Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan Instructions SFY 2017

Enter Board Name: MENTAL HEALTH and RECOVERY BOARD SERVING BELMONT, HARRISON & MONROE COUNTIES

NOTE: OhioMHAS is particularly interested in update or status of the following areas: (1) Trauma informed care; (2) Prevention and/or decrease of opiate overdoses and/or deaths; and/or (3) Suicide prevention.

Environmental Context of the Plan/Current Status

1. Describe the economic, social, and demographic factors in the board area that will influence service delivery. Note: With regard to current environmental context, boards may speak to the impact of Medicaid redesign, Medicaid expansion, and new legislative requirements such as Continuum of Care.

The Board area covers 1,400 square miles in rural southeastern Ohio, requiring over two hours to travel from the northwest corner of Harrison County to the southern portion of Monroe county. Over 31% of those working drive over 45 minutes to reach their workplace. This is 40% over the average Ohio drive time from home to place of employment. The topography is largely forested with over 90% of Monroe County covered in forests and over 70% in the other two counties. After residential, the majority of tax value is represented by agriculture or mineral interests.

The population is aging with a high percentage of families with children living below poverty levels. The number of individuals and families living under the poverty level is slightly higher than the state average with per capita income in the area averaging nearly 13% less than the state average and family income 16% below the statewide average. According to USDA statistics poverty levels are as follows: Belmont 13.7%, Harrison 16.4%, Monroe 17.1%. The counties' unemployment rates are all above Ohio's rate. They are as follows: Belmont 7.8%, Harrison 7.7%, Monroe 15.6% according to the Ohio Labor Market Information. The area has systematically lost population since the 1950s as graduates and those entering the workforce seek economic opportunities, as well as social and cultural experiences, out of the area. The remaining residents are older, living on retirement income. Both Harrison and Monroe counties have larger percentages of the population falling in the Under 17 and Over 65 age categories. Belmont County is only slightly more diversified by age.

When compared to the rest of the state, the area is less racially diverse, slightly more male and older. Unemployment percentages are higher in Belmont (6.6), Harrison (5.9) and Monroe (10.8) counties compared to the Ohio's percentage of 5.7. Since 2008 the area has seen some shifts within the industrial sector with employment in natural resources and mining growing over 44% and manufacturing decreasing by 29%. The information sector has also decreased in the area with 28% fewer jobs in 2014 than in 2008. On a positive note, professional and business services have grown in the same time period just over 12%. Throughout the region federal, state, and local government jobs have shrunk by as much as 25% with only Harrison County showing an uptake in state employment. However, with such a low population, little change in real numbers would inflate the percentages overall.

In the last published County Health rankings, Harrison and Monroe County ranked in the bottom 25% and Belmont County ranked in the bottom half of all 88 counties. In the three county area, cancer is the leading cause of death. This may be partially explained by the high rate of adult smoking in the three county area. The second two leading causes of death for

area residents are heart disease and cardiovascular disease which can also be tied to smoking.

The demographic make-up of the area in combination with the large geographic landmass has a bearing on access to treatment and the array (or continuum as stated in the Ohio Revised Code) of services offered. A larger population of older adults, more poverty, more smokers, and health issues predominately caused by personal choice and behaviors would call for more behavioral/physical health integration, more prevention activities, and strategies such as more in-home care, a more decentralized system, and more peer and non-traditional services, supports, and providers.

The expansion of Medicaid eligibility to 138% of poverty has many individuals who previously had their treatment paid for by the Board now eligible for Medicaid. Moving the cost of treatment for many of these individuals onto Medicaid has almost eliminated the Board drawing down its reserves to fund ongoing mental health and addiction treatment. The Board has also taken the position that it will not fund treatment services for individuals who are Medicaid eligible but refuse to access that type of insurance coverage. For the most part, treatment funded by the board is bridge support until insurance, Medicare, or Medicaid coverage is secured.

Since the Board is funding less traditional treatment services, it creates the possibility that more state funding and local levy can be applied to support less traditional services and supports or fund new services until they become eligible for Medicaid. An emerging group of individuals for whom providers are seeking reimbursement are those with private health care provided through a health exchange but who have deductibles and out of pocket limits that are so high they cannot afford to use their insurance. While a primary goal of the ACA was to improve the affordability of private health insurance through subsided and changed to insurance regulations, there was some concern that premiums and cost sharing may still be unaffordable to people with low and moderate incomes. The question then for local systems of care is whether state and local dollars will be used to pay for services in part already paid for with federal subsidies and monthly premiums as families struggle to comply with the federal law.

Another outcome of Medicaid elevation is that since Medicaid claims date no longer flow through the boards, it is more challenging for boards to obtain complete data about the number of people receiving community behavioral health services in their area. Neither the Board, nor most of its providers can describe penetration rates, who is served, with what array of services, utilization, why treatment was terminated, who is underserved, what treatment interventions produce the best outcomes, changes in health status or related health conditions. Unless a Board has invested in information technology (hardware, software, and personnel), it is virtually impossible to access how well the mental health and addiction needs of the resident population is being met or the utilization of many services. While the impact of the elevation and subsequent holding of the state funds at the state level to meet the required match varied by Board, the MHR Board was forced to budget reserves to provide level funding for the contract providers.

Assessment of Need and Identification of Gaps and Disparities

2. Describe needs assessment findings (formal & informal), including a brief description of methodology. Please include access issues, gaps in services and disparities, if any.

For the first time in its history the MHR Board engaged in a more formal needs assessment process. Staff completed a search of national, state, and local data relying on such sources as SAMHSA, Center for Disease Control and Prevention,

The Center for Community Solutions, the Ohio Department of Mental Health and Addiction Services, Belmont County Health Department, and the Barnesville Hospital Association to name a few for information, data, and findings. In the fall of 2015, the Board also conducted a system-wide Recovery Oriented System of Care (ROSC) assessment where 385 surveys were sent out with 160 returned (42% return rate). The assessment asked over 70 questions in 5 major domains: Focusing on Clients and Families; Ensuring Timely Access to Care; Promoting Healthy, Safe and Drug Free Communities; Prioritizing Accountable and Outcome Driven Financing; and, Locally Managed Systems of Care. The results of the surveys were shared in stakeholder meetings held in each of the three counties.

The MHR Board uses many other sources also to determine service needs and gaps in our community system. The process of obtaining information from our community partners is ongoing, pragmatic and has a problem solving focus. The MHR Board is at many community tables and continuously solicits input. In all three counties, there is a sense of cooperation and familiarity with many of the same people at different meetings focused on varying community problems and/or projects. The Board recognizes the importance of preventative services along with determining treatment needs. The Board considers historical and emerging need trends. Additionally, the Board considers the mission of the Board and the Board's strategic plan. Determining need can only occur with the Board's partners (Stakeholders) and community partners.

Community partners involved in our planning efforts include, but are not limited to: Departments of Job and Family Services, Children's Services Departments, Juvenile Courts, Adult Court systems, Family and Children First Councils, Provider staff and their governing Boards, Developmental Disabilities systems, state and local hospital staff and school personnel.

a. Needs Assessment Methodology: Describe how the board engaged local and regional planning and funding bodies, relevant ethnic organizations, providers and consumers in assessing needs, evaluating strengths and challenges and setting priorities for treatment and prevention [ORC 340.03 (A)(1)(a)]

Summary of formal and informal methodology:

Data Sources Utilized:
Contract Agency Assurances and Required Reporting; MACSIS Billings; FCFC Monthly Reporting; Board's Planning and Finance Committee Meetings; ABH UR Monthly Meetings; ABH Census Reports; Board Provider Network; ROSC analysis; SWOT analysis; and, Needs Assessment findings.

Data Source Types:
Quantitative and Qualitative Data was collected

Methodology:
Interview and discussion (large and small meetings); phone conferencing and email as well as feedback from prevention facilitators, Review of Published Information

Stakeholders Involved:
Family and Children First Council; Juvenile justice (Court, Detention, Probation); Criminal Justice (Courts, Police, Jail); General Public; Contract Providers (Mental Health and AoD); Board Members; County Commissioners; DJFS/Children Services; Local Schools; and, individuals and families receiving services.

The MHR Board reached out to other local and regional planning (Boards of Health, Boards of Developmental Disabilities,

Departments of Family Services; Suicide Coalitions; Belmont County Economic Development and Emergency Management) entities for assistance in identifying their concerns and perceived system of care needs. As part of the strategic planning process, staff and management from provider organizations, key community stakeholders, and board members participated in a SWOT (Strengths, Weakness/Challenges, Opportunities, and Threats) analysis. Eighty-four individuals who use system services responded through the ROSC assessment. The compilation of this information, in the form of the needs assessment and the MHR Board's Strategic Plan was shared with those who lent their time and ideas to the process.

The needs assessment and planning process culminated with the MHR Board's first Strategic Plan that lays out specific desired and measurable results that are aligned to the six Strategic Directions:

- Strengths based, innovative array of services and supports designed to help achieve identified and effective and positive health outcomes and recovery.
- Fiscal leadership should maximize resources and capitalize on emerging resource opportunities and promote positive outcomes for the residents.
- Board and staff embrace informed decision-making, combining accurate data, outcomes, and quality improvement strategies to demonstrate results.
- Promote community health and wellness through collaboration, advocacy and community awareness, education and prevention efforts.
- Seek a clinical and administrative culture that supports evolution, growth, and change in its efforts to offer strength-based, outcome producing programs, services and supports within a recovery oriented system of care.

b. Child service needs resulting from finalized dispute resolution with Family and Children First Council [340.03(A)(1)(c)].

The function of the children's clusters in all three counties is exemplary. In each county there is a comprehensive array of community organizations participating. Decisions around the needs of children are jointly made and funded. The funders include Departments of Job & Family Services, Juvenile Court systems, Developmental Disabilities Systems and the Board. The MHR Board has had a historically collaborative relationship with the local Family and Children First Councils. Families that are involved in multiple systems in the community have benefited most by the collaboration between the Council and the Board. The regular service coordination meetings involving Board contract agencies and the families involved, solutions have been generated to the satisfaction of the families in the majority of situations. There has been zero incidents of child service needs resulting in a finalized dispute resolution with the Family and Children First Council.

c. Outpatient service needs of persons currently receiving treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)].

The MHR Board via Southeast has a good relationship with local hospitals. Each year the MHR Board allocates funding to be used at the discretion of the contract agency responsible for Crisis Intervention Services (Southeast) in minimizing State Hospitalizations. The primary intent of these funds is to utilize local hospitals, where appropriate, to avoid state hospitalization placements. Specifically, trained hospital liaisons are in unique positions within our lead provider agencies that coordinate care and discharge planning for these individuals. The network of community providers support the discharge process for these same individuals and provide an intensive level of care needed to coordinate and ease their transition back into the community.

d. Service and support needs determined by Board Recovery Oriented System of Care (ROSC) assessments.

The landscape of behavioral healthcare is changing. No longer is it enough for community systems to just offer treatment

services, a healthy community begins with prevention and wellness programs and continues with ongoing services and supports throughout one's life. The ROSC assessment asked over 70 questions in 5 major domains. Three hundred eighty-five surveys were sent out with 160 returned for a rate of 42%. In general, the ROSC scoring indicated a high level of "Do Not Know" responses in most categories. This high percentage may be indicative of the overall system's (Board and providers) historic low profile, lack of outreach and/or relationships with other community members and targets a body of work in the future.

1. Community partners (other agencies within the community) just don't know what is available or appear to know how the system approaches access, funding, managing, and holding the system accountable.
2. Stigma plays a big role in access and acceptance of interventions and individuals sharing their stories
3. Demographics of living in a rural area play a major factor in access and identifies transportation as a much needed resource
4. There is an imbalance of resources within the 3 county area

- Needs and gaps in facilities, services and supports given the Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03(A)(1)].

During the past year, the MHR Board invested energy in several tools to begin to identify service and support needs of the local area. The MHR Board engaged conducted a Recovery Oriented System of Care (ROSC) needs assessment, using limited resources available a local environmental scan and needs assessment, a Board/Provider/Consumer SWOT Analysis, all of which culminated in a Strategic Plan. The intent of these efforts were not necessarily directed at meeting the expectations of a Continuum of Care portfolio, but rather to identify what local services, supports, and facilities, that system felt important.

From the voices of the system: consumers, providers, community, and the BHM—MHR Board, the identified needs and gaps are:

- Facilities: In Harrison County providers lack adequate space to increase mental health and addiction services. This includes inadequate space for group services such as intensive outpatient (AOD) and mental health groups. All provider facilities are leased space and landlords are reluctant to improve the esthetics that would make the building more attractive and less traumatizing for individuals. Because of the recent oil and gas exploration in Harrison County most usable space has been taken over by oil and gas companies and/or the rent for vacant space has reached unaffordable levels.

  In Belmont County, also experiencing an influx of oil and gas companies, rent space is not available or unaffordable. Thus agencies, especially the smaller ones, are afforded few options to find a facility that is affordable, meets needs in size and location, and provides an environment conducive to health and wellness. The largest provider does own their Belmont County locations, one being too small to meet consumer need and the other too far from town to allow easy access to consumers.

  In Monroe County, office space is utilized in a medical park as well as private leased space in Woodsfield the county seat. It appears both affordable and accessible.

  Residential facilities for substance use disorders are provider owned but are in need of updates and refurbishing. The mental health provider owns a HUD funded, twelve bed licensed ACF home that is well maintained. There is no recovery housing available nor Board or provider operated housing.

  Continuing work to improve the information management system is needed to increase the quality of existing

data, to expand capability to retrieve data on a timely basis, and to expand the types of data collected to increase information on outcomes is needed. This work should proceed with the overall goal of integrating existing and new data within a comprehensive quality improvement system.

- Services: Again, from the Board's needs assessments the following service needs and gaps were identified.

Prevention and education efforts in the area of mental health and emotional disturbances, especially for youth and adolescents. Increased efforts especially in the area of opioid use are desired as well.

Crisis intervention services that extend to the community—providing services beyond telephone intervention and pre-screening for admission to the state inpatient facilities is desired. Operating in local hospitals, community agencies, law enforcement agencies and "on the scene" would provide a more comprehensive community safety net.

Less traditional and a more innovated services (less office based and counseling led) would provide more access and improved clinical outcomes for individuals and their families. More use of evidence based practices and interventions (trauma informed care, specialty court dockets, MAT, and home based interventions) is a gap in the Board's provider service package. Also identified as service gap was thinking of services as an array where clients could come in and out of services of their choice not have to begin in on area and then "graduate" to a less intensive service.

The need to decrease turnover and increase the skill-level of children's community mental health and other providers of services for children/youth at the local level is ongoing, to better ensure continuity, equity and quality of services across all communities in the state, e.g., county health offices, teachers, foster care workers, and juvenile justice workers.

The need to address children with co-occurring disorders of serious emotional disturbance and intellectual and developmental disabilities in a more comprehensive way by expanding existing effective services and creating new approaches that facilitate cross system collaboration and education. Furthermore, there is a preference among the community partners for residential services that generate marginal change in behaviors.

Inadequate or uneven distribution of psychiatric prescriber time across the system with providers unwilling to "share individuals in treatment between treating providers" to afford more access.

Housing, both independent and permanent supported housing, for individuals with serious and persistent mental illness and recovery housing for substance users. Services are available somewhere within the three county area. That does not necessarily make them available since access can be compromised by available hours, provider expertise, lack of transportation, and community awareness.

The need for increased supported and independent employment options for adults with serious mental illness is ongoing.

Continued work to increase access to and to expand safe and affordable community-based housing options and housing related supports statewide for persons with serious mental illness is needed to support recovery. Accomplishing this goal will involve focusing the system response on supporting individuals to choose among community-based options for a stable home, based on their individual needs and preferences, which is consistent with the best practice of Permanent Supportive Housing (PSH).

- Supports: Gaps in supports to fostering recovery and wellness from the local system's need's assessment are:

The MHR Board believes the system would be enhanced by the presence of strong consumer advocacy, from

consumers and from family members. There is no local NAMI chapter, no consumer led or peer supported community opportunities, very limited consumer presence in agency decision making.

Individuals housed in more restrictive levels (ACF homes) in lieu of community housing opportunities. The Board's participation in a COG operating two 16 bed licensed ACF facilities staffed by state employees no longer meets the MHR Board needs and consumes large amount of resources that could be used elsewhere.

The lack of public transportation creates a dependency on the behavioral health care system relying on provider CPST workers for transportation to and from medical and behavioral health appointments.

The recognition that some of the desired supports lie outside the traditionally certified behavioral health providers and the risk attached in funding these supports.

The system is not actively involved in moving upstream in health and wellness promotion in a way that can over the longer term improve community health.

Specifically addressing the Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03 (A)(1)] the MHR Board reports lack of independent community housing and recovery housing, no ambulatory detox, and because of limited resources, a general disparity between the three counties in both mental health and substance use disorder treatment services.

Meeting the expectations of the Continuum of Care poses challenges for the MHR Board as it will for many other Boards within the State. One of the most glaring contradictions and ethical dilemma is the language itself which expected boards to establish a Continuum of Care "to the extent resources are available" but to some extent makes this section subservient to the recently adopted language under ORC 340.33 requiring certain services to be in place regardless of whether resources are available. In meeting the requirements of the Continuum of Care, services and supports previously available to mental health recipients may be up to the withdrawn to provide opioid and co-occurring services required under revised legislation.

2A. Complete Table 1: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area. (Table 1 is an Excel spreadsheet accompanying this document)

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

In addressing questions 3, 4, and 5, consider service delivery, planning efforts, and business operations when discussing your local system. Please address client access to services and workforce development.

3. Strengths:
    a. What are the strengths of your local system that will assist the Board in addressing the findings of the need assessment?
    b. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.

Improvements have been made with accessing services especially with regards to the more rural areas of our service population. The MHR Board maintains an excellent standard of collaboration with our community providers. Communication, interagency referrals and coordination of services for client care is improving. The notion of seeking treatment and services for behavioral health concerns is a positive option as opposed to a stigma. Compassion within the agency providers and within the system of care is easily observed.

Other identified strengths revealed that there is a solid base of traditional services within our providers' agencies, along with a variety of services for children and families. There has also been trend of limited and declining reliance on state hospital resources within our system of care.

The MHR Board was awarded the Three Year COQ Peer Certification which is a collaborative effort between OACBHA and its member Boards designed to enhance quality, statewide consistency and demonstrate accountability of Board operations. The MHR Board has made tremendous progress with developing Quality Management Plan/Indicators in conjunction with its contracted providers. A portion of the monthly contract directors' meeting and provider organization's internal quality committees will be utilized for decision making, development of performance measures and performance monitoring.

4. Challenges:
    a. What are the challenges within your local system in addressing the findings of the needs assessment, including the Board meeting the Ohio Revised Code requirements of the Continuum of Care?
    b. What are the current and/or potential impacts to the system as a result of those challenges?
    c. Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.

CHALLENGES

MHR Board is involved with several community partners in developing a framework for addressing prenatal substance abuse across systems. There is a need for additional training and technical support for evidence based gender specific treatment and interventions to be delivered to women who are pregnant and women with dependent children. Providers to be trained on core competencies as outlined by SAMHSA- "Addressing the Needs of Women and Girls: Developing Core Competencies for Mental Health and Substance Abuse Service Professionals."

Key highlights from our SWOT correlated to meeting the Ohio Revised Code requirements of the Continuum of Care:

- Lack of affordable and accessible detoxification services
- Lack of recovery supports (permanent supported housing, employment, consumer operated services, peer services)
- Limited evidence based practices for clinicians and prevention services
- Limited 'person center planning' in treatment in program design, implementation and evaluation

Challenges for the MHR Board-contracted Provider Network in their ability to meet the demands of consumers will be challenged by a rapidly changing reimbursements environment along with increased demand for price and quality transparency and performance reimbursements. We anticipate an increasing lack of availability of timely AOD and mental health treatment services for individuals falling outside of our prioritized populations. The lack of stable and sustainable direct care workforce translates into poor clinical relationship development as consumers experience high turnover within their primary team of individual care providers and lost productivity for the provider.

Housing is one of the primary needs across the spectrum from young adults in transition to the older adult population. In order to feel safe and be successful, more housing is needed in the more suburban areas, as these units are always filled with long waiting lists. In order for our youth to work towards successful independence, they need first to be in safe environment. An additional housing need is for persons who are sex offenders. Most of the available housing that is not cost prohibitive does not allow convicted sex offenders. Housing is also a need for our most difficult to serve population

who are currently being treated in the state regional psychiatric hospital. The common problem facing this population is finding appropriate housing at the level of care needed due to their resistance to treatment, including non-compliance with taking medication as prescribed; lack of follow-through with scheduled appointments with psychiatrists and case managers; lack of insight into their illness; lack of acceptance of illness; poor social skills; and lack of family support due to alienation of loved ones because of their medication non-compliance.

One of the significant strengths of the Ohio mental health system— the diversity of agencies and providers serving adults with mental illnesses and children with emotional disorders—is also a key weakness. Individuals and families must interact with a range of agencies to access services. This fragmentation results in frustration for consumers, potential duplication of services, increased costs, and interruptions in care. The situation is especially acute for certain groups, including youth transitioning to the adult system of care and individuals with mental health conditions who come into contact with the criminal justice system for lack of more appropriate alternatives. Deficits in coordinated care extend to mental health services offered by other agencies, as well social services more broadly, including law enforcement, legal aid, housing, and employment services.

Lack of consistent data and support for its use. The inability to collect consistent data and to share this information across agencies affects the state's ability to plan for and provide comprehensive services to adults and children with mental health conditions. Many agencies have neither the capacity nor the resources to implement EHRs. Redundancy and duplication in data collection and lack of uniformity in data definitions across agencies inhibit collaboration. Finally, neither state nor federal funding has been allocated to support HIT at the state or local level.

The following are Unmet Needs in the Adult Mental Health Service System which have been identified:

- Access to Services by Uninsured and Under-Insured individuals
- Affordable Housing
- Training and education in existing service venues on dynamic issues and mental health interventions in serving the LGBTQ population
- Reduction of the cracks and slippages in service for individuals with both Developmental Disability and Mental Illness.
- Emphasize and increase consumer roles in service provision with support for Peer Run Services in the State

5. Cultural Competency
    a. Describe the board's vision to establish a culturally competent system of care in the board area and how the board is working to achieve that vision.

The MHR Board embraces the principles of equal access and non-discriminatory practices in planning, funding and service delivery. We believe cultural competence might be achieved by identifying and understanding the needs and at-risk behaviors of the individuals and families within our community. We recognize behavioral health as an integral and inseparable aspect of primary care. Stigma, lack of education, misinformation, and staff turnover at various provider agencies remain. The Board is committed to the continuing effort of building and sustaining the most culturally competent system possible. The Board's contract, quality management plan, provider service plan, and reports challenge the providers to share in the vision for a culturally competent system as well.

Priorities

6. Considering the board's understanding of local needs, the strengths and challenges of the local system, what has the board set as its priorities for service delivery including treatment and prevention and for populations?

   Below is a table that provides federal and state priorities.

   Please complete the requested information only for those federal and state priorities that are the same as the board's priorities, and add the board's unique priorities in the section provided. For those federal and state priorities that are not selected by the board, please check one of the reasons provided, or briefly describe the applicable reason, in the last column.

   Most important, please address goals and strategies for any gaps in the Ohio Revised Code required service array identified in the board's response to question 2.d. in the "Assessment of Need and Identification of Gaps and Disparities" section of the Community Plan [ORC 340.03(A)(11) and 340.033].

Priorities for (enter name of Board)				
Substance Abuse & Mental Health Block Grant Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
SAPT-BG: Mandatory (for OhioMHAS): Persons who are intravenous/injection drug users (IDU)	Increase availability of Medication Assisted Treatment (MAT)	Expand MAT capacity and treatment options	Number of people receiving MAT	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for boards): Women who are pregnant and have a substance use disorder (NOTE:ORC 5119.17 required priority)	Decrease incidence of Neonatal Abstinence Syndrome (NAS)	Enhance system awareness of treatment resources for women who are pregnant. MHR Board has released a RFI for prevention and treatment services. Strengthen collaboration with Family and Children First Councils in regards to early Prenatal Care meetings.	Increase percentage of pregnant women that receive timely access to AoD treatment Decrease number of babies born with NAS	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for boards): Parents with SUDs who have dependent children (NOTE: ORC 340.03 (A)(1)(b) & 340.15 required consultation with County Commissioners and required service priority for children at risk of parental neglect/abuse due to SUDs)	Ongoing assessment and monitoring of child neglect/abuse from intake through length of treatment	Maintain Family Dependency Treatment Court in Belmont County Explore/Expand FDTC in Harrison County in cooperation with DJFS	Reduce length of out-of-home placements for youths Establishment of FDTC within Harrison County	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)				X No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Increase attendance rate of youth with SED, specifically focusing on youths referred to the three county cluster services coordination	Continue to develop and promote cross systems partnerships, specifically targeting Safe Schools, Healthy Students Initiative in Harrison County	Improved attendance within school systems Number of services accessible within the schools	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

	To assure children with SED have access to an array of core services	Continue to implement the Early Childhood Mental Health Training Grant Prioritize and increase services accessibility Add school based intervention and treatment in two Monroe County high schools		
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Decrease number of hospitalizations and recidivism rate of SPMI Decrease average length of stay of hospitalization Increase the number of adults with SMI that are independently and successfully integrated within their community	Provide additional supportive services Provide supportive housing services MHR Board has issued a RFI for housing support.	Number of individuals served Number of hospitalizations	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of permanent supportive housing	Increase access to permanent supportive housing for persons with mental illness or SUD	Increase specialized case management services to address barriers to person in recovery obtaining/maintaining safe, affordable housing.	Number of individuals served/housed	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Older Adults	To gain a more informed and data driven assessment of this target population	Partner with identified entities that tailor to the elderly population in assessing and gathering information regarding unmet needs.	Surveys collected and analyzed Service array modified dependent upon survey results	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH/SUD Treatment in Criminal Justice system –in jails, prisons, courts, assisted outpatient treatment	Ensure adequate and appropriate behavioral health services are available to meet the needs of individuals involved in the criminal justice system.	Continue to implement Community Innovations Grant which places behavioral health staff within the jail environment	Recidivism rate for reincarceration Reduce number of jail transfers between Belmont County jail and ABH	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

		Partner with Specialty Dockets/Courts Form a criminal justice collaborative within Belmont County to reduce the impact of behavioral health issues on the legal system and community Enhance services regarding discharge planning with inmates	Criminal Justice Collaborative generates a community plan to address impact of MH/AOD within all aspects of the community	
Integration of behavioral health and primary care services				__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Recovery support services for individuals with mental or substance use disorders; (e.g. housing, employment, peer support, transportation)	Increase certified recovery/peer supports within the system of care	Develop a service continuum to sustain recovery supportive services (housing, peer support, SE/ISP, etc)	Number of individuals trained Number of individuals accessing supportive services	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)	Encourage access to services to racial and ethnic minorities and LGBTQ populations	Collaborate with identified organizations identified as experts	Number of individuals served	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Ensure Naloxone is widely available in our 3 county service area along with proper education and training	Continue to encourage other entities in their implement of Project DAWN Community forums of to provide information and resource materials	Number of Kits distributed Number of lives saved	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Promote Trauma Informed Care approach	Ensure providers within Board's three county area are trained in Trauma Informed Care	Establish local Trauma Informed Collaborative Provided trainings to enhance understanding of lifelong impact of untreated ACEs	Number of providers trained Number of trainings provided Number of those attending the trainings and/or collaboratives	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

		Adopt a community wide screening tool		
Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents	Sustain preventative services across life spans and populations with a focus on families with children and adolescents Promote a healthier community through work with local health departments, social service agencies and other community-based organizations to address non-medical issues that impact health such as housing, violence, and access to opportunities for healthy eating and active living.	Enhance prevention service continuum to increase such services such as parenting programs, kinship care, transitional youth, foster care, etc. Increase the amount of funding the MHR Board makes available for prevention services	Increase percentage of agency providers within prevention continuum to provide services to children and adolescents Increase prevention services	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Increase access to evidence-based prevention	Identify EBP most prevalent in priority populations or underserved populations of concern to the Board	Evaluate training needs of providers within Board's three county area. Percentage of MHR Board funded prevention services will be EBP	Collect data to evaluate public health effectiveness of education and advocacy efforts Number of EBP	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Suicide prevention	Prevent and reduce attempted suicides and deaths by suicides among high risk populations Increase awareness of connection between substance abuse and suicide	Conduct 2 local trainings about annually Address common prevention tools and connection between suicide and SUD Participate in the Monroe County Suicide Prevention Coalition	Number of attendees at trainings	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	Enhance strategies to increase community awareness of problem gambling as well increase the number of screenings and referrals to treatment	Provide information of problem gambling and available resources through existing network of stakeholders. Identify consumers via gambling screening requiring additional behavioral health interventions to further avert subsequent gambling behaviors.	Number of media materials distributed Number of individuals receiving prevention and treatment services	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Reduce the number of youths placed in residential placements with limited success upon reentry into their natural environment	Implement psych-education for agencies, school personnel, & juvenile justice system on Trauma Informed Care Use of evidence-based practices for children & for parent education	Engage and educate community leaders and private businesses about the positive effects that enhanced access to behavioral health has on communities Expansion of behavioral health youth mentoring program, connecting provides with needs in the community	Decrease number of children placed in residential care
Reduce the number of adults (SMI) living long term in ACF	Increase the number of adults with SMI that are independently and successfully integrated within their community	Identify and expand supported employment services and permanent supportive housing to ensure successful transition from levels of care.	Evidenced by on-going communication between providers and intra-system referrals.
Eliminate access and service disparities between the counties and within individual counties	Identify service capacity in the service area, prevalence and penetration rates in targeted areas.	Add capacity (staff, hours, providers, sites) when identified and as resources allow.	Data analysis and dashboard reports will guide implementation and strategies to address access disparities.
Peer recovery and consumer operated services within our service area	Identify and expand supported peer-led services to ensure successful transitions from levels of care.	Redirect funding to recovery services and peer supported services. Public education about behavioral health and community wellness issues	MHR Board will contract (RFIs) for additional supports and services not now available.

Assure a system of care that offers choice in its array of services and in the provider network	Evaluate area service array for EBP, traditional and nontraditional services as well as accessibility and availability.	Develop and set performance standards, metrics, etc (CQI) process ensuring strong collaborative partnerships and shared accountability for delivery of high quality integrated services.	Develop new funding models that align with the goals of patient access, quality of care, and outcomes rather than quantity of care

Priorities (continued)

7. What priority areas would your system have chosen had there not been resource limitations, and why? If you provide multiple priority areas, please prioritize.

Priority if resources were available	Why this priority would be chosen
(1)Permanent Supportive Housing	Increase specialized case management services to address barriers to person in recovery obtaining/maintaining safe, affordable housing.
(2)RECOVERY HOUSING	Provide education, training and technical assistance for recovery support partnerships to create linkage between existing providers for expansion of scope of recovery and reduce duplication of services.
(3)AOD RESIDENTIAL	Ensure access and availability to broad and flexible array of effective, services within our three county area to decrease waitlist time.
(4)Mobile Crisis	Lack of capacity for local ERs to identify/manage/address/ acute crisis needs
(5)IHBT	To help youth and families understand what led to the crisis event, to identify and develop healthy and adaptable coping skills to decrease future crises or need for psychiatric inpatient hospitalization and to improve commitment to ongoing mental health counseling in the community.
(6) Aggressive Prevention Efforts	Providers that offer mental health education and skill-building services to children, youth, families and individuals so they can avoid the abuse of drugs and alcohol, make positive behavior choices, and improve the well-being of our community through advocating and building capacity with a unified voice for sustainable investments in safe, healthy, and engaging commitment.
(7)	
(8)	
(9)	
(10)	
(11)	
(12)	
(13)	

Collaboration

8. Describe the board's accomplishments achieved through collaborative efforts with other systems, consumers and/or the general public during the past two years. (Note: Highlight collaborative undertakings that support a full continuum of care. Are there formal or informal arrangements regarding access to services, information sharing, and facilitating continuity of care at a systems level?)

The community continues to benefit from the collaborative nature of the residents and organizations in Belmont, Harrison and Monroe Counties. The MHR Board continues to partner with a number of agencies on various projects.

The Monroe County Suicide Prevention Coalition
The MHR Board participates on the Monroe County Suicide Prevention Coalition whose goal is to prevent suicide by increasing public awareness by engaging a wider base of concerned stakeholders, providing training to gatekeepers and developing public relations/media activities to educate the public at large.

Strong Families, Safe Communities Grant
The MHR Board in conjunction with the BHN Alliance collaborated to provide intensive home based treatment services for youth at high-risk for out-of-home placement. The established relationship between our Board and the Developmental Disabilities system was instrumental in this collaborative initiative. This collaboration involved key partner agencies that provided positive family communication skills which impacted family functioning.

CIT
The training provided the officers an opportunity to build upon their knowledge of mentally ill individuals; increased their skills in assessing situations quickly and de-escalate those situations. The training also resulted in strengthening the relationship between law enforcement and our community system. The training was a joint collaborative effort between our Board, Belmont County Sheriff's Department, Harrison County Sheriff's Department and NAMI Ohio.

Family Service Coordination
Currently in all three counties, decisions around the needs of at-risk children are jointly made and funded. The funders include Departments of Job & Family Services, Juvenile Court systems, Developmental Disabilities Systems and the Board. The Board has had a historically collaborative relationship with the local Family and Children First Councils. Representatives from these entities work in unison in the community cluster process to keep placements costs within a predetermined allocation and the per diem placement costs are shared between the entities, as appropriate. Since the inception of this collaboration, residential costs have significantly declined.

Improved Access to Services
In an effort to decrease the amount of time it takes for individuals to be seen in our more rural areas, MHR Board partnered with provider agencies to develop a viable solution to this high demand for mental health services and medication management. This has made a remarkable impact upon the time it now takes to receive both an Intake/Diagnostic Assessment and to receive ongoing services.

Safe Schools, Healthy Students
Without excellent collaboration and coordination with the local school system of Harrison Hills, the program would not enjoy the success it does. The children referred for services within the school have a tendency to demonstrate challenging behaviors as a result of lacking crucial cognitive skills in the domains of flexibility, frustration tolerance and problem solving. Mental health counselors engage the children in solving problems collaboratively to enhance these cognitive skills.

Directors' Meeting
Our local "Core Providers" meet on a regular basis with the Board staff in order to discuss and problem solve various ongoing needs in our community. Working collaboratively on various projects has proven to be a win-win for all within Belmont, Harrison and Monroe Counties and this philosophy continues.

Recovery Summit
The Mental Health & Recovery Board of Belmont, Harrison and Monroe Counties has participated in an annual recovery conference for many years that has been co-sponsored by the Eastern Alliance Council of Governments and Collaborative to promote a greater understanding of recovery from mental illness. These conferences have required increased attention to assessing the recovery needs of those receiving treatment services through the Boards' contracts. Through planning and participating with this conference, the Board has been developing a focus on providing recovery-oriented services such as consumer operated services and supported employment as a means of developing a local recovery system during and post treatment for persons with mental illnesses and addictions.

AppCare became a more formal institution as a result of OhioMHAS collaborative funding initiatives. Members are the boards that admit to Appalachian Behavioral Healthcare (BHM, Jefferson, Muskingum Area, GJM, AVH, ASL, and Washington and ABH. While the member boards have a long history of working together, when OhioMHAS distributed funding to "regional collaboratives" the group became a tool to decide regional resource distribution. The group meets once a quarter to share ideas, best practices, and problem solve, consult and discuss issues of mutual concern.

Eastern Alliance is the organizational name for a Council of Government (COG) organization that was formed in 1996 with BHM, Muskingum Area, and Jefferson as founding members. The COG was formed to assure that individuals previously served in by or living in a state hospital (primarily Cambridge Psychiatric Hospital) were offered support and services in the area. Subsequent to its formation, the COG applied for and received capital funding to purchase and renovate Liberty Manor in Kimbolton and construct Country Garden Manor in Cambridge. The group also contracts with the State of Ohio to staff those two homes.

Inpatient Hospital Management

9. Describe the interaction between the local system's utilization of the State Hospital(s), Private Hospital(s) and/or outpatient services and supports. Discuss any changes in current utilization that is expected or foreseen.

The Regional State Hospital (ABH), our contract agency providing crisis intervention and preadmission screening, and MHR Board staff hold monthly teleconference meetings to facilitate discharge planning which includes individual's strengths and weaknesses and community resources. Our approach has been and continues to be successful. Our bed day usage declines, as we maintain the same best practice approach to client care. In addition, the MHR Board receives crisis reports/screening reports on all individuals screened for inpatient but not admitted.

In FY 2016 the MHR Board was one of three Boards admitting to ABH that received funding to decrease the number of jail transfers to the hospital. Placement of treatment staff within the jail has improved the "overall jail climate" and has helped reduce the number of individuals admitted to the hospital of the jail. Jail staff, in particular, report how having staff within the jail has provided them an additional resource to de-escalate situations before they intensify.

Innovative Initiatives (Optional)

10. Many boards have implemented innovative programs to meet local needs. Please describe strategies, policy, or programs implemented during the past two years that increase efficiency and effectiveness that is believed to benefit other Ohio communities in one or more of the following areas:
    a. Service delivery
    b. Planning efforts
    c. Business operations
    d. Process and/or quality improvement

    Please provide any relevant information about your innovations that might be useful, such as: How long it has been in place; any outcomes or results achieved; partnerships that are involved or support it; costs; and expertise utilized for planning, implementation, or evaluation.

    NOTE: The Board may describe Hot Spot or Community Collaborative Resources (CCR) initiatives in this section, especially those that have been sustained.

Community Innovations
Mental health and addictions counseling services are being offered within Belmont County jail through grant. The long term goal of this grant is to reduce jail transfers admissions from Belmont County Jail by 15% to Appalachian Behavioral Healthcare. We are also focusing on reducing the recidivism of people with behavioral health issues in the criminal justice system and strengthening efforts to enhance the continuum of care between assessment and discharge for the stabilization of gains made during services.

The Whole Child Matters Early Childhood Mental Health Centralized Intake and Workforce Expansion Initiative
The Mental Health and Recovery Services Board of Stark County and in partnership 10 partner counties including the BHM – MHR Board. This initiative focuses on the partnership between early identification, prevention and intervention in early learning environments for children ages 0-6 and their caregivers. Project goals include decreasing preschool and Kindergarten suspension & expulsion rates, decreasing behavioral challenges, developing a system of regional supports and resources and promoting social and emotional skills.

The MHR Board recently joined the Heartland East Administrative Services Center, a consortium of boards that came together initially in 1998 for the joint administration of MACSIS. The Board coupled its need to replace MACSIS, the state operated claims adjudication process, with its desire to produce information necessary for the Board, the providers, and the local system of care to successfully navigate the seismic shifts that are planned in the behavioral health care system.

Advocacy (Optional)

11. Please share a story (or stories) that illustrate the vital/essential elements you have reported on in one or more of the previous sections.

Open Forum (Optional)

12. Please share other relevant information that may not have been addressed in the earlier sections. Report any other emerging topics or issues, including the effects of Medicaid Expansion, which is believed to be important for the local system to share with the department or other relevant Ohio communities.

Community Plan Appendix 1: Alcohol & Other Drugs Waivers

A. Waiver Request for Inpatient Hospital Rehabilitation Services

Funds disbursed by or through OhioMHAS may not be used to fund inpatient hospital rehabilitation services. Under circumstances where rehabilitation services cannot be adequately or cost-efficiently produced, either to the population at large such as rural settings, or to specific populations, such as those with special needs, a board may request a waiver from this policy for the use of state funds.

To request a waiver, please complete this form providing a brief explanation of services to be provided and a justification. **Medicaid-eligible recipients receiving services from hospital-based programs are exempted from this waiver as this wavier is intended for service expenditure of state general revenue and federal block funds.**

A. HOSPITAL	UPID #	ALLOCATION

B. Request for Generic Services

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

B.AGENCY	UPID #	SERVICE	ALLOCATION

SIGNATURE PAGE

Community Plan for the Provision of Mental Health and Addiction Services SFY 2017

Each Alcohol, Drug Addiction and Mental Health Services (ADAMHS) Board, Alcohol and Drug Addiction Services (ADAS) Board and Community Mental Health Services (CMHS) Board is required by Ohio law to prepare and submit to the Ohio Mental Health and Addiction Services (OhioMHAS) department a community mental health and addiction services plan for its service area. The plan is prepared in accordance with guidelines established by OhioMHAS in consultation with Board representatives. A Community Plan approved in whole or in part by OhioMHAS is a necessary component in establishing Board eligibility to receive State and Federal funds, and is in effect until OhioMHAS approves a subsequent Community Plan.

The undersigned are duly authorized representatives of the ADAMHS/ADAS/CMHS Board.

_____

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

_____ _____

ADAMHS, ADAS or CMH Board Executive Director Date

_____ _____

ADAMHS, ADAS or CMH Board Chair Date

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

Instructions for Table 1, "SFY 2017 Community Plan Essential Services Inventory"

Attached are the SFY 17 Community Plan (ComPlan) Essential Services Inventory and some supporting files to enable the Inventory's completion.

Various service inventories have been included in the ComPlan in the past. The current Essential Services Inventory included with the 2017 ComPlan requires a new element: the listing of services for which the board does not contract. This new element is necessary due to recent changes in the Ohio Revised Code to detail the behavioral health (BH) continuum of care in each board area. The department and constituent workgroups, in pilot studies, have found this information necessary for boards to meet the Ohio Revised Code CoC requirements.

Some additional CoC information resources have been provided (Section VI) to assist in this process, but board knowledge is vitally important given the limitations of these included CoC resources. For example, the attached resources will not address BH services provided by Children Service Boards and other key providers within the local behavioral healthcare system.

Instructions for the Essential Services Inventory

The 1st file is the Services Inventory. The goal is to provide a complete listing of all BH providers in the board area. To be able to proceed, please click on the "Enable Editing" and/or the "Enable Content" buttons, if they occur on top of the spreadsheet, and enter the name of the board in the 1st row.

The spreadsheet lists the ORC required Essential Service Categories in each row. Also in each row are cells to collect information about how each category requirement can be met. The information requested includes:

- Provider Name. Also included in some Provider Name cells are prompts for descriptions of services for which there are no FIS-040 or MACSIS definitions. The prompts request that descriptions of how the Board provides for these services be put in the last column, "Board Notes". The prompts can be deleted to make room for a Provider Name.
- Mandatory individual service(s) that satisfy the ORC Essential Service Category
- Services related to the required category, but are needed to meet local BH needs, rather than the CoC mandate.
- "Yes" or "No" response indicating that the board contracts with the provider providing the service.
- Counties within the board where the provider provides the required "must be in the board area" service; or, out-of-board location when the required service is allowed to be provided outside the board area.
- Populations for which the service is intended to serve; or, for Prevention/Wellness services, the IOM Category.

Except for "Provider Name" and "Board Notes" cells, in which information is manually entered, all the other cells have a drop down menu from which services are chosen, and typed data entry cannot occur.

To use the drop down menu, click on a cell and a downward pointing arrow will appear. Click on the arrow and a drop-down list of services will appear. Click on a service and it will appear in the cell. Click on the service a 2nd time and it will erase the service entry in the cell; or highlight the unwanted service entry and click "Clear Content" from the right mouse button menu. Click on as many services as are needed for each provider cell in the row. Use the slide-bar on the right side of the drop down menu to see all available items in the list.

To add additional providers in a particular Essential Service row, highlight all cells in the row below the needed Essential Service, and click "Insert" from the right mouse button menu. All of the instructions and drop down menus for that Essential Service will be included in the "Inserted" rows.

Additional Sources of CoC Information

1. **MACSIS Data Mart Client Counts by AOD and MH services for 2015.**
   Explanation: If a required service or support is not found in a Board's budget, there may be a number of possible explanations, e.g.:
   a. Variation in how Boards account for services and supports in the budgeting process. A check of the MACSIS Data Mart may reveal budgeted services or supports that haven't been directly captured in the current budget.
   b. Required service or support is delivered by Providers serving Medicaid only clients. The Data Mart will show that the Medicaid paid service or support is being provided within the Board service area even though the Board has no contract with that Provider.

2. **OhioMHAS 2015 Housing Survey.**
   Explanation: Certain required housing categories may not be budgeted, e.g., Recovery Housing, or there may be lack of clarity between required housing categories and 040 reporting categories or specified in the Community Plan. The OhioMHAS Housing Survey brings greater clarity to classifications of housing services and environments and better track provision of those Continuum of Care (CoC) elements in Board service areas.
3. **SAMHSA 2014 National Survey of Substance Abuse treatment Services (N-SSATS), and the**

4. **SAMHSA 2014 National Mental Health Services Survey (N-MHSS).**
   Explanation: SAMHSA annually surveys AOD and MH Providers irrespective of their OhioMHAS certification status. The surveys provide a broad spectrum of information, including the existence of some AOD or MH services or supports within a Board's service district that are required essential CoC elements, but which are not found within the public behavioral health service taxonomy, or are not captured within the Board's budget. These surveys should be reviewed for existing required CoC elements delivered by Providers that are OhioMHAS certified (in network) and those Providers that are not (out of network).

Service Crosswalks between ORC Required Essential Service Category Elements and the Additional Information Sources

Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
A-Ambulatory Detox ‡		OP Detox ASAM Level I.D & II.D	
A-Sub-Acute Detox ‡		Residential Detox ASAM Level III.2-D	
A-Acute Hospital Detox		Inpatient Detox	
Intensive Outpatient Services: • A-IOP ‡ • M-Assertive Community Treatment • M-Health Homes		Intensive OP ASAM Level II.1 (9+ HRS/WK)	• Assertive Community Treatment (ACT) • Primary Physical Healthcare

Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
A-Medically Assisted Treatment ‡		• Naltrexone • Vivitrol • Methadone • Suboxone • Buprenorphine (No Naltrexone)	
12 Step Approaches ‡		Clinical/therapeutic approaches Used:.. • 12 step facilitation	
Residential Treatment: A-MCR-Hospital A-BHMCR-Hospital		Hospital IP Treatment ASAM IV & III.7	
Residential Treatment ‡: A-MCR- Non-Hospital A-BHMCR-Non-Hospital	Residential Treatment Medical Community Residence	Residential Short-Term ASAM Level III.5 (High Intensity)	
Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
Residential Treatment ‡: A-NMR-Non-Acute A-BH-Non-Medical-Non-Acute	Residential Treatment Medical Community Residence	Residential Long-Term ASAM Level III.3 (Low Intensity)	
Recovery Housing ‡	Recovery Housing		
M-Residential Treatment	Residential Treatment-MH		24 Hour Residential (Non-Hospital)
Locate & Inform: • M-Information and Referral			MH Referral, including emergency services
M-Partial Hospitalization			Setting: Day Treatment/Partial Hospitalization
M-Inpatient Psychiatric Services (Private Hospital Only)			Inpatient Services
Recovery Supports: • M-Self-Help/Peer Support • M-Consumer Operated Service			MH Consumer Operated (Peer Support)
Recovery Supports: • M-Employment/ Vocational Services			• Supported Employment Services • MH Vocational Rehabilitation Services

Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
Recovery Supports: • M-Social Recreational Services			Activities Therapy
M-Crisis Intervention			MH Psychiatric Emergency (walk-in)
Wide Range of Housing Provision & Supports: • M-Residential Care	Residential Care: • Adult Care Facility/ Group Home • Residential Care Facility (Health) • Child Residential Care/Group Home		MH Supported Housing Services
Essential Service Category Elements (‡ = ORC 340.033 Required)	2015 OhioMHAS Housing Survey	2014 National Survey of Substance Abuse Treatment Services (N-SSATs)	2014 Nation Survey of Mental Health Services Survey (N-NHSS)
Wide Range of Housing Provision & Supports: • M-Community Residential • M-Housing Subsidy	Permanent Housing: • Permanent Supportive Housing • Community Residence • Private Apartments		MH Housing Services
Wide Range of Housing Provision & Supports: • M-Crisis Bed • M-Respite Bed • Temporary Housing • Transitional	Time Limited/ Temporary: • Crisis • Respite • Temporary • Transitional		
Wide Range of Housing Provision & Supports: • M-Foster Care	Time Limited/ Temporary: • Foster		• Therapeutic Foster Care
Wide Range of Housing Provision & Supports: • AOD			• See Residential Treatment, above