

Structure of the Community Plan

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Appendix A: Table 1: Portfolio of Providers

Mental Health and Recovery Services Board
of Erie and Ottawa Counties

COMMUNITY PLAN FOR SFY 2008-2009

due April 2, 2007]

MISSION STATEMENT

The Board's mission (as an oversight agency and a guardian of State, Federal and local laws and values) is to reduce the incidence and severity of alcohol, drug addiction and mental health problems experienced by persons of all ages.

VISION STATEMENT

The Board does not have a vision statement; however we do have the following "Statement of Principles" that supports the mission.

In pursuing its mission, the Mental Health and Recovery Board of Erie and Ottawa Counties shall adhere to the following principles and values:

1. Ensuring the range of services available to the citizens of the two counties includes assessment, treatment, rehabilitation and prevention as well as various combinations of medical, housing, vocational and support programs. Such services and programs shall be effective, available, appropriate, accessible and acceptable to and used by persons who need them.
2. Ensuring services are provided according to the least restrictive treatment setting based upon the client's need and which encourage the client's involvement in a treatment plan.
3. Initiating, developing and supporting innovative programs and services, and natural supports, which respond to the needs, hopes and choices of persons requiring such supports to accomplish independent lifestyles.
4. Ensuring mechanisms are in place to assist and individual or family until they are able to access needed services or resources.
5. Ensuring the equitable distribution of public funds for purchase of services between the two counties from State mental health, alcohol and drug addiction subsidies, Federal grants and local levy contribution from each county.
6. Ensuring no client shall be denied services because of inability to pay for services.
7. Recognizing systems that rely heavily on public funds will always be asked to do more than is fiscally possible; therefore, all stakeholders must work cooperatively to expand and maximize available Federal, State, local and private resources.
8. Committing to the effective, efficient use of public resources, both human and financial.

9. Identifying and designating the high risk needs of each county and its citizens according to needs assessment data. Ensuring that mental health, alcohol and drug addiction services are provided in a higher proportion to high risk groups and high need areas of each county.
10. Ensuring the mental health system has the capacity and flexibility to respond to a variety of persons who need its services, while providing continuing services for persons with ongoing needs.
11. Evaluating and assuring the quality of mental health, alcohol and drug addiction services provided to clients.
12. Ensuring the rights, wishes and needs of persons who use services and that of their families are the forces that drive the system.
13. Recognizing and implementing the belief that direct involvement from families and consumers in planning, development and evaluation of services is essential to quality services.
14. Developing partnerships among a broad range of service providers (housing, welfare, vocational rehabilitation, children's cluster, etc.), consumers, families and the community at large to promote creative funding strategies, and coordinated, comprehensive care and services to meet basic living needs.
15. Assuring providers and other community representatives are involved in the process of planning and prioritizing those needs for its community.
16. Ensuring the mental health, alcohol and drug addiction system recognizes and values individual cultural differences and considers such needs in the development of all policies, hiring practices, training and service delivery.
17. Ensuring the mental health, alcohol and drug addiction system is involved in and influences the broader public policy agenda as it impacts persons served with mental health, alcohol and drug addiction problems; particularly the structure and funding of the health care system.
18. Recognizes that alcohol and other drug addiction are treatable diagnoses.

SECTION I: CURRENT CIRCUMSTANCES

Describing the current circumstances of the board's alcohol and other drug prevention and treatment and recovery services entails several elements. These include an explanation of the legislative and environmental context of the plan, characteristics of customers, listing of evidenced-based practices/strategies being utilized, overview of the system's workforce and a portfolio of providers.

1. Legislative Context

The legislative context of the plan involves identifying the statutory requirements that have bearing on local planning. The community plan guidelines template includes a section already developed for board use in describing the legislative context. Insert the board's name and use "as is" or modify as needed.

Legislative Context

The Mental Health and Recovery Board of Erie and Ottawa Counties is required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) a plan for the provision of alcohol and other drug addiction services in its service area. The plan, which constitutes the board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS. This plan covers state fiscal years (SFY) 2008 – 2009 (July 1, 2007 through June 30, 2009).

H.B. 317

Section 340.033(A) of the 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.

H.B. 484

Section 340.033(H) of the ORC requires 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.

HIV Early Intervention Services

Eleven board areas receive State General Revenue Fund (GRF) for the provision of HIV Early Intervention Services. Boards that are required to develop an HIV Early Intervention Investor Target include: Butler, Eastern Miami Valley, Cuyahoga, Franklin, Hamilton, Lorain, Lucas, Mahoning, Montgomery, Summit and Stark.

Federal Substance Abuse Prevention and Treatment (SAPT) Block Grant

The 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.

2. Environmental Context

Provide a narrative that describes relevant information about the board area, including major achievements from the previous Plan (SFY 2006 -2007) and recent trends such as changes in services and populations. Please address fiscal trends under d. Financial Status below.

a. Characteristics of Clients Receiving Services

The Department will provide a summary of Behavioral Health (BH) Module data specific to each board area to assist in identifying characteristics of treatment customers. Data will be sent to the board by November 6, 2006. This data will be incorporated into the Department's review of the Community Plan. The board may choose to augment this information and/or clarify any gaps in data. *Describe the characteristics of customers receiving prevention services and treatment services.*

For this section, unless otherwise noted we used the BH Module summaries for fiscal years 2005 and 2006 provided by ODADAS for our analysis. We also included data for the first half of fiscal year 07 for the majority of the categories. It is useful to reiterate here—as stated by ODADAS—that the BH module tends to under-count the number of clients assisted by the state and by county boards. As such, the data sets and analyses below do not necessarily reflect the totality of clients served by the Board, nor will the numbers in the various categories add up to the "total clients served" number.

Our community behavioral health system went through a major transformation over the two years preceding the 06 RFI and contracts. Thus, fiscal year 06 was the first year of the implementation of the results of that planning process. In essence, as a result of a comprehensive planning process the Board established clear values or priorities for the local system of care., funding and contracting processes shifted from a focus on historical utilization and agency-driven budgets to one based on explicit priorities and the implementation of programs and a service delivery structure consistent with these values.

As addressed extensively in the 06 Update, there was the perception by contract agencies and some community members that capacity for AOD treatment services for adults was significantly reduced. The fiscal and service data presented in the Update demonstrated that was not the case. The BH module data on client characteristics prepared by the Department also confirms this.

A total of 1096 clients were served as reported in MACSIS in FY 05 and 1150 in FY 06.

As demonstrated in the table below, the percentage of females served in FY 06 increased and more closely mirrored the state percentage. Beginning with the FY 06 contracts, the Board required the primary provider of AOD treatment services to offer a Women's Recovery Group as part of the service mix. This may have contributed to the increase. It's also possible that the emphasis on services to families impacted this number, as is the fact that many of the participants in the Erie Co. Family Dependency Court Program are female (for FY 06 and FY 07, approximately 15 persons were served: 13 women, 2 men). As that program continues to grow, personnel stabilizes and the referral protocol between the Court, JFS and the providers is strengthened we expect this trend to continue.

The Erie Co. Benchmark Adult Drug Court Program served 45 clients in FY 06: 28 men, 17 women; 39 White, 6 Black. For FY 07 (as reported through 12/31/06) 29 clients have been served: 16 men, 13 women; 26 White, 3 Black.

In general, the ratio of juveniles to adults remained about the same, and was consistent with what is seen across the state—the exception being the proportion of youth served statewide, which experienced a drop in FY 06 while Erie-Ottawa remained consistent. One of the Board's explicit priorities going into FY 06 was an emphasis on services to youth and greater family engagement. While FY 06 was somewhat a transition year in that those contracts were the first to implement the shift in values and corresponding funding, we hope to see a greater proportion of youth served as we move into FY 08.

Race and ethnicity of persons served remained about the same and generally reflect percentages seen statewide although a slightly larger proportion of total clients served by Erie-Ottawa are white.

Client Demographics (Note: the data in the table below—with the exception of the FY 07 data for the period 7/1/06 through 12/31/06—was from the BH Module summary provided by ODADAS)

			FY 05		FY 06		FY 07	State FY 05	State FY 06
		#	% of total	#	% of total	#	% of total	% of total	% of total
Gender	Female	215	28.48	332	36.09	229	34.08	34.61	35.65
	Male	540	71.52	588	63.91	443	65.92	65.39	64.35
Age	Juvenile (under 18)	80	10.60	94*	10.76	93	11.77	10.89	7.77
	Adult	675	89.4	780*	89.24	697	88.23	89.11	92.23
Race	Black	129	17.09	149	16.20	124	18.45	26.20	25.13
	White	601	95.70	740	80.43	523	77.83	71.14	72.00
	Other	1	0.13	2	0.22	3	0.45	0.66	0.56
	Unknown	24	3.08	29	3.15	22	3.27	1.96	2.31
Ethnicity	Latino	16	2.12	18	1.96			1.87	2.01
	Non- Latino	739	97.88	902	98.04			98.13	98.04

* noted a potential error in the submission or reporting of data, as the numbers of juveniles and adults total 874 as opposed to 920 in the rest of the categories

For comparison purposes (due to various reporting errors and under-counting that occurs), we pulled the reported BH Module data locally for the client demographics for FY 06. As you can see in the table below, we show 1144 total clients served (vs. 1150 in the state summary). The ratio of males to females was similar (64.95%/35.05% vs. 63.91%/36.09%) as was the breakdown by race. See Table Below.

ADA Client Demographics from BH Data 7/1/05 through 6/30/06 (FY06)

RACE COUNT	RACE	%	GENDER	GENDER COUNT	
1	ALASKAN NATIVE	0.09%	1	MALE	
2	NATIVE AMERICAN	0.17%	1	FEMALE	
			1	MALE	
35	UNKNOWN	3.06%	6	FEMALE	
			29	MALE	
187	BLACK	16.35%	54	FEMALE	
			133	MALE	
919	CAUCASIAN	80.33%	340	FEMALE	
			579	MALE	
1144	TOTAL		1144	TOTAL	
			743	TOTAL MALE	64.95%
			401	TOTAL FEMALE	35.05%

The table below illustrates the drug of choice as reported by persons receiving treatment in fiscal years 2005 and/or 2006. In looking at the BH module data on drug of choice prepared by the Department, Erie-Ottawa is providing service to a significantly higher percentage of non-users (presumably collateral/codependent clients) than is occurring statewide. And while alcohol and marijuana or hashish are reported as the first and second drugs of choice respectively both for Erie-Ottawa and statewide, the proportion of persons reporting alcohol as their drug of choice in our board area is significantly higher than the state for both fiscal years (56.69% vs. 42.24% in FY 05; 55.39% vs. 40.38% in FY 06). Likewise, the proportion of persons reporting marijuana/hashish use is significantly less than in the state profile (12.32% vs. 21.78% in FY 05; 16.10% vs. 22.25% in FY 06).

Drug of Choice

	FY 05	FY06	State-FY 05	State-FY06
	% of total	% of total	% of total	% of total
Non-user	20.13	20.13	9.63	10.12
Alcohol	56.69	55.39	42.24	40.38
Marijuana or Hashish	12.32	16.10	21.78	22.25
Heroin or Morphine	1.72	1.85	5.94	6.50
Crack or Cocaine	5.83	4.46	14.15	14.63
Other Narcotic	2.65	1.31	3.15	3.40
Hallucinogens	0.26	0.11	0.27	0.22
Methamphetamine or Speed	0	0.22	0.22	0.32
Other Stimulants	0	0	0.49	0.55
Depressants	0	0	0.07	0.04
Inhalants	0	0.11	0	0.45
All other drugs	0	0	0	0.48
Unknown	0	0	1.39	0.48

It would be interesting to view this data statewide broken down by age (juvenile/adult) and gender. Looking at these differences and trends would help identify program needs and inform and enhance practice. The table below shows this information for the Erie-Ottawa Board system for fiscal years 2006 and 2007. Note that the figures reported for FY 07 include only that data submitted through 12/31/06. Consistent with statewide figures, alcohol and marijuana are the primary drugs of choice, representing the majority of folks in treatment locally.

Drug of Choice	YOUTH		FY06 YOUTH		FY07 YOUTH	
	FY06	FY07	MALE	FEMALE	MALE	FEMALE
0401 Marijuana/Hashish	71	8	51	20	6	2
0201 Alcohol	61	10	34	27	8	2
0302 Other Cocaine	1	0	0	1	0	0
1001 Methamphetamine/Speed	1	0	1	0	0	0
0706 Other Narcotic Analgesics	0	1	0	0	1	0
2002 Other Drugs	1	0	1	0	0	0
TOTAL YOUTH	135	19	87	48	15	4

Drug of Choice	ADULTS		FY06 ADULTS		FY07 ADULTS	
	FY06	FY07	MALE	FEMALE	MALE	FEMALE
0201 Alcohol	523	153	328	195	118	35
0401 Marijuana/Hashish	101	36	71	30	30	6
0301 Crack	32	8	17	15	5	3
0302 Other Cocaine	27	9	13	14	6	3
0501 Heroin/Morphine	19	3	9	10	1	2
0706 Other Narcotic Analgesics	17	6	6	11	2	4
1101 Amphetamine	4	1	2	2	0	1
0703 Oxycodone	2	0	1	1	0	0
1001 Methamphetamine/Speed	1	0	1	0	0	0
1308 Other Benzodiazepine	1	0	1	0	0	0
TOTAL ADULTS	727	216	449	278	162	54

GRAND TOTAL 862 235 536 326 177 58

In FY 06, slightly more youth (under 18) reported marijuana use as primary (approximately 53% vs. 45% reporting using alcohol as drug of choice); it is impossible to predict whether that trend will continue for FY 07 given the low numbers reported to date. This is something we will continue to monitor however as it has program implications in that the juvenile drug court team in Erie Co. is interested in the implementation of the MET/CBT 5 treatment approach, part of the Cannabis Youth Treatment Series issued by the Center for Substance Abuse Treatment. Board contract agencies provide the treatment for youth involved in the program. There were some differences in drug of choice by gender as reported for FY 06. Approximately 42% of females reported using marijuana as their drug of choice vs. 56% alcohol; for males, approximately 59% reported marijuana vs. 39% alcohol as their drug of choice. Of course this data doesn't speak to poly-substance

abuse/dependency as we only looked at the data for primary drug of choice. The use of other substances as primary drug of choice was almost non-existent—3 youth total reported something other than marijuana or alcohol in FY 06.

For adults the report of drug of choice by males and females between marijuana and alcohol more closely approximated one another; 73% alcohol and 16% marijuana for males, 70% alcohol and 11% marijuana for females. There were a greater percentage of adults reporting use of other substances than was the case with youth. While there was some variability, crack/cocaine use was next in terms of numbers reporting its use as primary by approximately 7% of males and 10.4% of females, followed by heroin/morphine use by males at 2% and other narcotic analgesics use by females at 3.96%. For females however, heroin/morphine use was only slightly less, at 3.6%.

As far as the data on "Disposition of Discharge from Treatment" and "National Outcome Measures", we did not really find that of value locally or in looking at the statewide numbers. As we referred to in the FY 06-07 Community Plan and briefly in the Update, there is such variance in the way that agencies and clinicians within agencies interpret these fields, and in the verification of the data, that it is difficult to compare or analyze the results. Furthermore—particularly evident in the NOMS data set—there are no clear guidelines on what data elements have to be reported on (in BH Module) at discharge, thus what often appears as little or no change in status is misleading because in fact it wasn't addressed at all.

We are eagerly anticipating guidance from the Department around BH module reporting and NOMS and the work of the Blue Ribbon Panel. Staff of the Erie-Ottawa Board has been a Board representative on the Outcomes Committee since its inception (until it disappeared?) and thus witnessed and/or participated in the raising of many of these concerns over the past several years. It is hoped that ultimately the Department will provide clarification and standardization around the use of the BH Module data for NOMS reporting—in regard to clear definitions of data elements and the verifications, identification of which fields = which NOMS, and reporting timeframes (At admission? At discharge? Other?) at a minimum.

Client Characteristics of Persons Receiving Prevention Services

In relation to the characteristics of clients receiving prevention services, the data is more difficult to pull together. Since prevention service delivery strategies are billed in MACSIS via a pseudo client, demographics are not entered. While our contract agencies do track information on the clients served, this is often as part of the client records and is generally by program vs. by prevention service. Unlike that on the treatment side—via the Behavioral Health Module and specific (as opposed to pseudo) client information—there is no mechanized or standardized way in which the necessary local/state/federal reporting can occur. In general, as reported by our prevention provider in each county, the following data reflects total numbers served by gender and by age (children/youth = under age 21 vs. adult):

Erie: Children/Youth—1913, Adult—375=Total 2288; Male—999, Female—1289

Ottawa: Children/Youth—2850; Male—1481, Female—1369

ALEC (Alternative Learning Education Center): 741 Children/Youth

Intervention (Strengthening Families, implemented at the end of FY 06): 31 Children/Youth

We are able to pull out the mix of service strategies delivered, the number of units, and the dollars expended by service and in total, and that data is reported in some fashion in later sections of this report. Still, other than looking at funding trends over fiscal years that data in and of itself is not very useful from a planning perspective since the various prevention delivery strategies cross program/curricula lines, target populations, and program sites.

Thus, knowing the total dollars and units of education or problem identification and referral delivered by a given agency or across the system provides no specific or useful information about the population served by All-Stars or Life Skills or the Incredible Years, let alone the impact of these programs. As such, we are interested in the outcome of the pilot project ODADAS is engaged in around the web-based prevention data reporting system as it will reportedly allow for easily entered and extracted data and information necessary for both state and federal reporting as well as information of value to board systems in relation to prevention investor targets. Please refer to Section III: Prevention Services for further discussion of the issues raised here.

b. Workforce Development

Describe the board's role in working with ODADAS and providers to attract, retain and develop qualified direct service staff for the provision of prevention and treatment services. What is the current status of the local AOD system's workforce? Does the system have sufficient qualified licensed and credentialed staff to meet its service delivery needs? If "no", identify the areas of concern and workforce development needs.

The current AOD workforce available to meet service delivery needs appears to be adequate at this time. That is not to say however that contract agencies do not sometimes experience problems when trying to fill vacancies. There is also sometimes "friendly competition" among providers and other community agencies for the same staff. For instance, the therapist with the Board contract agency that provided treatment services to the Erie Co. Family Dependency Court participants recently left that position to fill the vacated Drug Court Coordinator position. And the prevention specialist with the contract agency that provided programming to an Ottawa Co. school system recently took a position with them directly.

One area in which we consistently have difficulty with recruiting and retaining qualified staff is in our home-based programs (Functional Family Therapy, Multi-Systemic Therapy). The training and education requirements coupled with the non-traditional service delivery hours, the reporting and documentation responsibilities, and the many potential issues with providing services in the clients' homes contribute to

these positions being difficult to fill. We currently have three MST therapists and four—the fifth person recently left the agency and they are in the process of trying to fill the position—FFT therapists.

Since these programs are somewhat limited in their capacity given the caseload and staff size, the loss of a therapist significantly affects the number of youth and their families we are able to serve. Once the agencies are able to replace the position, there is the time and cost of training and the “learning curve” involved with implementing the intervention—all which impact productivity.

We have explored several strategies in an attempt to address this issue. For instance, we have talked about offering a higher salary for staff delivering these programs. According to our contract agencies this presents some problems however, in that it affects the morale of other staff as it is perceived as unfair. The fact that productivity levels are often lower for these staff because of the maximum caseload size and the additional documentation/reporting requirements and travel time is already an issue at times since all staff struggle with achieving productivity while still completing all of the “un-billable” tasks.

We have also tried relaxing the education and licensure requirements—for instance, considering Bachelor’s level therapists in addition to Master’s level; candidates with non-independent licensure status; less experience in the field. This has not been very successful either, as the level of experience and skills necessary for successful implementation of these programs is extensive. We have also tried offering sign-on bonuses as an incentive to attract potential candidates. Unfortunately, there is high demand for Master’s level, independently or dually licensed clinicians around the state. Add this to the difficulties already encountered in attracting these workers to fill positions that involve nights and weekends, on-call hours, tedious paperwork requirements and providing services in people’s homes and you can see what we are faced with!

The table below depicts the staff employed by one or the other of our three contract agencies currently providing alcohol and other drug treatment services. The information is accurate through the second quarter of FY 07, as taken from data reported by the agencies as part of the board’s quarterly staffing pattern monitoring requirements.

Erie-Ottawa MHRB System Provider Staffing Information for Alcohol/drug Services

Position	Highest Professional Degree	Licensure
Therapist II-child, MH/CD*	MSW	LSW
Therapist II-adult-CD	BA	CDCA
AOD Services Coordinator	MA	PCC, LCDCIII, ICADC
Counselor AD**	MED	LICDC
Counselor AD	BSCJ	CDCA
Counselor AD	MA	LICDC
Intervention Counselor	BS	LSW
Chemical Dependency Counselor	MA	CCDCIII-E, LISW
MH/AD Supervisor	MA	LPC
ADA Counselor***	MA	CCDCI
Site Supervisor-CD	MA	LPC
Intervention Counselor	MA	LPC
Intervention Counselor	BA	LSW
Chemical Dependency Counselor	MA	LSW
Chemical Dependency Counselor	BA	CDCA
Family Drug Court Case Mgr.	BS	--

* CD=Chemical Dependency

**AD=Alcohol/Drug

***ADA=Alcohol/Drug Abuse

On a broader level, Erie-Ottawa board staff participates on several OACBHA committees that have looked at this issue. For instance, the Clinical Leaders committee has reviewed the work of ODADAS' Workforce Development Committee and provided feedback, has worked with Dr. Svendsen and ODMH around training of case managers and recruitment of child psychiatrists, and is in the process of developing a white paper on workforce development.

In terms of the qualifications of staff who deliver prevention services as part of the board-funded system, it appears that current providers within the agencies meet the education and experience requirements that are part of the prevention certification standards. The general perception is that recruitment of prevention staff will be facilitated as a result of the array of acceptable licenses—despite initial misgivings about the associated education and service delivery experience required by the rules. Still, both of the prevention agencies contracted with by the board have at least one staff person with an OCPS I or II. In addition, both agencies feel they are prepared to undergo the prevention program certification process, and plan on doing so in conjunction with their next outpatient program survey.

c. Capital Improvements

For the board’s local alcohol and other drug service system, identify the board’s capital (construction and/or renovation) needs. Capital (construction or renovation) needs must be addressed in the Community Plan to be considered in future Department’s capital requests.

While no specific capital needs have been identified at this time, we do have a Housing Committee that is looking at various issues and has as one objective the creation of a Capital Needs priority list in conjunction with their recommendations. Upon completion of this task we will incorporate this information into the community planning process and notify the Department via an amendment to the plan or as part of the Community Plan Update as appropriate.

d. Financial Status

Describe recent trends in funding (e.g. levy, Medicaid, Recovery Assistance/Recovery Health Assistance) and funding related issues (out-of-county services, incorporating programs previously funded through ODADAS grant application process, etc.) for the board and their implications for the provision of alcohol and other drug services for the SFY 2008-2009 biennium.

The MHRB successfully passed a .7 mil replacement levy in November 2006. The levy was a combination of two previously passed levies which had been last renewed ten years ago and were expiring. Obviously, this is going to result in more funds for the system and provides an opportunity for the board to invest in additional capacity and/or new programs. Given this rare opportunity, the board has a comprehensive plan in place to conduct specific needs assessment activities and to obtain feedback from community stakeholders. These processes to gather data/information and establish local priorities for funding for fiscal years 2008-09 are described in the section on Treatment and Recovery Services. The table below shows the change in calendar year levy collections on the (total) 1 mil levy.

Comparison of CY Levy Collections on 1 mil levy.

CY 08 includes the collections on the replacement of .7 mil

	CY 05	% change	CY 06	% change	CY 07 (est.)	% change	CY 08 (est.)
Levy	2598958	3.19%	2684519	0.14%	2688393	23.17%	3499296
Dollar change			+ 85,561		+ \$3874		+ \$810,903

Overall, local funds comprised approximately 32% of the total board budget for fiscal years 2006 and 2007. With the estimated increase in collections as a result of the replacement levy, that proportion will increase to approximately 38% for fiscal years 2008 and 2009 (Note: the percentage increase for 08 will be approximately half the total increase, as collections begin in January 2008, halfway through the fiscal year). Overall Medicaid expenditures (MH and AOD) were approximately 23% for FY 06 and 20% for FY 07 (based on figures to date). In this respect, the board has been fortunate in that we are not in the situation where the majority if not all of the board’s discretionary funds are consumed by Medicaid match obligations. As hard as it sometimes is to establish priorities and make difficult funding decisions among the many important needs of our communities, it is a good problem to have considering the struggles encountered by some of our peers! Many board areas across the state are not so fortunate, and essentially are not able to provide a full continuum—if any—of services for those without Medicaid.

Medicaid expenditures for alcohol and other drug treatment services for fiscal years 2006 and 2007 (to date) are outlined below. As you can see from the data, fiscal year 07 Medicaid utilization appears to be at a rate/amount consistent with that spent in 06.

FY 06:

Total=\$571,856 FFP=\$350,266 Match=\$221,590
 Of this total, \$206,450 (\$127,541 FFP, \$78,909 Match) was paid to out of county providers

FY 07 (through 12/31/06, with 90% of claims for December)

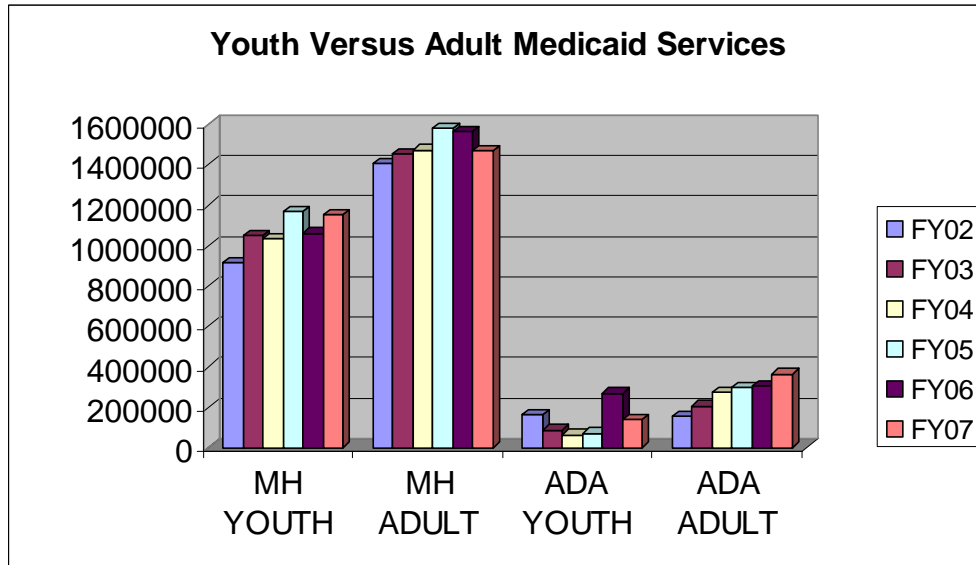
Total=\$251,794 FFP=\$151,966 Match=\$99,828
 Of this total, \$90,763 (\$54802 FFP, \$35961 Match) was paid to out of county providers

The tables and graphs below illustrate the trends in Medicaid expenditures over several fiscal years, from FY 02 through FY 07 (based on estimates for the second six months). Since the board has no control over Medicaid utilization—coupled with the responsibility to match eligible service provision—a substantive increase in Medicaid costs has direct impacts on the board’s ability to fund a comprehensive local continuum of care. This is further complicated by the fact that the board cannot really plan in relation to Medicaid due to the fact the benefit is an entitlement; thus the best estimate of usage is historical utilization, an art more than a science as illustrated by the variability in the tables below. This is also impacted by the provision of services to Medicaid eligible residents of the counties by out-of-county providers, which can fluctuate broadly from year to year.

Finally, there is the issue of the board having little or no control from a monitoring or oversight perspective for questionable services. Specifically, in FY06 our AOD Medicaid usage was up for youth because of one out of county provider billing an extreme amount of group counseling for approx 6 kids. While we were able to get billing records as well as a copy of the contract between the agency and the board from the county where the facility was located, we still had many unanswered questions and no clear avenue from which to pursue them. The ability to look at and respond to issues of quality and clinical appropriateness (i.e. medical necessity) of Medicaid services would be helpful.

Youth versus adult—Medicaid expenditures

	MH YOUTH	MH ADULT	ADA YOUTH	ADA ADULT
FY02	915840	1403459	159333	155745
FY03	1050060	1455529	86057	205309
FY04	1033005	1472953	63185	270161
FY05	1169223	1578144	71967	299095
FY06	1061589	1561919	268751	303105
FY07	1153948	1472606	139908	363680



State and federal funding from ODADAS for alcohol and other drug treatment and prevention services actually decreased by approximately 7.7% between fiscal years 2006 and 2007, from \$848,968 to \$783,464. This was primarily due to the decreases in prevention funds from the State Incentive Grant (SIG) and the Drug Free Schools and Community Act grant from ODADAS. Of course this impacted the board locally in that one of our priorities was to continue the prevention programs initiated with the SIG funds coupled with a board value to increase the amount of early intervention and prevention programs in the counties targeted at youth. The funds to accomplish this had to come from somewhere in the budget, thus impacting other programming (as discussed at length as part of the 06-07 Update).

In general, state funding (mental health and alcohol/drug)—which represents 37% of board funding—continues to be stagnant. That is one reason passing the replacement levy was so critical. For the past three years the Board has had to tap into its diminishing reserves just to continue meeting the basic needs of residents.

The following table and graph illustrate the amount (in dollars) of local levy funds used to support mental health and alcohol and drug abuse/dependency services for the period covering fiscal years 2002 through 2007 (note the second six months is estimated). This does not represent the total dollars invested into these services, only the amount of this particular funding stream into the mix for a given fiscal year. Local levy dollars are also used to fund a sliding payment scale for persons with no insurance and little income. They also allow the board the flexibility to fund local priorities and community-designed mental health and recovery programs.

LEVY DOLLARS USED TO SUPPORT MH & ADA SERVICES NON-MEDICAID

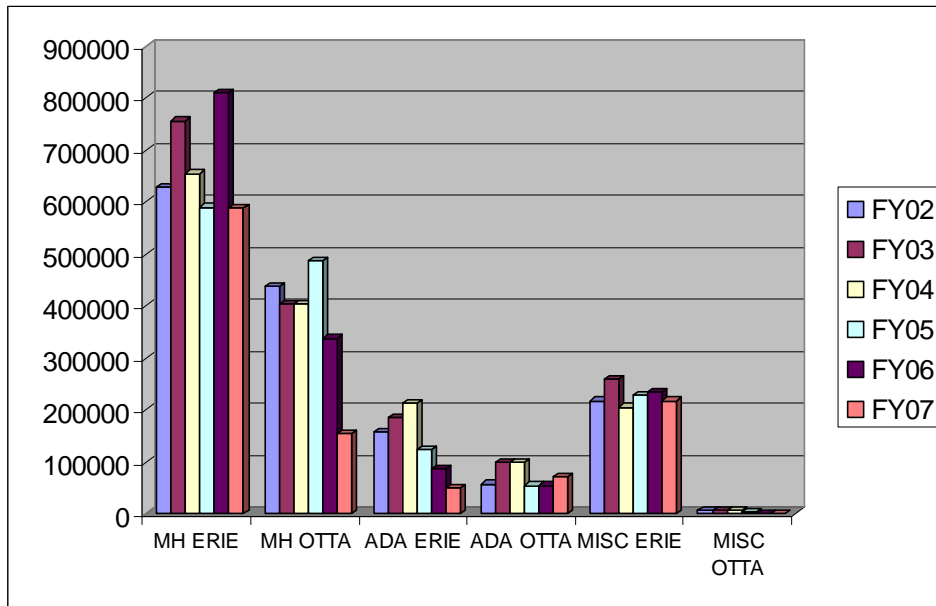
	MH ERIE	MH OTTA	ADA ERIE	ADA OTTA	MISC ERIE	MISC OTTA
FY02	628782	437063	158276	57426	217849	6888
FY03	756596	403154	185506	97915	259741	7074
FY04	654584	404660	212323	99565	205424	6000
FY05	590379	487885	123390	54495	227384	3739
FY06	810567	337732	86863	54021	235100	1000
FY07	588556	153496	50260	70950	217328	1000

Last 6 months of FY07 estimated

Misc Erie = CCA, ESN (part), Artisans, FCF, CAV, SIG sup.

Misc Otta = FCF, SIG sup.

Levy Dollars Used to support MH & AOD Services Non-Medicaid

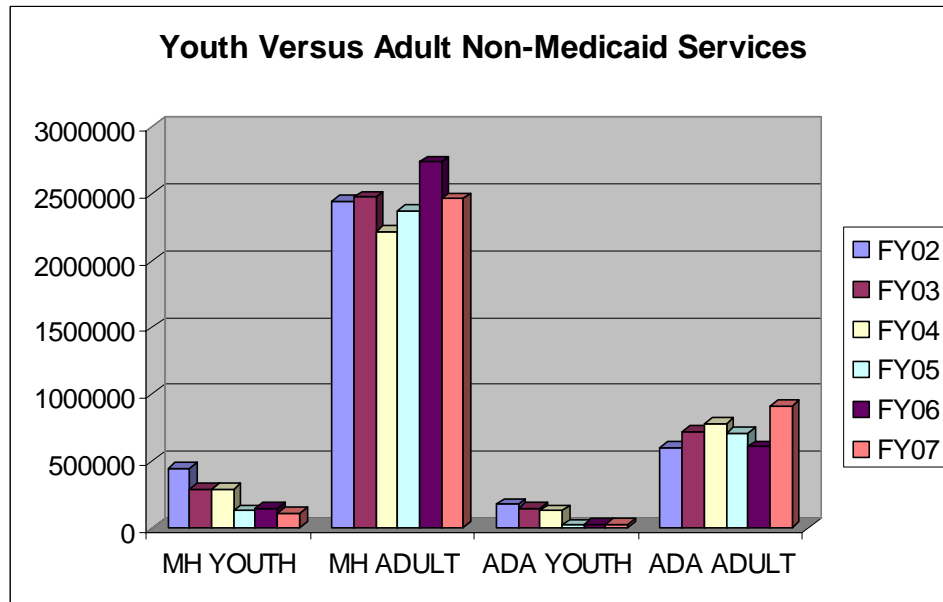


The next set of tables and graphs illustrates the amount of non-Medicaid expenditures for youth and adults for the period from FY 02-FY 07. Again, to get a sense of the total dollar picture one would need to add this to Medicaid expenditures for the same period. For instance, the majority of youth served are Medicaid eligible, thus what appears as a minimal investment in these illustrations does not accurately reflect the total board investment.

Youth vs. Adult—Non Medicaid Expenditures

	MH YOUTH	MH ADULT	ADA YOUTH	ADA ADULT
FY02	447471	2443926	175532	602479
FY03	288647	2479224	143183	723930
FY04	290801	2219942	128735	780834
FY05	129644	2377047	17051	707298
FY06	147131	2739621	26153	604641
FY07	108258	2464320	25966	912516

FY07 is estimated for 6 months

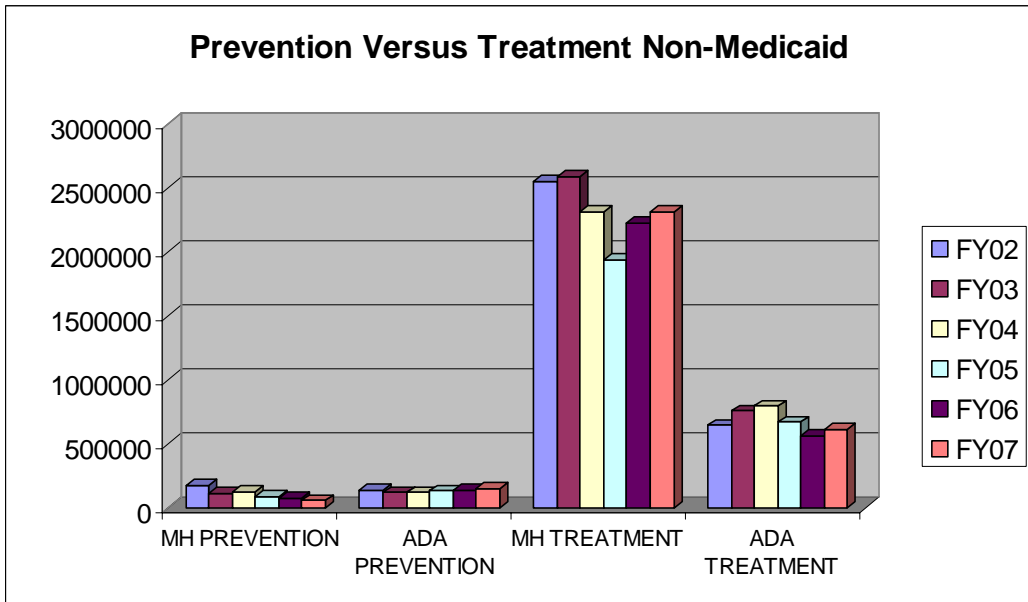
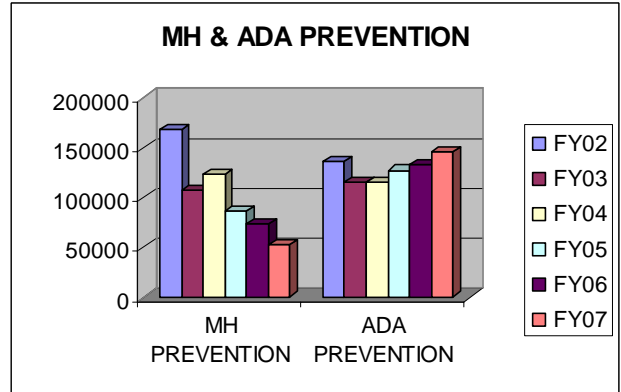
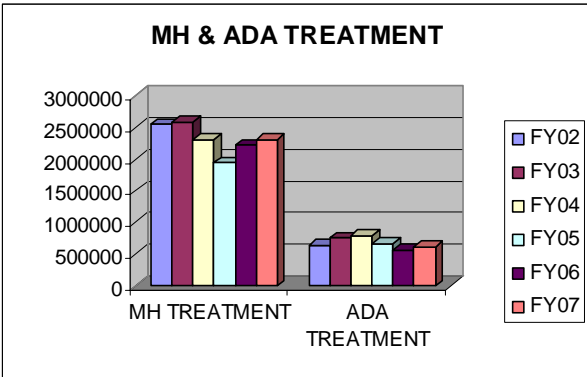


The following set of tables and graphs shows the board's non-Medicaid expenditures for the same time period among mental health treatment and prevention services and alcohol and other drug treatment and prevention services.

TOTAL PREVENTION VERSUS TREATMENT NON-MEDCAID

	MH PREVENTION	ADA PREVENTION	MH TREATMENT	ADA TREATMENT
FY02	168483	136188	2552228	641823
FY03	107448	115379	2590846	755734
FY04	122981	115500	2311682	794069
FY05	85990	127761	1941787	667815
FY06	73197	133402	2227905	562222
FY07	52562	145612	2311292	615335

FY07 last six months is estimated



The final data set provided is an excerpt from the board's FY 2006 Annual Report, and shows the expenditures by service or service area (i.e. counseling includes individual and group counseling services) for alcohol/drug treatment and prevention.

It is of interest that for fiscal year 06 the board's total expenditures (all revenue sources) for mental health services were \$6,107,584 or 80% of the total expenditures of \$7,626,176, while expenditures for alcohol/drug services were \$1,518,592. This is in large part a direct result of the disparity in state and federal revenue received by the two Departments. For FY 06, the board received \$2,793,144 in State funds from ODMH vs. \$342,807 from ODADAS. Federal funding totaled \$118,509 from ODMH vs. \$496,893 from ODADAS—a significant amount earmarked for prevention services. These revenue figures do not include entitlements (Title XX and Medicaid FFP).

FY 2006 Alcohol/Drug Services and Expenditures

Assess / Screen / Meds	258234		
Counseling	422053		
Case Management	97496		
Crisis Intervention	17965		
Intensive Outpatient	310173		
Prevention Services	292942	INCLUDES SIG	
Residential	59495		
Hotline/Intervention/Grants	60234	total AOD	1518592
			7626176
			TOTAL AOD and MH
			20% % AOD

e. Table 1: Portfolio of Providers

See Appendix B for instructions and to complete Table 1.

SECTION II: CAPACITY DEVELOPMENT

1. Access to Services

Identify the major issues or concerns for individuals attempting to access prevention and treatment alcohol and drug services in the board area.

What is the board's plan for addressing these issues?

We regularly monitor access to both mental health and alcohol/drug treatment services via the Capacity Management Report described extensively in previous Community Plan submissions. In essence, we monitor the times between initial contact, assessment, and the first therapeutic appointment. These access points are significant as research shows that wait times contribute to drop out rates (no-shows and cancellations), which in turn contribute to poor clinical outcomes, lost productivity and impacts on agency fiscal viability. National drop out rates are about 50% for both of these points.

For alcohol and drug treatment services, the agencies also report on the number of IVDU drug users receiving interim services, required by ODADAS as part of the Board's monitoring activities. Capacity Management Reports by agency and for the board system are then prepared and discussed on a quarterly basis with providers and the Board. These reports have undergone many changes over the years we have collected this data—most recently this week!—either as an attempt to streamline reporting responsibilities and administrative burden or to address different information needs. In general however, the information gathered from these reports along with service utilization data and program reporting does provide us with useful information around general access to treatment services.

The reports also allow us to look at trends over time. Hence, as programs and service delivery changes are made across the system we can view the impact on general access and wait times over several quarters of a given fiscal year or from one fiscal year to the next.

There are limitations to our Capacity Management Reports however. Based on the current format we are not able to use them to monitor access to different programs or services or by different populations. For instance, there is no distinction between SMD consumers and general population folks seeking mental health counseling; no way to tell if folks are able to get into individual counseling but not into IOP or in to see a psychiatrist; no way to pull out access and capacity information related to specific programs like MST, FFT or domestic violence programs. The reports also do not tell us whether access to general mental health or alcohol/drug treatment services varies by race, ethnicity, gender or age—all important. Because the information would be more useful in terms of monitoring and managing access if we could “drill down” to this level we are exploring potential changes in the way the reports are currently set up to facilitate this.

We also don't get the data by county, and since two out of three of our treatment providers serve both counties to some degree that can be an issue. This is especially the case for our provider of adult alcohol and drug treatment services, who serves as the primary provider in both Erie and Ottawa Counties. We will often see differences in the utilization of allocated resources/services via our monthly Service Usage monitoring reports—which does look at the counties separately—however it is not clear from the access reports if or to what extent there is a concurrent delay in getting services. Or, on occasion, sometimes we will hear about long waiting lists from referral sources or clients but not see that reflected in the various data sources.

The timeliness of the data is also an issue. Often we are looking at access retroactively, by months. And since the reports are generated quarterly, by the time we are first able to look at access for a given fiscal year half of the year is practically over! One of the recent changes made, along with streamlining the data reporting piece, was to move to a monthly schedule in an attempt to address this issue.

Originally we encountered problems related to how the various providers defined "waiting list." For example, we had one provider who scheduled everyone who called for service, thus did not consider themselves as having a waiting list. Yet clients were scheduled out four or five weeks later for their first appointment (which the board considered a waiting list!). Another provider chose to put persons on a waiting list to be seen initially rather than do an assessment and then not be able to offer the client indicated services until some time in the future. By looking strictly at the number of days between the various benchmarks—using actual service/claims data from MACSIS—we were able to resolve these definitional issues.

We have provided the access information from the fourth quarter of FY 06 to illustrate the data looked at as part of our capacity management reports. This report reflects data from both our primary and secondary providers in both counties. The numbers are reported in MACSIS and provided by Board; the Agency provides explanations as relevant. Although none were reported in conjunction with the fourth quarter reports, in general they include things like: "2 clients were no shows and rescheduled later"; "5 clients cancelled and rescheduled"; "19 clients did not return for treatment (5 simply did not return; 14 were on the waiting list for IOP and did not return when space became available)"; "25 clients needed no further services and were abstinent, 3 clients moved, 1 client was in jail and 3 clients rejected services". Finally, although not reported here because the number equaled zero, item (1. b.) is broken down by the total number of IVDU users on the waiting list, further delineated by those waiting for over 14 days, for over 120 days and for those receiving interim services.

4th Quarter: 04/01/06 to 06/30/06

1. Number of Requests for service:	<u> 331 </u>
a. # referred to another agency	<u> 3 </u>
b. # currently on waiting list	<u> 65* </u>
#IVDU users	<u> 0 </u>
c. # unable to engage for assessment	<u> 91 </u>
d. # scheduled or in process of scheduling	<u> 0 </u>
e. # seen w/no assessment billed and/or Crisis	<u> 41 </u>
f. # seen for assessment which were Board reimbursed	<u> 196 </u>

* At the time of the report, the primary provider reported 65 persons on the waiting list. 28 of those subsequently received a service.

2. Of the above clients seen for an assessment, the following occurred:

a. #seen within 3 working days	<u>24</u>
b. #seen within 4-20 working days	<u>102</u>
c. # seen greater than 20 working days	<u>70</u>

3. Of the clients seen for a second treatment service, the following occurred:

a. #seen within 5 working days	<u>53</u>
b. #seen within 6-20 working days	<u>51</u>
c. # seen greater than 20 working days	<u>36</u>
d. # with no service	<u>97</u>

Aside from the issues related specifically to the capacity management reports themselves and/or information gleaned from those reports, another issue—especially relevant for our adult AOD system—is the fact of no shows and cancellations and their impact not only on programming but on what the access data looks like. We have found that many clients who schedule an assessment are not unhappy with the delays in being seen, and even when we have been able to move them up (for example, because of cancellations, “open assessment” or “first come, first serve” time slots) they often decline. This is also true for those who have been seen for an assessment and may be waiting for IOP or another group but are offered pre-treatment or treatment readiness groups. Not only do these issues play havoc with the agency’s ability to structure staffing and programming at times, they also skew the data around access resulting in a sometimes misleading picture.

Two additional issues somewhat related to access are the delivery of integrated (mental health and alcohol/drug treatment) services to persons suffering from co-morbid mental health and substance abuse or dependency issues and the coordinated delivery of services to youth and adults of the same family. In reality, all three of our agencies have the capacity to provide both mental health and alcohol/drug treatment services to children, youth and adults as either a primary or secondary provider. By definition, a primary provider is funded to provide the entire range of services purchased by the Board, including—for adult AOD—IOP services, specialized treatment groups and intensive case management. For youth services, this includes home-based services (Functional Family Therapy, Multi-Systemic Therapy) in addition to more traditional office-based interventions and programs. Still, informal information received from various referral sources indicates a perception that access to treatment is not as seamless for the consumer as intended by the board via the contracting process.

Partially in response to information gathered over the years related to access and partially in response to the level of actual services provided to children and youth vs. the amount planned, the funds the Board traditionally invested in services to youth was increased beginning with FY 06. The scope of the funding group was also broadened to include reimbursement for services to family members of the youth involved in treatment as well as a greater emphasis on family-focused interventions. These changes were made consistent with local Board priorities beginning with the FY 2006 contracts, which included a desire to improve access to service for youth and families, and are good examples of using data to make informed decisions about planning and investment (a SFY 2006-2007 Capacity Development Target of the Board). We also worked with our secondary provider of adult AOD services in Erie Co. around using their limited allocation to help subsidize the provision of services to SAMI clients and for the provision of AOD counseling as appropriate to general population folks in treatment

for mental health issues.

Access to Prevention Services

Access to prevention services tends to be more related to systemic issues. Consider this feedback received from a contract agency as part of a narrative response in conjunction with our quarterly contract compliance and program progress reports (regarding progress related to the implementation of the Life Skills program beginning in FY 06 as agreed upon by the PfS partnership and funded by the board):

Two major factors come into play here when working with schools—availability of class time for the presentations and proficiency tests. Schools are under a great deal of pressure to have students pass proficiency tests and their response is to dedicate as much time as possible to teaching students what they need to know to pass. Thus teachers are either not willing or hesitant to give up any instructional time. This is understandable since their funding and reputation are being based on proficiency test scores. Schools do dictate when we can provide Life Skills and we are working with the schools around these issues. This year we also ran into a problem unfortunately with school personnel changes and although the staff wanted the programs they had a lot on their plate and they dropped the ball in getting the programs scheduled early enough in the school year to avoid conflicts.

In addition to these issues, there is the issue of timing in relation to school-based prevention programming—not only in relation to testing and preparation time, but also to school breaks and the necessary “transition time” before and after they occur. Offering prevention activities after school or in conjunction with other youth programs (i.e. Boys and Girls Club, YMCA) are possibilities, as are family-focused prevention and early intervention activities consistent with local (PfS) target impacts.

2. Capacity Development Targets

Identify the board’s Capacity Development Targets for SFY 2008 -2009. A board may adopt one or more of the Department’s Capacity Development Targets or identify alternative Targets of their own development that are mutually agreed upon by the Department (through discussion with the board’s regional coordinator prior to submission of the Community Plan). Indicate the ODADAS Capacity Target to which the board’s Capacity Target is contributing, if applicable.

The Erie-Ottawa Board's Capacity Development Target for SFY 2008-2009 is to increase the use of “evidenced-based” policies, practice, strategies and programs in the AOD system. This ODADAS Capacity Target is consistent with one of our local board values or priorities to balance (access to) a basic continuum of care with evidenced-based or “best practice” strategies. This community value is one that emerged as a result of the comprehensive planning process leading up to the FY 06 contracts, and as such, this target was one we selected to contribute to for the FY 06-07 biennium as well.

As part of the FY 2006 RFI and contracting process the board committed to providing training (and subsequently, adequate funding for implementation) on Functional Family Therapy (FFT) to the primary providers of youth/family services in each county. While we encountered many challenges—and are still working through some issues related to the consultation process and implementation—we were able to begin that (three year) process in June of 2006. Our five member team, comprised of two clinicians

from our Ottawa Co. provider agency and two clinicians and the lead/supervisor from our Erie Co. agency, has been delivering services for approximately seven months now, and is nearly through with the first year of intensive training.

The board was also able to provide additional capacity for Multi-Systemic Therapy, another evidence-based program that was already being provided in Erie County via funds from the Family and Children First Council and Juvenile Court. As a result of the board funding, the agency was able to open up the referral base, and in FY 07 was also able to begin serving Ottawa County families in a limited capacity.

In Ottawa County, the program "Thinking for Change" was implemented by the contract agency late in FY 06, in part to meet the needs of youth being referred from the juvenile court. Thinking for Changes is a cognitive behavioral program for adolescents that follows a simple straightforward principle—thinking (internal behavior) controls actions (external behavior). The program uses a combination of approaches to increase awareness of self and others. Attention to attitudes, beliefs and thinking patterns is combined with the teaching and building of interpersonal and other pro-social skills among participants for use in addressing present and future needs.

Our Erie County provider implemented Seven Challenges at the beginning of FY 2007 via joint funding from the board and the Erie County Juvenile Court. It is an evidence-based program designed for adolescent and young adult substance abusing or substance dependent individuals to motivate a decision and commitment to change. It helps young people look at themselves, understand what it takes to give up a drug abusing lifestyle - and prepare for and attain success when they commit to such change. The Seven Challenges is a comprehensive program that is developmentally appropriate, research based, culturally sensitive and holistic. This program ultimately replaced the IOP service in the youth alcohol/drug continuum of care.

We were also able to provide continued funding for the prevention programs started as part of each county's Partnership for Success (PFS) processes—made possible as a result of the SIG grant awarded by ODADAS—once the grant funds were depleted. Those evidence-based or "best practice" programs include Parenting Wisely in Ottawa Co. and the All-Stars program in Erie Co. In fact, we were able to expand All-Stars to additional sites in FY 07. As reported in the FY 06-07 Community Plan Update, we also required the provision of a minimum of one additional evidenced-based prevention program as part of our additional investment in early intervention and prevention services (another local board value) beginning with FY 06. That resulted in implementation of several programs in fiscal year 2006 and/or 2007 in both Erie and Ottawa Counties including Life Skills, Reconnecting Youth, Strengthening Families, and the Incredible Years. (Note: Reconnecting Youth did not continue for FY 2007 due to the lack of fit between the program and youth accepted into the Virtual Learning Academy where the program was delivered. Individualized prevention and intervention services are currently offered at that site).

We are pleased as a system of all that we were jointly able to achieve in relation to this Capacity Target and local priority throughout FY 2006 to date, and plan to continue the investment into the next fiscal year. Additional goals for the FY 2008-2009 include a restructuring of our alcohol and drug treatment system of care based on the Stages of Change model. This will include training on Motivational Interviewing as well as on other evidence-based strategies such as Cognitive Behavioral Therapy.

The Stages of Change Model (SCM) was originally developed in the late 1970's and early 1980's by James Prochaska and Carlo DiClemente at the University of Rhode Island when they were studying how smokers were able to give up their habits or addiction. The SCM model has been applied to a broad range of behaviors including weight loss, injury prevention, behavior changes related to diabetes, heart disease, etc., cancer prevention, smoking cessation, substance abuse, depression...even applied to keeping New Year's Resolutions!

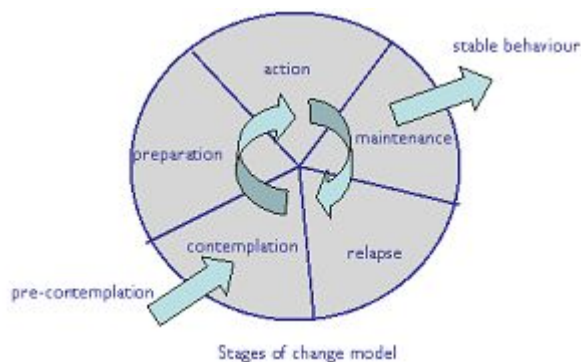
The idea behind the SCM is that behavior change does not happen in one step. Rather, people tend to progress through different stages on their way to successful change. Also, each of us progresses through the stages at our own rate.

So expecting behavior change by simply telling someone, for example, who is still in the "pre-contemplation" stage that he or she must go to a certain number of AA meetings in a certain time period is rather naive (and perhaps counterproductive) because they are not ready to change.

The stages of change are:

- Pre-contemplation (Not yet acknowledging that there is a problem behavior that needs to be changed)
- **Contemplation** (Acknowledging that there is a problem but not yet ready or sure of wanting to make a change)
- **Preparation/Determination** (Getting ready to change)
- **Action** (Changing behavior)
- **Maintenance** (Maintaining the behavior change)

There has been a great deal of research in relation to this model, including the development of assessment tools related to one's readiness to change as well as in relation to treatment and intervention strategies and development of the skills necessary to help individuals move through the stages.



Our tasks over the next 6-12 months will be in part focused on determining the role of the primary and secondary providers; determining whether to restructure the adult system only or the entire AOD service continuum; attaching a service mix and continuum of care to the stages, along with the appropriate funding levels; bringing in system T.A. and training/consultation on the SCM and related interventions such as Motivational Interviewing and Cognitive Behavioral Therapy; reviewing and adopting standardized assessment and readiness for change tools; working with referral sources

and community partners to educate them on the model and around expectations and outcomes associated with each stage; working with agencies around clinical documentation (esp. of medical necessity) and reporting and building a mechanism for monitoring and oversight by the Board.

We will also be exploring the implementation of the MET/CBT 5 program of the CYT series in Erie County. As stated previously in the discussion around youth drug of choice, the juvenile drug court team is interested in the addition of this program to the continuum of care available not only to youth in the drug court program but to all youth in the county. Our Erie Co. provider of youth services (which also serves Seneca, Sandusky and Wyandot counties) began providing this program in some of their other sites beginning in FY 2007, thus the capacity exists to expand if desired. One of the primary issues is the efficacy of the program and the outcome expectations if generalization occurs to those who do not use marijuana as the primary drug of choice—or use it rarely or not at all. While the curriculum has reportedly been delivered to youth with poly-substance abuse and/or those who use marijuana but as a secondary or occasional drug of choice, the outcomes studies are not complete. Our data for FY 06 demonstrated that marijuana is the drug of choice for 53% of youth in treatment, with approximately 45% reporting alcohol as primary.

The way the juvenile drug court is currently set up, youth involved in the program receive treatment via the public behavioral health system. Currently, about half are in the MST program and half are in Seven Challenges. As stated previously, training occurred early in FY 07 and was made possible through collaboration between the MHRB and Erie Co. Juvenile Court in terms of sharing the cost of the training.

Given the fact that the MET/CBT5 treatment curriculum is designed as a brief outpatient program there are questions about whether the intensity of the service and the level of care will meet the needs of the youth typically served in drug court. From a system perspective, we also need to look at the existing continuum of care available, the number of youth accessing services, outcomes or results of current programs/services, staffing capacity and other factors in determining what strategies and programs will most effectively meet the needs of the youth in our community.

SECTION III: PREVENTION SERVICES

Prevention Defined

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

Prevention Service Categories by Population Served:

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

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

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

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

Prevention Service Delivery Strategies

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

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

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

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

Environmental prevention is an AOD prevention strategy that represents a broad range of activities geared toward modifying systems in order to mainstream prevention through policy and

law. The environmental strategy establishes or changes written and unwritten community standards, codes and attitudes, thereby influencing incidence and prevalence of alcohol and other drug use/abuse in the general population.

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

1. Prevention Needs

This section of the Plan includes a description of information and data used to determine the board's prevention needs. Describe all needs identified through quantitative and qualitative sources while differentiating between met needs (enough resources are already available to address the need) and unmet needs (additional resources are needed to address the need).

Describe the process the board utilized to determine its current prevention needs, including data sources and types, methodology, time frames and stakeholders involved.

What were the findings of the needs assessment?

2. Prevention Priorities

This section of the Plan prioritizes the board's identified prevention needs. These priorities are determined locally keeping in mind the various priority populations identified either by statute or Department initiative. Key ODADAS prevention initiatives include: Fetal Alcohol Spectrum Disorder, Childhood/Underage Drinking, Youth-Led Prevention, Evidenced-Based Practice and Stigma Reduction. Note there is no rank order to these priority populations.

- Pregnant women and women of child-bearing age
- Children/adolescents
- Clients at risk of tuberculosis or other infectious disease
- Individuals involved in the criminal justice system
- TANF recipients
- Individuals involved in the child welfare system (H.B. 484)

Describe the process utilized by the board to determine its prevention priorities for SFY2008 – 2009. How did the board decide the most important areas in which to invest their resources?

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

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

The following narrative addresses the set of items addressed under (1) Prevention Needs and (2) Prevention Priorities in the Guidelines.

In general, the MHRB's priorities for the delivery of prevention services are consistent with the target impacts and set of associated risk/protective factors and developmental assets that resulted from the Partnership for Success (PFS) planning processes conducted over fiscal years 04-05. Since this was discussed extensively in both the FY 06-07 Community Plan and the Update, we will only briefly discuss it here. The following specifications for local prevention services/programs were excerpted from the FY 06 RFI (and remain in place to date):

In **Ottawa County**, they were as follows:

Target Impacts:

- Reduce Delinquent Behavior
- Increase School Success
(Truancy was identified as the connecting factor between these two targets).

Risk/Protective/Assets:

- Inconsistent and inappropriate discipline
- Lack of commitment to school
- Academic failure
- Children accept personal responsibility
- Increase parental supervision

In **Erie County**, they were:

Target Impacts:

- Reduce Substance Abuse
- Reduce Delinquent Behavior
- Reduce Risky Sexual Behavior

Risk/Protective/Assets:

- Family Boundaries
- High Expectations
- Positive Peer Influence
- Adult Role Models
- Family Support
- Restraint

B. The target population for Board prevention activities is youth (17 and under) and families with a special emphasis on the 0-12 population.

C. Programming could occur at the individual, the family, the school, the media and community organizations as applicable;

D. At least one evidence-based program or "best practice" must be implemented as part of the overall prevention programming

As a community, we are still working toward impacting these targets identified as part of that planning process. Unfortunately, once the SIG funds available for staff to coordinate the initiatives (and additional funds earmarked by the MHRB through year two of the planning processes) were depleted,

the processes were not picked up by the Family and Children First Councils in the same manner. While there has been some ongoing reporting and continuing contact with the consultants at the Center for Learning Excellence by folks in both counties who were actively involved in the PfS planning process, the coordinated monitoring and widespread community involvement/activities has not continued.

In Ottawa County, administrators and staff of the agency contracted with by the Board—also active participants in the county's PfS process over the three year grant period—have continued to work with other stakeholders around the identified target impacts as they have attempted to evolve their programming to meet the identified needs of the community. As discussed in other sections of this document, the process in that county resulted not only in the identification of reducing delinquent behavior and increasing school success as primary, but in agreement around the implementation of the Life Skills program as a means of impacting these targets. After much discussion, the recommendation was to initiate implementation at the middle school level, and expand to the elementary schools as additional funding became available. The fact that the Life Skills can be delivered flexibly—as an intensive mini-series or on an extended schedule—and is developmental in its approach was an attractive feature of the program. Note that the addition of Life Skills was in addition to implementation of the Parenting Wisely program, which was funded through the SIG.

There has been some change in the grades/ages of children and youth targeted by this program as well as in the schools in which the program has been implemented as a result of the agency's response to the various needs of the schools. The long term plan for county-wide implementation is as follows:

School Year 06-07	School Year 07-08	School Year 08-09	School Year 09-10
80% of schools participate; first year of Life Skills for 3 rd graders	100% of schools participate; second year of Life Skills for 4 th graders; first year of Life Skills for 3 rd graders	Third year of Life Skills for 5 th graders; second year of Life Skills for 4 th graders; first year for 3 rd graders	Ongoing—process continues

In regard to the Parenting Wisely program, referrals have dropped off with the implementation of the Functional Family Therapy program. While the dynamic underlying this is not clear, we will be exploring this issue in the upcoming months to determine how they might work together, what changes may need to occur regarding marketing and education of the program, and the differences in populations targeted by the respective programs.

In Erie County, the Sandusky City school system (the largest in the county) received a three million dollar, three year federal Safe Schools/Health Students grant in October 2004—in part as an outgrowth of the PfS planning process. SS/HS is funded through a cooperative grant awarded by the U.S. Department of Education, U.S. Department of Health and Human Services, and U.S. Department of Justice. Six core elements comprise all SS/HS grants:

- Safe school environment
- Violence, alcohol, and other drug prevention and early intervention
- School and community mental health preventative and treatment intervention services
- Early childhood psychosocial and emotional development services

- Educational reform
- Safe school policies

The Sandusky SS/HS Initiative is focused on prevention and family strengthening and follows a developmental path beginning with programs for newborns through 12th graders. The belief is that it is important to strengthen the family in order to strengthen the schools and communities. Sandusky SS/HS is a blend of programs that take place in the schools and the community, many of which are multigenerational. The concept of building developmental assets and reducing risk factors underlies the initiative and is evident in each of our programs. SS/HS has allowed our community to invest significant resources in preventing problems rather than waiting to intervene when a youth's problems have become severe and more difficult to remedy.

As was the case with programs funded via the Board beginning with fiscal year 2006 (see previous description of prevention program specifications), many of the programs implemented as part of the SS/HS project were consistent with the target impacts and set of risk and protective factors and developmental assets identified. Now that the program is into its third and final year of funding—not counting extended time as a result of allowable carryover—attention is focused more intensely on transition, sustainability and expansion to students/schools outside of Sandusky. While technically not (ongoing) PfS, the magnitude and scope of the initiative in conjunction with its many partners and its focus on prevention programming has been a primary driver relative to prevention needs and priorities in Erie County.

The board's role as a collaborator and partner in this process has been mutually beneficial, as an increased emphasis on early intervention and prevention activities and a focus on increasing access to services to youth and families are two of the board's priorities/values for the local system of care. At the December 2006 SS/HS meeting partners were asked to rank order the project programs in terms of importance for sustainability. While all programs were deemed important, the parenting related programs Strengthening Families and the Incredible Years and the All Stars program were ranked in the top five of the total thirteen programs. These programs are currently funded in Erie County under the board system in addition to the parenting programs offered to Sandusky residents under the grant.

A brief description of these three programs follows:

Strengthening Families is for families with children 10-14 years old. It is a 7 week program designed to help parents build on their strengths in showing love, setting limits, and helping families grow together. Parents and children meet separately for the first hour and then join together as a family for the second hour.

Incredible Years is a 10 week program is for parents and care givers with children 3 -8 years old. It is designed to teach parents effective ways to promote positive parenting strategies and assist them in managing children's challenging behaviors.

All Stars Program is designed to prevent substance use (alcohol, tobacco, marijuana, and inhalants), premature sexual activity, fighting and delinquency in young people. The program also enhances positive characteristics we all want young people to develop—idealism and a

belief in the future, commitment to a positive lifestyle, wholesome standards, resiliency, a sense of belonging, and positive relationships with parents and other adults.

As such, staff of the Board has worked with the Project Director around continued funding for many of the prevention programs initiated as part of the grant. For instance, board contract agency staff received training in both the Strengthening Families program and the Incredible Years program as a result of the SS/HS grant. These programs were expanded via board funds to residents outside of Sandusky City school district beginning with the FY 06 contracts. For FY 07, an additional cycle of the Incredible Years was funded in Erie Co. and funds were made available to offer a cycle in Ottawa County. Funding for both of these programs is expected to continue, and capacity will likely be extended to accommodate additional program cycles once the SS/HS grant funds are depleted.

In addition, midway through fiscal year 07 the Board picked up funding for the All-Stars program—already funded in other Erie county sites—delivered to Sandusky school students. Because of the timing of the delivery of the program in relation to the school year, this primarily resulted in funding of the booster sessions for this fiscal year; however ongoing funding and provision of the program to students in the Sandusky schools will be part of the board contract for fiscal year 2008. The board also picked up reimbursement for asset development activities, particularly as the board contract agency in Erie Co. was already being funded for this as part of their prevention contract. All of these programs are consistent with the Board's values and the requirements for prevention programming approved by the Board for the FY 06 RFI and continued to date.

Newer programming, implemented during this third quarter of FY 07 and planned for fiscal year 08, include prevention services (mental health and alcohol/drug) at the new youth center in Vermilion and bullying prevention programming in Erie County. Both of these programs grew out of ongoing collaboration and consultation with community stakeholders, and arose as a result of compatibility between identified needs and desires for services and the board's conclusions as a result of various needs assessment activities. Consensus around the specific bullying prevention program selected for implementation occurred as a result of board-initiated meetings with the Coordinator of the SS/HS program, the board prevention provider, the FCFC Director and members of the clinical committee and others. As a result, the Stop Bullying Now program is being delivered to at least seven sites in Erie County with more schools either expressing interest for the future and/or with which presentations are scheduled.

We have also worked with the Erie Co. FCFC around H.B. 289 planning, which requires OFCF and local FCFCs to do annual planning and reporting on increasing child well-being. In essence, state and local councils must collect data and measure progress toward meeting local priorities around one or more of the six commitments of child well-being which are as follows:

- Expectant parents and newborns thrive
- Infants and toddlers thrive
- Children are ready for school
- Children and youth succeed in school

- Youth choose healthy behaviors
- Youth successfully transition into adulthood

As part of the needs assessment activities associated with that process, feedback from nearly two hundred surveys was obtained from community gatekeepers, agency administration and staff and community members. The "H.B. 289 Planning Indicator Rank Order and Resource Assessment" survey asked respondents to rank order the six commitments to child well-being and within each commitment area, to identify the top two or three indicators. What emerged from that process was the identification of Commitment four—Children and Youth Succeed in School and Commitment three—Children Are Ready For School as the number one and two priorities. Within these two overall commitment areas, indicators related to social and emotional behavioral—and for the older youth, access to high-quality after school programming—were identified among others as of high priority, both which have implications for board funding of prevention and early intervention activities.

As is evident, these findings are consistent with the board priorities for FY 08 and 09 described above and provide support for the sustainability and expansion of the prevention programs initiated under the SS/HS project. The Council is currently working with a consultant around developing a structure to collect, report and analyze the associated outcome data required as part of H.B. 289 compliance. The issue is essentially to crosswalk the outcome information from the existing evidence-based programs to the appropriate indicators and Commitment areas. As described in response to the question on Prevention Investor Targets in this section, the board is experiencing this same conundrum in relation to the NOMS/ODADAS Prevention Targets.

Additional needs assessment activities include the Search Institute Attitudes and Behaviors survey which is being administered to all seventh and ninth graders in Erie County schools. This survey provides an aggregate portrait of the 40 Developmental Assets as experienced by youth in sixth through twelfth grades. This initiative was made available via funds from the SS/HS grant and ABC dollars, with Sandusky School students surveyed as part of the grant and the surveying of students in other Erie county schools coordinated by the Board's prevention provider in conjunction with FCFC. The E.D. of the Board will also be working with the Ottawa Co. FCFC at the March meeting (they only meet six times per year) around both prevention and treatment needs of youth and families relative to the local behavioral health system as well as in relation to FA\$T and ABC funds. Finally, a variety of activities related to gathering and sharing information relative to planning and funding needs and priorities in general—treatment and prevention, mental health and alcohol/drug—is planned over the next several months. These activities and timelines are outlined in the section on Treatment and Recovery Services.

Prevention Service Priorities

Given the information described above, the MHRB's prevention priorities for fiscal years 2008-09 generally include a continuation and expansion of funding of current programs. Additional funds (in comparison with FY 05 funding levels) were allocated to prevention activities beginning with the fiscal year 2006 contracts consistent with local board values, and increased again in FY 07 as a result of the board's decision to invest funds to continue the evidence-based prevention programs previously funded under the SIG grant. While all of the allocated funds were not drawn down, at this time no real changes in the funding levels are planned. In fact, it is expected that the total allocation will be utilized

as a result of the delivery of services at the youth center in Vermilion and the expansion of All-Stars, Asset Development, and Stop Bullying Now in Erie County and the enhancements and shifts in focus of Life Skills in Ottawa County. Of course, the Board will continue to monitor this via the quarterly agency and system contract compliance and progress reports. Furthermore, as indicated in the "Commitment to Adopt" submitted to the Department, we will discuss the information in Systems Integration meetings with providers and are prepared as appropriate to use the data and information to adjust programming if necessary. As appropriate, these discussions will be broadened to include other community partners integral to the successful implementation of these prevention programs.

As such, the board's highest prevention service priority—as listed at the beginning of this section—is children/adolescents. Services to families (many of whom are involved with the Child Welfare system, an ODADAS priority) are also a high priority. Services to individuals involved in the criminal justice system (also an ODADAS priority) is a secondary prevention service priority, at a medium level. In fact, one goal is to work more closely with the Juvenile Drug Court and Family Dependency Court in Erie County around offering the Strengthening Families program to participants. Obviously, the feasibility of this needs to be further explored given that about half of the juveniles in the drug court program are already involved in MST. Likewise, depending upon the level and type of care indicated for participants in the Dependency Court this intervention program may or may not be appropriate. Still, informal conversations have indicated that this is an area needing further discussion.

Prevention and intervention services are currently delivered at both Erie and Ottawa County detention facilities. The primary provider of adult AOD services was available to provide this service upon request. However, that arrangement did not appear adequate to meet the volume of service desired by the facilities. The secondary provider in Ottawa County, in an attempt to meet the expressed needs of the Ottawa County Detention and Misdemeanant Facilities, established a more regular program of Intervention services with additional funds made available in the latter half of fiscal year 2006. As a result, for FY 2006 the primary provider saw a total of 4 inmates over 2 days of service at the main facility and 20 inmates over 8 days at the Misdemeanant Facility. The secondary provider saw 218 inmates over 45 days of service at the main facility and 43 inmates over 13 days at the Misdemeanant Facility.

While there is clearly a demonstrated need for service at the detention facilities, we have learned from past experience that agency development of programming in direct response to community requests can sometimes have unintended consequences. While we can see the desirability of the agency being able to respond to requests for service or in the development of programs in conjunction with various community partners and/or referral sources, it can cause problems when it is not part of the larger system plan—either because the board has other priorities, communication about what funds were being used for was unclear, or because it wasn't addressed in partnership with the board for whatever reason. Ultimately, for sustainability of programs to occur via public funds, the board, implementing agency and other partners must jointly agree on the parameters, including funding levels and responsibilities.

The area of programming in the detention facilities is one that we will explore as part of the process going into the 08-09 funding years. Historically, providing services to folks in a detention facility has been challenging from several perspectives. First, there is the issue of residency and programming—

specifically the lack of payment for services by boards from the county of residence outside of Erie-Ottawa. This is complicated by the fact that (from the facility's perspective) an inmate is an inmate regardless of residency outside of the institution and/or the difficulties associated with offering a program/services in a facility that has to include screening for eligibility based on residency. Yet, in a competitive or fixed funding environment it is not good fiscal stewardship to spend funds for county residents on out-of-county persons. Second is the issue of follow up and continuity of care. Even if the issues described above were worked out effectively, there is no continuity of care since in most cases the person returns to their county of residence upon release. Certainly a referral can be made, but experience has demonstrated that the process is far from seamless.

Third, logistically it is difficult to provide treatment services in the jail because of the time and cost of conducting assessments, especially given the transient nature of the population. While we have structured services along these lines in the past, very few persons actually remained engaged upon their release. At the same time, a fourth difficulty is around the appropriateness of offering prevention or intervention services at the facility that are attended by persons for whom alcohol and drug abuse or addiction is already a problem—by client admission, previous involvement in treatment and/or drug abuse or related charges. And finally, detention facilities have (fiscal and service) responsibilities to inmates related to these issues as well which need to be taken into account in the development and funding of programming.

It should be noted here that the Strengthening Families program—while discussed in the prevention section—is currently funded as Intervention, which is a community service covered under the treatment standards in the ODADAS taxonomy. However, given the target population and focus of the program it could also be legitimately characterized as prevention. In fact, it is recognized as a “best practice” prevention program by the National Institute on Drug Abuse, the Office of Juvenile Justice and Delinquency Prevention and the U.S. Dept. of Education. It is also possible that additional prevention programs or services (i.e. alternatives) or expanded areas of priority could be funded during the latter half of FY 08 or in FY 09 as a result of the needs assessment and planning activities referred to above and described in Section IV. If that is the case, they will be summarized in the FY 08 Community Plan Update or submitted to the Department in the form of an amendment to the Community Plan as appropriate.

Prevention Investor Targets

Investor Targets should be framed in terms of what projected increase or decrease in condition or behavior for individuals, families, target groups, systems and/or communities the board has prioritized and seeks to achieve. They should be related to the priorities identified above. Prevention targets may span the entire life cycle and do not need to be limited to addressing children and adolescent populations.

Identify the board's Prevention Investor Targets for SFY 2008 -2009. A board may adopt one or more of the Department's Investor Targets or identify alternative Investor Targets of their own development that are mutually agreed upon by the Department (through discussion with the board's regional coordinator prior to submission of the Community Plan). Indicate the ODADAS Investor Target to which the board's Investor Target is contributing, if applicable.

Based on the prevention priorities described above and the resultant programs the board plans to fund we are adopting the

NOMS domains of abstinence and social connectedness and the corresponding ODADAS Investor Targets of "Programs that increase the number of customers who avoid ATOD use and perceive non-use as the norm" and/or "Programs that increase the number of customers who perceive ATOD use as harmful" and "Programs that increase the number of customers who experience positive family management".

However, as included in the FY 2006 Community Plan Update we are again requesting technical assistance in relation to these targets. Most of the programs we are currently funding are evidence-based programs with their own sets of pre and post tests and expected outcomes. While we may be able to extract measures that make sense as contributing to these abstinence or social connectedness targets on an intuitive level, they certainly aren't going to necessarily be valid and reliable proxy measures. For instance, while Strengthening Families, Parenting Wisely and the Incredible Years all likely result in customers who experience positive family management (as a result of the programs' focus), the specific measures and verifications are different, thus making comparison by non-researchers such as us difficult!

While we do require and monitor outcomes reporting for all our funded prevention activities, we have primarily looked at the results individually for each program, looking at performance or results in relation to the set of expected outcomes or results claimed by the program. We have not found a way to aggregate the information or make any judgments about their collective impact on the selected Investor Targets. Any assistance the Department might be able to offer in helping us set up this mechanism would be welcome.

SECTION IV: TREATMENT & RECOVERY SERVICES

1. Treatment Needs

This section of the Plan includes a description of information and data used to determine the board's treatment needs. Describe all needs identified through quantitative and qualitative sources while differentiating between met needs (enough resources are already available to address the need) and unmet needs (additional resources are needed to address the need).

Describe the process the board utilized to determine its current treatment needs, including data sources and types, methodology, time frames and stakeholders involved.

What were the findings of the needs assessment?

2. Treatment Priorities

This section of the Plan prioritizes the board's identified treatment needs. These priorities are determined locally keeping in mind the various priority populations identified either by statute or Department initiative. Key ODADAS treatment initiatives include: Reducing Stigma and Barriers to Service, Evidenced-Based Practice, Recovery Healthcare Assistance/Recovery Assistance, Tobacco Dependence Pilot, Statewide Adolescent Coordination Project, Older Adult Initiative, and the Criminal Justice Collaborative. Note there is no rank order to these priority populations with the exception of pregnant women and individuals involved in the child welfare system:

- Pregnant women
- Individuals involved in the child welfare system (H.B. 484)
- Women
- Injecting drug users
- Clients at risk of tuberculosis
- Children and adolescents
- Individuals involved in the criminal justice system
- TANF recipients

Describe the process utilized by the board to determine its treatment priorities for SFY2008 – 2009. How did the board decide the most important areas in which to invest their resources?

Based on the identified needs, list the board's treatment service priorities. These should be grouped in the following categories; high, medium or low.

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

The following narrative addresses the questions and issues relative to Treatment Needs and Treatment Priorities in this section.

Adults

The needs assessment activities and transition to an outcomes-based planning process in the years preceding the FY 2006 RFI process and the impact on treatment services to adults with alcohol/drug issues was discussed at length in the FY 06-07 Community Plan. Likewise, the resultant impact on the service delivery system and the issues related to implementation were presented in the FY 2006 Update. A brief summary is presented here.

In essence, the board established a set of local values/priorities for the system of care, coupled with a change in planning framework from one based on "hold harmless" agency funding based on historical utilization to one where investments were made based on a desired service mix and outcome expectations for various population groups. As a result, (as reported in the FY 06-07 Plan) treatment services to youth and families were of high importance, as were prevention and early intervention services. Services to adults were of low-medium importance (comparatively, across the entire system of care and given the finite amount of resources available).

In addition to funding level shifts consistent with board values/priorities, qualitative changes were made to the adult AOD treatment system as well. For instance, as part of the SFY 2006 RFI we built a richer array of group interventions into the adult service group description. We also built in intensive case management as a specific service—similar to the CSP model in mental health or the case management model employed successfully in drug court programs. Both our literature review and outcome information from our drug court evaluations (which show the addition of case management services to be a positive clinical outcome indicator) demonstrate this to be an effective addition to a continuum of care. Finally, we broadened the list of activities the Board would like to purchase to include services such as Intervention and Family Counseling.

The AOD primary provider experienced numerous issues—some clear and some not so clear—that resulted in a delay in implementation of the qualitative programming changes described previously (i.e. richer group array vs. the "one size fits all" IOP practice, intensive case management services). At the same time, there were reports by the agency, referral sources and clients of lengthy waiting lists and little access to treatment. In an attempt to address this issue, the Board increased contracts by approximately \$70,000 in additional funds—above initial allocations—to the primary provider (Erie and Ottawa) and \$5000 in additional funds to the secondary provider over the course of the fiscal year. Reports of waiting times for an appointment remained long however, and "no-shows" increased during that period. Also of interest along these lines, when we looked at duplicated and unduplicated totals of the number of adults served between fiscal years 2005 and 2006, there were actually MORE people served in 2006.

While adding dollars to the AOD Adult Service Group helped to bring the amount slightly closer to actual dollars spent in past years, it did not appear to be (the sole) solution to access to services in this case. As of billings by the primary provider through 6/30/06, approximately \$17,000+ was remaining in the Erie and Ottawa treatment service groups, and just under \$1500 in the Drug Court Service Group. And once final 2006 billing/data was in, we found that our primary provider of adult AOD services was actually reimbursed at a higher total dollar level in FY 06 (including Medicaid and non-Medicaid),

produced more units, and served more people! In looking at these data sources, along with other information (i.e. outcomes data in relation to Board Investor Targets, meetings with referral sources/partner agencies, discussions with board contract providers of AOD adult treatment services) we were able to include that the problems experienced were more complex than money, and simply increasing allocations was not going to fully address the issues.

We have struggled as a system with the issues of no-shows, drop-outs, court-mandated or attorney-recommended referrals, and the frequent “cycling” of clients through treatment for many years. We have also worked with stakeholders in the past around issues related to the continuum of care, often in the context of “one size doesn't fit all” or the fact that not everyone who enters the system needs the same IOP group. Issues related to level of care have been discussed—particularly in relation to requests for residential treatment from referral sources—as has the effectiveness of treatment and evidence-based practices or strategies such as CBT and Gender Responsive services.

Based on principles of effective treatment (i.e. ready access to treatment, no single approach meets all needs) and in response to issues identified locally, the Board built changes into the FY 06 RFI regarding the way services were to be delivered. In fact, the qualitative or programming changes referred to above (i.e. the purchase of an array of groups including Women's Recovery, Pre-treatment/Treatment readiness, and separate groups for abusers vs. dependents; intensive case management services a.k.a the model successfully used by the drug court programs) were direct attempts to provide solutions to some of the particular issues identified. However, as referred to previously, for several reasons—some simple, some complex—these qualitative changes did not get implemented timely/fully and thus did not have the intended effect.

As a result, we have collectively determined that further system change is necessary. As mentioned in the section on Capacity Development Targets, we plan to restructure our system based on the Stages of Change Model (SCM). A brief description of the model is also included in that section. As discussed at the 2/20/07 Board meeting in conjunction with the FY 08-09 Community Plan, system change will need to occur at the levels of:

- a. Clinicians—training on SCM, Motivational Interviewing, Cognitive Behavioral Therapy, screening tools, documentation, group curricula
- b. Agency (ies)—organizational culture shift, adoption of different and/or additional screening tools, documentation and reporting responsibilities, restructuring of services/UCR, administrative practices that support Stage-wide model, supervision and consultation roles/agreements, access
- c. MHRB—funding structure, service array and expectations, monitoring and oversight, TA (consultation, training agreements), community awareness, roles of primary and secondary providers in system
- d. Community (partners, referral sources, clients and family members)—awareness and education on model and accompanying strategies, consensus around “measures of success”, improved collaboration/communication, referral processes

In the context of the (draft) strategic planning outline and timelines presented below, our tasks over the next 6-12 months will be in part focused on:

- Determining the role of the primary and secondary providers (Who provides what level (s) of interventions? Is there to be consumer choice at the levels of pre-contemplation and contemplation? Should the treatment at the action stage be vested with the primary provider, and if so, what mechanisms need to be in place to ensure seamlessness for the client?)
- Determining whether to restructure the adult system only or the entire AOD service continuum
- Attaching a service mix and continuum of care to the stages, along with the appropriate funding levels
- Bringing in system T.A. and training/consultation on the SCM and related interventions such as Motivational Interviewing and Cognitive Behavioral Therapy
- Reviewing and adopting standardized assessment and readiness for change tools
- Working with referral sources and community partners to educate them on the model and around expectations and outcomes associated with each stage
- Working with agencies around clinical documentation (esp. of medical necessity) and around reporting and building a mechanism for monitoring and oversight by the Board

In addition to the transition to a SCM, we plan to continue support of the Benchmark Adult Drug Court Program in Erie County. We currently earmark dollars for the treatment of program participants (allocated via a separate service group) to ensure at least some capacity for the program regardless of other demands on the non-Medicaid funds. We also plan to meet with the Judge and his staff in Erie Co. around the continuation of support for case management services to participants in the Family Dependency Court. These services were originally funded via a federal grant awarded to the Court with matching funds provided by the MHRB. However, due to changes in the budget these funds were not available for years two and three as had been anticipated (funding ended at the end of FFY 06). As such, the board was able to step in and work collaboratively with the Court to continue those services for the remainder of SFY 2007.

Consistent with the ODADAS Capacity Development Target (and the board's for SFY 06-07), we were able to use billing and program data to determine the actual costs of sustaining the program in the public behavioral health system (as in consistent with ODADAS rules and billing mechanisms vs. what was allowable via the federal grant), identify program design issues that were resulting in inefficiencies and costs that were un-billable by the agency (i.e. requiring the Case Manager, the therapist, and the AOD Supervisor of the agency at team meetings when only the time for one person could be billed), and explore the issue of urinalysis screens in relation to cost and role of the agency vs. court staff. We will be using the information in collaboration with the court to identify what changes or modifications might be necessary or possible to address these issues as we plan for sustainability of this key element of the family dependency court.

We also want to explore the issue of on-site assessment services in Erie County at the Court and/or Job & Family Services. We have addressed this periodically over the past few years and interest around the potential benefits was expressed by all parties. It seems timely to raise this again given the improvements relative to access to service and earlier intervention we have seen with these programs in Ottawa County. Furthermore, it would help facilitate referrals to the Family

Dependency Court and is consistent with H.B. 484 goals and timelines around referral, assessment and treatment of parents, caregivers or guardians whose substance abuse or dependency is placing their children at risk for abuse, neglect or dependency.

Finally, we hope to move forward with our discussions with the courts in Erie and Ottawa counties around use of the IDAT or Indigent Driver's funds. This funding goes to the Courts and comes from reinstatement fees that persons pay to get their driver's license back after alcohol or drug related traffic violations. The Courts must spend the funds in conjunction with a plan developed with the MHRB, and the funds can only be used for assessment and treatment, not Driver's Intervention programs (i.e. DUI schools). The funds follow an individual once indigency is determined. For a variety of reasons and despite several attempts, we have had little success in getting those funds directed back into the system—yet referrals from the municipal courts in particular represent one of the biggest sources.

The exception is a recently developed protocol and Memorandum of Agreement with the Vermilion Municipal Court in conjunction with the Lorain Co. ADAS Board. Those procedures were worked out at the end of CY 06 and a meeting is scheduled to finalize things. If we are able to negotiate mutually beneficial plans in conjunction with the remaining courts, these funds will go a long way toward not only alleviating the access issues related to adult AOD services, but will offer opportunities for special programming that may more effectively meet the specific needs of this particular population (multiple DUI offenders being the target population of the funding stream).

Children/Youth

Much of this was presented in Section II: Capacity Development, #2, Capacity Development Targets.

In summary, we are still working on building the continuum of care and determining how the relatively newly implemented programs (Functional Family Therapy, increased capacity for MST, Strengthening Families, Seven Challenges) fit in. We plan to continue our investment in these programs, as well as to ensure continued capacity in our Youth/Family Service group consistent with local board values. Additional Ottawa County programming to youth with alcohol or drug abuse/dependency issues includes Understanding Substance Abuse for Youth and the Adolescent Recovery Plan (treatment and continuing care programs). We will continue to monitor these programs from the perspective related above as well.

Understanding Substance Abuse for Youth is an eight week/sixteen hour program offering education and personal growth for youth that have abused alcohol or drugs. The program involves the use of Interactive Journaling which exposes youth to the stages of change, teaches and encourages the adoption of strategies and techniques for positive lifestyle change, and provides factual information on alcohol and drug use and its effects.

The Adolescent Recovery Plan is an individualized program tailored to help youth aged 14-18 learn about dependency and recovery in a four phase approach that involves staff, peers, and family. The program focuses on four phases of growth: (1) accepting responsibility; (2) deciding to make changes; (3) making important changes; and (4) preventing relapse. Each of the four phases includes a certification program that allows the youth to receive recognition for honest completion. The Continuing Care program is targeted at those youth who have completed the Adolescent Recovery Plan program and/or who are

returning to their home or community upon completion of residential treatment. The program addresses critical relapse prevention issues and focuses on helping the youth prepare for life after treatment.

We will also be working with stakeholders via the process outlined below to gather additional feedback regarding the continuum of care and the current service delivery system. This will include exploration of support for implementing the Stages of Change Model for the youth system as well, particularly as many of the programs and service delivery strategies implemented in fiscal years 2006-07 are consistent with this framework. We will also be working specifically with the Erie Co. Juvenile Drug Court around the potential implementation of the MET/CBT5 curriculum as discussed in the section on capacity development.

In Ottawa County, we plan to continue funding of the Juvenile Court Assessment Program. We will also be meeting with the Judge and her staff around additional needs now that the Court has moved further in its implementation of a specialized docket for youth. We plan to meet with the Ottawa Co. Prosecutor's office as well in regard to potential collaboration around their diversion program. Finally, we want to meet with the schools in our districts that have elected to conduct drug screenings on their students regarding follow-up and linkages and/or other related programming.

FY 08-09 Strategic Planning/Timeline Recommendations

What follows is a brief outline of needs assessment activities and opportunities for community feedback planned over the next several months as the Board prepares to set priorities for the next biennium. In essence, we are planning to enter into six month contracts with our current providers at similar funding/programming levels. This is driven in part by the fact that the additional dollars generated by the replacement of the .7 mil levy in November will not begin to be collected until January 2008. Another factor contributing to this recommendation (as stated previously in this document) is that the approximate \$800,000 that will be generated provides the board and its community partners with a rare opportunity to invest in additional capacity, build new programs, or enhance existing services. As such, we want to exercise due diligence in determining the most effective and efficient investment of these funds across the range of (at times) competing needs across the mental health and alcohol and other drug treatment, prevention, and support systems.

(Adapted from information presented at the Board Meeting February 20, 2007—Outline and Chart in draft form; action planned for 3/20/06 Board meeting)

A. March 2007-August/September 2007

1. SIX MONTH CONTRACTS (1st half of FY 08, July 1, 2007-December 31, 2007)
 - a. no significant programming/provider changes
 - b. systemic adjustments to funding levels/capacity consistent with current priorities
 - c. FY 2007 Year in Review and Lessons Learned Session—See Commitment to Adopt
2. OUTCOMES/PERFORMANCE MEASURES
 - a. continue to identify desired outcomes/results by service group/priority
 - b. adopt and implement system CQI framework— closes feedback loop and last step in Outcomes-based planning framework

3. NEEDS ASSESSMENT ACTIVITIES

- a. Opportunities for Community feedback: Open Forums, April and May Board meetings; Focus groups; Referral luncheons; web-based survey/mail strategic planning survey*
- b. feedback from current providers via Systems Integration meetings on "conundrums" of (1) fiscal management of service groups vs. system disincentives to do so (2) need to balance expenditures across the system of care consistent with board priorities ("get what we plan for") and a given agency's ability to draw down anticipated contract dollars regardless ("get what we pay for") (3) need for flexibility as a system in response to new information or changing circumstances—"mid-course adjustments" without falling back into a system driven by agency budgets, staffing and infrastructure concerns in future allocations and (4) future service delivery/programming needs

*Goal is to work with referral sources and public to gather input to help direct prevention and treatment programming with additional levy funds

B. September/October 2007

4. LOCAL BOARD/SYSTEM VALUES

(Remember: ideals, "30,000 feet", future-oriented)

- a. Reaffirm (and reword) current system values
- b. Refinement/clarity
- c. Explicit value for SMD—Recovery model? Housing?
- d. Additional?

C. October/November 2007

5. STAFF RECOMMENDATIONS FOR LOCAL SYSTEM OF MH/AOD SERVICES AND FUNDING LEVELS

- a. Via Programming, Planning, Budgeting and Execution (PPBE) decision-making model*, taking into account State/Federal mandates and priorities, board values/priorities, cost-efficiency, quality, available resources

*Note: Recall that the PPBE model involves a presentation of options by staff (alternatives and the implications, including long and short term costs and benefits and related community issues) along with specific recommendations and the rationale; board deliberation of the options/recommendations using the "round robin" format; decision via formal vote on recommendation/amendment or a request for additional info.)

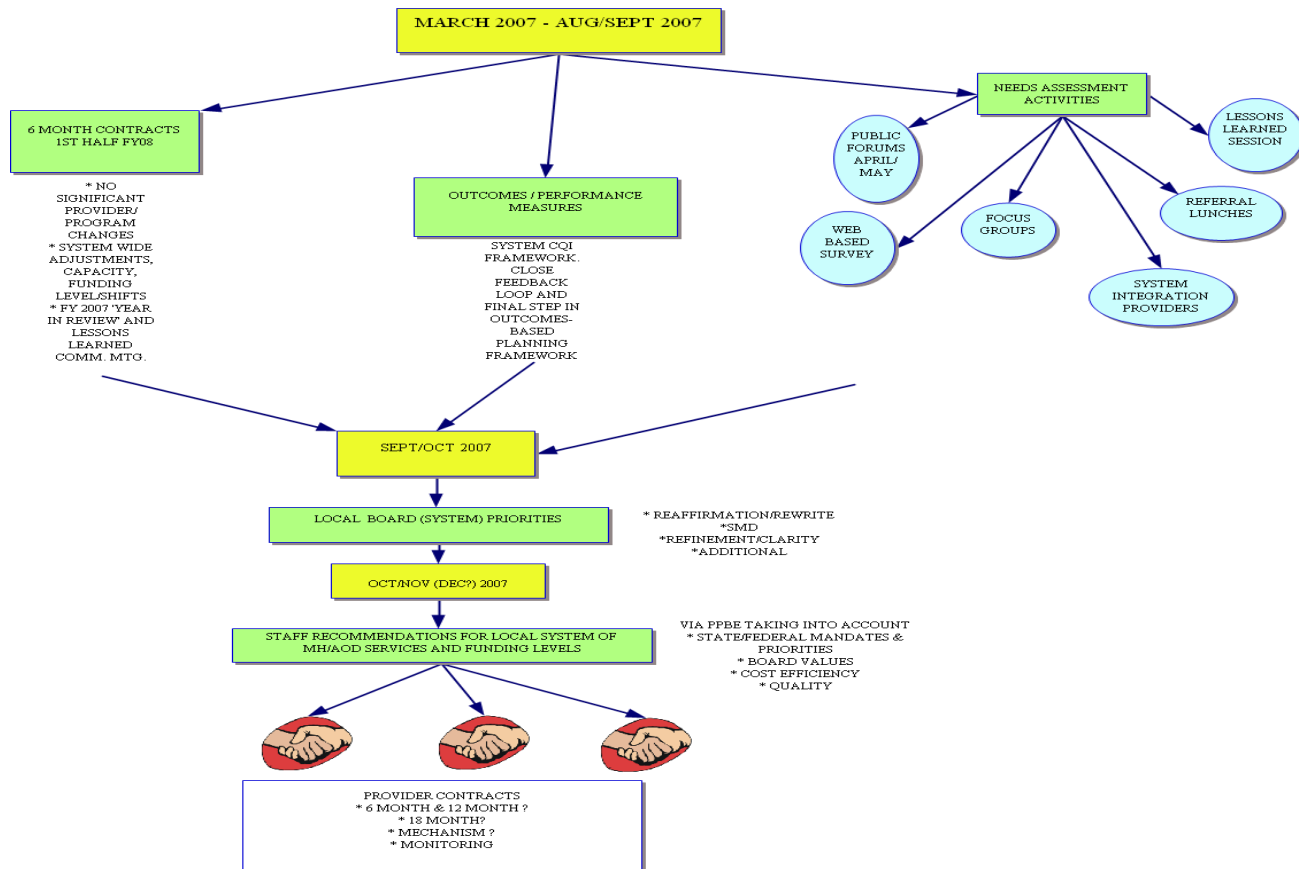
D. November 2007

6. PROVIDER CONTRACTS

- a. 18 month contracts (January 2008-June 2009) or 6 month contracts for "gear up" & 12 month contracts for full implementation (January 2008-june 2008) & FY 09 (July 2008-June 2009)
- b. Mechanism for procurement?

- c. Monitor implementation of Board values/priorities (Ends) and Investor targets via program reports, board system and agency progress reports, etc.
- d. Quarterly (i.e. Results and Learning) meetings with providers via SI meetings in conjunction with progress reports—See Commitment to Adopt

Note: Timelines are approximate as procurement timelines, board approval, termination notices and contracts all need to be in compliance with relevant rules/guidelines and incorporated into the Board Calendar/Agenda planning cycle as necessary.



3. Treatment Investor Targets

Investor Targets should be framed in terms of what projected increase or decrease in condition or behavior for individuals, families, target groups, systems and/or the communities the board has prioritized and seeks to achieve.

Identify the board's treatment Investor Targets for SFY 2008 -2009. A board may adopt one or more of the Department's Investor Targets or identify alternative Investor Targets of their own development that are mutually agreed upon by the Department (through discussion with the board's regional coordinator prior to submission of the Community Plan). Indicate the ODADAS Investor Target to which the board's Investor Target is contributing, if applicable.

The Board has selected the following Treatment Investor Targets for SFY 2008-2009:

Abstinence—Number of customers who are abstinent at the completion of the program (T1) and

Crime and criminal justice—Number of customers who incur no new arrests at the completion of the program (T3)

Note that these were the same Treatment Investor Targets selected for the FY 06-07 biennium. As discussed in previous plan submissions, the board and its providers worked together to identify fields in the BH module for use in reporting on these measures. We also agreed on standardized definitions, reporting timeframes and verifications.

For fiscal years 2008-2009 we will be looking at the fields the State uses to report on the NOMS to the federal government in order to consider any adjustments to what we have developed locally and/or to add additional targets or data relative to the NOMS to our reporting and monitoring system. That of course will be impacted by future guidance from ODADAS in relation to the Outcomes Initiative, standardization on a statewide level in relation to the NOMS, the BH module reporting rules and the work of the Blue Ribbon Panel (also discussed in Section I.2.a. Current Circumstances: Environmental Context, Characteristics of Clients Receiving Services).

What follows is a description of those measures and goals in place for FY 2007.

FY07 Outcome Measures and Goals

For FY07 the board will continue to develop and refine the outcomes that were implemented during FY06.

The Chart below shows what is being tracked and the percentage goals for AoD clients.

Description	BH Field	Code Used	% Goal
Abstinence at Discharge	Reason for Transfer/Termination	M	80
No Criminal Justice Involvement	Number of Arrests in Past 30 Days	0 (Zero)	80

Please note that at the agency level to verify that a client has been abstinent these steps are followed:

1. 30 days of clear drug screens
2. A clear drug screen at or near discharge
3. All collateral information on drug screens match up

Also at the agency level to verify no criminal justice involvement these steps are followed:

1. Information obtained from collateral sources indicate none
2. Information obtained from client indicate none
3. Any kind of criminal charge(i.e. arrest) is looked at as criminal involvement

To improve accountability and clarity related to H.B. 484 programming, boards are required to develop a specific Investor Target related to this allocation.

The Board will increase the identification and referral for assessment and treatment of parents, guardians and care givers of children involved in the child welfare system.

We will work to do this through more diligent protocols around the tracking of this population in our board database, thereby ensuring more accurate data around the number involved in our system, services received and dollars expended in regard to this priority population.

We will also work with the Departments of Job and Family Services of each county as well as the Juvenile Court in Ottawa Co. (via the Court Assessment Program) and the Family Dependency Court in Erie Co. around this process. These capacity building efforts may include the development of brief screening tools, onsite assessment services and/or training and education of staff.

Boards receiving a special allocation for HIV Early Intervention Services need to develop an Investor Target related to this allocation.

Not Applicable.

SECTION V: COLLABORATION

To develop an efficient, comprehensive prevention and treatment service system, maximize resources and improve customer outcomes, it is essential for boards to interact, coordinate and collaborate with provider agencies and a wide variety of other service systems and community entities some of which are statutorily required (e.g., County Family Planning Committee, Public Children's Service Agency, Family and Children First Council, clients/customers, the general public, and county commissioners.)

What systems or entities did the board collaborate with and what benefits/results were derived from that intersystem collaboration?

Staff of the board regularly interacts, coordinates and collaborates with provider agencies and other community partners and stakeholders. These interactions occur in a variety of ways, both informal and formal, via a variety of mechanisms (i.e. phone calls, board-hosted, structured meetings around a given purpose and joint participation in other meetings). Ongoing information and feedback is gained about all aspects of the prevention and treatment service system in this way. The board also engages in a variety of specific needs assessment and planning activities. Those occurring and/or planned for fiscal years 2007 and 2008 were described in Section IV—Treatment and Recovery Services.

The following list serves as a brief representation of some of the entities the board interacts with regularly:

- Case Coordination Team (reps of Juvenile Court and Probation, JFS, MHRB, Court Assessment Counselor, FCFC Director/Wrap-Around Coordinator)—monthly meeting around the coordination of care for youth at risk for or in out-of-home placement
- Family and Children First Councils—Erie, monthly Executive and Clinical committees; ad hoc work groups around issues like Service Coordination, ABC Transformation Planning, FA\$T; Ottawa, bi-monthly meetings, ad hoc committee for FA\$T/ABC planning
- Contract agencies—Systems Integration meetings (primary treatment and prevention providers), phone calls, individual meetings around agency specific issues and/or specialized meetings that are topic driven, such as FFT
- Erie Co. Juvenile Drug Court—monthly (steering/advisory) committee meeting
- Erie Co. Family Dependency Court-- monthly (steering/advisory) committee meeting
- Erie & Ottawa Co. Juvenile Court Judges & staff—meet periodically on a variety of issues including joint planning around shared funding projects (i.e. Case Management for Family Dependency Court, MST), collaborative programs (i.e. Ottawa Co. Juvenile Court Assessment Program)
- Job & Family Services/Children Services—Erie-planning committee, ad hoc committee around development of Specialized Respite Program, Safety Net (ODMH) residential funds; Ottawa—on-site intervention/screening, Safety Net (ODMH) residential funds
- Ottawa Co. Sheriff and staff—inmate service needs, data
- Erie Co. Common Pleas Court Judges and staff—mental health court planning
- Municipal Court Judges and Staff—Vermilion—joint meeting with Lorain Co. ADAS around IDAT funds
- County Commissioners—semi-annual reports, special meetings (i.e. around submission of grants, levy)
- Elected Officials—local, state
- Ottawa Co. Board of Social Concerns—monthly meeting
- United Way of Ottawa Co.—PfS planning, Conestoga planning
- Safe Schools/Healthy Students—partner meetings, sustainability committee
- Civic groups—presentations
- Vermilion mayor and staff, YMCA—exploration and development of youth center

Obviously, there are many benefits derived from intersystem collaboration. They range from information sharing to actual joint funding of particular programs or initiatives to increased understanding of the roles, barriers and opportunities relative to various systems to enhanced communication and streamlined referral protocols to consensus around community needs to identification of gaps in the continuum to the development of strategic plans to address identified community needs.

Describe the board's consultation with county commissioners regarding services for individuals involved in the child welfare system and identify monies the board and county commissioners have available to fund the services jointly as required under Section 340.033(H) of the ORC.

As stated above, the E.D. makes semi-annual presentations to the Commissioners in each county. We also provide an annual report of board programs and expenditures. Consultation for individuals involved

in the child welfare system primarily occurs via joint planning with the Courts and JFS Departments whose budgets go directly before Co. Commissioners. Currently, the board receives no money from either county.

The primary focus of the collaborative planning efforts with the Courts and Departments of JFS has been around reducing the numbers of children and youth who are either in or at risk for out-of-home (and especially out-of-county) placement. This has also been addressed in conjunction with the Family and Children First Councils in each county as part of the ABC Transformation Planning processes. We have worked together around the development of a continuum of care, including intensive and home-based services; enhancement and coordination of the service coordination process under FCFC and the TDM model employed by JFS—Erie Co.; planning and advocacy around the reinvestment of cost savings from reduced placement numbers back into social service/behavior health programs vs. the general coffers; and long-term planning for development and sustainability of programs consistent with the changing budgets among the three entities (i.e. surplus Reclaim spend-down and reduced funding in the future).

Beyond regular board/committee membership, how has the board involved customers and the general public in the planning process?

While we have always made efforts to involve customers and the general public in the planning process, the Board has made a number of changes over the last year and a half in direct response to issues and suggestions raised as part of our Stakeholder Interview/Survey that occurred during the first half of fiscal year 2006. These changes were in response to perceptions among some stakeholders and consumers that planning activities and information-sharing were not transparent and to suggestions around ways to improve communication and opportunities for feedback prior to board decision-making around system priorities and funding allocations.

For instance, the Board holds open public forums in April (Erie Co.) and May (Ottawa Co.) of each fiscal year. While these are advertised in the newspaper, the board newsletter, on the website, in contract agencies and at community sites throughout the two counties they have historically not been well attended. Feedback from the survey suggested that in general folks were not as aware of the forums as had been thought. Suggestions were also made about the structure and format of the forums. While they were deliberately designed to allow open discussion and feedback vs. topic-driven or specifically solicited feedback, some expressed the difficulty in raising issues in this format. There were also expressions of discomfort with the room/seating layout, and the feeling some had of "giving a speech."

As a result, efforts were made to broaden the advertising venues for the forums that occurred in 2006. In addition, folks were asked to speak to any or all of three broad questions relative to current and future system priorities and the service continuum. The E.D. and Board members personally extended invitations to community gatekeepers and other stakeholders to speak. A sign-up sheet was created so folks could select the 5-10 minute slot they wanted to speak in. The seating arrangement was changed so that it wasn't board members and staff on one side of the room and everyone else on the other. Instead, it was set up in a circular pattern and folks were commingled. In addition, instead of holding them at the traditional board meeting sites they were held at locations in the outlying areas of our two counties (Elmore, Vermilion). Similar changes are planned for the upcoming forums.

While there were some folks who felt the 6 p.m. Tuesday evening time preceding the monthly board meeting was not optimal we decided not to change it. Instead (as discussed in the section on treatment and recovery) we are exploring additional opportunities for general public input similar to those we did in conjunction with the levy campaign.

We also plan to offer presentations to civic organizations and others on an annual basis as we did during the replacement levy campaign. While always a priority, this has been difficult due to the limited number of staff at the board office. However, given the attendance at these functions, the number of invitations accepted, and the feedback in response to the information presented over the course of the two or three months preceding the general election—not to mention the increased awareness and education of folks that resulted—it has become a greater priority. Several informative power point presentations, fact sheets and revisions to board brochures also occurred and will continue. Effort was made to enhance the web site and include more information and links as well, and that process has continued. As described earlier in this document in the description of strategic planning/timeline recommendations, we are also exploring web-based survey sites, focus groups and other means of soliciting feedback.

Finally, we made significant changes in the annual Board agenda/planning cycle to build in opportunities for the Board to hear feedback from different customers—at a minimum, one each for referral sources, clients/family members, general population/community members, and contract agencies. This may involve summary reports to the board by staff or others based on targeted data collection and/or may involve direct presentation to the board. Based on suggestions for obtaining feedback from respondents during the Stakeholder survey process in late 2004, methods could include direct presentation to/dialogue with the board, focus groups, surveys, community breakfasts/luncheons, key informant interviews, e-technology (chat rooms, bulletin boards, email or web-based surveys), deliberative opinion caucuses, task forces and roundtable discussions.

SECTION VI: EVALUATION

1. Prevention Evaluation

Based on the stated Capacity Targets and Investor Targets for prevention services, what is the board's plan to determine whether the targets were achieved, and how does the board intend to verify results?

How will results and learnings be communicated within the local Alcohol and other Drug system?

Sustaining recently implemented evidence-based practice initiatives in the area of prevention and/or implementing additional programs or training will demonstrate achievement of the board's Capacity Development Target.

Please refer to the section on prevention investor targets (p. 42) for a discussion on technical assistance needs regarding cross-walking outcomes measured as part of the evidence-based programs with the Prevention Investor Targets selected by the board for fiscal years 2008-2009 ("Programs that increase the number of customers who avoid ATOD use and perceive non-use as the norm" and/or "Programs that increase the number of customers who perceive ATOD use as harmful" and "Programs that increase the number of customers who experience positive family management").

Results will be communicated within the local Alcohol and other Drug system via the annual "fiscal year in review" reports—first implemented for FY 2006 and planned for FY 2007 along with a Lessons Learned session with contract providers and the board as per our Commitment to Adopt submitted to ODADAS on 2-26-07. Monitoring of these targets will eventually be incorporated into the agency and board system quarterly progress reports presented to the board. In addition—again, as set forth in the Commitment to Adopt—we will begin having "Results and Learnings" meetings with our contract agencies via Systems Integration meetings in conjunction with these reports. The goal for the second half of FY 08 or the first half of FY 09 is to disseminate these reports on a broader basis and open up the Results and Learnings sessions to referral sources, partner agencies, consumers and other community members.

2. Treatment Evaluation

Based on the stated Capacity Targets and Investor Targets for treatment services, what is the board's plan to determine whether the targets were achieved, and how does the board intend to verify results?

How will results and learnings be communicated within the local Alcohol and other Drug system?

Progress in the AOD system transition to one based on a Stages of Change model, including the provision of training and consultation on motivational interviewing and/or cognitive behavioral therapy will be viewed as achievement of the board's Capacity Development Target. This would also include the incorporation of standardized assessment tools and/or tools related to readiness for change into practice.

As for the board's selected investor targets for treatment services, please refer to the discussion beginning on page 55. In summary, we developed a protocol consistent across all providers of

alcohol/drug treatment services in our system regarding the collection, reporting and monitoring of BH module data related to our targets of abstinence and crime/criminal justice. A description of those measures and goals is included in that narrative.

What follows are the outcomes results for these measures using data available through 2/27/08. As discussed previously, these results are included by agency on the quarterly progress reports and also in aggregate for the system. These reports are shared with the Board and contract agencies.

02/27/07

FY07 Clients Who Have Reported Abstinence at Discharge Using M + G

AgyID	No. Clients Who Were Abstinent	%	No. Clients Who Were Not Abstinent	%	Total
FCH	40	74.07%	14	25.93%	54
BCS	230	55.83%	182	44.17%	412
GT	14	51.85%	13	48.15%	27
SYSTEM	284	57.61%	209	42.39%	493

M = Abstience as decided by outcome committee
Goals Met, no additional services
G = needed

02/27/07

FY07 Clients Who Have Reported Abstinence at Discharge M Only

AgyID	No. Clients Who Were Abstinent	%	No. Clients Who Were Not Abstinent	%	Total
FCH	5	9.26%	49	90.74%	54
BCS	203	49.27%	209	50.73%	412
GT	10	37.04%	17	62.96%	27
SYSTEM	218	44.22%	275	55.78%	493

M = Abstinence as decided by outcome committee

02/27/07

FY07 Clients Other Reasons for Termination

Reasons for Termination		Number of Clients	%	FCH	BCS	GT
Referred to AOD Trt	A	18	7%	2	13	3
Referred to MH Trt	B	2	1%	0	2	0
Referred to MH & AOD Trt	C	2	1%	0	2	0
Referred to AOD Aftercare	D	46	17%	0	46	0
Referred to MH & AOD Aftercare	F	1	0%	0	1	0
Goals met, no additional srvs needed	G	66	24%	35	27	4
Needed srvs not avail.	H	9	3%	3	6	0
Client rejects contin.	I	17	6%	1	16	0
Client did not return	J	98	36%	6	83	9
Client Moved	K	15	5%	2	12	1
Client Died	L	1	0%	0	1	0
		275		49	209	17

02/27/07

FY07 Clients - Number of Arrests in Last 30 Days

Number of Clients	Number of Arrests	%
439	0	89.05%
42	1	8.52%
7	2	1.42%
1	3	0.20%
0	4	0.00%
2	5	0.41%
0	7	0.00%
1	10	0.20%
1	11	0.20%
0	12	0.00%

493

Number of Clients	Bayshore Number of Arrests	%	Number of Clients	Firelands Number of Arrests	%	Number of Clients	Giving Tree Number of Arrests	%
385	0	93.45%	36	0	66.67%	18	0	66.67%
21	1	5.10%	15	1	27.78%	6	1	22.22%
3	2	0.73%	2	2	3.70%	2	2	7.41%
0	3	0.00%	1	3	1.85%	0	4	0.00%
0	4	0.00%	0	4	0.00%	1	11	3.70%
2	5	0.49%	0	5	0.00%			
0	7	0.00%	0	10	0.00%			
1	10	0.24%	0	12	0.00%			
0	12	0.00%						

412

54

27

493

As stated previously, for fiscal years 2008-2009 we will be looking at the fields the State uses to report on the NOMS to the federal government in order to consider any adjustments to what we have developed locally and/or to add additional targets or data relative to the NOMS to our reporting and monitoring system. That of course will be impacted by future guidance from ODADAS in relation to the Outcomes Initiative, standardization on a statewide level in relation to the NOMS, the BH module reporting rules and the work of the Blue Ribbon Panel.

Results and Learnings will be communicated within the local alcohol and drug system via the same mechanisms described in this section under Prevention Evaluation. In addition, as the further

development of our system CQI process occurs, we will be looking more at the data from this perspective as well. Currently, agencies discuss the results internally via their performance improvement processes and often report back to the board. While we have also discussed the results at Board meetings and in Systems Integration meetings, it has not really been from a clearly established system performance improvement paradigm.

OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES

1. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through ODADAS may not be used to fund inpatient hospital rehabilitation services. Under circumstance 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.**

HOSPITAL	ODADAS UPID #	ALLOCATION

OHIO DEPARTMENT OF ALCOHOL AND DRUG ADDICTION SERVICES

2. 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	ODADAS UPID #	SERVICE	ALLOCATION

SIGNATURE PAGE

Community Plan for the Provision of Alcohol and Other Drug Addiction Services SFY 2008-2009

Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) and Alcohol and Drug Addiction Services (ADAS) Board is required by Ohio law to prepare and submit to the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) a plan for the provision of alcohol and other drug addiction services in its area. The plan, which constitutes the board's application for funds, is prepared in accordance with procedures and guidelines established by ODADAS. The Community Plan is for State Fiscal Years (SFY) 2008 - 2009 (July 1, 2007 to June 30, 2009).

The undersigned is a duly authorized representative of the ADAMS/ADAS board and on behalf of the board hereby acknowledges that the information contained in this application for funding, the Community Plan for SFY 2008 - 2009, is complete and accurate.

ADAMHS or ADAS Board Name (Please print or type)

ADAMHS or ADAS Board Executive Director

Date

Authorized ADAMHS or ADAS Board Member

Date

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

APPENDIX A:

Table 1: Portfolio of Providers Instructions

Identify the board's current portfolio of providers within its local alcohol and drug service system, including both prevention and treatment providers. Please include all programs in which the board invests public dollars including all Medicaid-only contract providers as well as programs grant-funded by ODADAS. Please include the following specific information within each level of care:

a) Provider name.

b) Program name.

c) Population information for each program (For Prevention programs: Describe the target population if applicable such as: Hispanic children of migrant workers; children from families where abuse or neglect is involved; white, female adolescents in rural setting, etc.) (For Treatment programs: Describe the target population if applicable such as: male, female, age group, race/ethnicity, TASC, other criminal justice involved, pregnant women, co-occurring, etc.).

d) For Prevention programs list the Institute of Medicine (IOM) service category: universal, selected or indicated as defined below. This information is requested to fulfill federal Substance Abuse and Mental Health Services Administration (SAMHSA) Substance Abuse Prevention and Treatment (SAPT) Block Grant annual reporting requirements.

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

e) Name of the prevention, intervention or treatment evidence-based program, practice, strategy or policy (EBP) used. For Prevention: please consider any of the following as a "working definition" from the Ohio Prevention Standards when responding to the items under this heading.

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

f) How many sites at which the program is provided.

g) If the program site is outside the board geographic area.

h) Indicate if the funding source is at least partially ODADAS board allocation/grant or Medicaid only.

i) List the MACSIS UPI number.

TABLE 1: PORTFOLIO OF PROVIDERS

Prevention Strategy and Level of Care	a. Provider Name	b. Program Name (Provider Specific)	c. Population Served	d. Prevention Level (Prevention only)	e. Evidence-Based Practice (EBP)	f. Number of sites	g. Located outside of board area	h. Funding Source (Check the box if yes)		i. MACSIS UPI
								ODADAS	Medicaid Only	
PREVENTION										
Information Dissemination							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	
Alternatives	BAYSHORE						<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6662
Education	FIRELANDS FIRELANDS BAYSHORE BAYSHORE BAYSHORE BAYSHORE GIVING TREE GIVING TREE GIVING TREE	ALL STARS FUNC. FAMILY THERAPY POWER PROGRAM INCREDIBLE YEARS ASSET DEVELOPMENT STOP BULLYING NOW TEEN INTERVENE STRENGTHENING FAMILIES FUNC. FAMILY THERAPY	MIDDLE SCHOOL AGE AGES 11-17 AGES 5-17 ADULTS YOUTH/ADULTS AGES 9-12 MIDDLE/HIGH SCHOOL AGE PARENTS/YOUTH 10-14 AGES 11-17	UNIVERSAL UNIVERSAL UNIVERSAL UNIVERSAL UNIVERSAL UNIVERSAL INDICATED UNIVERSAL UNIVERSAL	ALL STARS FFT INCREDIBLE YEARS ASSET DEVELOP. STOP BULLYING NOW TEEN INTERVENE STRENGTHENING FAMILIES FFT	2 1 4 2 3 5 1 1 1	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1168 1168 6662 6662 6662 6662 6689 6689 6689
Community-Based Process	BAYSHORE	CAPABLE FAMILIES/CAPABLE COMMUNITIES	ADULTS	UNIVERSAL		2	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6662
Environmental							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Problem Identification and Referral							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
PRE-TREATMENT (Level 0.5)	BAYSHORE	PRE TREATMENT GROUP	ADULTS			1	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	6662
OUTPATIENT (Level 1)										
Outpatient	FIRELANDS BAYSHORE GIVING TREE GIVING TREE	SAMI GROUP,CRISIS COUNSELING UNDERSTANDING SUBSTANCE ABUSE FOR YOUTH ADOLESCENT RECOVERY PLAN	SAMI ADULTS HIGH SCHOOL AGE AGES 14-18			1 2 1 1	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	1168 6662 6689 6689
Intensive Outpatient	BAYSHORE	IOP	ADULTS			2	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	6662
Day Treatment							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
COMMUNITY RESIDENTIAL (Level 2)										

Non-Medical	VOLUNTEERS OF AMERICA	RENT SUBSIDY	ADULTS			2	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> No	10168
Medical							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
SUBACUTE (Level 3)										
Ambulatory Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
23 Hour Observation Bed							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Sub-Acute Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
ACUTE HOSPITAL DETOXIFICATION (Level 4)										
Acute Detoxification							<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	

