Ohio

Department of Mental Health

Department of Alcohol and Drug Addiction Services

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Community Plan Guidelines for SFY 2012 – 2013

September 29, 2010

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Ohio Department of Mental Health
and
Ohio Department of Alcohol and Drug Addiction Services

Community Plan Guidelines for SFY 2012 – 2013

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INTRODUCTION

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

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

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

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

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

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

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

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

Application and Approval Process

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

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

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

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

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

Completing the Guidelines

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

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

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

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

Provision of additional information and inclusion of documents in appendices

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

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

Regional Webinars

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

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

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

- MH & Recovery Board of Wayne & Holmes Counties

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

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

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

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

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

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

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

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

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

Weekly Phone Question & Answer/Technical Assistance Sessions

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

Plan Review and Questions

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

Changes to the Plan

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

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

Instructions for Completing the Cover Page:

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

Instructions for Completing Mission, Vision and Value Statements:

MISSION STATEMENT

The ALCOHOL, DRUG ADDICTION AND MENTAL HEALTH SERVICES BOARD OF TUSCARAWAS AND CARROLL COUNTIES is a Public Board established by Ohio statute for the purpose of planning, funding, monitoring and evaluating contracted mental health, alcohol, and drug services provided to residents of Tuscarawas and Carroll Counties.

The Board is committed to providing cooperative leadership in fostering a quality, community based and comprehensive mental health, alcohol, and drug services delivery system for residents of the two-county district most in need of those services. That commitment also includes an assurance that services funded by the Board will be provided in the least restrictive manner, will be cost effective and publicly accountable with regard to quality and finance.

VALUE STATEMENTS

STATEMENT OF PRINCIPALS (Values Statements):

The ALCOHOL, DRUG ADDICTION AND MENTAL HEALTH SERVICES BOARD OF TUSCARAWAS AND CARROLL COUNTIES carries on its activities according to the following beliefs in its efforts to fulfill its mission:

- We believe in the effectiveness of a system which has community-based identification of needs and problems and the responsibility to determine solutions.
- We believe in cooperation between the Board, contract providers, other community organizations, the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services in the provision of quality services which are available, accessible, cost-effective, and directed to those with the greatest need.
- We believe accountability to community, consumers, taxpayers, and funders is accomplished through local management and decision making by a governmentally appointed body operating under Sunshine Law requirements.
- We believe that the Board has a special responsibility for the severely mentally disabled individual and that individuals with major mental illness, prolonged mental illness, and major personal crises are of primary concern for services.
- We believe that early intervention and prevention programs are important and should be an integral part of the community mental health, alcohol and drug system.

- We believe that the community system, its volunteers and professionals, should be strong and forceful advocates for those individuals needing and/or seeking services.
- We believe that mental health and substance abuse is a community concern and one that cannot and should not be addressed by our system alone, but rather, it must include cooperation with schools, churches, law enforcement, social services, employers, families, friends, and many others.
- We believe non-discrimination and confidentiality is essential in the delivery of services to all individuals.
- We believe in a service delivery system that provides services in the least restrictive environment possible and that many services are ideally provided in the consumer's own home.
- We believe that services should be designed to meet consumer needs and wants, not system needs; and therefore, non-traditional services may be the most consumer-effective service provided.
- We believe that an effective community delivery system requires local planning and responsibility, responsiveness to local needs and characteristics and the delivery of services in an accessible, available, and cost-effective manner.
- We believe that trained and competent professional staff are an essential component of quality of services. Staff at all levels are encouraged to pursue continued education, seminars, workshops, and other training activities to enhance their opportunity for self-growth and professional betterment.
- We believe that healthy communities develop and are networks of support and assistance and that appropriate responses to the delivery of services always involves the community in the planning and evaluation process.
- We believe that, as communities evolve and change, so must policies and programs; therefore, we value the ongoing process of assessment and evaluation.

Instructions for Completing Signature Page:

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Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.).

Section I: Legislative and Environmental Context of the Community Plan

Background and Instructions for Completing Section I of the Plan

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

I. Legislative Context of the Community Plan

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

II. Environmental Context of the Community Plan

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

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

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

Economic Conditions and the Delivery of Behavioral Health Care Services

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

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

The rate of employment and poverty within Tuscarawas and Carroll Counties, coupled with recent budget reductions, has significantly influenced the delivery and availability of treatment interventions within our service district. Furthermore, they have contributed to overall financial instability within our publicly funded behavioral health system relative to ensuring that access to our continuum of services is available against increased demand throughout the economic downturn. The cumulative effect of these factors has had a much greater impact on the mental health services continuum than the substance abuse service network. From State Fiscal Year (SFY) 2008 through State Fiscal Year (SFY) 2010 the ADAMHS Board allocation from the Ohio Department of Mental Health decreased $1,298,734. The substance abuse treatment and prevention allocation from the Ohio Department of Alcohol and Drug Addiction Services was reduced by $116,446. During the same time period, Medicaid dollars increased $412,140. The overall impact on substance abuse interventions was lessened because it has historically been underfunded since 1989 following the passage of H.B. 317- which essentially transferred management of the substance abuse treatment benefit to the ADAMHS Boards.

The specific affects of these economic realities on our system of care, which is comprised primarily of three discretionary contract treatment agencies, a consumer operated service and numerous auxiliary contract providers (e.g. inpatient services, education) has been varied. Our provider and systems' response to these factors mirrors the findings from the Ohio Department of Mental Health's Office of Research and Evaluation's recent report titled "Demand for Mental Health Services Increases during the Economic Downturn". In summary, with our provider organizations each having annual operating budgets of less than $8 million per year, slack resources (defined as staff, technology and money) although available, were not adequate to mitigate problems related to access, availability and the management and delivery of services. The amount of the reductions and their timing were significant factors in decision-making at the board and provider level.

A snapshot of these cost-saving and operational efficiencies are as follows: Community Mental Healthcare, Inc, the largest provider of services to non-Medicaid enrollees and the Board's designated pre-screening agency has responded to budget reductions in the following manner: closed two satellite offices within Tuscarawas County; reduced agency hours of operation; reduced direct service staff; experienced wait times in excess of four months for an initial visit with a Psychiatrist for Medicaid enrollees and capped service access to existing non-Medicaid eligible populations; psychologist time was significantly reduced- subsequently, psychological

services provided on behalf of DJFS, Community Corrections, attorneys and other stakeholder agencies at no cost were eliminated; a major remodel of crisis intervention and pre-screening services occurred- health officers are on-call and can take upwards of 45 minutes to respond at a location; use of supervisors to provide a substantive amount of direct care.

The Boards other primary provider of mental health services to non-Medicaid recipients, Personal and Family Counseling Services, enacted the following operational efficiencies and cost-saving measures as a result of economic factors within the system: closure of a satellite office in Carroll County; reduced hours of operation; reduced contract treatment staff and reduced full-time employees through attrition.

Additionally, the ADAMHS Board discontinued the portion of its allocation to our consumer operated service agency ACE, Inc for all transportation related expenses. Fortunately, ODMH was able to make one-time grant funding available to ACE in order to continue this important ancillary service available to consumers in the two-county area.

Passage of a replacement levy in November 2010 will enable the Board to increase access to treatment interventions for non-Medicaid eligible populations beginning in the second half of FY ’12.

Conversely, our Board and provider network agencies have maintained their focus on developing new technologies and exploring alternative funding resources and programs (including foundation and fund-raising activities), while maintaining their focus on quality care for service recipients- in spite of the economic downturn and purchase of service reductions. Use of new technologies including telepsychiatry, provision of mental health and medication assisted addiction treatment via general and family practitioners, expanded involvement by the Board in the delivery of coordinated care for children and families via the Family and Children First Council, and continued efforts to improve service coordination and benefits for adults, training in support of evidenced-based practices (Integrate Dual Disorder Treatment, Trauma Focused Cognitive Behavioral Therapy), will all add value to the local behavioral health system and capability to be responsive to local referral sources.

Advantages of Existing Structure of System.

The organization of our local behavioral health system has enabled it to continue to function in spite of the historic budget reductions for a number of reasons, including responsive decision-making and planning by provider agency management personnel and their Boards of Directors. Although access to services by individuals and families not eligible for Medicaid is problematic, the management and organizational configuration of our three primary recipients of Board discretionary resources has played a major role in enabling the system to continue to provide core sets of services to clients most in need within the two-county area. The sustainability of this network is attributed to their managements’ commitment to diversifying their revenue streams, exploring opportunities related to non-behavioral health programs and services, developing meaningful collaborations with the criminal justice and other human services systems.

Dual certifications by the two largest providers of behavioral health services have enabled them to be responsive to the needs of their clients as well as other consumers of the system. Community Mental Healthcare and Personal and Family Counseling Services have been dually certified for a number of years. Additionally, PFCS assumed management of a private, non-profit that was operating a domestic violence shelter and women's half way house in 2005. Significant administrative cost saving was achieved through this merger and special block grant funding was maintained within the community.

Our largest provider of addiction recovery services, the Alcohol and Addiction Program, is a division of the Tuscarawas County District Board of Health. As a program within the larger operations structure of the Health Department, a number of operational efficiencies have always existed including centralized accounting, office space, administrative, medical and human resources and funding flexibility have enabled this organization to operate at a very efficient level.

Implications of Health Care Reform on Behavioral Health Services

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

The Affordable Care Act includes coverage expansions, integration projects, payment and delivery system reforms, quality requirements, and comparative effectiveness research programs that will all impact the behavioral health system. As the federal government develops rules and regulations and the state government makes implementation decisions, the behavioral health system must remain involved to ensure that these decisions are made in the best interest of the consumers. However, with the results of the recent election, changes in health care reform can be expected at both the federal and state level.

Health Care Reform will impact the Board's system of care as many individuals that receive treatment services with non-Medicaid dollars will become Medicaid eligible and many will be eligible to purchase insurance through the health benefit exchange. These new coverage options will include alcohol, drug addiction and mental health treatment services, but the benefit package is not yet known. The coverage expansions will impact how treatment services are financed, but will not fund recovery support services. As we position ourselves for changes with health care reform, we must address how the community will continue to provide necessary recovery support services to individuals in need. Additionally, the Affordable Care Act provides incentives that focus on the integration of physical and behavioral health care and begins to look at the workforce capacity necessary to serve individuals in need of behavioral health services.

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

Question 3: *Discuss the change in social and demographic factors in the Board area that will influence service delivery. This response should include a description of the characteristics of*

customers/clients currently served including recent trends such as changes in services (e.g., problem gambling) and populations for behavioral health prevention, treatment and recovery services.

There has been little change in social and demographic factors since the last biennium in both Tuscarawas and Carroll Counties. General demographic data illustrates a mostly static racial composition and a slight variance in economic factors in both counties the past two years.

Both Tuscarawas and Carroll Counties are relatively homogenous counties in relation to racial composition. The residents of both counties are primarily Caucasian (Tuscarawas – 97.8%; Carroll – 97.7%) which corresponds with the racial demographic of those who seek services (97.2% are Caucasian.) A decrease in poverty level from 12.9% to 12.4% can be seen for Carroll County from 2000 to 2008. In Tuscarawas County there has been an increase during the same time period from 10.8% to 11.4% of residents living at or below the poverty level.

When comparing unemployment rates from February 2009 to November 2010 in both counties, an increase is seen in Tuscarawas County from 10.7% to 11.1%. Carroll County's unemployment has remained the same at 13.6%. Both are higher than the statewide unemployment rate of 10.2%. While the changes may appear slight, the culmination of the increasing unemployment rates and poverty rates, in conjunction with the continued budget reductions, has significantly impacted the local service delivery system.

One example of the impact of the increasing unemployment rate and poverty rate is the increased number of consumers in the local service delivery system. From SFY 2008 to present the Board has seen an increase in the number consumers seeking services, most substantially in the Medicaid population. From SFY 2008 to SFY 2010, the number of Medicaid eligible children enrolled in the system annually increased from 974 to 1068. Medicaid consumers over the age of 18 increased from 1749 to 1957 annually while non-Medicaid adult consumers increased from 2456 in SFY 2008 to 2497 in SFY 2010. It is believed that if funding had been available the number of non-Medicaid adult consumers would have increased proportionately to the Medicaid adult consumers. Data shows that the need continues to rise for all types of treatment across age levels but the financial resources are not available.

Drug and Alcohol

When reviewing data from State Epidemiological Outcomes Workgroup (SEOW), alcohol related problems are higher than average in both counties compared to Ohio and similar Appalachian counties. SEOW data regarding alcohol related motor vehicle crashes shows an increase in Carroll County incidences from 2001-2009. In 2009, Carroll County ranked the third highest in alcohol related motor vehicle crashes when compared to other Appalachian counties. Carroll County is four times as likely to have an alcohol-related crash than the state average. It is interesting to note that alcohol dependence is the second most commonly diagnosed condition in Tuscarawas County for the 18-30 age group but this diagnosis doesn't appear as a most frequently diagnosed condition in Carroll County until the 31-45 age group. Tuscarawas County residents report higher incidence of alcohol dependence based on diagnostic data but are less likely than Carroll County residents to be involved in alcohol related accidents. While alcohol is the most frequently abused drug in both counties at a rate higher than the state average, abuse of other drugs is apparent as well.

The rate of unintentional deaths caused by drug use is increasing both in the Board catchment area and across the state. It is noteworthy that Carroll County's unintentional death rate related to drug use increased each year from 2004 to 2008. Tuscarawas County death rate has been inconsistent throughout the past four years but has most recently has been below the state average and is lower than similar Appalachian counties.

According to local data, both Tuscarawas and Carroll Counties have also seen an increase in opiate abuse during the past three years. The ADAMHS Board has been attempting to address this growing need by collaborating with local physicians regarding the use of Suboxone and Vivitrol but, until recently, funding has not been available to pursue this opportunity.

Mental Health

In addition to trends related to drug and alcohol use, the Board also reviews the frequently diagnosed behavioral health disorders. During the past two years diagnostic categories have remained consistent in most age groups. Mood disorders are one of the most frequently diagnosed disorders with depression being the most commonly diagnosed condition in the over 18 population. Utilization data indicates that crisis services such as the Crisis Stabilization Unit and Crisis Assessment have been two of the top five highest cost services during the past three fiscal years. The diagnostic data as well as utilization data indicates the importance of sustaining the local crisis services which are 100% funded by the ADAMHS Board.

When reviewing diagnostic information regarding the under 18 population, children age 0-12 are most frequently diagnosed with a behavioral disorder such as Oppositional Defiant Disorder or Attention Deficit Hyperactivity Disorder. The frequency of the behavioral disorders persists through age 17 although the occurrence of Mood Disorder Not Otherwise Specified begins in the 13-17 age group. The children exhibiting problematic behaviors are often multi-system involved and are frequently referred to Family and Children First Council (FCFC) for service coordination.

It is through ADAMHS involvement in FCFC that another trend is apparent. Children referred to the service coordination process and at risk of disruption of placement typically are children with mental illness and developmental disability. Work is being done in the local system to improve service delivery through collaboration with the mental health system and the developmental disability system to support these families. With the discontinuation of a home-based counseling program two years ago as well as the home-based parent education program in the past month, the local community realizes it importance of developing alternative higher levels of care locally to support families and prevent out-of-home placement.

A survey of kinship caregivers also provided information about factors that lead to custody relinquishment. The ADAMHS Board led a data collection effort through Foster Care Planning Committee (FCPC) to determine how the local child serving systems could support kinship caregivers and maintain these placements. Finances, respite, and difficulty managing one's own stress and frustration were the top three triggers to placement disruption. Caregivers who had

custody of children longer than five years reported a higher level of stress (5.6 out of 7) and greater stress between the caregivers and the biological parents (4.7 out of 7). The ADAMHS Board, in collaboration with the FCPC, is examining ways to support this population and maintain placements when safe and appropriate for all involved.

Forensic
Trends related to forensic clients are more difficult to assess due to the relatively low number. Most forensic clients are middle aged males who have had an array of services locally prior to their forensic status. Most crimes relate to boundary violation of another individual although the most recent client on forensic status destroyed a structure. This population will continue to be assessed for trends.

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

Question 4: *Describe major achievements.*

Replacement Levy: Our primary achievement during FY 11 was organizing a grass-roots levy campaign that ended in successful passage of a .5 mill replacement levy for the ADAMHS Board. A cross-section of volunteers representing the ADAMHS Board and contract agency personnel were active in all facets of the campaign beginning in February 2010. The current levy was generating approximately .21 mills and its passage will return revenue to its full yield. Although revenue from the levy will not be generated until calendar year 2012, a portion of the funding will be available for community-based services for budgetary planning purposes within the FY'12 budget cycle.

Public Awareness: An ancillary benefit of our recent levy campaign was development and use of social marketing mediums to increase our community's awareness of mental illness, addictive disorders and the role and importance of our locally managed system of care. The ADAMHS Board developed a specific website in support of levy-related public awareness that included, among other items, stories of success experienced by children, adults and families that have or are currently receiving services within the network. An ADAMHS Board Facebook page was also created and utilized by a number of our constituents to share information about services and events within Tuscarawas County. These resources will now be incorporated within our overall communication strategy with key stakeholders, constituents and the public. We also anticipate that these social networking sites will enhance communication among providers, the Board and our referral sources. Specific public awareness achievements included the following: Created a levy operations committee that included agency directors and key staff, Board staff and Board members where key dates, activities and work committee assignments were established; The campaign was chaired by a retired School superintendent with a track record of success with school levies; Conducted a ½ hour long presentation to the County Commissioners when they were considering the issue that included consumers, agency directors, ADAMHS Board staff which was covered extensively by the local media outlets; Adopted a "You-Know-Me" campaign theme and incorporated a variety of human silhouette images that were used on all printed materials (mother and children, armed service officer, football player, adult male and female- modeled after silhouettes used by Stark County ADAMHS Board); Produced 20 adult-size, stand-up silhouettes that included narratives about treatment success stories, Vote Yes on

issue 7 placards and important facts about mental illness and addiction. These were placed throughout the community during festivals, health fairs, in grocery stores, etc. (Stark County ADAMHS Board shared this strategy with us along with some of their materials); Created a "You-Know-Me.org" website with client success stories, a map that was developed by our County GIS Department reflecting the number and municipality where people accessing services reside and important facts about the levy; Initiated an agency-based, voter registration drive that included registering consumers and family members with scheduled appointments as well as mailing voter registration reminder postcards to all consumers that did not have an appointment scheduled at the agency during the two months leading up to the election; On a daily basis, mailed between 100 and 300 "Vote Yes on Issue 7" and important facts about Issue 7 informational postcards to voters receiving absentee ballots. The pamphlets included information on the number of individuals receiving services from the Board, the types of services and facts about the cost of the levy; Conducted ½ hour long call-in show on a local radio station with Campaign Chair, ADAMH Board member and Executive Director; Mailed 25,000 "Vote Yes" on Issue 7 postcards to all registered voters within the County the week prior to the election. The card included a copy of the editorial Board endorsement of the levy by the local paper titled "Small Price to Pay"; Printed 25,000 pamphlets titled "important facts about Issue 7" that were handed out at speaking engagements, physician's offices, drug stores, hospital waiting rooms, agencies, and were also placed on the windshields of vehicles at high school football games close to the election; Purchased 4 billboards that were rotated at key intersections throughout the campaign; Placed 20 large and approximately 800 small yard signs at residences and businesses throughout Tuscarawas County; Ran a "Vote yes on issue 7" ad in a daily news pamphlet produced by the local radio station which is distributed at numerous restaurants, stores, grocers throughout the county; Ran a full page ad in support of Issue 7 in the newspaper on Sunday prior to the election with the names of 400 individual supporters including elected officials, key stakeholders, etc., a re-print of the actual ballot language, agency logos, and information about the number of people we serve and key services; Conducted numerous speaking engagements throughout the county; Conducted direct mail donation solicitation to over 500 businesses and individuals which included an overview about the levy and ADAMHS Board; We had several stories about the levy written in the local newspaper as well as stories about the budget reductions from the state over the last 2 years; Conducted a mailing and support Issue 7 request to all churches within the County; Organized golf outings, chicken barbeques, raffle, to raise money in support of the issue PAC. **Criminal Justice Collaboration:** The ADAMHS Board, in conjunction with the Corrections Planning Board, secured competitive grant funding from the Ohio Office of Criminal Justice Services to expand substance abuse treatment interventions for drug offenders under community control through the local community corrections office. Implementation of these expanded services which focused on both outpatient and jail-based services for non-violent, drug involved offender resulted in an improved success rate for this population. The project Director attributes reductions in recidivism and relapse to the intensity of individual's treatment and specialization in opioid education activities made available through the grant as contributing to the success. Additionally, the Ohio Department of Rehabilitation and Correction allocated additional matching funds to the project in order for the community corrections department to expand their offices in order to improve the delivery of services to the target population.

Suicide Prevention: The ADAMHS Board, in conjunction with the Tuscarawas Regional Survivors of Suicide, secured a planning grant from the Ohio Suicide Prevention foundation for

the purpose of creating a joint county suicide prevention coalition. Although relatively new, the Coalition has improved our region's awareness about the importance of reducing the incidence of suicide and raising awareness about the importance of support for survivors of suicide. Two public awareness events were held in conjunction with World Suicide Prevention Day in September followed by a Gatekeeper training for a number of professionals and volunteers during mental illness awareness week in October.

Family and Children First Council: The ADAMHS Board played a leadership role in modifying the existing structure of Tuscarawas County Family and Children First Council in order to improve the service coordination component of the Council. The primary changes included modifying the service coordination mechanism and hiring of a service coordinator through a shared funding agreement with nearly all of the mandated members of Council. Additionally, the ADAMHS Board became administrative agent of Council effective July 1, 2010. This change resulted the following: Existing Council staff becoming employees of the ADAMHS Board; development and management of a revised financial reporting structure, and; provision of supervisory and management functions being transferred to the Board. Primary goals related to these changes concern improve coordination of services, expansion of Council provider agencies involved in the services coordination mechanism, improved use of limited and existing private and public resources and fiscal accountability of Council.

Medication Assisted Treatment: The ADAMHS Board, via a contract with Summa Health Systems' St. Thomas Hospital in Akron, developed a contract for the purchase of Suboxone induction therapy for individuals addicted to opioid derivatives and heroin. Clients enrolled in the program received outpatient chemical dependency treatment services from the Alcohol and Addiction Program during their medication regimen. This was the first agreement of its kind in the area. Following the induction phase, clients were then asked to pay for on-going treatment out-of-pocket.

Consumer operated service agency: Advocacy, Choices and Empowerment, a consumer operated service agency started by the ADAMHS Board in 1994, obtained certification by the Ohio Department of Mental Health during FY '10. Major changes in the management structure of this organization occurred as a result of the ACE Board's interest in separating from a management agreement between the agency and a local mental health treatment agency. ACE was able to hire an Executive Director, review their policies and procedures via technical support by the Statewide Consumer Operated Services Association and then obtain licensure for peer support and consumer operated services from the Ohio Department of Mental Health.

Capacity Grant: The ADAMHS Board was successful in securing a capacity building grant from the Corporation for Supportive Housing (CSH). The grant will enable the Board to participate in the 7 Dimensions of Quality Supportive Housing sponsored by CSH. This seven month, two day per month training program is designed to improve the coordination and delivery of supportive services to adults with disabilities residing in independent living environments. This training is part of the Board and systems' goals of improving access and retention of housing for consumers with severe mental illnesses. Additionally, the training will improve the Board's ability to successfully assume management of the Shelter Plus care program on behalf of the local housing continuum effective Jul 1, 2011. Twenty-three Shelter Plus care vouchers will be available in FY '12.

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

Several initiatives within our local system were either not realized or implemented with only limited success during the FY ’10-’11 planning cycle.

HUD 811 and HUD 202 Housing projects: Following one of the recommendations of our mental health consumer housing leadership report, we coordinated completion of both a HUD 811 and 202 applications for housing start-ups for adults and older adults with severe mental illness. Neither of the projects was awarded, however our architectural consultant will be re-submitting an 811 application during the next notice of funding availability via the U.S. Department of Housing and Urban Development. A purchase option on the proposed site was extended in anticipation of resubmitting the grant. We are also exploring a tax credit project in conjunction with another housing consultant via the Ohio Housing Finance Agency.

Adult Service Coordination: Our adult service coordination mechanism, ACSIS, is not reaching its full potential. Conceptually, all of the key stakeholders agree that it makes sense to jointly develop intervention strategies to meet the treatment needs of individuals involved with multiple systems including law enforcement. Obstacles continue to exist in sustaining the referral and intervention process and appear to be related to a lack of clarity (policies) relative to the manner in which referrals are made. Human resources issues also exist for agencies unable to make the necessary time commitment to the meetings which need to occur frequently in order to improve the outcomes for these individuals and families.

OCJS offender services: Although services to substance abusing felony offenders were expanded with OCJS funds during FY ’10, an enhancement grant application for the purpose of continuing these expanded jail and community-based services beyond December 31, 2010 was not awarded. Services to this target population will return nearly to the same levels they were prior to the initial grant.

Law Enforcement CIT training: The ADAMHS Board, our designated agency for pre-hospital screening and crisis intervention (Community Mental Healthcare) and the Tusc-Carroll chapter of NAMI, worked closely with law enforcement officials in an attempt to coordinate a weeklong, CIT training. Our planning efforts included a formal presentation to a joint-county Police Chiefs Association meeting which is also attended by representatives of the Ohio Highway Patrol. Michael Woody, a regional and national expert on CIT training, was our keynote speaker. We followed-up with a formal participation letter which was submitted to each law enforcement organization. From the law-enforcement side, the Tuscarawas County Sheriff’s Department was very supportive of the concept and committed several officers to participate. Other departments were either unable to commit officers to the weeklong training program or uninterested.

HPSA - During the creation of the 2010-2011 Community Plan, the designation of Health Professional Shortage Area was obtained by the Board area. When this designation was received, it was hoped that additional clinicians and physicians would be drawn to the area to increase the pool of providers and increase access to services. This has not been the case. Not only have there been no new providers drawn to our rural counties, the existing providers have had difficulty accessing the tuition reimbursement benefits of the designation. Ultimately, the HPSA designation has had no impact on our local provider network.

Medication-Assisted Treatment - During the last planning period, the ADAMHS Board and the local prescreening agency put a great deal of work into building relationships with a hospital in northern Ohio to address the needs of our growing population of opiate addicted individuals. In addition to contracting with the facility for a 23 hour observation bed and subsidizing initial prescriptions of Suboxone, the Board attempted to build relationships with physicians throughout

Northeastern Ohio who would be willing to prescribe Suboxone. Despite contacting physicians listed as Suboxone prescribers, the physicians were already at their patient capacity, were concerned about the issue of transportation from our rural counties to their offices, or were unwilling to see patients unless they have insurance. Ultimately, this goal went unrealized when budget cuts prevented the Board from subsidizing Suboxone and a physician was unable to be secured for follow-up care. This remains a priority area for the ADAMHS Board.

WMR - The Board attempted to incorporate Wellness Management and Recovery programs into our local array of services during the past biennium. Both programs were seen as intervention approaches that benefited not only our consumers but the local system. While interest was shown for CIT by local police departments, the financial burden and time commitment of police officers for the 40 hour training prevented us from moving forward. Additionally, the cost and training time for the WMR program was also a barrier. Local providers struggled with the losing contact hours with their already overwhelming caseloads as well as the cost to agencies of losing billable hours. The state of finances locally has increased our conservatism and impacted our system's ability to be planful about incorporating additional best-practices. This remains a priority for SFY 2012-2013.

Section II: Needs Assessment

Background and Instructions for Completing Section II of the Plan

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

Process the Board used to assess behavioral health needs

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

The Board utilizes a variety of methods and sources of information to determine its current behavioral health needs. These fall within both quantitative and qualitative sources. Our primary quantitative source of data related to establishing priorities is the Multi Agency Community Services Information System (MACSIS). The MACSIS system includes a variety of information available throughout an individual's enrollment in our plan for services, the assignment of a UCI and is then followed by cumulative information generated through the adjudication of claims. Diagnoses, gender, frequency of service, Medicaid eligibility, dates of service, age and numerous other data elements are important pieces of information analyzed by the Board for purposes of contracting for community services. For contract services not included in the MACSIS taxonomy like crisis intervention, inpatient psychiatric and detoxification services, information is reported to the Board using a series of data collection tools that provide a greater degree of clinical and demographic data related to circumstances surrounding access to these acute episodes of care. Information contained within the assessment and pre-screening forms allow the Board and system to identify how key stakeholders become involved in the referral process and subsequently it becomes a valuable tool for identifying community needs. For example, if law-enforcement officers are involved in the psychiatric intervention then the circumstances are often described. Our system can use these details to address service intervention/coordination issues as well as training opportunities in order to improve the delivery of services. Consumer interactions with Job and Family Services, adult protective, hospital emergency room personnel and other organizations are often described in the referral or assessment process and details of their involvement are listed on these forms. Since the ADAMHS Board has created consumer access to nearly all levels of care either through contracts with community-based service providers or other ancillary service agreements (with the exception of residential substance abuse services), problems with access are generally related to miscommunication during care coordination, financial eligibility, or consumer non-compliance issues, rather than identified "gaps" in service.

Another important source of quantitative data available to the Board and system is the Behavioral Health module used by ODADAS certified agencies. Although claims data on Board

purchased substance abuse treatment services is also available via MACSIS, the BH module is a significant enhancement to this information since an entirely different set of demographic and qualitative issue can be evaluated since it is administered both at admission and discharge from service on each client enrolled. This includes, but is not limited to, the following: drug of choice; frequency of use; referral source; prior episodes of treatment; employment status and primary age of first use.

The Board uses a variety of recently completed and on-going qualitative methods for determining needs of individuals with behavioral health disorders. This includes communication with a variety of constituency groups including feedback from contract providers, the populations they serve, continuous feedback from representatives of NAMI, continuous feedback from the ADAMHS Board's consumer operated service, and feedback from a variety of customers of the ADAMHS Board including the judicial system, law enforcement, health and human services, juvenile court, and initiatives developed by the Family and Children First Councils. Parent representatives on of the Family and Children First Councils provide meaningful feedback on a monthly basis to ADAMHS Board staff concerning their satisfaction with contracted mental health and substance abuse services. Several processes were utilized by the Board during the previous biennium to determine current and future priorities. These processes concerned information gathering activities at both the Board and provider level.

The ADAMHS Board initiated an internal Board member self-evaluation to gauge priorities from the Board level. Additionally, the Board completed a key informant survey for purposes of soliciting feedback from a variety of private and public individual's organizations representing Tuscarawas and Carroll Counties. The Board self-evaluation was helpful in lending direction to the staff on administrative and system organizational issues. When asked about areas of focus for SFY 2010-11, Board members would like to concentrate on public awareness of the Board and system roles and responsibilities as well as to improve the use of service utilization and cost data collected by the Board to improve services. Board members also stressed the need to increase revenue to expand the existing array of services. When asked about ways to improve the Board performance, the Board prioritized consumer housing, service coordination and expanding resources as its top three areas. Ensuring the continuation of the women's halfway house service is also a priority of the Board.

The second major information gathering process undertaken by the Board was a web-based key informant survey of over 391 public and private organization and local officials. We received a 26% response rate to the survey in which key informants were asked to provide the Board with feedback on ways to improve the delivery of both mental health and substance abuse services within our catchment area. The other focus of the survey concerned their feedback on conditions which exist within our catchment area which may be contributing to behavioral health illnesses. Responses were solicited from police chiefs, sheriff's department, county commissioners, school superintendents, school principals, school guidance counselors, the NAMI Tuscarawas-Carroll membership, provider agencies, mayors, township trustees, and agencies represented on the Family and Children First Councils within both Tuscarawas and Carroll Counties. Individuals and organizations familiar with the publicly supported system almost universally agreed that more resources are needed to improve access to care. When service organizations were asked about behavioral health issues that impact their organizations, untreated and undiagnosed

behavioral health disorders were cited as major obstacles preventing individuals and families from achieving customary standards of living. They also cited indirect costs of untreated behavioral health disorders as concerns which included lost productivity, need for foster care, law enforcement, and public assistance. Non-behavioral health organizations primarily refer individuals with behavioral health disorders to services and attempt to educate, to the extent possible, their employees about substance abuse and behavioral health disorders. When asked about ways in which the ADAMHS Board system can assist their organizations or our communities to reduce behavioral health problems, more public awareness and outreach to the community was most often cited as well as expanding hours of operation of the mental health services and increasing access to services. Better coordination of service among ADAMHS Board supported providers was also a top priority of key constituents.

Other sources of information utilized by the ADAMHS Board in determining priorities concern contract provider agency's internal evaluations, which are generated on an annual basis. These service plans contain a wealth of management information concerning a variety of qualitative issues about the delivery of services. In addition to addressing needs assessment, goals and objectives, analysis of strengths, weaknesses, opportunities, and threats (SWOT), the evaluations address important patterns of use information relative to clients served. Patterns of use data is provided in conjunction with general demographic information concerning gender, types of service provided, number served by program, prior treatment episode, new clients served, time in treatment, referral source, and other important information which assists the Board to establish service and funding priorities. These evaluations are also an opportunity for providers to give the Board some insight into political, economic and other local factors which influence the provision of services. An internal mechanism for logging requests from the public on a variety of issues has also been helpful in gauging service priorities. The Board is often asked to assist individuals with access and care management issues which are documented and brought to the attention of provider agencies.

All of the services currently supported by the ADAMHS Board are important to our consumers and stakeholders. Although resources are not adequate to address the volume of services from a program versus client level of support, the Board is capable through our relationships with providers, to address unique and acute needs along the mental health disability continuum. The ADAMHS Board continues to invest significantly in community psychiatric support services for our most severely mentally ill clients to ensure that they are capable of functioning in the least restrictive forms of care within our community. The Board also invests significantly in inpatient psychiatric services at non-state hospital facilities to ensure that we can address the needs of individuals requiring an intensive level of care. Investment in the hot line and crisis intervention and prescreening services continues to be an important priority for the ADAMHS Board to ensure that individuals have an immediate access to the system of services. Additionally the ADAMHS Board's investment in consumer support programs operated by NAMI is relatively small from a financial standpoint; however they are a tremendous value to our consumers and network of care. Ensuring that all persons regardless of payer source have immediate access to care and emergencies will always be a priority for the board and the Board will invest appropriately to ensure that all persons have access to this level of care regardless of demand.

Timeframes involved in decision-making- The aforementioned episode of care information used by the Board and system in determining treatment and intervention needs coincides with our budget planning and contract allocation process from March through May of each contract cycle. Data elements assist in the decision-making process when revenues projections are available and we determine the following: The levels of care to be purchased; amount of each level of care to be purchased; the financial eligibility requirements of persons whose care will be covered by the Board (Medicaid commitments followed by Non-Medicaid eligible populations). The Board and system are also able to make adjustments in purchased services during the contract period through monthly analysis of claims and utilization data reported to the Board. Although historical utilization data permits us to be very precise in the amount and type of service that can be purchased for behavioral health consumers, there is unpredictability related to inpatient care and crisis intervention needs for transient adult populations and the impact of our lack of services for non-Medicaid eligible individuals. Little variance exists on the resource side to be able to address a rapid increase in the need for inpatient, crisis intervention and subsequent aftercare requirements. The cumulative effect of the previous three years' budget reductions has placed our network of care and consumer access at significant risk.

Findings of the needs assessment

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

In the discussion of findings please be specific to:

a. Adult residents of the district hospitalized at the Regional Psychiatric Hospitals **(ADAMHS/CMH only)**;

The population of individuals at Regional Psychiatric Hospitals (RPH) is an even division of men and women, all of whom are single, divorced or widowed. This potential lack of a close support person or significant other may impact the individual's overall health and wellness and increase their vulnerability. Additionally, 30% of the referrals for individuals at RPH were from the sheriff or police department, again indicating the potential benefit of the Crisis Intervention Training/CIT. The most frequent diagnoses of individuals admitted from FY 2010 to present are Bipolar I and Schizophrenia/Schizoaffective. Individuals in the Board area diagnosed with Schizophrenia or other psychotic disorders had an average length of stay of 25.4 days and an average 11.7 admits at RPH from the date of their first admit to present as indicated through the Patient Care System. Individuals diagnosed with Bipolar I disorders had, on average, a length of stay of 14.7 days and, on average, 3.25 admits at RPH.. From this data a reasonable conclusion would be that our local system of care could increase our referrals and awareness to supportive services that may help stabilize consumers and help them remain in the community. Additionally, discharge planning including housing and timely access to psychiatric services is an area that the Board is diligently working to address with our high need consumers.

b. Adults with severe mental disability (SMD) and children and Youths with serious emotional disturbances (SED) living in the community **(ADAMHS/CMH only);**

Due to the impact of budget reductions, our local crisis services underwent a significant transition.

A primary component of that transition was the decrease in the hours of crisis services staff and a shift to primarily on-call status for crisis assessments. This has had a significant impact on adults with SMD who previously were able to call crisis services as a preventative measure. Because resources are now so limited, crisis workers are forced to focus only on those cases where there is an immediate risk of harm to others. The opportunity to de-escalate consumers and prevent crises versus solely intervening when the crisis is present was removed when staffing was reduced. Consumers repeatedly discuss this as having a negative impact on their well-being. The Board is looking to develop a warm-line and encouraging consumers to reach out to other informal supports or supportive services such as our Consumer Operated Organization or our local chapter of NAMI.

Additionally, adults with SMD and children with SED report being negatively impacted by the lack of timely access to psychiatric services. As discussed in previous sections, efforts have been made to engage and recruit psychiatrists to our area through the Health Professional Shortage Designation, incorporation of tele-psychiatry, and multiple contacts with medical schools and the medical board but presently there is a severe shortage of psychiatric services locally. This shortage results in a longer wait for service initiation and longer wait between sessions. The shortage of psychiatrists has also created difficulty discharge planning for individuals leaving psychiatric hospitalizations.

The ADAMHS Board also played an integral role in the development of the Service Coordination Mechanism in both Tuscarawas and Carroll County Family and Children First Councils. An ADAMHS staff member serves as chair on the service coordination committee in both counties. Based on an evaluation completed by family members and providers in 2009, an overhaul of the service coordination process was required to increase effectiveness and community buy-in. This is discussed in further detail below in Section f.

c. Individuals receiving general outpatient community mental health services (**ADAMHS/CMH only**);

In examining diagnostic information from SFY 2010 it is noteworthy that the most frequently diagnosed conditions for the 0-12 population were behavioral conditions. The most common diagnoses were disruptive/oppositional behaviors and attention deficit hyperactivity disorders. It is also worth noting that in both counties, the number of children served from age 0-7 is proportionate to the number of children in the 8-12 age group. It is believed this is due to the work that is done by local providers to support Early Childhood Mental Health. Additionally, other than the 62+ population, individuals age 13-17 are the least likely to engage in treatment based on data from the contract agencies. While behavioral diagnoses are still common in the 13-17 age group, mood disorder diagnoses begin to be seen and remain present through the later age group categories. Another surprising result was that alcohol abuse and dependence had decreased in rank from SFY 2008 to SFY 2010 in each age category it was present. It is also interesting to note that there are fewer individuals diagnosed with a psychotic disorder in SFY 2010 than in SFY 2008.

While data regarding trends and patterns in the system is useful, a concern continues to be the length of time between the initial phone call for an appointment and the time between sessions. The Board and providers agree that Evidence Based Practices are a priority. The length of time between sessions impedes the ability of our providers to have high fidelity with prescriptive Evidence Based Practices that indicate sessions are to occur at a certain frequency. A twelve week treatment program gets extended in relation to staff availability and caseload size. This is especially impactful

to adult SPMI/SMD consumers and children who most benefit from consistent ongoing contact and focus on retention and generalization of skills and information.

Over the past two years, the Board has paid close attention to the frequency and effectiveness of many services including cross-system collaboration and coordination and found that significant improvements could be made both in regard to adults and children. To meet this need, the ADAMHS Board has taken the initiative, in conjunction with Carroll and Tuscarawas Family and Children First Councils, to restructure the county service coordination mechanisms. The goal of this process is to maintain children in their homes when it is safe and appropriate. There has been a coming-together of child-serving systems to increase our collaborative relationships, focus on family-voice and family-choice, and increase fiscal responsibility by clearly identifying responsibilities between systems to prevent duplication of services. The new mechanisms and increased collaborative philosophy has only recently begun but it is expected it will have a significant impact on the services of this and higher-need consumers. This model has been initiated for Carroll County adults as well.

d. Availability of crisis services to persons without Medicaid and/or other insurance. (**ADAMH/CMH only**)

As stated above, the crisis services were significantly changed as a result of budgetary reductions with the shift to decreased staff and on-call crisis assessors. A primary impact has been the loss of crisis prevention phone responses vs. crisis intervention. Clients and systems also report occasional dissatisfaction with the amount of time between the report of a potential crisis and the response time of on-call workers. While the delivery of the service has been altered, managing and intervening in crises continues to be a primary focus for discretionary dollars. Clients continue to receive crisis services regardless of payer source as well as the opportunity to use the local crisis stabilization service.

e. Adults, children and adolescents who abuse or are addicted to alcohol or other drugs **(ADAMHS/ADAS only)**

While alcohol dependence and abuse has decreased as a most frequent diagnosis, the Alcohol and Addiction Program Intensive Outpatient group is at capacity with no funding available to hire additional staff. As the abuse of opiates, benzodiazepines, and alcohol continues to rise, community members and providers turn their attention to options such as Suboxone and Vivitrol as treatment options.

The access to residential drug and alcohol treatment is also a concern. The most frequent request for service calls received by the Board relate to residential treatment. While Harbor House Halfway House is available for women with addiction, the site typically operates at capacity with a waiting list. There is no comparable local service for men. This gap in service and the inability of the local system to fund out-of-county residential treatment service leaves consumers with a local level of care that is often not appropriate to meet their need.

Data indicates that the age of first use is overwhelmingly the 14-18 age group. A school based drug and alcohol prevention program present exists targeting school aged children but funding was lost for fiscal year 2011 to maintain the DARE to Be You family-based prevention program. Any loss in

prevention programs increases the risk and need for intervention programs for the system now and in the future.

It is also worth noting the progress is made regarding employment status. Data supports success of individuals gaining full or part time employment during the treatment episode.

f. Children and Families receiving services through a Family and Children First Council;

The Board has played an integral role in the reorganization and restructuring of Family and Children First Councils (FCFC) in both Tuscarawas and Carroll Counties, becoming the Administrative Agent for Tuscarawas FCFC. During the restructuring process, special attention was paid to reducing the number of meetings and streamlining the meeting content, improving service coordination, and engaging more members in Council. Recent Council or community mandates such as the Family and Civic Engagement initiative, the Service Coordination Mechanism, and the Shared Planning approach will allow Council to suggest data-supported program development for the local child-serving systems. It is expected that as the gaps and needs emerge through the child-serving systems, local systems will collaborate to obtain funding to support program development.

A need that has clearly emerged in both counties is the treatment of dually diagnosed children and adolescents. Children with a mental health diagnosis and a developmental disability are the most common group seen in the service coordination process, are most often at risk of removal or placement, and have parents who report the highest level of stress. As the restructuring in both Counties comes to a close, it is expected that Council and the mental health and developmental disability systems will work to develop a plan to address this growing need.

Through the Shared Planning process, Family and Civic Engagement and the Parent and Communities Together team, additional needs have come and will come to the attention of the Councils. Examples of these community needs are: Bullying Prevention Program, parent involvement to increase a child's school success, increased understanding and advocacy across all systems for children with special needs, and stabilizing adoptive homes. Since Council does not have the resources to address each of these needs, the Shared Plan will help the child and family-serving systems to prioritize and identify which needs the Councils are most able to impact.

g. Persons with substance abuse and mental illness (SA/MI); and

The Board and providers recognize the need for more SAMI services locally. There are a few SAMI providers in the counties but individuals in need of both drug and alcohol and mental health services often see two different providers at two agencies. As more funding is available, the Board sees the incorporation of Integrated Dual Disorder Treatment (IDDT) as a priority. In the mean time, area providers have begun working together more collaboratively between agencies to create treatment teams to support individuals.

h. Individuals involved in the criminal justice system (both adults and children)

A strong collaboration has been built through the Tuscarawas County Courts, the Alcohol and Addiction Program and the ADAMHS Board to address the treatment needs of individuals with both addiction and legal involvement. A grant through the Ohio Criminal Justice Services has provided

for a licensed counselor and a case manager to work with individuals involved in the local Drug Court program in addition to the existing providers that manage group treatment. This program has increased collaborative relationships and proved to be successful with 65% of referrals to drug and alcohol services originating in court or the criminal justice system. Additionally, the ADAMHS Board participates in the Community Corrections Planning Board and therefore is actively engaged in discussion regarding needs of local consumers as well as potential areas of growth.

Past conversations have occurred between the Board and Tuscarawas County Courts regarding the potential of a Mental Health court. The availability of staff to develop and run this program is a primary barrier. In identifying priorities, the Board determined that the limited resources are better spent working with law enforcement to strengthen the collaborative relationship with the mental health system, addressing stigma that may impact the interactions between law enforcement and consumers, and developing a plan to support the consumers that have consistent involvement in both systems to prevent involvement in the court system.

i. Veterans, including the National Guard, from the Iraq and Afghanistan conflicts

Over the past three years the Board has formed a relationship with the Veterans Administration Office in New Philadelphia specifically around issues related to mental health and suicide prevention. Through collaborative work on the Suicide Prevention Coalition, the mental health system, the Veterans administration, and other local providers have partnered to increase awareness of warning signs, local resources, and prevention efforts for civilians and veterans. Due to the high rate of suicides post-discharge from the military as well as the high rate of suicides of civilians in Carroll County, a collaborative approach was a natural fit to meet an ongoing need. The partnering of these two systems also impacts stigma related to mental health services and opens doors for veterans to engage local treatment services.

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

Access to Services

Question 8:

a) Identify the major issues or concerns for individuals attempting to access behavioral health prevention and treatment services in the Board area. In this response please include, when applicable, issues that may exist for clients who are deaf or hard of hearing, veterans, ex-offenders, problem gamblers, and individuals discharged from state Regional Psychiatric Hospitals and released from state prisons without Medicaid eligibility.

There are currently several issues and concerns for individuals attempting to access behavioral health services related to treatment capacity within the local system of services. These factors impact all populations including veterans, the hearing impaired, offenders, problem gamblers and persons released from penal institutions. The primary issue is a lack of funding to support services for individuals not eligible for the Community Medicaid program. A finite number of slots currently exist within our system for non-Medicaid enrollees seeking behavioral health services, with the exception of crisis, emergency services and inpatient psychiatric care. Non-Medicaid populations already enrolled in service prior to the Board enacting contract service reductions were at less risk of disruptions in their care. Persons attempting to access services for the first time during the current biennium and that would otherwise have been eligible for Board funded treatment interventions, are generally placed on waiting lists until a slot becomes available.

Additionally, we are currently experiencing a significant shortage of psychiatrists within the community due in part to reductions in funding. This results in significant delays for consumers requiring medications as a component of their outpatient care. Our lack of psychiatrists also contributes to problems in discharge planning for individuals released from inpatient Board contract beds. This primarily affects persons hospitalized for the first time and those without a primary psychiatrist prior to their admission. Inpatient providers are often unable to schedule follow-up appointments for these persons following their release from inpatient hospitals within 30 days of discharge. Some inpatient services providers have become hesitant to admit persons from our catchment area and designated pre-screening agency knowing that their client will not have access to a psychiatrist within the community.

The ADAMHS Board has made significant progress in ensuring that consumers have access to a variety of mental health prevention and recovery supports and treatment services within the catchment area. Access to prescreening and emergency services and associated clinical and quality improvement systems have been in place for a number of years. Emergency access to a variety of inpatient facilities has been established in order to ensure that the required number of slots for individuals needing these levels of care currently exists. A significant number of recovery support programs have recently been initiated by NAMI of Tuscarawas and Carroll Counties. These include the Hand-to-Hand, Peer-to-Peer, and Family to Family programs which are offered on a regular basis in each of the Counties and expanded via a contract between the ADAMHS Board and NAMI. The ADAMHS Board provides a significant amount of in-kind support to NAMI including the production of their curriculum materials, newsletters, and making meeting space available to NAMI. Additionally NAMI is offering their peer support program titled “Hopeful Hearts” on the crisis stabilization unit of Community Mental Healthcare. The ADAMHS Board's consumer operated service, ACE Inc, is a significant source of recovery support for consumers with severe mental illnesses. ACE's membership currently stands at approximately 130, of which a significant percentage are active in social and recreational and peer support programs provided at the agency’s location in New Philadelphia, Ohio. The ADAMHS Board also recently organized a multi-agency adult service coordination mechanism titled “ACSIS-Adult Consumer Support, Intervention and Stabilization” in order to improve clinical outcomes in quality of living improvements for high risk consumers with dual disorders. This intervention team consists primarily of mental health and substance abuse treatment agencies and family members, who in turn jointly determine how and when to engage other non-

traditional forms of recovery support and education services (healthcare, law-enforcement, MR/DD, Adult Protective, Probation and other judicial staff, etc) to assist our higher risk target populations. Transportation for consumers of mental health services is an ongoing problem. The ADAMHS Board's consumer operated service added a van and part-time van driver to their staff in order to ensure that residents of Carroll County and Tuscarawas County have reliable transportation to the consumer drop-in center.

b) Please discuss how the Board plans to address any gaps in the crisis care services indicated by OAC 5122-29-10(B). **(ADAMHS/CMH only)**;

The Board's designated pre-screening agency, Community Mental Healthcare (CMH), currently provides all aspects of crisis intervention services as described in OAC 5122-29-10 (B). Additionally, the procedures related to this service are outlined in a designated agency agreement between the ADAMHS Board and CMH for purposes of fulfilling the requirements of OAC. Recent budget reductions have altered the delivery of crisis intervention and pre-hospital screening services. The primary change involved placing health officers in an on-call status rather than having them located at the agency and available 24-7. This has created some delays in response time. Referral sources of the Board, particularly law-enforcement officials and emergency room personnel, have voiced concerns about the additional wait times for pre-screeners. Additionally, pre-screening personnel are generally only able to arrive to perform after hour face-to-face interventions at the Union Hospital emergency room or other secure facility and not in the home environment of the individual in crisis.

The ADAMHS Board and CMH are committed to ensuring the continued availability of the crisis respite unit in spite of the budget reductions. If the unit were to close we would have a significant gap in our crisis intervention continuum.

The ADAMHS Board, in collaboration with CMH (dually certified emergency and prescreening agency) and the Alcohol and Addiction Program (AAP) (a division of the Tuscarawas County Board of Health) continue to work closely on issues related to substance abuse crises and other screening/assessment issues related to the emergency services continue on. Since the ADAMHS' Boards primary outpatient substance abuse contract provider, AAP, does not offer 24-hour hotline and information and referral services, CMH and AAP collaborated on training and information/referral system in order to make substance abuse crisis assessments available 24-7. Access to their clinicians is provided through an arrangement with CMH's crisis unit personnel.

23 hour observation bed services were added to our crisis response continuum during FY 10 and will continue to be available during FY '12-'13. We believe that this is an important "transition" service that needs to be available in the clinical decision-making process. It is particularly important for medical department and pre-screening personnel while they are attempting to make informed clinical decisions for individuals experiencing a crisis when they are under the influence and/or persons with dual disorders.

b) Addressing gaps in crisis services - The ADAMHS Board and it designated pre-screening agency, Community Mental Healthcare, focus a significant amount of our direct and

administrative efforts in managing the local continuum of crisis intervention services. A meaningful system of communication that includes intra-agency clinical reporting systems and care elements included within the ODMH's SOQIC reporting format has enabled the local system to continuously improve our response to consumers in crisis. Services are provided in accordance with ORC 5122-29-10B.) In other words, immediate phone contact capability with individuals, parents, and significant others and timely face-to-face intervention is accessible twenty-four hours a day/seven days a week. Although clinicians are generally not available to accompany law-enforcement on site during the intervention process, access is available at pre-determined sites including the crisis respite unit, hospital emergency rooms and the jail when necessary. Consultation with a psychiatrist continues to be available twenty-four hours a day/seven days a week. Concerning crisis worker training, they are well-versed in de-escalation, stabilization and crisis resolution techniques. Training specifically identified in ORC 5122-29-10 is required of crisis workers and must be documented prior to application for Health Officer Designation. These issues as well as service provision and collaboration with community and emergency providers are reviewed with the Board as well as local crisis providers on a case by case basis.

c) *Please discuss how the Board identified and prioritized training needs for personnel providing crisis intervention services, and how the Board plans to address those needs in SFY 2012-13.* **(ADAMHS/CMH only)**;

Board identified and prioritized training needs for personnel providing crisis services. As stated previously, training needs with personnel providing crisis intervention services started with a review and update of the existing Health Officer Policy and the identification of crisis-specific trainings for all Health Officers as well as ongoing training for crisis workers. OAC 5122-29-10 was used as a guideline to maintain compliance with Ohio law. We will continue to encourage our designated pre-screening agency, Community Mental Healthcare to pursue certification from the American Association of Suicidology. Attaining this certification at any level would allow agency and providers to exemplify best practices, policies and programs currently being used throughout the United States. While this is still in consideration, barriers that presently exist are available funding to attain the certification as well as availability of employees to participate in the process due to significant budget cuts. The Board is considering how to support Community Mental Healthcare in pursuing this certification. As the opportunity for certification is being examined, the ADAMHS Board is working with the local crisis services provider to organize trainings specific to crisis services. A significant change to the existing Health Officer Policy specifies that all workers attempting to renew their designation must document at least 6 hours of training approved by the Counselor, Social Worker and Marriage and Family Therapist Board related to crisis services. These trainings are determined based on need as well as those topics that the crisis services workers identify as important to their service delivery. The responsibility associated with this designation, as well as this field, warrants that the crisis services workers are up to date on the most effective research, theory, and intervention to manage the needs of individuals in Tuscarawas and Carroll Counties. An initial training on Suicide Prevention was offered to all Tuscarawas and Carroll County crisis services workers in June 2009. Community Mental Healthcare in Dover, Ohio operates a five-person capacity crisis unit. The agency and unit are conveniently located next to Union Hospital which provides 24 hour emergency medical clearance for consumers. The crisis stabilization unit is a critical point along our service

continuum for adult SMI consumers within the Board's service district. Certified by ODMH as a residential level of care, the unit is an important juncture in relation to care management as individuals move between either more or less intensive levels of care (e.g. prior to admission to a hospital, admitting a consumer from the hospital) medical clearance is often secured from Union Hospital for individuals being admitted to Heartland Behavioral Healthcare. A review of sample cases from SFY 2007 revealed that approximately 24% of individuals (subsidized by the Board) leaving inpatient hospital settings are discharged directly to the crisis unit for purposes of easing their transition to the community and less intensive levels of care. We believe that this contributes to the Tuscarawas and Carroll Board system maintaining one of the lowest readmission rates within 30 days of discharge (5%) of counties admitting consumers to Heartland Behavioral Healthcare (IBHS reports). The crisis unit and CPST staff work closely with consumers utilizing supportive and independent housing in order to minimize problems related to temporary admissions.

Question 9: ***Workforce Development and Cultural Competence****:*

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

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

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

The ADAMHS Board worked very closely with ODMH personnel and our provider network during the FY '10'11 biennium in order to secure a mental health professional shortage designation from the federal government. We anticipated that this educational debt relief program would be a meaningful incentive to mental health professionals, both existing and new, to consider or maintain their employment at local mental health and substance abuse treatment agencies. Several local mental health professionals have attempted to explore this opportunity without success. Factors related primarily to the manner in which agencies are licensed and the ratio of persons receiving Board subsidies within their agencies to support treatment costs have, this point, prohibited anyone from taking advantage of this program. The overly prescriptive nature of the application process is a significant obstacle as well as a lack of support by federal personnel to assist counselors throughout the process. Our lack of success with this program has

hindered proposed outreach to educational institutions that may have been able to offer financial incentives to medical school graduates.

Our joint county suicide prevention coalition has sponsored several trainings, including a Gatekeeper training in October, in order to improve the overall response of our community to this target population by non-mental health professionals. School personnel, human service personnel, consumer advocates, volunteers and others are now positioned to connect persons experiencing suicidal thoughts and ideations to the correct community resource.

Also, we recently began to focus our training efforts on trauma-informed care interventions in an effort to improve the consistency with which providers can intervene on behalf of children and families that are victims of sexual abuse or severe abuse and neglect. These efforts are being coordinated in conjunction with a newly created Child Advocacy Center within Tuscarawas County.

A general lack of mental health professionals continues to be cited as a problem in our catchment area by provider agencies. Ultimately these are related to a lack of resources via significant losses in funding. We continue to hear anecdotally that direct service personnel continue to migrate to northern regions of Ohio for employment opportunities with better pay scales. Some of our providers also provide tuition reimbursement in order to develop qualified staff. They are also sites for field placements for students in hopes that they will become employees after completing their degree.

Question 10: ***Capital Improvements****:*

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

Some changes have occurred with respect to capital improvement needs of agencies within the local network of care since the FY '10-'11 planning cycle. Recent budget reductions will likely further jeopardize our ability to provide matching resources for any meaningful capital projects during the FY '12-'13 biennium. Updates and an overview of our needs are as follows: The Board has asked for any existing capital funding grant previously under consideration from ODMH to be re-purposed in support of a planned request to the U.S. Department of Housing and Urban Development. Our capacity goal is to create 12-24 independent housing units via the HUD 811 program, while also developing a new consumer operated service facility that will be located in close proximity to the proposed housing development. Our existing COS program, ACE, Inc. which is currently supported through a capital grant from ODMH, would enable us to build a new facility for ACE with adequate activity space, offices, commercial appliances and areas for food preparation, restrooms, parking, and outdoor recreation areas.

Another capital improvement project within the catchment area concerns establishing an adult male residential substance abuse treatment program. This project will be managed either through a collaboration with an existing treatment agency or via creation of a private not-for-profit to manage the program. The need for this level of care within Tuscarawas and Carroll Counties is well documented. The ADAMHS Board is currently chairing a committee comprised of various

constituents interested in establishing this level of care in our community. This subcommittee of the local Community Corrections Planning Board includes Judge Elizabeth Thomakos, who operates a Common Pleas Drug Court Program; James Seldenright, Tuscarawas County Commissioner; administrative staff of the Alcohol and Addiction Program (housed within the District Board of Health); representatives of the Southern District Court; a representative of the adult parole authority and several concerned citizens who are active in human service related initiatives in our district.

Another project which warrants consideration for capital improvement funding from the Department of Alcohol and Drug Addiction Services is a halfway house for women and women with dependent children. This project is operated by Personal and Family Counseling Services and is located in a century old home which is not adequate for the volume of individuals served by the program. Significant upgrades are needed with respect to HVAC, plumbing and commercial appliances. As recently as October 2008 the, Halfway House management of Personal and Family Counseling Services stated that they were strongly considering ceasing operations of the facility due to stagnant funding from the Department and ongoing resource problems associated with the program. The ADAMHS Board of Tuscarawas and Carroll Counties allocated additional resources to the program which has temporarily stabilized the operation.

Management of the Alcohol and Addiction Program (AAP) continue to be concerned about their space limitations within the District Board of Health. AAP serves a very high volume of consumers and would like to expand their operation to improve access to medication assisted treatment interventions. We have had some preliminary discussions with management of the health Department concerning strategies to possibly move their operations to another location. The district Board of Health would maintain administrative oversight of the program at a different location.

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

Background and Instructions for Completing Section III of the Plan

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

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

DEPARTMENT CAPACITY GOALS

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

Behavioral Health Capacity Goals

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

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

DEPARTMENT PREVENTION PRIORITIES AND GOALS

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

Alcohol and Other Drug Prevention Priorities:

Key ODADAS prevention initiatives include:

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

ODADAS Priority Populations:

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

Mental Health Prevention Priorities:

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

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

ODMH Priority Populations include:

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

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

Alcohol and Other Drug Prevention Goals:

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

Mental Health Prevention Goals:

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

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

DEPARTMENT TREATMENT AND RECOVERY SERVICES PRIORITIES AND GOALS

Alcohol and Other Drug Priority Populations and Key Initiatives

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

Mental Health Priorities

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

ODADAS Treatment and Recovery Services Goals

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

ODMH Treatment and Recovery Support Goals

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

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

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

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

Processes utilized by the Board to determine treatment priorities during SFY '12 and '13 have remained consistent throughout the previous biennium, many of which were cited in the "determining community needs" section within this plan.

Board prioritization of resources follows ORC 340 with respect to ensuring that inpatient treatment capacity is available for persons requiring the continuum of care for interventions through and resulting in an involuntary hospitalization (e.g. crisis intervention, ambulance transportation, discharge planning) and companion statutes for forensic admissions related to court ordered placements for individuals whose placements are the financial responsibility of the ADAMHS Board (e.g. competency restoration, ICT-NR). All planned versus actual inpatient usage, including private hospital contract beds, are important sources of data and critical considerations within the Board service prioritization process. Individuals at risk of acute withdrawal from substances, primarily alcohol and benzodiazepines, requiring inpatient care, are

also priority populations of the Board, including SAMI clients, due to the life-threatening consequences of untreated acute withdrawal. Information obtained from inpatient facilities by are designated pre-screening agency and which assist in continued LOS decision-making are considerations in determining priority service considerations in discharge planning. A full continuum of community-based services, including crisis respite services are prioritized by the Board for individuals to ensure that they be served in the least restrictive environment possible and one in which they can be immediately engaged in services and recovery at local agencies.

Intensive outpatient, partial hospitalization, community psychiatric, CPST, outpatient counseling, housing subsidies (ACF and non-ACF), peer support services and hotline comprise an array of service priorities for the Board for both mental health and recovery service target populations.

A critical component of local services for SMI populations is our consumer operated service, ACE. Inc. ACE provides the only form of peer support for a large group of SMI consumers engaged at providers throughout the two county area and is consistently cited by them as a vital component of their recovery. ACE provides extensive opportunities for socialization and peer interaction and support for numerous consumers and fills a critical service needs within our community. Without ACE, we believe that many consumers experiencing SMI within the two county area, would become socially isolated and lack an integral form of therapeutic support. This in turn would increase the frequency of acute relapses for SMI adults resulting in further dependence on clinical interventions. The effect would be significant cost increases along the treatment continuum, particularly crisis intervention, psychiatric support and CPST. The importance of ACE is routinely communicated to the Board directly by its members and their family members. ACE is also utilized by consumers within supportive housing programs within the community, including ACF operators and its importance is regularly communicated to the Board of ACF operators.

To reiterate, the Board uses data/information from the following processes to assist in determining capacity, prevention, treatment and recovery priorities: Inpatient hospital usage report; Key informant survey; Self-evaluation; MACSIS claims and cost data; Behavioral Health module data analysis; Waiting list management processes; Pre-hospital screening and crisis intervention reports; Major unusual incident reporting forms; Request for Services logs; Claims modifiers; Child Fatality Review committee reports.

There are also a variety of non-quantitative mechanisms through which the Board receives feedback from mental health and recovery services constituents that are used in developing priorities. These include routine communication with our local NAMI chapters, Family and Children First Councils; Community Corrections personnel (specialty docket court); Foster Care planning Committee; Child Fatality Review Board; Law enforcement incident reporting (e.g. crisis interventions); Consumer operated services; Agency Internal Evaluations; Consumer complaints referred by agencies; General feedback from the community.

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

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

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

	Priorities	*Goals*	*Objectives*
Capacity	1. Incorporate the use of Evidence Based Practices (EBPs) to maintain a highly effective workforce.	1. Increase the opportunity for providers to receive training in EBPs locally.	1. Should funding be available, ADAMHS will organize a free or reduced-cost training for local providers in an EBP that relates to the needs of the community. 2. Should funding be available, ADAMHS will collaborate with the Child Advocacy Center to host Trauma Focused Cognitive Behavioral Therapy training for local providers.
	2. Maintain access to crisis services for persons with SPMI, SED, and SMD regardless of ability to pay	1. The Board will maintain the current level of crisis services including hotline, crisis intervention, hospitalization, and crisis stabilization regardless of ability to pay.	1. The number of individuals referred to the Ohio Benefits Bank will increase during the next biennium to determine Medicaid eligibility. 2. ADAMHS will continue to explore options and funding opportunities to provide case management services to non-Medicaid adult consumers. 3. The Board will meet quarterly with the prescreening agency to monitor funding and service access for non-Medicaid individuals
Prevention	1. The Board sees the maintenance and potential development of additional early-intervention programs as a priority	1. The Board will maintain programs presently functioning in our system of care aimed at addressing prevention and early intervention.	1. If possible, funding will be secured and earmarked to maintain the Early Childhood Mental Health Program and the Takin'it to the Schools drug and alcohol prevention program. 2. If funding becomes available, the Board will support the development of additional drug and alcohol prevention programs for the under 18 population.
	2. Support the growth and	1. Maintain and strengthen existing collaboratives related	1. Explore additional opportunities for the ADAMHS Board and the Veterans Administration to work together to impact

	expansion of the Suicide Prevention Coalition of Tusc. And Carroll Co.s	to the prevention of suicide.	suicides in the military population.
		2. Continue community awareness efforts to reduce stigma and educate the public regarding suicide	1. Review the existing strategic plan and determine the coalition's priority population and public awareness activities for 2011-2012.
Treatment and Recovery Support Services	1. Consider additional supportive interventions to address relapse prevention	1. Explore the viability of medication-assisted drug and alcohol treatment locally	1. Additional ODADAS funding will be used to support the use of Vivitrol and Suboxone as an adjunct to treatment 2. Identify local physicians who would be willing to prescribe these medications 3. Develop a contract with the physicians to administer the medication and collaborate on an ongoing basis with the drug and alcohol treatment provider
	2. Providers in local systems will increase collaboration and participation in service coordination	1. Provider involvement in and referrals to an adult SMD/SPMI service coordination mechanism and child SED service coordination mechanism will increase	1. In the role of TCFCFC administrative agent and CCFCFC Board Chair, ADAMHS will work collaborative with systems to educate direct service staff (teachers, mentors, counselors) on the service coordination mechanism. 2. In the role of CCFCFC chair and CCFCFC Service Review Committee Chair, ADAMHS will support activities designed to increase public awareness of the mechanism and referral opportunities. 3. In both counties, ADAMHS will support the involvement of mental health and drug and alcohol treatment provider's involvement in the service coordination process. 2. A Quality Assurance tool will be developed to track the effectiveness of the service coordination process and adjust the process to meet the needs of the system and the community 3. Referrals to the adult and child service coordination process will increase in number and from a variety of systems
	3. Increase access to	1. Adult consumers will have adequate	1. The ADAMHS Board will maintain participation in the local HOME Net housing

	housing	supportive housing options locally	initiative 2. The ADAMHS Board will continue to work to obtain HUD 811 funding to develop housing for adult SMD consumers 3. ADAMHS will maintain an active role in local collaboratives and activities designed to address the housing needs of individuals with disabilities.
	4. Increase access to non-traditional supports upon release from psychiatric hospitalization	1.. Increase awareness of support options for individuals released from psychiatric hospitalization	1. ADAMHS and NAMI will collaborate to contact consumers with their consent upon their release from psychiatric hospitalizations to discuss local supportive and advocacy options such as NAMI and the Consumer Operated Organization

When addressing capacity goals and objectives please address the following:

Access to Services

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

ACCESS ISSUES

The Board identifies an access issue related to non-crisis services for non-Medicaid adult SMD, SPMI, consumers	1. The Board will increase the availability of non-crisis services to non-Medicaid adult consumers	1. The number of individuals referred to the Ohio Benefits Bank will increase during the next biennium to assess consumer Medicaid eligibility. 2. ADAMHS will continue to explore options and funding opportunities to provide case management services to non-Medicaid adult consumers. 3. ADAMHS will continue to fund non-Medicaid case management services on a case-by-case basis taking into consideration how the absence of case management services may impact the individual's risk

		of psychiatric hospitalization.
The Board identified an access issue related to the availability of psychiatric services locally	1. The Board will bolster outside resources to meet the psychiatric needs of the communities	1. ADAMHS Board will work with local providers to support the development of tele-psychiatry. 2. The Board will develop relationships with primary care physicians to serve the less severe mentally ill clients thereby decreasing workload of existing psychiatrists and increasing accessibility. 3. The Board will increase local primary care physicians awareness of the Pediatric Psychiatry Network as a consultation service

Workforce Development and Cultural Competence

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

The Board and provider network are keenly aware of workforce development issues confronting our network of care. Changing the dialogue from a Board and provider perspective concerning broadening the concept of workforce, and its potential benefit within our system, is a valid and not previously addressed issue.

Providers and the Board obviously point to staff turnover as a negative influence not only on continuity of care for existing consumers, but also on the way it can negatively influence their ability to maintain meaningful relationships with other constituents and partners on the service continuum (e.g. juvenile justice, JFS, educational settings, supportive housing providers). We often hear anecdotal information about direct service personnel migrating to northern regions of Ohio for employment opportunities with better pay scales. A general lack of qualified mental health professionals is also cited as a problem in our catchment area by provider agencies. This lack of professionals is attributed to a lack of expansion of necessary important services, particularly in Carroll County.

In the past biennium, the ADAMHS Board has used internal resources to support workforce development and decrease stigma related to mental illness from the general public. While trainings varied and, in some cases, were based on initiatives identified by the local social services network, ADAMHS focused on addressing crisis services and depression. In 2009, ADAMHS hosted two trainings targeting these issues. The first was Dr. Jim Rogers training for local providers on Suicide Prevention and Treatment in Crisis Services. In addition to overview of techniques and theory, Dr. Rogers trained local providers on issues specific to rural,

Appalachian counties. Providers shared with Dr. Rogers prior to the training local scenarios and the training was tailored to meet our local needs. Following this training, local providers including a child psychiatrist, counselors, and a social worker specializing in gerontology, volunteered their time to train local providers and community members on Depression across the Lifespan. This training, provided by individuals who work in the local community, combined research-based information with the issues and characteristics typical of many of our local consumers. This training was well attended by students, providers and community members, including a local county commissioner. Finally, the ADAMHS Board in conjunction with the Suicide Prevention Coalition of Tuscarawas and Carroll Counties hosted a Gatekeeper Training. This training was timely in light of the murder/suicide that occurred in Carroll County two days prior to the training. The presenter was able to relate training content to this tragedy, increasing the audience's understanding of risks associated with rural areas and service personnel.

Target areas for 2012-2013 have been identified by the Board based on local needs as well as through ADAMHS involvement in community collaboratives with other social services systems. The continuous attainment of knowledge and growth of clinician skill set to better meet the changing needs of the community is a priority of the ADAMHS Board.

Board's SFY 2012-2013 Workforce Development and Cultural Competence Goals and Objectives

Goal	Objective
1. Increase local opportunities for free or reduced cost training in Evidence Based Practices (EBP) or Promising Practices.	1. Facilitate the development of a local Child Advocacy Center (CAC) through the partnership between Job and Family Services, the Prosecutor's office, law enforcement and Juvenile Court. 2. Through the CAC collaborative, ADAMHS will co-sponsor a local training on Trauma Focused Cognitive Behavioral Therapy, an evidence-based approach to trauma treatment. 3. ADAMHS will investigate the cost and options of training local providers on EBP in areas related to dual diagnosis, substance abuse/mental illness,
2. Increase provider understanding of culture of poverty.	1. Investigate cost related to poverty/Appalachian culture trainings, specifically Bridges out of Poverty and sponsor training if financial resources are available or can be garnered.
3. Increase provider understanding of Hispanic/Guatemalan culture local to Tuscarawas and Carroll Counties	1. Consult with local Hispanic Ministries to determine their willingness to sponsor a free training on the Hispanic Culture. 2. Consult with the Multiethnic Advocates for Cultural Competence, Inc./CARE OHIO regarding the cost and feasibility of hosting a training locally. (www.maccinc.net)

Presently provider agencies complete consumer satisfaction surveys and report the information to the ADAMHS Board. These surveys can be used to assess consumer satisfaction comparatively among different race groups. The proportion of non-Caucasian individuals who seek treatment in Tuscarawas and Carroll Counties is under 2%. While work can be done to address cultural competence in areas such as Hispanic population and African American population, many of our consumers are living at poverty level. This is the most salient cultural competence issue faced in our service area but poverty level or income level is not accounted for in the client satisfaction surveys. It is possible that work can be done to incorporate this into a satisfaction survey.

When addressing treatment and recovery services goals for <u>ODADAS</u>, please address the following:

<u>ORC 340.033(H) Goals</u>

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

Board's SFY 2012-2013 Drug and Alcohol Funding Goals and Objectives

Goal	Objective
1. Explore the viability of medication-assisted drug and alcohol treatment locally	1. Additional ODADAS funding will be used to support the use of Vivitrol and Suboxone as an adjunct to treatment 2. Identify local physicians who would be willing to prescribe these medications 3. Develop a contract with the physicians to administer the medication and collaborate on an ongoing basis with the drug and alcohol treatment provider
2. Maintain the collaborative approach to treatment developed by the ADAMHS Board, Tuscarawas County Courts, Adult Parole Authority, and the Alcohol and Addiction Program.	1. Continue ADAMHS involvement in the Community Corrections Planning Board which manages and monitors this treatment program. 2. Through involvement in the Community Corrections Planning Board, monitor the outcomes measures of the program and review ways to strengthen as needed.
3. Maintain funding to support the Harbor House Halfway House drug and alcohol treatment center for women.	1. Maintain collaborations with local government, legal, and judicial systems to ensure ongoing community and financial support of the program. 2. Explore the potential of a more defined financial arrangement regarding the use of IDAT funds to provide ongoing support of the program. 3. Monitor outcome measures of the program and review ways to strengthen as needed.

HIV Early Intervention Goals

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

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

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

The Board plans to meet the needs of all consumers to the best of our ability through the planning process, creation of individualized treatment teams, and community collaboratives.

The Board contracts with a local mental health service provider to serve in the function of forensic monitor. The forensic monitor maintains communication with the facility where the individual is hospitalized and attends court hearings to determine the individual's status, upcoming release, and discharge plans. She collaborates with the social workers at the different facilities to create as smooth a transition as possible for the individual. Additionally, this provider also is employed as a case management supervisor and had been in a management role in crisis intervention. The individual in this position has extensive awareness of community resources for all consumers including housing and supportive services and has been actively involved in discharge planning for many individuals stepping down from hospitalization.

The Board's involvement in the Community Correction Planning Board provides the opportunity for discussion and planning to occur around individuals with mental health or drug and alcohol diagnoses who also have any level of criminal charge. This collaborative relationship provides the opportunity for program development with shared financial responsibility.

The Board also facilitates the development of a team for consumers with high needs, with the involvement of law enforcement or judicial system as appropriate. This process occurs for individuals in the community as well as individuals discharging from state hospitals. The Board and the team understands that there are cases where existing local resources will not meet the needs of some consumers, so a plan is created during the individual's hospitalization and is in place prior to discharge. This has allowed in the past and will allow in the future for creative options to maintain consumers in the community with the appropriate services and supports.

Implications of Behavioral Health Priorities to Other Systems

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

We are not aware of other systems that have not been included in the prioritization process or routine needs assessment processes within Tuscarawas or Carroll Counties. The Board attempts to minimize the implications of the prioritization process by connecting individuals to any service necessary. For children and families this can occur via service coordination teams on behalf of multi-need children and adults via the Family and Children First Councils in Tuscarawas and Carroll Counties. These teams, which meet on a monthly basis and as needed, are able to discuss prevention and education needs of their organizations and on behalf of the clients they serve. This strategy has resulted in cross system training in order to provide updates on resources available through the ADAMHS Board, Ohio Department of Mental Health, and Ohio Department of Alcohol and Drug Addiction Services. ADAMHS Board staff are routinely invited to discuss our network of services and provider financial and clinical eligibility determination processes at the Board of Developmental Disabilities, Department of Job and Family Services, civic organizations, consumer operated service providers and other organizations. Contract agency personnel also often routinely provide training on their services and initiatives.

The ADAMHS Board intends to a play an enhanced leadership role with respect to coordination of services per the councils in each county. We continue to be actively involved in analyzing the findings of community assessment initiatives on behalf of juvenile sex offenders, victims of severe sexual abuse and physical abuse and neglect, youth risk behavior surveys, foster care planning and others. The ADAMHS Board also recently initiated a survey of councils' member agencies concerning their opinions about service coordination on behalf of families and children. Although the response rate to this web-based survey was low, we were able to determine that we need to improve our outreach, interventions, and follow up with multi-needed families and children as a Family and Children First Council agency.

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

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

A 10% reduction in funding to the Board during the remainder of FY '11 will likely mean an immediate reduction in the number of non-Medicaid eligible consumers that can be served at provider agencies receiving discretionary resources from the ADAMHS Board. We anticipate that waiting lists for individuals not currently being seen at provider agencies will increase. Existing non-Medicaid eligible clients currently enrolled in our plan for services where a portion of ADAMHS Board funding pays for their services or where we pay for 100% of their service, may have their services modified to less intensive intervention or they may be asked to pay for an additional portion of the cost of their care.

A 10% reduction in our base allocation will not adversely impact access to services for minorities, veterans or other special populations any more than the" "general" population of persons with behavioral health issues. Our local Department of Veterans Affairs directly provides and has access to a comprehensive array of services to meet the behavioral health needs of both active and retired armed service personnel. Veterans served through the VA are receiving behavioral healthcare more promptly than individuals attempting to access care at our local mental health providers.

Section IV: Collaboration

Background and Instructions for Completing Section IV of the Plan

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

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

Key collaborations and related benefits and results

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

Involvement of customers and general public in the planning process

Close collaboration occurs on an ongoing basis between the ADAMHS Board, the Department of Developmental Disability, Juvenile Court, Job and Family Services, and county commissioners, as well as other child and family serving agencies, both as a result of Ohio Summit on Children and through Family and children First Councils in both counties. The ADAMHS Board was the impetus for an evaluation and revision of Council structure and functioning, with specific focus on improving the Service Coordination Mechanism, in both counties and is represented on the Family and Civic Engagement Teams, House Bill 1, in both counties.

The ADAMHS Board serves as the past Chair of the Carroll County Family and Children First Council and the Chair of the Service Review Committee. ADAMHS collaborated with a team of professionals to revise and streamline the service coordination mechanism and ensure that all possible is being done to coordinate services and safely maintain children in their homes. Additionally, Carroll County FCFC developed a presentation for different schools, churches, PTOs, physicians, etc. to inform them about the functioning and benefits of Council and, specifically the service coordination process. Through Council, ADAMHS has also initiated a Mental Health Matters meeting where Carroll County providers meet with representatives of the mental health system to discuss issues related to access, service delivery, and capacity.

The ADAMHS Board assumed the role of Administrative Agent for Tuscarawas County Family and Children First Council in July 2010 and began by facilitating a strategic planning process to re-engage mandated members and clarify Council goals and priorities. This process resulted in a complete revision of service coordination to incorporate the Wraparound Model as well as the hiring of a full time Service Coordinator. ADAMHS Board serves in the role of Chair of the Tuscarawas County Service Coordination Committee and in the function of supervising to the Service Coordination. In addition to the Council structure revision and changes to service coordination, the ADAMHS Board worked closely with Council to recruit additional child and family service providers to participate in Council and played an integral role in the formation of Council's parent advocacy and support team.

There has been close collaboration between the ADAMHS Board, TCJFS, Tuscarawas County Juvenile Court, and the Prosecutor's Office to develop a Child Advocacy Center (CAC) in our community. ADAMHS serves on the CAC Board and is presently working in conjunction with other systems to fine-tune protocols to submit for national accreditation. Fund raising and grant writing are also priorities of the Board. The level of commitment and motivation of the individuals participating in this process will undoubtedly result in a benefit to children and families in Tuscarawas County. A tentative date for the opening of the CAC is April 1, 2011.

ADAMHS Board, in conjunction with its prescreening agency, has developed meaningful business partnerships with private hospitals and has expanded access to both inpatient psychiatric and inpatient detoxification services. Currently the board maintains contracts with three private psychiatric hospitals. One is located in Tuscarawas County, another in Lake County, and the third in Summit County. A contract was developed twelve months ago with SUMMA Health Systems and specifically St. Thomas Hospital in Akron, for the purchase of inpatient psychiatric services, 23-hour observation bed services, and detoxification. Improved protocols related to access,
continued stay decision-making, and discharge planning have been addressed in formal agreements either contractually or in memorandums of understanding. During the course of the partnership, concerns have arisen locally and through St. Thomas related to the availability of psychiatrists locally for follow-up care. While we continue to look for solutions, ongoing meetings and conference calls between the ADAMHS Board and professionals at St. Thomas illustrate their desire to work collaboratively to address the lack of local psychiatric services.

Although ODADAS eliminated Drug Court funding to the ADAMHS Board, the Alcohol and Addiction Program has been able to maintain adequate levels of support to a local felony drug

court which is offered in conjunction with the Community Correction Program and Tuscarawas County. AAP provides a significant amount of court and agency based services on behalf of the Drug Court Program. AAP also provides assessment and treatment services for both municipal courts that referred drug involved offenders to treatment. The ADAMHS Board is able to stay involved in the administration of this service through ongoing involvement in the Tuscarawas County Corrections Planning Board.

Board staff also have involvement with systems and county commissioners through the Tuscarawas County Foster Care Planning Committee (FCPC). The FCPC began five years ago with the goal of evaluating the present state of the foster care system, reducing the number of children placed in out-of-home care when safe and appropriate and making collaborative decisions related to stepping down children to less restrictive levels of care. There have been many initiatives developed from this committee including a focus on support and program development related to Kinship Caregivers, the Residential Review Committee charged with monitoring all children in residential treatment centers, an evaluation of factors that lead to TCJFS involvement and potential removal of children, and potential plan for public awareness campaigns and program review across systems as they relate to these factors.

A final example of collaborative relationships between the Board and local systems relates to housing. The Board presently chairs Home Network which is comprised representatives from area agencies and is charged with addressing homelessness in Tuscarawas County.

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

Customers, including our local provider network and the general public are engaged in the behavioral health planning process in a variety of ways. As previously mentioned, during the previous biennium, the Board conducted a comprehensive key informant survey and mental health consumer housing satisfaction and needs assessment. Both of these projects were large scale data collection efforts that resulted in feedback that continues to influence the delivery and public awareness/education efforts within the network of care. The results of these efforts are contained in the Board's previous annual reports and an electronic format- both of which are contained on the Board's website. Each can be downloaded.
Contract agencies of the Board conduct referral source satisfaction surveys in conjunction with their customers as on-going activities associated with their continuous quality improvement plans. These are also required by provider accreditation bodies including CARF and JCHO.

Another important method of collecting information from the public involves phone calls from consumers and family members which are logged internally by the Board. Information related to resolution of these calls is periodically reviewed by the Board staff and often responded to immediately. The frequency of these calls has recently been high as a result of reductions in Board discretionary funding to support psychiatric outpatient services. The lack of access to psychiatrists within the service district is also a common concern voiced by consumers and family members.

In an attempt to use non-traditional forms of soliciting input into the planning process, the Board is currently making decisions on how to utilize social marketing tools like Facebook and enhanced website applications to create communication loops between the Board, customers, providers and the general public. These methods are a more recent consideration in our efforts to engage the public and our customers and are the result of methods we developed for improving communication with the public during our recent levy campaign.

The ADAMHS Board and our providers are meaningfully involved in numerous inter-agency collaboration processes where up-to-date feedback on behavioral health interventions is routinely shared and acted upon in response to identified needs. Customers of the Board (e.g. law enforcement, Jobs and Family Services, etc) do not hesitate to share information with us on feedback they receive from the public and their constituents on access, quality and service delivery. This includes both positive and negative feedback. These collaborations include the following: The Family and Children First Councils of both Tuscarawas and Carroll Counties- specifically the service coordination mechanism adopted by each Council- The ADAMHS Board is the administrative agent of the Tuscarawas County Family and Children First Council; The Tuscarawas County Corrections Planning Board; An ADAMHS Board staff member is currently a Board member of the Stark Regional Community Corrections Center; Healthy Tusc; Tuscarawas County Foster Care Planning Committee; Child Fatality Review Board of Tuscarawas and Carroll Counties; An ADAMHS Board staff person is a Board member of HomeNet- the local housing continuum of care (ADAMHS Board will be administering the Shelter + Care program on behalf of the continuum effective July 1, 2011); Family and Civic Engagement Teams established in each school district in the County actively engaged with it's Family and Children First Council; An ADAMHS Board staff person in is currently a Board member of the Child Advocacy Center of Tuscarawas County; the Suicide Prevention Coalition of Tuscarawas and Carroll Counties; the Tuscarawas Regional Survivors of Suicide Support Group; Board staff attend Police Chiefs' Association meetings; The ADAMHS Board recently created a private, non-profit named "Gateway Housing Collaborative" to enhance, evaluate and manage hosing resources for adults with severe mental illnesses.

Board staff are routinely asked to speak at civic group functions within the community where we field a variety of questions about eligibility, demographic makeup or our service system and access to our continuum of services both in and out of county.

Regional Psychiatric Hospital Continuity of Care Agreements

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

The Board has reviewed the continuity of care agreement and a copy has been submitted to the ADAMHS Board's designated pre-screening agency. Feedback was obtained regarding the agreement and follow-up meetings have been attended by ADAMHS staff and staff of the pre-

screening agency regarding the ease of the process at Heartland Behavioral Healthcare. In addition, the ADAMHS Board Directors in the region meet routinely with HBH staff to discuss continuity of care issues and problem-solve issues related to the agreement. We routinely discuss the quality of the communication between hospital staff and the designated agency and have initiated contact with the hospital when there has been an issue with the process.

The pre-screening agency completed an in-house training of all crisis services staff on the logistics and implementation of the agreement. The Director of Crisis Services attends follow-up meetings at HBH to keep apprised of issues related to continuity of care.

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

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

The Board consults with commissioners in both counties in two manners. ADAMHS staff work closely with commissioners through the Family and Children First Councils (FCFC). Through Council the Board and commissioners have the opportunity to review patterns and trends related to needs of children and families and develop a plan to address these needs. As appropriate, both the Board and commissioners use discretionary funding to support activities to address families in crisis and attempt to maintain children in their homes. One example of this is the financial support of the service coordinator position. In both counties financial support is provided to FCFC to support Council activities with priority placed on the service coordination process.
Additionally, in Tuscarawas County the ADAMHS Board works with the county commissioners on the Foster Care Planning Committee (FCPC). This committee focuses their efforts on reviewing data and information regarding children placed outside of their home, determining where an impact can be made, and developing a plan to address the issue. While there is presently no funding agreement or local services or resources between the Board and commissioners, the ADAMHS Board and county commissioners jointly subsidize services for children placed outside of their home. It is possible that in the future that as a result of the cost savings by the FCPC, the Board and commissioners can work together more closely to fund prevention efforts.

Section V: Evaluation of the Community Plan

Background and Instructions for Completing Section V of the Plan

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

Ensuring an effective and efficient system of care with high quality

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

The primary focus of our system of service evaluation processes concerns regular analysis of cost and cost efficiency related to Board contract services for both Medicaid and non-Medicaid services. Although community-based services provided to Medicaid recipients are not subject to any form of Board management relative to amount, scope and duration, they directly impact the capacity of our local system to provide services to SMI/AOD adults and children with available discretionary resources- this includes non-Medicaid services provided to Medicaid enrollees (e.g. residential, hotline, education, information and referral, peer support, etc).

We review on a monthly basis purchased contract services for all levels of care and at all providers, both discretionary and Medicaid only providers. Additionally, the Board routinely considers requests by Medicaid only providers, made on behalf of consumers, to provide financial assistance in support of their treatment costs. Circumstances which might jeopardize their continued treatment, including a limited Medicaid benefit related to their "spend down" or other scenarios, are reviewed and approved on a case by case basis.

Patterns of use within the system are also periodically analyzed by Board staff and include the following characteristics of purchased services: Average cost per episode of care; average cost of Medicaid versus non-Medicaid episodes of care; Most frequently occurring diagnosis by age category including 0-7 through 65 and older; Average length of stay in private and state hospitals, re-admittance to psychiatric hospitalizations in 12 months; Medical necessity of treatment interventions; and review of level of care.

Elimination of the 06 rule reviews has significantly hampered our ability to dialogue with providers about the appropriateness of Board purchased treatment services versus our purchased service data generated by MACSIS and the OHBH system.

Determining Success of the Community Plan for SFY 2012-2013

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

a. How will the Board engage contract agencies and the community in evaluation of the Community Plan for behavioral care prevention and treatment services?

The Board has recently acquired the volunteer efforts of a local graduate student in the capacity of data collection and evaluation. An effort by the ADAMHS Board to evaluate, assess and improve local prevention and treatment services is also an effort by the direct service providers. Their input will be obtained regarding the creation of the assessment tool as well as the least

intrusive way to gather information from staff and community. Additionally, the Board will ask community partners to complete the assessment tool and provide feedback.

b. What milestones or indicators will be identified to enable the Board and its key stakeholders to track progress toward achieving goals?

Progress toward goals indicated relative to capacity, Prevention and Treatment Services and Recovery and Support Services will be monitored relative to the objectives stated previously. Many goals listed are dependent on obtaining funding or reallocating funding at a time when needs are overwhelming and funding availability is at an all time low. The ADAMHS Board acknowledges the importance of system evaluation and growth but struggles with the fact that the financial resources aren't available to strengthen our existing system of care as well as expand services in a way that is satisfactory. The ADAMHS Board and provider agencies have closely examined existing services to ensure that they are provided in the most efficient, beneficial and cost-effective manner possible as well as identifying an ideal state based on funding availability.

Capacity Goals
1. Increase the opportunity for providers to receive training in EBPs locally.
Indicator: The ADAMHS Board will provide training in an EBP specific to community needs such as Trauma Focused Cognitive Behavioral Therapy.
2. The Board will maintain the current level of crisis services including hotline, crisis intervention, hospitalization, and crisis stabilization regardless of ability to pay.
Indicator: Discretionary funds will continue to support and maintain the present level of crisis services. **Indicator:** Referrals to the Ohio Benefits Bank will increase and will be monitored by local OBB staff.
Prevention Goals
The Board will maintain programs presently functioning in our system of care aimed at addressing prevention and early intervention.
Indicator: Programs presently providing a prevention function will maintain through SFY 2012-2013 should funding remain stable. Should funding decrease, the ADAMHS Board will look at all possible options to maintain these services.
Continue community awareness efforts to reduce stigma and educate the public regarding suicide
Indicator: The Suicide Prevention Coalition of Tuscarawas and Carroll Counties will review the strategic plan and identify priority populations and activities for SFY 2012-2013.
Maintain and strengthen existing collaboratives related to the prevention of suicide.
Indicator: Meetings will occur on an ongoing basis between the ADAMHS Board and the local Veterans Administration office to determine the effectiveness of our collaborative relationship as it relates to the prevention of suicides in our service men and women.
Treatment and Recovery Support Goals
Explore the viability of medication-assisted drug and alcohol treatment locally

Indicator: If funding and physicians are available on an ongoing basis, ADAMHS will initiate a medication-assisted treatment program with in the catchment area by SFY 2013**.**

Provider involvement in an adult SMD/SPMI service coordination mechanism and child SED service coordination mechanism will increase
Indicator: The number of referrals to both the child and adult service coordination mechanism will increase in SFY 2012 and SFY 2013.
Adult consumers will have adequate supportive housing options locally
Indicator: ADAMHS will complete the training focusing on administration and management of supportive housing and will take over as administrative agent for Shelter Plus Care.
Increase awareness of support options for individuals released from psychiatric hospitalization
Indicator: A procedure will be developed between the ADAMHS Board, the local pre-screening agency, and NAMI to offer supportive contact and discussion of local consumer support options post-discharge with client consent.

c. What methods will the Board employ to communicate progress toward achievement of goals?

The ADAMHS Board will include information regarding progress toward system goals and objectives in the Annual Report. On a more on-going basis, the ADAMHS Board will utilize its e-notify program to alert consumers, providers, stakeholders and community members regarding progress and changes to the local system of care. In addition, the ADAMHS Board has enjoyed the support of local newspapers as well as local radio stations who have allowed and encouraged the ADAMHS Board to make public their successes as well as upcoming events. It is through these methods that the ADAMHS Board will report progress and achievements.

INSTRUCTIONS TO COMPLETE PORTFOLIO OF PROVIDERS:

Table 1: Portfolio of Alcohol and Drug Services Providers Instructions

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

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

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

Evidence-Based Programs Defined:

Alcohol and Other Drug Prevention

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

Alcohol and Other Drug and Mental Health Treatment

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

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

APPENDIX A:

List of Separate Attachments for Submission

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

Microsoft Word Document:

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

Microsoft Excel Documents:

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

APPENDIX B:

Definitions of Prevention

Prevention Defined—Alcohol and Other Drug Specific

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

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

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

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

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

Prevention Service Delivery Strategies

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

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

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

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

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

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

<u>Prevention Defined—Mental Health Specific</u>

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

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

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

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

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

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

Prevention Service Categories by Population Served:

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

APPENDIX C:

Definitions and Evaluation Criteria for Completing Section V Community Plan Evaluation

A. Definitions

1. Cost Analysis: Measurement and analysis of expenditures incurred by Boards related to the purchase of alcohol, drug addiction and mental health services pursuant to the Community Plan. Can be operationalized by costs accounted through MACSIS.

2. Cost effectiveness: This measure is defined as the ratio of cost to non-monetary units, and is used when both outcomes and costs are expected to vary. Can be operationalized by measuring cost as identified in state or local data systems (MACSIS, PCS, OHBH, etc.).

3. Cost efficiency: This analysis is used when differing services are known to produce the same outcome, and therefore the intent is to find the lowest cost way of producing the outcome. Can be operationalized by measuring cost as identified in state or local data systems (MACSIS, PCS, OHBH, etc). The difference between cost-effectiveness and cost-efficiency is that to use cost-efficiency, the outcomes-equivalence of various programs must be first established.

4. Community acceptance: Primary constituents' assessment of and satisfaction with services offered by the alcohol, drug and/or mental health providers and with the Board planning process. Primary constituents are comprised of consumers, families, other organizations and/or systems (particularly major referral sources such as schools, justice, public welfare, etc). For example, community acceptance may be assessed every two years through a survey of relevant planning and administrative organizations to determine the acceptability of the Board's planning and coordinating efforts among these organizations. Patterns of client referrals to provider organizations from schools, justice, public welfare, etc., may be analyzed on an annual basis to determine level of acceptance.

5. Consumer outcomes: Indicators of health or well-being for an individual or family as measured by statements or observed characteristics of the consumer/family, not characteristics of the system. These measures provide an overall status measure with which to better understand the life situation of a consumer or family.

6. Community Plan: The plan for providing mental health services as developed by a Board and approved by the ODMH in accordance with section 340.03 of the Revised Code and for providing alcohol and other drug prevention and treatment services as developed by a Board and approved by ODADAS in accordance with section 340.033 of the Revised Code.

7. Criterion: A standard upon which a judgment is based. This is currently not used.

8. Cultural relevance: Quality of care that responds effectively to the values present in all cultures.

9. Effectiveness: The extent to which services achieve desired improvements in the health or well being for an individual or family. (See cost-effectiveness.)

10. Efficiency: Accomplishment of a desired result with the least possible exertion/expense/waste. (See cost efficiency.)

11. Evaluation: A set of procedures to appraise the benefits of a program/service /provider/system and to provide information about its goals, expectations, activities, outcomes, community impacts and costs.

12. Patterns of service use: The analysis of relevant characteristics of persons in alcohol, drug addiction or mental health treatment compared with relevant characteristics of services received to determine who is receiving what level of service, and how those levels of service may appropriately differ among agencies. This information, when compared to persons who are not in treatment (e.g., persons on waiting lists, Census data, prevalence/incidence data, etc), is the basis for accurate needs assessment, utilization review and other determinations of appropriate service delivery. A calculation of certified community services by unit of analysis and time period can be conducted via the Claims Data Mart.[1]

13. Quality: The degree of conformity with accepted principles and practices (standards), the degree of fitness for the person's needs, and the degree of attainment of achievable outcomes (results), consonant with the appropriate allocation or use of resources.

B. Evaluation Criteria

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

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

2. Measurement and analysis of the cost of services delivered in the service district by unit of service, service pattern, client characteristics and provider agency.

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

3. Measurement and analysis of the levels of consumer outcomes achieved by clients in the service district, by service patterns, client characteristics and provider agency.

4. Measurement and analysis of the cost-effectiveness and cost efficiency of services delivered in the service district, by service pattern, client characteristic and provider agency.

5. Measurement and analysis of the level of community acceptance of services offered by the alcohol and other drug and mental health providers and with the Board planning process.

6. Other measurements and analyses of quality, effectiveness and efficiency of services as agreed upon among ODMH, ODADAS and one or more Boards.

C. Evaluation Data

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

D. Criteria for Data Quality

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

APPENDIX D:

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

❖ Cultural Competence

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

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

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

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

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

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

- Continuous treatment of six (6) months or more, or a combination of the following treatment modalities: inpatient psychiatric treatment, partial hospitalization or six (6) months continuous residence in a residential program (e.g. supervised residential treatment program or supervised group home); or
- Two or more admissions of any duration to inpatient psychiatric treatment, partial hospitalization or residential programming within the most recent twelve (12) month period; or
- A history of using two or more of the following services over the most recent twelve (12) month period continuously or intermittently (this includes

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

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

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

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

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

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

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

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

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

crisis intervention; or

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

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

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

I. Zero (0) years of age through seventeen (17) years of age (youth aged 18-21 who are enrolled in high school, in Department of Youth Services or Children Services custody or when it is otherwise developmentally/clinically indicated may be served to assist with transitioning to adult services), and

II. Individuals with any DSM-IV-TR diagnosis, except developmental disorders (tic disorders, mental retardation, pervasive developmental disorders, learning disorders, motor skills disorders and communication disorders), substance-related disorders, or conditions or problems classified in DSM-IV-TR as "other conditions that may be a focus of clinical attention" (V codes) unless these conditions co-occur with another diagnosable mental or emotional disorder, and

III. Assessment of impaired functioning at age appropriate levels and difficulty with age appropriate role performance with a Global Assessment of Functioning Scale (GAF) score below 60. Clinical discretion may be used to place individuals with GAF scores between 50 and 60 in a lower intensity of services (Mental/Emotional Disorder), and

IV. Duration of the mental health disorder has persisted or is expected to be present for six (6) months or longer.

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

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

APPENDIX E:

COMMUNITY PLAN REVIEW CRITERIA

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

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

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

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

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

Section: Signature Page

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

Section I: Legislative and Environmental Context of the Community Plan

Sub-Section II. Environmental Context for the Community Plan

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

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

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

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

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

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

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

Question Regarding: Major Achievements

Question 4: *Describe major achievements.*		
☐ Minimal description, much missing information., **or** ☐ Partial description but significant omissions.	☐ Adequate description, relevant areas addressed (i.e., complete documentation).	☐ An outstanding description (i.e., outstanding clarity, organization and documentation).

Question Regarding: Unrealized Goals

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

Section II: Needs Assessment

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

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

Sub-Section: Findings of the needs assessment

Question 7: *Describe the findings of the needs assessment identified through quantitative and qualitative sources.*		
☐ Minimal description, much missing information., **or** ☐ Partial description but significant omissions.	☐ Adequate description, relevant areas addressed (i.e., complete documentation).	☐ An outstanding description (i.e., outstanding clarity, organization and documentation).

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

Question Regarding: Access to Services

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

Question Regarding: Access to Services

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

Question Regarding: Access to Services

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

Question Regarding: Workforce Development and Cultural Competence

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

Question Regarding: Workforce Development and Cultural Competence

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

Question Regarding: Capital Improvements

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

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

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

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

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

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

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

Question Regarding: Access to Services

Question 13: *What are the Board's goals and objectives for addressing access issues for behavioral health services identified in the previous section of the Plan?*		
☐ No relationship between Needs Assessment and Goals & Objectives , **or** ☐ Discontinuities between Needs Assessment and Goals & Objectives	☐ Relevant areas of Needs Assessment are adequately addressed in identifying Goals & Objectives	☐ There is an outstanding description of the relationship between Needs Assessment and the identification of Goals & Objectives

Question Regarding: Workforce Development and Cultural Competence

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

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

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

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

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

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

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

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

Question Regarding: Implications of Behavioral Health Priorities to Other Systems

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

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

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

Section IV: Collaboration

Question Regarding: Key collaborations and related benefits and results

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

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

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

Question Regarding: Regional Psychiatric Hospital Continuity of Care Agreements

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

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

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

Section V: Evaluation of the Community Plan

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

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

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

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

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

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

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

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

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

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

Section: ODADAS Waivers

Was an ODADAS Waiver Requested for:

Generic Services _____ Yes _____ No

Inpatient Hospital Rehab Services _____ Yes _____ No

Section: Template for Submitting the Community Plan

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

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

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

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

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

Review Team Recommendation:

Recommend Plan Approval: _____ Date: _____

Recommend Plan Approval with Corrective Action: _____ Date: _____

Specify Corrective Action Required:

Recommend Plan Disapproval: _____ Date: _____

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

Review Team Members (Name and Department):

_____

_____

_____

_____

TEMPLATE FOR SUBMITTING THE COMMUNITY PLAN

[INSERT BOARD NAME HERE]

COMMUNITY PLAN FOR SFY 2012-2013

[INSERT DATE SUBMITTED HERE]

MISSION STATEMENT

VISION STATEMENT

VALUE STATEMENTS

SIGNATURE PAGE

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

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

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

_____

ADAMHS, ADAS or CMH Board Name (Please print or type)

_____ _____

ADAMHS, ADAS or CMH Board Executive Director Date

_____ _____

ADAMHS, ADAS or CMH Board Chair Date

[Signatures must be original or if not signed by designated individual, then documentation of authority to do so must be included (Board minutes, letter of authority, etc.)].

I. Legislative & Environmental Context of the Community Plan

A. Economic Conditions
B. Implications of Health Care Reform
C. Impact of Social and Demographic Changes
D. Major Achievements
E. Unrealized Goals

SECTION I: LEGISLATIVE AND ENVIRONMENTAL CONTEXT

Legislative Context of the Community Plan

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

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

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

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

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

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

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

ORC Section 340.033(H)

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

OAC Section 5122-29-10(B)

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

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

HIV Early Intervention Services

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

Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant

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

Federal Mental Health Block Grant

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

Environmental Context of the Community Plan

Economic Conditions and the Delivery of Behavioral Health Care Services

Implications of Health Care Reform on Behavioral Health Services

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

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

II. Needs Assessment

A. Needs Assessment Process
B. Needs Assessment Findings
C. Access to Services: Issues of Concern
D. Access to Services: Crisis Care Service Gaps
E. Access to Services: Training Needs
F. Workforce Development & Cultural Competence
G. Capital Improvements

SECTION II: NEEDS ASSESSMENT

Process the Board used to assess behavioral health needs

Findings of the needs assessment

Access to Services

Workforce Development and Cultural Competence

Capital Improvements

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

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

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

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

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

Access to Services

Workforce Development and Cultural Competence

ORC 340.033(H) Goals

HIV Early Intervention Goals

Addressing Needs of Civilly and Forensically Hospitalized Adults

Implications of Behavioral Health Priorities to Other Systems

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

IV. Collaboration

A. Key Collaborations
B. Customer and Public Involvement in the Planning Process
C. Regional Psychiatric Hospital Continuity of Care Agreements
D. County Commissioners Consultation Regarding Child Welfare System

SECTION IV: COLLABORATION

Key collaborations and related benefits and results

Involvement of customers and general public in the planning process

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

Funds available for parents/caregivers in the child welfare system

V. Evaluation of the Community Plan

A. Description of Current Evaluation Focus
B. Measuring Success of the Community Plan for SFY 2012-2013
C. Engagement of Contract Agencies and the Community
D. Milestones and Achievement Indicators
E. Communicating Board Progress Toward Goal Achievement

SECTION V: EVALUATION OF THE COMMUNITY PLAN

Ensuring an effective and efficient system of care with high quality

Determining Success of the Community Plan for SFY 2012-2013

Portfolio of Providers and Services Matrix

Table 1: Portfolio of Alcohol and Drug Services Providers

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level (Prevention only)	e. Evidence-Based Practice (EBP)	f. Number of sites	g. Located outside of Board area	h. Funding Source (Please specify)		i. MACSIS UPI
				(Universal, Selected or Indicated)	(List the EBP name)		(Please specify)	ODADAS	Medicaid Only	
PREVENTION										
Information Dissemination	Alcohol & Addiction	Community Programs	Teachers, Schools, Civic	Universal		2	No	Yes	No	1520
	Alcohol & Addiction	Problem Dependency	all	Selected		2	No	Yes	No	1520
	Alcohol & Addiction	Relapse Prevention Group	all	Universal		2	No	Yes	No	1520
	Alcohol & Addiction	Aftercare	all	Universal		2	No	Yes	No	1520
	PFCS	Takin' It To The Schools	Elementary Students	Universal		1	No	Yes	No	8310
Alternatives										
Education	Alcohol & Addiction	Substance Abuse Intervention Diversion	age 21 under	Selected		2	No	Yes	No	1520
	Alcohol & Addiction	Prevention/Education	all	Indicated		2	No	Yes	No	1520
	PFCS	Takin' It To The Schools	Elementary Students	Universal	based on Children's Program developed by Jerry Moe	1	No	Yes	No	8310
Community-Based Process										
Environmental										
Problem Identification and Referral	Alcohol & Addiction	Referrals	all	Universal		2	No	Yes	No	1520
PRE-TREATMENT (Level OUTPATIENT (Level 1)										
Outpatient	Alcohol & Addiction	Ind. Counseling	all			2	No	Yes	Yes	1520
	Alcohol & Addiction	Family Counseling	all			2	No	Yes	Yes	1520
	Alcohol & Addiction	Changing Course (Group)	ages 13-18					Yes	Yes	
	Alcohol & Addiction	Anger Management (Group)	all			2	No	Yes	Yes	1520
	CMH	Ind. Counseling	Adolescents and Adults			2	No	Yes	Yes	10071
	CMH	Group Counseling	Adolescents and Adults			2	No	Yes	Yes	10071
	PFCS	Ind. Counseling	all			1	No	Yes	Yes	8310
Intensive Outpatient	Alcohol & Addiction	IOP	adults			2	No	Yes	Yes	1520
Day Treatment							Yes No	Yes No	Yes No	
COMMUNITY RESIDENTIAL (Level 2)										
Non-Medical	PFCS	Harbor House Halfway	Adult Women		MI, TF-CBT	1	No	Yes	No	8310
Medical										
SUBACUTE (Level 3)										
Ambulatory Detoxification										
23 Hour Observation Bed										
Sub-Acute Detoxification	Crisis Intervention &	CIRC	Adolescents and Adults			1	Yes	Yes	Yes	1492
ACUTE HOSPITAL DETOXIFICATION (Level 4)										
Acute Detoxification										

Promising, Best, or Evidence-Based Practice	a. Provider(s) Name(s)	b. MACSIS UPI(s)	c. Number of Sites	d. Program Name	e. Funding Source (Specify all that apply as funding source for practice)				f. Population Served (please be specific)	g. Estimated Number in SFY 2012	h. Estimated Number in SFY 2013
					Medicaid + Match	GRF (Not as Medicaid Match)	Levy (Not as Medicaid Match)	Other (Not as Medicaid Match)			
Integrated Dual Diagnosis Treatment (IDDT)	x				Yes No	Yes No	Yes No	Yes No			
Assertive Community Treatment (ACT)	x				Yes No	Yes No	Yes No	Yes No			
TF-CBT	PFCS	8310	1		**Yes** No	**Yes** No	**Yes** No	**Yes** No	<18	35	50
Multi-Systemic Therapy (MST)	CCFCFC - CIS	1492	1		**Yes** No	**Yes** No	Yes **No**	Yes **No**	<18	15	20
Functional Family Therapy (FFT)	x				Yes No	Yes No	Yes No	Yes No			
Supported Employment	x				Yes No	Yes No	Yes No	Yes No			
Supportive Housing	CMH	10071	2		**Yes** No	**Yes** No	**Yes** No	Yes **No**	>18	35	35
	PFCS	8310	1						>18	35	35
Wellness Management & Recovery (WMR)	x				Yes No	Yes No	Yes No	Yes No			
Red Flags	x				Yes No	Yes No	Yes No	Yes No			
EMDR	x				Yes No	Yes No	Yes No	Yes No			
Crisis Intervention Training (CIT)	x				Yes No	Yes No	Yes No	Yes No			
Therapeutic Foster Care	x				Yes No	Yes No	Yes No	Yes No			
Therapeutic Pre-School	x				Yes No	Yes No	Yes No	Yes No			
Transition Age Services	x				Yes No	Yes No	Yes No	Yes No			
Integrated Physical/Mental Health Services	x				Yes No	Yes No	Yes No	Yes No			
Ohio's Expedited SSI Process	x				Yes No	Yes No	Yes No	Yes No			
Medicaid Buy-In for Workers with Disabilities	x				Yes No	Yes No	Yes No	Yes No			
Consumer Operated Service	Advocacy, Choices & Empowerme		1	ACE	Yes **No**	**Yes** No	**Yes** No	Yes **No**	>18	40	50
Peer Support Services	NAMI Tusc-Carroll		1	NAMI	Yes **No**	Yes **No**	**Yes** No	Yes **No**	>18	50	50
	Advocacy, Choices & Empowerme		1	ACE	Yes **No**	**Yes** No	**Yes** No	Yes **No**	>18	40	40
MI/MR Specialized Services	x				Yes No	Yes No	Yes No	Yes No			
Consumer/Family Psycho-Education	NAMI Tusc-Carroll		2	Hand to Ha	Yes **No**	Yes **No**	**Yes** No	Yes **No**	>18	50	50
	NAMI Tusc-Carroll		1	Peer to Pe	Yes **No**	Yes **No**	**Yes** No	Yes **No**	>18	50	50
	NAMI Tusc-Carroll		1	Hopeful He	Yes **No**	Yes **No**	**Yes** No	Yes **No**	>18	50	50

Please complete the following Service Level Checklist noting anticipated changes in service availability in SFY 2012:

SERVICE LEVEL CHECKLIST

Note: This checklist relates to your plan for SFY 2012. The alignment between your planned and actual service delivery will be determined using MACSIS and Board Annual Expenditure Report (FIS-040) data during February 2012.

Instructions:
In the table below, please provide the following information:

1) For SFY 2011: What services did you offer in FY 2011?
2) For SFY 2012: What services do you plan to offer in SFY 2012?
3) For SFY 2012: How do you expect Medicaid consumer usage to change in SFY 2012?
4) For SFY 2012: How do you expect Non-Medicaid consumer usage to change in SFY 2012?

	SFY 2011	SFY 2012		
Service Category	**(Question 1) Offered Service** **Yes/No/Don't Know** *Specify the answer for each category*	**(Question 2) Plan to:** **Introduce (Intro)** **Eliminate (E)** **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**(Question 3) Medicaid Consumer Usage:** **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**(Question 4) Non-Medicaid Consumer Usage**: **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*
Pharmacological Mgt. (Medication/Somatic)	**Yes** No DK	Intro E **I** D NC DK	**I** D NC DK	I **D** NC DK
Mental Health Assessment (non-physician)	**Yes** No DK	Intro E I D **NC** DK	**I** D NC DK	I D **NC** DK
Psychiatric Diagnostic Interview (Physician)	**Yes** No DK	Intro E **I** D NC DK	I D **NC** DK	I D **NC** DK
BH Counseling and Therapy (Ind.)	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I **D** NC DK
BH Counseling and Therapy (Grp.)	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I **D** NC DK
Crisis Resources & Coordination				
24/7 Hotline	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
24/7 Warmline	Yes **No** DK	Intro E I D NC **DK**	I D **NC** DK	I D **NC** DK
Police Coordination/CIT	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Disaster preparedness	**Yes** No DK	Intro E I D **NC** DK	I D NC **DK**	I D NC **DK**

School Response	**Yes** No DK	Intro E I D **NC** DK	I D NC **DK**	I D NC **DK**
	SFY 2011	**SFY 2012**		
Service Category	**(Question 1) Offered Service** **Yes/No/Don't Know** *Specify the answer for each category*	**(Question 2) Plan to:** **Introduce (Intro)** **Eliminate (E)** **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**(Question 3) Medicaid Consumer Usage:** **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**(Question 4) Non-Medicaid Consumer Usage**: **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*
Respite Beds for Adults	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Respite Beds for Children & Adolescents (C&A)	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Crisis Face-to-Face Capacity for Adult Consumers				
24/7 On-Call Psychiatric Consultation	**Yes** No DK	Intro E I D **NC** DK	I **D** NC DK	I **D** NC DK
24/7 On-Call Staffing by Clinical Supervisors	**Yes** No DK	Intro E I D **NC** DK	**I** D NC DK	I D **NC** DK
24/7 On-Call Staffing by Case Managers	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Mobile Response Team	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Crisis Central Location Capacity for Adult Consumers				
Crisis Care Facility	**Yes** No DK	Intro E I D **NC** DK	**I** D NC DK	**I** D NC DK
Hospital Emergency Department	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Hospital contract for Crisis Observation Beds	**Yes** No DK	Intro E I D NC **DK**	I D **NC** DK	I D **NC** DK
Transportation Service to Hospital or Crisis Care Facility	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Crisis Face-to-Face Capacity for C&A Consumers				
24/7 On-Call Psychiatric Consultation	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
	SFY 2011	**SFY 2012**		
	(Question 1) Offered Service	**(Question 2) Plan to:**	**(Question 3) Medicaid Consumer Usage:**	**(Question 4) Non-Medicaid Consumer Usage**:

Service Category	**Yes/No/Don't Know** *Specify the answer for each category*	**Introduce (Intro)** **Eliminate (E)** **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*
24/7 On-Call Staffing by Clinical Supervisors	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
24/7 On-Call Staffing by Case Managers	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Mobile Response Team	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Crisis Central Location Capacity for C&A Consumers				
Crisis Care Facility	Yes **No** DK	Intro E I D **NC** DK	**I** D NC DK	I **D** NC DK
Hospital Emergency Department	**Yes** No DK	Intro E I D **NC** DK	**I** D NC DK	I **D** NC DK
Hospital Contract for Crisis Observation Beds	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Transportation Service to Hospital or Crisis Care Facility	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Partial Hospitalization, less than 24 hr.	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Community Psychiatric Supportive Treatment (Ind.)	**Yes** No DK	Intro E I D **NC** DK	**I** D NC DK	I **D** NC DK
Community Psychiatric Supportive Treatment (Grp.)	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Assertive Community Treatment (Clinical Activities)	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Assertive Community Treatment (Non-Clinical Activities)	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Intensive Home Based Treatment (Clinical Activities)	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
	SFY 2011	**SFY 2012**		
	(Question 1) Offered Service	**(Question 2) Plan to:**	**(Question 3) Medicaid Consumer Usage:**	**(Question 4) Non-Medicaid Consumer Usage**:

Service Category	**Yes/No/Don't Know** *Specify the answer for each category*	**Introduce (Intro)** **Eliminate (E)** **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*
Intensive Home Based Treatment (Non- Clinical Activities)	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Behavioral Health Hotline Service	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Other MH Svc, not otherwise specified (healthcare services)	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Other MH Svc., (non-healthcare services)	Yes No **DK**	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Self-Help/Peer Svcs. (Peer Support)	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Adjunctive Therapy	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Adult Education	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Consultation	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Consumer Operated Service	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Employment (Employment/Vocational)	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Information and Referral	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Mental Health Education	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Occupational Therapy Service	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Prevention	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
School Psychology	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Social & Recreational Service	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Community Residence	Yes **No** DK	**Intro** E I D NC DK	**I** D NC DK	I D NC **DK**
Crisis Care/Bed **Adult** [see service definition below]	**Yes** No DK	Intro E I D **NC** DK	**I** D NC DK	**I** D NC DK
	SFY 2011	**SFY 2012**		
	(Question 1) Offered Service **Yes/No/Don't Know**	**(Question 2) Plan to:** **Introduce (Intro)**	**(Question 3) Medicaid Consumer Usage:** **Increase (I)**	**(Question 4) Non-Medicaid Consumer Usage**: **Increase (I)**

Service Category	*Specify the answer for each category*	**Eliminate (E)** **Increase (I)** **Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*	**Decrease (D)** **No Change (NC)** **Don't Know (DK** *Specify the answer for each category*
Crisis Care/Bed **Youth** [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Foster Care **Adult**	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Foster Care **Youth** [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Residential Care **Adult** (ODMH Licensed) [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Residential Care **Adult** (ODH Licensed) [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Residential Care **Youth** [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Respite Care/Bed **Adult** [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Respite Care/Bed **Youth** [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Permanent Supportive Housing (Subsidized) **Adult** [see service definition below]	**Yes** No DK	**Intro** E I D NC DK	I D **NC** DK	I D **NC** DK
Independent Community Housing **Adult** (Rent or Home Ownership) [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Temporary Housing **Adult** [see service definition below]	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Forensic Service	**Yes** No DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK
Inpatient Psychiatric Service **Adult** (Private hospital only)	**Yes** No DK	Intro E I D **NC** DK	**I** D NC DK	**I** D NC DK
Inpatient Psychiatric Service **Youth** (Private hospital only)	Yes **No** DK	Intro E I D **NC** DK	I D **NC** DK	I D **NC** DK

ODMH 2012 Community Plan Adult Housing Categories

Please answer the following question for each category for your SPMI/SMI population:

For SFY 2012, please indicate the number of planned Units & Beds for Adults who are SPMI/SMI.

ODMH is also interested in knowing for each category how many beds/units are set-aside for the forensic sub-population and for those sex offenders who are a sub-population of SPMI/SMI.

Housing Categories	Definition	**Examples**	***Number of SPMI/SMI*** ***(Please include Forensic & Sex Offender Sub-***	**Number of Units**	**Number of Beds**
Crisis Care	Provision of short-term care to stabilize person experiencing psychiatric emergency. Offered as an alternative to inpatient psychiatric unit. Staff 24 hours' day/7 days a week. Treatment services are billed separately.	• Crisis Bed • Crisis Residential • Crisis Stabilization Unit	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*	1	5
ODMH Licensed Residential Care	Includes room and board, and personal care 24/7 if specified in license. Rules in program or service agreement attached to Type 1: Room & Board; Personal Care; Mental Health Services Type 2: Room & Board; Personal Care Type 3: Room and Board	• Licensed as Type I, II or III (Residential Facility Care) • Residential Support • Supervised Group Living • Next-Step Housing from psychiatric hospital and/or prison	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*		
ODH Licensed Residential Care	Includes room and board, and personal care 24/7 if specified in license. Rules in program or service agreement attached to housing are applicable. Treatment services are billed separately. Usually operator owned and staffed; provides 24-hour supervision in structured environment.	• Adult Care Facilities • Adult Family Homes • Group Homes	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*		
Respite Care	Short-term living environment, it may or may not be 24-hour care. Reasons for this type of care are more environmental in nature. May provide supervision, services and accommodations. Treatment services are billed separately	• Placement during absence of another caretaker where client usually resides • Respite Care	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*		

Temporary Housing	Non–hospital, time limited residential program with an expected length of occupancy and goals to transition to permanent housing. Includes room and board, with referral and access to treatment services that are billed separately.	• Commonly referred to and intended as time-limited, short term living • Transitional Housing Programs • Homeless county residence currently receiving services • Persons waiting for housing • Boarding Homes • YMCA/YWCA (not part of a supportive housing program)	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*		
Board / Agency Owned Community Residence	Person living in an apartment where they entered into an agreement that is NOT covered by Ohio tenant landlord law. Rules in program or service agreement attached to housing. Refers to financial sponsorship and/or provision of some degree of on-site supervision for residents living in an apartment dwelling. Treatment services are billed separately.	• Service Enriched Housing • Apartments with non-clinical staff attached • Supervised Apartments • No leases: NOT covered by Ohio tenant landlord law	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*		
Permanent Supportive with Primary Supportive	Person living in an apartment where they entered into a lease with accordance to Ohio tenant landlord law or a mortgage and, in instances where ODMH allocated funds have been used, an exit strategy for the subsidy has been developed. Treatment services are billed separately. (The landlord may be a housing agency that provides housing to mental health consumers.)	• HAP • Housing as Housing • Supervised Apartments • Supportive Housing • Person with Section 8 or Shelter Plus Care Voucher • Tenant has lease • **Supportive Services staff primary offices are on-site and their primary function are to deliver supportive services on-site; these staff many accompany residents in the community to access resources.**	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*	0	0

Permanent Supportive with Supportive Services	Person living in an apartment where they entered into a lease with accordance to Ohio tenant landlord law or a mortgage and, in instances where ODMH allocated funds have been used, an exit strategy for the subsidy has been developed. Treatment services are billed separately. (The landlord may be a housing agency that provides housing to mental health consumers.)	• HAP • Housing as Housing • Supervised Apartments • Supportive Housing • Person with Section 8 or Shelter Plus Care Voucher • Tenant has lease • **Supportive Services staff <u>primary</u> <u>offices</u> are <u>not</u> <u>on-site</u>; supportive serve staff may come on site to deliver supportive services or deliver them off-site.** (In this model a primary mental health CPST worker may be delivering the supportive services related to housing in addition to treatment services.	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*	4	6
Independent Community (Rent or Home Ownership)	Refers to house, apartment, or room which anyone can own/rent, which is not sponsored, licensed, supervised, or otherwise connected to the mental health system. Consumer is the designated head of household or in a natural family environment of his/her choice.	• Own home • Person with Section 8 Voucher (not Shelter Plus Care) • Adult with roommate with shared household expenses • Apartment without any public assistance • Housing in this model is not connected to the mental health system in any way. Anyone can apply for and obtain this housing.	Total Number: *Forensic Sub-Population Total:* *Sex Offender Sub-Population Total:*	0	0

ODADAS Waivers

Waiver Request for Inpatient Hospital Rehabilitation Services

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

A. HOSPITAL	ODADAS UPID #	ALLOCATION

B. Request for Generic Services

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

B.AGENCY	ODADAS UPID #	SERVICE	ALLOCATION

SFY 2012 & 2013 ODMH Budget Templates

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

Additional ODMH Requirements
(Formerly Community Plan – Part B)

Notification of Election of Distribution – SFY 2012

The _____ Alcohol, Drug Addiction and Mental Health Services Board or Community Mental Health Board has decided the following:

_____ The Board plans to elect distribution of 408 funds.

_____ The Board plans not to elect distribution of 408 funds

Signed: _____

Executive Director
Alcohol, Drug Addiction and Mental Health Services Board or Community Mental Health Board

Date: _____

State Hospital Inpatient Days

BOARD NAME _____ 2012 Planned Use of State Hospital Inpatient Days By Hospital/Campus	
1. Regional Psychiatric Hospital Name	
Total All State Regional Psychiatric Hospitals Inpatient Days	

* When specifying a Regional Psychiatric Hospital, please indicate a particular campus.

Signed _____
ADAMH/CMH Board Executive Director

CSN Services

I anticipate renewing contracts for CSN services.

_____ Yes

_____ No

Board Membership Catalog for ADAMHS/CMHS Boards

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

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

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

Board Name		Date Prepared
Board Member	Appointment Sex Ethnic Group Officer Hispanic or Latino (of any race)	
Mailing Address (street, city, state, zip)		

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

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

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

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

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

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

Board Name			Date Prepared
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Mailing Address (street, city, state, zip)			
Telephone (include area code)	County of Residence		Representation: select all that apply: Mental Health ☐ Consumer ☐ Family Member ☐ MH Professional ☐ Psychiatrist ☐ Other Physician Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member ☐ Professional ☐ Advocate
Occupation			
Term		Year Term Expires	

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

Board Name		Date Prepared
Board Member		Appointment Sex Ethnic Group Officer Hispanic or Latino (of any race)
Mailing Address (street, city, state, zip)		
Telephone (include area code)	County of Residence	Representation: select all that apply: Mental Health ☐ Consumer ☐ Family Member Alcohol Other Drug Addiction ☐ Consumer ☐ Family Member
Occupation		

Term	Year Term Expires	☐ MH Professional ☐ Psychiatrist ☐ Other Physician ☐ Professional ☐ Advocate

Board Name	Date Prepared

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

Board Name	Date Prepared

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

Board Name	Date Prepared

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

Board Forensic Monitor and Community Linkage Contacts

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

Name	Street Address	City	Zip	Phone Number	Email

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

Name	Street Address	City	Zip	Phone Number	Email

INSERT ADDITIONAL BOARD APPENDICES AS NEEDED