The Mental Health and Recovery Board of Erie and Ottawa Counties

Fiscal Year 2014 Community Plan—Executive Summary

Mind Your Health—Mental Health Matters

Recovery Rocks!

Fiscal Year 2014 Community Plan

Purposes of the Plan

- Budget and System Advocacy
- Compliance with O.R.C./Block Grant Requirements
- System Improvement-- means for developing a Learning Community for the Boards and MHAS AND the creation of a synthesis report, which will enable informed state and local action
- Response to grant opportunities
- Accounting for use of public funds

Executive Summary

The Board's Community Plan was prepared in accordance with the SFY 2014 Community Plan Guidelines issued by the Ohio Department of Mental Health and Addiction Services (MHAS). The Executive Summary is organized around the same sections and questions contained in the Guidelines, and is the abstract of the more comprehensive set of data, information and narrative found in the Plan as approved by the Board and submitted to Ohio MHAS.

The Board's Continuous Quality Improvement (CQI) Planning Framework & Community Plan

How are they related?

They are organized around the same framework; key components of both processes include activities related to:

- ✓ Assessment of needs in the community and the determination of priorities for services and populations
- ✓ Regular interaction, coordination & collaboration with provider agencies, consumers, the general public and other community partners and stakeholders
- ✓ Funding and contracting for services and programs
- ✓ Monitoring and evaluation of outcomes, performance, service/fund utilization & other factors to provide information about the benefits of the system

The Community Plan is the vehicle in which Boards demonstrate the findings and the integration of processes and methods used in all aspects of planning. Through narrative descriptions and the use of qualitative and quantitative data, it represents the:

- ✓ Tangible benefit of a Board's planning responsibilities per the O.R.C.
- ✓ Connection between a Board's local planning process and its decisions on funding and service priorities

At the same time, our Board's **General System Program/Budget** approved each fiscal year is the means through which local service and population priorities are addressed:

- ✓ Based on a clear set of identified fiscal and program considerations and implemented through program and fund (Service Group) requirements in agency contracts
- ✓ Informed by data and information obtained from ongoing needs assessment, collaboration and evaluation activities
- ✓ Translation of the Board's beliefs, principles and values (ENDS) into specific fiscal and programming recommendations
- ✓ Implementation of goals and objectives in Community Plan

Rather than representing a "beginning" or an "end" however, it is important to remember that these are merely "snapshots" of the system of care as informed by the CQI planning process at a given time.

Environmental Context of the Plan: Factors Influencing Service Delivery

ECONOMIC FACTORS

We have two separate levies, one for .3 mil and one for .7 mil. The .3 mil was last replaced on 11/3/2009 for five years and expires in 2014. The .7 mil was last replaced on 11/7/2006 for ten years and expires in 2016.

Local revenues decreased each subsequent year due to the decline in real property values, limited new construction, and the loss of Tangible Personal Property (TPP) tax revenues. As a result, projected levy revenue for FY 14 is equivalent to the level prior to the last replacement.

Local Levy Funds

FY 10	$3,813,955
FY11	$4,107,071
FY12	$4,018,730
FY13	$3,919,093
FY14*	$3,903,913

*projected

Impact of Loss of TPP Reimbursements

CY 2010	$285,974
CY 2012	$136,411
CY 2013 & Thereafter	$61,629

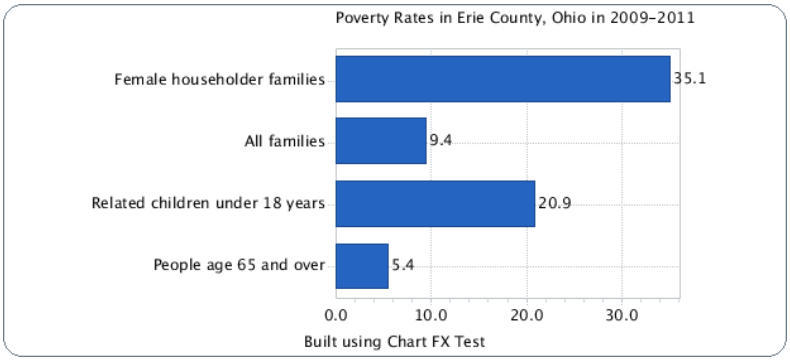
Erie County's rate of unemployment was equivalent to Ohio's for 2010-2012. The rate relative to the rest of Ohio's counties improved however, with a 12.5% jump in rank from 2010 to 2012. Ottawa County's unemployment rate was 2.6-3.3% higher than the Ohio averages for the same period, placing the county in the top 15% of all 88 counties.

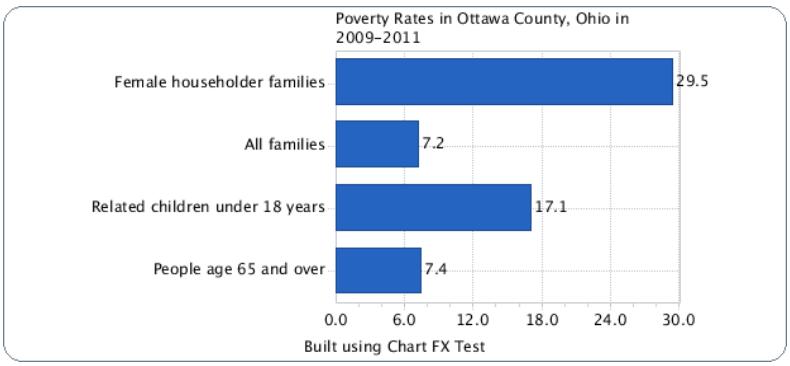
Unemployment Rates

	2010 Rate/Rank	2011 Rate/Rank	2012 Rate/Rank
Erie County	9.3%/61st	8.8%/55th	7.3%/50th
Ottawa County	12.1%/12th	11.9%/9th	9.8%/12th
Ohio	9.5%/NA	8.6%/NA	7.2%/NA

Source: Ranking of Ohio County Unemployment Rates, 2010-2012; ODJS, Office of Workforce Development

Poverty can result in an increased risk of mortality, prevalence of medical conditions and disease incidence, depression, intimate partner violence, and poor health behaviors. According to information found in the 2013 County Health Rankings, a 1990 study found that if poverty were considered a cause of death in the US, it would rank among the top 10 causes.





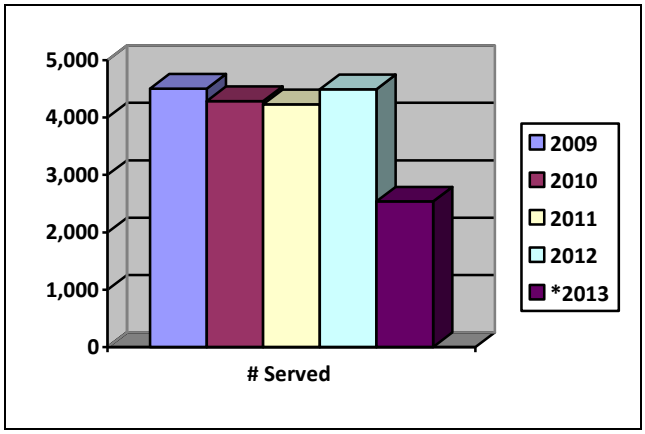
Source: U.S. Census Bureau, 2009-2011 American Community Survey

SOCIAL AND DEMOGRAPHIC FACTORS

The overall populations of both counties have remained relatively stable over the last twelve years. Using 2000 and 2010 Census figures, there was a 3.1% decrease in the total population of Erie County and a 1.1% increase in Ottawa County.

Currently, the catchment area for our Board is comprised of 117,737 people; about 35% Ottawa Co. residents and 65% Erie Co. This is important relative to allocation of funds, and we are diligent in ensuring that all per capita and local dollars are contracted on this basis.

Number Clients Receiving Treatment Services



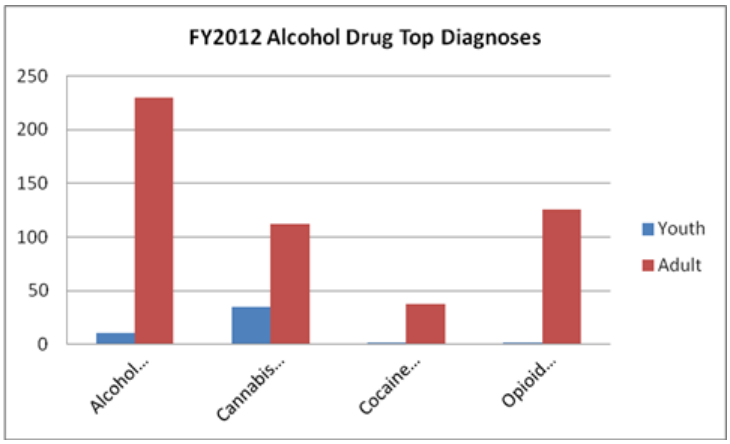
Based on an unduplicated client count for paid claims for treatment services in MACSIS

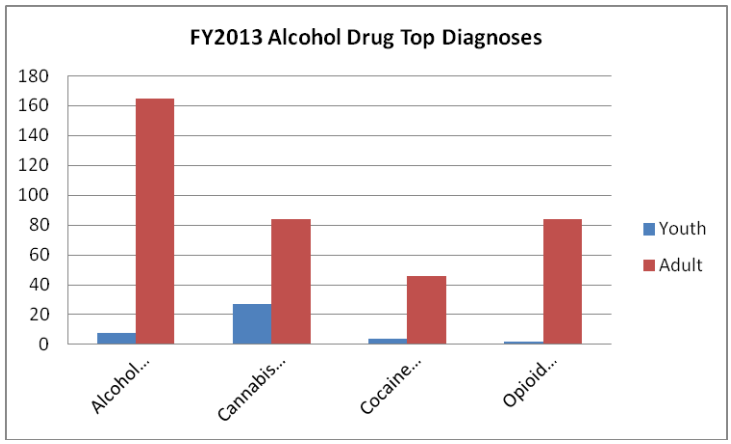
*Does not include Medicaid claims

The general proportion of males to females served in both the youth (0-17) and adult (18-64) populations, for mental health and for alcohol/drug services, remained consistent across all three fiscal years.

Of those receiving mental health treatment services, approximately 45% of adults were male and 55% female; for youth, approximately 60% were male and 40% female.

For those receiving alcohol/drug treatment services, approximately 62% of adults were male, 38% female; for youth, approximately 75% were male and 25% were female.





*FY 13 does not include Medicaid clients

OPIOID-RELATED DRUG USE—FY 13

The number of persons in treatment for an opioid-related drug is higher if you also take into consideration those who reported use of those substances as secondary or tertiary drugs of choice. A total of 150 clients (unduplicated count; nine of those clients had two treatment episodes) receiving treatment reported using heroin and/or other opiates and synthetics; of these, 113 reported opioids as primary, 24 as secondary, and 13 as tertiary. Of those reporting opioids as primary, 35 reported no use of any other substances.

Children/Youth Services

The numbers below reflect the total number of youth receiving alcohol/drug and mental health treatment services by Board-contract providers. They do not include Erie-Ottawa youth receiving services from out-of-county providers (primarily Medicaid), nor do they include youth receiving only prevention, education, or consultation services or those billed to non-Medicaid covered service categories such as Family Counseling and Intervention. These services—including programs such as Life Skills or P.O.W.E.R. (school-based prevention programming), Strengthening Families, and Early Childhood Mental Health Consultation to name a few—are an important component of the continuum of care.

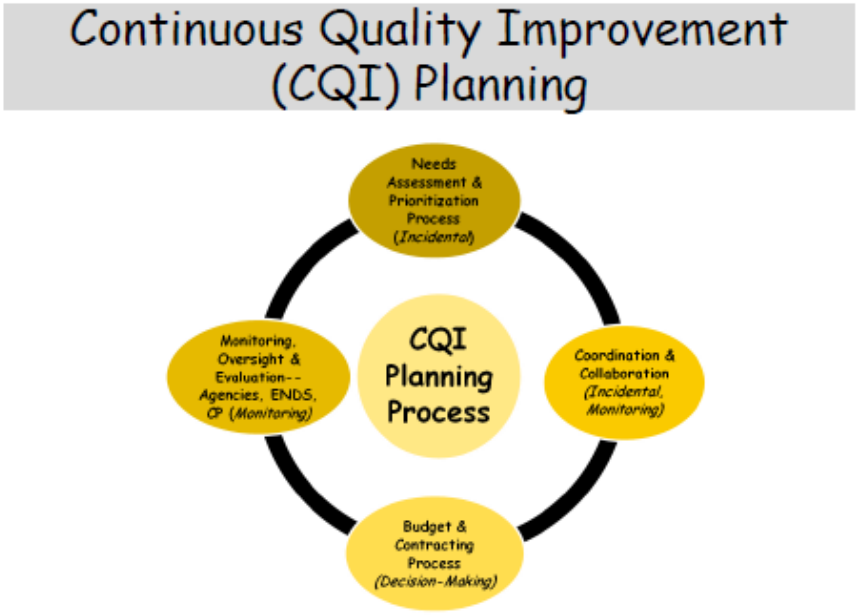
Number of Youth Served

Fiscal Year	Total # Youth	# Youth non Medicaid	# Youth with Medicaid	% Youth with Medicaid
2008	1019	264	755	74.09%
2009	995	231	764	76.78%
2010	973	181	792	81.40%
2011	923	149	774	83.86%
2012	1031	152	879	85.26%
2013*	X	160	X	X

*Administration of the Medicaid program was elevated to the State beginning FY 13; as such, claims for persons covered by Medicaid no longer flow through MACSIS and the Board does not have access to that data

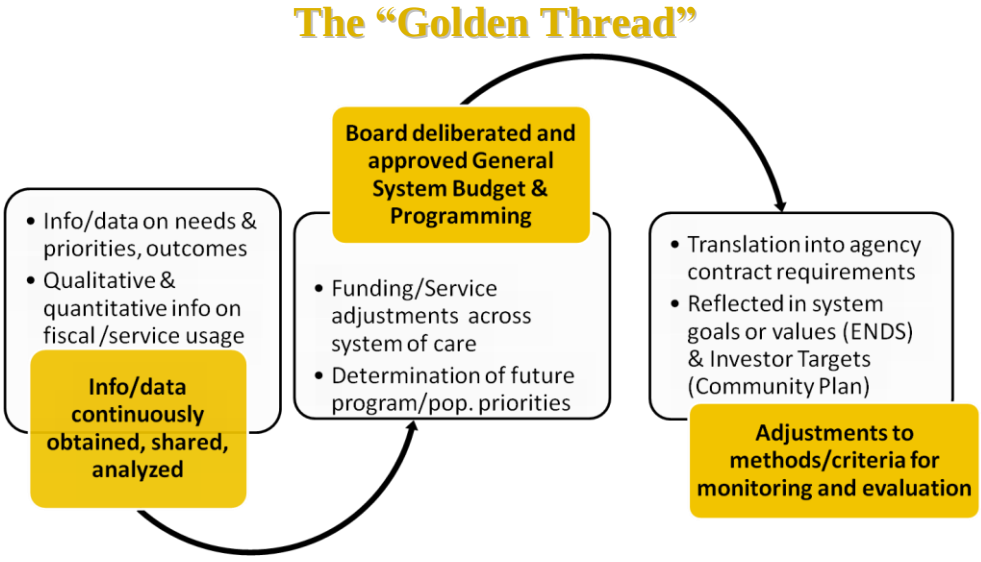
While there were fluctuations in the total number of youth served across the period examined, the percent of youth served with Medicaid coverage hovered around 75% for fiscal years 2008-2009 (and conversely, around 25% of the total for non-Medicaid), jumping to 81.4% in FY 10, with slight increases each year thereafter. A decrease in the number of non-Medicaid youth served post FY 09 was expected as a result of the significant reduction in state revenue the latter part of 09 and in FY 10-11. That is in fact evident here, although there wasn't as much a decrease in the overall number served as the percentage of youth with Medicaid increased during the same period; thus, some of the decrease in numbers can be explained by a shift in payer source.

Assessment of Need and Identification of Gaps and Disparities



Activities related to needs assessment, planning, monitoring and evaluation processes occur on a daily basis, via both formal and informal mechanisms. The Board uses multi-faceted processes to determine current behavioral healthcare needs, to monitor and evaluate the benefits of the system, and to provide information about goals or values, service and program activities, outcomes, and costs. Along with the qualitative and quantitative information and data obtained through the various needs assessment strategies and activities, information learned as a result of the Board's monitoring and evaluation processes is used to inform decisions around funding priorities.

The goal is to balance programming and funding across system program & population priorities within the context of funding and policy constraints. Results of the various activities are integrated into the CQI planning process and inform individual service/program decisions as well as the development of and changes to the overall continuum of care. Because they are ongoing, there is a continual reassessment of needs, programs and outcomes/benefits and how they will be used to direct the plan for the system of care.



STRATEGY, METHODOLOGY & FINDINGS

The Board uses a variety of qualitative and quantitative data sources and types, strategies, methodologies, and time frames in the needs assessment process. In addition to formal Board-specific or board-initiated needs assessment activities, staff and trustees work in collaboration with other county and organization needs assessment and strategic planning processes. These partnerships occur in many ways including financial support, representation, and leadership. Furthermore, duplication of effort and expense is minimized and shared investment in the process results in a more cohesive process, the determination of mutual priorities, and the development of a more comprehensive and coordinated plan or response to identified needs or gaps in resources and services. Quantitative data sources include:

- Service and fiscal utilization data from MACSIS; client demographics & other population characteristics reported in the Behavioral Health Module
- Program/Service information (i.e. quarterly Agency Program Reports)
- U.S. Bureau of Census data—population demographics, poverty, households, employment, education, income
- County Job and Family Service (JFS) data
- Ranking of Ohio County Unemployment Rates
- NSDUH, SAMHSA, CDC, ODH—incidence, prevalence
- County Health Rankings, Robert Wood Johnson Foundation
- 2010 Ohio Family Health Survey (OFHS)
- Ohio Automated Rx Reporting System (OARRS) statistics
- My Outcomes, Ohio's Statewide Epidemiological Outcomes Workgroup (SEOW), Ohio Substance Abuse Monitoring Network (OSAM)
- Erie & Ottawa County Community Health Assessments
- Erie County-2011/2012 Children with Special Needs Health Assessment Report
- Erie County Community Health Improvement Plan (CHIP)—2013-2015
- Partners for Prevention of Erie County Coalition Strategic Plan
- Erie & Ottawa County Family and Children First Councils Shared Plans-SFY 13

TOOLS/METHODS:

- Data Surveillance
- Collaborative Initiatives
- Key Informants
- Public Forums
- Surveys
- Focus Groups
- Interviews

GENERAL FINDINGS

Transportation Barriers--limited public transit services in both counties impact access to services, making engagement with and participation in services particularly difficult for clients with limited resources

Lack of Specialized Housing and Supports—a critical tool for maintaining community recovery for some individuals is the ability to provide a secure residential setting. Along with increasing capacity for housing and related supports and expanding the continuum of housing categories available locally for clients with SPMI, current needs include: 1) secure housing for those persons with mental health and alcohol/drug disorders and criminal justice involvement, particularly those with a sex offender label; 2) housing options for individuals with co-occurring developmental disabilities/autism spectrum disorder and mental health/substance abuse issues that are not eligible under the DD system but who need housing; and 3) Recovery Housing

Case Management and Service Coordination--service definitions for case management and Community Psychiatric Supportive Treatment Services (CPST) are very specific and are based on medical necessity as are all covered treatment services. The clinical focus is very different from case management services provided from the traditional social services perspective and/or from those often allowed in or desired by other systems. Yet these types of supportive services and activities are among those most often identified as needs—primarily by referral sources, and to a lesser extent, clients.

Increased Opioid Abuse/Dependence—there is an upward trend of persons in treatment with a primary opioid-related diagnosis at admission to treatment as well as in client reports of use of heroin, non-prescription methadone, and/or other opiates/synthetics secondary or tertiary drug drugs of choice. Local providers and referral sources have also noted a larger number of people seeking help for problems with opiate abuse/dependence. Quantitative data from a number of sources provide evidence of the impact use of heroin and prescription opiates and other synthetics is having on Erie an Ottawa Counties as well.

CHILDREN, YOUTH AND FAMILIES

There is an inherent complexity when addressing social, emotional and mental disorders in children and youth including differences in the primary mission or purpose of the many systems that work together to serve the youth/family; funding issues (within and across systems) including inadequate funding levels as well as separate and restrictive eligibility, service delivery, administrative & reporting requirements; lack of comparable data and integrated information management systems; and issues related to service availability, capacity and coordination. **Examples of key findings and identified needs of this population from qualitative data and interactions with various community partners include but are not limited to:**

- Sustainability of High-Fidelity Wraparound services
- Availability of non-clinical services and supports for families (i.e. in-home behavioral interventions, respite care)
- Services for younger children with serious emotional disturbance (ages 8-11)
- Community alternatives to costly out-of-county placements in residential treatment facilities or foster homes
- Parenting Programming: education, training, mentoring, supportive services
- Timely access to geographically feasible emergency inpatient psychiatric hospitalization services

While the percentage of both Erie and Ottawa youth seriously contemplating and/or attempting suicide remained stable or slightly decreased, 10% reported struggling with thoughts of suicide. Furthermore, the number of youth reporting they felt sad or hopeless almost every day for two weeks or more in a row increased in both counties to about 25%, and about 20% of youth in each county reported they have purposefully hurt themselves by cutting, burning, scratching, hitting, biting, etc at some time in their life. -- Erie & Ottawa Co. 2012 Health Assessments

- Underage drinking is a problem, with over half of youth between the ages of 12-18 reporting having had at least one drink in their lives. Given that the majority of youth who drink reported that a parent or someone over age 21 gave it to them or bought it for them, addressing this community problem will require a commitment to the enforcement of minimum legal age drinking laws and constant education of vendors, servers, and parents/guardians

- Abuse of prescription and/or OTC medications is a problem, as 14% of youth in each county reported using medication that was not prescribed for them or taking more than prescribed to feel good or get high at sometime in their lives

- Safety and violence are concerns as well, with half of youth in each county reporting they had been bullied in the past year and over a quarter reporting they had been involved in a physical fight

- Erie County parents discussed the following topics with their 6-11 year olds: negative effects of tobacco (80%), negative effects of alcohol (75%), negative effects of marijuana and other drugs (66%), and refusal skills (54%). 14% of parents did not discuss any of the topics above with their 6-11 year old

- 15% of Erie County parents reported that someone in their neighborhood has demonstrated mental health, alcohol, or addiction problems which have caused a disturbance of the neighborhood

ADULTS

Feedback from both community members and key stakeholders indicates that timely access to services—assessment, treatment, and psychiatrist/medication—are important. Similarly, the availability of crisis intervention and hotline services, "safe-site" locations for crisis/emergency assessments, and suicide risk assessments were deemed critical. Access to detox services and residential and/or inpatient treatment for substance use disorders—especially heroin and other opiates—has also been identified as a need by various stakeholder groups including courts, consumers, family members and coalitions or task forces such as Weed and Seed and the Sandusky Crime Prevention Council. Integrated treatment for persons with co-occurring substance use and mental health disorders continues to be identified as a gap.

Many people/agencies expressed a lack of information about what resources are available in the community and how to find out, emphasizing the need for education and public awareness. Finally, an increased need for outreach, engagement and linkage services has been identified, partly as a result of the Conestoga Program, a neighborhood-based community development initiative of which the provision of mental health and alcohol and other drug treatment services to identified individuals in the target area is a primary component. Quantitative data from a variety of sources substantiates these needs and provides additional valuable information about the scope and degree of alcohol and other drug use and mental health related problems.

18% of Erie Co. adults rated their mental health as not good on four days or more in the previous month; 20% reported poor physical or mental health kept them from doing their usual activities, such as self-care, work, or recreation. 11% of Ottawa Co. adults had a period of two or more weeks when they felt so sad and hopeless nearly every day that they stopped doing some usual activities; 8% reported they were diagnosed or treated for a mood disorder in the past year, 4% for an anxiety disorder, less than 1% for a psychotic disorder, and 1% for some other mental health disorder.

-- Erie & Ottawa Co. 2012 Health Assessments

SPECIAL POPULATIONS

INDIVIDUALS INVOLVED IN THE CRIMINAL JUSTICE SYSTEM (ADULTS AND CHILDREN)

- On-site services at the Juvenile and Adult Detention Centers—prevention, intervention, assessment, treatment services, crisis intervention & mental health/suicide screening and follow-up
- Issues around psychiatric medications were identified as particular concerns—the cost to jails, prescriptions/supply upon release of inmate, timeliness and notification relative to linkage with agency for Pharmacologic Management Services
- Linkage and transition to community services for persons being released from jail/prison
- Standardized jail assessment/screening form and/or protocols for following up on mental health screens conducted at intake
- Need for protocols/clarification around court orders and coordination of responsibility for payment of services in cases where client is indigent; concerns raised about 25% client co-pay for domestic violence programming
- *Duplication of programming identified in many cases in Ottawa County—Courts operate separate IOP/T4C programs, parenting programming (*disparity vs. need—despite expressed need and capacity for prevention and treatment services for all populations, utilization has decreased in the past several years)

ADULTS WITH SPMI

- Sustainability of Consumer-operated and Peer/Self-Help agencies
- Housing and related supports
- In terms of treatment services, availability of case management, psychiatrists and pharmacological management services, and medications were identified as most important

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

STRENGTHS

- Shared business operations with the Huron County ADAMHS Board around CFO Services and MACSIS Claims Processing provide our Board additional financial resources and collaborative knowledge sharing concerning State and local issues. Furthermore, the alliance has resulted in improved efficiencies for both boards and provides a backup system for the smaller board.

- Consistent with the Board value (as stated in our ENDS policy) to place a priority on establishing a stable and diversified economic base supporting local mental health and alcohol/drug services, we are active in the pursuit of additional funding through competitive application for numerous Local, State and Federal grants. These are mutual efforts involving collaboration with various community stakeholders.

- The Board's network of contract service providers is also a strength. There are three treatment agencies across both counties with varying capacity for primary and/or secondary service provision for mental health and alcohol/drug services to youth and adults. This allows for consumer choice for general outpatient or routine services and also facilitates access to care geographically. Additionally, prevention programming is primarily provided through two of these agencies, one in each county. All three are certified through both the (now former) Departments of Mental Health and of Alcohol and Drug Addiction Services and have national accreditation through CARF. In addition, all are stable and mature organizations, professionally managed, and financially secure. Crisis/emergency services are centralized, with our largest agency serving as the provider for the system of care. Similarly, a single agency manages the majority of the funded housing for clients with severe and persistent mental illness. The exception to this is funds for clients in out-of-county placements that are administered through "pass-through" contracts with our primary mental health providers. We also have three contract providers of peer/self-help and Recovery support services, fulfilling a valuable role in the local continuum of care.

- The Board is working with a variety of others around the integration of physical and behavioral healthcare, recently adding two new initiatives in partnership with Firelands Counseling & Recovery Services. Funding was provided for the program *From Cancer to Health*™ , which helps people having emotional difficulties dealing with a recent cancer diagnosis. Research has shown the program helps people reduce stress, improve social support and communication with health care providers, and have fewer physical side effects from cancer treatments. The Board is also providing funds for lab work to monitor psychotropic medications and ensure compliance with medication protocols for indigent consumers with SPMI enrolled in the Health Home via a SAMHSA grant awarded to the agency. A Primary Care Practitioner and lab draw station were embedded onsite, making it convenient for the consumer. As a result, several very significant health care conditions were diagnosed that have been neglected and untreated for a long period of time because of the individual's lack of resources.

CHALLENGES

- With the retirement of our Senior Program Consultant in April 2012, we moved to a total of five positions including the Executive Director, down from a full staff of seven. This has presented some challenges from an operational standpoint. A functional job analysis was conducted, with position descriptions revised to reflect different/additional duties. This was able to occur in part because of the reduced workload around enrollments and other business operations related to elevation of the Medicaid program and in part because the tenure and experience of remaining staff allowed the realization of efficiencies due to the streamlining of routine tasks, improvements in time management and organization, and other efforts. Still, the reduction

in staff does have an impact on what new initiatives can be undertaken and/or the amount of attention that can be paid to "non-essential" but value-added activities related to planning and other Board responsibilities.

- Another challenge has been around the recruitment and retention of Board members. For many years membership was stable, with most appointees serving two full terms. Between those members' expiring terms and a variety of personal and professional issues resulting in the resignation of several of their replacements, we are left with a number of vacant positions. Members of both staff and the Board have and are engaged in a variety of marketing and recruitment efforts in an attempt to obtain applications for consideration by the various appointing authorities.

- Unintended consequences of the transfer of administration of the Medicaid program to the state have resulted in some concerns as well. The segregation of responsibility for a significant portion of the counties' population has resulted in some fragmentation of local systems of care. Available data is limited and there is no ability to cross walk to historical data. Moreover, categorizing clients by payer source (Medicaid versus non-Medicaid) tends to overlook the fact that Medicaid clients are major consumers of services that are paid for with non-Medicaid dollars such as crisis services, housing, vocational and peer support services. This makes it difficult to effectively provide coordinated care.

CPST-Related Issues

- We have encountered some challenges relative to rules for the provision CPST service as well, both in relation to Health Homes and the service limits imposed as part of the Medicaid cost containment efforts. Based on an internal analysis on client numbers using the proposed tier system and eligibility criteria for the next phase of expansion of the health home for persons with SPMI under the Medicaid program, the revenue generated by the PM/PM rates for the eligible population would not be sufficient to cover the cost incurred by our provider of building a system that includes the necessary supports needed for any primary care model to succeed with this population. We are concerned that the current plan for implementation of the Medicaid Health Home will not allow agencies to provide the intensive support services at the Care Management and HH Specialist levels necessary to actually improve the health status of this population.

- We have also experienced difficulties in circumstances where Erie-Ottawa residents are placed in group homes in Lucas County, which was part of the Phase I implementation of the Medicaid Health Home. Upon enrollment in the health home, case management and/or CPST billings are no longer permissible, yet the Board/contract agencies still have monitoring responsibilities and are still involved in case planning to some extent. In fact, upon placement the Board contract agencies have to sign an agreement which includes acceptance of the responsibility to pay for necessary behavioral health services not otherwise covered, lab tests or studies, and unreimbursed costs were the client to exhaust Medicaid service limits. The inability to submit claims for CM/CPST presents a hardship and impedes the ability of our agencies to provide the necessary monitoring and oversight. While the Board has devised another mechanism to reimburse the providers for these services in the interim, in essence it is a cost-shift.

- A final challenge related to provision of the CPST service is related to service caps under the Medicaid system. As reported by providers, toward the end of FY 13 there were a number of clients that were going over the cap in CPST for whom prior authorization was requested for additional hours. This is a very involved process, takes a great deal of time, and usually resulted in approval for some but not all requested hours. The agencies did not discontinue services, providing what was needed despite the inability to submit claims. Of course, they can only provide a certain amount of non-reimbursable services before it begins to impact them financially. Similarly, there is concern about the caps on counseling since that is limited to 52 hours per year and is not sufficient for persons seen individually and in an intensive group setting.

Priorities

Goals (in the grey text boxes) and Strategies (numbered sentences beneath each one) related to identified Board priorities for service delivery—including treatment and prevention and for various populations—are listed below. They are consistent with mandated state and federal priorities and with local Board values/Ends per Policy IV-A.

Improve timely access to services and supports to adults involved in the child welfare system in Erie County

1. Collaborate with Juvenile Court Judge around use of the IDAT funds for treatment services to this population where substance abuse is a contributing factor to legal charges.
2. Through the planning committee for the family drug court, identify treatment service needs specific to this population.

Stabilization and treatment of parental mental illness and/or substance use disorder to prevent removal of children from the home and/or to promote successful reunification of families when issues are present

1. In partnership with Board contract agencies, work with caseworkers at Departments of JFS and staff at family/juvenile courts to improve identification and referrals of families in need of intensive home-based services (IFAST).
2. Provision of services—including case management—to participants in the O.C. HOPE Court (Helping Our Families Excel) Family Dependency Treatment Court program.

Improve access to juvenile emergency/crisis psychiatric inpatient hospitalization and/or community residential stabilization

1. Purchase 22 crisis/respite bed days through the Juvenile Crisis Hot Spot Project of the NW Collaborative to expand range of available options available.
2. Meet with reps of juvenile courts, treatment, and sheriffs' office to identify issues around process.
3. Continue to work with NW Collaborative as follow up to Private-Public Hospital Initiative around possible regional solutions.

Reduce the stigma of cancer patients seeking behavioral health treatment for the emotional toll that diagnosis and on-going cancer treatment can have upon patients

Maintain funding for *Cancer to Health*, an emerging best practice approach that integrates behavioral health and cancer treatment (a pilot group was funded at the end of FY 13).

Increase access to BH treatment and promote the integration of physical and behavioral health care

Provide funding for on-site screening for mental health and substance use disorders, consultation and engagement services to youth and adults at Family Health Services of Erie County.

Improve earlier identification of physical health problems and ensure compliance with psychotropic medication protocols

Provide funding for lab work for indigent consumers with SPMI enrolled in the non-Medicaid Health Home via a SAMHSA grant awarded to the Board contract agency.

Priorities

Increase employment of persons with mental and/or substance use disorders who want to work

1. Expand eligibility under the board-funded Supported Employment Preparation and Linkages Services (SEPALS) program to include adults from the MH-General Population and AOD Service Groups.
2. (**Depending upon outcome of VRP3 Program**) Redirect local match funds and/or invest additional funds into supported employment programs targeted at persons with SMI/SPMI/AOD **OR** Maximize the provision of vocational rehabilitation and employment services and other supports via BH-VRP3 program.

Develop system capacity for peer-delivered support services

1. Work with local CCAR trained Recovery Coaches and Lorain Area Recovery Coaches network to define service delivery model for use of Recovery Coaches.
2. Provide training for 4-7 Erie-Ottawa consumers as Certified Peer Supporters (CPS) through joint sponsored training with Lorain ADAS Board for the 40-hour OMHAS training through OCA.

Arrest the spread of opiate addiction among residents of Erie and Ottawa Counties

1. Continue to gather quantitative & qualitative on range/scope of current problem.
2. Work collaboratively with Weed and Seed, Sandusky Crime Prevention Council, Let's Get Real and others to explore feasibility of developing a Community Opiate Task Force to identify and pursue mutual goals.
3. Increase community awareness around the dangers of opiate use (i.e. promote use of drop-boxes, prevention programs).

Strengthen families and parents through education, training and skill-building

1. Provide funding for parenting programs—Loving Solutions, Active Parenting, Strengthening Families.
2. Expand continuum to include program focused on prevention of underage drinking (i.e. Parents Who Host…).
3. Create opportunities for parent mentoring and support through collaboration with FCFCs.
4. Maintain capacity for school-based services (classroom and individual prevention services) including Life Skills.

Decrease stigma as a barrier to early intervention for emotional problems and mental illness

1. Provide funds to train one person in Mental Health First Aid to deliver the program Erie-Ottawa Counties.
2. Convene a Board-Agency Public Education Steering Committee with a focus on the creation of a set of topic-specific presentations for use in community presentations to help increase understanding about the issues of mental illness and alcohol/drug abuse and dependency.
3. Promote the Board website as a resource in the community.
4. Increase the use of PSAs.

Improve access to and utilization of BH services for high-minority population in CDBG focus area of South Sandusky neighborhood via Weed and Seed and Conestoga Committee oversight collaboration.

1. Reduce stigma and fear of involuntary hospitalization which historically has been a major concern of residents in African-American Community.
2. Canvass focus area in collaboration with Erie-Huron-Richland CAC to engage population and determine need for CD and BH services.
3. Develop appropriate ISPs for an estimated 300 families in focus area, and start cross-system implementation.

Collaboration

Ongoing involvement, interaction, and collaboration with service and referral agencies and other community partners and stakeholders occur as part of the effort to develop and ensure and efficient and comprehensive system of mental health and alcohol/drug services and supports; maximize resources and minimize duplication of services; and improve consumer outcomes. As a result, timely and current feedback is obtained and used in many ways—from joint funding of programs or initiatives to identification of gaps in the service continuum; to enhanced communication and streamlined referral protocols. A representation of various partnerships and mutual endeavors is presented below.

Let's Get Real, Inc. is a recently formed information and referral community center assisting families and loved ones in their journey from addiction to recovery located in Vermilion, a city that is located partly on the east end of Erie County and partly in the west end of Lorain County. The Board has provided administrative and office support (i.e. copies, mailings) and has worked with them to coordinate a Cross-County Collaboration meeting as a forum for community members to hear about available resources and to share concerns and ask questions of a panel of professionals (including our Board E.D.) from both Erie and Lorain Counties regarding their interests and concerns as they relate to drug problems in Vermilion.

The Board is also working with the **Sandusky Crime Prevention Council**, a volunteer group of about 12 Sandusky City residents who came together to improve the city by researching and initiating various methods of involvement and cooperation between residents, law enforcement and social services with a common goal of reducing crime and thereby improving the quality of life for everyone in the community. The Board contributed financial support for and participated in one of their initial efforts, a community meeting in October of their "Clear Vision" drug awareness program.

An ongoing and multi-year effort of the Board has been working with the various courts to establish programs around use of the **Indigent Driver Alcohol Treatment (IDAT) Funds**. Through programs set up with the Sandusky and Ottawa Co. and Municipal Courts—the latter program just established the second quarter of FY 12—31 people received addiction treatment services paid through these funds, for a total of $25,605.07. We have also been working with Vermilion Municipal Court and the Lorain ADAS Board around administering an IDAT program. Still, there are significant funds remaining that would go far in expanding capacity and addressing local emergent needs (i.e. increasing opioid drug abuse and dependence).

Ottawa County Common Pleas Court: Staff members of the Board and provider agencies worked with the Judge and staff of the Court to develop and implement a specialized docket drug court program (DATA Program) that just began in mid-November. In order to streamline the times between program application, diagnostic assessment (DA), and acceptance into drug court, we will be expanding the role of the Board-funded Court Assessment Program currently in place for the O.C. Juvenile Court to include assessment of those individuals screened for possible inclusion in the Drug Court program. This will also have the result of standardizing the format in which the results of the DA and any treatment recommendations are presented. As with other specialized docket programs, agency staff are prepared to participate as part of the treatment team and attend weekly meetings/hearings. In addition, designated case management services will be provided to DATA Program participants.

Peer Supporters/Recovery Coaches: In FY 13, the Board supported the training of two individuals as Recovery Coaches through a CCAR training coordinated by the Lorain ADAS Board. Both are active in the Lorain Area Recovery Coaches network and meetings. We are also partnering with the Lorain ADAS Board to bring Ohio Citizens Advocates to Lorain for a peer supporter training that would be open to persons from both counties. OCA will conduct the 40-hour (5 consecutive days) training and will provide attendees with the OMHAS' certified peer supporter credential. We will be working with our consumer and peer support agencies to identify possible candidates for this training, and will be providing financial support.

Partners for Prevention of Erie County Coalition: Staff and trustees of the Board and provider agencies are actively involved in this coalition of agencies, youth, adults, and others dedicated to reducing the negative outcomes and impact of alcohol, tobacco, and other drug (ATOD) use and abuse in the community and upon its citizens. The Board is contributing to identified goals of reducing underage drinking and emphasizing targeted developmental assets (Search Institute) through the determination of shared priority and investment areas.

Inpatient Hospitalization Management

Interaction between the local system's utilization of the State Hospital, Private Hospital(s) and/or outpatient services and supports

The Board contracts with Firelands Counseling and Recovery Services ("Firelands") for emergency services programming for the system of care. Services are available 24/7 for youth and adults and include a crisis hotline, pre-screening, inpatient psychiatric hospitalization (for adults), and transportation service to the hospital/crisis care facility. In Ottawa County, they have an agreement with the Giving Tree to provide pre-screening and face-to-face emergency assessments during normal business hours with responsibility shifting to Firelands for evenings and weekends. The Board contracts with Rescue Mental Health Services ("Rescue") for residential crisis stabilization services for youth and adults. The Board also contributes funding for 2-1-1, a 24/7 "warm line" providing information and referral services for Health & Human Services assistance.

Emergency Psychiatric Services

According to data collected as part of a NW Collaborative survey on psychiatric emergencies and placements for FY 13, 1308 adults received emergency psychiatric services. Of these, just over half (658 persons) were committed to a public psychiatric hospital or private hospital psychiatric unit. The three greatest challenges related to the provision of emergency psychiatric services to adults were noted as follows: 1) length of time arranging for admissions, particularly related to labs/medical clearance; 2) lack of available beds at the RPH at times; 3) lack of alternatives to Inpatient Care/capacity for crisis residential. Twenty-one of 177 youth (ages 0-17) receiving emergency psychiatric services in FY 13 were admitted to a private hospital psychiatric unit or a community-based crisis stabilization unit. The greatest challenges were noted as the length of time spent arranging for placements and the fact that hospital admission criteria varies from one facility to another.

Looking at the costs of emergency psychiatric services for fiscal years 12 and 13, the Board spent a total of $681,604 on inpatient psychiatric hospitalization, crisis stabilization, and transportation for 439 persons in crisis in FY 12 for an aggregate cost per client of $1552.63. For FY 13, a total of $530,467 was expended for 338 persons at an aggregate cost per client of $1569.43. These figures do not include other components of the crisis care system such as the hotline.

Emergency Psychiatric Services: Rescue and Firelands (FY 12-FY 13)

	FY 12			FY 13		
	Total Cost	**# Clts**	**Cost/Client**	**Total Cost**	**# Clts**	**Cost/Client**
Firelands	$239,610	100	$2396	$164,037	75	$2187
Rescue (w/o emergency transportation costs)	$403,523	339	$1190.33	$331,317.05	263	$1259.76
Rescue (with emergency transportation costs)	$441,994	NA	$1303.82	$366,430	NA	$1393.27

Erie-Ottawa MHRB Contract Providers

Bayshore Counseling Services
Big Brothers Big Sisters
Center for Cultural Awareness
Erie Shore Network
Firelands Counseling and Recovery Services
Oak House
Sandusky Artisans
The Giving Tree
Volunteers of America

For additional information on the Mental Health & Recovery Board (MHRB) of Erie and Ottawa Counties, the Provider Agencies, or for general information and resources related to mental health and substance use disorders, visit the Board's website at:

www.mhrbeo.org

For questions or additional information on the content of this document, the Community Plan, or the Continuous Quality Improvement (CQI) Planning process contact:

Deborah Kelley LISW-S, LICDC-CS
Deputy Director of Planning & Policy
debbiek@mhrbeo.com
(419) 627-1908