable outcomes, our two United Way chapters and MHRB can identify gaps and address unmet needs within our communities on a broader scale. MHRB serves on United Way and local health foundation advisory boards that are empowered to make funding decisions and participate in the grant selection process. Utilizing a Collective Impact (CI) framework, MHRB often operates as a backbone organization and serves as a catalyst for funding collaborations with other entities involving a diverse group of stakeholders. MHRB Board members and staff are in leadership roles for United Way funding campaigns and grant awards in mutually reinforcing ways.

Together with community partners and coalitions, the Board uses its position in the community and funding streams to encourage local funding groups to invest in best practice coalition efforts and to employ evidence-based strategies. For instance, MHRB advocated to use State Opioid Response (SOR) dollars to employ environmental strategies for coalitions. As a result, this fall we are funding two separate Community Anti-Drug Coalitions of America (CADCA) trainings for local coalitions. Not only will these trainings increase understanding among coalition members of evidence-based strategies, but they also will help increase leadership capacity so that coalitions are less reliant on MHRB and are truly community-led. This is part of MHRB's coalition philosophy that focuses on providing technical assistance and consultation to encourage grassroots leadership development. Shifting our philosophy and financial investments to build coalition infrastructure will better lead to sustainable change that is less reliant on one person or entity, and which better empowers coalitions themselves. In turn, it will allow MHRB staff to invest less time in coalition work and ultimately will strengthen the organic pathway to informal needs assessments in our community.

MHRB staff already utilize the CI approach to guide our work, and board members have expressed interest in focusing on using CI to inform strategic direction and priorities. We hope to provide opportunities for Board members to learn more about CI soon, as original plans to do so this spring were hampered by Covid-19. Looking forward, Board Mental Health & Addiction Program Committee meetings will be focused on providing educational training for Board members and staff in order to best operationalize the CI approach and to apply it in concert with data strategy. CI helps systems work better together by identifying a common agenda, by tracking progress and continuous improvement, by applying mutually reinforcing strategies, by practicing continuous communication, and by having backbone support that includes individuals or organizations who are highly committed to the goal. This approach also

can be used to braid funding that is able to address the most critical community needs; funders pool dollars and used evidence-based techniques to create lasting, measurable change.

As evidenced by recruiting practices for our Board members, our representation across geographic and special populations, and our focus on elevating perspectives from individuals and families who experience mental illness and substance use concerns, our Board values differing perspectives and seeks continuous feedback. We have a history of sponsoring clinical and frontline staff workforce development in cultural competency to better serve racial, ethnic, faith-based, and minority groups using evidence-based practices. In November 2018, MHRB sponsored Eye-Movement Desensitization and Reprocessing (EMDR) training and ongoing supervision since then to better serve populations who are more likely to experience trauma. We now are utilizing that network of trainers for the Responder Resilience Program (RRP). RRP is a new pathway for first responders, including behavioral health workers, teachers, and public health workers to receive discreet, free care. We also utilized the EMDR network last year to promote free, trauma-informed treatment for individuals affected by the tornadoes and Oregon District active shooter tragedy. Since evidence suggests that trauma is common among specific populations—especially among minority, faith-based, and ethnic groups—MHRB infuses trauma-informed care throughout pathways to care.

As previously stated, we are heavily involved in the CHA & CHIP processes, which formally gather primary data and elicit feedback from the community about how to better serve minority populations. MHRB staff play active roles on the executive steering committees for each county; we select assessment questions, strategize for community focus groups (i.e., to include individuals and families affected by mental illness and addiction), and negotiate the plan components. In the future, we hope to better articulate our value in shared efforts with public health entities and to differentiate participation from MHRB-led initiatives.

Staff involvement in suicide prevention and substance use coalitions is one strategy MHRB uses to identify and address concerns. Using logic models, MHRB helped identify strategies to reach individuals and families with lived experience, faith communities, and underrepresented ethnic groups to increase help seeking and pathways to effective care. For example, Get Recovery Options Working (GROW), a coalition effort in Clark County, goes into areas that are more impoverished, have higher rates of crime, and consequently, reaches those who experience more trauma to offer resources and promote pathways to treatment.

Last July, MHRB volunteered to host the first listening session for Governor DeWine's RecoveryOhio Minority Health Working Group. A former Board member is co-chair of this working group. This connection provides us with direct access to learn from minority health leaders across the state and to relay our local needs to state leaders. We selected panelists who represented a range of ages; both male and female; several minority communities; and a variety of socioeconomic backgrounds, including: LGBTQ, Hispanic and bilingual populations, diverse Black/African American communities, individuals and family members with lived experience of mental health and substance use concerns; and a medical doctor with integrated physical-behavioral health experience. During the event, MHRB publicly committed to continue working with minority populations, to learn more about their experiences, and to help increase access to care. We have honored that commitment throughout the year. Last fall, a former Board member led a session during Crisis Intervention Team (CIT) training about trauma of special populations. This year, staff plan to integrate the subject throughout the week. Most recently, staff and Board members engaged in conversations around racial equity, surveyed contract care providers to learn more about whether they offer culturally competent care for various racial and ethnic groups and the racial diversity of client-facing staff, and focused communication efforts on minority populations. In the last few months, several of our press releases have been picked up by local media, including those about resources for individuals who identify as LGBTQ+, trauma and racial inequity, racism as a public health crisis, and an editorial from our CEO calling for culturally competent care. Social media content also prominently featured topical information for Pride Month in June and National Minority Mental Health Month in July, and most recently, staff volunteered to promote Covid-19 testing for minority groups. Finally, as Covid-19 has unfolded MHRB has worked with Emergency Operations Centers and other key partners to respond, they have adopted a lens that focuses on promoting minority health solutions.

To complement and to better inform our work locally around serving minority populations, Board members plan to lead focus groups with faith-based organizations with large minority memberships, the National Association for the Advancement of Colored People, and other ethnic organizations representing a range of social-economic backgrounds.

Finally, in recent years, MHRB made a concerted effort to increase the diversity of Board members and to include more persons of color. We also strive to build leadership opportunities for individuals and families with lived experience. In fact, we exceed the minimum number of people and families with lived experience required to serve as Board members.

MHRB wholeheartedly adopts the philosophy of including people with lived experience, and thread it throughout our work. We advocate for the inclusion of people with lived experience and their families and encourage them to serve on any committee we participate in—whether it is within our network or led by other planners or funders. Inclusion of individuals with lived experience is invaluable. It easily builds an immediate feedback loop to guide our work, destigmatizes seeking help, and allows others to understand underlying issues that might contribute to or exacerbate mental health or substance use concerns. It also empowers those with lived experience and their family members to inform policy change and to share directly with audiences about their perception of unmet needs and barriers.

MHRB regularly holds formal and informal focus groups of people with lived experience around the topics of prevention, recovery supports, Recovery-Oriented Systems of Care (ROSC), gaps and needs, suicide prevention strategies, and overdose risk, among other relevant topics.

It should be noted that while MHRB tries to infuse and elevate individuals with lived experience, we are aware that there is a risk of those individuals being triggered or traumatized. As such, we make every effort to include only those who wish to have a voice, and to arm them with protective factors that can minimize harm. One way in which we do this is by continually talking with those in recovery about their needs and boundaries and by communicating with contract care providers about how to continue to strengthen the supervision, self-care, and resilience of individuals to ameliorate compassion fatigue.

Another way our Board area has upheld people with lived experience is by supporting the peer and family member workforce. When OhioMHAS began certifying peers, MHRB was an early adopter. We immediately offered to host peer training, continued to do so in the subsequent years, and are committed to continually investing in our peers. We continue to incentivize contract care providers to utilize peer recovery supporters and integrate peer workers into larger strategies. For example, we recently leveraged Covid-19 crisis funds to start a warmline that is run by Thrive certified peer supporters. As part of the program, we partnered with Ohio Means Jobs in Clark, Greene, and Madison Counties to recruit and employ local peers. We also have invested heavily in standing up a group for peers to collaborate, discuss issues, and support one another. The group is facilitated by an MHRB employee who is a trained peer supporter.

As our contract care providers continue to integrate peers into their workforce, we are committed to helping them create a cultural shift—not only in terms of direct service

provision and grassroots advocacy, but also by offering insights about how to organizationally have the right supports and protective factors to affirm peers. This is integral to the success of employing peers, because they are exposed to ongoing risk of recurrence and harm due to having lived experience and by the very nature of their work (e.g., exposure to people in active addiction, risky environments, and hearing traumatic stories over time). MHRB recognizes this delicate balance and works to have ongoing conversations with contract care providers about how to keep peers healthy and well.

As demonstrated above, MHRB talks informally with our more than twenty contract care providers throughout the year. This informal communication has been paramount during Covid-19, as MHRB and contract care providers pivoted to respond to the pandemic. MHRB leaders met virtually daily during the first few months of Covid-19 to develop a plan for assessing the needs of our contract care providers. We quickly surveyed providers to identify needs and shifted funding accordingly to support them with the transition to telehealth, to provide them with personal protective equipment, and to fill other gaps to ensure continuity of care. MHRB uncovered similar gaps in the behavioral health community beyond our contract care providers. To fill these gaps, we provided additional supports to adult care facilities, recovery support centers, and non-contract care treatment providers, including faith-based providers.

We also require every contract care provider to submit formal Agency Allocation Requests (AARs) and Strength, Weakness, Opportunity, and Threat (SWOT) analyses annually. These documents provide us with environmental context; offer anecdotal data about the needs, gaps, and disparities in our catchment area; inform us about the current landscape of Behavioral Health Redesign and its financial impact on service provision; and offer insight into care providers' relationships with Managed Care Organizations.

SWOT analyses submitted annually to MHRB also help us to identify common challenges among our contract care providers. They have informed MHRB about workforce issues and competition with for-profit wages, local transportation barriers, housing needs, and specific pain points our emergency departments are experiencing because of the opioid epidemic. Note that this list is not exhaustive.

In addition to these annual evaluations, MHRB asks its care providers—as well as community members and leaders—to fill out the Ohio Association of County Behavioral Health Authorities' survey on Recovery-Oriented Systems of Care (ROSC) biannually. This specific data will be further discussed in a later section.

MHRB also collaborates with local suicide and substance use coalitions to disseminate surveys and to brainstorm how to proceed with forums and educational events within the new Covid-19 environment. MHRB, in partnership with the coalitions, recently collected data to identify community understanding of mental health and substance use disorder, familiarity with local resources, knowledge of how to access care, and perceptions regarding stigma.

Question 1a: "If the Board's service and support needs were determined by the Board Recovery Oriented System of Care (ROSC) assessment, how will these identified service and support needs be addressed by the Board?"

Similar to last year's Community Plan, MHRB continues to leverage the August 2018 ROSC survey results. Care providers, people in recovery, community members, and community stakeholders responded to the survey. The ROSC Assessment (Recovery-Oriented Systems of Care: Statewide Assessment Result, 2018) provided an opportunity to "examine the degree to which state and local behavioral health systems are recovery-oriented" and to identify strengths and opportunities for growth. The five key domains are focusing on clients & families; ensuring timely access to care; promoting healthy, safe, and drug-free communities; prioritizing accountable & outcome-driven financing; and locally managing systems of care allowed for MHRB to identify, prioritize and address accordingly, the service and support needs in the three-county Board region. Examples of how MHRB has addressed and continues to address the opportunities are described below.

Opportunities that focus on clients & families: MHRB recognizes it is optimal to focus on reducing access barriers to services, on emphasizing engagement, and on delivering trauma-informed care to individuals in their natural environments. For instance, given that we know that 70 percent of individuals who have a substance use disorder are employed, a focus on job-seekers, employers, and the workplace is a priority. MHRB continues to contract with Working Partners®, experts in drug-free workplace efforts. In conjunction with Working Partners®, MHRB developed a strategic plan in fall of 2018 to help employers navigate workplace issues related to mental health and substance use concerns. The plan was updated and enhanced in 2019 using a data-driven approach using results from the Drug-Free Workplace Community Initiative Employer survey, which was distributed to a statistically significant sample of about 3,200 businesses and 1,500 community leaders statewide. Data suggested that absenteeism, decreased productivity, and a shortage of viable employees were prevalent concerns for employers. MHRB continues using this robust strategy to engage a population that is inherently hard to reach (adults), to provide tools for creating recovery supportive workplaces, and to connect with employers and employees in a natural environment

(workplace). Other strategies to reach employees and employers organically include the creation and distribution of a variety of resources like: an infographic for employers called Recovery WORKS, an assortment of electronic articles, links to video content, and a toolkit crafted for the purpose of supporting recovery at work which aim to increase awareness and reduce stigma.

MHRB expanded the workplace strategy by formalizing a partnership with Ohio Bureau of Workers' Compensation (BWC) as part of the Substance Use Recovery and Workplace Safety Program which provides employers with reimbursement for technical assistance to analyze and develop policy, training for both employees and employers related to workplace policies, supervisor and manager training to help support people in recovery, and drug testing for current and prospective employees.

Opportunities that focus on timely access to care: MHRB is committed to the development and increased integration of peers across the behavioral health system. Efforts include increased outreach strategies for the re-entry population, peer support services, workforce support and development of certified peer supporters, and utilization of feedback from people with lived experience. In 2019, Clark County participated in a Sequential Intercept Mapping process which identified five priority areas, one of which was peer support access across the intercepts. As a result, a workplan was created and a workgroup including peers convened to develop and execute an action plan. MHRB also has invested in and hosted training for peers to become certified including the certification of an MHRB staff member. This decision continues to produce many benefits from influencing and informing internal efforts with and amongst MHRB staff to the development of bi-weekly virtual meetings to provide support to an ever-growing network of peers across all three counties. Additional efforts to integrate peer approaches are the creation of the 24/7 Clark Greene Madison Warmline contracting with a peer run organization and peers to answer calls. There was an emphasis on working with the local Ohio Means Jobs (OMJ) programs to identify, train, and employ underemployed people with lived experience to respond to calls from a variety of callers in need of a trained, compassionate listener. MHRB sought additional funding to engage a new provider, SoberGrid to increase access to peer support using an app. One significant success is the availability of 24/7 accessibility to either a peer or a virtual recovery community. Another success has been to provide relief to the existing peer support workforce.

Opportunities to promote health, safe and drug-free communities: MHRB continues to promote health through Early Childhood Mental Health consultation (ECMH) by providing sustained funding and increasing partnerships with both Clark County and Greene County Educational Service Centers to build capacity of the ECMH credentialed

providers. Consultation occurs with providers of childcare, preschool, and families with children 0-6 years old as one strategy to improve timely access to care and reduce risk of more severe mental health problems later in life. To maximize future available state and local funding, MHRB staff recommend contracting with various qualified vendors to provide ECMH consultation throughout the region.

MHRB also aligns with RecoveryOhio to prioritize stigma reduction and education. MHRB approaches to address harmful stigmatization using education and awareness strategies. MHRB staff and Board member training to avoid words and myths regarding people with substance use disorders or mental illness have been implemented and place value on using person-first language. MHRB is engaging with other boards in the region to implement a campaign to decrease stigma and efforts to interface with media partners to use trauma-informed report practices.

Opportunities to improve locally managed systems of care: An Ad Hoc Data Strategy Committee of the Board has been convened to provide a more defined structure for evaluating the success of the services provided, to identify the gaps unique to populations, and to guide us in ethical budget funding amid constrained resources.

MHRB forged a partnership on behalf of Madison County with Mental Health and Recovery Board of Union County, who applied for and secured three years of Strong Families, Safe Communities funding. This system of care grant has been instrumental in expanding access to and better coordinating care for multi-system youth and families. As a result, Madison County Department of Family & Children and Family and Children First Council have built local capacity in managing and adopting high-fidelity wraparound and supportive services. Participation in a regional learning community, increased service provision, tracking and data collection, and training for personnel are some of the significant areas of strength and growth. Sustainability planning to preserve youth services and family supports have been underway over the last year and will continue in SFY 2021- 2022.

Question 2: "Considering the Board's understanding of local needs and the strengths and challenges of the local system, please identify the Board's unique priorities in the area provided on Page 2. Please be specific about the chosen strategies for adults, children, youth, and families and populations with health equity and diversity needs in your community. OhioMHAS is still interested in any RecoveryOhio priorities Board areas may be addressing. Please address goals and strategies for any gaps in the Ohio Revised Code required service array identified in ORC 340.03(A)(11) and 340.033.
Identify at least one measurement indicator, and subsequent baseline data, that will be used to track progress towards meeting the identified priority(ies)."

Board Local System Priorities			
Priorities	**Goals**	**Strategies**	**Measurement**
Support mental health and substance use disorder needs of everybody and every family in Clark, Greene & Madison Counties during the Covid-19 pandemic	Assess needs through informal and formal processes and pivot funding to support local providers and residents Support providers as they transition to telehealth Offer personal protective equipment to providers and regional adult care facilities	Distribute a quarterly survey to contract care providers and other local providers to assess needs and provide support as needed Invest in a new regional warmline to provide extra support to the public Launch the Responder Resilience Program to provide discreet, free care to those on the front lines of the epidemic, including mental and physical health workers, public health workers, law enforcement, fire and emergency medical services personnel, and teachers	**Measurement indicator**: Increase usage and awareness of Clark Greene Madison Warmline as an option for non-clinical, non-crisis support. **Baseline data**: The first month of the warmline, it received 44 calls. **Target**: 150 or more warmline calls per month.
Align efforts with RecoveryOhio priority of stigma and education	Address harmful stigma that can prevent people from getting and staying mentally well	Encourage internal and external audiences to avoid stigmatizing language and combat myths about mental illness and substance use disorders	**Measurement indicator**: Share information with media contacts about responsible reporting tactics. Track through Google Analytics how many clicks our preferred language and/or media resources receive.

		Collaborate with Regional Affiliate Boards (RAB) on a multi-county anti-stigma campaign Work closely with media to increase awareness about responsible reporting practices related to suicide and overdose Communicate regularly with businesses about mental health and substance use concerns in the workplace, including through a monthly e-newsletter and other efforts	**Baseline data**: Our baseline is zero, as we have not previously directed media outlets to our website. New website capabilities effective SFY 2021. **Target**: Click rate of 20 percent for target audience.

Question 3: "Describe all environmental factors that influenced the identification of the chosen priorities within the Board area. Factors could include: economic, social and demographic factors, transportation, unemployment, uninsured/underinsured population, poverty rates, housing availability, incarceration rates, etc. Note: Regarding current environmental factors, Boards may describe the continuing impact of Behavioral Health Redesign including Medicaid Managed Care carve-in."

Overarching concerns that influence service delivery in Clark, Greene, and Madison Counties were complex even before the Covid-19 pandemic. As our local communities respond to unprecedented levels of trauma and environmental challenges, MHRB is poised to lead them as they navigate uncharted waters. Our Board area recognizes that these solutions require partnership with systems as well as deliberate involvement in and cooperation with local, state, and federal policy.

Health Policy Institute of Ohio's (HPIO) 2019 Health Value Dashboard ranks Ohio 46 out of 50 states and the District of Columbia on health value. This ranking indicates that while Ohioans spend more on health care compared to other state's residents, they remain less healthy.

One key indicator of health value is access to quality healthcare. People living in rural areas are disproportionately more likely to struggle with accessing care providers than those living in urban or suburban areas, and our Board's three counties average more than 70 percent rural farmland. Provider shortages, constrained financial resources, and lack of efficient public transportation accentuate this challenge for our region. Transportation issues can create extra expense and limit preventative care, leading to more acute issues later. Patient-to-provider ratios continue to trend better than state averages but remain inadequate for quality care.

According to a recent article in *Dayton Daily News*, psychiatrists, especially child psychiatrists, are retiring faster than the next generation can be trained. Simultaneously, demand for mental health services in the area is increasing. The article reported that nearly 20 percent of Americans have some type of mental health issue, but only a third receive treatment. This trend is reflected throughout our Board area, and we anticipate that chronic stress, loss, and uncertainty from Covid-19 will only increase the disparity between community needs and workforce capacity. As such, we continue to look for ways to support our workforce. So far, we diverted crisis funds to help ease the transition to telehealth for our contract care providers; granted contract extensions to ensure continuity of care; secured and delivered personal protective equipment to local providers and adult care facilities; increased communication efforts to share key information with contract care providers; and introduced the Responder Resilience

Program to connect frontline workers, including mental health and substance use workers with discreet, free, trauma-informed care.

Access-related issues are critical, but they are only a piece of the puzzle. Research indicates that access to care constitutes only about 20 percent of overall health. The remaining 80 percent is shaped by social, economic, and physical environments as well as health behaviors. The importance of factors that are unrelated to access is palpable in HPIO's dashboard, which identified three reasons for Ohio's poor ranking: "not all Ohioans have the same opportunity to be healthy, resources are out of balance, and addiction is holding Ohioans back" (p. 9-11). These reasons align with environmental and social, economic, and demographic factors in Clark, Greene, and Madison Counties.

Environmental and social factors in Clark, Greene & Madison Counties
Drug overdose and overdose deaths continue to be a focus for our Board area, especially considering challenges posed to those trying to obtain or sustain recovery during Covid-19. While local treatment providers remained open throughout the pandemic, other factors like self-quarantine guidelines, limited transportation options, and financial stressors impacted access to care.

Although individual and group therapy sessions and support groups now are available through online platforms, initial gaps in service during the transition to online platforms coupled with lack of internet access and preference for in-person meetings have been barriers to recovery. Following the transition to telehealth during March and April, our counties experienced increased overdose deaths.

Given that social support is a key tenant for maintaining recovery—and that social isolation is a risk factor for recurrence—local treatment providers continue to prepare for a surge, as our counties already are reporting increased rates of suspected drug overdose rates when comparing the first and second quarters of 2020, according to Ohio Department of Health's suspected overdose dashboard.

Increased use of drugs and alcohol during Covid-19 is widespread, as demonstrated by the "Wine with DeWine" trend—and by liquor sales. Data from the Ohio Department of Commerce Division of Liquor Control indicates that liquor sales surged in March and April, as people stocked up for quarantine. Twenty-three percent more gallons of liquor were sold in March 2020 compared to March 2019, and April liquor sales had a 10.7 percent increase from last April. This increased alcohol use could trigger old drug habits or act as a gateway to other substance use for both adults and youth. As part of economic relief for businesses during Covid-19, Ohio policy was more lenient about

liquor sales. For instance, it granted restaurants and bars the ability to sell cocktails for carry-out. Favoring economic policy over health considerations is in line with other policy decisions we've seen locally, like the addition of a Designated Outdoor Refreshment Area (DORA) in Springfield and Fairborn Outdoor Refreshment Area in Greene County. While economically beneficial, policies like these create additional barriers and challenges for certain populations like individuals in recovery or families who don't want their children around alcohol or other drugs.

We know that while specific drug use trends change, the underlying issues that lead to and perpetuate addiction must continue to be addressed. As opioid-related deaths in our area decrease, use of other drugs like methamphetamine increase. Fentanyl continues to drive overdose deaths, along with rising cocaine, methamphetamine, and combination drug use. Changes indicate that the prevention strategies for people who use substances may need to expand to more broadly address use of non-opiate drugs.

While all of our counties have been touched by the opiate epidemic, Clark County remains the most heavily impacted. Data trends from the 2019 Clark County Drug Death Report suggest that the highest rates of unintentional overdose occur in different age groups each year, illustrating that no age group has been left untouched. A recent report from Ohio Department of Health indicated that unintentional overdose also touches several races and ethnicities. In 2017, Black non-Hispanic males had the highest overdose rates for the first time since 2008. In addition, nonintentional overdose rates have been rapidly increasing for white non-Hispanic females, Black non-Hispanic females, Hispanic males, white non-Hispanic males, and Hispanic females.

While large-scale issues like the opiate epidemic and Covid-19 pandemic affect all people, they disproportionately affect people of color. A recent brief by Health Policy Institute of Ohio joins other entities—including MHRB—in designating racism a public health crisis, as it yields inequities and disparities that lead to negative health effects. Locally, MHRB is engaging Board members and staff to address racism and identify actionable strategies for eliminating barriers for people of color to access treatment for mental health and substance use concerns. One such strategy will be holding focus groups with various ethnic groups to gain additional perspective about how to better serve minority communities with which participants identify.

Ripple effects of the opioid epidemic continue to be widespread. The economic, emotional, and social burdens are felt by our health departments, hospitals, children's services, criminal justice systems, providers, first responders, and other systems-level partners alike. Just as no age group has been left unaffected, no system is untouched.

Notably, these systems that already were spread thin are the same systems directly involved with responding to Covid-19.

For instance, last year our Clark County contract care provider United Senior Services identified an increased need for grief, caregiving, and financial support for grandparents who are raising their grandchildren due to parental addiction or overdose. Covid-19 has posed other mental health concerns for older adults, like increased isolation and loneliness—and those effects occur on top of feeling increased anxiety of contracting the virus, as a high-risk group. Likewise, Greene County contract care provider The Hope Spot identified a need for grief, loss, and trauma support for the behavioral health workforce and greater community members impacted by overdose. Delayed by Covid-19, MHRB had co-sponsored this provider to feature Dr. Alan Wolfelt in an education series.

First responders also are heavily impacted by high overdose rates. Repeated exposure to overdose, death, and trauma takes an emotional toll on first responders, and it can contribute to the development of mental health issues like depression or Post-Traumatic Stress Disorder (PTSD). Cultural norms and disincentives to seek help within police and fire departments can exacerbate these negative effects. Locally, we hear seasoned first responders talk about how the constant overdose runs are severely impacting their mental health—and some are even quitting (or are tempted to do so) after years of service. In some instances, mental health issues among first responders have led to increased suicide rates. Ruderman Family Foundation's 2018 white paper *Mental Health and Suicide of First Responders* indicated that police officers and firefighters now are more likely to die by suicide than in the line of duty. Immense pressure and scrutiny on law enforcement following the death of George Floyd and countless others may accentuate negative effects or create cognitive dissonance as talks of institutional and structural racism continue.

Suicide deaths are rising dramatically among the general population. In November 2019, Ohio Department of Health released a report indicating indicated a 45 percent increase in Ohio's suicide rate between 2007 and 2018. Shockingly, among youth ages 10-24 during the same time period, suicide deaths increased by a staggering 56 percent. Although the highest suicide rates occurred in the Appalachian region, rural and suburban areas which mirror the makeup of Clark, Greene, and Madison Counties experienced the greatest increase. Covid-19 may be further exacerbating additional risk factors for suicide like increased isolation, hopelessness, and existing or untreated mental health and substance use concerns. As such, MHRB leveraged grant funding and reallocated levy dollars to create a peer-run warmline to help stave off crises and support our communities during this time. We also developed and distributed a toolkit

for Suicide Prevention Month to local partners, contract care providers, and other Boards statewide.

A 2016 report from the Centers for Disease Control and Prevention indicated that farmers have high suicide rates compared to that of other occupations due to stress, financial risk, the isolating nature of the job, and lack of access to health services. Farmers also are at risk for experiencing depression, anxiety, and substance use concerns. Given that Clark, Greene, and Madison Counties all have high percentages of agricultural land—67 percent, 63 percent, and 88 percent—respectively, this is particularly relevant to our Board area. Last year's agricultural challenges, including unprecedented levels of rainfall, increase our concern and apprehension about the mental health of this specific population.

In May 2019, tornadoes caused widespread damage to businesses and homes in Greene County. Just a few months later, in August 2019, the area experienced another traumatic incident: the Oregon District active shooter tragedy. Although the event occurred in Montgomery County, victims of the incident were from Clark and Greene Counties. The perpetrator and his family also were from Greene County.

Emotional and psychological effects continue to affect the region. Even individuals who were not directly involved in these incidents may be impacted, especially since Covid-19 and the recent racial unrest add complex layers of trauma. In some cases, the events may reopen prior incidences of trauma or set back adults who have made positive progress in addressing their previous mental health concerns. For example, symptoms of anxiety may recur, coping mechanisms may become overwhelmed, or individuals may return to unhealthy patterns of numbing or avoiding painful feelings or engaging in risky behaviors or using drugs and alcohol more frequently.

Exposure to these tragic events, even vicariously through news coverage or noticeable changes of trusted adults, may constitute Adverse Childhood Experiences (ACEs), which can lead to health issues later in life. As HPIO suggests in its 2019 Dashboard, ACEs contribute to Ohioans being left behind, threatening their opportunity to grow into healthier adults. Further, childhood trauma can contribute to a range of health issues later in life, including risk for substance use disorder, mental illness, and unhealthy substance use habits.

Another factor contributing to overall health is safe and affordable housing. Even before Covid-19, affordable housing was a challenge in our local communities. But the pandemic also has placed further emphasis on safe housing. Confinement to the home poses concerns for victims or survivors of domestic violence. While quarantine and

isolation practices are important public health practices, they also make leaving an abuser even more dangerous and difficult or isolate those trying to heal from abusive relationships. In the same vein, as schools and daycares closed and children received education remotely, they also were isolated to the home and restricted from interacting with teachers and other trusted adults whom they might usually confide in about abuse and neglect in their home environment.

Even in safe home environments, the closing of schools and daycares added additional stressors for parents. With high unemployment rates, many residents who were barely getting by now are unable to pay basic expenses. Those who continue to work may be facing childcare issues or unwelcome distractions from work.

Economic factors in Clark, Greene & Madison Counties

Research indicates that social and economic factors account for about 40 percent of overall health. These factors are highly intertwined. Covid-19 has created social challenges like increased isolation and loneliness—but its economic consequences also have contributed to negative health effects. On top of experiencing anxiety about health impacts of Covid-19, our communities have felt the mental pressures of financial uncertainty. Many were abruptly unable to afford their previous lifestyles. Navigating new stressors is challenging under normal circumstances but is even more difficult amid a worldwide health crisis.

Unemployment rates often are used to designate economic hardship, and clearly illustrate the strain posed by Covid-19. During the first six months of 2020, Ohio's unemployment rate increased from 4.1 percent in January and February to 5.8 percent in March, and 17.6 percent in April before tapering to 13.9 percent in May and 10.9 percent in June, according to the U.S. Bureau of Labor Statistics. The pandemic has overshadowed all other factors influencing the economic wellness of our counties. As such, MHRB has pivoted to support the behavioral health workforce so they are able to weather the economic burden of Covid-19 and continue providing care. Some strategies include shifting funding, reallocating crisis dollars, helping as providers transitioned to telehealth, and extending contracts to ensure continuity of care.

The 2019 Census estimates the median household income in Clark County is $48,502. 14.9 percent of Clark County residents are living in poverty, which is 3.10 percent above the national average.

The 2019 Census estimates the median household income in Madison County is $65,264, with 10.7 percent of Madison County residents living in poverty.

The 2019 Census estimates the median household income in Greene County is $67,109, meaning 11.6 percent of Greene County residents are living in poverty.

While unsubsidized families who receive insurance through the Affordable Care Act saw their insurance premiums decline slightly in 2019, out-of-pocket costs are still rising. Limited median household incomes in Clark County and pockets throughout our other counties—such as Xenia and Fairborn in Greene County—make it hard for citizens to cover the cost of treatment.

Demographic information by county

Clark County

Clark County is 397.47 square miles with approximately 337 persons per square mile and an estimated total population of 134,083. The 2019 United States Census estimates show a continued population decline of 3.1 percent between the 2010 Census and the 2019 adjusted estimates. According to 2019 Census estimates, 86.9 percent of Clark County residents are White, 9.0 percent are Black or African American, 3.6 percent are Hispanic or Latino(a), and 0.7 percent are Asian.

In the University of Wisconsin Population Health Institute's 2020 County Health Rankings, supported by Robert Wood Johnson Foundation, Clark County ranked 68 out of 88 counties for health factors which is slightly higher than its 2019 ranking of 69; however, there was a significant drop in ranking for health outcomes, which dropped 11 rankings. Health outcomes in Clark County ranked 81 out of 88 counties in Ohio.

Greene County

Greene County is 413.73 square miles with approximately 408 persons per square mile and an estimated total population of 168,937. 2019 Census estimates show a 4.6 percent increase in population between the 2010 Census and the 2019 adjusted estimates. According to 2019 Census estimates, 86.1 percent of Greene County residents are White, 7.3 percent are Black or African American, 3.0 percent are Hispanic or Latino(a), and 3.1 percent are Asian.

In the 2020 Health Ranking Report, Greene County ranked 11 out of 88 counties for health factors, the same as its 2019 ranking. The county's health outcome ranking, however, dropped from 14 to 17.

While development in the western portion of Greene County continues to bring commercial and residential growth, the eastern portion of the county has maintained its agricultural roots. The county consists of nearly 244,000 acres, of which 177,000 remain

agricultural. This provides Greene County with diversity that is not seen in many Ohio counties.

Madison County

Madison County is 465.88 square miles with approximately 96 persons per square mile and an estimated total population of 44,731. The 2019 Census estimates show a 3.0 percent increase in population between the 2010 Census and the 2019 adjusted estimates. According to 2019 Census estimates, 90.0 percent of Madison County residents are White, 6.5 percent are Black or African American, 2.3 percent are Hispanic or Latino(a), and 1.4 percent are Asian.

In the 2020 Health Ranking Report, Madison County ranked 33 out of 88 counties for health factors, a three-county rise in rankings compared to 2019; it also rose in rankings for health outcomes, moving from 41 in 2019 to 37 out of 88 counties in Ohio. Notably, from 2018 to 2019, Madison County had a significant drop (11 spaces) in ranking for health outcomes. Thus, while outcomes improved from 2019 to 2020, they remain lower than 2018 outcomes.

Question 4: "Describe any child service needs resulting from finalized dispute resolution with county Family and Children First Council(s) [340.03(A)(1)(c)]."

Not applicable.

Question 5: "Describe how the future outpatient service needs of persons currently receiving inpatient treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)] are identified."

MHRB employs several strategies to assess the outpatient needs of individuals who are admitted to our state regional psychiatric hospital, Summit Behavioral Health (SBH). The planning for discharge begins prior to admission. The primary strategies are as follows: pre-admission gatekeeping, monthly utilization review meetings, the designation of local contract care providers as liaisons to the state hospital, and the implementation of community needs assessments to identify gaps in the continuum of care and development of agreements with a number of out-of-county resources to stand in the gap upon discharge from the most intensive level of care.

As gatekeepers to the state regional psychiatric hospitals, Boards have a unique perspective about the outpatient service needs of persons currently receiving treatment in state facilities due to a systems-level knowledge of the continuum of care. MHRB's gatekeeping role begins at pre-admission by referrals from local providers, hospital or emergency department staff, jail administrators, or other community stakeholders who are advocating on behalf of an individual with mental health needs. The gatekeeper role serves a variety of purposes but one primary function is to assist in locating the best possible resource to address the acuity of the individual in need. Admission to SBH has become a rare commodity for those not compelled by the courts, therefore it is often necessary to create concurrent plans. The inaccessibility of acute care hospital beds for those who have limited options and are most in need (e.g., lack of payor source, transient, limited social capital, unstable mental health or co-occurring conditions, multi-system involved) of state hospital access pose many challenges prior to admission in addition to the difficulties of discharge in today's landscape.

As stewards of this limited resource, MHRB staff prioritize the role of gatekeeper for civil admissions when meeting eligibility criteria for state hospital level of care. While we are engaged in the process of discharge of the forensic admissions, the courts are in the driver's seat for those admitted for competency restoration or when found not guilty by reason of insanity (NGRI), thereby circumventing the gatekeeping process.

MHRB engages with the referral source and state hospital admission staff to determine whether a state hospital is the most appropriate placement and ensure that alternatives for local care have been exhausted. Beds at SBH are rarely available, meaning that individuals who meet criteria often must be re-directed to another state hospital, posing even more challenges. When admitted to a state hospital other outside of our region,

systematic processes like the utilization review meetings are not accessible to our local system of care.

We know that involvement of families in treatment can yield better outcomes. Yet, due to the regional re-alignment of hospital catchment areas and need to access available hospital beds outside the catchment area, individuals are often dislocated from local supports. Care providers and family members have difficulty participating in the treatment planning needs of patients admitted due to the distance; for example, Madison County is approximately 72 miles from SBH.

Next, MHRB facilitates a monthly utilization review team meeting with the designated liaisons from MHRB contract care providers and state hospital staff to review the progress, barriers, and discharge planning needs of each Clark, Greene, or Madison County resident currently in the state hospital.

Efforts are made by local contract care providers, MHRB, and state hospital staff to coordinate outpatient service needs. For those who are not interested or who are unable to return to their home community, there are additional complex barriers.

Transportation alone can be cost prohibitive. Individuals often agree to relocate in order to leave the hospital, but may not have the ability or intention to follow through with outpatient treatment. In many instances, the proper support upon discharge either does not exist or is not available to both civil and forensic populations. This can cause further distress for patients, families, and providers. Efforts to address the barriers continue but gaps in outpatient service needs are complex and require creative partnerships across systems and accessible resources. A "one size fits all" approach is not feasible due to the diverse and unique needs of those typically requiring the most intensive level of care. Lack of outpatient restoration and robust assisted outpatient commitment programs are additional gaps.

Another strategy used to identify and respond to the identified needs of those returning from the state hospital includes conducting ongoing community needs assessments. This has resulted in the development of agreements with a number of out-of-county resources to stand in the gap upon discharge from the most intensive level of care. When resources don't exist locally it is often necessary to create access to a level of care outside the Board region. MHRB has developed agreements with group homes, residential programs, and supervised settings outside of the immediate region to meet the step-down needs of those leaving institutional settings. While not ideal, these options are necessary to avoid less-desirable plans which often include placement in the less supportive, unsupervised, or unsecure settings like motels or homeless shelters.

The link between safe, stable, and affordable housing and mental illness is clear: individuals who do not have their basic needs met are less likely to have the stability they need to stay well. Our communities need resources for more supervised and supportive housing environments where individuals can stay in long-term recovery. Offering supportive services like stable housing or integrated healthcare can help prevent crises or recurrence before they occur.

In addition, there are disparities in the capacity to support individuals with severe co-occurring mental illness and substance use disorders, along with chronic physical health problems or developmental disorders. Those with co-occurring illness often have a greater level of acuity and require complex, at times longer-term care. There is a need for more integrated outpatient services to respond to these needs.

Apart from these issues, capacity at the right level and the right time is a glaring issue. Since de-institutionalization, the number of beds has decreased, despite the growing need for inpatient treatment. Meanwhile, hospital beds are increasingly allocated to forensic patients, leaving little to no room for civil patients. As a result, our care providers stopped requesting state hospital placements on behalf of clients, assuming beds are unavailable. Without a specific number of denied requests, we are unable to accurately identify what volume is needed.

This lack of capacity not only does a disservice to individuals who need help, it also impacts families and other systems. Distressed family members frequently contact Board staff to advocate for a hospital level of care for their loved one. First responders continually come into contact with individuals who are severely and persistently mentally ill, but are presented with decisions difficult to navigate when resources are limited or unavailable. As a result, these individuals end up intersecting with the criminal justice system rather than accessing adequate care.

Question 6: "Describe the Board's planned collaborative efforts with other systems, people living with mental illness or addiction, family members, providers, and/or the general public for SFY 2021-2022 that will be needed to implement funded priorities. (Note: Highlight collaborations needed to support a full continuum of care. Are there formal or informal arrangements regarding access to services, information sharing, and facilitating continuity of care at a systems level?)"

Utilizing prevention- and recovery-oriented frameworks, MHRB will formalize collaborations for SFY 2021-2022 in prevention services, crisis emergency services, and services involving criminal justice. Many are continuations of pre-existing relationships, while others are new.

The first planned focus area is for prevention services. During the last quarter of SFY 2020, the Board hired an experienced, certified prevention specialist to lead a strategic prevention framework process in each county with other key partners. This effort is not yet complete and will continue in SFY 2021. It will assess and strengthen the Board's data infrastructure for tracking, decision-making, and prioritizing investments. This process will update the current prevention strategic plan and involve school-based, community-wide, culturally responsive population strategies across the lifespan. In addition, formal prevention agreements have been secured with educational service centers for early childhood, K-12 schools, Ohio National Guard counterdrug prevention initiatives, Family & Children First Councils, and with drug-free workplace policy experts and stakeholders (e.g., Bureau of Worker's Compensation).

The second planned focus area is for crisis emergency services with existing contract care providers and with two new behavioral health care providers. In the last quarter of SFY 2020, a new provider began offering ASAM 3.7 inpatient substance use withdrawal management, which previously was not available in our region. A formal agreement will be secured and pathways will be created from existing contract care providers for referral, care coordination, and discharge with this new resource. Pathways to this level of care have been provided through out-of-county provider contracts, but utilization and coordination has proven difficult for clients and families with barriers due to transportation and provider care coordination. In SFY 2021, another new level of care became available when MHRB launched a 24/7 warmline peer support service through a new formal care provider contract and with the help of OhioMHAS' emergency Covid-19 grant funding. Initial engagement, utilization, and data monitoring show promise. These two new levels of care will be folded into an overall crisis strategic planning process. Phase one of the plan will assess current access and gaps in crisis care with existing and new contract care providers. The second phase of planning will be done in coordination with local hospital emergency systems. Crisis strategic planning

will adhere to looking through equity and trauma-informed lenses and from a client and family-centered perspective. Information sharing between providers, emergency services, and the Board will be necessary to fund crisis in a sustainable way and in a way that can be evaluated for effectiveness.

The third planned focus area is with criminal justice by using a Stepping Up framework and Sequential Intercept Model (SIM) to target areas for intervention. For law enforcement at intercept 1, MHRB is adapting our annual Crisis Intervention Team training to plan for virtual models during Covid-19. In partnership with OhioMHAS state hospital and forensic services, MHRB is piloting a judicial training in the southwest region to inform and improve collaboration with the criminal justice system. At intercept 3, MHRB continues to be involved with and prioritize support for specialty dockets for youth, families, and adults (e.g., Addiction Treatment Program) across the region for populations who have substance use and mental health problems and who are veterans. Also for intercept 3, MHRB will assess current treatment access and identify gaps in jail-based mental health and substance use services provided by contract care providers serving Clark, Greene, and Madison (tri-county) jails. Finally, at intercept 4 (re-entry), MHRB will develop a systematic outreach process (e.g., Community Transition Program) that will be adequately funded for forensically involved populations.

Beyond the above three collaborative focus areas, MHRB will continue to foster collaborations to tailor communication and awareness education strategies to the general public and with all key system partners. MHRB designates key partnerships within the following categories: 1) business and employers; 2) criminal justice; 3) education; 4) emergency services; 5) healthcare; 6) family, community, and peers; 7) faith community; and 8) policy and government. Collaborations with these partners are featured through a newly launched website promoting access to resources and through multimedia awareness campaigns to promote trauma-informed pathways to care to ultimately reduce suicide and overdose.

Question 7: "Describe what partnerships will be needed between the Board and the State Hospital(s), Private Hospital(s) and/or outpatient providers for the identification of needed services and supports.
a. How will the Board coordinate the transition from the hospital to the community? (i.e.; discharge planning).
b. Who will be responsible for this? Discuss any planned changes in current utilization that are expected or foreseen."

Partnerships that will be needed between MHRB, the state hospital, private hospitals—both behavioral health and emergency departments (EDs)—and outpatient providers for the identification of needed services and supports on the surface may seem obvious. However, the regional psychiatric hospital (RPH), otherwise referred to as Summit Behavioral Healthcare (SBH) is just one resource in a complex, comprehensive system of care. A variety of partnerships with community resources, policymakers, and funders are critical when striving to create a seamless system of care for the residents of Clark, Greene, and Madison Counties who either have or may develop conditions requiring access to mental health resources, including hospitalization.

MHRB resides in the SBH catchment area, but the hospital itself is in Hamilton County. Pertaining to the "needed partnerships," minimally the formal relationships are defined in the Continuity of Care Agreement between SBH, MHRB, and lead contract care providers, intended to "create an atmosphere of cooperation between all Parties" (Continuity of Care Agreement, Preamble). Clients with a forensic legal status and those not forensically involved are equally entitled to the same continuity of care. Unfortunately, state hospital beds, and SBH in particular, largely have been at capacity with forensic clients during SFY 2019-SFY 2020, restricting availability for the otherwise eligible individuals in need of a hospital level of care. There is no indication from OhioMHAS that either forensic or civil bed capacity at SBH will increase.

This highlights the need for solutions, funding, and relationships beyond those defined by the Ohio Revised Code and that reach across systems or stakeholders not noted in the formal agreement. Key partners include, but are not limited to judges, prosecutors, private behavioral and physical health hospitals. It is also incumbent on MHRB to create agreements with levels of care that may not exist in our three-county region to respond to the unfolding needs of individuals in an attempt to prevent a high acuity level of care and to fill gaps that exist when hospital level of care is no longer required but return to independent living is not recommended (i.e., step-down).

Examples of needed services and supports have been identified for special populations. Individuals with co-occurring disorders like developmental/intellectual disabilities and

mental illness for instance, are particularly challenged to find proper care due to the fragmented nature of the healthcare system and siloed departments. Partnerships, solutions, and funding will be required by the state and between MHRB and providers in the developmental disability system to address the integrated care needs for those with these co-occurring concerns. Additional specialty treatment provider partnerships or contracts are therefore required to address the ongoing treatment needs of those released from SBH with sex offending tendencies, who need a prescriber, and other specialists in high demand, are costly and in limited supply (psychiatrists, sex offender treatment experts, etc.).

MHRB's role as gatekeeper, as noted Question 5 regarding access for non-forensic individuals to SBH requires consideration of the anticipated hospital admission/discharge needs. This necessitates the cooperation between system representatives at many points of contact (e.g., hospital EDs, behavioral health providers, and first responders) to first examine alternatives to SBH referral, anticipate barriers to discharge if admitted like the need to return to a long-term care facility, and a multi-disciplinary approach to coordinate on behalf of the individuals requiring admission.

Transition from hospital to community begins with community needs assessment and planning to determine needs, gaps, and to identify changing demands on access and capacity. As an example, the impact of Covid-19 on the mental health of individuals or vulnerable populations, related or pre-existing housing instability, loss of employment, changing education/childcare expectations and the correlated need for access to care are illustrative of the ever-changing demands placed on the behavioral health system to respond and pivot. It is therefore necessary to create a robust continuum that includes health promotion, prevention, access to a variety of treatment levels, and resources that support recovery in order to protect the finite resources such as RPH hospital beds for those who have needs that can't be met elsewhere. These shortcomings, in addition to lack of access to data, place additional pressures on the local system. In order to relieve the pressure, there must be policy change at the state level.

Behavioral health has notoriously been underfunded and without state parity coordination and enforcement, disparities exist from rural to urban communities, from county to county. When likened to more traditional healthcare, an individual with a chronic physical health condition might require hospitalization to meet the acute care needs for a cardiovascular condition. When discharged, there must be consideration for the living arrangements (i.e., restrictions to stair climbing), coordination between primary and specialty care physicians as part of a comprehensive treatment plan, access to medication, transportation to cardiovascular rehabilitation, resources to support

lifestyle and dietary recommendations, and so on. Barriers to access for any or all of treatment recommendations may result in a variety of complications or relapse such as readmission, cardiac surgery, or worse, the possible demise of the individual.

MHRB engages on behalf of and with individuals with the interdisciplinary RPH staff and with contract care providers in the process of discharge planning at the earliest opportunity to ease both civil and forensic transition to community-based treatment, concurrently working to remove barriers to the indicated services or access resources. Despite the lack of accessibility and minimal admission/discharge movement to and from SBH, MHRB staff continue to convene state hospital and contract care provider staff in monthly conference calls to plan for successful community reintegration. For forensic cases, MHRB staff confer quarterly with our contract forensic monitor and care provider staff. MHRB maintains contractual arrangements with contract care providers from each county to provide care coordination for individuals from the three-county region admitted to SBH.

MHRB accesses civil inpatient hospital care through a variety of processes and in some cases contractual arrangements. One is a stand-alone, inpatient unit run by a community provider; a variety of private hospitals outside of the region are often necessary to meet the needs. Despite designated MHRB funding for crisis services and formalized pathways to access inpatient levels of care there is often not enough capacity. Whenever possible, care providers locate beds outside of the region and plan for clients to return to their home communities when appropriate. There are physical health hospitals who are often on the frontline and perform coordination for those who present at EDs. Often the local behavioral health providers and MHRB are involved, and individuals are diverted to remain in the hospital system posing problems at times with linkage back to the local system for continuity.

Planned utilization changes are not anticipated for the near future. However, MHRB has advocated for and is participating with the SBH-region Boards to coordinate with SBH, OhioMHAS, and key criminal justice stakeholders. The goals are to create a common understanding regarding access to state hospital level of care and to identify community-based alternatives, like outpatient competency restoration. This region is piloting a training for Boards, OhioMHAS, and judges to better coordinate and utilize limited resources.

Question 8: "Complete the attached spreadsheet: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area. Instructions are found on Page 10 of the Guidelines.

Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03(A)(1)]."

Please see attached document.

Question 9: "The following pages of this template contains a table that provides the specific federal and state priorities for: Mental Health Block Grant (MH-BG), Substance Abuse Prevention and Treatment Block Grant (SAPT-BG), SAMHSA and OhioMHAS treatment and prevention priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board's priorities. For those federal and state priorities that are not selected by the board, please check one of the reasons provided or briefly describe the applicable reason in the last column.

Identify at least one measurement indicator, and subsequent baseline data, that will be used to track progress towards meeting the identified priority(ies)."

Priorities for Mental Health & Recovery Board of Clark, Greene & Madison Counties				
Substance Abuse & Mental Health Block Grant Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU) Align with RecoveryOhio's Goal 5 of harm reduction	Increase the availability and timeliness of quality treatment and recovery services across the continuum of care for residents who have IV substance use problems (IDU), while also addressing the social determinants of health that increase chances that the care is successful	Expand the continuum of care (with existing and new providers) for IDU by more strategically reviewing allocation usage and adjusting funding accordingly Support the development process for specialized dockets (Fairborn Municipal Court Drug Court/Addiction Treatment Program (ATP); new certified drug courts) with a focus on increasing the number of treatment and recovery resources (increase supports and funding to address barriers) for families and individuals Support community-led harm reduction efforts like Project DAWN and needle exchange programs, jails/court assessment and linkage, primary physician care	**Measurement indicator**: Availability of treatment and recovery services across the continuum of care. **Baseline data**: Not available; must collect from contract care provider survey data. **Target**: Increase availability where contract care provider data indicates a gap.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		prescribers (DATA2000, forums), peer support, and safe housing		
SAPT-BG: Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE: ORC 5119.17 required priority)	Increase access to gender-specific treatment for pregnant women across the three-county region	Continue to fund gender-specific treatment for women who are pregnant Continue to assess and evaluate the scalability of the current structure to best increase regional capacity	**Measurement indicator**: Amount of funding provided to Women's Recovery Center and other women-specific programs. **Baseline data**: Fiscal Year 2020 funding to Women's Recovery Center and other women-specific programs. **Target**: Sustain funding amid budget constraints.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for boards): Parents with SUDs who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Increase juvenile, family treatment, and adult drug courts' ability to connect this population to Board-funded services in prevention (i.e., early childhood mental health consultation), treatment, and recovery supports	Increase access to local specialty care including placements, parent education, high-fidelity wraparound, and respite care by enhancing funding through Family & Children First Council partnerships (developmental disabilities, juvenile court, Children's Services, Job & Family Services, and contract care providers) Partner with courts and local Job & Family Services departments to coordinate and obtain more funding to support the volume of need in our community	**Measurement indicator**: Funding provided for local specialty care, including placements. **Baseline data**: Fiscal Year 2020 funding to specialty care, including placements. **Target**: Sustain funding amid budget constraints.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)	Due to the rising incidences and correlation between communicable disease and mental illness/ addiction, we are improving partnerships with local public health and contract care providers to	Partner on Community Health Assessments and Community Health Improvement Plans with the public health districts in Clark, Greene, and Madison Counties	**Measurement indicator**: Support providers in implementing transition to telehealth. **Baseline data**: SFY 2020 telehealth utilization.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Align with RecoveryOhio's Goal 5 of harm reduction and Goal 8 of data measurement and system linkage	promote awareness and eliminate spread of disease to our populations	Collaborate with local health districts and contract care providers on harm-reduction projects (e.g., needle exchange projects that are active in Clark and Greene Counties, naloxone in Madison)	**Target**: Usage increase of 25% in SFY 2021.	
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED) Align with RecoveryOhio's Goal 6	Increase school, Job & Family Services, Family & Children First Council, juvenile, family treatment, and adult drug courts' ability to respond to and connect children with SED and their families to Board-funded services in prevention (for example, early childhood mental health consultation), treatment, and recovery supports, keeping in mind the least restrictive environments, and ensuring entry into continuum of care when needed	Collaborate and facilitate monitoring multi-system youth being connected to services and support needs and access to appropriate levels of care through the Family & Children First Councils Increase awareness of access related to special placements, parent education, high-fidelity wraparound, and respite care by enhancing funding through Family & Children First Council partnerships (developmental disabilities, juvenile court, Children's Services, Job & Family Services, and contract care providers) Participate in inter-agency review committees across three counties in partnership with FCFCs: • Pooled funding agreements to support IHBT, residential access, and coordinator salary • Social-emotional prevention, support, and coordination with schools • Monitor multi-system youth expense	**Measurement indicator**: Use of funding provided to Family & Children First Councils for special placements. **Baseline data**: Expectations identified within funding requirements. **Target**: Family & Children First Councils meet all requirements related to funding.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		Continue to assess youth crisis service needs		
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI) Align with RecoveryOhio's Goal 6 of treatment and recovery supports	To leverage and integrate trauma-informed and Recovery-Oriented System of Care principles in order to better serve individuals with SMI and their families within our Board area	Sponsor certified peer support training Support NAMI drop-in centers for individuals with SMI in two counties Include panels with NAMI representation at regional Crisis Intervention Team trainings to increase understanding of what it's like to live with SMI through personal stories Evaluate and increase capacity of housing support for adults with SMI Address transportation barriers (e.g., funded a van for NAMI) MHRB staff trained and certified as peer supporters	**Measurement indicator**: Assessment of capacity/# of beds **Baseline data**: Volume of beds available in Fiscal Year 2020. **Target**: Maintain or exceed baseline.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of supportive housing	Provide consistent funding to support the existing and growth of permanent supportive housing solutions for those living with mental illness, including co-occurring addiction Work toward developing a resilient approach for safe, transitional, and recovery housing so that we can sustain a robust structure that can survive the ebb and flow of demand	Participate in the RAB 5 Regional Plan, CSH Supportive Housing Intensive Housing Institute Housing Solutions of Greene County is a contract care provider and funding partner in capital plan Participate in BOSCOC Region 15 meetings and activities	**Measurement indicator**: Track volume increase of available housing with our Board area **Baseline data**: Volume of supportive housing available within our catchment area in Fiscal Year 2020. **Target**: Maintain availability of Fiscal Year 2020 within a challenging financial landscape.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

		Host and attend collaborative meetings to address the needs of individuals in housing policy		
MH-Treatment: Older Adults	Leverage and integrate trauma-sensitive and Recovery-Oriented System of Care principles in order to better serve seniors and their families within our Board area	Conduct Question, Persuade, Refer (QPR) training Collaborate with Dementia Friendly Communities Advisory Committee in Yellow Springs Collaborate with health districts in our Board area to obtain better data regarding this population Contract with United Senior Services to support this population	**Measurement indicator**: Volume of Question, Persuade, Refer (QPR) suicide prevention trainings for older adults. **Baseline data**: Number of QPR trainings conducted in Fiscal Year 2020. **Target**: Maintain Fiscal Year 2020's volume of trainings amid challenges related to Covid-19.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH/SUD Treatment in Criminal Justice system–in jails, prisons, courts, assisted outpatient treatment Align with RecoveryOhio's Goal 7 of special populations	Identify, educate, and influence a trauma-sensitive, Recovery-Oriented System of Care that connects the criminal justice and behavioral health systems to help minimize criminal justice involvement for persons with mental illness and/or substance use disorders Promote a trauma-sensitive, recovery-oriented system for individuals and their families who are involved with criminal justice systems	Adopt Stepping Up framework across the region Adopt Sequential Intercept Mapping model in each county across the region Lead Criminal Justice Behavioral Health Linkage projects with key partners Facilitate annual regional Crisis Intervention Team trainings	**Measurement indicator**: Delivery of regional Crisis Intervention Team (CIT) training. **Baseline data**: CIT training delivered once annually to 35-40 participants. **Target**: Maintain same volume of participants while adjusting to an online training platform and other limitations presented by Covid-19.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

		Participate on Criminal Justice Council Support, fund, and monitor jail-based services (e.g., Greene Leaf) Advocate for and support development of specialized dockets		
Integration of behavioral health and primary care services			**Measurement indicator:** **Baseline data:** **Target:**	__ No assessed local need ✓ Lack of funds __ Workforce shortage __ Other (describe
Recovery support services for individuals with mental illness or substance use disorders; (e.g., housing, employment, peer support, transportation)	In order to break the cycle of individuals coming in and out of receiving episodes of clinical or supportive care, we are focusing on the foundational strategies to address the social determinants of health (i.e., housing, poverty, trauma, transportation, access to care, employment, incarceration, literacy, sense of community, hope, education, income)	Increase training access for peer support; assess housing, vocational, funding needs Strategically partner with system leadership to find better ways to align our combined focus on social determinants of health Create more awareness of re-entry pathways back into the system whenever a recurrence or new episode of mental illness/addiction happens that might be brought on by unexpected trauma (e.g., community violence, job loss, natural disasters)	**Measurement indicator:** Number of peer support certification trainings hosted. **Baseline data:** We did not provide this in Fiscal Year 2020. **Target:** Host one peer support certification training.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Promote health equity and reduce disparities across populations (e.g., racial, ethnic & linguistic minorities, LGBT)	Promote health equity and increase awareness and knowledge to reduce disparities across all populations (e.g., linguistic minorities, those who identify as	Gain insights to better understand barriers that stand between specific minority groups (i.e., African American women) and treatment	**Measurement indicator**: Number of focus groups or events conducted over the next year. **Baseline data**: MHRB held two events: Governor Committee	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

	LGBTQ, individuals who are disabled, and racial and ethnic minorities) Address racism as a public health crisis and align Board efforts with the Governor's Plan of Action to Advance Equity	Engaging board members in conversations about racial and ethnic equity. Members will be facilitating focus groups and conducting surveys of people and organizations serving minority populations in our board area to gain a deeper understanding of why certain populations are underserved Contract and funding practices to support agencies serving disparate populations Participate in/host local and state-level events that promote health equity and reduce disparities across populations (e.g., Minority Health Listening Tour for Governor's Committee) Obtain funding to support the uninsured/underinsured Promoting and retain diverse board member representation Communication strategies developed from stakeholder feedback (e.g., preferred language) Diversity and Cultural Competency Training for staff	Minority Health Listening Tour and radio show segment on minority mental health. **Target**: Ten events or focus groups over the next year.	

		Use ROSC framework and survey findings to prioritize and plan		
Prevention and/or decrease of opiate overdoses and/or deaths OhioMHAS Prevention priority: Increase access to evidence-based prevention Align with RecoveryOhio's Goal 4 of prevention and/or decrease of opiate overdoses and/or deaths	People who are addicted to opiates will have access to SUD services and supports necessary to prevent overdose or death by accidental overdose	Support substance abuse coalition strategies in each of the three Board region counties using strategic planning processes and best practices Participate in Drug Death Review in all three counties	**Measurement indicator**: Number of trainings provided to coalitions about best practices and adopting evidence-based practices. **Baseline data**: We did not provide this in Fiscal Year 2020. **Target**: Provide at least two trainings for each coalition in Fiscal Year 2021.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Promote trauma-informed care approach	Trauma-informed approaches will be preferred, supported, and integrated across providers and systems	Host and support trauma-informed initiatives Provide Eye-Movement Desensitization and Reprocessing (EMDR) training. Utilize those trained as part of Responder Resilience Program, which provides free, discreet care for those on the frontlines Promote trauma-informed policing	**Measurement indicator**: Increase the awareness of our Responder Resilience program; number of calls about the program. **Baseline data**: In the first two months, we received six calls. **Target**: Increase awareness of the program to continue to drive, on average, five calls per month.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
OhioMHAS Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting

Prevention: Ensure prevention services are available across the lifespan			**Measurement indicator:** **Baseline data:** **Target:**	__ No assessed local need ✓ Lack of funds ✓ Workforce shortage __ Other (describe
Prevention: Increase access to evidence-based prevention (see prevention and/or decrease of opiate overdoses and/or deaths above & suicide prevention and/or decrease of suicide below)			**Measurement indicator:** **Baseline data:** **Target:**	__ No assessed local need __ Lack of funds __ Workforce shortage ✓ Other (describe: priority is embedded into two other priorities: one to prevent overdose, and the other suicide)
RecoveryOhio and Prevention: Suicide prevention and/or decrease of suicide	Reduce death by suicide in our three-county region	Support coalition strategies in each of the three Board region counties using strategic planning processes and best practices Serve as a planning and implementation team member for the first ever statewide suicide prevention plan Two staff serve on OACBHA Committee to Address Suicide, one of whom chairs the committee Develop and promote digital media toolkit for Suicide Prevention Month	**Measurement indicator**: Number of people that are trained to deliver the QPR curriculum in our area. **Baseline data**: Fiscal Year 2020 number of individuals trained to deliver the QPR curriculum. **Target**: Increase the number of QPR trainers in our area by 10 percent over the next year.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

		Develop and maintain relationships with media; promote responsible coverage of suicide and suicide reporting guidelines Promote LOSS Team and postvention throughout region Create warmline to increase access to early intervention and stave off crises Host Question, Persuade, Refer (QPR) suicide prevention trainings and train the trainer events		
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations			**Measurement indicator:** **Baseline data:** **Target:**	__ No assessed local need __ Lack of funds ✓ Workforce shortage ✓ Other (describe: lack of understanding and awareness of the need within clinical workforce, often hidden co-occurring disorder)