

SFY 2010-2011 Community Plan
The Mental Health and Recovery Board of Wayne and
Holmes Counties

As submitted to and approved by:

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

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MISSION STATEMENT

We, the Mental Health & Recovery Board of Wayne and Holmes Counties, believe that the primary mission of this Board is to promote the development of a comprehensive and responsive system of mental health and substance abuse services for the citizens of Wayne and Holmes Counties. As the statutory substance abuse and mental health authority for its service area, our mission is to be accomplished through strong community leadership and through the planning, funding, monitoring, and evaluation of quality mental health services. In carrying out this mission, the Board subscribes to the following ideals and service philosophy:

1. The most effective services are recipient driven and place the person above the organization.
2. Since community needs change, establishing service and funding priorities is an ongoing process.
3. Resources shall be applied toward services that are measurably effective.
4. The Board advocates for the community it serves and demands accountability.
5. Prevention, education and treatment services are complementary, not mutually exclusive.
6. Effective services are accessible services for the community served.
7. A community worth living in looks after its own, in all its diversity.)

Vision Statement

VISION STATEMENT

We, the Mental Health & Recovery Board of Wayne and Holmes Counties, believe that the primary mission of this Board is to promote the development of a comprehensive and responsive system of mental health and substance abuse services for the citizens of Wayne and Holmes Counties. As the statutory substance abuse and mental health authority for its service area, our mission is to be accomplished through strong community leadership and through the planning, funding, monitoring, and evaluation of quality mental health services. In carrying out this mission, the Board subscribes to the following ideals and service philosophy:

VALUE STATEMENTS

1. That the Board is called upon in the discharge of its duties and responsibilities to take into account the broad mental health and substance abuse needs of all citizens.
2. That the Board bears a special responsibility for seriously troubled persons. Consequently, we believe a primary concern of the Board must be services for persons with severe and prolonged mental illness and substance abuse and persons experiencing major personal crises. We also hold that no one

shall be denied services because of severity of disability or resistance to treatment.

3. That early intervention and prevention programs are important and should be an integral part of our system of mental health and substance abuse services.
4. That the concept of a Community Support System, wherein persons are supported in their home communities, provides a sound basis upon which to plan and develop mental health services. We are committed to making a Community Support System a reality through the development of a network of services which responds to the full spectrum of needs for persons in our district who have mental health problems.
5. That the Board is an integral component of Ohio's mental health system, with special responsibilities to the Ohio Department of Mental Health.
6. That the Board is an integral component of Ohio's alcohol and drug addiction services system, with special responsibilities to the Ohio Department of Alcohol, and Drug Addiction Services.
7. That an effective community mental health and substance abuse system requires local planning and responsibility, responsiveness to community needs and characteristics, and the delivery of services close to home in a manner which insures accessibility.
8. That we are to be strong and forceful advocates for the mentally ill and victims of substance abuse. We believe that special responsibilities for community education and de-stigmatization are inherent in the role of the Board.
9. That community mental health and substance abuse is a broad community concern that can only be addressed through partnerships with schools, churches, criminal justice, social services, employers, family, friends, and many others.
10. That the Board, in being accountable, must take affirmative steps to ensure that decision-making processes are open and fair, that funds are spent prudently, and that management systems are clearly understood and equitable to all involved.
11. That non-discrimination in the delivery of services is essential. We believe that both the community as a whole and individual consumers are best served by a system which strives to make quality services accessible to all, regardless of economic circumstances.

Section I: Current Circumstances (State Required Wording – Pages 3-5)

The Mental Health and Recovery Board of Wayne and Holmes Counties 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 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 (SFYs) 2010 – 2011 (July 1, 2009 through June 30, 2011).

The requirements for are broadly described in state statute. In addition, federal requirements that are attached to state block grant dollars regarding allocations and priority populations also influencing. 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 a 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
- 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) Assessing service needs and evaluating the need for programs;
 - 2) Setting priorities;
 - 3) Developing operational plans in cooperation with other local and regional planning and development bodies;
 - 4) Reviewing and evaluating substance abuse programs;
 - 5) Promoting, arranging and implementing working agreements with public and private social agencies and with judicial agencies; and
 - 6) Assuring 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)

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

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

HIV Early Intervention Services

Eleven Board areas receive State General Revenue Funds (GRF) for the provision of HIV Early Intervention Services. Boards that receive these funds are required to develop 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.

Environmental Context for the Board Area and Clients Served

Board Area and Clients Served including recent trends such as changes in services and populations II.A.1 - The Mental Health & Recovery Board of Wayne and Holmes counties provides for Mental Health and Alcohol/Drug Addictions treatment, intervention and prevention service through 8 local non profit services agencies and a variety of special contracts for out-of-county services. The Board provides for these services through the use of state and federal revenues supplied by ODMH and ODADAS and a local 1 mil levy paid by the citizens of the

two county area. More than 6,000 individuals receive treatment services per year and nearly a quarter of the total population receives a prevention service.

The Board conducted further retrenchment of the services delivery goals originally stated in our FY08-09 s in FY09. Significant financial cuts were passed on to the community in order to respond to the financial budget cuts and balance our local budget. The largest portion of our lost GRF funds included cuts to the Counseling Center where SMD and SED consumers are served in both counties. The results of these cuts, both past and present, were of great concern to our Board, our consumers and family members, as well as, community partners. Even though we made tough, well thought out choices through an open community process, the future does not look promising with an economy that is continuing to stagnate. Unknowns about stimulus funding at the state level in both departments at this point only allow us to assume that these cuts will be carried forward into FY10-11.

While this paints a grim picture, we as planners and stewards of public funds, must continue to plan through challenging fiscal circumstances so we do not lose precious ground we have gained for the last 20 years. Ohio, as a home rule state, has been fortunate that most Boards have been able to pass local levies and use that non- Medicaid funding to create local, culturally appropriate programming and needed community support services for severely affected adults and children, such as housing for both MH and AOD consumers, as well as, recovery programs, wrap around services for children and adults, wellness recovery, family and consumer peer support and more. All these programs are now being threatened by an uncertain climate forced by declining revenue and also forced by the efforts of the state to respond to the larger statewide Medicaid funding crisis that is taking more and more from the state budget.

Behavioral health care is not the only element of the state budget that has been affected by the state's economy, nor is it the driving force for Medicaid expenditures, (just 3-5% of the overall Medicaid burden). Still, sweeping changes such as Medicaid Elevation and changes in the 408 formula are being accelerated to meet state funding needs. No one doubts that changes need to be made, but the question now is: what is the best mechanism for change to enable the system of Boards and the state departments the opportunity to make progress in spite of the difficult times and enable all concerned to not lose the progress of the last twenty years? It is our hope that both Departments will move ahead cautiously and engage their community partners and external customers as well, to make sure our investments in people's lives are not completely undone through lack of thoughtful planning in a rush to cure a problem that has taken years to unfold.

We here in Wayne–Holmes Counties are proud of our accomplishments, not only of the past biennium but ongoing, which we feel reflect progress toward the goals of consumer recovery. We started a monitoring process for agencies based on a

balanced scorecard model with quarterly feedback on issues of access, utilization, outcomes, management and cost effectiveness.

We have consistently been recognized statewide in both Counties for our work with our local Family and Children First Councils. This has enabled us to leverage additional dollars for children and families with severe mental health and AOD issues that we could not afford alone. We have embraced the expansion of EBPs in both prevention and treatment and continue to monitor the results of those changes. For example, with support from the Garrett Lee Smith research grant, we have SOS, an evidenced based teen suicide prevention program, operating in 10 high schools and 2 junior highs. Through this research model, we have shown that classroom teaching and screening is the most effective model for teen suicide prevention. We are leaders in the STAR SI and NIATX programs, which have resulted in changes in our AOD agencies including eliminating waiting lists and improving client engagement.

We have created a cost effective administrative services center, Heartland East that leads the state in report generation, plus problem solving and participation in statewide MIS issues.

It is important to us to continue all these partnerships to improve the lives of the citizens in our district who have addiction and mental illness disorders. An obligation that such partnerships carry with them, when funding is cut is that we must honor understanding that the responsibility for dismantling any of these services, is not ours alone We must consider our partners and this needs to be taken into account when making funding reductions not only locally but at the state level as well.

Wayne and Holmes Counties, Ohio share a contiguous east-west border in mid-north central Ohio. The two counties are home to a population of 156,000 people that are largely English speaking. Most of these descended from English, Irish, German and Scotch immigrants to America. Our largest ethnic minority is the Amish. They represent an estimated 23,000 individuals and speak English as a second language. The Amish culture is very successful economically and is based in a separatist religious model. Amish people tend not to participate in the activities of other groups, but their seclusion does not protect them from alcohol/drug abuse addiction or mental illness. Their culture is very strong in southern Wayne and Eastern Holmes counties and has a significant influence on the values of the general area.

The African American population is 1.6 % of the total, the combined Hispanic group is less than .8%, and Asian and others equal 1.9%. The area is peppered with small communities ranging from 300 – 25,000 in population and all of these have discrete family, church and community traditions for taking care of our own.

The history of our local economy is largely agricultural. Wayne and Holmes Counties' economy continues to have a strong farm economy, but as a point in fact only 3% of the workforce in the two counties is now employed directly on the farm. Economically, farming has been replaced by related commerce (Smucker's Jam/Jellies) and related light industrial manufacturing. The recent downturn in

the economy has had a negative impact on the plastic/steel related light industry here. Also the sense of permanence that went with the family farm has been changing as family generations no longer desire to continue to farm.

Behaviorally, changes in the economic base seem to increase strain on family and child care. Unemployment and underemployment is a problem now for individuals who are supporting families with the more marginal jobs associated with the less technologically competitive manufacturing concerns, i.e. machine operators, assembly, etc. The people who have depended on these jobs are generally less well trained technically than their peers in the more technical companies and their value in the employment market is low. The current unemployment rates in Wayne County, 9.6%, exceed both the national and state averages. Holmes County has a large amount of small, or cottage industries and the Holmes unemployment rate, 7.8% is lower than Ohio's current average, 9.4% and that of the nation as a whole, 8.1%. It is a struggle for parents to provide direction and a sense of future for their children, when they themselves are struggling to find this future. The local economic downturn started five years ago with the exit of Rubbermaid, and the current downturn is threatening more companies that were retail or auto related suppliers. As these companies leave the area, their middle and upper-class workers also have left. The number of school children in Wooster on reduced or free lunch jumped dramatically from FY 06 to FY09. Families, who cannot afford to move, stay here, and the local school system and social services agencies are noticing an environmental change in the schools with the amount of discipline and truancy.

The area is extremely scenic with many beautiful pastoral settings. Tourism around the Amish culture has become a major industry in eastern Holmes County. The people of the area keep up their properties, both out of pride and in an interest relative to the tourism. The horse and buggy culture, gentle rolling hills sprinkled with hay stacks, quality farms and homes and efficient looking factories are a pleasure to view. The religious traditions are varied including conservative, liberal Christian and non Christian denominations with many of these being literalist, faith based and strongly inclined towards church-centered lifestyles.

During the biennium the Board successfully replaced its one mil, 10 year, local levy. Pre levy research done by Oscar McKnight at Ashland University, confirmed the pious nature of our counties, when respondents said their personal beliefs supported the care of the least of their brethren. Respondents also admitted to caring about the health of their community and wanted to ensure services were available to all who needed them.

The AOD recovery community is strong in both counties, as the influence of Summit and Stark counties (the origins of the AA movement) is great. It isn't unusual for individuals to go to meetings throughout the area and have personal histories including attendance at the meetings in the larger, neighboring counties. It can be said that local AA groups are traditional.

Faith, belief and traditionally structured lifestyles are important here and people with those values often see recreational drug use, abuse or addiction as a challenge to, and failure of their traditional belief systems. Stigma against users occurs when illicit drug use or AOD use/lifestyles are cited as the cause of all lifestyle changes that are viewed as negative changes from the more traditional ones. Such changes in lifestyle are more related to economics (as was pointed out above), cultural mobility and changes stemming from new technology and its effects. In its last strategic planning session in FY 2007 the Board selected destigmatization of both mental health and substance abuse as a high priority. The new science of brain disease and finding positive ways to speak to a community in experiencing stigma are key elements in our plan to transform this role and speak to the general public in performance terms related to economy and the value of community. Professionals in the local AOD field struggle for recognition for their status as professionals due to the stigma. In the public's view alcohol and other drug treatment, intervention and prevention services are not highly differentiated, in the public's view, from social service professionals, particularly regarding funding and program development. AOD professionals tend to be lumped with all social services. When the value of all social services is being questioned, AOD providers suffer more. Generally the value questions that are being asked of the AOD field are these:

1. Why should the community continue to provide supportive care to alcoholics and drug addicts as their conditions are perceived to be the result of poor decision making?
 2. What is the added value of these specific services to the community?
- Characteristics of Clients Receiving Substance Abuse Prevention Services

II.A.2.a - PREVENTION:

AOD prevention services were provided as universal, selected and indicated interventions during FY07 & 08. As the chart titled, "The Wayne/Holmes AOD Demographic Chart" in the Upload Section indicates, the largest amount of these services has continued to be with universal. However, the Board has developed a plan for developing a System of Care focused on Intensity of Need which includes moving prevention to selected/indicated populations. It is the Board's position that prevention should be viewed as a risk reduction strategy; and that selected and indicated services should be targeted towards reducing risk in target populations that are fundamentally connected to the Board's highest intensity treatment risks. In this way, prevention will be seen as directly associated with risk and, therefore, function in an integrated way within our system.

Characteristics of Clients Receiving Substance Abuse Treatment and Recovery Support Services II.A.2.b - Characteristics: The information on the following chart regarding Client Characteristics was taken from several sources, i.e. the FY 08 Annual Reports provided to the Board by Alcohol and Other Drug Treatment and Prevention Service providers who were under contract to the Board during that period and was included in the 06 Update; from information available to the

Board from automated reports taken from MACSIS and the ODADAS MACSIS information. There were a few differences noted between the numbers in these reports.

TREATMENT: The Wayne/Holmes AOD Demographic Chart in the “Upload” section depicts a customer characteristic that is majority male, white and between the ages of 18-55. The majority of the people treated are of European descent, with African and Asian Americans being the other significant racial groups. This characteristic is typical of what we have seen here over the years. Data also reflects that the majority of those serviced come specifically from the larger cities and towns, but that over half the customers live in either small towns or in rural areas. While there are always comments about how transportation affects access, the patterns indicate that customers do access services from all parts of the two county region. This does not mean that all potential customers have access. The percentages of male/female and adult/youth suggest that women and youth are underserved, and this may reflect cultural barriers, as well as access to transportation.

Characteristics of Clients Receiving Mental Health Prevention, Consultation & Education (P, C&E) Services including Crisis Intervention Teams

II.A.2.c –

As our census figures and MACSIS data and agency reports reveal, Wayne and Holmes Counties are largely homogeneous in their ethnicity, primarily white. As a result, Mental Health Prevention and Education Crisis intervention, consultation and serve primarily a white clientele.

Our largest minority of non English speaking persons is the old order Amish. We have no way to track these individuals by creed. We have two agencies who provide mental health education and prevention; the Counseling Center of Wayne and Holmes Counties, our primary mental health center; and Every Woman’s House, our domestic violence provider. Over 80% of the mental health education and prevention provided by these two agencies are to children under age 22, often in a school setting. Most services involve the use of an evidence based practice, such as suicide screening, or work with indicated populations; such as children in SBH classes. Less than 5% of prevention is provided to universal audiences. We do offer Amish “Family to Family” classes and hold a monthly Amish family support group as well. These services are coordinated through the Counseling Center and the Wayne Holmes Mental Health Coalition. The WHMH Coalition consists of our local consumer group, the NAMI chapter and Suicide Prevention Coalition.

Wayne Holmes has one of the oldest established 24/7 crisis response services in the state. In 1970 the Counseling Center initiated the innovative model of clinicians riding with police and offering a mobile crisis response service unit, which the rest of state eventually copied. Our system enjoys an excellent relationship with local doctors, law enforcement, clergy and other professionals

as well as, the general public for their prompt and judicious response to crisis requests.

For service statistics to these populations (Please see the file uploads titled Profile of the 3489 Wayne/Holmes Adults and Children served - SFY 2008-3-09; and Profile of the 3489 Wayne/Holmes Children served - SFY 2008-3-09) In FY08 crisis services were given to the following break out by age, race, and gender. See the Uploaded file titled Crisis Services Stats Race and Age.

Characteristics of Clients Receiving Mental Treatment and Recovery Support Services II.A.2.d –

Census data and MACSIS data reveal that mental health treatment and recovery services are typically delivered to a mostly white population in both counties.

The uploaded chart, Wayne Holmes Race Scorecard, compares census data to rates under treatment data and highlights areas represented in our local client caseloads per population estimates.

We also prepare quarterly reports that are run by Heartland East that reveal the ethnicity, age, ability to pay, amount of services delivered by county and by contract agency. These are reviewed as part of an overall CQI strategy. There is a table for all MH clients and one for adults and kids separately. See uploaded Profile of the 3489 Wayne/Holmes Adults and Children served - SFY 2008-3-09; and Profile of the 3489 Wayne/Holmes Children served - SFY 2008-3-09)

II.A.2.e Mental Health Crisis Care Services Question

Available In SFY 09?

Planned For SFY 10?

Community Resources & Coordination

24/7 Hotline No No

24/7 Warmline Yes Yes

Police Coordination/CIT Yes Yes

Disaster Preparedness Yes Yes

School Response Yes Yes

Respite Beds for Adults No Yes

Respite Beds for Children & Adolescents
(C&A) Yes Yes

Face-to-Face Capacity for Adult Consumers

24/7 On-Call Psychiatric Consultation Yes Yes

24/7 On-Call Staffing by Clinical Supervisors Yes Yes

24/7 On-Call Staffing by Case Managers Yes Yes

Mobile Response Team Yes Yes

Central Location Capacity for Adult Consumers

Crisis Care Facility Yes Yes

Hospital Emergency Department No No
 Hospital contract for Crisis Observation Beds No No
 Transportation Service to Hospital or Crisis Care
 Facility Yes Yes

Face-to-Face Capacity for C&A Consumers

24/7 On-Call Psychiatric Consultation Yes Yes
 24/7 On-Call Staffing by Clinical Supervisors Yes Yes
 24/7 On-Call Staffing by Case Managers Yes Yes
 Mobile Response Team Yes Yes

Central Location Capacity for C&A Consumers

Crisis Care Facility No No
 Hospital Emergency Department No No
 Hospital contract for Crisis Observation Beds No No
 Transportation Service to Hospital or Crisis Care
 Facility Yes Yes
 Community Resources & Coordination - Other
 Face-to-Face Capacity for Adult Consumers - Other
 Central Location Capacity for Adult Consumers - Other
 Face-to-Face Capacity for C&A Consumers - Other
 Central Location Capacity for C&A Consumers - Other
 Board plans to address any gaps in the crisis care services indicated by ORC
 5122-29-10(B):

II.A.2.d.i –

We have one child psychiatrist who is available two days a week locally. We can access her for crisis emergencies 24/7. We feel we have one of the best crisis response teams in the state and have been a long term leader in this area.

We have two of the largest children's residential providers in the state in our district: The Village Network and Christian Children's Home of Ohio. They routinely have children from other counties in their care, that at age 18 decide they no longer want to stay in care. These children leave these institutions and end up quite often in local shelters and requiring crisis services. The Board has had dialog with Carol Hernandez, Deputy Director at ODMH about the need to address this issue of transitioning SED youth statewide. We also have a capital grant request into ODMH to build durable housing with respite care aimed at this population to try to help stabilize them. In our opinion, this issue of transitioning youth from the child MH system to the adult system has implications for crisis services planning statewide.

Identification and prioritization of 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 –

We have one agency, the Counseling Center, who provides 24/7 crisis response. All clinical staff are trained in Non-Violent Crisis Intervention every year (four hour training provided by clinicians Mike Hamill and Mark Weaver). Each is also trained in first aid every two years and is certified in CPR. At the time a new employee is hired, he or she receives extensive training prior to being authorized to provide crisis services. To bill for a crisis these individuals must attend a training currently provided by Diane Myer, LPCC our Director of Emergency Services. The training includes risk assessment, mental status evaluation, procedures for voluntary and involuntary hospitalization, and community resources. Each crisis worker is also provided with a list of community resources to carry at all times.

This training information is monitored on a spreadsheet by the agency to assure that staff training is kept up to date. The dates for training renewals from this spreadsheet are posted throughout the agency on a regular basis. Each staff member also has computer access to their own training data 24 hours a day. Prior to the required training becoming delinquent, clerical staff also notify staff of the required renewal.

Capacity to Provide Services**Access to Services**

Access to Alcohol and Drug Prevention and Treatment Services

II.B.1.a –

Transportation is clearly one of the most significant access issues in this region. There is no public transportation system of any kind. System agencies currently have satellite offices in three cities outside of Wooster, the County seat of Wayne County, for MH and AOD services. All of our contract agencies provide services in both Wayne and Holmes Counties. We pay through our business plan for consumers who receive out-of-county non-Medicaid services up to a limit, with a special request process if services are to continue beyond that limit. Private drivers, local ODJFS, and hospitals provide transportation for consumers as do CPST workers and case managers, to get consumers to needed services. Our consumer group provides transportation vouchers to members who need rides to activities.

Lack of certain, available Levels of Care (LOC) is also an issue; however the Board acquires these by outsourcing most often through FCFC service coordination for kids. The Board's business plan allows citizens to access out-of-county services that are non-Medicaid funded, if appropriate to their plan of care and not available in the County. We have a VA sponsored veterans counseling office in Wayne County for veterans of both counties to access VA provided counseling. Our local agencies accept Tri Care insurance and serve veterans. We have an ADA service broker fund at the Board that agencies can draw upon to hire interpreters for deaf, hard of hearing and foreign language interpreters.

Access to Mental Health Prevention, Recovery Support, and Treatment Services

II.B.1.b –

Our Board is suffering from the same shortage of psychiatrists the whole state is experiencing. We currently have a vacancy for 8 hours of psychiatric time that we have been unable to fill for two months. Whenever this happens we end up with a substantial waiting list for adult psychiatry. As mentioned earlier we are under capacity for child psychiatric services, and parents often take their children to neighboring counties to see this specialty. As a result of shortages we triage people in pharmacological management services. Persons in crisis are addressed first and regular cases scheduled. First time appointments take more psychiatry time and are fit in as time allows.

To address this issue in FY09, we began a dialog with the Margaret Clark Morgan Foundation and SUMMA psychiatric services in Akron. The purpose was to assess our ability to recruit and train Primary Care Physicians (PCPs) to help reduce waiting lists. Our goal is that these will agree to see more stable patients, administer medicines, and continue to follow them. This effort will involve developing training through CMEs, support via consultation or telemedicine, and linkage with CPST workers and outpatient counselors at the Counseling Center. We are hopeful about creating this joint effort between mental health and physical health. We will be monitoring improvements in physical health outcomes, as well as, for consumers who opt for this program. This will be developed more in FY10-11.

Board staff are working with the local general hospital on joint recruitment efforts to attract additional psychiatrists to the area. Our Board also continues to maintain our designation as a J-1 visa shortage area. We have benefited in the past from the commitment of a J-1 doctor who served our area for three years. Unfortunately once their obligation is finished these do not want to remain at a community mental health center or seek higher pay and benefits than a rural center can offer; therefore they relocate, leaving us with a full time vacancy to fill.

Workforce Development and Cultural Competence

II.B.2.a –

Workforce Development takes dollars, vision and a sense of purpose/future to recruit and maintain quality providers. This includes providing good working conditions, input into the development of direction and service deliver strategies. It is a struggle to maintain these. It is true that competent people, pursuing their vocation, are willing to make sacrifices to accomplish their goals. This isn't always easy to do.

All contract agencies are also licensed to be providers of CEUs for counselor and social workers and/or chemical dependency counselors. They typically provide regular in-service training to their staff to keep them abreast of current trends in service provision, as well as, meet certification requirements for cultural competency training, crisis training, risk management training etc. In addition, the

Board supports culturally competent staff development through a program called FIT, Free In-service Training, in conjunction with Your Human Resource Center. FIT offers monthly 1.5 units of CEUs for free to any staff person and is operated in both Wayne and Holmes Counties. The local AOD agencies continue to have relatively low staff turnover rates, based on their reports, with some exceptions in the area of prevention services. This was particularly true in FY08. Both agencies have done well in keeping staff with treatment and prevention credentials.

In mental health, staff turnover is more problematic due to competition from larger markets offering better pay, is a deterrent to retention. In order to recruit qualified licensed clinical professionals, the agencies often retain staff that chooses to commute from surrounding areas due to the fact that our rural counties do not have the population to support local development of these credentialed staff. Commuting can get tedious over time and this affects staff longevity. (For comments on psychiatry shortages see section.

II. B. 1. b above).

We also have specialty residential children's agencies; The Village Network and Christian Children's Home, who find it hard to recruit house parents, treatment foster care homes, and CPST workers due to the unique nature of these jobs and the severity level of their clientele. In addition, in FY08 and FY09, we continued to see a trend in increased absenteeism and use of FMLA at our largest agency, which affected client caseloads and expected productivity.

In the past, the Board has noted three problematic market dynamics around workforce development, and these continue today as noted below:

1. The downturn in both the local and state economy. In past years the Board has been able to provide a Cost of Living Adjustment (COLA) to the agencies which has been passed on to the local agency workforce. State budget cut, during FY09 and their continuation in FY10 reflect this downturn and, the Board can no longer provide COLA increases for its contracts. One result is that agencies are decreasing their staff development funding.
2. AOD and MH professional salaries locally are lower than nearby urban areas
3. Local programs are often driven by staff personality. It is not unusual to see the development of a specialty staff position for intensive home based counseling or a prevention EBP provider recruited by another agency or county for these developed skills. These losses are predictably followed by lengthy replacement and training periods which have the effect of reducing service delivery.
4. The retirement of baby boomer aged staff.

In addition to market dynamics and reductions in funding affecting the workforce, the Board had concerns about the following as well:

1. How to find knowledgeable service providers that are capable of delivering science and evidence based services

2. How to promote quality over quantity as a means of allowing salary rates to rise in a system that would follow outcomes.
3. Promote the use of grants and advocacy as a means to achieve higher pay rates.
4. Advocate the value of having a workforce that is oriented to promote the value of being drug free with businesses and other key elements of the community infrastructure
5. Retaining staff whose performance enhances our local system of care model.
6. Promote a system of care that enables agencies to attract revenue from additional sources, and in turn, view each other as resources rather than as competitors.
7. Hire staff that are open to scrutiny and evaluation.
8. Workforce development efforts should focus on partnership with the state system in promoting, developing interacting with state and national legislatures, partnering with foundation, or corporate partners as a means to attract other investments to maintaining our workforce.

II.B.2.b.1 –

The response that appears here in II. B.2.b.1 applies to all of the above sections listed from ii.B2.b.1 to II.B2.b.3 As stated earlier, the Mental Health & Recovery Board monitors the race, age and gender mix of its constituents quarterly to observe and adapt to any changing trends. The most stable racial factor is our mostly, white homogeneity. Typically minority populations, as per the census, remain below 1% in both counties with only African Americans at 1.6%. Despite smaller percentages of ethnic diversity we continue strategies to address racial diversity as well as handicaps, age and cultural differences of our local populations.

In the case of race/culture, all agencies perform annually cultural competency training that relates to the populations they serve. This has included Hispanics, African Americans, the Amish, Appalachian and Asian cultures. The frequency and topics of those trainings are filed and reviewed as part of agency QA reports.

The Board maintains a fund that agencies can access to provide interpreters for foreign language, or for the deaf or hard of hearing, as needed.

As mentioned above, the Board routinely monitors “rates under treatment” information and works with Heartland East (HE) to examine any large trend changes. The largest increases recently are an influx of Hispanics who work in the local chicken processing plants. Their numbers represent less than 1% of the local population; however, they account for the largest increase in minorities served in our system in the past year. Their primary service is substance abuse treatment and the majority is English speaking; therefore our interpreter services have been used sparingly.

Our largest ethnic minority is the Old Order Amish accounting for over half the population of Holmes County, approximately 23,000 people. Since 1989 the

Board has, through levy funds, provided a CPST worker who speaks Pennsylvania Dutch, and works exclusively with the Amish population. The Board works with a local representative of the Amish culture, Daniel Weaver, who is trained in NAMI's Family to Family curriculum. Daniel provides an Amish speaking Family to Family class in Holmes County. The Board funds an Amish family support group that meets monthly. The Counseling Center has maintained an Amish Bishops advisory group, to discuss policy or new programs.

In FY10-11, Daniel Weaver has approached the Board to help him start an Amish lead consumer support group that would host regular meetings to do culturally appropriate work or activities for men and women. The office of Veteran's Affairs (VA) have a local counseling office for returning veterans in Wooster. That office has been holding specialized training for any social workers/counselors dealing with returning veterans. Our local agencies do accept TriCare veteran's insurance. The Board has a mental health forensic monitor that works with the court and prisons to connect ex offenders to treatment. Our AOD agencies have treatment programs for incarcerated adults and youth. These include jail based intensive AOD treatment and linkage to community agencies once released.

Finally, the centerpiece for the Board's F10/11 is to create a system of care that is organized around Intensity of Need (ION). In FY10-11 the Board will be organizing capacity around need, with priorities based on intensity, urgency and clusters, along with prevention to a complete system of care built around need and risk reduction.

Clearly, cultural awareness is a part of assessing intensity, and the sensitivity involved with assessing need is critical for accurately assigning individuals to the correct level of care based on need. The Board holds, in developing this plan, that capacity will be organized around an intensity of need (which usually requires matching to service intensity) which incorporates cultural sensitivity as a core element in assessing the need of intensity.

The Board further holds that its Mental Health and Alcohol and Other Drug Services need to be integrated, both because there is much cross over in the client populations, and because the risk reduction strategies are very similar. This model is consistent with several other of the major service planning processes currently being used in Ohio, i.e. the ODADAS Levels of Care Treatment Planning and the Cluster Based ODMH pilot which address different levels of need with different intensities of similar services; and the approach to prevention that uses universal, select and indicated service approaches to target prevention services.

The Integrated Intensity of Need (ION) system is more fully explained in Section VI. Evaluation.

II.B.2.b.2 - See the response that appears in II. B.2.b.1 applies to all of the above sections listed from ii.B2.b.1 to II.B2.b.3

II.B.2.b.3 - See the response that appears here in II. B.2.b.1 applies

to all of the above sections listed from ii.B2.b.1 to II.B2.b.3

II.B.2.b.4 - See the response that appears here in II. B.2.b.1 applies to all of the above sections listed from ii.B2.b.1 to II.B2.b.3

Capital Improvements

II.B.3.a –

The Board is currently working with local agencies to pursue a variety of capital grants. In FY09, ODMH notified the Board, that it would fund a capital project request for the biennium for durable housing for transitional youth. This notification came in December with a response due in January. At that same time, funding cuts were made and shovel ready stimulus plans announced. The Board worked with ODMH capital staff to consider how we might couple “shovel ready dollars” as match for the capital request. Our lead agency, the Counseling Center, already has a shelter care plus grant to provide vouchers for homeless young adults who would reside in this facility for the next five years. We will continue to work cooperatively with ODMH on this project into FY10-11.

The Board submitted, under the shovel ready stimulus initiative website:

ohiorecovery.org, a request for funds for a drop-in/clubhouse to be run by consumers. Consumers tell us they want a place they can control and program themselves. They are just beginning to gather information about models in other communities. They know they have to find their own funding or locate a donated space for this project due to our budget cuts. Should stimulus monies be available for purchase of the clubhouse space, this would greatly aid this effort.

In the late winter of FY09, ODADAS issued a notice for capital repair and renovation grants. The Board is advocating that one of these be allocated to STEPS at Liberty Center for improvements to the women’s residential treatment facility.

STEPS at Liberty Center is one of only two publicly funded Alcohol and Drug Treatment agencies in Wayne and Holmes Counties. STEPS is the only one of the two that offers residential treatment services and Beacon House is the only Women’s Residential Treatment Facility. Beacon House is located in a neighborhood in Wooster at 732 Spink Street. The location is comfortable, but the house is old, typical of the neighborhood. The wear and tear on the facility, plus its utility as a residential treatment facility, makes it a good investment for a capital grant at this point. The capital request is to undertake an extensive repair and remodeling of this facility. The remodeling plan features making the facility more energy efficient in order to save utility cost. The agency will need to find capital support for this project from some source, which makes this ODADAS capital opportunity fortunate and well timed. The agency has recently completed a major fund drive for community contributions to purchase and develop its men’s residential treatment center; therefore, this request to ODADAS seems balanced.

Financial Status Impact of reduction in services.**II.B.4.a –**

The Wayne/Holmes Board undertook a rigorous budget reduction process starting in December of 2008 to prepare for and conduct a budget cut that would reflect the 10% state ODADAS-ODMH reductions. The Board specifically designed the process to include contract agency providers, Family and Children First Council representatives and consumers. The budget reductions that were required by the Board were made more difficult due to the fact that the plan needed to include a means to reduce a deficit in the Board's budget that existed prior to the state cuts. The process approached the reduction problem by addressing expense reductions and strategies to increase revenues. Ultimately each contracting agency, other than those agencies that are Medicaid only, were asked to make a cut. Agencies and constituencies were asked to recommend areas of potential reductions.

Input about the ODADAS/ODMH Non Medicaid revenue percentage that the agencies received through their contract with the Board was also taken into account for the final recommendations. This percentage did not include the special project grants that pass through the Board to the agencies outside of the Board's basic decision making process. The effect of these cuts was different for each of the agencies affected. STEPS at Liberty Center pared back expenditures over all its treatment services and did not have to make any personnel cuts. Your Human Resource Center (YHRC) made personnel cuts, by eliminating one FTE and cutting another one back to .5 FTE. It should be noted here, that both of these two AOD agencies (STEPS and YHRC) had already suffered major cutbacks just prior to the beginning of the fiscal year, due to losses of large federal drug abuse and a state tobacco grant. Each of these losses reduced their staffing by 3 FTE's.

The largest contract provider of the Board, the Counseling Center, a MH agency only suffered the largest cuts and closed three programs, Partial Hospitalization, Social Recreation and Employment. This reduced their staffing by a combination of 17 full and part time positions. The Board's decision was to cut services to severely mentally ill adults based on consumer input, outcomes and cost benefit analysis, and agency recommendations. The partial and social recreation these programs served was no more than 25 adults at a time. All persons in these programs were also enrolled in other agency services and community programs. The efficacy of these programs was marginal with some consumers staying for long periods in partial or in social recreation and not moving forward in their recovery. The Board, in conjunction with the local consumer group, is also working on more peer support recovery activities to replace social recreation such as a drop in center.

For employment, we had already been alerted that our consumer employment outcomes were not met due to no available employment. This program was totally funded with 505 GRF funds and those were the funds reduced by ODMH.

The Director of the program has been retained in another position, and more than any other program, the employment program could be brought back quickly as it is easier to recruit non licensed staff should new funding options open up. In the meantime, we can refer clients to BVR and Goodwill and have CPST workers work with consumers on reaching their employment goals.

In addition to these cuts, a temporary reduction in the percentage of funds the Board would contribute to FCFC service coordination plans was renegotiated by the Board with the Family and Children First partners in both counties. This gave the Board needed budget relief and avoided the above reductions becoming larger. The Board also expects agency and Board under spending in FY09, which will create budget relief to stabilize our reserves.

Due to the budget reductions, and with input from all constituencies, we are reconsidering how we organize our thinking in an environment of shrinking resources and uncertainty. Therefore, for FY10-11, we are setting out an ambitious agenda to retool our local system of care using these concepts: intensity of need, maintenance of recovery, cost effectiveness, consumer responsiveness (which includes: access, availability, consumer input, satisfaction and outcomes) and service clusters. The Board envisions this to be a more responsive system of care that reflects intensity of need, and risk reduction, and more rational criteria for making future spending adjustments. This dovetails well with our participation in the ODMH cluster based services pilot and places more emphasis on natural peer and community supports. All of this depends on the availability of future funding.

Factors contributing to the costs of services.

II.B.4.b –

There are many reasons that our costs have risen in recent years: rising employee health care costs, fixed costs rising, demand for licensed qualified personnel, urban competition with higher staff compensation, costs of transportation built into service delivery unit costs, new technology hardware and software costs at almost every agency, staff turnover and retraining time, lack of supply of specialists e.g. in home workers, crisis workers and psychiatrists, and the volume of methadone and medical detoxification services increasing. What cost-saving measures and operational efficiencies.

II.B.4.c –

The Board in its deliberations of what programs to reduce did look at those with less cost efficiency and effectiveness. We reduced expensive programs that had high costs due to transportation and high staff to client ratios, in partial and social recreation. In employment, clients were not obtaining employment in a timely manner and the Board did not want to just buy employment readiness units. Instead it retained the Director of this program and has encouraged CPST workers to help clients with readiness issues and hope to find another source of funding for employment or partners to work with to create job opportunities.

Contract agency efficiencies were realized from reductions in administrative overhead. Two agencies are entering into talks about possible joint programs or merger which could reduce even more overhead. Another agency was able to realize considerable cost savings by reorganizing its administrative services.

Family Council partners are committing a larger share of funding to service coordination plans. Family Council Diversion teams are making a concerted effort to reduce expensive out of home placements and use wrap around, family resource specialist and home based treatment where possible to reduce costs of care.

The Board has participated in a multi county agreement to use a shared administrative services center, called Heartland East, which is located in Stark County as part of the Stark MHRB offices, since the beginning of MACSIS. Heartland East provides the Board tremendous efficiencies while producing some of the best monitoring tools and reports in the entire state regarding evaluation and claims processing. The rest of the state could possibly benefit from this model and reduce costs to individual Boards. Heartland East has openly offered to help any Boards who want to pursue their model. This type of administrative services center is a smart way to reduce Board overhead regionally without losing the advantages of home rule, local oversight and consumer/agency accessibility to management.

In FY08-09, the Board researched and implemented a new best practice Opioid detoxification process using suboxone or Buprenorphine to manage opiate detoxification to reduce these costs. As a result, the Board is no longer recommending inpatient opiate detoxification is funded.

Other budgetary planning efforts.

II.B.4.d –

The Board's leadership has moved other funders in the community to invest in AOD and MH services because they realize that they are getting a good bargain due to the quality management and the percentage of cost that is being underwritten through the Board in these arrangements.

There is a complex relationship between the Board, local providers and these other funders, i.e. United Way, DJFS, Commissioners, Juvenile/Adult Courts and 3rd party payers. Locally, standard conventions and networks for doing business along the lines of trusted partnerships require many years to develop. While these partnerships are both formal and informal, the net result is that these partner funders have developed trusted working relationships on these ventures. There is almost cyclical understanding or predictability about trends with these funding partnerships over the years. This has led to a process in which the Board's local planning efforts anticipate these trends and adjust to them when possible.

Historically, discretionary grants from the various funding partners have been generally steady over the years. Generally speaking, income from self-paid fees

and insurance has increased over the long run, though during the last three biennia, income from client insurance coverage has decreased, largely due to changes in the coverage patterns and to managed care. In many cases where vital programming has been disrupted by changes in this informal equation, the Board has been able to replace losses with its local levy dollars or other grants (note above under workforce).

Today it is clear that our local service economy is deeply affected by the general economy of the state. This is becoming an increasing source of concern and discontent. There is no element of the infrastructure that hasn't felt the impact of the slowdown in the Ohio economy and the subsequent losses in tax revenues that translate into reduced operating funds for various services.

The result of shrinking resources has lead the Board to rethink how it will proceed with the allocation of limited funds. This effort was begun in FY09 at the Board planning retreat where it was discussed that our system of care may have to change to adapt to the changes in funding support. The Board plans in FY10 to put forth a services model of Intensity of Need (ION) across all levels of care in MH or AOD. Agencies are being asked in their FY10 applications to arrange their services array in a grid that reflects ION and begin a dialog with the Board along with internal and external customers about how our local system of care can evolve into a system that still ensures a safety net exists for citizens in need.

This will provide a rationale for any future funding reductions that may occur in FY10 or 11.

In addition to planning reductions, the Board also formed an ad hoc committee on revenue generation that is working on alternatives from grants, levies, fund raisers and market penetration. Specifically this included converting Medicaid eligible customers, who receive our services but are not currently enrolled. The Board had Heartland East prepare reports for each agency so they could see how many of their clients were served by Medicaid and those who were not. Each agency felt they could increase the enrollments of clients in Medicaid for FY10 by at least 5%, if not more. There are people in our community who are reluctant to utilize available Medicaid funds due to valuing their independence from governmental interventions.

The Board has arranged through the Wayne County DJFS office to do a system wide training on how to enroll or help clients enroll in Medicaid. This will include Medicaid buy in and acting as a client authorized representative for those who may be too hesitant to go to the DJFS office by themselves. The Board would realize budget relief for each local dollar replaced by a Medicaid dollar. Even with the current FFP of .6214 our system could garner, we estimate, \$125,000 to offset state and levy dollars currently spent. If the FFP increases as suggested in the stimulus plan, then the additional 6.2 cents would make this amount increase even higher. Enrolling more clients in Medicaid also allows them access to other Medicaid funded medical care they may not be currently able to afford.

Tables 1 and 2: Portfolio of Providers

Section II: Capacity Development

Access to Services

The Mental Health & Recovery Board of Wayne and Holmes Counties holds that its mission is to meet its legal requirements by promoting the development of a comprehensive and responsive system of mental health and substance abuse services for the multi ethnic rural/suburban culture in this area. The strategic priority of the Board is to destigmatize mental illness and alcohol/drug addiction as related and treatable neurobiological brain diseases from which individuals can recover their place in the community without moral conflict or shame. The approach has been integrated into all services and activities supported by the Board.

The retrenchment experienced in FY09, due to the state budget crisis, has caused the Board to make this plan an integrated means to maintain the financial viability of our system. Equally, the plan is a means to preserve the service and workforce capacity that the Board has been developing since 1988 by passing/maintaining a 1 mil local levy, maximizing Medicaid, and building collaboratively sponsored service funding solutions in the community. Along those lines, the Board's FY 10/11 is designed to:

1. Enhance service quality and pursue a progressive orientation to service delivery.
2. Develop leadership and support organization efforts among families and consumers.
3. Develop a needs-based System of Care (SOC) through partnerships with contracted agencies and the broader community in the spirit that was used to build the TOGETHER grant submitted to SAMHSA earlier this year.
4. Assess need collaboratively by surveys, analysis of data, and by intensity.
5. Create a seamless prevention/intervention, treatment and recovery services based on a system of care grid that combines AOD/MH neurobiological need by Intensity of Need (morbidity and urgency).
6. Reduce risk through creative uses of Psychiatric/Medical Services, Crisis Teams, Service Coordination and Evidence-Based Prevention services aimed at selected and indicated target groups.
7. Use of Process Improvement and Continuous Quality Improvement systems which are available within/through the agencies under contract with the Board.
8. Evaluate services and initiatives by the use of performance targets derived from the Board's priority service populations and domains as they align with those of the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services.

Workforce Development and Cultural Competence

The Board plans to continue to pursue the consumer access and workforce issues already described in the plan in sections II. B. 1. a and II. B. 2.a.(See

those sections for details) In addition to those plans the Board continues to monitor, through its CQI process, customer satisfaction through review of agency annual reports, satisfaction surveys, monitoring of consumer complaints, and incident reports.

Due to reductions in programming, the Board plans to work with our local MH consumer and family agency, the Wayne Holmes Mental Health Coalition and the newly formed OASIS, an AOD consumer run social club, to find avenues to address access issues and service losses such as social recreation through the use of more consumer operated services and natural community supports. The Board plans to continue its line item that agencies can draw upon for language or deaf interpreters or other ADA accommodations. The Board plans to continue to be part of the pilot cluster based analysis ODMH project to develop service packages around clusters of like treatment traits and levels of need for MH consumers to address treatment disparities and more cost effective interventions.

Capacity Development Targets

C.1 - CAPACITY DEVELOPMENT:

The Mental Health & Recovery Board of Wayne and Holmes Counties defines capacity goals both numerically, as organizing resources (community and its own) and as potential (the ability to meet goals). The metric capacity goals of the Board relate to maintaining quality access for age, ethnic, racial and gender targets, individuals experiencing barriers due to culture, the isolation that is sometimes implicit in the rural environment, lack of access to web based information and training systems and diversity in the workforce. Maintaining and developing a system of care that has quality potential is important. The potential for quality is as is exemplified through the use of evidence-based programs, best practices, use of data in decision making and interfacing with the key elements of the community's infrastructure, i.e. the family, education, health and the work place. The following four goals were identified as a Board strategy retreat in FY07 as areas of special concern for the Board. They continue to be consistent with the Board's efforts to create a streamlined system of care which is based in urgency, the intensity of need and risk reduction.

- I. Addressing issues of stigma and discrimination
- II. Maintaining the financial viability of our system
- III. Enhancing service quality and pursuing a progressive orientation to service delivery.
- IV. Leadership Development

These goals represent areas where the Board is facing new challenges and/or where additional efforts appear to be necessary and appropriate for the Board to fulfill its mission in the context of today's world. Below each of the goals is stated with a list of process type outcomes that were taken from the retreat.

(One) - Addressing issues of stigma and discrimination – The struggles of individuals and families who are affected by mental illnesses and diseases of

addiction are made immeasurably more difficult by the burden of misunderstanding and discrimination our society continues to place upon them. As a consequence, persons needing help avoid seeking it, those affected by these conditions are frequently isolated, impoverished and misunderstood, and insufficient resources are available to afford adequate help to those in need. Efforts of the Board to confront these issues will be characterized by the following:

- o Organized and comprehensive campaign (smart, effective and designed for the long run and ideally part of a larger statewide effort).
- o Promote the active involvement of families and consumers.
- o Public education and use of media.
- o Education of key gatekeepers and opinion leaders (clergy, law enforcement, physicians, educators, etc.).

(Two) - Maintaining the financial viability of our system – The Board’s long-range financial projections indicate that current funding arrangements are not viable over the long haul. If nothing changes, the underlying dynamics will result in a fiscal crisis within the next three to five years that will require significant retrenchments and the erosion of core services.

Strategies to address this issue will encompass the following:

- o Advocacy and governmental affairs, since the issues involve major public policy questions and any approach based solely on local efforts will likely prove to be inadequate.
- o Incorporate appropriate care management approaches into operations, with these ideally to encompass Medicaid, as part of a comprehensive and holistic approach based upon a goal of a unified system-of-care.
- o Looking for system-level efficiencies and additional opportunities for collaboration.
- o Passing a replacement levy and addressing erosion of the local tax base upon which it is based.
- o Creative in efforts to generate additional resources, to include exploration of our pursuing a special children’s mental health levy.

(Three) - Enhancing and building service quality and pursuing a progressive orientation to service delivery – We have built a solid system-of-care in which all can take pride, but we cannot rest on our laurels. Our knowledge base about what works and what does not continues to evolve and even knowing what “best practices” and “evidence-based treatment” looks like does not guarantee that these will be put into practice. Likewise, our local communities continue to change and evolve and what made sense at one point in time may not longer be valid in today’s circumstances. Maintaining the reputation for quality the progressiveness that we currently enjoy will require the following:

- o Foster system-oriented, collaborative approaches.
- o Strive to maintain balance between prevention and early intervention versus fulfilling our statutory and ethical responsibilities to assist those most in need and to ensure the well-being of the larger community.
- o Continue efforts to promote the implementation of meaningful quality and outcomes measures and to incorporate these into contracting/funding methodologies.
- o Promote the active involvement of families and consumers and incorporate recovery/resiliency principles.
- o Explore how to provide for greater attention to physical health needs of clients.
- o Implement deliberate measures to respond to the increasing diversity in our communities and to ensure the services are provided in ways that are culturally competent and accessible to all.

(Four) - Leadership development – We have benefited from strong, competent leadership at all levels of our system. This should not be taken for granted; maintaining a quality and effective system-of-care and achieving the goals outlined above will require attention be given to efforts such as the following to ensure that we continue to have persons with the vision, dedication and competence needed to move the system forward:

- o Develop leadership and support organization efforts among families and consumers.
- o Engage and build partnerships with broader community.
- o Encourage maintenance of a strong, competent work force: recruitment, retention and staff development efforts (at all levels of our system). See Uploads for file named Agency Capacity Priorities (ODADAS Capacity Targets)

C.2 - C.2, 3.

The Board, as mentioned above, at its last strategic planning session and in the deliberations for budget reductions for FY09, attempted to continue to maintain the mental health capacity targets for individual contract agencies, Board partners and Board administration. These include the targets already mentioned earlier which overlap on top of the state generated targets including: addressing issues of stigma and discrimination, maintaining the financial viability of our system, enhancing service quality and pursuing a progressive orientation to service delivery, and leadership development.

The State's capacity targets are included in the following:

Addressing issues of stigma and discrimination:

Includes these state capacity targets: To reduce the stigma of seeking care, provide mental health and other physical health services through media, public events, speaking engagements, and wellness events such as Arts for Wellness in May. Maintain access to services to all age, ethnic, racial and gender

categories as reflected in bi annual compliance reports. Continue the cultural competence of the mental health system; maintain access to services for the Amish and other groups.

Maintaining the financial viability of our system:

This includes the following MH state capacity targets and more: Increase the diversity of funding sources as reported to the Board and the state, increase availability of professionals through HPSA shortage designation, implement cost-effectiveness of EBP services, increase collaboration with funding partners to broaden the base of support for mental health services. Decrease the number of uninsured by enrolling more in Medicaid. Encourage agencies to pursue joint efforts to reduce administrative overhead, share staff and/or merge treatment locations.

Enhancing service quality and pursuing a progressive orientation to service delivery:

This includes the following MH state capacity targets: Maintain/increase access to: service enriched housing, peer support, CPST and wellness management tools, increase training in EBP's, maintain use of EBP's, and restore supported employment.

Continue to measure adult and family and youth consumer's report of satisfaction with the quality of their care and participation in treatment. Continue to monitor and evaluate consumer progress toward treatment outcomes and recovery through implementation of balanced scorecards. The Board in conjunction with its system of care partners will increase the availability of school-based mental health services, the availability of specialty care, youth sex offender, trauma-informed care, wrap around services including recovery assistants and family resource specialists, reduce out of home placements for children, and employ evidence based practices for children, support early childhood initiatives including: Help Me Grow, training in Incredible Years and Triple P, and infant/toddler mental health consultation.

Leadership development:

The Board will continue in its local leadership role to: develop leadership and support organization efforts among families and consumers, engage and build partnerships with the broader community, encourage maintenance of a strong, competent work force: recruitment, support retention and staff development efforts (at all levels of our system). To promote the importance of mental health and AOD treatment to key constituents including: voters, local divisions of government, state legislators, federal legislators, law enforcement, teachers, health professionals, and clergy.

Section III: Prevention Services

Prevention Needs

Needs Assessment Methodology

A.1 - Prevention Needs:

The Board, since its inception, has felt strongly that consultation, education and prevention (CEP) are required to have a full continuum of care for those who need mental health or substance abuse treatment and their families. Modern recovery requires this as the emphasis is on the consumer taking charge of their treatment and being empowered with knowledge and resources to move forward. This includes training and education on relapse prevention in both AOD and MH, education to families on how to support their loved one, training of partners such as law enforcement, clergy and schools to better understand and destigmatize these brain diseases. The Board relies on needs assessments, rates under treatment data, key informant input, risk profiles and risk reduction strategies to determine its prevention, consultation and education needs.

The Board solicits key informant feedback and examines risk behavior trends to inform its CEP planning. Examples would include: responding to community events such as the brutal murder of two young women by sex offenders, an increase in teen suicides, a need for more support groups for families of loved ones who have mental illness or are suicidal, increased reports of violence and bullying in our schools, toddlers being expelled from local daycare centers for unruly behavior, development of school alternatives such as more SBH classrooms and the Opportunity School for potential drop outs and the Juvenile Courts reporting increased reports of unruly youth and parental conflicts causing falling grades, truancy and family reunification problems. Our local MH consumer and family groups over the years have expressed a desire to have wellness recovery, peer and family support for their members. Also due to the involvement of the Board and its contract agencies in both counties' FCFCs, our system partners keep us abreast of their prevention needs and we respond appropriately when resources are available. Need assessments regarding alcohol and drug abuse and addiction or mental health prevention are not the exclusive domain of the Mental Health and Recovery Board of Wayne and Holmes Counties. The Board's is a reflection of the Wayne/Holmes community and its assessments will continue to be derived through a community process.

Four years ago, the Board worked closely with the Partnership for Success program of the Glenn Center for Excellence (CLEX) at OSU. CLEX had provided grants for an independent PFS processes in both Wayne and Holmes Counties. Both of these required extensive assessment of both adults and youth in the communities. While these assessments were done separately, in a localized fashion, each discovered that drug use by youth was the top one or two needs in the area.

During FY09, other prevention assessments were done in these counties, for example, the Holmes County Prevention Coalition assessment. Holmes County is a very rural, sparsely populated county in north central Ohio and a part of the

Board region. It is the home of the largest Amish settlement in the United States. On September 28th of 2008, the Holmes Coalition completed an extensive community assessment (23 pages) for a Community Anti-Drug Coalition of America, or CADCA drug abuse prevention grant that was received by the Holmes County Family and Children First Council. This assessment was a follow up to the PFS survey in which 1000 Holmes residents participated. The assessment included the completion of a national standardized “PRIDE Survey for Grades 6-12” by 1,643 students in the East Holmes, West Holmes, and Southeast Local School Districts (East Holmes: 7th-12th grades, including 7th and 8th graders in the Amish public schools; West Holmes: 6th-12th grades; Southeast: 6th grade at Holmesville Elementary School).

The CADCA community assessment also included:

- Town meetings
- Family/youth demographics
- Parent survey
- Alcohol and tobacco availability
- Drug use trends analysis
- Community resources

SCHOOL BASED ASSET/DRUG SURVEYS.

In the spring of 2008 in the Orrville Municipal School District; and again on December 12, 2008, Wooster City School District the Youth Asset/Substance Use Survey was administered to the 6th, 8th, 10th and 12th grade students who were in attendance. Background: In 2002, the Mental Health & Recovery Board of Wayne and Holmes Counties, as a member of the Family and Children First Council of Wayne County, began promoting asset development as the primary criteria to use for the selection and funding of prevention programs by the FCFC membership. The Council adopted the asset building philosophy as a way to reduce high risk behavior in youth. Various surveys, purchased from the Search Institute and America’s Promise were used. Five years later the Council made a decision that the Search Institute’s survey was not a viable method of measuring assets due to cost and the unwillingness of the Search Institute to provide information regarding the validity and reliability of the survey. The Council set out to find other alternatives to measuring assets. The Youth Asset Survey (YAS), funded under a grant from the National Institute of Health and developed by the University of Oklahoma, under the direction of Dr. Ray Oman, was selected. At the suggestion of Liberty Center Connections, the YAS was combined with another survey for measuring the levels of substance use by youth. By combining the two instruments together, the school would only have to administer one survey, and the information derived would provide powerful analysis regarding the connection between assets and substance use.

Needs Assessment Findings

A.2.a - The Holmes County (AOD) Prevention Coalition assessment in Holmes

County ultimately concluded the following:

PROBLEM STATEMENTS

Through the community assessment process described, the Holmes County (AOD) Prevention Coalition has identified two primary problems to focus on initially:

1. Too many Holmes County youth drink alcohol.
2. Too many Holmes County youth use tobacco products.

In the conclusion of SCHOOL BASED ASSET/DRUG SURVEYS, the principal researcher stated:

“Because this is the first year in which the asset survey was administered, there is no trend data to report. The relationship between assets and non-use of substances appear to be strong. This is especially true for peer role models and making responsible choices. The number of assets also plays an important fact in predicting non-use of substances with those having more assets being less likely to use substances than youth with fewer assets.” Working collaboratively with its local partners through the Family and Children First Councils (FCFC) in both Wayne and Holmes Counties, the Board has developed an automated, on line means of doing the survey described just above. The FCFC has also been developing an agreement to have the schools participate in this survey on a yearly basis for a series of grades starting with the middle school years. In this way the Board is going to be able to establish baselines and controls for variables to study the use rates and effect of programming in the schools.

The Board’s planning process is one that works with providers by providing general guidelines for prevention performance targets rather than only buying a select few. For FY 10/11 the Board is moving to the Intensity of Need SOC in which prevention will be used as a risk reduction tool to be aimed at the source targets for the intensity, as well as using relapse prevention and other approaches. The Board intends to study this approach during early FY10 and then begin to implement these strategies in FY11, or possibly sooner with pilots or initiatives. Along those lines, the Board has negotiated certain performance targets and program strategy in the past and will continue to in the future based on the ION model.

Starting in FY02 and each year since that time, the Board has published a list of 7 domains or Investor Targets that it requires providers to select from for their prevention programming. Each of these has a list of outcomes that must also be selected for performance targets.

A.2.b –

As described in the previous section, the findings from both quantitative and qualitative sources have shaped our prevention, education and consultation effort

over the years. We identified local prevention needs for Child Assault Prevention, Youth and Adult Suicide Prevention, Prevention of Violence in our Schools, (including dating violence and bullying) consultation and parenting training for families, day care providers and other gatekeepers who work with young children and for older children involved in the juvenile court system as well as support for consumers and their families. School based SBH classes requested help with prevention. Law enforcement training was provided through CIT. Our largest agency, The Counseling Center, for most of 20 years, has performed Mental Health Consultation as part of our mutual standard for continuity of care within their organization and to external customers

Prevention Priorities

Method for Determining Prevention Priorities

B.1 -

The Board will be maintaining the prevention efforts started in previous years for FY10-11. However, the potential of another funding cut in FY10-11 would alter these plans to continue the current level of CEP programs.

In reality, the MHRB cannot arbitrarily reduce CEP programs because there are simply too many other funding bodies and authorities working with the local AOD and MH certified agencies independent of the Board (including ODADAS prevention pass through dollars) for the Board to be recognized as a single, controlling factor in the development of CEP activities. However, the Board's planning process is one that works with providers by providing general guidelines for prevention performance targets rather than only buying a select few. For FY 10/11 the Board is moving to the Intensity of Need SOC in which prevention will be used as a risk reduction tool to be aimed at the source targets for the intensity, as well as using relapse prevention and other approaches. The Board intends to study this approach during early FY10 and then begin to implement these strategies in FY11, or possibly sooner with pilots or initiatives. Along those lines, the Board has negotiated certain performance targets and program strategies in the past and will certainly, in the future, based on the ION model.

Starting in FY02 and each year since that time, the Board has published a list of 7 domains or Investor Targets that it requires providers to select for their prevention programming. Each of these has a list of outcomes that must also be selected for performance targets. These are listed in B.1 of the Treatment Section in this plan.

Grouping of Priorities (High, Medium and Low)

B.2.a –

The Board's Statutory Service (Prevention and Treatment) Priorities as listed below and explained fully in section B.1., under Treatment Services are combined within an environmental context (domains). For FY10/11 the Board is moving toward streamlining the complementary relationship between Prevention

and Treatment in a methodology defined as Intensity of Need (ION). ION is the methodology that the Board is using to develop a System of Care (SOC). In this SOC, prevention services will be used to reduce the need intensity being experienced by the target populations that are identified for service. This complementary relationship is explained briefly below the priority list. The BOARD (STATUATORY) SERVICE PRIORITIES A

1. Emergency Services,
2. Community Support for SMD Adults,
3. Services to SED children,
4. Probate commitments,
5. State Hospital Obligations,
6. Forensic Monitoring Responsibilities,
7. Alcohol/Drug Services to Special Populations:
8. Pregnant Women,
9. IV-Drug Users,
10. Persons with AIDS,
11. At-Risk Youth,
12. Families involved with Child Protective Services,
13. Family and Children First Council Service Coordination Plans,
14. Substance Abuse Prevention (Required by Federal/State PCN).

Prevention Outcome Priorities:

- Abstinent at completion
- Movement from Pre Contemplation (SAMI Selected Populations)
- Continuation of Care at lower LOC (Relapse Risk Reduction)
- Employment
- In School
- Social Connectedness
- No Arrests
- Other Measures

YOUTH INTENSITY OF NEED GRID (To demonstrate the relationship to prevention) See the Uploaded file titled "Need Grid Related to Prevention" to visualize the following explanation.

The uploaded graph shows 5 levels of Need Intensity that fit within either ODADAS or ODMH service populations. They are arranged from Highest to Lowest needs in descending order.

Below this listing, these risk sets are matched with a set of risk reduction strategies titled Complementary Risk Reduction Strategies. These include Psychiatric Services, Crisis Teams, Family Council Service Coordination and Prevention. The idea behind this design is to use these listed strategies to reduce

risk or the intensity of need. Therefore, Prevention Services strategies (selected and indicated), are to be used with ION targets to reduce this risk. In this way, Prevention services will become a complementary part of the Board's system of care (SOC), rather than operating as an unrelated set of services. This is explained more fully in the Treatment and Evaluation sections.

B.2.b –

As described in this section, many of the programs discussed below are co-funded in conjunction with our community partners e.g. schools, Head Start, Foundations, and collaborative fund raising. The Board spends approx. \$350,000 annually on MH CEP and additional other dollars contributed from other systems is approx. \$225,000. All Education and Prevention programs have pre and post test evaluations and also use other standardized tools such as the ODMH outcomes tools and the BASC2 to measure the success of these programs. In the case of the SOS program we collect data as part of Ohio's state-wide Garrett Lee Smith grant study through the OSU research foundation.

The Board priorities below all encompass the ODMH priorities:

- 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)

MH High Priority:

- SMD –SED case consultation - indicated consumers
- SED prevention - school based therapy - indicated youth
- Evidence based program for selected youth - suicide screening prevention and education
- Safety and Violence Prevention in schools – selected youth
- Education for selected groups: law enforcement CIT, families of SMD and SED consumers English & Amish - indicated populations
- Prevention support groups for indicated populations, SMD, suicide survivors, Amish, indicated populations MH Medium Priority:
- Evidence based ECMH consultation and education to selected populations
- Evidence based Parenting programs to selected groups
- Evidence based abuse prevention to selected elementary school youth
- Promising practice bullying and dating violence education programs in schools
- Maternal depression education and screening training selected gatekeepers MH Lower priority:

- Universal educational programs by request of the public or gatekeepers
The MHRB has, over the years, streamlined its mental health consultation, prevention and education priorities to contract with only two agencies. In the case of the Counseling Center, the Board places a high priority on consultation services as part of responsible continuity of care. The Board has done this because there is no other payer for this service which enhances SMD and SED consumer outcomes and provides incentives to staff that foster internal and system collaboration. The Center also provides a high priority prevention service via an SBH classroom in Wayne County jointly funded by the schools and the Board. Another high priority is the evidence based practice, “Signs of Suicide” screening and classroom prevention program, for which the Board received additional funding through the Ohio Suicide Foundation Garrett Lee Smith grant. This is the third year of the research project which allowed us to expand from 2 school districts to 10 districts over the last three years. We understand in FY10-11 OSU will be reapplying for continuation of the research project and hope funding will continue so we can add the two remaining school districts in our area.

Another high priority of FY09 was helping to implement the HB9 school curriculum mandated for all school staff by the state. This curriculum included training in bullying, suicide prevention, violence prevention, child abuse prevention and substance abuse prevention. Through the Board’s support of the local Suicide Prevention Coalition, Board staff helped the local school system modify the state’s power point training so that it communicated clearly with the local school culture. This coalition also presented a live local training for free to all school districts.

The family support groups are another high priority education program. The Board places a high priority on services to the Amish which represent half the population of Holmes County and provides an Amish family support group and has an Amish led Family to Family curriculum. In addition to this other education/prevention programs run by NAMI, which is part of our local mental health coalition, includes, Family to Family, Hand to Hand, CIT, peer support groups, family support groups, and a PALS support group.

The Board places a medium priority on early intervention programs in conjunction with both counties’ Family Councils. Through the ECMH early childhood consultation grant dollars the Board has sustained the adoption and momentum for the use of the Incredible Years curriculum. Board staff is currently involved in a joint effort with a local pediatrician to use “Triple P”, another evidence based practice to train physicians and the community in better parenting techniques. Of medium priority were education programs funded jointly with the courts including a promising practice seminar requested by the courts called Helping Children Succeed after Divorce, and the parenting project, which is an evidence based program that gets referrals from juvenile courts, schools, and other social services. Partners in advocacy is a medium priority, jointly funded project with Head Start in which a home based PIA therapist made at least weekly visits to

families and children referred by Head Start. It was started with a grant in 2006 and has continued. Another medium level program is Child Assault Prevention (CAP), which is an evidence based practice in which elementary school students are taught about self protection by trained volunteers. This program was initially developed as a result of a child kidnapping and death 15 years ago and was reinforced after a teenage girl was brutally murdered by a neighbor who was a recently released sex offender.

Also of medium priority are the two programs the Board funds through its domestic violence program on school bullying and dating violence. The state is considering mandating dating violence curriculum for all schools similar to the HB9 requirements. Legislation has been introduced by Rep. Sandra Harwood of Niles, Ohio.

In addition, through an Ohio Suicide Foundation mini grant along with CFHS grant funds in Wayne and Holmes Counties, the Suicide Prevention Coalition sponsored three workshops for health care providers and social workers/counselors on using the Edinburgh Maternal depression screening tool last June/July. In addition a maternal depression informational brochure was designed and copies distributed to our hospital, doctors and social service agencies. Another workshop will be held in April 2009 for family physicians for specific training in medications and treatment of pre and post natal mothers with depression.

Of lower priority are the occasional universal education requests the Board and the Counseling Center receive to do speaking engagements to larger audiences. Only 150 units of service per year are devoted to these engagements which we feel are necessary to maintain local levy funding and to continue destigmatization efforts with the general population.

Implications of Identified Priorities to Other Systems

B.3 -

The Board has moved to requiring an established outcome process for its investments rather than mandating specific performance targets. This method is “inclusive” of community and decided multilaterally. The Board requires that certain measures be applied to the performance targets; see the performance charts below for the process.

Prevention Investor Targets

C.1 -

For CEP related to mental health populations, the following investor targets are being proposed for FY10-11:

- Programs that increase social and peer support for adult and youth consumers

- Programs that promote destigmatization of mental illness and consumers of MH services
- Programs that maintain and improve the community stability of youth and adult consumers
- Programs that decrease the number of junior high and high school youth who are at risk for depression or suicide and provide screening and referral of those identified at risk youth
- Education and training programs for gatekeepers that increase the number of mothers at risk for maternal depression who receive mental health screenings, assessments or referrals to services;
- Education, support and prevention programs that increase the understanding of mental illness for the local Amish population
- Programs that increase the number of youth in SBH classes who demonstrate school (success) and educational commitment;
- Training programs that increase the knowledge about mental illness of gatekeepers in the criminal justice system, and reduce mistreatment and stigma of consumers.
- Maintenance of consultation services between agency and system partners to enhance consumer recovery outcomes related to their MH treatment plans.
- Suicide Prevention Education, i.e. Signs of Depression.

A complete list of the Investor Targets and Target areas currently installed on the ODADAS Web Based Prevention system by this Board for the ODADAS Special Projects, and Board Prevention Projects that use ODADAS PCN or Board levy dollars or both can be seen in the Upload titled, CURRENT CLONED ODADAS/BOARD INVESTOR TARGETS AND TARGET AREAS. These particular Investor Targets and Target areas were in place for FY09 on the ODADAS Web System and then “cloned” into the FY10 application. The Board’s model prevention framework for Evidence Based Services is included in the Uploads to this plan, titled Board Prevention Target Model. This meets the Board’s requirements, but it may not necessarily fit the ODADAS web based system. It is clear that there will be changes (reductions and targets) in the total prevention capacity through the Board system of care for FY10/11, the Board is not yet able to state clearly what these will be. These assumed changes will be the result of two causal factors:

1. The reductions of State PCN during FY 09 into FY10.
2. The Board intent to use preventions strategies in a way that more clearly complements treatment services and drives down the risk thereof. This is articulated above where the Board’s Intensity of Need Strategy is discussed.

Section IV: Treatment and Recovery Support Services

Treatment and Recovery Support Needs Needs Assessment Methodology.

A.1 -

Because of stagnant or reduced funding resources, the Board in the last biennium and projected for FY10-11, cannot meet all the needs of local citizens with MH or AOD. Overall services have been reduced, as mentioned elsewhere in this document, and renders the findings of needs assessments helpful when used only as guides to retrenchment. This is why the Board is undertaking in FY10-11 to reorder its priorities against an intensity of need model to be ready to address further anticipated cuts. While some re-engineering, mergers, and fund raising are anticipated, we will not be able to add additional services in FY10-11 and may have to further reduce our services array.

The Wayne Holmes Mental Health & Recovery Board, its contract agencies and system partners use rates under treatment reports and patterns of use to confirm they are reaching populations that reflect local characteristics and priority needs. Rates under treatment data from service providers indicate that they provide services to every ODADAS priority population. As part of routine CQI, agencies report on their waiting lists as an indicator of client need. The agencies have developed strategies to reduce waiting lists.

As indicated in the prevention section, the Board and system partners have done extensive community needs assessments in recent years including partnerships for success in both counties, substance abuse pride surveys and asset surveys in schools, and focus groups to confirm that services funded are meeting local priority needs.

Further, the Board monitors outcomes of both MH and AOD consumers and makes actionable changes in services delivery such as the use of EBPs and current recovery models where appropriate. For instance, the Board performed an 18 month review of treatment patterns and options for SAMI clients and came up with a new protocol for streamlining referrals of AOD customers to psychiatrists at our mental health center from our two AOD agencies and added an AOD loaned treatment professional to help facilitate the SAMI group at the mental health center.

The Board holds quarterly meetings of all agency QA Directors to review CQI reports generated by Heartland East to discuss treatment trends, increases or decreases in demand and make recommendations for additional study or action. (See evaluation section for more detailed discussion of tools used to evaluate services and need.)

In FY 10-11, the Board plans to review its present continuum of care service array against an Intensity of Need (ION) framework. This effort will help the Board develop strategies for reallocation of resources.

Findings of the Needs Assessment

A.2.a –

The Board monitors the census daily at the regional hospital, Heartland Behavioral Health. We have 4.5 people in the hospital on a given day. We have maintained that level of service. The Counseling Center has a service broker fund for private hospital use and reports routinely on the use of those dollars. In addition, we have an adult diversion committee at the Center that meets weekly or as needed, to discuss any cases of adults known to them that may be at risk of decompensation. If viewed at risk, the crisis team is alerted for possible contact and a crisis assistant assigned to do reassurance calling to that individual as required. This effort has helped us keep on top of possible hospitalizations and divert them where possible.

Our more challenging issue is adults who present for pre-screening that we have never seen before. This is a challenge statewide. We often cannot judge based on having no history whether an unknown client can be managed in the community, and this may result in a short hospital stay. PCS data from Heartland including recidivism, length of stay and connection to services at discharge is reviewed as part of routine CQI, to make sure we are on top of our at risk population needs.

A.2.b - Adults with severe mental disability (SMD) and children and adolescents with serious emotional disturbances (SED) living in the community (ADAMHS/CMH only).

As mentioned earlier, with the reductions in state funding we are trying to maintain the remaining services to SMD and SED populations. Needs are running higher for these populations as their network of supports is dwindling due to layoffs from work of friends and family, their own inability to find work and the fallout from a downward economy. Our largest unmet treatment need is psychiatry, both adult and child. We are currently down 8 hours of psychiatry and this creates a waiting list. While we are exploring other means to deal with this shortage like contracting with SUMMA health systems in Akron for psychiatry and embarking on a joint project with SUMMA to train more PCPs to handle psychiatric medications, we know we are not currently meeting the need and are always vulnerable to losing psychiatric coverage as there is a general shortage of psychiatry nationwide. We are working with our local general hospital as well in joint recruitment efforts and hope all these approaches combined will help us to better meet the need of our SED and SMD consumers.

An area of increased emphasis where there is need, will be consumer operated peer support activities for SED and SMD consumers in FY10-11. With the reduction of our Partial and Social Recreational services the Wayne Holmes Mental Health Coalition consisting of NAMI, Advocates for Mental Health and the Suicide Prevention Coalition will be considering opening a consumer run drop in center, providing more Hand to Hand, Family to Family and Bridges programs to consumers and families as an alternative to those traditional programs.

A.2.c –

As an active FCFC partner, the Board works in both counties to reduce out of home placement and lower risk to multi-need children served by the Councils. The FCFCs undertake a self evaluation process against a set of program indicators (see upload FCFC annual report "What's Up With Our Kids") to show whether they are meeting the needs of their population and what other programs should be considered. As a result using FAST and ABC dollars additional intensive home based workers and family resource specialists/wrap around were added in FY08-09. It remains to be seen whether the FY10-11 budget will have sufficient dollars to continue to support this program expansion, which has helped reduce out of home placement in both counties. FCFC needs assessments also showed an increased need for school based mental health for which the Board applied in FY09 for a System of Care SAMHSA grant to implement more school based mental health services. The Board relied on its system partners to adjust their portion of shared treatment plan costs for FCFC children in FY09 and FY10 but their ability to do this beyond that time frame is unknown. Securing adequate funding is a top priority of the two FCFCs. The community will not support an additional levy being put on the ballot so that limits our funding options for the future should more cuts be made. At this point we feel we are doing all we can to meet local need and are concerned about where resources will come from in the future to allow our system of care efforts to continue.

A.2.d - Persons with substance abuse and mental illness (SA/MI):

In FY 06-07 the Board undertook an 18 month SAMI needs review involving key informants and review of services use by our SAMI population. As a result new procedures were put into place in FY07-08 to streamline referrals from our substance abuse agencies to our psychiatrists for MH medications. In addition, a partnership was formed between the main MH center and one of our AOD agencies who agreed to provide an additional SAMI counselor to staff SAMI groups at the Center. We also formally adopted the IDDT fidelity measures and use those to monitor our progress with our SAMI program. We have unmet need in this area and do not have the resources to add staff, so we are trying a shared staff model as indicated above and our Center and one of our AOD agencies have entered into an agreement to explore ways they can work together to bridge that gap and produce system efficiencies.

A.2.e - Our system contracts with four local certified agencies to provide general mental health outpatient services. Rates under treatment data shows us that all except those seen at our battered women's shelter have diagnoses that reflect a high level of need. The battered women's shelter is the only one of the four that has v-code diagnoses codes because domestic violence parental disturbance is a v-code classification. We feel we are delivering outpatient services to persons with a high level of diagnostic need. We do not have waiting lists for outpatient. Also in our area it is common for churches to have their own pastoral counseling programs which many people chose to participate in rather than our publicly funded agencies.

A.2.f - As already mentioned in the SAMI section above, our needs assessment in FY06-07 looked at needs of our local constituents and placed them in the Dartmouth 4 quadrant model. As a result we implemented the new referral protocols between agencies and made a recommendation to the MHRB to add an additional SAMI counselor to the Counseling Center's program. Lack of additional funding is the only barrier to meeting this unmet need currently.

Treatment and Recovery Support Priorities Method for Determining Treatment Priorities

B.1 -

Historically the Board has determined its treatment priorities by studying the demand for treatment IV., A., 1., assuming a more or less continuous flow of treatment demand from year to year; and then by assessing this demand against its statutory priorities; and what it has selected as its (Board Domains - the environmental context where it expects to meet its statutory priorities).

For FY10/11, the Board has decided to assess its treatment demand on the basis of an Intensity of Need (ION) Grid (see the graphic art in the upload). This grid has been designed to enable the Board to see where the resources it manages are being utilized based on need intensity. The Board is proposing to use FY10 as a period of time in which it develops that grid, creates a study group (consumers, providers, community partners) to review and create recommendations for the Board's planning process in FY11. The object of this process is to enable the Board to do a utilization study and gaps analysis by need and statutory priority. Further, crisis, psychiatric services, FCFC Service Coordination, and prevention are all linked to this grid as risk reduction strategies.

The ION grid will enable the Board to take its traditional methods for prioritization and switch them to a method built around a system of care theory based on the intensity of need theory. The ION theory is that resources should be directed toward need intensity; with the goal to drive down intensity by risk reduction strategies. Treatment providers will be able to provide services at lower levels of intensity until such time as the customers we are serving are able to achieve recovery status, or have been successfully diverted from needing services. This will allow appropriate customers to be in the least restrictive environments when they receive services. The Statutory priorities, domains and an explanation of the ION grid follow:

BOARD (STATUATORY) SERVICE PRIORITIES

1. Emergency Services,
2. Community Support for SMD Adults,
3. Services to SED children,
4. Probate commitments,
5. State Hospital Obligations,
6. Forensic Monitoring Responsibilities,
7. Alcohol/Drug Services to Special Populations:

8. Pregnant Women,
9. IV-Drug Users,
10. Persons with AIDS,
11. At-Risk Youth,
12. Families involved with Child Protective Services,
13. Family and Children First Council Service Coordination Plans;
14. Substance Abuse Prevention (Required by Federal/State PCN)

BOARD DOMAINS

1. Adults involved with the criminal justice system, especially those referred by municipal and county courts for alcohol and drug issues,
2. Adults involved with the Criminal Justice System, especially those referred by municipal and county courts for alcohol and drug issues,
3. Children and youth, along with their families, who evidence traits which make them at-risk for the abuse of alcohol and other drugs,
4. Adults involved with cash benefits and job placement programs for who alcohol and drug related issues have been identified as a barrier to progress,
5. Multi-need youth, along with their families, involved with multiple service systems who are at risk of or involved with out-of-home placements,
6. Multi-need youth, along with their families, involved with multiple service systems who are at risk of or involved with out-of-home placements,
7. Adults with severe and persistent mental illness, especially those who may be homeless or at risk of hospitalization. As appropriate this domain encompasses families of these persons.
8. Persons in crisis situations involving psychiatric problems and/or alcohol and drug abuse,
9. Children and youth who are severely emotionally disturbed, along with their families (exclusive of those multi-system situations which are the focus of the Family and Children First Councils).

The Integrated Planning Principles of this approach and the grid are as follows:

1. Build the plan on existing BH, Claims and Outcome data regarding current customer information and service utilization.
 - Projected Cost of Services and Resources.
 - Intensity of Customer Need (AOD and MH). Consider Intensity as based in (morbidity) and the immediate need for Treatment (Urgency).
 - a. Study and organize the ratio of resources around the “intensity centers” listed on the grid
 - b. Do Gaps Analysis regarding the “intensity centers and/or service clusters” with respect to new grants and funding initiatives
 - c. Develop a rational approach to expanding or cutting services.

2. Develop the integration of treatment processes where service needs and intensity need requirements overlap, i.e. services to the substance abusing mentally ill (SAMI).
3. Develop prevention strategies that are aimed at reducing existing treatment service risk (need and intensity).
 - The immediate (immediacy of) need for Treatment is a higher priority than the need for (Universal) Prevention Services.
 - Promote “Risk Reduction” as the Board’s operative definition of prevention and that helping to reduce need intensity is the overall goal of all services.
 - Risk Reduction strategies will be understood to include:
 - a. Stabilization and Maintenance of high intensive need clients
 - b. Reducing Intensity of Need
 - c. Selected and Integrated Prevention (SAMHSA construct)
 - d. Family and Children First Collaborative Service Diversion Activity
 - e. Psychiatric Services
 - f. Crisis Intervention Services
4. Contract for treatment and prevention programs that are proved to work (through evaluation and evidence based services).
5. Maximize the ability of Treatment and Prevention programs to produce financial support inside and outside of the Board’s fiscal system (includes Medicaid).
6. Develop and/or continue fruitful collaborations with other systems in the community that provide services to the priority customers of the Mental Health & Recovery Board of Wayne and Holmes Counties.
7. Develop with the existing agency structures.
8. FY 10 will be a baseline year for this process. The MHRB will strategically use the Combining process for FY 10-11 as a method to move the Board’s contracts to an integrated system of care based on intensity of need by 2011. The Board’s FY10 activities will involve consumers, providers and the public in constructing the integrated system of care proposed in the Board’s Plan for FY11. This means that the Board is requesting that local contracted providers will project their existing service arrays in the attached intensity of need grid, which will be treated as a baseline for planning in the remainder of FY10 and then in FY11. Intensity of Need (ION) and Risk Reduction Grid with rules for completing the FY10 Agency Plan (Model). See Upload.

This ION grid is meant to be a starting place for a planning conversation and newly developed process which will ensue in FY 10 for the FY 11 plans.
Grouping of Priorities (High, Medium and Low)

B.2

- The ION Grid (as described above in B.1.) automatically lists these in the high, medium and low categories. Implications of Identified Priorities to Other Systems.

B.3 -

It is our intent to study the implications of our strategies for the various intensity levels during FY10. The Board intends to create a study group to study the way the Board is currently addressing need by morbidity and urgency to identify where more services might be added (gaps) or integrated (service clusters, process improvement or best practices), where there might be service overlaps, and if any services that are currently being provided need to be altered or dropped in this system of care. The implications of this process to other systems will be that some community partners may be requesting the provision of services which do not fit well in this grid, i.e. a lower level need that has been elevated as a priority for our system by an entity outside the system. This will likely lead to developing business plans for focusing the Board's resources on priority needs. Developing revenue enhancements to the Board's system by requiring that these partners purchase additional services rather than compete with current priorities is a potential outcome. This assumes that the Board will continue to have discretionary funding.

Treatment and Recovery Support Investor Targets***Treatment and Recovery Support Investor Targets*****C.1 -**

For the past two years our Mental Health Certified agencies have been reporting outcomes (investor targets) in a balanced scorecard format. (See uploads balanced scorecard). The scorecards are based on previous milestone and investor target work by the Board and the Rennslerville Institute over the last 8 years. The Board and agencies mutually agreed to set up targets that could be measured using MACSIS claims, outcomes and BH data for convenience of analysis and ease of collection. The scorecards are reviewed quarterly or when reliable data is available in the year. They include an at a glance dashboard feature where targets not met or met are easily identifiable as red-unmet, yellow-met, or green-exceeded. In FY09 OPER created improvement targets for the ODMH adult and child outcomes tools based on statewide data. A decision was then made locally to adapt our targets to match the state's interpretation of what constituted reliable change so we could make comparisons against the state database. Due to new outcomes tools selection for FY10, agencies agreed to update their targets once ODMH has identified their new tools for adults and

children. Hopefully we can make these adjustments before FY10 data collection begins.

All the target/indicators reviewed reflect, to some degree, the ODMH selected treatment and recovery targets stated above and have been mutually discussed with Carol Hernandez, ODMH Deputy Director, for approval. This effort was recognized in last year's ODMH as exemplary. ODMH also adopted this format to report progress with goals in their flexible performance agreement with the Governor's office. (see:

<http://b9962ed140049a571a710839f1f71c989aaf09ce.gripelements.com/pdf/who-weare/fpa-report-2008.pdf>)

AOD Treatment Investor Targets: The Board has developed a set of 7 standardized treatment milestones to be used with all AOD consumer based Treatment Performance Targets. These have been sharpened due to subsequent learnings and, are designed for use at all levels of care (LOC), but may be modified as necessary to fit the LOC or a special population. In addition to the Performance Targets, this standardized set of milestone markers also indicates which of those consumers hitting the performance target also met the federal NOMS (outcome measures) and three common measures of interest to this Board, i.e. 484 Referrals, Indigent Drivers, co-occurring disorders. It is our belief that this standardized process methodology gets at the true purpose of Investment Outcomes by eliminating the invention of new milestones for every population. The Board has also developed a standardized milestone approach to address the 484 population. This can and will be done for the populations listed on the ION grid.

BOARD TARGET MODEL - KEY TREATMENT OUTCOME DEFINITIONS:

INVESTOR TARGETS: Board Domains (populations) identified above.

CONSUMERS: Clients that the agency will serve within the domain.

OUTCOMES: Specific service results/changes upon which the agency intends to focus.

PERFORMANCE TARGETS: % of outcome level is to be achieved.

MILESTONES: Markers that are used to track progress towards meeting the selected outcome performance target.

VERIFICATIONS: Documents or evidence that milestones and outcome performance targets have been accomplished.

STANDARDIZED MILESTONES

Total Admissions (Substance Abusers and Substance Dependent Identified).

Total Substance Dependent only (implied at IOP or greater LOC). Number signing TX Plan including Abstinence Agreement, and Recovery Education Component Number Completing TX Recovery Education Sessions included in

the plan Total Case Closures Total Performance Target: Example- abstinent at discharge, or abstinent at points following discharge, etc.

Number of Performance Targets who were assessed as (SD) Substance Dependent

1. Number of SD with Improved Stages of Change
2. Number of SD with decreased LOC

Number of Positive SD Discharges Meeting NOMS

1. Abstinent at Discharge
2. Employed
3. In School
4. Stable Housing Number of Positive SD Discharges who are:
 1. 484 referrals
 2. Indigent Drivers (131)
 3. Co-occurring disorders

ORC 340.033(H) (HB 484) Investor Target

C.2 -

The Board has developed a Treatment Program Framework for this investor target. See Upload for Treatment Program Framework - 484.

HIV Early Intervention Investor Target

C.3-

Wayne/Holmes does not receive this allocation.

Section V: Collaboration

Continuity of Care Agreements

A - The continuity of care agreement with Heartland Hospital will be signed and completed in May of FY09. A completed boiler plate was finished last month and each board who utilizes Heartland will be tailoring the details of their crisis response and hospital liaison/treatment team participation as well as aftercare sections by the end of May for final signatures. In the case of the Wayne Holmes Board its lead agency for implementation of the agreement and pre-hospital screening, the Counseling Center, is planning to hold an in-service training on the document early in FY10.

The Board's Chief Clinical Officer, who is also the CCO for the Counseling Center, will make sure all levels of pertinent staff will be trained. Center staff are already familiar with the content of the agreement itself because they were involved in helping to write certain sections such as prescreening procedures.

Benefits/Results Derived from Collaborative Relationships

B - As examples of collaboratives, the Family and Children First Councils in Wayne and Holmes Counties symbolize the way in which this Board addresses the community. The Council partners' collaboration is strong in both counties. Attendance is always good and both Councils have a full set of working committees, and versions of revenue pooling and cost sharing for operations and projects.

It is normative that the AOD & MH agencies and the Board take projects to the Council for endorsement and approval. In the previous biennia, the Councils have both approved the Asset Development approach for prevention and treatment services for children as an approach which should be family based and multidisciplinary in scope. AOD & MH treatment services are very valued by the FCFCs, but are expected to interact with other elements of the community service structure in a multidisciplinary manner. The Council endorses the view that youth have complex needs that justify multidisciplinary planning. This is a powerful model. It does have intrinsic difficulties around information sharing and there is, from time to time, a certain amount of tension between a provider's need to practice "self determination" and the need to maintain multilateral approaches for all the membership. Increasingly all members including AOD & MH are expected to be outcome driven, asset and family approach based, and team players. The various alcohol and drug agencies are heavily utilized by the Councils for both prevention and treatment services. As stated above the MHRB participates in both counties' FCFCs. Because we are a two- county Board, we are considered a separate taxing authority and our funding is not part of the county budget. Each Family Council partner who contributes to a service coordination plan states what percentage of the child's costs they are able to afford. Typically this involves the Juvenile Court, ODJFS/CSBs, the MHRB and the schools. MRDD and others, including parents, may contribute on a case by case basis. Agreements for each child's treatment plan costs are developed and contributor's sign a joint agreement which outlines the percentage of costs of care that each will cover. In addition, in each county the FCFCs have a pooled fund for diversion of cases to keep them out of high end care by purchasing: after school family assistance, respite care, day camp, YMCA memberships etc.

The MHRB historically has made a one third contribution to most plans with Juvenile Court and CSB making up the rest as one third a piece. In FY09 and FY10 adjustments are under negotiation due to MHRB cuts in funding. If a child gets a Medicaid funded out of county service, the service agreement allows for mutual contributors to also help fund the match for that child as well, allowing Board dollars to be saved for others in need. In FY09 that will be about \$144,000 in additional matching dollars to the Board.

In FY09, \$723,818 was budgeted for shared FCFC service coordination plans and \$10,000 was budgeted for FCFC diversion funds. The Board also contributes a share to the overhead costs of both FCFCs in the annual amount of \$12,692 for Holmes County, and in Wayne County the Board houses/employs the FCFC coordinator spending about \$125,000 annually on administrative overhead. This

includes the salary and benefits of the coordinator and expenses as the fiscal agent for the Wayne FCFC. Wayne FCFC partners contribute over \$76,000 toward the administrative overhead costs of the Board.

There are other collaborations that the Board has involvement with in addition to the Family Council. Again, these represent memberships of organizations functioning along specific lines of interest. The infrastructure of the community is complex, and collaborations have a unique way of creating multifaceted connections to it. The Board's current plans are systematic and require collaborations in the development of plans and service delivery is a means to connect and develop relationships that strengthen the public's interest in the Board's responsibility to create a greater amount of public passion for overcoming the stigma and root causes of AOD or MH issues in the wider community. Besides the Family Council, the Board continues to play a leadership role in collaborations with the following:

- The School & Community Partnerships of both Wayne and Holmes Counties which now include – Transitions/21st Century & Project Stay
- The Wayne County Common Good - Employment/Employer Service Providing Organizations.
- The Multi County (six counties – Wayne, Holmes, Tuscarawas, Carroll, Stark, Columbiana) Detention and Residential Treatment Services for youth.
- The Community Corrections Board of both Wayne and Holmes Counties
- The Wayne County Common Pleas and Municipal Court Mental Health HOPE Court
- The Regional annual consumer conference, RSVP, a joint effort of our district, Ashland and Richland Counties
- Early childhood collaboration with CFHS consortiums in both counties, day care providers, ODJFS, 21st Century, Head Start, and local hospitals (maternal depression) and pediatricians in the Triple P CATCH grant project.
- The Wayne County Housing Coalition – Advocates, NAMI and Suicide Prevention
- Homeplace Housing a joint project of the WHMHRB and Wayne Metropolitan

Housing

- The Wayne Holmes Mental Health Coalition
- Heartland Hospital Collaborative
- Ohio Program Evaluators Group
- Margaret Clark Morgan, SUMMA hospital, MHRB psychiatric shortage training initiative
- Systems of Care SAMHSA grant submission: "Together". FCFCs, Kent State, OSU
- The Wayne Holmes Emergency Services Coalition
- The Ohio Association of Community Behavioral Health Authorities
- Free In-service Training Committee – workforce development, and provision of free professional CEUs.

As mentioned previously, the Board has worked in collaboration with surrounding counties to develop the Heartland East Administrative Services Center(HE). This collaboration has not only been a cost efficient operation, but also cost effective. The reports, research, innovations and efficient response of the HE staff have been worth much more than our Board's mere investment of \$51,000. Through this arrangement we have access to seven additional staff who we work with on various projects. The Board can receive same day report generation, if necessary, to prepare for grants, state data requests, partner data requests, or prepare planning documents. HE does mapping, creates routine monitoring reports for the Board and their contract agencies. Monthly claims reports help the contract agencies stay on top of billing and cash flow making their operations more efficient as well. This collaborative effort could easily be a model for the rest of the state and would save scarce dollars.

The Board has only one three way signed private hospital agreement between ourselves, Barberton Hospital and the Counseling Center for indigent beds. The Counseling Center manages a service broker fund, which they use to pay for these bed days, where appropriate. The Center pre-screens, places and does discharge planning for all admitted.

484 Services: Since the advent of H.B. 484 and before, there has been considerable concern over how to deal with AOD involved youth and their families with serious neglect, abuse, or behavioral control issues.

The family structure around these youth is seriously affected and the youth often must be removed from the home for care. This is an extremely expensive situation, and one which does not lend itself to easy solutions. It often involves developing treatment strategies for the youth, parents and family members.

The Board's current policy has been to prioritize such youth and families for service and to develop a collaborative service approach between the Wayne and Holmes Juvenile Courts, Children Services, STEPS at Liberty Center, Your Human Resource Center and the local Family and Children First Councils. This approach has taken the form of an agreement created around OH HB 484. The agreement entails referrals, referral criteria, background checks, assessment specifications, treatment planning/outcomes and collaborative public oversight around AOD referrals through these partners. This creates, in essence, a systematic response. The agreement has been a foundation for billings to a special allocation established by the Ohio legislature. The Board has been able to use this agreement to create a record base that is usable through MACSIS, and has been able to generate statements back to ODADAS and complete that account. There is a plan in the outcome section for dealing with some engagement issues that have arisen around referrals from the Wayne CSB. Engagement is low and these tend to be difficult cases. Multi County Juvenile Detention (Attention) System (MCJAS) Related to 484 above, is the Board's relationship with the Juvenile Courts in both Wayne and Holmes Counties. These

are similar, but different from those with CSB. The Juvenile Court has a different mission. It must protect the public from unruly/delinquent kids and it is expected to do rehabilitation. The Juvenile Courts expect our help with the probation process, detention and rehabilitation. They do not share the exact placement motivations that the Family Council promotes or those of Children Services in terms of out-of-home placements. To serve the Courts, the Board must be able to assist with their priorities, while at the same time, balancing those of the Family Council which seeks to reduce out-of home placements whenever possible. These priorities are not always in complete harmony and the responsibility rests with the Board to determine how to work with each of these systems simultaneously and to do it well. This information points to another facet of community – not all partners want the same results out of a relationship; therefore, to work with each, is to be able to balance the differences in a way that satisfies. Over the past 4 years, state budget cuts in the Department of Youth Services and the County fund have made the budget of the Multi County Juvenile Detention System difficult and has created strife between the judges and commissioners on this issue. The Board has been called on to work on the quality of care for the system. The Board has collaborated with the University of Cincinnati to address the subject of best detention treatment practices. In addition to this, the Board is working with local juvenile courts to develop a re-entry discharge methodology that is based, behaviorally, on the addictions recovery model.

Adult Criminal Justice System Services: Alcohol and drug addiction/abuse creates neurobiological and psychosocial types of problems. In the social arena, many of these problem behaviors are the consequences of impaired judgment which result in legal problems. 14 years ago local criminal justice programming became jail-based or jail related due to legal actions against the counties for not providing adequate care and services. Service has grown since then to include various probation referral programs as well. The Board is not officially involved in any DUI programming since this is handled privately between courts and providers. The Board is able to draw down dollars from county-based funds created by H.B.131 legislation. Service provided to individuals charged with more than one “Driving Under the Influence” offense and a diagnosis of alcohol dependency can be charged to this fund if the individual is indigent. The Board’s associate director continues to sit on the County Corrections Boards of both Wayne and Holmes Counties. Wayne County: Programs developed by this Board, in conjunction with the Ohio Office for Criminal Justice Services and the Wayne Co. Commissioners for jail based services are now being funded largely by the Commissioners and the PAY-TO-STAY “work off your sentence”, program. However, this arrangement is not solid and may be phased out in FY10 to shift to a “drug court” model.

Holmes County. The Holmes Jail and Community Based Program initiated through a grant from OCJS is now being supported completely by the Board.

The Hard-to-Employ/Welfare Reform. Since the onset of Welfare Reform, which in essence began well before 1997, the Wayne and Holmes Departments of Job

and Family Services (CDJFS) continues to work directly with the Board to create and fund service contracts with local agencies. The reasoning behind this activity is that many of the individuals and families that are most entrenched in that system are involved in AOD use, suffer loss of motivation and impaired judgment due to AOD abuse. Many of these individuals have a correspondent external dependency to the welfare system (among other externalized stimulus). Again, this is very much a “where the rubber hits the road” issue. Those persons at the margins of our community, economy, etc. are more noticeable, as are the results of our work with them. We are a valued partner, and this work is a true example of the community members collaborating together for results. Because of this parallel, the AOD system from top to bottom is frequently called on to help meet the goals of Welfare Reform. This relates to specific AOD counseling and intervention services and to working with a wide array of employment readiness services using educational techniques, and behavioral and cognitive type treatment approaches. During the past two years, the Board and the various contracting agencies have become much more involved with the Workforce Investment Act (WIA) activities that operate through the CDJFS.

Business and commercial ventures. Welfare Reform, by its nature has led AOD services into developing relationships and services with local employers. This is related to the Reform goals and the fact that our economy requires fit workers. The Board has provided leadership in the development of the Wayne County Common Good, a collaboration of agencies/services around employer/employee issues. This has led to many exciting ventures and spin off activities related to “results” work. It was through the Common Good the Board became involved with The Rensselaerville Institute’s Outcome Framework activity. The Common Good has been the local leader in promoting an Employment and Training One Stop, which finally was completed this past year as the Employment and Training Connection (ETC) of Ashland, Wayne and Holmes Counties. The Board played a key role in the design and continuation of this framework for ETC’s business, and job seeker networks. The Board’s interest in this aspect of community life is connected to economy, commerce and visions of future development in this area.

The Board’s effort to address the stigma of mental illness and AOD abuse/addiction is ongoing in these collaborations, particularly around referrals from Children Services, the Adult Courts and the Department of Job and Family Services, because these populations are heavily stigmatized. This is a good example of how collaboration enables community interaction on the major social issues of our time.

Consultation with county commissioners regarding services for individuals involved in the child welfare system C - The Board’s primary approach to working with the commissioners with regard to the child welfare system, is through either the Holmes or Wayne County Family and Children First Council. The Commissioners of both counties attend their respective Family and Children First Council and this has enabled a very focused form of communication with the commissioners. Cooperative service plans or pooled funding agreements are

used to pay for services to multi need youth, or for special programs to target populations. Using the FCFC, the Board is able to address the needs of youth from the Children Services Board, Juvenile Courts, schools and families. The Commissioners contribute to some of these programs. Some of these families qualify for 484. The Board has a longstanding 484 agreement between the Children Services Boards and provider agencies, which is signed by the Juvenile Court. This channels services to these families and enables the Board to bring in 484 dollars from ODADAS, based on claims. The Board also participates in the Case Flow Management committee of the Wayne and Holmes Juvenile Courts, Children Services and the Guardian Ad Litem. This committee plays a watchdog role for cases of mutual concern to the courts and CSB which also have AOD or MH needs.

Involvement of customers and the general public in the planning for service provision

D –

Historically, the Board has exceeded the statutory requirements by adding one more consumer of MH and AOD and one more family member than required to the program planning committee of the Board to insure more consumer and family input. The Board is actively involved, and provides a liaison to, the Wayne Holmes Mental Health Coalition, which includes consumers, family members and friends. This enables the Board to stay in touch with their planning efforts and affords the Coalition a feedback loop to the Board. When the Board does its strategic plan update, consumers and family are active participants in the process.

The Board works to include its internal and external customers also, which include the entire list of collaborators in the previous section, as well as, the general public. We reach the general public through our county fair booths in each county and by performing surveys. The general public is made aware of the Board through public presentations, radio spots and community events, like “Arts for Wellness”. This is the Board sponsored annual art show that opens in May, which is Mental Health Month. Any community member can enter to display art that promotes their mental health.

The Board participates in other types of needs assessments already mentioned where feedback is obtained through key informant surveys, focus groups and interviewing such as in the partnership for success initiative. Another way the Board involves constituents in planning is working on joint projects such as: grant submissions, the RSVP conference, and other community planning groups such as Rotary, Kiwanis, and both counties’ chambers of commerce.

For instance, earlier in FY 09, the Board decided to pursue a SAMHSA System of Care (SOC) that would integrate service to youth with serious MH needs in the Wayne and Holmes County area. The Board pulled together representatives of community agencies and schools through the Family and Children First Council process to determine the need for such a SOC. The product of this work was the

development of a proposal titled TOGETHER, which was submitted to SAMHSA for consideration. The planning and grant writing process were both collaborative and involved representatives from eight community social service agencies, plus the Board and all of the major school systems in the two county area. The proposed multi year project, will unite consumers, providers, school systems, and the Board to create a SOC involving communities, families, service providers, schools and the social service planning network involved in the Family Councils. TOGETHER represents a major change in the process of developing proposals, and if funded will represent a major change in delivery of services. TOGETHER is a collaborative effort that now symbolizes the way the Board is approaching its work in the community and has been the SOC design behind the Intensity of Need (ION) system discussed in the prevention, treatment and evaluation sections of this plan

Section VI: Evaluation

Board's Approach to Evaluating the Effectiveness and Efficiency of Services in the Overall System of Care

A –

The Board uses a broad based analysis for its evaluation process. This includes reviews of process improvement/outcomes including: access, engagement, length of stay, utilization review, targeted QA studies, rates under treatment reviews, cost efficiency and cost effectiveness reviews. In addition, the Board looks at measures of consumer outcomes, and measures of consumer satisfaction. The Board updates its CQI plan and goals on a biennial basis. For AOD and Mental Health Services, the Board worked with the Rensselearville Institute to implement the investor target model, prior to its adoption by ODADAS. Annually the Board's AOD agencies report on progress toward investors' targets chosen as part of the process improvement/outcomes reviews:

Access/engagement: The Board, through Heartland East (HE) Administrative Services Center and the Ohio Association of County Behavioral Health Authorities) OACBHA have created care management reports that are produced routinely to examine processes and outcome improvement variables. These include time of first contact to time of first appointment, the number of days from state hospital release until the first appointment at a MH agency, percent of people who have a crisis service only and no other follow up visit, and service penetration rates. In addition to those indicator tables, HE produces quarterly services reports for individual agencies and the Board as a whole with demographic statistics for in and out of county enrollees that is reviewed for outliers. (See uploads LAO reports).

Utilization review/rates under treatment: The Board gets quarterly comparative reports of claims submitted by service against budgeted amounts of services expected, year to date. Quarterly, the Board receives a summary of diagnoses for adults and children receiving services in that quarter. The Board receives a report which looks at utilization across all of Heartland to see variances in the

amount of services delivered on average across like programs and diagnoses. HE also prepares reports on: race, gender, age and average number of units consumed per consumer. HE has a reports catalog where any pre-established report can be obtained for one's district by request. One can also request new reports at any time and most are completed within two days. (see uploads Episodes of care utilization reports for MH and AOD agencies across Heartland East). Targeted QA studies: The Board's contract agencies perform targeted QA studies where they review services in identified problem areas such as suicides and services to special populations.

Cost effectiveness and cost efficiency reports are produced using ODMH outcomes tools, which are soon to be changed comparing that to the amount and type of service, as demonstrated by a mutual definition of a successful treatment episode. Agency annual financial audits are presented to the Board for their approval and issues of losses, cost increases or other financial influences of note are discussed.

It should be noted that none of the above reports would be possible without access to BH data, claims and outcomes data. The Board hopes that ODMH and ODADAS will work diligently to assure that access to these valuable data sources does not diminish as changes are implemented in BH and MH outcomes. Consumer satisfaction: is measured by annual consumer satisfaction surveys that agencies perform as part of their CQI plans. Annual evaluation and QA summaries are submitted to the Board as part of agencies year end reports and these are reviewed and reported at Board Committees.

Consumer Outcomes: for both MH and ODADAS agencies are measured by reviewing data for investor targets. For MH agencies, the Board has taken the final target in the milestone charts for each agency and made that into a dashboard balanced scorecard that is submitted quarterly and reviewed for Board comment. ODMH agencies use the ODMH outcomes tools to project improvement on the sub scales or questions for adults and children that reflect improvement while in treatment. (See uploads Balanced Scorecards) For agencies, where the Board is a minor funder or a Medicaid only funder, participation in the scorecards was optional and agencies could choose service outcomes that made sense to jointly evaluate rather than complete entire scorecards.

Because ODMH is changing their consumer outcome tools for FY10-11, these scorecards will have to be redone, to match new data elements, which will replace previous indicators of progress in treatment. The Board and the Counseling Center are participating in the ODMH cluster pilots which will provide us another set of program evaluation data with which to review services delivery.

FOR AOD AGENCIES-PROCESS IMPROVEMENT:

The Board has had some indirect involvement with Process Improvement (PI) through the ODADAS STAR SI – Process Improvement grants and in participating in the original that STEPS at Liberty Center conducted with change

teams. While the Board itself has not identified specific functions to examine via the walk through and change test process, it is aware of the potential benefits of this process. In many ways, the Intensity of Need (ION) organizational change focus is a process change in which PI can be used. Further, the Board has observed the CQI work that David Lloyd has done around documentation and scheduling and noted that such forms of PI can be very meaningful when service delivery organizations need to be more efficient with their revenues. It is likely that the collaborative work that the Board intends to do with local providers around ION, particularly with streamlining intake and assessment will involve this type of PI.

OUTCOMES:

Prevention and Treatment Investor Targets. The Board has provided templates for its Prevention and Treatment Investor Targets in Sections III. & IV above; and has synchronized these with the ODADAS web based Investor Targets and Target areas.

Providers will be expected to produce outcome frameworks with specific prevention and treatment performance targets in their applications to the Board. The Providers will provide the Board with quarterly reports on these performance targets which will be followed by quarterly/bi annual meetings between the Board and the provider to discuss these, lessons learned, course modifications and checking verifications. The Board has learned (in this process) that it is much more meaningful to require the providers to produce these reports on the basis of continuously running quarters, running from year to year rather than restarting each year. The restarts distort the results and are not helpful. Further the Board has standardized the milestone process for these to assure that the Performance Targets are actually meaningful. This process is identical for Prevention and Treatment and there is no need to speak to these in separate sections.

As noted in Sections III. & IV., the Board has standardized the milestones, but does not dictate the outcomes per se, or the performance targets of the providers. These are left to their choice within the Board's statement of investor targeting, subject to negotiations upon submission of the plans. The Board's Investor Target statement is broad, but informed about local need so that this system is flexible for the provider, yet structured to local need for the Board. Therefore, provider choice is incorporated into this system. FY 09 is Year 1 for the ODADAS Web Based Prevention System. The Board is still learning how to use this tool for Evaluation and intends to work with ODADAS in utilizing the power of this system with the prevention programs that are either Board funded (Levy dollars) or through the ODADAS Prevention PCN.

During FY09, the Board conducted intensive evaluation and research on the phenomena of increased demand for opiate and alcohol detoxification (withdrawal) services. Late in FY09 the demand trend lines for this increased nearly six fold. The projected costs for this trend were overwhelming, particularly right at a time when the Board was experiencing revenues losses at every turn. The Board researched service records, alternative treatment process, Risk

Reduction concerns and discovered that it was reasonable to believe that an alternative form of treatment to sub acute medical detoxification – Rapid Suboxone Opiate Detoxification, could be used. The Board brought together a group of local medical doctors and developed a protocol for dealing with detoxification, specifically opiate. The result of this research into alternative approaches has been that the Board has now launched this new service as a safe and effective means to reduce this cost.

Further, the Board has embarked on the process of developing a SOC around Intensity of Need (ION); and has specific objectives for evaluating how services fit within the Grid for this ION SOC, which include the use of Prevention. The Board intends to use FY10 to determine how to use these evaluation tools to evaluate the System of Care.

SYSTEM OF CARE (SOC):

In Section IV: Treatment and Recovery Support Services Section of this Plan, the Board indicated that it intended to organize its capacity around an Integrated Intensity of Need planning system based on:

1. The intensity/urgency of customer need; and
2. On risk reduction strategies with regard to that need.

The Board has developed a planning grid based on intensity of need and risk reduction around which it proposes to organize its contracted services. This organization will enable the Board to evaluate how efficiently the services it supports are allocated in the community by evaluating their distribution, both on the MH and AOD side, based on an Intensity of Need System which will enable the Board to address consumer need on the basis of intensity, urgency, risk, cost and stigma.

Providers are being required to represent the services they are proposing for FY 10 along the lines of this grid. The narrative is to be written:

1. By category on the grid:
2. Reference all Treatment services listed on the agency UFMS 047
3. Include the number of treatment units of service, cost and target population (The priorities reflected in the “MHRB Service Priorities and The “Domains of Particular Interest & Concern for the MHRB. (Outcomes can be attached at this point).
4. Describe all Relapse; Indicated and Selected Prevention programs that you propose to offer and detail the ION which you propose to reduce by using them.
5. Include the number of Prevention services listed on the agency UFMS units of service, cost and target population per ION category item. Collaboration with the Agencies in Evaluating Services.

The Board works closely with agency CQI staff and the staff of Heartland East to create reports of mutual interest and reports that help us both to monitor our effectiveness. As already mentioned the Board and agencies have agreed to a routine set of monthly, quarterly, and annual data reports from HE that are automatically produced on a schedule and sent to all parties. In addition, the Board has established a regular quarterly meeting of all agency CQI Directors, Board staff and HE staff to discuss data needs and work together on joint evaluation and quality assurance projects.

Agencies provide the Board with annual evaluation reports in which they address the results of client grievances, complaints, incident reports and any other special evaluation reports performed throughout the year. Board members are assigned agency annual reports to review. They are given a copy of these reports to read and then travel to the agency to visit and ask questions of agency directors then report back to the Board's Program Committee their findings.

However, there continues to be change at the state around the rules and formats for doing outcomes and BH, which slows the progress we make locally in developing mutual success indicators that use/rely on this information. This Board has been a consistent voice in the call for access to quality BH data to use in outcome evaluations. The Wayne/Holmes Board has been a leader locally of the "Heartland Boards" to develop an information system that we can trust and use the data with confidence to inform service planning. It is well known that the quality of BH data at both the state and local levels has been diminished by changing entry and gathering practices. The Board anticipates that the ODADAS certified agencies enter their BH data online July 1st. Non ODADAS certified agencies are invited to use this system, but not required. As a result BH data will not be collected by over one half of the agencies with which the Board currently contracts for FY10/11. In addition, the lack of ability to batch enter BH data from agencies proprietary software is hampering data entry. We hope mutually derived solutions will be forthcoming from the state, as we need solid data on which to plan. Finally, the devastating budget cuts for FY09 and 10 have had the effect of "defocusing both the Boards and providers" from regular evaluation and spreading the work of both the Boards and providers so thin on evaluation, that the whole process remains in the background, rather than serving as a driver for quality improvement. We fear that if further cuts occur the likely result is that CQI staff will be eliminated to reduce agency overhead at a time when evaluating effectiveness and efficiency is a top priority.

Systematic Investment: There are developments that do require the Board to develop specific Investor Performance Targets. These have to do with demands placed on the Board by interests of its partners, ODADAS requirements, or projects that the Board is attempting to foster. For this biennium, there are five targets that are being pursued for either extrinsic or intrinsic reasons.

These are:

- Improved accountability and clarity related to H.B. 484 programming- this is ODADAS required □ Development of a joint SAMI project to be operated by the three largest treatment agencies under contract with the Board.
- Transitions through lower LOC for adults receiving Board supported sub acute or acute medical detoxification services.
- Advancement of EB Prevention Services designed to delay onset of use. Services or Programs Having the Highest Priority for the Evaluation of Effectiveness and/or Efficiency C - We prioritize based on populations in the highest need. In FY10-11 the Board will be working with its entire contract agencies to examine how their services address the most in need populations using the already mentioned Intensity of Need grid. (ION) The populations of most concern to the Board are SED, SMD, 484, SAMI and person requiring detoxification or methadone maintenance. We expect contract agencies to have set outcomes standards for all the services we purchase and from a CQI standpoint are looking at all funded services to see if they are having the impact intended. This CQI process requires action reviews from lessons learned and modifications, if required. In FY10-11, the Board will be looking at the phenomena of reduced funding as a catalyst to do system reengineering so that priority populations are served effectively and efficiently. This may include innovative shared arrangements to meet need or a redirection of scarce resources from lower intensity needs populations to higher intensity of need.

Using the Results from the Evaluation of Programs/Services

D –

As previously mentioned, the Board in its contracts with both the MH and AOD agencies requires them to submit quarterly updates on agreed upon investor targets. In addition to these meetings, the MH agencies submit their reports in a scorecard model with dashboard indicators. Staff can review at a glance which targets are behind from the color coding of red under target, yellow at target or green above target. Staff calls the agency to discuss any questions they may have with targets that are unexplainably below expectations and reports this as part of routine QA reporting to the Executive Director and to the Board's planning committee.

In addition, agencies comment in their annual evaluation report on other measures of interest they may have employed to evaluate their services such as: the results of annual customer satisfaction surveys, pre and post test knowledge increases seen in educational or prevention programs, and results from all other QA and CQI activities for the year their agency may have accomplished. The Board also does an annual report for the community and distributes this to a large mailing list and often publishes this report of progress in the local papers. All of the above activities apply to both adults and children. Throughout this document examples have been used of how we use evaluation results to shape

decisions. This includes, but is not limited to the following examples: switching from inpatient opiate detoxification to outpatient suboxone, adding an AOD staff person to SAMI groups at our counseling center, changing intake and engagement procedures at the AOD agencies, establishing a better referral system for AOD customers to access psychiatry, training PCPs to help with psychiatric medication prescribing and monitoring, funding evidence based practice prevention programs and screenings.

Strategies to Evaluate Child & Adolescent Services Versus Adult Services E - As mentioned in the last section the Board uses similar mechanisms to evaluate services to adults and children. In collaboration with the two counties' FCFCs, the Board also receives evaluative data on FCFC funded projects as part of their FCFC ongoing evaluation. This includes FCFC annual reports that use indicators of child health and welfare to monitor impact of FCFC programming. These include recidivism rates back into juvenile justice, improved scores on standardized tools such as the BASC2 , depression inventories, ODMH youth scales and GAF scores, success in school, reduced truancy, reduced out of home placement, reunification of families, and successful transition to adulthood.

Section VII: Ohio Department of Alcohol and Drug Addiction Services Waivers

A. Waiver Request for Inpatient Hospital Rehabilitation Services

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

Agency UPID Allocation 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.

Agency UPID Allocation Services

Integrated Level of Intensity Need Grid (Compliments Level of Care & Cluster and System of Care)

PREVENTION SERVICES	Medically Ill Chemically Dependent, non SED Youth	Severely SED SAMI Youth	Severely SED MH Youth	PSYCHIATRIC SERVICES	FCFC DIVERSION TEAMS	ADULT HOSPITAL DIVERSION TEAMS	CRISIS TEAM SERVICES	Severe SMD MH Adults	Severe SMD SAMI Adults	Medically Ill Chemically Dependent Non SMD Adults	PREVENTION SERVICES
	Stabilization, Risk Reduction, Relapse Prevention, Diversion, Crisis and Psychiatric Services							Stabilization, Risk Reduction, Relapse Prevention, Diversion, Crisis and Psychiatric Services			
	Chemically Dependent Non SED Youth	SED SAMI Youth	SED MH Youth					SMD MH Adult	SMD SAMI Adults	Chemically Dependent Non SMD Adults	
	Relapse Prevention and Psychiatric Services							Relapse Prevention and Psychiatric Services			
	Early Stage Chemically Dependent Non SED Youth	Non SED SAMI Youth	Non SED MH Youth					Non SMD MH Adult	Non SMD SAMI	Early Stage Chemically Dependent Non SMD Adults	
	Indicated Prevention and Psychiatric Services							Indicated Prevention and Psychiatric Services			
	AOD Youth	MH Youth						MH Adult	AOD Adults		
	Selected Prevention and Intervention Services							Selected Prevention and Intervention Services			
	NON CLINICAL INTERVENTIONS AT Risk AOD & MH Youth							NON CLINICAL INTERVENTIONS AT Risk MH Adult & AOD Adults			
	PREVENTION SERVICES	Universal Prevention Services By Grants And Special Funding Only (No Board Funding).									