



Ohio Department
of Mental Health



Department of Alcohol &
Drug Addiction Services

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Community Plan Guidelines for SFY 2010 – 2011

December 5, 2008

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

Community Plan Guidelines for SFY 2010 – 2011

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Introduction and Instructions for
Completing the Community Plan Guidelines for SFY 2010 – 2011

INTRODUCTION

Attached please find a copy of the combined ODMH/ODADAS Community Plan Guidelines and Review Criteria. These guidelines, which will cover SFY 2010 and 2011, 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.

This year, Board Community Plans will be submitted on-line through a web-based tool currently being developed with an expected completion date of December 31, 2008. Plans submitted to the Departments through the web-based tool will be reviewed by a joint ODMH/ODADAS team and Boards will receive one set of feedback on strengths of the plan, areas in which the plan could be strengthened and areas in which technical assistance may be recommended. 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 first ODMH/ODADAS combined 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 and 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 shared community priorities.

In summary, the Community Plan Guidelines for SFY 2010-2011 place an emphasis in clarity of outcomes and results within a planning process. Boards are asked to describe Board Investor Targets (outcomes) that are consistent with and contribute to Department Investor Targets (outcomes) as well as to describe a plan for verifying that results are achieved.

INSTRUCTIONS FOR COMPLETING THE COMMUNITY PLAN GUIDELINES FOR SFY 2010 - 2011

Application and Approval Process

The Community Plan for Alcohol, Drug Addiction and Mental Health Services for SFY 2010 – 2011 is **due by April 13, 2009**. Boards are required to submit their plan to ODMH and ODADAS using a web-based tool that is currently under development. More information and instruction on the use of the web tool will be sent under separate cover. **All Boards (ADAMHS, ADAS and CMH) must also submit two original hard copies of the completed signature page (page 33 of the guidelines) to:**

**ATTN: Matt 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's tentative approval or any required modifications or additions. Complete application approval can occur only after:

- ❖ ODMH and ODADAS receive and approve the SFY 2010 – 2011 Community Plan;
- ❖ SAMHSA notifies ODADAS of its final SAPT Block Grant award for FFY 2009;

- ❖ Boards are informed of their final allocations for SFY 2010 by ODADAS.
- ❖ ODMH receives written notification of the decision to opt in or opt out from ADAMHS and CMH Boards. In addition, Boards will need to provide their bed days by hospital site.
- ❖ ADAMHS and CMH Boards have an approved and signed Continuity of Care Agreement with its local state psychiatric hospital.

The Community Plan Guidelines are available on the ODMH and ODADAS website: www.mh.state.oh.us and www.ada.oh.gov . Applications will only be accepted via web submission.

Completing the Guidelines

Boards can complete responses to each required item in Microsoft Word or WordPerfect and cut and paste the responses into the web based tool under development. The Board is expected to provide a response to all items in the Guidelines that are identified.

Regional Forums

In order to assist Boards in completing the application and introducing boards to the web tool for submission of the plan, regional forums will be held. This year, in response to budget and time constraints, we will be conducting all but the Columbus forum via video conferencing technology. Dates and times for the regional forums are:

Monday, 12/15 from 10:00 AM -12:30 PM: The **SW & NW Collaborative Boards** with the hospital sites being Summit & Toledo.

Thursday, 12/18 from 9:30 AM -12:00 PM: The **Heartland Collaborative Boards** with the hospital site being Video Conference Site will be Heartland.

Friday, 12/19 from 9:30 AM – 12:00 PM: **Central Ohio Boards** will meet at Rhodes State Office Tower 806A. This will not be a video conference.

Friday, 12/19 from 1:00 PM – 3:30 PM: The **NE Collaborative Boards** and **SE Collaborative Boards** with the hospital sites being Cleveland, Northfield and Athens. Cambridge will also be an available site. Members of the Southern Consortium should work with Steve Trout for local connections.

Plan Review and Questions

Review criteria are attached in Appendix C 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

If the Board determines that a substantive change or revision to an approved plan is necessary, the Board is to submit the proposed change to the Chief of the Division of Planning, Outcomes and Research at ODADAS and Carol Hernandez, Assistant Deputy Director, Program Policy and Development at ODMH. A substantive change involves changing a Board's priorities and/or investor targets. If the Departments do not respond within 30 days of the date of receipt, the revision will be considered approved.

ODADAS Waivers

While waiver requests are rare, ODADAS has implemented a waver process for which ADAMHS/ADAS Boards may apply regarding: 1) inpatient hospitalization services and 2) generic services. Waiver forms and instructions are attached.

Mental Health and Recovery Board of Ashland County

COMMUNITY PLAN FOR SFY 2010-2011

April 5, 2009

Please provide the Board's mission, vision, and values statements:

MISSION STATEMENT

The Mental Health and Recovery Board of Ashland County, through a network of providers, ensures the availability and accessibility of quality services that support recovery for individuals with mental illness and/or alcohol and drug addiction.

VISION STATEMENT

To create an environment that brings hope and improves the quality of life for persons affected by mental illness and substance abuse.

VALUE STATEMENTS

- *Everyone is entitled to live a quality life in the community*
- *Recovery is Possible; Stigma can be eliminated & Resources are available*
- *Person Centered*
- *Priority Directed*
- *Recovery Focused*
- *Comprehensive and Holistic*
- *High Quality/Research-Based*
- *Accountable*
- *Client Driven*

SECTION I: CURRENT CIRCUMSTANCES/ “AS-IS” STATE

Describing the current circumstances, or “as-is” state of the Board’s alcohol, drug addiction and mental health prevention and treatment services entails several elements. These include an explanation of the legal and environmental context of the plan, characteristics of customers and the capacity to provide services.

The capacity to provide services includes the explanation of several dimensions: access to services, workforce development and cultural competence, capital improvements, financial status and a portfolio of providers.

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. Responses to the Community Plan will help to inform these efforts.

I. Legal Context of the Community Plan

The Mental Health and Recovery Board of Ashland County is 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. Four ADAS Boards submit plans to ODADAS, four CMH Boards submit plans to ODMH, and 46 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) 2010 – 2011 (July 1, 2009 through June 30, 2011).

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 evaluating 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 evaluating 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) (H.B. 484)

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)

An 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 an HIV Early Intervention Investor Target 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.

II. Environmental Context for the Community Plan

A. Board Area and Clients Served

1. *Description of Board Area: Provide a narrative that describes relevant information about the Board area, including but not limited to major achievements from the previous Plan (SFY 2008 -2009), sociodemographic, economic and cultural aspects of the service area.*

II.A.1. Response Needed from ADAMHS, ADAS, CMH Boards

Major Achievements from SFY 08-09 Plan:

- Growth in Buprenorphine Treatment for persons addicted to heroin/opiates.
- Continued growth in EBP's (Supported Employment, Integrated Dual Disorder Treatment, Network of Care, Early Childhood Mental Health, Incredible Years, Intensive Home Based Services, Motivational Interviewing, School-Based Behavioral Health Services, Consumer Operated Services, and NAMI).
- 3-year Culture of Quality Certification (thru OACBHA) in January 2009.
- R.S.V.P. "Recovery" Conference held in September of 2008
- 2nd Annual R.S.V.P. scheduled for September 30, 2009

Sociodemographic Aspects of the Service Area:

Ashland County is a rural county with a number of light industrial facilities. The U. S. Census Bureau estimates that the population in Ashland County in 2006 was 54,727 and has increased an estimated 4.2% from 2000 to 2006. It is in the outer reaches of the growth corridor from Akron/Cleveland and Columbus. This is influenced by its location on I-71. Much of the growth continues to be in the Northwest area of the county and also in a suburban-like ring around the county seat of Ashland.

The county and city government has recently built a new justice center, which holds the county jail, the Sheriff's Department, City Police and Municipal Court. This has allowed for the development of improved alcohol/drug services on-site at the jail.

In terms of prevention the aforementioned growth indicates that there will be a need for gradual growth in this area of service. Another aspect of this will be that schools are being expanded with the likelihood of increased demand for services. It may be the case that many of the youth coming into the county may be coming from more urbanized areas and may be somewhat more affluent. This may result in some change in the nature of the youth population and may have implications for how students are approached in prevention programming. Migration to the county may also result in a slightly higher level of racial diversity although the recent census still shows a lack of diversity in Ashland County.

The Boards only contract alcohol/drug provider is the **Ashland County Council on Alcoholism & Drug Abuse (ACCADA)**. ACCADA has been an extremely stable agency serving the needs of Ashland County for more than 20 years. ACCADA provides out-patient services, jail services

and is the Board's gatekeeper for residential and detox services. ACCADA provides services that are accessible, client-centered and cost-effective. **Appleseed Community Mental Health Center** is the primary mental health contract agency of the board. They provide the entire array of outpatient services including crisis intervention services and 24/7 Hotline services. The board also contracts with **Catholic Charities Community Services** for limited mental health and drug/alcohol prevention services. Finally the board contracts with **Lifeworx**, for consumer-operated services. Each of the agencies listed above, have made significant contributions to the development of this Community Plan

Economic Aspects of the Service Area:

Ashland County reflects the economic downturn that has been experienced throughout the state and nation. There are several local manufacturing industries that have either significantly reduced their workforce, have relocated, or have been completely dissolved. U.S. Department of Labor statistics indicate Ashland County's unemployment rate has changed from 7.8% in October of 2008 to **13%** in March of 2009 (an increase in 5.2% over just 5 months); the State of Ohio saw an increase from 7.3% to 8.8% over the same time period.

The Board and its partners have noticed a downturn in the number of consumers of mental health and/or alcohol/drug services with insurance which may be related to the changes noted in employment. This is expected to result in higher percentages of the cost of services being born by the Board. Insurance coverage for clients, when present, has been steadily declining in quality as well as coverage. It is unclear what impact the recent passed legislation on Mental Health Parity will have on employed individuals with mental health and/or alcohol and/or substance use disorders.

The Board has been severely impacted by the recent presence of a "Medicaid Only" mental health agency. Despite numerous efforts by the Board to educate the agency of the potential negative effects to the county; they continue to operate. In just three years the Board's Medicaid Match responsibility has increased *by over 100%* to an average of \$300,000 per fiscal year. The economic and programmatic impacts of this situation to the Board and the County are significant. The Board's ability to fulfill its statutory obligations has also been challenged by the presence of this agency. Solutions to this situation involve the reform of Medicaid at the State level, an issue widely discussed in years past. It seems clear that Ashland County as well as the rest of the state will continue to struggle with Medicaid related challenges until the political will exists in Columbus to make necessary reforms.

Cultural Aspects of the Service Area:

The county is not racially diverse in that Caucasian-Americans represent **97.5%** of the population and African-Americans are represented at the rate of **1%** while all other race categories are **less than 1%**. Ashland is adjacent to Holmes County, home to the world's largest concentration of Amish settlements, and has a sizable Amish population.

There are 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.

In responding to 2a-2d. below, a description of client characteristics **must include separate sections for elderly (65 and older), adult (18 – 64) and youth/child (aged 0 -17)**. Client characteristics may include, but are not limited to, or required to include a description of the service population by: Gender, Race, SMD or SED Status, Diagnostic Group, Employment, Living Situation, Education, Marital Status, Special Population Status (i.e., MR/MI, SA/MI, deaf, blind, forensic, newly arriving immigrants, veterans, ex-offenders), Referral Source, Income Source, Income Level, Custody or Mandated Treatment Status.

Data Sources that may be of help include:

Medicaid/Non-Medicaid status can be obtained from the Claims Data Mart. For the MACSIS Data Mart, go to: <http://www.dwcubes.mh.state.oh.us/>

Client characteristics for mental health consumers can be obtained from the MACSIS Data Mart, the Outcomes Data Mart, and/or the Board's own database of BH Module records. For the Outcomes Data Mart, go to: <http://www.mh.state.oh.us/oper/outcomes/data.mart.index.html>

2. Describe the characteristics of customers/clients currently served including recent trends such as changes in services and populations:

a. Substance Abuse Prevention Services

II.A.2.a. Response Needed from ADAMHS, ADAS Boards

Characteristics of Customers/Client currently receiving AoD Prevention Services:

-Youth/Child (ages 0-17) Section:

Data collected thru our collaborative partners suggests that customers receiving AoD Prevention Services are typically students in Ashland County Schools. Students in both Ashland City and surrounding rural school districts receive programming, so some customers come from a small town/city environment and others live in a rural setting. The older customers participate in Teen Institute (TI) groups and classroom prevention programs while the elementary students primarily receive classroom instruction. The population reflects that of a rural county with very little ethnic or racial diversity as evidenced by the census and prevention service data. The classes served are roughly 50/50% female and male. They come from families with a range of incomes (typically low to moderate income) although the county's unemployment has been rising (above state/national averages) and several large employers have left the area. This has left of number of families (children) experiencing financial stress."

Approximately 1,800 youth were served by AoD prevention services during fiscal year 2008.

-Adult (18-64) Section:

The adults served are typically found at health fairs or other informational occasions. Alcohol and other Drug Prevention material is provided on an “as opportunities present” basis.

-Elderly (65 & Older) Section:

As with the Adults section above, the Elderly are typically engaged via health fairs thru the Senior Center, the local Council on Aging and Golden Center program. Whenever informational occasions present, preventative efforts are deployed.

Recent Trends (i.e. changes in services or population) in Prevention Services:

-Youth/Child (ages 0-17) Section:

Our collaborative partners indicate the following trends:

-“Still not seeing a lot of AoD abuse with parents. More families losing jobs, more stress on the youth. The stress at home about job loss seems to be all the youth want to talk about. More stress in general on the families. 2008 Christmas was hard for the youth.”

-“The most recent change in services is the new program that we have added to our offerings: *Too Good for Drugs*. While this program offers curriculum for grades k-12, A.C.C.A.D.A. is currently using only the 2nd and 3rd grade levels. This program has been well received by teachers and students. It has changed the population served in that we have added some new classrooms that we did not previously do programs with.”

FY 2009 was the first year for Ashland County to receive Safe and Drug Free School Funding. Catholic Charities Community Services has initiative the S.A.F.E. program. The following is an excerpt from the agencies director. “Strengthening Families Workshops (we have held 2 so far) and the participants are raving about it. As you know the Strengthening Families curriculum has 2 parts, the first hour the parents and youth separate and learn prevention/parenting skills and then the second hour the parents and teens work together. Celia [a worker] told me at the workshop on Monday the kids had enjoyed the combined part of the workshop so much the week before that they couldn’t wait until they got together again with their parents. When was the last time you heard 10-14 year olds begging to spend time with their parents!”

-Adult (18-64) Section:

“No remarkable changes/trends were seen in this subgroup for prevention services.”

-Elderly (65 & Older) Section:

Most data indicate that this population continues to grow and that a significant number may abuse alcohol and/or other drugs. The Board will consider additional preventative or treatment services for this group in the future with an emphasis on partnering with local primary health providers and other providers of “senior” services.

b. Substance Abuse Treatment and Recovery Support Services

II.A.2.b. Response Needed from ADAMHS, ADAS Boards

Characteristics of Customers/Client currently receiving AoD Treatment/Recovery Support Services:

-Youth/Child (ages 0-17) Section:

<u>Service</u>	<u>Unique Clients</u>	<u>Cost</u>
Assessment	52	\$9,902
Individual Counseling	29	\$9,537
Group Counseling	17	\$16,347
Case Management	12	\$2,894

-Adult (18-64) Section:

<u>Service</u>	<u>Unique Clients</u>	<u>Cost</u>
Assessment	271	\$52,901
Individual Counseling	213	\$98,002
Group Counseling	57	\$12,901
Case Management	45	\$9,030

-Elderly (65 & Older) Section:

<u>Service</u>	<u>Unique Clients</u>	<u>Cost</u>
Assessment	3	\$647
Group Counseling	1	\$29

Recent Trends (i.e. changes in services or population) in Treatment/Recovery Support Services:

-Youth/Child (ages 0-17) Section:

Increases in Ashland County Youth receiving AoD Treatment Service outside the County:

<u>Service</u>	<u>Unique Clients</u>	<u>Cost</u>
Intensive Outpatient	4	\$39,667
Lab/Urinalysis	7	\$1,689
AoD Med Somatic	5	\$11,250

In-county volume and service mix unremarkable.

-Adult (18-64) Section:

Individual Counseling continues to be the predominant treatment modality in the County.

-Elderly (65 & Older) Section:

Most data indicate that this population continues to grow and that a significant number may abuse alcohol and/or other drugs. The Board will consider additional preventative or treatment services for this group in the future, but at present those older adults seeking treatment are very low (3). Research further suggests models of “co-location” where the AoD agency has a presence and relationship within a general medical clinic is superior when trying to increase the number of older adults to follow thru with either MH or AoD services.

*c. Mental Health Prevention, Consultation & Education (P, C & E) Services
(Response must include a discussion of Crisis Intervention Teams.)*

II.A.2.c. Response Needed from ADAMHS, CMH Boards

Characteristics of Customers/Client currently receiving Mental Health P, C & E Services):

-Youth/Child (ages 0-17) Section:

School aged youth make up the vast majority served in this subgroup. Teen Screen Programming and Red Flags is utilized to meet both student and teacher need.

-Adult (18-64) Section:

Caucasian, Middle-aged men make up the bulk of those P, C & E activities for this subgroup. Programming is focused on Suicide Prevention activities.

-Elderly (65 & Older) Section:

As with the adult section above, older Caucasian males make up this subgroup with Suicide Prevention activities predominating.

Crisis Intervention Teams:

The Board facilitated the first CIT training in the fall of 2007. As a result 24 members of law enforcement, including the courts and local university security, received a full week of training as outlined by the CIT Center of Excellence. The Board will explore CIT training in the fall of 2009 if there are a sufficient number of participants willing to make the commitment.

Recent Trends (i.e. changes in services or population) in Mental Health P, C & E Services:

-Youth/Child (ages 0-17) Section:

The need for early childhood mental health consultative services as well as programs like Incredible Years, Teen Screen and Red Flags continue to be needed.

-Adult (18-64) Section:

Continued need for suicide prevention activities are indicated, particularly for white, middle-aged males.

-Elderly (65 & Older) Section:

The need for suicide prevention activities is indicated for this group, particularly elderly males

- d. Mental Health Treatment and Recovery Support Services (Recovery Support Services include Housing/Residential; Employment; WMR (or similar programs, e.g., Bridges, WRAP), respite beds, self-help/peer support, consumer operated service, clubhouse, social/recreational service, etc.)*

II.A.2.d. Response Needed from ADAMHS, CMH Boards

Characteristics of Customers/Client currently receiving Mental Health Treatment/Recovery Support Services:

• Housing/Residential –

-Youth/Child (ages 0-17) Section:

The Board does not fund Housing/Residential services for youth/children. Some youth/children are affected by Board funding for the Adult population (see below).

-Adult (18-64) Section:

The Board supports Housing/Residential services in the county by providing funding to assist a contract agency in offering housing/residential services for adults with severe mental illness. This housing can be temporary until more preferable long-term options are secured; or, in some cases, the housing can be permanent. In some units, adults with children are accommodated. Additionally the board provides funding for HAP Loans. Adults utilizing these housing supports are typically receiving SSI/SSDI; Diagnosed with a Severe Mental Illness; Possibly Diagnosed with a co-morbid Substance Use Disorder; at risk for Psychiatric Hospitalization and in need of more intensive outpatient services.

-Elderly (65 & Older) Section:

The Board does not provide funding for elderly specific Housing/Residential services.

• Employment –

-Youth/Child (ages 0-17) Section:

The Board does not directly fund WIA Youth programming, however, agencies contracted with the board work collaboratively with the WIA program.

-Adult (18-64) Section:

The Board initially helped to fund the development of Supported Employment services in the county. Recent funding reductions have not allowed the Board to continue funding, but the program continues to endure. In SFY 08 19 unique adults were assisted at a funding level of \$10,564.

-Elderly (65 & Older) Section:

The Board does not have any specific initiative regarding employment for this sub-group.

- **WRAP/Bridges, etc. –**

- Youth/Child (ages 0-17) Section:

Not applicable for this sub-group.

- Adult (18-64) Section:

WRAP & Bridges training is provided thru the board contracted Consumer Operated Service; Lifeworx. Both individual and group formats are provided. The Network of Care has also been utilized to help secure personal health information in a secure manner.

- Elderly (65 & Older) Section:

No specific targeting for WRAP & Bridges for his sub-group has occurred.

- **Respite Beds –**

- Youth/Child (ages 0-17) Section:

The Board funds respite beds for youth/children in crisis on an as-needed basis. The Board uses a combination of FAST funding as well as local levy/408 and 505 funding.

- Adult (18-64) Section:

The Board funds respite beds for Adults and Older Adults in crisis on an as-needed basis. In SFY 2008 respite beds were used for 60 adults and older adults at a cost of \$27,611. Respite beds continue to play a vital role in assisting person being discharged from the State Hospital and preventing individuals from State Hospital placement when a lower level of care (less restrictive) is sufficient to ameliorate their behavioral health crisis.

- Elderly (65 & Older) Section:

The Board funds respite beds for Older Adults and Adults in crisis on an as-needed basis. In SFY 2008 respite beds were used for 60 adults and older adults at a cost of \$27,611. Respite beds continue to play a vital role in assisting person being discharged from the State Hospital and preventing individuals from State Hospital placement when a lower level of care (less restrictive) is sufficient to ameliorate their behavioral health crisis.

- **Consumer Operated Service –**

- Youth/Child (ages 0-17) Section:

The service is designed to serve adults 18 and over. Therefore no youth/children are directly served by this service.

- Adult (18-64) Section:

Lifeworx is certified by ODMH to provide Consumer Operated Services. Their certification was the result of years of hard work by consumer-survivor members; local agencies and the Board. The following is a summary of their activities over the first two years (SFY 07-08) as a certified agency:

One member graduated from NCSC with honors

Four members attended college

Two members working on GED

Seven members are employed in the community

Sixteen members volunteered in the community

Lifeworx provided transportation to all Ashland County residents along with transportation to NCSC

Lifeworx served 70 persons in 2007-2008 fiscal year

Lifeworx produced over 576 hours of small groups (roughly 5760 hours of non billable productivity)

Groups included, but not limited to: Boundaries, Depression/Anxiety, Bridges, Budgeting, Nutrition, Art, Coping Skills, Forgiveness, Empathy, Responsibility, Social Behavior, Attitudes

Lifeworx assisted in the:

- NAMI Walk in Oct. 2007
- RSVP Conference

Lifeworx Members are currently involved in:

- Ohio Community Support Planning Council (3 members)
- NAMI (3 members)
- Homeless Coalition (1 member)
- RSVP Conference (2 members)

Representatives from Lifeworx attended the 2007 Ohio Advocates Conference and 2007 Alternatives Conference

Lifeworx members also volunteered working at the County Fair, Loudonville Fair, and Kids Day at the Conservation Farm

-Elderly (65 & Older) Section:

While elderly are able to participate in Consumer operated services, currently no one 65 or over is involved with the program.

Recent Trends (i.e. changes in services or population) in Mental Health Treatment/Recovery Support Services:

-Youth/Child (ages 0-17) Section:

Dramatic increase (+100%) in Medicaid Eligible Treatment/Recovery Services due to the presence of an out of county Medicaid-only agency. More youth receive Individual Counseling than any other modality but more funding is expended on Individual CPST services. A significantly lower percentage of youth receive Crisis Intervention Services as a percentage of total youth served as compared with Adults and Older Adults: 6.8% versus 17.5% and 21.4% respectively. Without appropriate controls over Medicaid, the Board will soon be in the position of having to reduce non-Medicaid services to youth/children.

<u>Service</u>	<u>Unique Client Count</u>	<u>Cost</u>
Assessment (Physician)	398	\$72,068
Assessment (Non-Phy)	5	\$795
Crisis Intervention	46	\$16,951
Group CPST	53	\$24,027
Group Counseling	32	\$38,028
Individual CPST	312	\$472,467
Individual Counseling	494	\$341,035
Partial Hosp.	2	\$350
Pharm. Management	<u>336</u>	<u>\$240,088</u>
TOTALS	676	\$1,205,811

-Adult (18-64) Section:

The majority of services to Adults cluster around “the big three” Individual CPST, Counseling and Pharmacological Management. This sub-group is particularly vulnerable to unchecked increases in Medicaid only funding and/or Medicaid Only providers. The loss of Non-Medicaid services would have significant impacts on Crisis Intervention Services and State Hospital Utilization.

<u>Service</u>	<u>Unique Client Count</u>	<u>Cost</u>
Assessment (Physician)	597	\$92,628
Assessment (Non-Phy)	3	\$801
Crisis Intervention	218	\$80,776
Group CPST	26	\$4,522
Group Counseling	27	\$26,808
Individual CPST	624	\$530,323
Individual Counseling	643	\$313,612
Partial Hosp.	1	\$8,410
Pharm. Management	<u>647</u>	<u>\$383,436</u>
TOTALS	1,249	\$1,441,317

-Elderly (65 & Older) Section:

Older Adults are far less likely to receive Board Funded Mental Health & Recovery Services than the other sub-groups. As indicated in other sections of the Community Plan; research indicates that this is a growth area. The Board’s already established “Older Adult Behavioral Health Coalition” is aware of the changing demographics and the need for behavioral health services going forward.

<u>Service</u>	<u>Unique Client Count</u>	<u>Cost</u>
Assessment (Physician)	15	\$2,223
Assessment (Non-Phy)	1	\$211
Crisis Intervention	15	\$4,615
Group CPST	4	\$687
Group Counseling	1	\$286
Individual CPST	38	\$21,650
Individual Counseling	14	\$7,055
Partial Hosp.	0	\$0
Pharm. Management	<u>25</u>	<u>\$17,725</u>
TOTALS	70	\$54,451

e. For ADAMHS and CMH Boards, please indicate in the following table which Crisis Care Services were provided in SFY 2009 and which the Board is planning to fund in SFY 2010-11. For items with an asterisk () indicate “yes” only in cases where the Board will contract with an agency that is certified by ODMH to provide crisis intervention mental health service.*

II.A.2.e. MENTAL HEALTH CRISIS CARE SERVICES		
Service Area	Available in SFY 2009?	Planned for SFY 2010-2011?
Community Resources & Coordination		
24/7 Hotline	Y	Y
24/7 Warmline	N	N
Police Coordination/CIT	Y	Y
Disaster Preparedness	Y	Y
School Response	Y	Y
Respite Beds for Adults	Y	Y
Respite Beds for Children & Adolescents (C&A)	Y	Y
Other (Please specify in text box, below:)		
Face-to-Face Capacity for Adult Consumers		
24/7 On-Call Psychiatric Consultation	Y	Y
24/7 On-Call Staffing by Clinical Supervisors	Y	Y
24/7 On-Call Staffing by Case Managers	Y	Y
Mobile Response Team	N	N
Other (Please specify in text box, below:)		
Central Location Capacity for Adult Consumers		
Crisis Care Facility*	N	N
Hospital Emergency Department*	N	N
Hospital contract for Crisis Observation Beds*	N	N

Transportation Service to Hospital or Crisis Care Facility	Y	Y
Other (Please specify in text box, below:)		
Face-to-Face Capacity for C&A Consumers		
24/7 On-Call Psychiatric Consultation	Y	Y
24/7 On-Call Staffing by Clinical Supervisors	Y	Y
24/7 On-Call Staffing by Case Managers	Y	Y
Mobile Response Team	N	N
Other (Please specify in text box, below:)		
Central Location Capacity for C&A Consumers		
Crisis Care Facility*	N	N
Hospital Emergency Department*	N	N
Hospital contract for Crisis Observation Beds*	N	N
Transportation Service to Hospital or Crisis Care Facility	Y	Y
Other (Please specify in text box, below:)		

II.A.2.e.(continued) Response Needed from ADAMHS, CMH Boards for Table where “Other” was identified

N/A

- i. Please discuss how the Board plans to address any gaps in the crisis care services indicated by ORC 5122-29-10(B):*

II.A.2.d. i. Response Needed from ADAMHS, CMH Boards

Board Plan(s) to Address Gaps in Crisis Care Services:

Please note that ORC 5122-29-10(B) is/are “Requirements and Procedures for Mental Health Services Provided by Agencies” If agencies are desirous to continue to be certified by ODMH in this service, they must comply with any/all applicable standards. Recent changes to the Ohio Administrative Code (specifically the “06” rule) have marginalized the Board’s ability to ensure that services provided are consistent with the Departments standards. The Department has replaced the Board’s role with the S.U.R. Process. A process without, as yet, established efficaciousness.

As indicated in the above chart, currently Ashland County is not experiencing gaps in Crisis Care Services. Over the past 5 years the County has been able to improve Crisis Care Services to such a degree that State Hospital Bed Day Reservations have dropped from 1350 days to 500 days. This has helped to re-direct funding to the community to re-invest in non-Medicaid services and other evidence based services prioritized by the Board our contract agencies and partners.

- ii. 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 2010-11.

II.A.2.d.ii. Response Needed from ADAMHS, CMH Boards

How Board Identified & Prioritized Training Needs for Personnel Providing Crisis Intervention Services:

The Board is not in the best position to identify and prioritize training needs in Ashland County for Crisis Intervention Services, rather the contract agency providing crisis intervention services is the entity best positioned to identify, prioritize and provide any training necessary. The Board ensures that all prescreeners or “Health Officers” have received appropriate training to become Health Officers, including formal Board approval and training around the probate process.

How the Board Plans to Address Identified Training Needs in SFY 2010-11:

The Board collaborates with the contract agency responsible for providing crisis intervention services around identified training needs. Where possible, the Board provides funding to the agency for this need.

B. Capacity to Provide Services:

1. Access to Services

- a. Identify the major issues or concerns for individuals attempting to access alcohol and drug 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 or ex-offenders.*

II.B.1.a. Response Needed from ADAMHS, ADAS Boards

Access Issues/Concerns for AoD PREVENTION Services:

There are no major issues or concerns with regard to accessing prevention services in the county at this time. It should be noted that the competing demands of the educational system make it challenging to work in school-based prevention strategies, but this has been, and is anticipated to be, possible.

Access/Issues/Concerns for AoD TREATMENT Services:

With respect to access issues related to treatment services, the primary challenge is in accessing detox/residential services. The regional Medical Detox and Hospital Residential treatment program closed its doors in FY 04. This closing has made Detox/Residential services more

difficult to access. A.C.C.A.D.A. continues to act as the Boards designee/gatekeeper in placing consumers in need of Detox/Residential services. While A.C.C.A.D.A. has developed a contract with Glenbeigh and other State Detox/Residential providers the logistics of arranging services at a much further distance are significant. With this in mind, the Board has increased funding for Detox/Residential over the last two fiscal years and anticipates a small increase in fiscal years 08 and 09. While Ashland County does not offer Intensive Outpatient services, A.C.C.A.D.A. intensifies existing individual and group treatment to meet the needs of persons served.

- b. Identify the major issues or concerns for individuals attempting to access mental health prevention, recovery support, and treatment services in the Board area. Please discuss Board efforts to meet the needs of Board defined priority populations.*

II.B.1.b. Response Needed from ADAMHS, CMH Boards

Access Issues/Concerns for Mental Health Prevention Services:

Neither the Board, its contract agencies nor community partners have identified any access issues/concerns for mental health prevention services. The Board has prioritized Mental Health Prevention as a “low priority” service.

Access/Issues/Concerns for Mental Health Treatment/Recovery Support Services:

There are no identified access/issues or concerns for Medicaid Mental Health Treatment and Recovery Support services; however non-Medicaid Mental Health Treatment/Recovery Support services are in jeopardy. While the Ohio Legislature continues to debate the Governors budget and the Boards and Board Association continue to discuss potential funding formula changes, current funding levels and funding policies increasing defund/reduce (505 funding) those resources needed to provide non-Medicaid services to communities. If not for Federal Stimulus Funds it is likely that 505 funding would have been completely de-funded in SFY 10-11. As it is, that scenario will play out in SFY’s 12-13. Available funding for Boards will thus be limited to 408 funding and local levy (where available). Since Boards are obligated to provide the match to Medicaid services first, it is very likely that access to non-Medicaid services in the years to come will be increasingly limited with ramifications too dynamic to know at this time.

Board Efforts to Meet the Needs of Board Defined Priority Populations:

As mentioned elsewhere the Board is statutorily obligated to meet the match for Medicaid Behavioral Health Services and will continue to do so in SFY’s 2010-11. The question as posed is a bit misleading. The Board is not empowered with the tools necessary to manage Medicaid such that other non-Medicaid Priorities could be sufficiently met. Unfortunately, this longstanding lack of control will continue to erode the Behavioral Health System of Care and put in jeopardy the Mental Health Act of 1988.

The Board is fortunate to have a local Behavioral Health levy that it is using to help in meeting locally identified non-Medicaid needs. The Board will continue to work with the Departments with regard to any funding formula changes/revisions. Additionally the Board will continue to

advocate for policy and funding changes that will improve the type, sufficiency and quality of Behavioral Health services in the County/State.

2. 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 alcohol, drug and mental health services. Does the local service system have sufficient qualified licensed and credentialed staff to meet its service delivery needs for substance abuse and mental health services? If "no", identify the areas of concern and workforce development needs. .*

II.B.2.a. Response Needed from ADAMHS, ADAS, CMH Boards

Boards Role in Ensuring Availability of Direct Service Staff:

The MHRB has been supportive of its primary AOD provider's workforce development efforts in a number of ways. The Board supports ACCADA in training and staff development and viewing both as a priority. The Board understands that excessive productivity demands can be detrimental to attracting and retaining qualified staff and is therefore supportive of reasonable productivity expectations. The Board provides periodic training to promote current best practices and supports the agency in accessing quality training. When possible the Board lends financial support to the agency. For example, health insurance costs at the agency have increased and the Board has been able to offset some of those costs in its contract with the agency.

Currently the Mental Health and Recovery Board of Ashland County's primary AOD provider reports a well-developed and qualified staff.

Board Statement on Sufficiency of Qualified, Licensed & Credentialed Direct Service Staff:

At present the Board is of the opinion that sufficiently qualified (combination of licensure, credentialing and experience) direct service staff exist within or in the surrounding counties to meet current workforce needs. This issue will require ongoing attention as some sources indicate potential workforce shortages in the future.

- b. *Describe the Board's current activities, strategies, successes and challenges in building a local system of care that is culturally competent for:*
- (1) Mental Health Treatment Services (ADAMHS/CMH)*
 - (2) Substance Abuse Treatment Services (ADAMHS/ADAS)*
 - (3) Mental Health Prevention, Consultation & Education Services (ADAMHS/CMH)*
 - (4) Substance Abuse Prevention Services (ADAMHS/ADAS)*

ADAMHS and ADAS Boards, 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 or ex-offenders

I.I.B.2.b.1. Response Needed from ADAMHS Boards

Boards Current Activities to Build a Culturally Competent System of Care (MH Treatment Services):

It is instructive to point out that a recent needs assessment conducted by the Multiethnic Advocates for Cultural Competence reported the following:

“There is lack of clarity and consistency regarding the definition of “Cultural Competence” behavioral health care.

Based on the survey results as well as, anecdotal information collected during forum and cultural specific groups, there is neither a common definition for cultural competence nor standards for providing culturally competent care. While MACC did provide a working definition during these events to give participants a starting point, many did not agree with the definition or thought it was either deficient in some way or too verbose and academic. The failure to consistently articulate what cultural competence means within the behavioral health care arena affected the thoughts and comments provided regarding the degree to which the system was culturally competent or how it could improve in this area.”

Clearly State agencies, Boards and Provider Agencies are still trying to articulate what is meant by a “Culturally Competent System of Care” and how such a system could be identified, on what criteria, according to whose standards, under what conditions, etc.

In Ashland County our Activities proceed from the following guiding values and principles:

- a.) Ashland County embraces the principles of equal access and non-discriminatory practices in planning, funding and service delivery;
- b.) Ashland County believes cultural competence might be achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families;
- c.) Ashland County believes that culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and the community at large; and
- d.) Ashland County recognizes behavioral health as an integral and inseparable aspect of primary health care.

Boards Current Strategy(ies) to Build a Culturally Competent System of Care (MH Treatment Services):

1. Model a culturally competent system of care (CCSoC) at the Board level and seek to instill that system of care first through the Board’s contract agencies, secondly thru the Board’s partner agencies and lastly to the community at large.”

1.a Adopt Board Mission, Vision and Values consistent with a culturally competent system of care.

- 1.b Embed CCSoC principles in agency funding application guidelines and contract assurances
- 1.c Embed CCSoC principles in community events, including public relations, trainings and the Board's Annual Dinner.

Boards Current Successes in Building a Culturally Competent System of Care (MH Treatment Services):

The Board has experienced success in garnering agreement with its contract agencies as to the Board proposed CCSoC principles.

Boards Current Challenges in Building a Culturally Competent System of Care (MH Treatment Services):

The Board is still challenged to extend its CCSoC principles to partner agencies and the community at large.

II.B.2.b.2. Response Needed from ADAMHS Boards

“As indicated by the above statements, the Board does not view the separation of MH, AoD and P, C & E as a viable concept in pursuing a culturally competent system of care. Please see the corresponding sections above or read the duplicate below.”

Boards Current Activities to Build a Culturally Competent System of Care (AoD Treatment Services):

In Ashland County our Activities proceed from the following guiding values and principles:

- a.) Ashland County embraces the principles of equal access and non-discriminatory practices in planning, funding and service delivery;
- b.) Ashland County believes cultural competence might be achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families;
- c.) Ashland County believes that culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and the community at large; and
- d.) Ashland County recognizes behavioral health as an integral and inseparable aspect of primary health care.

Boards Current Strategy(ies) to Build a Culturally Competent System of Care (AoD Treatment Services):

1. Model a culturally competent system of care (CCSoC) at the Board level and seek to instill that system of care first through the Board's contract agencies, secondly thru the Board's partner agencies and lastly to the community at large.”

1.a Adopt Board Mission, Vision and Values consistent with a culturally competent system of care.

1.b Embed CCSoC principles in agency funding application guidelines and contract assurances

1.c Embed CCSoC principles in community events, including public relations, trainings and the Board's Annual Dinner.

Boards Current Successes in Building a Culturally Competent System of Care (AoD Treatment Services):

The Board has experienced success in garnering agreement with its contract agencies as to the Board proposed CCSoC principles.

Boards Current Challenges in Building a Culturally Competent System of Care (AoD Treatment Services):

The Board is still challenged to extend its CCSoC principles to partner agencies and the community at large.

II.B.2.b.3. Response Needed from ADAMHS Boards

“As indicated by the above statements, the Board does not view the separation of MH, AoD and P, C & E as a viable concept in pursuing a culturally competent system of care. Please see the corresponding sections above or read the duplicate below.”

Boards Current Activities to Build a Culturally Competent System of Care (P, C & E Services):

In Ashland County our Activities proceed from the following guiding values and principles:

- a.) Ashland County embraces the principles of equal access and non-discriminatory practices in planning, funding and service delivery;
- b.) Ashland County believes cultural competence might be achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families;
- c.) Ashland County believes that culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and the community at large; and
- d.) Ashland County recognizes behavioral health as an integral and inseparable aspect of primary health care.

Boards Current Strategy(ies) to Build a Culturally Competent System of Care (P, C & E Services):

1. Model a culturally competent system of care (CCSoC) at the Board level and seek to instill that system of care first through the Board’s contract agencies, secondly thru the Board’s partner agencies and lastly to the community at large.”

1.a Adopt Board Mission, Vision and Values consistent with a culturally competent system of care.

1.b Embed CCSoC principles in agency funding application guidelines and contract assurances

1.c Embed CCSoC principles in community events, including public relations, trainings and the Board’s Annual Dinner.

Boards Current Successes in Building a Culturally Competent System of Care (P, C & E Services):

The Board has experienced success in garnering agreement with its contract agencies as to the Board proposed CCSoC principles.

Boards Current Challenges in Building a Culturally Competent System of Care (P, C & E Services):

The Board is still challenged to extend its CCSoC principles to partner agencies and the community at large.

II.B.2.b.4. Response Needed from ADAMHS Boards

“As indicated by the above statements, the Board does not view the separation of MH, AoD and P, C & E as a viable concept in pursuing a culturally competent system of care. Please see the corresponding sections above or read the duplicate below.”

Boards Current Activities to Build a Culturally Competent System of Care (AoD Prevention Services):

In Ashland County our Activities proceed from the following guiding values and principles:

- a.) Ashland County embraces the principles of equal access and non-discriminatory practices in planning, funding and service delivery;
- b.) Ashland County believes cultural competence might be achieved by identifying and understanding the needs and help-seeking behaviors of individuals and families;
- c.) Ashland County believes that culturally competent organizations design and implement services that are tailored or matched to the unique needs of individuals, children, families, organizations and the community at large; and
- d.) Ashland County recognizes behavioral health as an integral and inseparable aspect of primary health care.

Boards Current Strategy(ies) to Build a Culturally Competent System of Care (AoD Prevention Services):

1. Model a culturally competent system of care (CCSoC) at the Board level and seek to instill that system of care first through the Board’s contract agencies, secondly thru the Board’s partner agencies and lastly to the community at large.”

1.a Adopt Board Mission, Vision and Values consistent with a culturally competent system of care.

1.b Embed CCSoC principles in agency funding application guidelines and contract assurances

1.c Embed CCSoC principles in community events, including public relations, trainings and the Board’s Annual Dinner.

Boards Current Successes in Building a Culturally Competent System of Care (AoD Prevention Services):

The Board has experienced success in garnering agreement with its contract agencies as to the Board proposed CCSoC principles.

Boards Current Challenges in Building a Culturally Competent System of Care (AoD Prevention Services):

The Board is still challenged to extend its CCSoC principles to partner agencies and the community at large.

3. Capital Improvements

- a. *For the Board's local alcohol, drug and mental health service system, identify the Board's capital (construction and/or renovation) needs.*

II.B.3.a. Response Needed from ADAMHS, ADAS, CMH Boards

Boards Capital (construction and/or renovation) Needs:

• **Drug/Alcohol:**

ACCADA has recently (June of 2004) purchased the facility that it had previously rented. This will allow the accumulation of equity that in the future may be used toward renovation/remodeling of its current facility or the purchase of a new facility at some future date. The Board has been supportive of A.C.C.A.D.A.'s purchase and provided funding in the past to repair the roof of their facility. With the recent announcement from ODADAS that State Funding for Capital Projects was available (memo: February 27, 2009), A.C.C.A.D.A. has submitted a proposals to upgrade windows and phone systems that will directly affect consumer services.

• **Mental Health:**

Currently, the Board does not have any construction needs. If funding is made available, renovation of several apartments owned by Appleseed Community Mental Health Center would be explored.

4. Financial Status

ODMH is requiring ADAMHS and CMH Boards to complete a proposed mental health budget and narrative with the plan. This budget will be based on the funding levels of the Governor's recommended budget (i.e. the introduced version of the budget bill) and due with the Plan. A preliminary allocation spreadsheet for individual Board allocations will be provided after the recommended budget is released. If changes occur in the appropriation amounts between the introduced version of the bill and the final enactment of the biennial budget, Boards will be asked to submit an amended budget and narrative **by August 31, 2009**. Both templates will be available on ODMH's web-site after the budget bill is introduced.

For ODADAS and ODMH funds please answer the following questions:

- a. Describe the services that will be reduced with a potential reduction in state funding of 10 percent (reduction in number of people served, reduction in volume of services, types of services reduced, etc). Please identify how this reduction in services affects specific populations such as minorities, veterans and "high-risk" groups.

II.B.4.a. Response Needed from ADAMHS, ADAS, CMH Boards

Boards Response to a 10% Funding Reduction in ODMH Funding from FY 09 Levels:

With any potential reductions in funding the Board will first seek to absorb as much of the reductions as possible before considering passing these reductions on to the community.

Please note that the numbers presented are **estimates only!** It is not possible to predict with 100% certainty the number of people served, volume, types, etc. effected by a 10% reduction. Based on the current data available, the following represents a “best guess.”

Types of Services to be potentially reduced/eliminated include:

- a. Community Consultation & Education
- b. Transportation subsidy
- c. Early Childhood Programming
- d. Hospital Diversion Funding
- e. Core Services to Non-SMD (Adult) & Non-SED (Youth/Children) Populations
- f. Housing subsidy
- h. HAP/HOPE
- i. Youth Mentoring Program (Golden Center)
- j. Ashland Connects to Teens Program

Reduction in # of People Served	Fiscal Reduction Amount
a. Approximately 50 people	\$10,290
b. Approximately 10 people	\$4,000
c. Approximately 75 people	\$52,350
d. Approximately 68 people	\$41,250
e. Approximately 125 people	\$ 12,500
f. Approximately 46 people	\$25,000
h. Approximately 24 people	\$14,903
i. Approximately 85 people	\$4,530
j. Approximately 50 people	38,500

• The extent to which the reduction affects specific populations:

Minorities: No affect to this population is anticipated

Veterans: No affect to this population is anticipated

“High Risk Groups”

For the purpose of the Community Plan “High Risk Groups” are defined by persons diagnosed with a Severe Mental Disability (SMD) or Severe Emotional Disability (SED) and persons without an SMD/SED diagnosis receiving Board funded Behavioral Health services. Persons with SMD/SED diagnoses will be affected in various and unforeseen ways by a 10% reduction as outlined above. Persons without SMD/SED diagnoses will be affected in various and unforeseen ways by a 10% reduction as outlined above.

Boards Response to a 10% Funding Reduction in ODADAS Funding from FY 09 Levels:

With any potential reductions in funding the Board will first seek to absorb as much of the reductions as possible before considering passing these reductions on to the community.

Please note that the numbers presented are **estimates only!** It is not possible to predict with 100% certainty the number of people served, volume, types, etc. effected by a 10% reduction. Based on the current data available, the following represents a “best guess.”

Types of Services to be potentially reduced/eliminated

- g. Detox & Residential Services (Drug/Alcohol)
- k. Jail Program (Drug/Alcohol)
- l. Prevention Programming (Drug/Alcohol)

Reduction in # of People Served	Fiscal Reduction Amount
g. Approximately 18 people	\$54,236
k. Approximately 282 people	\$87,684
l. Approximately 1,800 people	\$71,787

• The extent to which the reduction affects specific populations:

Minorities: No affect to this population is anticipated

Veterans: No affect to this population is anticipated

“High Risk Groups”:

For the purpose of this Community Plan “High Risk Groups” are defined by those persons in need of Alcohol and/or Drug Addiction Services funded through the Board. All persons in need of Alcohol or Other Drug Prevention/Treatment services would be affected to some extent with unknown magnitude by a 10% reduction as outlined above.

- b. In the last several years, what factors (e.g., technology, training, staff turnover) have contributed to the costs of services provided?

II.B.4.b. Response Needed from ADAMHS, ADAS, CMH Boards

Board Statement on the Factors Contributing to the Costs of Services Provided:

It is not possible to accurately quantify the costs of factors contributing to service provision. The Board believes that technology may have contributed to the costs of services in both a negative/positive direction. Costs are incurred to stay current with technological infrastructure (Computers, Servers, Software, etc.) while costs are saved through technological innovations (SOQIC Forms Completed on Computer during session). Training may have contributed in both a negative/positive direction as well. Costs are incurred to train staff/administers in the work of behavioral health however, costs may be saved through more advanced and evidenced based direct service and administrative practices. Similarly, staff turnover increases costs in that staff no longer providing services reduces revenues and requires additional revenues to replace, orient, and train. Reductions in costs due to staff turnover might be seen in a reduction in payroll expenditures.

The single biggest factor contributing to increased service cost has been the continued presence of a “Medicaid-Only” agency within the County. In just three years the Board’s Medicaid Match

responsibility has increased *by over 100%* to an average of \$300,000 per fiscal year. The economic impact of this situation to the Board and the county are significant. The Board's ability to fulfill its statutory obligations has also been challenged by the presence of this agency. Solutions to this situation involve the reform of Medicaid in the State an issue widely discussed in years past. It seems clear that Ashland County as well as the rest of the state will continue to struggle with Medicaid related challenges until the political will exists in Columbus to make necessary reforms.

c. What cost-saving measures and operational efficiencies have been implemented to reduce program costs?

II.B.4.c. Response Needed from ADAMHS, ADAS, CMH Boards

Boards Statement Identifying Cost-Saving Measures and/or Operational Efficiencies Implemented to Reduce Program Costs:

The following Measures and/or Efficiencies have been implemented to reduce program costs:

- Reduced Board Admin Costs through benefit reductions/salary freezes.
- We have been working on automating certain respective tasks such as extract management, file processing, report processing, and utilization monitoring;
- Taking advantage of the tools that are already built into the systems that we have such as Group Policy and various SQL Server tools for data management (saves money by utilizing less 3rd party commercial tools)
- Use free and low cost alternatives when available such as open source tools and other services.
- Actively encouraging office-wide efficiencies to reduce costs related to supplies, travel and utilities.
- Shared office space and office equipment with 2 other organizations

d. Describe any other budgetary planning efforts the Board is preparing for the next fiscal year.

II.B.4.d. Response Needed from ADAMHS, ADAS, CMH Boards

Board's Budgetary Planning Efforts for FY 10 & FY 11:

The Budgetary Planning Efforts for FY 10-11 are thought to be some of the most difficult in recent memory. Due to a myriad of factors (multiple FY 09 budget reductions; lack of a clear understanding of the impact of federal stimulus funding; proposals by the ODMH director to fund boards by region and radically change the 408 funding formula) are just a few of the challenges making planning extremely challenging. First and foremost the Board attempts to forecast its revenue for the next biennium. Agency Application Guidelines are then issued which takes this forecast into consideration. Board staff and members will meet with contract agencies to review their proposal and ultimately the Board will vote on what services will be supported and at what level. This process does not culminate until the May 26, 2009 Board meeting. As of the submission of this plan the forecast has been completed (although tentative) and the guidelines have been issued. Agency's will return their applications by May 1, 2009 and Board staff and Board members will begin review, discussion and meetings with each of the agencies submitting a proposal. The Board's planning efforts continue to evolve based on feedback received each year. The Board has tried to be sensitive and reduce the administrative burden to agencies in the application process while at the same time ensuring that Board members and staff have all the information necessary to make sound decisions regarding support and funding.

5. Tables 1 & 2: Portfolio of Providers

See Appendix A for instructions and to complete Table 1 for Alcohol and Other Drug Services Providers and Table 2 for Mental Health Service Providers. These tables are used in part to gather information on evidence based practices for reporting to the Substance Abuse and Mental Health Services Administration.

SECTION II: CAPACITY DEVELOPMENT

A. Access to Services

What is the Board's plan for addressing access issues for both AOD and MH services identified in the previous section of the plan?

A. Response Needed from ADAMHS, ADAS, CMH Boards

Board's Plan to Address Access Issues for MH Services:

As indicated above, currently Access Issues are minimal for MH Services. Adult/Youth Psychiatric Services are typically the most challenging in accessing; however the Board's lead contract agency has taken steps to be as efficient as they can with scheduling/re-scheduling clients to try and reduce wait times.

Board's Plan to Address Access Issues for AoD Services:

As indicated above, with respect to treatment services, the Board has recently decreased and anticipates additional reductions in funding to ACCADA to assist persons served in accessing Detox/Residential services.

A good collaborative working relationship with local schools will ensure that school-based prevention services continue to receive time/priority in the classroom.

B. Workforce Development and Cultural Competence

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.

What are the Board's plans for SFY 2010 and 2011 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 2010 and 2011 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.

B. Response Needed from ADAMHS, ADAS, CMH Boards

Board's Plan to Foster Workforce Development & Increase Cultural Competence:

The MHRB has been supportive of its primary AOD provider's workforce development efforts in a number of ways. The Board supports ACCADA in training and staff development and viewing both as a priority. The Board understands that excessive productivity demands can be

detrimental to attracting and retaining qualified staff and is therefore supportive of reasonable productivity expectations. The Board provides periodic training to promote current best practices and supports the agency in accessing quality training. When possible the Board lends financial support to the agency. For example, health insurance costs at the agency have increased and the Board has been able to offset some of those costs in its contract with the agency.

Currently the Mental Health and Recovery Board of Ashland County's primary AOD provider has a well-developed and qualified staff. The Board feels the local system does have sufficient qualified and licensed/credentialed staff to meet our service delivery needs

Board's Plan to Identify, Increase & Assess Cultural Competence for the following:

- **Consumer Satisfaction with Services & Staff:**

The Board will continue to collect annual consumer satisfaction survey data which includes measures consumer satisfaction and cultural satisfaction.

- **Staff Recruitment:**

The Board does not recruit staff for contract agencies; but with regard to the hiring of Board staff, the Board will continue to hire the most qualified candidates for open positions.

- **Staff Training:**

The Board will continue to promote and offer staff training that is consistent with its Mission, Vision and Values.

- **Disparities in Access:**

The Board is unaware of any disparities in Access based on culture or any other factor.

- **Disparities in Treatment Outcomes:**

The Board is unaware of any disparities in Treatment Outcomes based on culture or any other factor.

C. Capacity Development Targets

Capacity development targets refer to infrastructure development goals that improve the system's ability to provide services. Boards are expected to align with Department targets and demonstrate that the Board's efforts are making a contribution to the achievement or success of at least one of the Department capacity targets through funding, activities, or outcomes. The capacity development targets for ODADAS and ODMH include:

ODADAS Capacity Targets

- Reduce stigma (eg. advocacy efforts).
- Addiction is recognized as a legitimate health care issue 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 adult.
- A highly effective workforce for the AOD system.
- Increase diversity of revenue sources to support Ohio's Alcohol and other drug system (e.g., apply for foundation and SAMHSA discretionary grants).
- Increase the use of "evidenced-based" policies, practices, strategies and programs in the

AOD system.

- Increase the use of data within the AOD system to make informed decisions about planning and investment.

ODMH Capacity Development Targets

- Reduce the stigma of seeking care.
- Provide mental health and other physical health services in an integrated manner.
- Maintain access to services to all age, ethnic, racial and gender categories.
- Improve cultural competence of mental health system.
- Maintain access to services in rural areas.
- Maintain/increase access to ACT, IDDT and Supported Employment, service enriched housing, peer support, CPST and WMR.
- Decrease nursing facility admissions and increase consumer choice consistent with Olmstead recommendations and 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 training in EBP's.
- Increase access to web-based training systems.
- Increase availability of professionals through HPSA in areas with shortages.
- Increase the availability of school-based mental health services.
- Increase availability of trauma-informed care.
- Increase use of best practices:
 - Wellness Management and Recovery;
 - IDDT;
 - Supported Employment;
 - CIT;
 - Intensive Home-Based Treatment (IHBT).
- Increase diversity of funding sources as reported in FIS-040 (August).
- Evaluation of services will be planned.
- Under development: Cost-effectiveness of EBP services.

1. *ADAS and ADAMHS Boards: Identify the Board's Capacity Development Targets for SFY 2010 -2011. A Board may adopt one or more of the Ohio Department of Alcohol and Drug Addiction Services' Capacity Development Targets or identify alternative Targets of their own development that are mutually agreed upon by the Department (Boards must e-mail their request to communplan@ada.ohio.gov). **Indicate the ODADAS Capacity Targets to which the Board's Capacity Targets are contributing, if applicable.***

C.1. Response Needed from ADAMHS, ADAS Boards
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Board's Capacity Development Targets for SFY 2010-11:

The Board would like to adopt/continue the following ODADAS Capacity Targets for SFY 2010-2011:

1. A highly effective workforce for the AOD system.
2. Increase the use of “evidenced-based” policies, practices, strategies and programs in the AOD system.
3. Increase the use of data within the AOD system to make informed decisions about planning and investment.

2. *CMH and ADMAHS Boards: Identify the Board's Capacity Development Targets for SFY 2010 -2011. A Board may adopt one or more of the Department of Mental Health's Capacity Development Targets or identify alternative Targets of their own development that are mutually agreed upon by the Department (Boards must e-mail their request to communplan@ada.ohio.gov). **Indicate the ODMH Capacity Targets to which the Board's Capacity Targets are contributing, if applicable.***

C.2. Response Needed from ADAMHS, CMH Boards

Board's Capacity Development Targets for SFY 2010-11:

The Board would like to adopt the following ODMH Capacity Targets for SFY 2010-2011:

1. Maintain access to services in rural areas.
2. Reduce the stigma of seeking care.
3. Maintain access to services to all age, ethnic, racial and gender categories.

SECTION III: PREVENTION SERVICES

Prevention Defined—Alcohol and Other Drug Specific

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

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

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

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

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

Prevention Service Delivery Strategies

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

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

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

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

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

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

Prevention Defined—Mental Health Specific

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

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

Mental Health Consultation service means a formal and systematic information exchange between an agency and a person other than a client, which is directed towards the development

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

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

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

Prevention Service Categories by Population Served:

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

A. Prevention Needs

This section of the Plan includes a description of information and data used to determine the Board's alcohol and other drug prevention and mental health prevention, consultation and education (PC&E) needs. Describe all needs identified through quantitative and qualitative sources while differentiating between met needs (enough resources are already available to address the need) and unmet needs (additional resources are needed to address the need).

1. *Describe the process the Board utilized to determine its current alcohol and other drug and mental health prevention, consultation and education needs, including data sources and types, methodology, time frames and stakeholders involved.*

A.1. Response Needed from ADAMHS, ADAS and CMH Boards

Board Process Utilized to Determine AoD and MH P, C & E Needs:

- **Summary**

The Board recognizes the importance of the preventative services. When determining prevention priorities the Board employs a similar process to that used when determining treatment priorities.

The Board considers cost effectiveness, resource availability, degree of evidence-based support and extent the prevention priorities are consistent with the mission of the Board and Board's strategic plan. The Board initiates discussions with A.C.C.A.D.A. (AoD Agency), Appleseed (MH Agency) & Catholic Charities (MH Agency) and our community partners (Juvenile Court, FCFC, DJFS, Schools, etc.) before determining prevention priorities. The Board is keenly aware that without this process of including key stakeholder groups in discussions, its prevention priorities would be incomplete.

- **Data Sources Utilized:**

Contract Agency Assurances and Required Reporting; MACSIS Billings; FCFC Monthly Reporting; School-Community Liaison Program Reporting; Board's AoD Committee

- **Data Source Types:**

Quantitative and Qualitative data was collected.

- **Methodology:**

Interview and discussion (large and small meetings), phone conferencing and email as well as feedback from prevention facilitators.

- **Time Frames:**

SFY 2008 thru first half of SFY 2009.

- **Stakeholders Involved:**

Family and Children First Council; Juvenile Justice (Court, Detention & Probation); Criminal Justice (Courts; Police & Jail); General Public.

2. *Describe the findings of the needs assessment identified through quantitative and qualitative sources while differentiating between met needs (enough resources are already available to address the need) and unmet needs (additional resources are needed to address the need). Include findings specific to:*

a. *alcohol and other drug prevention (ADAMHS, ADAS)*

b. *mental health prevention, consultation and education (PC&E) findings (ADAMHS, CMH)*

A.2.a. Response Needed from ADAMHS and ADAS Boards

-Alcohol & Other Drug Prevention

Needs Assessment Findings (Quantitative Sources):

- **Met Needs (enough resources are already available to address need):**

MACSIS Extract reporting show the following prevention services were funded at a total of \$145,030 for SFY 2008 in Ashland County with the vast majority directed at the 0-17 demographic.

-AoD Alternatives:

-AoD Community Based Process

-AoD Information Dissemination

-AoD Problem ID & Referral

-AoD Education

-AoD Consultation

Resources exist to meet current needs at this time.

- **Unmet Needs (additional resources needed to address need):**

None at this time.

Needs Assessment Findings (Qualitative Sources):

- **Met Needs (enough resources are already available to address need):**

Conversations and discussions with our contract agencies as well as community partners confirm what our quantitative sources indicate, namely; that sufficient resources exist to meet current needs. However, as indicated below, unmet needs may occur in the future as changes in funding to other systems present gaps/opportunities for AoD prevention.

- **Unmet Needs (additional resources needed to address need):**

None at this time. Consensus was that resources exist to meet current needs. One caveat was that the local county DARE program was in jeopardy of being de-funded. If that were to occur, agreement existed that additional resources would be needed to help “fill the void” that would be created by the absence of the County DARE program.

A.2.b. Response Needed from ADAMHS and CMH Boards

-Mental Health Prevention, Consultation & Education

Needs Assessment Findings (Quantitative Sources):

- **Met Needs (enough resources are already available to address need):**

MACSIS extract reports indicate the Board funded Mental Health P, C & E at the level of \$7,878.73 in SFY 2008. Given that the Board has identified MH P, C & E as a lower priority; this level of funding is sufficient to meet currently identified needs.

- **Unmet Needs (additional resources needed to address need):**

None. Resources exist to meet current needs.

Needs Assessment Findings (Qualitative Sources):

- **Met Needs (enough resources are already available to address need):**

Contract agencies, schools, Juvenile Justice, Board AoD committee report that current needs are being met.

- **Unmet Needs (additional resources needed to address need):**
None. Consensus was that resources exist to meet current needs.

B. Prevention Priorities

This section of the Plan prioritizes the Board's identified prevention needs. These priorities are determined locally keeping in mind the various priority populations and/or initiatives identified either by statute or ODADAS/ODMH initiatives.

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, include 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)

ODMH Priority Populations include:

- SMD—Adults*
- SED—children/adolescents*
- Consumers and family members
- Children/adolescents
- Transitional-aged Youth

- Older Adults
- Deaf and Hard of Hearing
- Military Personnel/Veterans
- Individuals involved in the criminal justice system including Forensic clients
- Individuals involved in the child welfare system

*The definition of serious emotional disturbance (SED) for children and adolescents 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.

*1. Describe the process utilized by the Board to determine its **prevention priorities** for SFY 2010 – 2011. How did the Board decide the most important areas in which to invest their resources?*

B.1. Response Needed from ADAMHS, ADAS and CMH Boards

Board Process Utilized to Determine Prevention Priorities:

The Prioritization of Identified Needs is a complex process. The Board takes into account the amount of need (# of persons in need of service), the ramifications of not meeting the needs of a person(s), available & type of funding, capacity of contract agencies to meet need, community acceptance of need and service(s) to impact, and the Board Strategic Plan, including Board Mission, Vision and Values.

2. Based on the identified needs, list the Board's prevention priorities. These should be grouped in the following categories; high, medium or low.

a. Alcohol and Other Drug Prevention (ADAMHS, ADAS)

b. Mental Health Prevention, Consultation and Education (PC&E) (ADAMHS, CMH)

B.2.a. Response Needed from ADAMHS and ADAS Boards

AoD Prevention Priorities:

<u>Prevention Program</u>	<u>Priority Population</u>	<u>Priority (High, Med, Low)</u>
SAFE (Safe & Drug Free Schools)	Children/Adolescents	Medium
Teen Mentoring (ACT)	Children/Adolescents	Medium
Medicine Show/Medicine or Candy?	Children/Adolescents	Medium
Wee Too! (Resiliency Enhancement)	Children/Adolescents	Medium
Prime for Life – Under 21	Children/Adolescents	Low
TRAP (Tobacco Risk Awareness Program)	Children/Adolescents	High
SOS (Study of Substances	Children/Adolescents	Medium
SOS II (Study of Substances II)	Children/Adolescents	Medium
Choosing A Healthy Me (Children/family members of addicts)	Children/Adolescents	Low
Life Skills Training	Children/Adolescents	High
BABES (Beginning Alcohol & Addiction Basic Education Studies)	Children/Adolescents	High

B.2.b. Response Needed from ADAMHS and CMH Boards

MH P, C & E Priorities:

- **High**
Consultation & Education Opportunities through the Suicide Coalition (QPR); and possible Crisis Intervention Team Training
- **Medium**
Youth Anger Management groups at Juvenile Detention Center
- **Low**
Non-coordinated, diffuse MH P, C & E activities throughout the County.

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

B.3 Response Needed from ADAMHS, ADAS and CMH Boards

Implications of Limited Funding Available to Board for Prevention Services:

Possible implications include service gaps resulting in unmet needs. The Board is hopeful that any potential gaps are identified as early as possible and changes made to eliminate those gaps through increased/targeted services. Changes of this type would be reflected in the Community Plan Update.

C. Prevention Investor Targets

Investor Targets 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 above. Both AOD and MH Prevention targets may span the entire life cycle and do not need to be limited to addressing children and adolescent populations.

Alcohol and Other Drug Prevention Targets:

- 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 Targets:

- Programs that increase social connectedness;
- Programs that promote mental health and wellness;
- Programs that decrease the negative effects of mental illness;
- Programs that decrease the number of persons at risk of developing mental health problems and/or at risk for suicide;
- Programs that increase the number of persons that receive mental health screenings, assessments or referrals to services;
- Programs that increase the number of formal and informal supports in diverse cultural/ethnic populations;
- Programs that increase recovery, resiliency and protective factors;
- Programs that increase the number of persons who demonstrate school bonding (success) and educational commitment;
- Programs that increase the employment of persons with emotional problems and/or mental illness;
- Programs that decrease or eliminate stigma related to emotional problems and mental illness; and
- Programs that increase the number of persons involved in the criminal justice system who receive mental health services.

1. Identify the Board's Prevention Investor Targets for SFY 2010--2011. A Board may adopt one or more of the ODADAS or ODMH Investor Targets or identify alternative Investor Targets of their own development that are mutually agreed upon by ODADAS and ODMH. ADAMHS Boards must identify at least one ODADAS target and one ODMH target. ADAS Boards must identify at least one ODADAS target. CMH Boards must identify at least one ODMH target. Indicate the ODADAS and/or

ODMH Investor Target to which the Board's Investor Target is contributing, if applicable.

C.1. Response Needed from ADAMHS, ADAS and CMH Boards

Board's AoD Prevention Investor Target(s) for SFY 2010-11:

- 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.

Board's MH Prevention Investor Target(s) for SFY 2010-11:

- Programs that promote mental health and wellness.

SECTION IV: TREATMENT & RECOVERY SUPPORT SERVICES

A. Treatment and Recovery Support Needs

1. *Describe the process the Board utilized to determine its current treatment and recovery support needs, including data sources and types, methodology, time frames and stakeholders involved.*

A.1. Response Needed from ADAMHS, ADAS, CMH

Board Process Utilized to Determine Current Treatment & Recovery Support Needs:

- **Data Sources**

MACSIS; Board Provider Network; Board Community Partners

- **Data Types**

Quantitative Data (i.e., MACSIS Costing/Volume Data) and Qualitative (i.e., Provider and Community Partner Feedback and Formalized Satisfaction Survey's).

- **Methodology**

Volume of Service by population groupings, gender, diagnostic criteria analysis
Cost of Service by population groupings, gender, diagnostic criteria and analysis
Aggregate analysis of satisfaction survey data based on highest/lowest rated

- **Time Frames**

Primary time frames include SFY 2008 and SFY 09 up to February of 2009.

- **Stakeholders Involved**

Board Provider Network; Board Community Partners (Schools, Juvenile Court, DJFS/Children Services, Family and Children First Council, Local University, Local Hospital, Police/Sheriff

2. *Describe the findings of the needs assessment identified through quantitative and qualitative sources while differentiating between met needs (enough resources are already available to address the need) and unmet needs (additional resources are needed to address the need). Include findings specific to:*
 - a. *Adult residents of the district hospitalized at the regional state psychiatric hospitals (ADAMHS/CMH only);*
 - b. *Adults with severe mental disability (SMD) and children and adolescents with serious emotional disturbances (SED) living in the community (ADAMHS/CMH only);*
 - c. *Children and Families receiving services through a Family and Children's First Council;*
 - d. *Persons with substance abuse and mental illness (SA/MI);*
 - e. *Individuals receiving general outpatient community mental health services /ADAMHS/CMH only); and*
 - f. *Adults, children and adolescents who abuse or are addicted to alcohol or other drugs.*

A.2.a. Response Needed from ADAMHS and CMH Boards

Adult State Hospitalizations:

Needs Assessment Findings (Quantitative):

- **Met Needs**

The Board anticipates continuing to reserve 500 State Hospital Bed Days. The Board has a strong relationship with Heartland Behavioral Health and Appleseed Community Mental Health. The Board has consistently utilized bed days within 100 bed days of 500.

- **Unmet Needs**

No additional resources are required at this time around Adult State Hospitalizations.

Needs Assessment Findings (Qualitative):

- **Met Needs**

Both the Board and agency responsible for Crisis Intervention Service are in agreement with the reservation of 500 days for SFY 2010.

- **Unmet Needs**

The Board's contract agencies and partners do not report a need for additional resources at this time around Adult State Hospitalizations.

A.2.b. Response Needed from ADAMHS and CMH Boards

Community SMD/SED Population:

Needs Assessment Findings (Quantitative):

- **Met Needs**

Sufficient resources currently exist to provide most of the services necessary to SMD/SED populations as long as the services are funded by Medicaid. Waiting list times are negligible.

-It is important to note that using ODMH's Data Mart (or Data Cube) the SMD/SED population count has increased by 145% between SFY 2000 and SFY 2008 (355 versus 871).

- **Unmet Needs**

Additional funding for non-Medicaid services like Housing and Supported Employment programming is needed. Continued reluctance on the part of Ohio leadership to provide Boards with sufficient tools to effectively manage Medicaid will continue to undermine the system of care for persons with SMD/SED diagnoses in need of Non-Medicaid services. The Board was required to reduce and then eliminate funding for Housing subsidies and the Supported Employment program.

- Pharmacologic Services continue to be at a premium; the Board will continue to monitor any increases in needs/waiting times throughout the year.

Needs Assessment Findings (Qualitative):

- **Met Needs**

Provider agencies and community partners have voiced agreement that current resources are sufficient to meet most routine SMD/SED services funded via Medicaid. Satisfaction Surveys confirm any waiting time for services are negligible.

- **Unmet Needs**

Agreement between the Board and Provider agencies that additional resources are necessary to provide non-Medicaid services to persons identified as SMD/SED as well as Non-SMD/SED.

A.2.c. Response Needed from ADAMHS, ADAS and CMH Boards

Family & Children Receiving FCFC Services:

Needs Assessment Findings (Quantitative):

- **Met Needs**

First half FY 09 numbers show that 167 children have received services through the Help Me Grow program; 16 families and 34 youth have received Parent Support Mentoring; 2 families and 3 children have received Kindergarten Readiness; 10 youth and families participated in the Wraparound Program and 12 youth and 12 families have received assistance through the council's service coordination teams.

- **Unmet Needs**

Due to funding reductions; the joint Board-Council Wraparound Program had to be suspended. Both the Board and Council recognize the continued need for Wraparound Services in the county.

Needs Assessment Findings (Qualitative):

- **Met Needs**

Discussions with the County's FCFC Coordinator and other members of Council indicate that the Help Me Grow program and Parent Support Mentoring were going well and resources existed to meet the needs of the programs. Concern with Help Me Grow and other Early Childhood Programs going forward in SFY 10-11 was voiced due to the current Budget Discussions in Columbus.

- **Unmet Needs**

Discussions with County's FCFC Coordinator pointed to three top unmet needs:

1. In-county foster care and therapeutic foster care;
2. Service Coordination and School Readiness services for children aged 3-5 years.
3. After school programming for middle and high school aged youth

A.2.d. Response Needed from ADAMHS, ADAS and CMH Boards

Persons with a Dual Disorder of MI and AoD:

Needs Assessment Findings (Quantitative):

- **Met Needs**

Ashland County is fortunate to have a high fidelity IDDT program. In FY 2008 **38** distinct persons with a co-occurring mental health and substance use disorder received services through the program.

Utilizing a newly conceived strategy; IDDT specific MACSIS Affiliation Codes have been assigned to each participant in the program allowing the agency, board and State Depts to track service utilization; state hospitalizations; central pharmacy and eventually consumer outcomes. Both utilization and associated costs can be tracked.

- **Unmet Needs**

At present sufficient resources exist to continue support for persons with MI and AoD disorders.

Needs Assessment Findings (Qualitative):

- **Met Needs**

The IDDT Team at Applesseed Community Mental Health Center is lead by a very experienced clinician dually credentialed by both ODMH and ODADAS. Additionally he has received advanced training in Motivational Interviewing and is qualified to train others in MI. The ongoing collaboration with the IDDT Center of Excellence is seen as important to the ongoing success of the program.

- **Unmet Needs**

The IDDT Team has identified a lack of affordable/available housing; particularly wet or damp housing to assist in their work with persons in the early stages of IDDT. Additionally the impending reductions in Non-Medicaid services due to State funding reductions will present unmet needs to the program and persons involved.

A.2.e. Response Needed from ADAMHS and CMH Boards

Non SMD/SED General Outpatient Population:

Needs Assessment Findings (Quantitative):

- **Met Needs**

Consumer Operated Services have received Board discretionary funding and it is anticipated that the Board will be able to continue funding to meet the needs of the Consumer Operated agency (Lifeworx) in SFY's 2010-11.

- **Unmet Needs**

The Board had to reduce or eliminate funding for the Supported Employment Program; Housing Program; Art's in Action Program; Transportation Program; HAP/HOPE Program; Community Consultation/Education and Wraparound programming. It is unclear at this time to what degree non-Medicaid Assessment; Counseling; Pharm Mgt and CPST services will have to be reduced to the

non SMD/SED populations. The Board is waiting to see the final budget approved by congress and the Governor as well as the result of ongoing negotiations between the Boards and ODMH regarding 408 Formula changes.

Needs Assessment Findings (Qualitative):

- **Met Needs**

Meetings with Board and staff members of the Consumer Operated Agency confirm that funding, while not optimal, is sufficient for the programming at this time.

- **Unmet Needs**

Meetings with Board contract agencies confirm the unmet needs listed above are accurate.

A.2.f. Response Needed from ADAMHS and ADAS Boards

Outpatient Alcohol and/or Other Drug Service Population:

Needs Assessment Findings (Quantitative):

- **Met Needs**

Resources currently exist to meet local Outpatient AoD service needs with the exception of Residential/Detox services (mentioned below).

- **Unmet Needs**

The Board in collaboration with the lead AoD contract agency has had to reduce the resources for Residential-Detox services in FY 2009 and this reduction appears to be necessary in the upcoming biennium. The Board would be willing to consider additional State funding for Residential-Detox services if they are made available.

Needs Assessment Findings (Qualitative):

- **Met Needs**

Discussions with contract agency, partner agencies, Board AoD committee members and members of the public support the Board's position that as of FY 2009 sufficient resources existed to meet Outpatient AoD service needs.

- **Unmet Needs**

As indicated above; discussions with relevant partners support the Board's position that additional funding for Residential-Detox services are needed and could be utilized if made available.

B. Treatment and Recovery Support Priorities

1. *Describe the process utilized by the Board to determine its treatment priorities for SFY 2010 – 2011. How did the Board decide the most important areas in which to invest their resources?*

B.1. Response Needed from ADAMHS, ADAS, CMH

Board Process for Prioritization of Treatment Services:

The Prioritization of Identified Needs is a complex process. The Board takes into account the amount of need (# of persons in need of service), the ramifications of not meeting the needs of a person(s), available funding, capacity of contract agencies to meet need, community acceptance of need and service(s) to impact, all applicable statutory requirements of the Board, State defined needs/priorities and the Board's Strategic Plan, including Board Mission, Vision and Values. After meeting with all relevant stakeholder groups the Board developed and formally approved a prioritization continuum for both Treatment and Prevention Services funded by the Board.

- 2. Based on the identified needs, list the Board's treatment service priorities. These should be grouped in high, medium and low categories for alcohol and drug treatment and recovery support and mental health treatment and recovery support.*

B.2. Response Needed from ADAMHS, ADAS, CMH

Boards **Mental Health** Treatment & Recovery Support Service Priorities:

- **High**

Crisis Services, Core Services to SMD/SED (Medicaid), Levy funded School Based Services; Consumer Operated Services

- **Medium**

Early Childhood Programming, Hospital Diversion Funding, Core Services to Non-SMD (Adult) & Non-SED (Youth/Children) populations, HAP/HOPE, Housing subsidy.

- **Low**

Community Consultation and Education

Boards **AoD Treatment** & Recovery Support Service Priorities:

- **High**

Outpatient Services (Assessment; Counseling; and Case Management Services).

- **Medium**

Detox/Residential Services (Provided outside of county); Jail-Based Services

- **Low**

Sub-acute Detoxification

- 3. Based upon the Board's prioritization process, some needs may go unaddressed or under-addressed. What are the implications to other systems?*

B.3. Response Needed from ADAMHS, ADAS, CMH

Implications of Limited Funding for MH and AoD Treatment & Recovery Support Services:

Possible implications include service gaps resulting in unmet needs. The Board is hopeful that any potential gaps are identified as early as possible and changes made to eliminate those gaps through increased/targeted services. Changes of this type would be reflected in the Community Plan Update.

Where needs go unaddressed and/or under-addressed it is possible that other systems including juvenile justice, schools, primary health, JFS, faith-based organizations and other social service organizations will have to play an increased roll.

Unfortunately, need is always in excess of resources necessitating a community response to mental health and substance use disorders.

There is the Potential for an increase in State Psychiatric Hospitalizations Bed Day Utilization due to less community supportive services. Refer to Non SMD/SED above. As the Board's funding moves more and more to "Medicaid Only" services vital Non-Medicaid services will go unfunded or underfunded. This creates a significant challenge for the Board to fulfill its Goal of assisting persons with behavioral health disorders thrive in their communities. The very services that assist persons to thrive may be eliminated or significantly reduced due to a combination of State Policy and Funding decisions. The question of whether the Mental Health Act of 1988 is being funded adequately or appropriately will be discussed throughout the next two years and, possibly, beyond.

C. Treatment and Recovery Support Investor Targets

ODADAS Treatment and Recovery Support Investor Targets

- Number of customers who are abstinent at the completion of the program.
- Number of customers who are gainfully employed at the completion of the program.
- Number of customers who incur no new arrests at the completion of the program.
- Number of customers who live in safe, stable, permanent housing at the completion of the program.

ODMH Treatment and Recovery Support Investor Targets

- Number of consumers reporting positively about their quality of life.
- Increase competitive employment.
- Decrease school suspensions & expulsions.
- Decrease criminal and juvenile justice involvement.
- Increase Access to Housing.
- Decrease homelessness.

1. *Identify the Board's treatment and recovery support investor targets for SFY 2010 -2011. Investor targets should be framed in terms of what projected increase or decrease in condition or behavior for individuals, families, target groups, systems and/or the communities the Board has prioritized and seeks to achieve. ADAMHS and CMH Boards*

must define how they will address the needs of civilly and forensically hospitalized adults, including conditional release and discharge planning. Additionally, a Board may adopt one or more of the Departments' investor targets or identify alternative investor targets of their own development that are mutually agreed upon by the Departments. Indicate the ODADAS and ODMH investor target to which the Board's investor target is contributing, if applicable.

C.1. Response Needed from ADAMHS, ADAS, CMH

Boards MH Treatment & Recovery Support Investor Target(s) for SFY 2010-2011:

- Number of consumers reporting positively about their quality of life. (The Board will utilize the ODMH newly created outcomes measures to collect this data.)
- **Projected Increase/Decrease in Condition or Behavior Identified –**
The Board would project in increase in the number of consumers reporting positively about their quality of life, once involved with services.

Boards AoD Treatment & Recovery Support Investor Target(s) for SFY 2010-2011:

- Number of customers who are gainfully employed at the completion of the program
- Number of customers who incur no new arrests at the completion of the program
- Number of customers who are abstinent at the completion of the program
- Number of customers who live in safe, stable, permanent housing at the completion of the program
- **Projected Increase/Decrease in Condition or Behavior Identified –**
The Board projects the following:
 - At least a 1% increase in customers who are gainfully employed at the completion of the program. (County unemployment at 13%; trying to maintain those with employment)
 - At least 75% of customers will incur no new arrests at the completion of the program
 - At least 75% of customers will report abstinence at the completion of the program
 - At least 80% of customers will report living in safe, stable, permanent housing at the completion of the program.

Given the new format of this year's community plan, the Board will work with its provider agencies to make adjustments to targets established in this years "baseline" plan.

Boards Plan to Address Needs of Civilly and Forensically Hospitalized Adults:

- **Conditional Release Parameters –**

The Board's primary MH contract agency will work within the Continuity of Care Agreement to plan, as appropriate, for those persons qualifying for conditional release. In general, the Board prefers an individual forensically committed to be released on a conditional release status rather than "maxing out" their sentence at the hospital. Conditional release allows for increased treatment

options (e.g., Hospitalization) in the event there are challenges trying to assist the person in flourishing in a community environment.

- **Discharge Planning Procedure –**

As indicated in the Continuity of Care Agreement; discharge of forensic and civilly committed persons is a joint process between the person served, involved family/friends, hospital treatment team and the Board's primary mental health agency. It is the Board's position that State Hospitalizations, outside of forensic commitments, should be of the least duration necessary that allows for the person to return to their home environment. Discharge begins at Admission. The Board strives to see 80% of their civil discharges with lengths of stay equal to or less than 7 days.

ORC 340.033(H) (HB 484)

2. *To improve accountability and clarity related to H.B. 484 programming, ADAMHS and ADAS Boards are required to develop a specific investor target related to this allocation.*

C.2. Response Needed from ADAMHS, ADAS

Boards Investor Target Related to H.B. 484 Programming:

- Increase the number of children and families who have accessed AOD services utilizing 484 funding. The Board would like to fully expend these funds annually.

Plan to Determine Achievement:

Working with the Family & Children First Council, County Commissioners and local children services to identify more families and children eligible for these funds.

The Commissioners and Board work collaboratively and fund services jointly in the following manner. When residential/out of home placement is necessary the County Commissioners, via Child Welfare, fund room and board costs while the Board funds the Medicaid eligible treatment services needed. This collaboration is seen most clearly during regular Family & Children First Council meetings where the needs of local residents involving both systems are discussed. Additionally the Board and County Commissioners have determine that existing 484 funds will be used primarily for outpatient services and in some cases for higher levels of care including detox and residential treatment. ACCADA recently hosted a consultation meeting with the Children Service supervisor to assure that there continues to be a good working relationship between the two systems and alcohol/drug provider agency.

Verification of Results:

The Board will utilize the MACSIS system to verify any increases. Quarterly reports are already submitted to the ODADAS.

HIV Early Intervention

3. *ADAMHS and ADAS Boards receiving a special allocation for HIV Early Intervention Services need to develop an investor target related to this allocation.*

C.3. Response Needed from select ADAMHS, ADAS

Not Applicable to the Mental Health and Recovery Board of Ashland County

SECTION V: COLLABORATION

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.

A. 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 trained on the Continuity of Care Agreements.

A. Response Needed from ADAMHS and CMH Boards. Include the number of system staff trained on Continuity of Care Agreements.

Boards Process to Implement “Continuity of Care Agreement”:

By working with Heartland Behavioral Health Care; The Heartland Collaborative and Appleseed Community Mental Health Center, the Board was able to construct an agreement that helped to ensure continuity of care for persons admitted to the State Hospital from Ashland County. The process involved several in-person, phone and email discussions to work through the various sections of the agreement.

- **Training Provided to Pre-Screening Agency Staff –**

Preliminary training on the agreement began during FY 09 and will continue in FY 10 and FY11. As new Health Officers are approved; training will be provided. Please note that the agreement is now part of the standard training/orientation for all new Health Officers.

- **Number of System Staff Trained on the “Continuity of Care Agreement – 100% of Staff (9 people) were trained on April 9th 2009**

B. 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.

B. Response Needed from ADAMHS, ADAS, CMH

Listing of Systems/Entities Board Collaborated with Regarding “CoC Agreement:

- Heartland Behavioral Health Care (Dr. Thompson (chief clinical director), Sandra Jesionek (nurse executive), Eric Carpenter (CEO).

- Heartland Collaborative (Boards representing the following counties: Ashtabula, Tusc/Carrol, Stark, Medina, Richland, Wayne/Holmes, Portage, Trumbull and Columbiana.)
- Applesseed Community Mental Health Center

Benefits/Results of Collaboration:

By working in a collaborative fashion with the entities above, the Board feels it acted in an efficient and uniform way. By involving the Hospital at the beginning of the process; the Board feels potential disagreements were avoided.

Statement of the Board’s Relationship with Private Hospital(s):

The Board has a good relationship with Private Hospitals. The Board has set funding aside to be used at the discretion of the contract agency responsible for Crisis Intervention Services. The primary intent of these funds is to utilize Private Hospitals, where appropriate, to avoid state hospitalization placements. Med-Central Mansfield, Barberton Citizens and Akron Children’s Hospital are the three private hospitals most often used by Ashland County.

C. 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 (commonly referred to as H.B. 484)

C.Response Needed from ADAMHS, ADAS

Summary of the Board’s Consultation with County Commissioners Regarding Services for Individuals involved in the Child Welfare System:

The Commissioners and Board work collaboratively and fund services jointly in the following manner. When residential/out of home placement is necessary the County Commissioners, via Child Welfare, fund room and board costs while the Board funds the Medicaid eligible treatment services needed. This collaboration is seen most clearly during regular Family & Children First Council meetings where the needs of local residents involving both systems are discussed. Additionally the Board and County Commissioners have determine that existing 484 funds will be used primarily for outpatient services and in some cases for higher levels of care including detox and residential treatment. A.C.C.A.D.A. recently hosted a consultation meeting with the Children Service supervisor to assure that there continues to be a good working relationship between the two systems and alcohol/drug provider agency. The Board, along with its contract agencies and the FCFC are trying to enhance/improve communication/collaboration with the Child Welfare System, particularly for those youth/families at risk for either out of home/county placement or for those parents who may feel as if custody relinquishment is the only way that their child/children can get the help he/she/they might need.

Joint Funding Between the Board & County Commissioners:

For fiscal year 2009, the Board received \$18,787 in HB84 funding.

D. 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)?

D. Response Needed from ADAMHS, ADAS, CMH

Board Mechanism to Involve Customers & the General Public in the Planning Process:

The Mental Health and Recovery Board of Ashland County involve customers and the general public in the planning process through four major avenues:

1. Contract Agency Customer/Community Satisfaction Surveys;
2. Board Customer/Community Satisfaction Surveys
3. Board initiated community focus groups, and
4. Board involvement with the Family & Children First Council

All of this data is incorporated to the ongoing planning process for Mental Health and Alcohol/Drug services.

The Mental Health and Recovery Board of Ashland County regularly collaborates with the following local systems:

- Juvenile Court
- Jail
- Education/School Superintendents
- Family and Children's First Council
- Department of Jobs and Family Services
- Directors of contract agencies
- Homeless Coalition
- School Liaison Coordinator
- Domestic Violence Shelter
- Rape Crisis Program
- Prosecutor's Office
- Faith Based Organizations
- District V Area Agency on Aging
- Council on Aging
- Municipal Court
- Law Enforcement
- Hospital
- Salvation Army (Kroc Center)
- Service Organizations (Rotary, etc.)

The benefits of intersystem collaboration are enumerable. The Mental Health and Recovery Board of Ashland County values its collaborative efforts. They are critical in determining community needs/gaps in services as well as a source of satisfaction for services currently being offered. Innovative programs like our Jail program would not have come to be if not for the intersystem collaboration that exists. The Board has started CIT which involves collaboration with several systems as well as Supported Employment and Intensive Home Based programs to name just a few.



SECTION VI: EVALUATION

Based on the Guidelines provided in Appendix B, how did the Board evaluate services?

- A. What methods does the Board plan to use to evaluate the effectiveness and efficiency of services in the overall system of care?

A. Response Needed from ADAMHS, ADAS, CMH

Method(s) Board Plans to Employ to Evaluate Effectiveness:

The Board's method to evaluate the extent to which funded services in the overall system of care achieve desired improvements in the health or well being for an individual or family is still pending at this time due to the Departments decision to revise the Ohio Outcomes/Ohio Scales process. For 2 out of the 4 contract agencies; the revised Ohio Outcomes/Ohio Scales will be utilized to evaluate effectiveness. For the consumer operated agency that the Board contracts with, an Annual Satisfaction Survey instrument will be modified to ask consumers specifically about their perception of the effectiveness of the program. For the AoD agency under contract with the Board a combination of BH data; milestone data and Community Plan Targets will be utilized to gauge the extent desired improvements for an individual or family is measured.

Method(s) Board Plans to Employ to Evaluate Efficiency:

The Board's method to evaluate the accomplishment of desired results with the least possible exertion/expense/waste in the overall system of care is still pending at this time due to the Departments decision to revise the Ohio Outcomes/Ohio Scales process. It stands to reason that Efficiency cannot be measured unless/until Effectiveness measures are in place. The Board is hopeful based on conversations and email correspondence with the Department that Ohio Outcomes/Ohio Scales will be available and in place for agencies to begin using either at the beginning of FY 2010 (July 1, 2009) or beginning the second half of FY 2010 (January 1, 2010).

For the AoD agency under contract with the Board, MACSIS fiscal data will be matched with appropriate BH, Milestone and Community Plan Target data to evaluate results in light of resources utilized (Efficiency).

- B. Describe your level of collaboration (e.g., division of labor) with the agencies in evaluating services.

B. Response Needed from ADAMHS, ADAS, CMH

Board's "Division of Labor" to Evaluate Services with Agency Participation:

There is a high level of collaboration between the Board and its agencies around the evaluation of services. As stated elsewhere, the Board has regular (monthly or every other month) meetings with its contract agencies and part of each meeting is a discussion around the evaluation of services. The Board, with agency input, has established a “Reporting Matrix” whereby both the agencies and Board Staff are clear on what reports to the Boards are due by when.

Agencies are responsible, as indicated through the contracting process, to supply the Board with regular reports around all manner of ongoing contract compliance issues. The evaluation of services is thus a multifaceted discussion between the agencies and Board Staff and can include multiple reports. For example, when evaluating the contracted service of “Crisis Intervention” the agency and Board Staff evaluate the volume of services (actual versus projected), the outcome of those services, any consumer feedback that exists relevant to those services, the impact on State Hospitalizations targets and any staffing challenges that have impacted or might impact the delivery of the service and any additional information deemed relevant by the agency or Board Staff. This process is repeated for all contracted services.

For simplicity, contract agencies are primarily responsible for the collection of data needed to evaluate services, while Board Staff are primarily responsible to analyze the data for trends and patterns. The agencies and Board Staff collaboratively work to discuss the implications of the data gathered and analysis conducted.

C. Which services or programs does your Board see as having the highest priority for the evaluation of effectiveness and/or efficiency?

C.Response Needed from ADAMHS, ADAS, CMH

Board’s Statement Regarding Services/Programs Having the Highest need for Evaluation of Effectiveness and/or Efficiency:

While the Board sees the value in determining the effectiveness/efficiency of all programs the highest need is that of Emergency Services.

Rank Ordered:

1. Emergency Services
2. Medicaid Funded Outpatient Services to SMD/SED Populations
3. Levy Funded School-Based Services

D. Describe what you are doing with your evaluation results. How are you using the results from your evaluation of programs/services? (For those Boards utilizing the ODADAS performance management system, what is the Board’s plan to determine whether the targets were achieved and how will results and learnings will be communicated within the local Alcohol and other Drug system?)

D.Response Needed from ADAMHS, ADAS, CMH

Board's Process for the Utilization of Evaluation Results:

1. How are we using the results from program/service evaluations?

Results from evaluations help the Board understand to what extent programs/services are meeting the expectations of the Board, Contract Agencies, Consumers, and Community at large. Future decisions as to what programs continue and at what level are influenced by program/service evaluations. With limited funding, the Board is committed to supporting the most effective programming and services it can.

2. How will we know targets have been reached?

Simply put; by tracking. Once baseline data has been determined for a given service/program, targets are set in mutual agreement with contract agencies and monitored via regular reporting and discussion to determine to what extent targets are being reached, and when necessary, when targets need to be adjusted.

3. How will results and learnings be communicated within the local AoD system?

The MHRB has regular meetings with the Director of the local AoD agency where information regarding results and learnings can be communicated. At a minimum the MHRB and the Director of the local AoD agency meet monthly. The Director of ACCADA in turn utilizes weekly staff supervision, peer review and training to further communicate results and learning's to staff. Additionally, the Board has established, as statutorily required, an AoD Committee which meets at a minimum three times yearly to discuss the community plan and learnings.

E. Does your Board rely on different strategies to evaluate Child & Adolescent services versus Adult services (Yes/No)? Please describe.

E.Response Needed from ADAMHS, ADAS, CMH

No, we use the same evaluation strategies.

OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES

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
N/A	N/A	N/A	N/A

SIGNATURE PAGE

Community Plan for the Provision of Alcohol, Drug Addiction and Mental Health Services
SFY 2010-2011

Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Alcohol and Drug Addiction Services (ADAS) Board and Community Mental Health (CMH) 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) 2010 – 2011 (July 1, 2009 to June 30, 2010).

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 2010 - 2011, has been reviewed for comment and recommendations by the Board's Standing Committee on Alcohol and Drug Addiction Services, and is complete and accurate.

[Mental Health and Recovery Board of Ashland County](#)

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

ADAMHS, ADAS or CMH Board Executive Director

Date

Authorized ADAMHS, ADAS or CMH Board Member

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.).]

APPENDIX A:

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 programs in which the Board invests public dollars including all Medicaid-only contract providers as well as programs grant-funded by ODADAS. Please include the following specific information within each level of care (the matrix to be completed appears on page 34): 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. the 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 programs in which the Board invests public dollars including all Medicaid-only contract providers. Please include the following specific information within the matrix (the matrix to be completed appears on page 35): provider name; MACSIS UPI; number of sites; program name; funding source; estimated number of clients served in SFY 2009; and estimated number of clients served in SFY 2010.

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, or NREPS), 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

TABLE I: 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 (Check the box if yes)		i. MACSIS UPI
								ODADAS	Medicaid Only	
				(Universal, Selected or Indicated)	(List the EBP name)		(Check the box if yes)			
PREVENTION										
Information Dissemination	A.C.C.A.D.A.	SOS/TRAP	Elementary School	Universal	N/A	3	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
Alternatives	A.C.C.A.D.A.	Teen Institute	Middle & High School	Universal	Teen Institute	5	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
	Catholic Charities Services	Teen Mentoring Program	Middle & High School	Selected	N/A	1			<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	12762
Education	A.C.C.A.D.A.	BABES/Wee Too	Elementary School	Universal	N/A	2	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
			Middle & High School	Universal	Life Skills	3				
Community-Based Process	A.C.C.A.D.A.	A.C.C.A.D.A.	Middle & High School	Universal	N/A	1	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
Environmental							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problem Identification and Referral							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PRE-TREATMENT (Level 0.5)										
OUTPATIENT (Level 1)										
Outpatient	A.C.C.A.D.A.	Outpatient Assessment, Treatment Planning, Counseling & Case Management Services	Adults and Youth; Male and Female		-Motivational Interviewing; -Buprenorphine; -Cognitive-Behavioral Therapy; -Network of Care	1	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	01010
Intensive Outpatient							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Day Treatment							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
COMMUNITY RESIDENTIAL (Level 2)										
Non-Medical							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Medical							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SUBACUTE (Level 3)										
Ambulatory Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23 Hour Observation Bed							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sub-Acute Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ACUTE HOSPITAL DETOXIFICATION (Level 4)										
Acute Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

TABLE 2: PORTFOLIO OF MENTAL HEALTH SERVICES PROVIDERS

Promising, Best, or Evidence-Based Practice	Provider(s) Name(s)	MACSIS UPI(s)	Number of Sites	Program Name	Funding Source (Check all that apply as funding source for practice)				Estimated Number Served in SFY 09	Estimated Number Planned for in SFY 10
					Medicaid + Match	GRF (Not as Medicaid Match)	Levy (Not as Medicaid Match)	Other (Not as Medicaid Match)		
Integrated Dual Diagnosis Treatment (IDDT)	Appleseed CMHC	1882	1		Yes No	Yes No	Yes No	Yes No	30	35
Assertive Community Treatment (ACT)	Appleseed CMHC	1882	1		Yes No	Yes No	Yes No	Yes No	50	75
Intensive Home-based Treatment (IHBT)	Appleseed CMHC		1		Yes No	Yes No	Yes No	Yes No		
	New Beginnings at City Hill	10042	1(Satellite of OOCNTY)		Yes	No	No	No	140	154
Multi-Systemic Therapy (MST)	N/A				Yes No	Yes No	Yes No	Yes No		
Functional Family Therapy (FFT)	N/A				Yes No	Yes No	Yes No	Yes No		
Supported Employment	Appleseed CMHC	1882	1		Yes No	Yes No	Yes No	Yes No		
Supported Housing	Appleseed CMHC	1882	3 Sites/11 Units		Yes No	Yes No	Yes No	Yes No	15	18
Wellness Management & Recovery (WMR)	N/A				Yes No	Yes No	Yes No	Yes No		
Red Flags	Appleseed CMHC	1882	2 or 3 classrooms		Yes No	Yes No	Yes No	Yes No	60-90	60-90
Ohio Youth Risk Assessment (Teen Screen)	Appleseed CMHC	1882	2 or 3 classrooms		Yes No	Yes No	Yes No	Yes No	60-90	60-90
Crisis Intervention Training (CIT)	Board + Agencies + Community Partners	N/A	1 class trained		Yes No	Yes No	Yes No	Yes No	25	25
Therapeutic Foster Care	N/A				Yes No	Yes No	Yes No	Yes No		
Therapeutic Pre-School	N/A				Yes No	Yes No	Yes No	Yes No		
Transition Age Services	N/A				Yes No	Yes No	Yes No	Yes No		
Integrated Physical/Mental Health Services	N/A				Yes No	Yes No	Yes No	Yes No		
Older Adult Services	N/A				Yes No	Yes No	Yes No	Yes No		
Sexual Offender Services	N/A				Yes No	Yes No	Yes No	Yes No		
Consumer Operated Service	Lifeworx!	N/A	1	Lifeworx	Yes No	Yes No	Yes No	Yes No	70	80
Clubhouse	N/A				Yes No	Yes No	Yes No	Yes No		
Peer Support Services	N/A				Yes No	Yes No	Yes No	Yes No		
MI/MR Sepcialized Services	N/A				Yes No	Yes No	Yes No	Yes No		
Consumer/Family Psycho-Education	NAMI-Family to Family & Hand to Hand	N/A	1	NAMI Ashland	Yes No	Yes No	Yes No	Yes No	30	40

APPENDIX B:

Definitions and Evaluation Criteria for Completing Section VI 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 data systems (MACSIS, PCS, etc.) and by measuring outcomes as those identified in the Mental Health Consumer Outcomes System or the ODADAS Performance Management approach (outcomes framework).
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 data systems (MACSIS, PCS, etc) and by measuring outcomes as those identified in the Mental Health Consumer Outcomes System or the ODADAS Performance Management approach (outcomes framework). 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. This can be operationalized as the Ohio Mental Health Consumer Outcomes System, as defined in

The Ohio Mental Health Consumer Outcomes System Procedural Manual.¹ or the ODADAS Performance Management approach (outcomes framework)

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.²
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

1 <http://www.mh.state.oh.us/oper/outcomes/instruments/procedural.manual.pdf>

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

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.
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), 5119.61(H) and OAC 5122-28-04.

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.

Board Membership Catalog for ADAMHS/ADAS/CMHS Boards

Board Name		Date Prepared
Mental Health & Recovery Board of Ashland County		4-15-2009
Board Member J. B. Burns		<u>Appointment</u> ODMH <u>Sex</u> M <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 158 Glenwood Drive Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-289-2126 (Lifeworx)	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation None		<u>Mental Health</u> X Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term 07/01/06 - 06/30/10 (first term)	Year Term Expires 06/30/10	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Linda Cuzzolini		<u>Appointment</u> ODMH <u>Sex</u> F <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 852 Woodview Drive Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-281-7969	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation Religious Education Coordinator		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member X MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term 07/01/06 – 06/30/10 (second term)	Year Term Expires 06/30/10	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member John Leininger		<u>Appointment</u> County <u>Sex</u> M <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 288 TR 2602 Loudonville, Ohio 44842		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-994-4345	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation Retired, Ohio Cooperative Extension State University		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term 07/01/05 – 06/30/09 (second term)	Year Term Expires 06/30/09	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Ryan Emmons		<u>Appointment</u> County <u>Sex</u> M <u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 702 Keen Ave. Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-651-1765	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation Whitaker Myers		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional
		<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional

Term 07/01/08 – 06/30/12 (first term)	Year Term Expires 06/30/12	<input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<input type="checkbox"/> Advocate
Board Member Ed Fulton		<u>Appointment</u> ODADAS	<u>Sex</u> M
Mailing Address (street, city, state, zip) 940 Avalon Drive Ashland, Ohio 44805		<u>Ethnic Group</u> Caucasian	
Telephone (include area code) 419-289-0780		County of Residence Ashland	
Occupation Retired		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>	
Term 07/01/08 – 06/30/12 (first term)		Year Term Expires 06/30/12	
		<u>Representation: select all that apply:</u>	
		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input checked="" type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Tom Gaus		<u>Appointment</u> County	<u>Sex</u> M
Mailing Address (street, city, state, zip) 753 Co. Rd. 1775 Ashland, Ohio 44805		<u>Ethnic Group</u> Caucasian	
Telephone (include area code) 419-281-6805		County of Residence Ashland	
Occupation Hillsdale Middle School Principal		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>	
Term 07/01/06 – 06/30/10 (first term)		Year Term Expires 06/30/10	
		<u>Representation: select all that apply:</u>	
		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member John Guliano		<u>Appointment</u> County	<u>Sex</u> M
Mailing Address (street, city, state, zip) 2319 Creek View Court Ashland, Ohio 44805		<u>Ethnic Group</u> Caucasian	
Telephone (include area code) 419-651-9171		County of Residence Ashland	
Occupation Cornerstone Psychological Affiliates/ Emmanuel United Methodist Church		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>	
Term 07/01/08 – 06/30/12 (second term)		Year Term Expires 06/30/12	
		<u>Representation: select all that apply:</u>	
		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Dwight McElfresh		<u>Appointment</u> County	<u>Sex</u> M
Mailing Address (street, city, state, zip) 925 Thomas Drive Ashland, Ohio 44805		<u>Ethnic Group</u> Caucasian	
Telephone (include area code) 419-289-1048		County of Residence Ashland	
Occupation Telego Center for Educational Improvement, Director		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>	
Term 07/01/06 – 06/30/10 (second term)		Year Term Expires 06/30/10	
		<u>Representation: select all that apply:</u>	
		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate

Board Member Rebecca Owens		<u>Appointment</u> County	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 1913 Co. Rd. 655 Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u> Chairperson		
<u>Representation: select all that apply:</u>				
Telephone (include area code)	County of Residence	<u>Mental Health</u>		<u>Alcohol Other Drug Addiction</u>
419-368-3084	Ashland	<input type="checkbox"/> Consumer		<input type="checkbox"/> Consumer
Occupation Richland County Catholic Charities		<input type="checkbox"/> Family Member		<input type="checkbox"/> Family Member
Term	Year Term Expires	<input type="checkbox"/> MH Professional		<input type="checkbox"/> Professional
07/01/06 – 06/30/10 (first term)	06/30/10	<input type="checkbox"/> Psychiatrist		<input type="checkbox"/> Advocate
		<input type="checkbox"/> Other Physician		
Board Member Rebecca Osbun		<u>Appointment</u> County	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 202 Ferrell Ave. Ashland, Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
<u>Representation: select all that apply:</u>				
Telephone (include area code)	County of Residence	<u>Mental Health</u>		<u>Alcohol Other Drug Addiction</u>
330-464-5595	Ashland	<input type="checkbox"/> Consumer		<input type="checkbox"/> Consumer
Occupation Kingston of Ashland, Social Service Director		<input type="checkbox"/> Family Member		<input type="checkbox"/> Family Member
Term	Year Term Expires	<input type="checkbox"/> MH Professional		<input type="checkbox"/> Professional
07/01/06 – 06/30/10 (first term)	06/30/10	<input type="checkbox"/> Psychiatrist		<input type="checkbox"/> Advocate
		<input type="checkbox"/> Other Physician		
Board Member Pat Risser		<u>Appointment</u> ODMH	<u>Sex</u> M	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 154 Ronald Ave. Ashland ,Ohio 44805		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u>		
<u>Representation: select all that apply:</u>				
Telephone (include area code)	County of Residence	<u>Mental Health</u>		<u>Alcohol Other Drug Addiction</u>
503-655-2530	Ashland	<input type="checkbox"/> Consumer		<input type="checkbox"/> Consumer
Occupation Consultant		<input checked="" type="checkbox"/> Family Member		<input type="checkbox"/> Family Member
Term	Year Term Expires	<input type="checkbox"/> MH Professional		<input type="checkbox"/> Professional
06/26/06 -06/30/09 (first term)	06/30/09	<input type="checkbox"/> Psychiatrist		<input type="checkbox"/> Advocate
		<input type="checkbox"/> Other Physician		
Board Member Beth Ring		<u>Appointment</u> County	<u>Sex</u> F	<u>Ethnic Group</u> Caucasian
Mailing Address (street, city, state, zip) 2953 TR 659 Loudonville, Ohio 44842		<u>Officer</u> _____ <u>Hispanic or Latino (of any race)</u> Immediate past Chairperson		
<u>Representation: select all that apply:</u>				
Telephone (include area code)	County of Residence	<u>Mental Health</u>		<u>Alcohol Other Drug Addiction</u>
419-994-2123	Ashland	<input type="checkbox"/> Consumer		<input type="checkbox"/> Consumer
Occupation McMullen School		<input type="checkbox"/> Family Member		<input type="checkbox"/> Family Member
Term	Year Term Expires	<input type="checkbox"/> MH Professional		<input type="checkbox"/> Professional
07/01/08 – 06/30/12 (second term)	06/30/12	<input type="checkbox"/> Psychiatrist		<input type="checkbox"/> Advocate
		<input type="checkbox"/> Other Physician		
Board Member David Sanders		<u>Appointment</u> County	<u>Sex</u> M	<u>Ethnic Group</u> Caucasian

Mailing Address (street, city, state, zip) 1122 Cooper Drive Ashland, Ohio 44805		Officer _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-207-1741	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation Pastor		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term 07/01/06 – 06/30/10 (first term)	Year Term Expires 06/30/10	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Shari Shafer		<u>Appointment</u> <u>Sex</u> <u>Ethnic Group</u> ODADAS
Mailing Address (street, city, state, zip) 711 Hillcrest Dr. Ashland, Ohio 44805		Officer _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-289-3571	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation Teacher		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term 07/01/08 – 06/30/12 (second term)	Year Term Expires 06/30/12	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer X Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Member Gail Sweet		<u>Appointment</u> <u>Sex</u> <u>Ethnic Group</u> ODADAS F Caucasian
Mailing Address (street, city, state, zip) 177 Ronald Ave. Ashland, Ohio 44805		Officer _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-496-2274	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation Retired		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term 07/01/05 – 06/30/09 (first term)	Year Term Expires 06/30/09	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional X Advocate
Board Member Barbara Workman		<u>Appointment</u> <u>Sex</u> <u>Ethnic Group</u> ODADAS
Mailing Address (street, city, state, zip) 1024 Twp. Rd. 984 Ashland, Ohio 44805		Officer _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-289-3900	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation Samaritan Hospital		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term 07/01/07- 06/30/11 (first term)	Year Term Expires 06/30/11	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member X Professional <input type="checkbox"/> Advocate
Board Member Katie Wright		<u>Appointment</u> <u>Sex</u> <u>Ethnic Group</u> County F Caucasian

Mailing Address (street, city, state, zip) 115 State Route 42 West Salem, Ohio 44287-9613		Officer _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code) 419-869-7153	County of Residence Ashland	<u>Representation: select all that apply:</u>
Occupation Cinnamon Lake Front Gate		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term 07/01/06 -06/30/10 (second term)	Year Term Expires 06/30/10	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate
Board Name		Date Prepared
Board Member	<u>Appointment</u> <u>Sex</u> <u>Ethnic Group</u>	
Mailing Address (street, city, state, zip)		Officer _____ <u>Hispanic or Latino (of any race)</u>
Telephone (include area code)	County of Residence	<u>Representation: select all that apply:</u>
Occupation		<u>Mental Health</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> MH Professional <input type="checkbox"/> Psychiatrist <input type="checkbox"/> Other Physician
Term	Year Term Expires	<u>Alcohol Other Drug Addiction</u> <input type="checkbox"/> Consumer <input type="checkbox"/> Family Member <input type="checkbox"/> Professional <input type="checkbox"/> Advocate