Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan SFY 2017

TRUMBULL COUNTY MENTAL HEALTH AND RECOVERY BOARD

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.

As the data in Tables 1 and 2 suggest, the "perfect storm" of negative social forces that we first described in our *FY2012–FY2013 Community Plan* continues to buffet Trumbull County. Between 2000 and 2014, the total population of the county declined by nearly 20,000 (–8.8 percent) while the number of residents living in poverty increased by nearly 13,000 (+58.4%). Trumbull County's poverty rate was below the statewide rate in 1990 and 2000, but exceeded the statewide rate by more than 2 percentage points in 2010. The growth in poverty was most pronounced for children. In 2010, the county's child poverty rate far exceeded the statewide rate for children (23.1 percent). In that year, nearly one–third (31.4 percent) of all children in Trumbull County were living in poverty.

TABLE 1

Persons in Poverty: 2000

	Trumbull County		*Ohio*
	N	*%*	*%*
All ages	21,844	9.9	9.8
Under 18	8,199	15.3	14.1
County population:	**225,116**		

Persons in Poverty: 2010

	Trumbull County		*Ohio*
	N	*%*	*%*
All ages	37,359	18.2	15.8
Under 18	14,352	31.4	23.1
County population:	**210,312**		

Persons in Poverty: 2014

	Trumbull County		*Ohio*
	N	*%*	*%*
All ages	34,593	17.2	15.8
Under 18	11,982	28.3	22.7
County population:	**205,255**		

Data Sources: US Census Bureau, Small Area Income and Poverty Estimates, http://www.census.gov/did/www/saipe/index.html
Ohio Development Services Agency, Ohio County Population Estimates, https://development.ohio.gov/files/research/P5007.pdf

Between 2009 and 2015, unemployment in Trumbull County followed the same general pattern as the statewide trend: declining between 2009 and 2012, rising again in 2013, then declining in 2014 and 2015 (see Table 2). And while Trumbull County has followed the statewide pattern, our unemployment rates were higher than the state average in every year. Trumbull's rate rose from 6.2 percent of the labor force (6,600 persons) in 2007 to 13.8 percent of the labor force (14,700 persons) in 2009. This ranked Trumbull County first among the fifteen counties with the largest populations and civilian labor forces (CLFs[1]). This dubious distinction continued from 2009 through 2015, interrupted only in 2011, when Lucas County's rate exceeded ours by two–tenths of one percentage point. In that seven–year span, Trumbull County's labor force shrank by nearly 15 percent (from 107,200 to 91,700 persons) as we experienced large–scale plant closings (Delphi Corporation), temporary layoffs along with permanent reductions in force (General Motors' Lordstown Assembly), and numerous work force reductions and business closures (e.g., restaurants, supermarkets, retailers, automobile dealerships, etc.).

TABLE 2

Civilian Labor Force (CLF) Information: Ohio and Trumbull County, 2009–2015

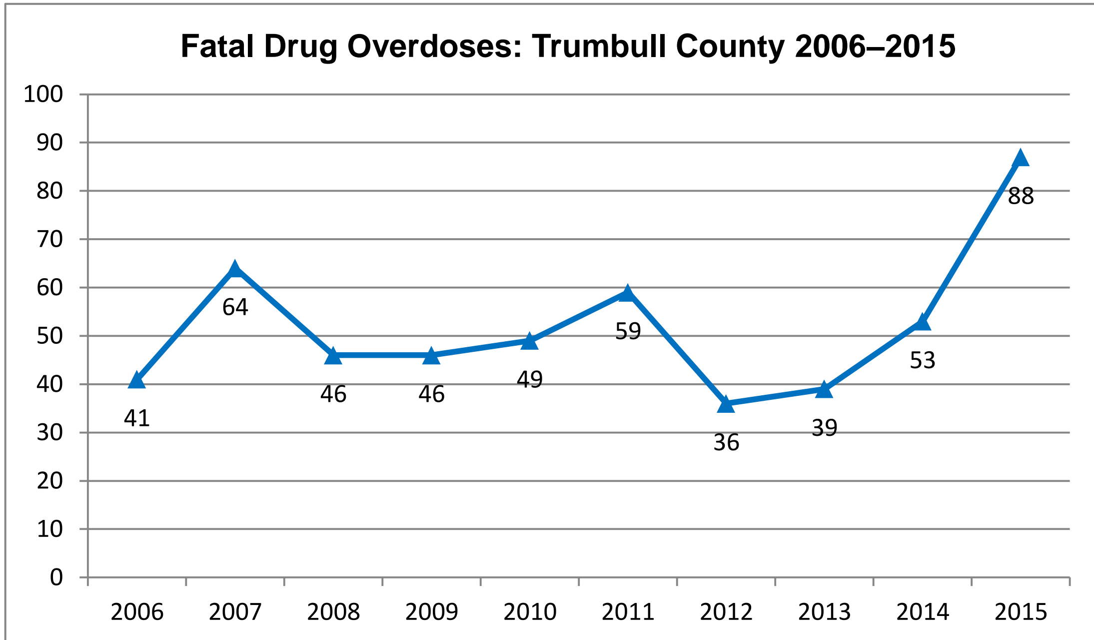
OHIO	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***
Labor Force	5,929,000	5,864,000	5,806,000	5,747,900	5,717,000	5,703,000	5,700,000
Employed	5,328,000	5,279,000	5,305,000	5,334,900	5,290,000	5,373,000	5,423,000
Unemployed	601,000	586,000	501,000	413,000	427,000	330,000	277,000
Unemployment Rate	10.1	10.0	8.6	7.2	7.5	5.8	4.9
TRUMBULL COUNTY	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***
Labor Force	107,200	104,800	101,700	100,400	94,700	92,600	91,700
Employed	92,500	92,400	91,900	92,200	85,800	85,900	85,700
Unemployed	14,700	12,300	9,800	8,100	8,900	6,700	5,900
Unemployment Rate	13.8	11.8	9.6	8.1	9.3	7.2	6.5
Unemployment Rank (15 largest counties/CLFs)	1	1	2	1	1	1	1

Data source: Ohio Department of Job and Family Services, Local Area Unemployment Statistics, http://ohiolmi.com/laus/laus.html

Poverty and unemployment have well-established relationships with stressors and high-risk behaviors. Increases in poverty and unemployment predictably lead to increases in our community's behavioral health needs, including a wide range of substance abuse and mental health problems, which are expressed in a variety of ways. While many persons—nearly 12,000 in FY2015—receive behavioral health services from the ADAMHS network, some seek services outside our system (e.g., primary care physicians, clergy), some receive services involuntarily

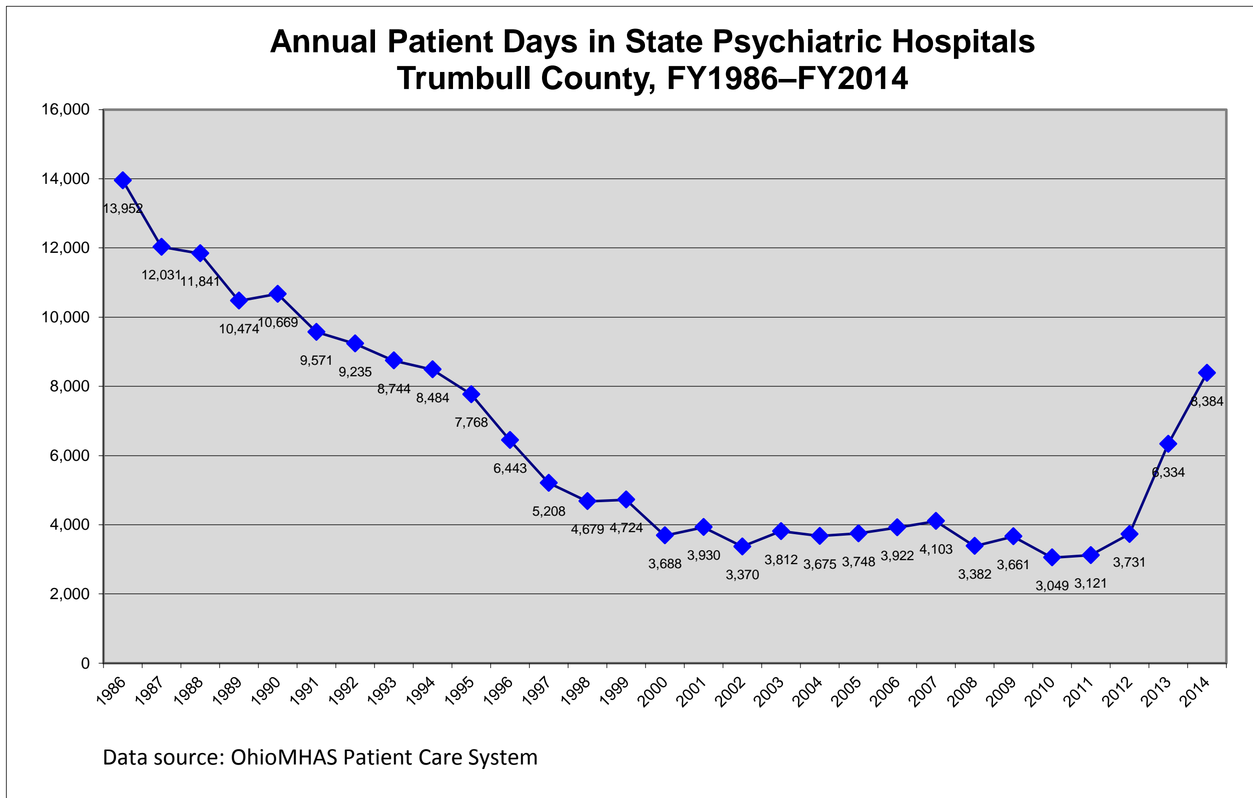
[1] The fifteen counties with the largest overall populations and Civilian Labor Forces (2015) in descending order of CLF size are: Franklin, Cuyahoga, Hamilton, Summit, Montgomery, Lucas, Stark, Butler, Lorain, Lake, Warren, Mahoning, Clermont, Delaware, and Trumbull.

TABLE 3



Data source: Trumbull County Coroner's Office

TABLE 4



Data source: OhioMHAS Patient Care System

or in crisis situations (e.g., "pink slips," probates, emergency hospital admissions), while many others engage in no overt help–seeking behavior. This last category would include persons with untreated substance use or mental health disorders and persons contemplating, attempting, or completing suicide. Finally, Trumbull County's opiate epidemic has exacerbated poverty and unemployment trends. The data displayed in Table 3 show a 112% increase in fatal drug overdoses in the county between 2006 and 2015 while Table 4 shows that our use of state psychiatric hospitals in recent years has risen to levels not seen since the 1990's. Both of these trends are discussed in detail in subsequent sections of this plan.

In their study of the impact on the Mahoning Valley of the abrupt closing of Youngstown Sheet and Tube Corporation on "Black Monday" (September 19, 1977), Terry Buss and Stevens Redburn make an important observation:

> . . . increased threats to the mental well–being of a community do not automatically dictate an increased need for the existing services of the community's mental health service providers. Although it is likely that mental health service agencies will be a useful resource for such communities, it is uncertain whether they should have the primary role in responding to an increase in mental needs produced in economic crisis.[2]

In addition to traditional outreach approaches, we have used a variety of non–traditional strategies to reach distressed members of our community. These have drawn heavily on our community partnerships, discussed in detail elsewhere, and in recent years have included Trumbull County's Housing Collaborative, Alliance for Substance Abuse Prevention, Domestic Violence Task Force, Community Corrections Planning Board, Human Services Planning Committee, Family and Children First Council, and many other partnerships.

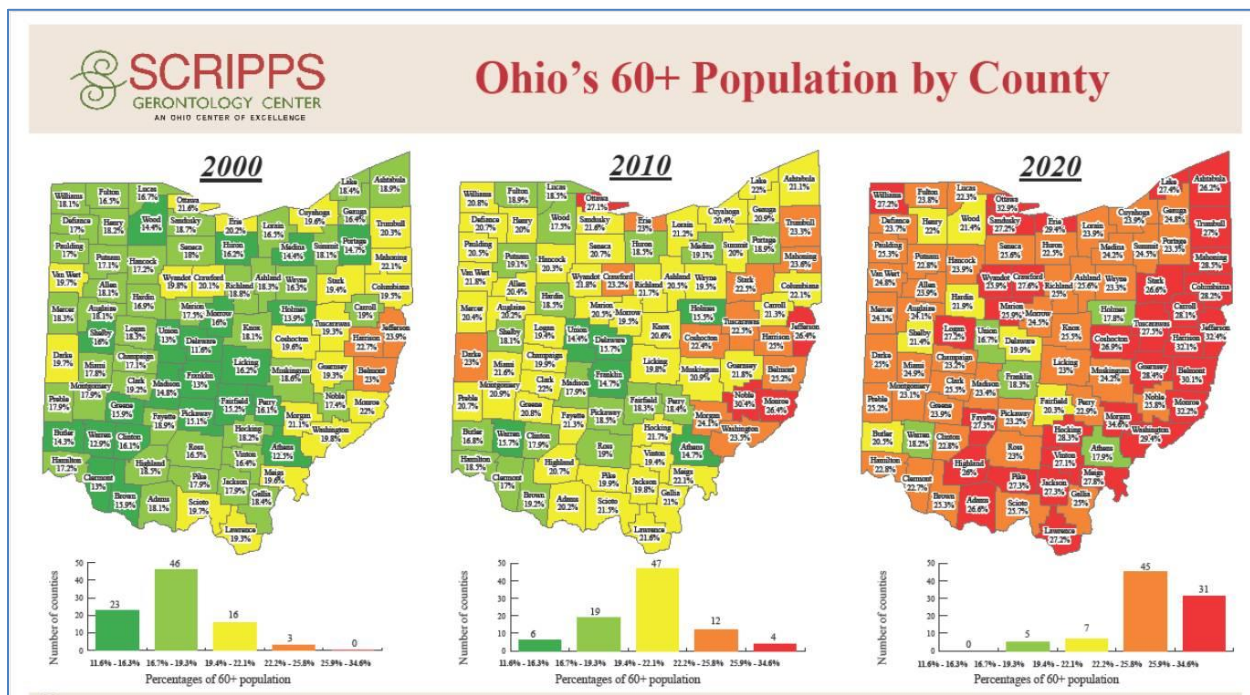
The University of Wisconsin's Population Health Institute in collaboration with the Robert Wood Johnson Foundation maintains a system of ranking counties in each state on key public health indicators. According to their website (www.countyhealthrankings.org), the *County Health Rankings* "show the rank of the health of nearly every county in the nation and illustrate that much of what affects health occurs outside of the doctor's office. The *Rankings* help counties understand what influences how healthy residents are and how long they will live. The *Rankings* look at a variety of measures that affect health such as the rate of people dying before age 75, high school graduation rates, unemployment, access to healthy foods, air and water quality, income, and rates of smoking, obesity and teen births. Based on data for each county, the *Rankings* are unique in their ability to measure the overall health of each county in all 50 states on the many factors that influence health, and they have been used to garner support among government agencies, healthcare providers, community organizations, business leaders, policymakers, and the public for local health improvement initiatives."

In the 2016 rankings, Trumbull County ranks 65th out of 88 Ohio counties on *health outcomes*, a composite measure combining life expectancy/premature death, poor physical and mental health, and low birthweight. Only three of the state's 15 largest counties rank below Trumbull on this measure. We rank 72nd on *health factors,* a composite measure combining health behaviors (e.g., smoking, obesity, teen birth rate) clinical care (e.g., number of primary care physicians, dentists, uninsured persons), social and economic factors (e.g., education, unemployment, child poverty, violent crime), and physical environment (e.g., air quality, healthy food, drinking water safety). Only one other county among Ohio's fifteen largest, ranks below Trumbull on *health factors.* Clearly, our county is disadvantaged

[2] Terry F. Buss & F. Stevens Redburn, *Shutdown At Youngstown: Public Policy for Mass Unemployment* (Albany: SUNY, 1983), p. 43.

in a number of interrelated areas.

A final trend worthy of mention is the change in the *age composition* of the county's shrinking population. Between 1990 and 2010, the proportion of the county's population represented by youth declined slightly from about 21 percent to about 18 percent. At the other end of the life cycle, the number and proportion of persons age 65 and older increased, from less than 15 percent in 1990 to over 17 percent in 2010. As noted earlier, poverty has increased among the youth population while the size of the youth population has grown smaller. Less is currently known about poverty among older persons. It does seem certain that the proportion of the county's population 65 and over will continue to place it near the top of Ohio's 88 counties, as shown in the maps below from the Scripps Gerontology Center at Miami University. The three maps depict categorical rankings of Ohio's 88 counties based on the proportion of the population ages 60 and over in 2000, 2010 and 2020 (projected). In 2000, Trumbull was in the third category (of five) with 20.3 percent of the population 60 and over. In 2010, we had moved up to the second category with 23.3 percent of the population ages 60 and over, and by 2020 we are projected to be in the top category with 27 percent of the population ages 60 and over.



Source: http://www.scripps.muohio.edu/sites/scripps.muohio.edu/files/Scripps_OH_60plus_map_ver4_margin_OCT18_2011.pdf

Older persons have long been underserved by America's community mental health systems. This lack of utilization should not be taken to mean that older persons have no needs for behavioral health services. To the contrary,

> Epidemiological evidence suggests that much of the psychiatric morbidity in older adults is either undetected or poorly managed by the mental health services delivery system as it is currently structured.[3]

Following Buss and Redburn's suggestion, we have been retooling many of our traditional outreach and service delivery

[3] Jane A. Scott–Lennox and Linda K. George, Epidemiology of psychiatric disorders and mental health services use among older Americans, in *Mental Health Services: A Public Health Perspective,* Bruce Levin & John Petrila, eds., New York: Oxford, 1996, 253-289

strategies as the dynamics of at–risk populations in our community evolve and change.

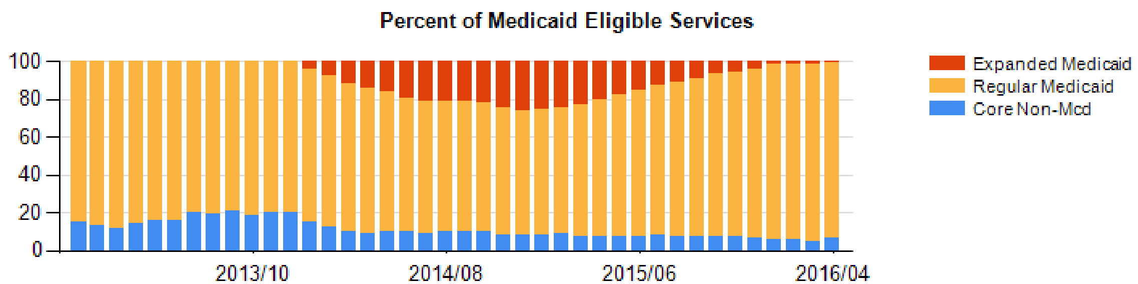
The Heartland East Boards continue to use MACSIS and although we are contracting with a new billing entity now we will not be able to discontinue our use of MACSIS prior to SFY 2018. As Behavioral Health Redesign moves forward, it is important that we maintain the ability to contract with our treatment agencies using the same code sets as Medicaid as appropriate. We understand the intricacies of the redesign changes and the limitations of MACSIS and we know that investing resources into development for MACSIS to handle the entirety of the changes is not fiscally sound. We do, however, intend to contract with our agencies for services associated with many of the new codes and would like to request that they be operational in MACSIS in time to "go live" at the same time as Medicaid Redesign.

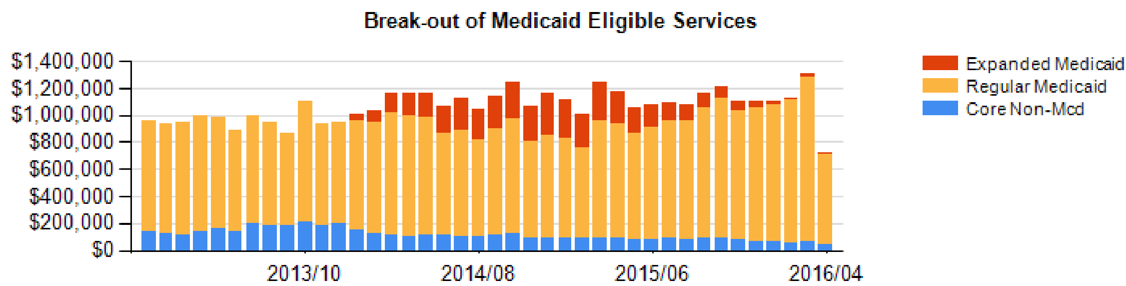
The creation of the necessary infrastructure in MACSIS to use new codes that are intended to be used as "Primary" billing codes (i.e. procedure codes, medical definitions, modifiers, benefit rules) is imperative to maintain operations and pay providers. We also want to continue to capitalize on MACSIS as fully as is realistic to ensure that both Medicaid and we remain good stewards of public funds and maintain the existing process to prevent duplicate payments to provider agencies for these new codes.

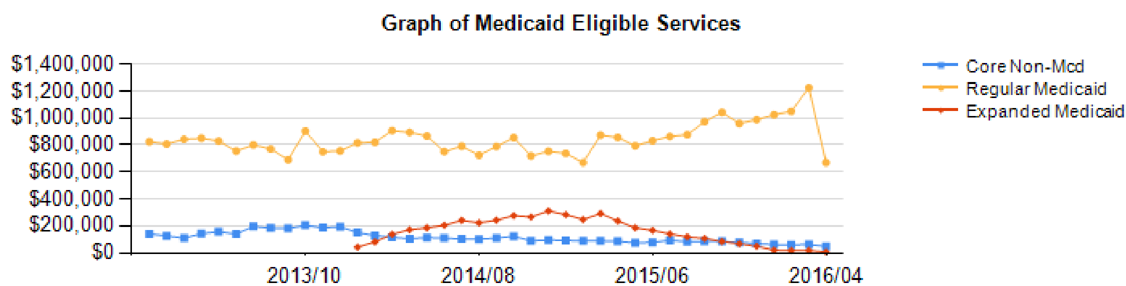
We understand the scope and timing of the work we're requesting be done, and our Heartland East experts are willing to join a workgroup to work out the details and assist in any way possible.

While Medicaid expansion has enabled many people to get their behavioral healthcare paid for, the TCMHRB has paid $623,760 in core services alone for indigent care through April of 2016 (see Heartland East exhibits, below and on the next page). Through the changes proposed in Medicaid Redesign, Heartland East is projecting further costs being pushed onto Boards to continue to provide the behavioral healthcare people so desperately need. Provider agencies have already asked Boards to pick up the costs for client care once clients hit their caps in the new benefits proposed. While we understand that the purpose of the redesign is to save money and move behavioral health under managed care, mental health and addiction issues are different with each person we serve; it's not like a doctor setting a broken arm and expecting a good outcome a few months down the road. We need flexibility to meet the needs of the people where they are and the managed care system does not yet understand how different behavioral health is from physical health.

Just a few short years ago we were required to invest in regional projects. With the Continuum of Care requirements we will be penalized if all of the requirements aren't offered within our county borders. We are investing time and money into meeting all of these requirements but it still doesn't make sense to us to have to provide each of those offerings in Trumbull County when we pay for people to receive treatment in other Ohio Counties and in Pennsylvania, whose border aligns with ours.







	Core Non-MCD	Expanded MCD	Regular MCD	Total
CY 13 Actual	$1,950,446.17		$9,567,395.80	$11,517,841.97
CY 14 Actual	$1,331,060.12	$2,370,890.76	$9,672,365.46	$13,374,316.34
CY 15 Actual	$989,750.29	$1,968,715.92	$10,453,584.74	$13,412,050.95
CY 14/13 Variance	($619,386.05)	$2,370,890.76	$104,969.66	$1,856,474.37
CY 15/13 Variance	($960,695.88)	$1,968,715.92	$886,188.94	$1,894,208.98
CY 13 Avg Month	$162,537.18		$797,282.98	$959,820.16
CY 16 Avg Month*	$60,094.52	$17,682.72	$1,036,293.94	$1,114,071.17
CY 16/13 Variance	($102,442.66)	$17,682.72	$239,010.95	$154,251.01
Annualized	($1,229,311.93)	$212,192.58	$2,868,131.42	$1,851,012.07
*** For services between 1/1/2014 and 2/29/2016**				

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.

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)].

In their now–classic guide to needs assessment techniques, the Needs Assessment Task Group identify six basic approaches: three are characterized as "data oriented" and three as "perception oriented" (see box). We draw on elements of all six approaches in our ongoing efforts to identify, understand and address our community's changing behavioral health needs.

Basic Needs Assessment Approaches[4]

Data Oriented	Perception Oriented
1. Demographic / social indicators	4. Key informants
2. Rates under treatment	5. Community forum
3. Epidemiological study	6. Community survey

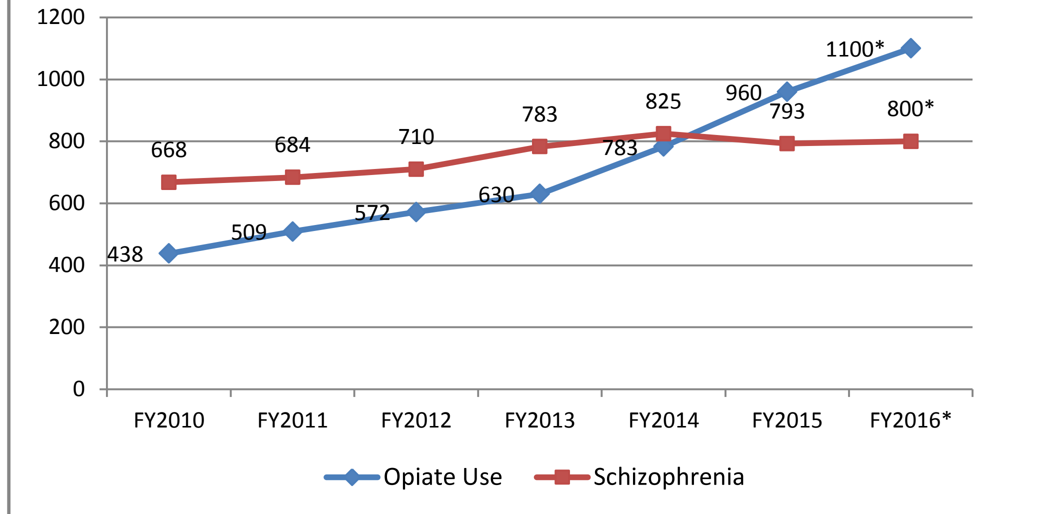
Demographic / social indicators   Most of the information included in our response to Item #1 (above) on changes in population size and composition, poverty, unemployment, and health exemplifies this approach. Data are drawn from the US Census, several Ohio Departments, and private foundations/research centers (Robert Wood Johnson, Scripps), among other sources.

Rates under treatment   We are a member of the Heartland East Administrative Services Organization, which processes enrollment and claims for Medicaid and non–Medicaid payment systems. Heartland East also provides its members with a wide variety of reports on the characteristics (demographic, diagnostic, etc.) of persons receiving services, service encounters (e.g., frequency, duration), etc. This resource also allows us to develop time–series pictures to quantify trends being reported by community members. Table 5 shows that between 2010 and 2016, the number of adults receiving treatment for schizophrenia increased by nearly 20 percent, from 668 persons in FY2010 to a projected 800 in FY2016. During the same period, the number of county residents receiving treatment for opiate use disorders increased by more than 150 percent, from 438 persons in FY2010 (230 fewer than those with schizophrenia) to a projected 1100 (300 more than those with schizophrenia) in FY2016. Taken together, the data in Tables 3 and 5 clearly show that the word "epidemic" in not inappropriate to describe the explosive growth of opiate addiction.

We also utilize Rates Under Treatment data to monitor capacity and encounters in state psychiatric hospitals (see Table 4 and Table 6), at Riverbend Treatment Center (crisis/diversion facility), Christy House Emergency Shelter, and other facilities.

TABLE 5

[4] Needs Assessment Task Group, *The Mental Health Needs Assessment Puzzle: Guide to a Planful Approach,* Columbus: Ohio Department of Mental Health, 1984.



Data Source: Heartland East LA02 reports, FY2010—FY2016

<u>Epidemiology</u> This approach is concerned with establishing the *incidence* (new cases occurring in a specific geographic area and period of time) and *prevalence* (total number of cases in a specific geographic area and point in time) of social and health–related phenomena. Epidemiological findings can appear superficially similar to those from Rates Under Treatment analyses because both can be expressed as frequencies and rates and because both can be organized into standardized time periods (e.g., months, years). The big difference is that epidemiological findings cover *all* cases and not just that portion that is seen in treatment systems. Not surprisingly, determining the true incidence or prevalence of schizophrenia or heroin addiction is much more difficult (and costly) than determining whether or not the number of people receiving treatment for these disorders is increasing or decreasing and true epidemiologies are beyond the capacity of most ADAMHS boards. Our best incidence and prevalence data come from the Trumbull County Coroner's Office that maintains very thorough records on all deaths due to drug poisoning. From these records we are able to see clear patterns related to race, sex, and age (see Table 7).

TABLE 6

OhioMHAS Hospitals FY2016
Length of stay data for discharges

Data for April are official

	Jul-15	Aug-15	Sep-15	Oct-15	Nov-15	Dec-15
OPENING CENSUS	18	17	20	16	16	15
TOTAL ADMISSIONS	14	19	11	9	7	9
Civil	13	19	10	9	7	8
Forensic	1	0	1	0	0	1
TOTAL DISCHARGES	15	16	15	9	8	10
Civil	15	15	15	7	8	10
Forensic	0	1	0	2	0	0
TOTAL LOS	333	404	265	382	123	276
MEAN LOS	22.2	25.3	17.7	42.4	15.4	27.6
Civil	22.2	22.6	17.7	33.3	15.4	27.6
Forensic	– –	65.0	– –	33.3	– –	– –
MEDIAN LOS	15.0	16.5	16.0	35.0	15.5	15.0
Civil	15.0	15.0	16.0	35.0	15.5	15.0
Forensic	– –	65.0	– –	74.5	– –	– –
DAYS THIS MONTH	688	587	546	471	502	441
AVG DAILY RES POP	22.2	18.9	18.2	15.2	16.7	14.2

	Jan-16	Feb-16	Mar-16	Apr-16	May-16	Jun-16
OPENING CENSUS	14	22	19	19	18	
TOTAL ADMISSIONS	22	15	19	18		
Civil	20	14	19	18		
Forensic	2	1	0	0		
TOTAL DISCHARGES	14	18	19	19		
Civil	12	18	17	19		
Forensic	2	0	2	0		
TOTAL LOS	369	968	658	252		
MEAN LOS	26.4	53.8	34.6	13.3		
Civil	28.8	53.8	16.1	13.3		
Forensic	12.0	– –	192.0	– –		
MEDIAN LOS	14.0	12.0	12.0	9.0		
Civil	14.0	12.0	12.0	9.0		
Forensic	12.0	– –	192.0	– –		
DAYS THIS MONTH	533	529	572	526		
AVG DAILY RES POP	17.2	18.2	18.5	17.5		

	FY2016 HBH & NBH	FY2015 HBH	FY2014 HBH	FY2013 HBH	FY2012 HBH	FY2011 HBH	FY2010 NBH & HBH	FY2009 NBH
ADMISSIONS	143	271	320	306	260	134	104	98
MO. AVG	14.3	22.6	29.1	25.5	21.7	11.2	8.7	8.2
DISCHARGES	143	274	321	303	254	135	105	99
MO. AVG	14.3	22.8	29.2	25.3	21.2	11.3	8.8	8.3
TOTAL LOS	4,030	6,674	6,084	8,288	14,326	2,802	6,800	3,136
MIN LOS	1	1	1	1	1	2	1	1
MAX LOS	742	662	403	187	10,632	343	4,164	230
MEAN LOS	28.2	24.4	19.0	27.4	56.4	20.8	64.8	31.7
MEDIAN LOS	14.0	9.0	9.0	9.0	8.0	10.0	16.0	21.0
TOTAL DAYS	4,953	6,810	8,500	6,364	3,731	3,121	3,049	3,661
MO. AVG	495	568	773	530	315	260	254	305
*FY ADRP**	18.01	18.66	25.37	17.4	10.194	8.551	8.353	10.030
*3 Year Base ADRP***	18.87	16.30	15.15	15.3	*na*	*na*	*na*	*na*
FY ADRP – 3 year base ADRP	-0.86	2.36	10.22	2.1	*na*	*na*	*na*	*na*

* prior to 2013: civil only, FY2013 & later: civil + forensic   ** Civil + forensic   ADRP = Average Daily Resident Population

TABLE 7

2015 Fatal Overdoses, Breakdown by Age, Sex, and Race

	MALE		*FEMALE*		*ALL*	
	N	*%*	*N*	*%*	*N*	*%*
AGE						
<30	7	12.7	7	21.9	14	16.1
30–49	33	60.0	15	46.9	48	55.2
>49	15	27.3	10	31.3	25	28.7
	55		32		87	
MEAN AGE	41.6		43.1		42.2	
RACE						
Caucasian	50	90.9	31	96.9	81	93.1
African-American	5	9.1	1	3.1	6	6.9
ALL PERSONS	55	[63.2]	32	[36.8]	87	[100.0]

Data Source: Trumbull County Coroner's Office

Key informants First among the perception–based techniques is the use of "people who are particularly knowledgeable and articulate—people whose insights can prove particularly useful in helping . . . [to] understand what is happening."[5] Question 8 (below) describes the many collaborative groups and efforts of which the Board is a part. We are continuously acquiring new information, data, and insights from our network's providers of direct services, supervisors and administrators via our Core Providers meetings, colleagues in parallel systems (Developmental Disabilities, Children Services, schools, Probate Court, Jail and Juvenile Court authorities, Health Department), members of community coalitions like the Alliance for Substance Abuse Prevention, Human Services Planning Committee, Local Community Corrections Board, Veterans Assistance Program, Trumbull Advocacy and Protective Network (local senior citizens' "cluster"), consumers and family members, recovery housing operators, persons in recovery, NAMI Ohio and NAMI Mahoning Valley, law enforcement, county commissioners, etc.

"The danger in using key informants is that their perspectives will be distorted and biased . . . data obtained from informants represent perceptions, not truths."[6] The dangers in *not* attending to the perceptions of key informants include being out of touch and unaware of new developments affecting the system of care.

Community Forum Defined as "an open town meeting set up to discuss mental health problems and services in the community,"[7] community forums are another important source of perception-based information from diverse stakeholders. Regular meetings of the Alliance for Substance Abuse Prevention (ASAP) feature a roundtable discussion of whatever is on attendees' minds, including information on new substances, services, policies, events, etc. The Family and Children First Council provides a similar opportunity for participation and input at its meetings. ASAP sponsors an annual *Hope for Recovery from Addiction* event that is targeted at families of persons with substance use disorders. This event provides multiple opportunities for individuals in recovery, family members, and other stakeholders to provide input and feedback on treatment, prevention, access, and other issues. ASAP's annual *Drug Summit* also provides open-

[5] Michael Quinn Patton, *Qualitative Evaluation and Research Methods, 2/e*, Newbury Park: Sage, 1990, p. 263.
[6] *Ibid*, p. 264.
[7] Needs Assessment Task Group, *Op cit*., p. 11.

forum opportunities.

In the winter of 2015, a member of the TCMHRB Board of Directors whi is employed as a police and parole officer, held a community opiate needs assessment with close to 50 state and local leaders. This was another initiative in response to our opiate epidemic. At the conclusion of the process it was determined that the community needs a long–term residential facility for people with addiction issues. A subcommittee continues to work on the initiative.

Community Survey In the words of the Needs Assessment Task Group, "A community survey can provide information about community awareness of services, willingness to use services, barriers to receiving services, and . . . can help to gauge the intensity of the perceived needs."[8] In FY2016, we administered the Recovery Oriented System of Care (ROSC) survey to stakeholders in our network via Internet (SurveyMonkey) and paper forms. Findings are summarized in section 2d (below).

In addition to these efforts by the TCMHRB, the Trumbull County Family and Children First Council engaged in a shared planning process during the first half of 2016 using a model developed by The Ohio State University's Center for Education and Training for Employment. The model is based on collective impact and includes the following components:

- Common agenda
- Shared measurement
- Mutually reinforcing activities
- Continuous communication
- Backbone support

To develop the shared plan, as required by Ohio Family and Children First office, the Trumbull County Council reviewed the initiatives it is now engaged in. Several of those mirror state priorities and will be included in the local shared plan. These joint local/state priorities are:

- Infant Mortality
- Trauma Informed Care
- High need, multi system youth

In order to determine additional shared priorities, the Council Coordinator requested suggestions from all Council members, asking them to identify unmet needs within the community. This resulted in a list of about eight suggestions. At a Council meeting, these were reviewed and prioritized. A consensus was reached: the Council will focus on the priorities shared with the state and the following:

- Reduce opiate and heroin overdose deaths
- Increase social/recreational opportunities for youth.

The final steps of the process are to gather baseline data, assess reinforcing activities (those programs and services that are addressing these needs at this time) and work as a Council to strengthen and expand them. When all activities are complete, the final plan will be submitted to the Ohio Family and Children First office and implementation shall begin.

2b. Child service needs resulting from finalized dispute resolution with Family and Children First Council [340.03(A)(1)(c)]

The Trumbull County Family and Children First Council's Service Coordination Mechanism includes a dispute resolution process for use when a decision made by a Council committee or program is unacceptable to a party to the decision. Though such a dispute happens very rarely, there was a recent example. A decision was made by the Council's Wraparound Oversight Committee involving a request for payment for specific services. The organization that made the request was not satisfied with the decision and entered the dispute resolution process. To initiate

[8] Ibid, p. 13.

the process, the organization completed a standard form and submitted the required documentation. The Council Coordinator, upon receipt of the paperwork, assembled a committee to review the disputed decision. As per the Service Coordination Mechanism, the committee was comprised of a member of the Family and Children First Council, a member of the Council's Executive Board and a member of the Wraparound Oversight Committee. Prior to the meeting of this ad hoc committee, the Council Coordinator provided the documents to each member.

Following timelines identified in the Service Coordination Mechanism, the committee met within twenty days of receipt of the dispute. Over the course of several hours, committee members conducted interviews with the disputing parties, reviewed documentation, conferred in private and reached a decision. This decision was accepted by both parties, and the process ended.

2c. Outpatient service needs of persons currently receiving treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)]

As Trumbull County experiences a consistent increase in persons presenting and needing mental health and addiction services, we have conversely been experiencing a decrease in available psychiatrists, local inpatient psychiatric beds and most notably, long term hospitalization. Our local private, general hospital and our probate court have expressed concerns, multiple times, regarding the decrease in the average length of stay at the state hospital level for persons with severe and persistent mental illness (SPMI). In addition, the decrease in state hospital beds has created a backlog in our local hospital emergency rooms of persons needing to be hospitalized psychiatrically.

In FY 2014, as a response to needing a more intensive level of treatment, Trumbull County enhanced the staffing at Riverbend Treatment Center so that higher acuity clients could be admitted, both as a diversion to hospitalization as well as a step down from hospitalization (either state or private), with the goal of decreasing inpatient lengths of stay. In addition, a collaboration among several ADAMHS boards created a longer term residential facility for our most difficult to place clients with SPMI, so as to decrease state hospital lengths of stay and readmission rates. These programs have reached capacity, and while they have alleviated the revolving door for many clients, there continues to be a need for longer term hospitalization for those needing extended time to stabilize in a safe and secured (i.e., locked) facility. As our local psychiatric units and identified state psychiatric hospital continue to run at nearly full capacity, the struggle for placement continues, even as we contract with other private hospitals for those patients who are indigent.

2d. Service and support needs determined by Board Recovery Oriented System of Care (ROSC) assessments

As mentioned in item 2a, we administered the Recovery Oriented System of Care (ROSC) survey to stakeholders in our network via Internet (SurveyMonkey) and paper forms. No sampling design was used and while the validity of individual responses was believed to be quite high, their representativeness and generalizability could not be assessed. The instrument was reviewed at an ASAP meeting and a number of items were eliminated due to ambiguous or "double–barreled" wording (e.g., 7, 16, 28, 46, 47, 53, 55, 72). Two hundred valid responses were received from four self–identified categories of respondent/stakeholders: persons in recovery (n=47), family members (n=24), service providers/administrators (n=61), and others (68). Responses were tabulated for all 200 respondents and for each of the four sub-groups. Detailed results are on the next three pages and highlights of the findings are on page 15.

Item #	SELECTED FIVE–POINT RATING ITEMS (5=strongly agree, 1=strongly disagree)	Group 1 Consumers		Group 2 Providers		Group 3 Family Members		Group 4: All Others		ALL RESPONDENTS	
		Mean Rating	*Pct "Don't Know"*	*Mean Rating*	*Pct "Don't Know"*	*Mean Rating*	*Pct "Don't Know"*	*Mean Rating*	*Pct "Don't Know"*	*Mean Rating*	*Pct "Don't Know"*
	DOMAIN 1: FOCUSING ON CLIENTS AND FAMILIES										
5	People in recovery can choose (and change, if desired) the therapist, psychiatrist, physician, or other service provider with whom they receive services	4.1	8.5%	3.9	12.1%	3.4	12.5%	3.9	23.0%	3.9	14.7%
8	Service providers listen to and follow choices and preferences of participants.	3.5	10.6%	3.7	10.3%	3.6	33.3%	3.6	17.5%	3.6	15.6%
9	Progress toward goals (as defined by person in recovery) is regularly monitored	3.9	8.5%	4.1	3.4%	4.0	13.0%	4.1	17.7%	4.0	10.5%
12	Barriers (i.e. childcare, transportation) are addressed for participants	3.9	23.4%	3.6	10.3%	3.6	20.8%	3.6	17.5%	3.6	17.2%
17	Age appropriate services are offered to children, adolescents, young adults and seniors	4.0	21.3%	3.9	10.3%	3.7	20.8%	3.9	19.4%	3.9	17.3%
	DOMAIN 2: ENSURING TIMELY ACCESS TO CARE										
18	Individuals have timely access to the services and supports that are most helpful for them	4.0	8.7%	3.3	7.1%	3.3	13.0%	3.3	11.3%	3.5	9.6%
19	Groups, meetings, and other activities are scheduled in the evenings and on weekends to minimize conflict with other recovery-oriented activities (e.g., employment or school)	3.5	15.2%	3.8	12.5%	3.7	4.3%	3.9	21.0%	3.7	15.0%
20	Staff routinely assist individuals in the pursuit of education and employment	3.9	13.0%	3.6	7.3%	3.8	21.7%	3.7	25.8%	3.7	16.7%
30	Age appropriate peers are used in community outreach and early engagement efforts	3.6	32.6%	3.2	37.5%	3.5	26.1%	3.6	40.3%	3.5	35.8%
32	Interim services are available for people on waiting lists and/or who are not ready to commit to treatment	3.6	37.0%	2.9	29.1%	3.6	21.7%	3.4	35.5%	3.3	32.2%
	DOMAIN 3: PROMOTING HEALTHY, SAFE, AND DRUG–FREE COMMUNITIES										
37	The community receives education about mental illness and addictions	3.9	8.7%	3.6	5.6%	3.8	4.3%	3.5	3.3%	3.7	5.4%

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Mean rating < 3.5 Mean Rating > 3.9 >30% Don't Know

Item #	SELECTED FIVE–POINT RATING ITEMS (5=strongly agree, 1=strongly disagree)	Group 1 Consumers		Group 2 Providers		Group 3 Family Members		Group 4: All Others		ALL RESPONDENTS	
		Mean Rating	*Pct "Don't Know"*	*Mean Rating*	*Pct "Don't Know"*	*Mean Rating*	*Pct "Don't Know"*	*Mean Rating*	*Pct "Don't Know"*	*Mean Rating*	*Pct "Don't Know"*
39	Cities, township ordinances are receptive to sober lifestyle communities (housing, self-help groups, consumer advocacy groups)	3.8	19.6%	3.0	21.8%	3.3	8.7%	3.4	18.3%	3.4	18.5%
42	The community formally acknowledges and celebrates the achievement of goals of people in recovery	3.7	10.9%	3.3	3.6%	3.6	17.4%	3.6	16.4%	3.5	11.4%
44	Strategies to decrease stigma are conveyed to all partners and are consistently implemented in communities	3.6	19.6%	3.3	5.5%	3.8	8.7%	3.4	14.8%	3.5	12.4%
	DOMAIN 4: PRIORITIZING ACCOUNTABLE AND OUTCOME–DRIVEN FINANCING										
48	People in recovery (service recipients) and their family members are actively involved in the evaluation of services and programs	3.6	28.3%	3.7	29.1%	3.2	26.1%	3.6	33.9%	3.6	30.1%
54	Behavioral Health is included as an indicator in the community	4.0	15.2%	3.9	25.5%	4.0	26.1%	3.5	28.8%	3.8	24.0%
60	Outcomes are connected to community plan priorities	3.8	45.7	3.6	38.9%	3.9	39.1%	3.6	46.6%	3.7	43.1%
	DOMAIN 5: LOCALLY MANAGING SYSTEMS OF CARE										
63	Procedures are clear about the options for referrals to other programs and services if a provider cannot meet the needs of a	3.9	21.7	3.7	18.5%	3.6	23.8%	3.7	44.8%	3.7	28.5%
64	Young adults as adolescent peer support specialists are active in the community	3.8	30.4	3.2	40.7%	3.8	19.0%	3.5	39.7%	3.5	35.2%
67	Meaningful traditions to celebrate people's wellness exist and include individual and family member input	3.6	32.6	3.7	25.9%	3.8	4.5%	3.7	23.7%	3.7	24.3%
69	Safe, sober and fulfilling activities are offered in the community	4.0	8.7	3.8	7.5%	3.7	13.6%	3.9	10.2%	3.9	9.4%
70	Communities are proactively addressing emerging issues	3.9	15.2	3.6	15.1%	3.8	13.6%	3.6	10.2%	3.7	13.3%
71	Partnerships exist with local businesses to increase opportunities for employment	3.6	23.9	3.2	32.1%	3.6	18.2%	3.3	22.0%	3.4	25.0%

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Mean rating < 3.5 Mean Rating > 3.9 >30% Don't Know

Item #	YES / NO / DON'T KNOW ITEMS	Group 1 Consumers		Group 2 Providers		Group 3 Family Members		Group 4: All Others		ALL RESPONDENTS	
		Pct "Yes"	Pct "Don't Know"	Pct "Yes"	Pct "Don't Know"	Pct "Yes"	Pct "Don't Know"	Pct "Yes"	Pct "Don't Know"	Pct "Yes"	Pct "Don't Know"
	DOMAIN 6: CONTINUUM OF CARE										
73	Prevention and wellness management services are available in the community.	82.6%	15.2%	86.3%	13.7%	78.3%	21.7%	83.3%	9.3%	81.9%	14.7%
74	People in recovery work alongside providers to develop and provide new programs and services.	73.9%	15.2%	52.1%	31.3%	39.3%	50.0%	53.7%	29.6%	55.3%	30.7%
75	Treatment services are available in the community, including outpatient, residential, partial hospitalization, and sub–acute detoxification.	84.8%	10.9%	94.0%	2.0%	72.7%	22.7%	82.1%	3.6%	82.7%	7.8%
76	Recovery supports are available in the community, including peer support, housing, and transportation.	78.3%	6.5%	88.2%	7.8%	65.2%	26.1%	73.2%	16.1%	76.5%	12.8%
77	Workforce programs and supports are available to help individuals get back to work.	73.9%	15.2%	74.5%	19.1%	45.8%	41.7%	61.1%	22.2%	63.1%	24.6%

Page 3 of 3 < 50% YES Mean Rating > 3.9 > 30% DON'T KNOW

Recovery Oriented Systems of Care (ROSC) Survey: Selected Highlights

Strengths of the local system as identified by respondents include

9. Progress toward goals as defined by the person in recovery is regularly monitored
73. Prevention and wellness services are available in the community
75. Treatment services are available in the community, including outpatient, residential, partial hospitalization, and sub-acute detoxification

Opportunities for improvement include

18. Individuals have timely access to the services and supports that are most helpful to them
39. Cities and township ordinances are receptive to sober lifestyle communities (housing, self-help groups, consumer advocacy groups)

- More than 30 percent of each stakeholder group answered “don’t know” to many key items, indicating a general lack of knowledge about the local system

2e. 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)

There are two gaps currently in the Trumbull County Continuum of Care but these will be remedied in FY17.

1. Ambulatory Detox with treatment focus of AOD opiates will be provided by either First Step Recovery or Meridian Healthcare at Compass/Community Solutions. Both of these facilities are in the county seat, Warren, which is an urban area and most plagued by the opiate epidemic. Both Directors have agreed to create a plan to provide ambulatory detox at their facilities.
2. Medically Assisted Treatment with AoD non-opiates only, treatment focus, is currently only being provided through New Start’s smoking cessation program in Warren, Ohio. Meridian Healthcare is using Vivitrol with persons with alcohol dependence in Mahoning County, and they will extend the practice to the Compass/Community Solutions, Warren site in the fall of 2016. The partnership between Compass/Community Solutions and Meridian Healthcare is possible because of a capital grant from OhioMHAS to help pay for building renovations so that additional services on the AOD treatment spectrum can be provided.

2A. Complete Table 1: Inventory of Facilities, Services, and Supports Currently Available to Residents of the Board Area

(attached)

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 needs assessment?**

Our systems of care are built on a solid foundation of providers who are experts at providing clinical and supportive services for persons with virtually the entire range of mental health and substance use disorders. With very few exceptions (e.g., ambulatory detox) all services thought to be essential for recovery are in place in our community and are being used with great success. This range of services includes many evidence-based and best practices including supported employment, assertive community treatment, high-fidelity wraparound, medication assisted treatment, critical time intervention, crisis intervention team, and the FIRST program. The network also provides supportive services, including social and recreational, homeless outreach and sheltering, prevention, housing assistance, recovery housing, and other services, which enhance and magnify the impact of treatment and clinical care.

The issues facing individuals and families that utilize our systems of care frequently fall into multiple categories and cut across conventional boundaries. Each of our network providers communicates, coordinates, and collaborates with other network providers, both at case and macro-systems levels. Continuous Quality Improvement meetings are held twice a month with core providers, the state hospitals and the forensic center so that the best care may be provided to our highest need mental health clients in the least restrictive environment. We have community treatment plans in place so that entities use the same clinical protocols that will be most beneficial to some of the most challenging clients. We also have monthly agency director meetings where we share systems information and ensure Director level communication. Trumbull County providers are well known for having good relationships with each other and the board, which further ensures constant communication so that gaps in services may be filled and persons in need get good quality care.

Communication, coordination, and collaboration extend beyond our provider network to include our extended network of community partnerships and cross-system collaborations. We are actively involved in both the Heartland Hospital and Northcoast Hospital regional meetings as well as at the state level. Our local partnerships are described in detail elsewhere. The Trumbull County Mental Health and Recovery Board only has nine staff members yet their involvement locally and throughout the state mirrors much larger Boards.

Our FY2015 *Annual Report* lists our community partners in two categories:

Contract Agencies

Coleman Professional Services
Community Solutions Association/Compass F&CS
Compass Family and Community Services
Forensic Psychiatric Center of NE Ohio
First Step Recovery
Glenbeigh
Greater Warren-Youngstown Urban League -Christy House
Guardianship and Protective Services

Heartland Behavioral Healthcare
Help Hotline Crisis Center, Inc.
Homes For Kids/Child and Family Solutions, Inc.
Mercy Health/Humility of Mary Health Partners
Meridian Community Care
Neil Kennedy Recovery Clinic
Northcoast Behavioral Healthcare
ONE Health Ohio
PsyCare, Inc.
Ravenwood Mental Health Center
Salvation Army
St. Joseph's New Start Treatment Center
SUMMA Health System
ValleyCare/Trumbull Memorial Hospital
Turning Point Chemical Dependency Treatment Center
Turning Point Counseling Services
Valley Counseling Services

Community Partners
Area Agency on Aging 11
Belmont Pines Hospital
Catholic Charities
Columbiana County Mental Health & Recovery Board
Mahoning County Mental Health & Recovery Board
Mahoning/Trumbull Recovery Project
Mahoning Valley Consortium for Early Care & Education
Mahoning Valley Early Childhood Planning Group
Mahoning Valley NAMI
Mahoning Valley Organizing Collaborative
Northeast Ohio Children's Consortium
Ohio Association of County Behavioral Health Authorities
Trumbull Advocacy & Protective Network
Trumbull County Board of Developmental Disabilities
Trumbull County Bridges Out of Poverty Steering Committee
Trumbull County Child Assault Prosecution Unit
Trumbull County Child Fatality Review Board
Trumbull County Children Services
Trumbull County Commissioners
Trumbull County Community Corrections Planning Board
Trumbull County Disaster Preparedness Teams
Trumbull County Domestic Violence Task Force
Trumbull County Family & Children First Council
Trumbull County Family Dependency Treatment Court

Trumbull County Drug Court
Trumbull County Family Court
Trumbull County Family Wraparound Oversight Committee
Trumbull County Housing Collaborative
Trumbull County Juvenile Drug Court
Trumbull County Human Services Planning Committee
Trumbull County Adult Justice Center
Trumbull County Probate Court
Trumbull County Suicide Prevention Coalition
United Way of Trumbull County

b. Identify those areas, if any, in which you would be willing to provide assistance to other boards and/or to state departments.

The TCMHRB provides assistance to other Board areas in many ways. Our certified Wraparound Coordinator provides trainings and ongoing consultation throughout the state to assist other Board areas in implementing the Wraparound model to fidelity in their communities. The ASAP coalition has been visited by many board areas so that they might learn from our process and replicate it in their communities. The ASAP Director, a TCMHRB staff member, has presented about the ASAP coalition at state meetings and has shared its strategic plan and processes with other Board areas.

The Board has also assisted other counties in navigating and understanding the new law that modifies and provides clarification regarding court ordered outpatient treatment. Due to the Trumbull County Probate Court's unique interpretation of ORC 5122 prior to the update of the Civil Commitment statute, the TCMHRB and agencies have been engaged in outpatient civil commitment procedures and processes for many years. We have also shared policies, procedures and documents that will be included in the AOT information being compiled and distributed by NEOMED.

The TCMHRB compiled a list of housing and treatment options for the Heartland Region. This was shared with Boards and providers throughout the region as well as the state department. The TCMHRB shared its policies, application and contracting process for recovery housing with the Heartland region. TCMHRB staff assists local universities and corrections facilities with the CIT process and resources. We would be pleased to continue to provide assistance to others in these and any other areas.

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?

There are multiple challenges within the Trumbull County system of care, both as a result of meeting the ORC requirements of the Continuum of Care as well as due to the change in landscape regarding persons diagnosed with a mental illness and/or substance use disorder. As has always been a challenge, which is now being felt within the state psychiatric hospital system, Trumbull County has been on the cusp of not having a sufficient number of psychiatrists given our demographics. The majority of the psychiatrists who have worked in our area over the past decade have been approaching retirement, and at this point, many of them have either retired or

moved out of our area, leaving a huge gap in our system of care. In addition, due to the shortage of psychiatrists state-wide (as well as nationally), many of our local physicians have been enticed by agencies in other counties and therefore no longer provide services in Trumbull County. Even our local for-profit general hospital that has two psychiatric units and is part of a large, national hospital system, cannot find psychiatrists to work locally.

Another challenge, that is rather recent in our area, is the lack of direct service providers going into the mental health / substance use field. Even with our local university, which has both bachelors and masters level programs in the behavioral health field, the number of persons looking for employment, as well as the number of qualified persons, has diminished. Many of our agencies within our system of care have commented about the level of competence (or lack thereof) of potential employees. The majority of our agencies have several, if not many, open direct service positions due to the lack of qualified and quality candidates.

With the decrease in local, regional and state hospital psychiatric beds, our local prescreening agency, along with the local hospital emergency rooms have been challenged with placement issues. More often than not, patients are spending over 12 hours in the emergency rooms due to lack of bed availability. This is not only true locally, but also regionally, for patients with insurance, Medicaid, Medicare or indigent, as the Board has contracted with several for-profit hospitals with psychiatric units. The result is unfair to patients having to wait, while in crisis, in emergency rooms; and to those who may be diverted to other hospitals due to emergency room capacity. In addition, it is just poor patient care.

With the impending implementation of the Medicaid re-design, the challenges to our system of care will be exacerbated due to the change in services afforded. Many of our clients will be without services as they have no income to cover the insurance co-pay and many of our smaller providers may be forced to close because of the changes in reimbursement.

Currently, we have no Trumbull County provider offering ambulatory detoxification, although there is a provider in an adjacent county who does offer the service. “Requiring” a provider to offer this service, yet not contracting/offering funding is challenging.

b. What are the current and/or potential impacts to the system as a result of those challenges?

As the challenges increase within Trumbull County’s system of care, so does the impact to our residents. Along with lack of psychiatrists, decreased accessibility of behavioral health beds, increased need for behavioral beds and lack of long term hospitalization, one of our local hospital CEO’s has contemplated closing their psychiatric units. Should this happen, it would exacerbate the problem for our patients needing hospitalization, as well as for the community, as more time will be spent on crisis rather than on working with patients to keep them stabilized in the community.

In addition, with more people needing psychiatric intervention, yet fewer psychiatrists, we are burning the service candle at both ends within the criminal justice system. More of our patients may end up in jail, when they are really in need of psychiatric care/stabilization.

c. **Identify those areas, if any, in which you would like to receive assistance from other boards and/or state departments.**

Assistance from other Boards and the state department in recruiting psychiatrists would be very helpful.

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.**

Consistent with the National CLAS (Culturally and Linguistically Appropriate Services) Standards,[9] we view *culture* broadly, in term of racial, ethnic and linguistic groups, as well as geographical, religious and spiritual, biological and sociological characteristics.[10] Since the 1990's, when the Board partnered with the Ohio Department of Mental Health on projects to enhance services to African–American and Amish communities in Trumbull County, cultural competence has been a service–delivery priority. Over the years, we have used several general strategies to operationalize this priority:

- Encouraging improvements in the cultural diversity of our network's workforce and the cultural competence of workers
- Creating programs targeted at reaching specific cultural populations
- Developing culturally competent policies, procedures, organizations, and systems of care
- Including cultural competency and diversity requirements in contracts. Our current purchase-of-service contracts contain these provisions:

> 3.6.8 Services shall be culturally competent and shall respond effectively to:
> a. The individual's needs and values present in all cultures, including, but not limited to, African–American, Appalachian, Asian, Latin, Hispanic and Native American cultures
> b. The needs of persons with disabilities, including persons who are hearing impaired
> c. The needs based on each client's gender and sexual orientation
> d. The needs based on each client's age

Several key programs exemplify the incorporation of the principles of culturally and linguistically appropriate care into routine policies and practices:

- FIRST Trumbull County, a program of the Best Practices in Schizophrenia Treatment (BeST) Center and Coleman Behavioral Health, which targets young adults who are experiencing first psychotic episodes
- The Trumbull Intensive Community Treatment Team (TICTT), a program of Compass Family & Community Services that incorporates assertive community treatment (ACT) for adults with severe psychotic disorders
- Amish outreach, a program that reimburses Ravenwood Mental Health Center in Geauga County for non–crisis services provided to members of Amish communities in Trumbull County who decline

[9] US Department of Health and Human Services, Office of Minority Health, *Enhanced National Standards for Cultural and Linguistically Appropriate Services in Health and Health Care*, April 2013

[10] https://www.thinkculturalhealth.hhs.gov/pdfs/NationalCLASStandardsFactSheet.pdf

Medicaid enrollment on religious grounds

- Trumbull County Family Wraparound, a program of the Trumbull County Family and Children First Council

All four recognize the importance of culture in the lives of the persons and families they serve and incorporate culture in the development and implementation of treatment and crisis plans.

A specific example is the *Strengths, Needs, and Culture Discovery* (or SNCD) portion of the Wraparound facilitation process. Both an event and an ongoing process, SNCD is described as the most important step of the Wraparound process because it leads to strength-based options for meeting the needs of the youth and family that reflect the culture of the family. Ultimately the SNCD should form the foundation of a Wraparound Plan that "looks like" and "feels like" the family, i.e., is culturally competent and therefore more likely to be a plan the youth and family will buy into and participate in.[11]

The Board and providers sponsor a limited number of trainings each year that aim at understanding cultural diversity based on race, ethnicity, language, religion, gender, sexual orientation, age, or other social characteristics and enhancing the cultural competence of the workforce. Recent events have included Bridges Out of Poverty, Youth and Young Adults in Transition, and SafeZone, which teaches supportive options for LGBT youth.

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 <u>only</u> 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.

<u>Most important</u>, 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].

[11] Northeast Ohio Regional Training Committee, *Welcome to Hi–Fidelity Wraparound Facilitator/Service Coordinator Training, pp.15-25.*

Priorities for Trumbull County Mental Health and Recovery 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)	Reduce the number of Trumbull County residents dying by unintentional drug overdose	1. Prevention programming in schools and community 2. Community Wide collaboration through ASAP coalition/ ASAP Opiate Task Force 3. Contracts for provision of detoxification services and recovery housing for indigent residents 4. Diverse outpatient treatment options 5. Increase accessibility to Medication Assisted Treatment 6. Promotion and funding of Project DAWN 7. Collaborate with Trumbull County Health District on needle exchange program	1. Number of schools receiving prevention services from TCMHRB contract provider agencies. 2. Number of participants in ASAP community awareness activities. 3. ASAP meeting and event attendance 4. Availability of full continuum of care as evidenced by the completion of Table 1: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area 5. Number of patients receiving MAT at new clinic being established by Compass Family & Community Services and Meridian Healthcare 6. Number of Project DAWN kits distributed 7. Establishment of a needle exchange program in Trumbull County 8. Number of unintentional overdose deaths	__ 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 neo natal abstinence syndrome	1. Collaboration with the Family & Children First Council of Trumbull County 2. Collaboration with Trumbull	1. Number of babies born with neo natal abstinence syndrome 2. Number of pregnant women on MAT 3. Successful implementation of	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		Memorial Hospital Obstetrics Department 3. Increase access to treatment 4. Implement M.O.M.S. Project	M.O.M.S. Project	
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)	Decrease in number of youth involved with the child welfare system due to parental SUD Parents with SUDs complete treatment and achieve recovery	1. Continue collaborative funding arrangement with Children Services and Family Court to maintain the Trumbull County Family Dependency Treatment Court (FDTC) 2. Maintain active participation on FDTC Steering Committee 3. Ensure court protocols incorporate evidence-based practices	1. Number of children maintained in the biological parents home 2. Number of reunified families 3. Number of FDTC graduations	__ 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.)	Decrease incidence of new cases of Hepatitis C and AIDS.HIV	Collaborate with Trumbull County Health District on syringe exchange program	Start date of Trumbull County syringe exchange program	X No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe): According to the Trumbull County Combined Health District, we are a low risk county for TB. We had one case in 2015 that was extra pulmonary (not infectious) and the Health District is still following this case for 2016. We have a newly diagnosed extra pulmonary (not infectious) case for 2016, which makes 2 so far for 2016. This still makes us low risk.

MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	1. Increase the number of youth with SED who graduate from school 2. Decrease the number of youth with SED involved in the juvenile justice system 3. Decrease out of home placements for youth with SED	1. Prevention 2. Early Identification 3. Treatment provided in the least restrictive environment 4. High Fidelity Wraparound	1. Number of youth with SED who graduate from high school. 2. Number of youth and families engaged through the Trumbull County Early Childhood Mental Health Consultation Initiative and the Whole Child Matters program 3. Preschool expulsion rates 4. Number of daycare providers engaged through Trumbull County Early Childhood Mental Health Consultation Initiative and the Whole Child Matters program. 5. Number of Wraparound involved youth maintained in their home 6. Number of youth and families engaged in Wraparound	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	1. Decrease the number of hospitalizations 2. Decrease hospital recidivism rates 3. Decrease the average length of stay of difficult to place adults	1. Provide additional supportive services 2. Provide supportive housing services locally 3. Diversify placement options so as to better meet the needs of clients	1. Number of hospitalizations 2. Rate of hospital recidivism 3. Hospital length of stay	__ 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	1. Locate/engage unhoused persons 2. Expand emergency accommodations 3. Increase number of formerly homeless persons in permanent supportive housing 4. Prevent homelessness among high-risk populations	1. PATH/CABHI outreach program (HHCC/CCRA) 2. Implement OHFA grant for Christy House Emergency Shelter 3. Expand Shelter Plus Care 4. CQI and Community Linkages to prioritize housing for persons leaving state hospitals and prisons	1. Completion of renovations at Christy House 2. Apply for additional S+C vouchers. 3. Monitor Christy House utilization for LOS and re-admissions by primary provider	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Older Adults	1. Increase the number of older adults receiving mental health treatment	1. Encourage providers to expand Medicare approved providers 2. Work more closely with Area Agency on Aging to link clients with appropriate resources 3. Continue collaboration with various agencies through TAPN (senior	1. Number of older adults receiving treatment	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)

		collaborative) 4. Utilization of Board levy dollars to provide case management for Medicare clients		
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	Improve transition, engagement and integration for persons returning to community from prisons / jail	1. Community Linkage program 2. Jail Navigator program 3. Re-Entry Coalition 4. Partnership with Trumbull Correctional Institution's CIT	1. number of persons served 2. re-incarceration 3. housing continuity	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Integration of behavioral health and primary care services	1. Maintain partnership with One Health, our local FQHC, to provide integrated primary and behavioral health care. 2. Maintain current contractual relationship with First Step Recovery to provide physical, mental health and addiction services to First Step clients. 3. Integrated addiction and primary care services will be offered at Community Solutions/Compass through their partnership with Meridian in Warren, Ohio in the Fall of 2016.	1. Continue to pay co-pays of patients at OneHealth who can't afford them who also receive behavioral health services at core provider agencies. 2. Continue to pay for addiction services such as detox and treatment for those who do not qualify for Medicaid. 3. The TCMHRB will promote the integrated services available through marketing efforts. 4. Indigent care will be provided via levy funds.	1. The number of persons benefiting by the co-pays will be counted. 2. Overall health will improve. 3. The number of persons receiving services will increase. 4. Clients will achieve recovery and overall improved health. 5. The number of persons receiving services will be documented. 6. ED visits for emergency care will decrease	__ 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)	1. Increase the number of certified recovery coaches 2. Increase accessibility to recovery housing	1. Collaborate on peer support trainings 2. Meet regularly with recovery housing operators 3. Provide rent stipends to recovery houses for indigent Trumbull County residents	1. Number of certified peer supporters 2. Number of employed peer supporters 3. Number of individuals receiving peer support 4. Number of recovery houses in contract with TCMHRB 5. Number of residents receiving rental	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		4. Increase funding line item for agencies to hire peer supporters 5. Increase funding to employment services for collaboration with the Center of Innovative Practices to improve services	stipends in recovery houses 6. Number of individuals receiving employment services	
Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)	1. Increase understanding of LGBTQ population and issues 2. Increase trained providers	1. Provide educational training programs like SafeZone 2. Collaborate with identified organizations identified as experts	Two different trainings have been provided to local agency providers so as to increase their understanding and skill level in working with the LGBTQ population.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Reduce the number of Trumbull County residents dying by unintentional drug overdose	1. Prevention programming in schools and community 2. Community Wide collaboration through ASAP coalition/ ASAP Opiate Task Force 3. Contracts for provision of detoxification services and recovery housing for indigent residents 4. Diversify outpatient treatment options 5. Increase accessibility to Medication Assisted Treatment 6. Promotion of Project DAWN	1. Number of schools receiving prevention services from TCMHRB contract provider agencies. 2. Number of participants in ASAP community awareness activities. 3. ASAP meeting and event attendance 4. Availability of full continuum of care as evidenced by the completion of Table 1: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area 5. Number of patients receiving MAT at new clinic being established by Compass Family & Community Services and Meridian Healthcare 6. Number of Project DAWN kits distributed 7. Number of individuals receiving treatment for an opiate use disorder 8. Number of unintentional overdose	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

			deaths	
Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Promote Trauma Informed Care approach	Establish Trumbull County as a Trauma Informed Community of Caring	1. Attend Trumbull County Trauma Informed Steering Committee 2. Attend OhioMHAS Lower Northwest Trauma Informed Care Regional Collaborative meetings 3. Provide trainings to enhance understanding of the lifelong impact of untreated adverse childhood experiences 4. Adopt a community wide trauma screening tool	1. Number of meetings attended 2. Number of trainings provided 3. Number of agencies who adopt and implement the screening tool	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Prevention: Ensure prevention services are available across the lifespan with a focus on families with children/adolescents	Prevention in Trumbull County addresses the needs of all Trumbull County residents in a culturally sensitive manner	1. Prevention programming in schools 2. Early Childhood Mental Health Consultation Initiative 3. Safe medication disposal campaign 4. ASAP summer track meet 4. PRIDE surveys 5. Community wide education regarding responsible gambling	1. Number of Trumbull County schools receiving prevention programming 2. Number of children, families and daycare centers engaged in the Trumbull County Early Childhood Mental Health Initiative 3. Number of youth and families who participate in the ASAP summer track meet 4. Amount of medications dropped off at safe disposal collection sites 5. Number of parents who sign up to receive "Know" tips at the summer track meet 6. Number of schools that administer the PRIDE surveys to their students 7. Number of units of gambling prevention provided 8. Number of individuals identified in	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

			prevention activities who become engaged in gambling treatment	
Prevention: Increase access to evidence-based prevention	1. Increase in the number of school districts implementing evidence based prevention activities 2. Increase the number of certified prevention specialists 3. Increase in number of individuals trained in evidence based prevention practices	1. Increase funding to Meridian Healthcare to provide evidence based prevention practices within schools including youth led prevention initiatives 2. Partner with Trumbull County Education Services Center to provide a drug prevention training for school personnel 3. Provide funding to TCMHRB contract agencies for staff to pursue gambling prevention education (i.e. attend state wide gambling conference) 4. Include prevention education at ASAP 2017 Drug Summit	1. Number of new school districts utilizing prevention services through TCMHRB contract providers 2. Number of certified prevention specialists employed by TCMHRB contract providers 3. Number of units of prevention activities provided 4. Number of prevention trainings held 5. Number of participants in prevention trainings	__ No assessed local need __ Lack of funds Workforce shortage __ Other (describe):
Prevention: Suicide prevention	1. Increase understanding and skills in working with middle age men, older adults and their families. 2. Increase trained providers	DBT training, funded by OhioMHAS, is being planned collaboratively with Lake and Ashtabula Counties.	Decrease the number of suicides.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	All TCMHRB contract agencies integrate problem gambling screening questions in their diagnostic assessment. 2. Decrease the frequency of problem gambling. 3. Increase number of clients engaged in gambling treatment, attending recovery support groups and obtaining a sponsor. 4. Increase in gambling prevention	1. Continue Multi- County gambling steering committee meetings 2. Public awareness campaign regarding what is problem gambling and how to engage in services 3.Cross systems trainings on problem gambling 4. Increase gambling treatment capacity 5. Partner with local universities on problem gambling prevention	1. Number of certified gambling treatment providers 2. Number of community and professional development trainings completed 3. Units of gambling prevention provided 4. Number of clients in gambling treatment 5. Number of universities participating in gambling awareness activities 6. Number of students participating in on campus gambling awareness activities	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

	activities.	activities, especially during problem gambling awareness month		

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
Anti-Stigma	1. Reduce negative impressions and the stigma that surrounds mental illness. 2. Reduce stigma experienced by consumers and families to increase self-image, unwillingness to seek help and isolation.	1. Pool money with the Mahoning and Columbiana ADAMHS Boards to produce and air television commercials and create print and billboard ads. 2. Continue Call a Counselor event during Mental Health Awareness month in partnership with local television station and the Mahoning and Columbiana ADAMHS Boards. 3. Provide financial support to Mahoning Valley NAMI 4. Promote family and consumer involvement in NAMI activities	1. Number of callers during Call a Counselor event 2. Number of television spots aired 3. Number of billboard impressions 4. Number of members of NAMI Mahoning Valley

Priorities (continued)

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

Priority if resources were available	Why this priority would be chosen
Inpatient Detoxification and Long Term (30 days +) Residential Treatment for Substance Abusers	Trumbull County has seen a record spike in the number of unintentional overdose deaths in the past two years, and the number continues to climb this year. The TCMHRB staff regularly receive calls for individuals seeking residential substance abuse treatment and/or inpatient detox services. There are nearly 200,000 people living in Trumbull County and only one facility that provides detox inpatient treatment. Due to the Federal Center for Medicaid regulations, that facility can treat only 16 individuals at a time. This does not nearly meet the local need. Individuals are placed on waiting lists, at which time one Ohioan dies every six hours as a result of an accidental drug overdose. Of the individuals that are able to successfully complete detox, the majority are unable to continue in treatment in the level of care needed due to lack of financial resources. With additional resources, the Board could support providers in opening additional inpatient treatment facilities and provide funding to indigent clients for long term residential treatment.
(4)	

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?)

Early Childhood Program Trumbull County has a long history of providing early childhood mental health consultation, and was recently able to expand this programming to additional child care centers and home-based childcare providers after receiving state funding through the Whole Child Matters Early Childhood Mental Health grant. Trumbull MHRB partnered with D&E Counseling Center (Mahoning County) and the Counseling Center of Columbiana County to form a three county collaborative. The Mahoning Valley Whole Child Matters Collaborative has pooled their knowledge and resources to improve their services and establish consistency across the counties in how the ECMH services are delivered. Currently, Trumbull MHRB contracts with three provider agencies, Valley Counseling, PsyCare and Homes for Kids/Child and Family Solutions.

Family Wraparound State Fiscal Year (SFY) 2016 was a record breaking year for Trumbull County Family Wraparound, an initiative of the Trumbull County Family and Children First Council, with over 100 families enrolled in this strength-based planning process. The Trumbull County Mental Health and Recovery Board has been a strong supporter of this process since it first came to Trumbull County, just over 20 years ago. The Board contributes to the Wraparound Pooled Fund, a key element in the ongoing success of this program. The Children's Program Coordinator of the Board provides Wraparound training and coaching, maintains Wraparound enrollment for the county and is in charge of fidelity monitoring. Trumbull County utilizes two different Wraparound fidelity tools and consistently scores well above the national mean. Trumbull County is part of the 1st cohort of ENGAGE (Engaging the New Generation to Achieve Goals through Empowerment), a statewide initiative made possible by a four-year System of Care Expansion Implementation Grant from SAMHSA. So far Trumbull County has enrolled 22 youth into ENGAGE-Wraparound, which is specifically geared toward youth and young adults ages 14-21. The Children's Program Coordinator of the Board was designated as Trumbull County's lead contact for ENGAGE, and invited to become a statewide Wraparound Coach, providing technical assistance and coaching to communities throughout the state.

The Alliance for Substance Abuse Prevention (ASAP) The Trumbull County Mental Health and Recovery Board is the sole funder of ASAP, a community coalition that engages strategic partnerships to solve our community's substance abuse problems. Its members are a network of people including health professionals, parents, educators, elected officials, merchants, business members, police, administrators, and students. ASAP creates and distributes educational materials, hosts community awareness and education events, advocates for prevention and recovery supports and fosters collaborative relationships to change social norms in Trumbull County. The coalition also works to reduce accessibility to opiates by partnering with TAG Law Enforcement Task Force on drug take back events (collecting nearly 1 million pills in 5 years), and advocating for the installation and use of permanent medication drop off locations. There are currently twelve permanent drop-off locations in Trumbull County.

Suicide Prevention During 2015, the Trumbull, Columbiana and Mahoning County Suicide Prevention Coalitions have worked collaboratively, which they have done many times in the past, to provide a suicide prevention workshop focused on the connection between substance use disorders and suicide. With grants provided by the Ohio Suicide Prevention Foundation, the speakers included Theodore Parran, MD, Will Heininger and Capt. Jeffrey Coady, PsyD, the SAMHSA Region 5 Administrator. Over 100 people were in attendance, which included clinicians as well as community members.

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.

Collaboration between our local hospital, the probate court and Northcoast Behavioral Healthcare and Heartland Behavioral Healthcare has been challenging. The Trumbull Memorial Hospital (TMH) psychiatrist and CEO and the Probate Court continue to be frustrated that the state hospitals are often at capacity, that people wait in the local emergency room for days at a time and that once patients are transferred to the state hospital the median length of stay is around 12 days. Our local partners believe that long term hospitalization is necessary for anyone reaching the level of state hospitalization. They are frustrated that state hospitals have become crisis intervention facilities with a quick return to the community. The TMH CEO has threatened to close the local psychiatric unit on a number of occasions. Many patients re-present at the local hospitals not long after discharge and the "revolving door" cycle that these clients enter into is frustrating for our partners and for our clients and their families. Another result of no access to long term care is that the probate court puts clients on outpatient commitment to the board at a higher per capita rate than any other county in the state. Our system is very risk adverse and the belief that people need to be in a "safe" environment will likely continue long term.

Exacerbating the Trumbull County situation is the fact that we continue to have forensic patients at Heartland Behavioral Healthcare and civil patients in Northcoast Behavioral Healthcare, which has increased the work of provider and Board staff as we attend meetings with both collaboratives and coordinate care for our clients.

We are also experiencing a devastating shortage of psychiatry in our area. Many of the psychiatrists that remain are in their seventies and there does not appear to be a viable workforce to replace them. Coleman Behavioral Health, our crisis screening agency and front door to our system of care, has put a moratorium on psychiatry referrals. The TMH psychiatrist also works at two agencies in our system of care, which may lead to diminished patient care.

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 Collaborative Resources Projects Horizon House is a 12-bed, 24 hour residential facility that provides treatment and ongoing stabilization for hard to place adults experiencing a severe and persistent mental illness that impedes their ability to function in a less supervised community residence. Located in Mahoning County, the collaboration involves Mahoning, Trumbull and Tuscarawas/Carroll County Mental Health and Recovery Boards. The concept, utilizing Community Collaborative Resources (CCR), was developed regionally in response to the growing need for a level of care between group home placement and hospitalization. The collaborations funding of the project, through the use of the CCR funding, was a total of $533,638.

The facility is owned and operated by Compass Family & Community Services, a dual county behavioral health provider. Residents continue to work with their outpatient providers, as the ultimate goal is for the clients to step down from Horizon House to a lower level of care. Various agencies from Mahoning and Trumbull Counties are involved with the residents, including Valley Counseling and Turning Point Counseling. For those individuals from counties further away, Compass provides the services and ongoing communication occurs with the respective boards of those residents. When discharge planning occurs, the resident's county board as well as the provider agency to which the client is being referred is actively involved in the process. In addition, any other supportive service agency with whom the client will be involved is an active participant so as to help with the transition process. Placement at Horizon House is approximately 6 – 12 months; therefore, a well-developed transition plan is important for success.

Another collaborative project, through the use of Community Collaborative Resources, is "Multiple Crisis Step Down", which include Riverbend Treatment Center (Trumbull County) and Turning Point Crisis Unit (Mahoning

County). With the $282,820 through the CCR, both programs were enhanced with additional staffing, including 24/7 clinical services and 16 hours of medical staff (RN or nurse practitioner), more acute clients are being served. This expanded population includes dually diagnosed MH/DD, and persons who need medication management and/or adjustments.

The collaborative projects utilizing the CCR were created in order to reduce the number of state hospital admissions, and subsequent state costs, of clients who can be diverted from state hospitalization. These programs are now primarily supported with local levy dollars.

Project DAWN In 2015, TCMHRB, partnered with the Trumbull County Combined Health District to make naloxone kits available to Trumbull County residents. TCMHRB provides financial support, as well staff support, to the program. TCMHRB staff and consultant assist with the creation, printing and distribution of marketing materials. Through this collaboration, 96 naloxone kits were distributed in 2015. Sixty seven (67) kits have been distributed to date in 2016. The project has yielded 5 successful reversals.
TCMHRB also drafted and mailed a letter encouraging more police departments to receive training through the Trumbull County Combined Health District to begin carrying naloxone. At least 2 departments responded and are now carrying the lifesaving antidote.

Juvenile Detention Alternative Initiative (JDAI) TCMHRB is a member of the Trumbull County JDAI steering committee led by the Trumbull County Juvenile Court. This collaboration which focuses on local detention reform, has already led to a number of positive changes. Through this effort, the TCMHRB has allocated funding for 2 full time case managers housed within the juvenile detention facility. These case managers will administer the Massachusetts Youth Screening Instrument (MAYSI)/(MAYSI-2), a brief screening instrument designed to identify potential mental health needs of adolescents involved in the juvenile justice system, as well as a locally development risk assessment. This collaborative effort will better serve the mental health needs of youth involved with the juvenile justice system.

Criminal Justice Initiatives We received a FY2015 Criminal Justice and Behavioral Health Linkages grant from OhioMHAS during FY2014. The grant made possible telemedicine in the Trumbull County Adult Justice Center (jail) using physicians and advanced practice nurses at Valley Counseling Services and Coleman Behavioral Health. Although the project has faced a series of technological problems, we have been successful in addressing medication needs of jail inmates and, most importantly, in connecting inmates with needed behavioral health services after their release.

Finally, we were contacted by officials at the Trumbull Correctional Institution and the Ohio Department of Rehabilitation and Corrections in the spring of 2016 and asked to assist them as they prepared a special Crisis Intervention Team (CIT) training program for corrections officers at the prison. ODRC announced plans to include CIT training in all state prisons and TCI was selected to be the first, due in part to its favorable organizational culture. We have trained eight corrections officers from TCI in our community CIT courses, including one officer who will be in TCI’s first CIT class. We were able to provide some technical support and, thanks to the generosity of Compass Family and Community Services, to offer Riverbend Center for the site-visit portion of the training.

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.

Delores is a 22 year old female who is dually diagnosed with a mental illness and developmental disability. Her mother completed suicide when Delores, an only child, was a young teen and she was raised by her father. She had not been involved in the mental health or developmental disabilities system until she was in her mid- teens, which is when she began to act out in anger and became physically violent. Delores was hospitalized both locally and in the state psychiatric hospital multiple times, and was placed in a variety of different group homes, all of which she proceeded to either run away from, become aggressive/violent to staff and peers, and destroy property. A variety of interventions, different medications, and longer lengths of hospital stays were attempted, with the same outcome occurring after each new placement.

After the most extensive length of stay at the state psychiatric hospital and the denial of placement at a group home in which Delores was looking forward to moving, a placement was tentatively secured within the developmental disabilities system. A detailed plan was developed between the hospital, developmental disabilities system, group home, mental health agency and mental health and recovery board to help Delores transition into the new home and work program.

Delores was discharged from the state hospital to the community in the beginning of the year, and during that time, she had one minor set-back within the first month, at which time she was hospitalized locally. Since then, Delores has been tremendously successful in the community. She has not been hospitalized in over 4 months; she has handled her anxiety and frustrations in an appropriate manner; she has become involved in the Special Olympics; she attends her counseling appointments as scheduled and takes her medications as prescribed; and she attends workshop daily.

Mulva has a long history of mental illness, illegal drug usage, non-compliance with prescribed medication and gender identity issues. She has been hospitalized multiple times in both local and state hospitals, and whenever she was discharged to the community, she would stop taking her prescribed medications and would link up with persons who could provide her with drugs. She would also put herself in dangerous situations and there was much concern that she would end up being severally hurt due to her aggressive nature.

Mulva was recently discharged to a group home after a several year state hospitalization. Another intensive discharge plan was developed, with the group home operator, ACT team and hospital. Although Mulva has had a few bumps along the way, she has been making progress in the community. She is taking her medications as prescribed, has remained in the same group home, developed personal goals for herself (e.g., get her driver's license), and she is involved in a supportive employment program. Although she continues to have issues with anxiety, she has been handling difficult situations in a much more appropriate manner, and she is able to state that she is proud of herself, which is a tremendous accomplishment for her.

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.

Medicaid Redesign is already having a significant impact on providers in Ohio. Another Trumbull provider recently merged and others that we use have already stopped providing services that they will not be able to afford to continue to provide in the future. I project that several small agencies will not survive the redesign and move under managed care. This will leave people in need without the community care necessary to keep them out of crisis and out of the state and local hospitals. I anticipate the need for state hospital beds will increase even though the state continues to reduce bed availability. Analysis by our billing entity, Heartland East, shows that the reduction of the rates in general matters much more than the differences between credentialing levels. While differences in rates between the credentialing levels has an effect on some of the codes, that impact is insignificant compared to the impact of the rate reductions overall. This is then compounded by the caps set in the redesign. Each provider has already come to the Board asking if we will pay for the Medicaid clients for continued care once they reach their cap. This is just another example of costs being forced onto the local communities when there is a huge rainy day fund that could help with this problem. We have been told to provide a "recovery oriented system of care" and to offer all supports on the spectrum as well as increase prevention in schools, fund jail programs and fill in the homeless and housing gaps that will be even greater with the new HUD definitions of homelessness. Trumbull County has a population of approximately 205,000 people and a 3.2 million dollar levy. Addictions services alone cost a million dollars this year because of the opiate epidemic. We hope we will not see an increase in tragic outcomes involving people with mental health or substance use disorders as a direct result of Medicaid redesign.

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
TRUMBULL COUNTY MENTAL HEALTH AND RECOVERY BOARD

____ _______________
April J. Caraway, ADAMHS Board Executive Director Date

____ _______________
Virginia Pasha, ADAMHS 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