Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan SFY 2019 and 2020

Trumbull County Mental Health and Recovery Board

NOTE: OhioMHAS is particularly interested in areas identified as priorities for RecoveryOhio, including: (1) access and capacity changes for mental health and addiction services for both adults and children/youth; (2) health equity concerns for racial and ethnic minorities and people living in Appalachia or rural Ohio; (3) distinctive challenges for multisystem youth, families involved in child welfare, and for criminal justice-involved Ohioans; (4) prevention and/or decrease of opiate overdoses and/or deaths; and/or (5) suicide prevention.

Environmental Context of the Plan/Current Status

1. *Describe the economic, social, and demographic factors in the board area that influence service delivery. Note: With regard to current environmental context, boards may describe the impact of Behavioral Health Redesign including Medicaid Managed Care carve-in.*

As the data in Tables 1 through 5 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 2018, the total population of the county declined by more than 26,000 from 225,116 to 198,627, a reduction of 11.8 percent. The 2018 estimate by Ohio's Development Service Agency represents the first time our county's population fell below 200,000 since the Census of 1950. At the same time that the population of Trumbull County was shrinking, the number and proportion of persons living in poverty was increasing—from 9.9 percent (N=21,844) in 2000 to 17.2 percent (30,109) in 2017. The county's poverty rate was below the statewide rate in 1990 and 2000, but exceeded the statewide rate by more than 3 percentage points in 2017. The growth in poverty was most pronounced for children. In 2010, the county's child poverty rate (31.4%) far exceeded the statewide rate for children (23.1%). In that year, nearly one–third (31.4 percent) of all children in Trumbull County were living in poverty. Although child poverty rates at both state (19.8%) and county (24.1%) levels declined in 2017, our rate was still 4 percentage points higher than the state's rate.

Between 2009 and 2018, 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, holding steady around 5 percent in 2015-16-17, and declining again in 2018 (see Table 2). And while Trumbull County has generally followed the statewide pattern, our unemployment rates were higher than the state average in every year. In 2009, Trumbull's

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: 2017

	Trumbull County		*Ohio*
	N	*%*	
All ages	30,109	17.2	13.9
Under 18	9,765	24.1	19.8
County population:	**200,314**		

Data Sources: US Census Bureau, Small Area Income and Poverty Estimates (2000, 2010, 2017)
http://www.census.gov/did/www/saipe/index.html

Ohio Development Services Agency, 2018 Ohio County Population Estimates,
https://development.ohio.gov/files/research/P5007.pdf

annualized unemployment rate was the highest among the fifteen Ohio counties with the largest populations and civilian labor forces (CLFs[1]). This dubious distinction continued from 2010 through 2018, interrupted only in 2011, when Lucas County's annualized unemployment rate exceeded ours by two–tenths of one percentage point. In that ten–year span, Trumbull County's labor force shrank by over 18 percent (from 107,200 to 87,700 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.). General Motors' decision to completely shut down its Lordstown Assembly Plant was announced earlier this year. Lordstown

[1] The fifteen counties with the largest overall populations and Civilian Labor Forces (2018) in descending order of CLF size are: Franklin, Cuyahoga, Hamilton, Summit, Montgomery, Lucas, Stark, Butler, Lorain, Lake, Warren, Mahoning, Clermont, Delaware, and Trumbull.

was one of Trumbull County's largest employers and idling over 1,400 hourly workers, has had repercussions locally and nationally.

Between 2009 and 2018, 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, holding steady around 5 percent in 2015-16-17, and declining again in 2018 (see Table 2). And while Trumbull County has generally followed the statewide pattern, our unemployment rates were higher than the state average in every year. In 2009, Trumbull's annualized unemployment rate was the highest among the fifteen Ohio counties with the largest populations and civilian labor forces. This dubious distinction continued from 2010 through 2018, interrupted only in 2011, when Lucas County's annualized unemployment rate exceeded ours by two–tenths of one percentage point. In that ten–year span, Trumbull County's labor force shrank by over 18 percent (from 107,200 to 87,700 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.). General Motors' decision to close its Lordstown Assembly Plant was announced earlier this year. Lordstown was one of Trumbull County's largest and idling over 1,400 hourly workers, has had repercussions locally and nationally.

TABLE 2
Unemployment: Ohio and Trumbull County, 2009–2018

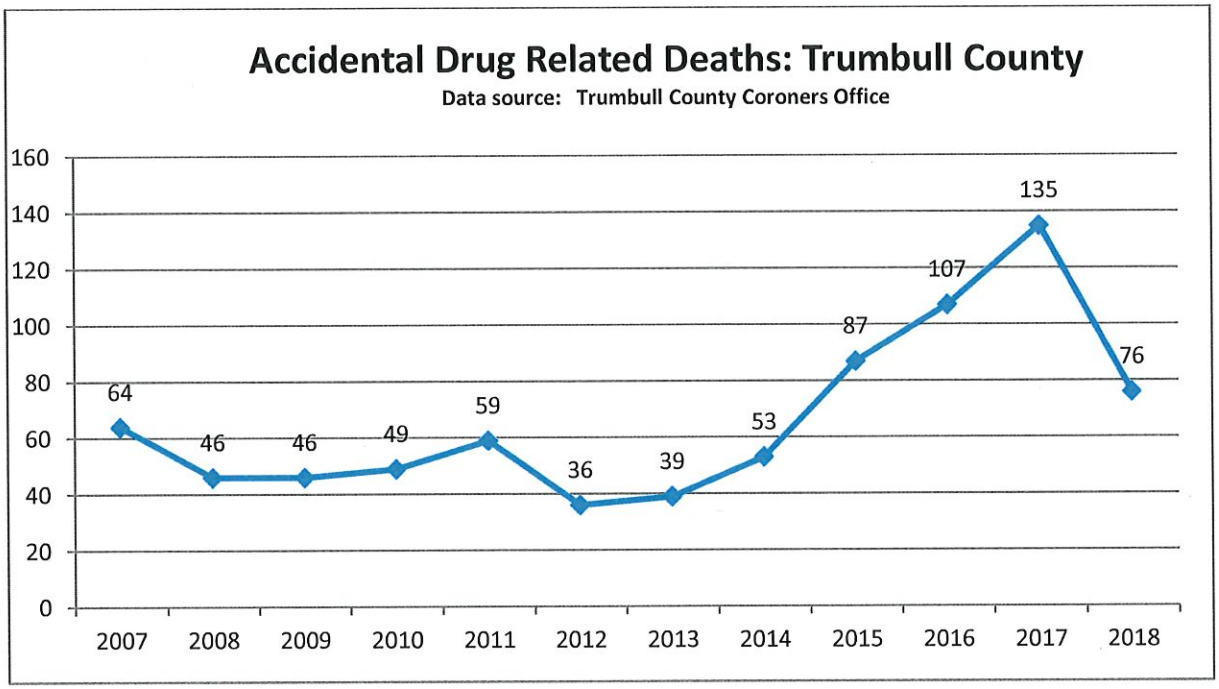
OHIO	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***	***2016***	***2017***	***2018***
Unemployment Rate	10.1	10.0	8.6	7.2	7.5	5.8	4.9	5.0	5.0	4.6
TRUMBULL COUNTY	***2009***	***2010***	***2011***	***2012***	***2013***	***2014***	***2015***	***2016***	***2017***	***2018***
Unemployment Rate	13.8	11.8	9.6	8.1	9.3	7.2	6.5	6.7	7.2	6.2
Trumbull County's Unemployment Rank Among Ohio's 15 largest counties / CLFs)	1	1	2	1	1	1	1	1	1	1

Source: Ohio Department of Job and Family Services, Local Area Unemployment Statistics http://ohiolmi.com/laus/laus.htm

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—over 12,000 in FY2018—receive behavioral health services through our provider network, some seek services outside our system (e.g., primary care physicians, clergy), some seek and/or receive services involuntarily or in crisis situations (e.g.,

emergency hospital admissions, probates, Narcan revivals), 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 and other drugs epidemic has exacerbated poverty and unemployment trends. The data displayed in Table 3 show a steady increase in fatal drug overdoses in the county between 2012 and 2017. (Trends in county deaths by overdose and by suicide are discussed in greater detail in subsequent sections.)

TABLE 3



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]

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

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 county rankings 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 2019 rankings, Trumbull County ranks 72nd 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 one of the state's 15 largest counties ranks below Trumbull on this measure. In 2016, our rank was 65th. We rank 77th on *health factors*, down from 72 in 2016, 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*.

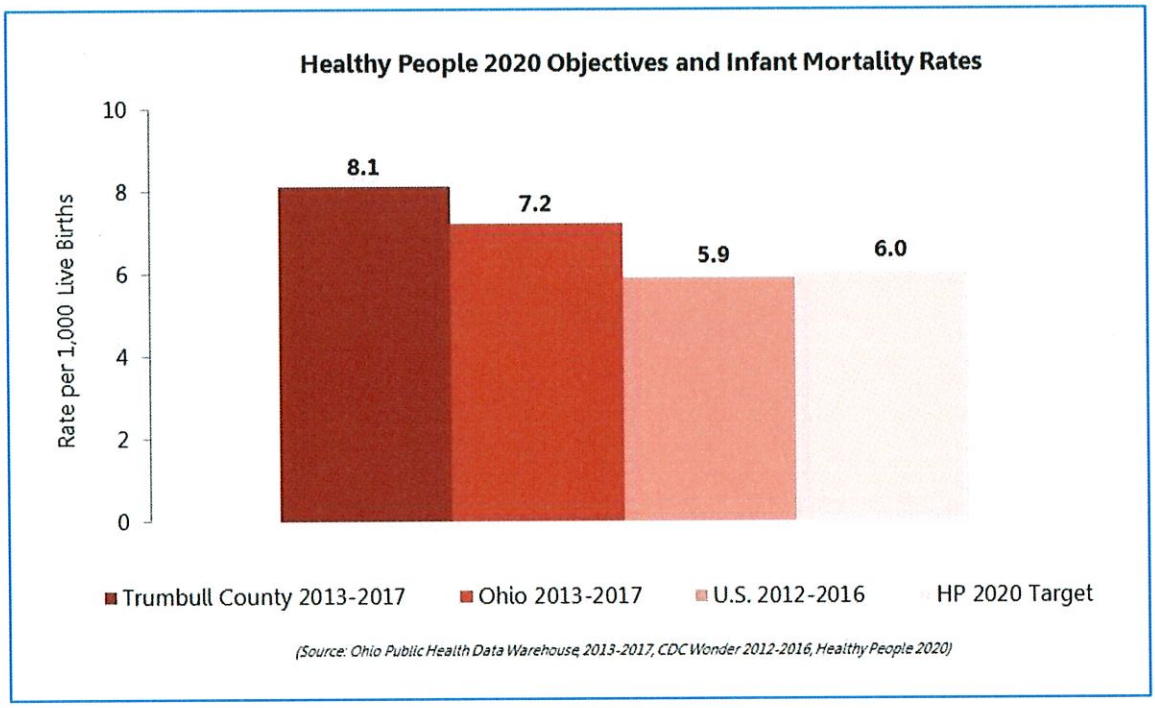
The relationship between socioeconomic status and a wide variety of health indicators is well established in the fields of medical sociology and public health. As noted in one classic text

> Social class inequities have been found for so many causes of sickness and death and have proved so enduring that it is plausible to infer that a generalized susceptibility to disease is a condition of lower–class life.[3]

[3] Mervyn W. Susser, et al., *Sociology in Medicine, 3/e,* New York: Oxford University Press, 1985, pp. 253-254.

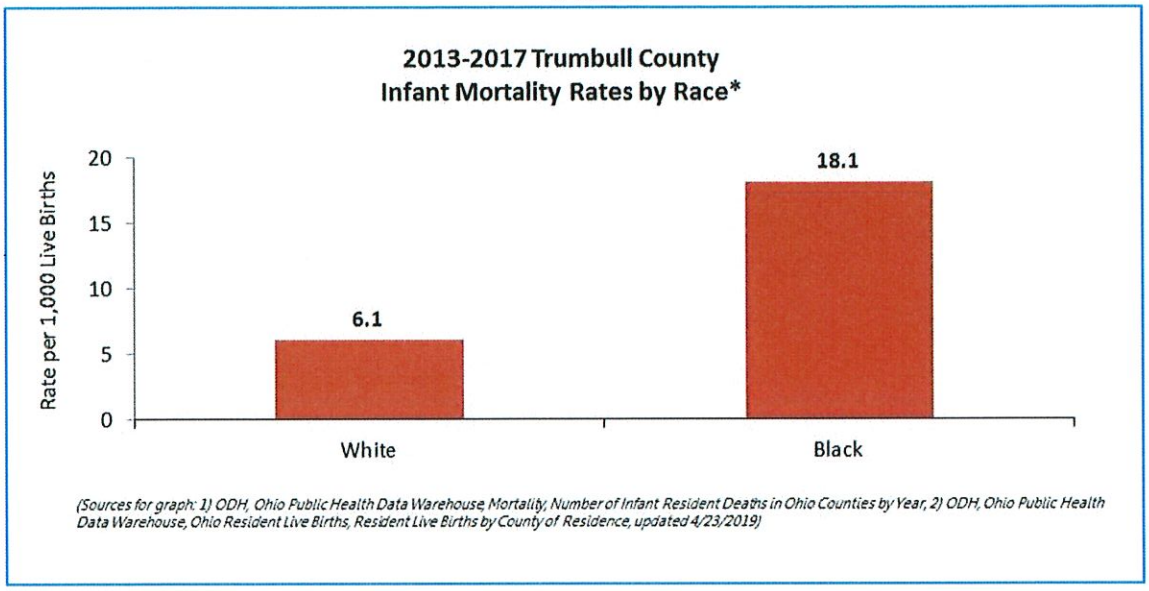
A health disparity is a health difference that is closely linked with social, economic, or environmental disadvantage. Minority populations have long been associated with health disparities. African Americans comprise the largest minority group in Trumbull County representing approximately 8.3 percent of the total population. Staff from the TCMHRB participated in the development of The Trumbull County Combined Health District's FY2020 County Health Assessment and Improvement Plan (more is said about this in subsequent sections). In the course of that project we learned about health disparities based on race. These include generalized ratings of overall health and mental health, obesity, oral health and, perhaps most disturbing, infant mortality. Tables 4 and 5 summarize this information. The target rate established by the federal government's *Healthy People 2020* initiative is 6.0 per 1,000 live births. Trumbull County's overall rate is 8.1, which is higher than Ohio's rate (7.2), or the US rate (5.9). Within Trumbull County the rate for whites is 6.1; for African Americans the rate is 18.1.

TABLE 4



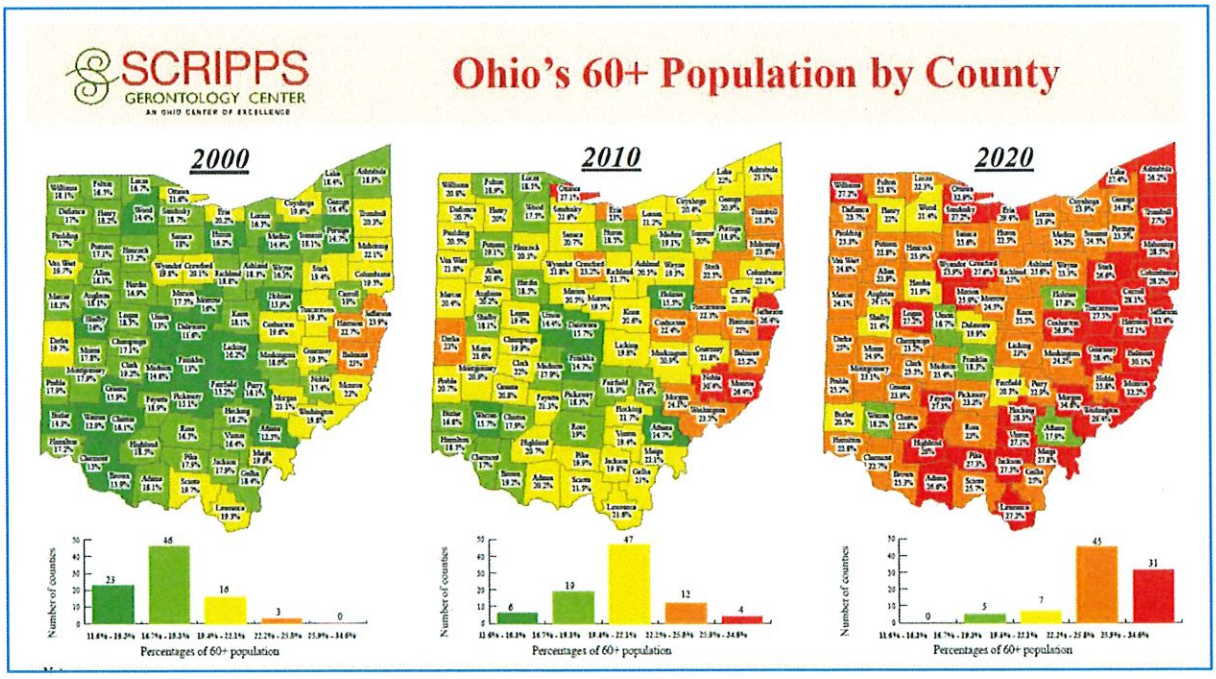
A final trend worthy of mention is the change in the *age composition* of the county's shrinking population. Between 1990 and 2010, the proportion of the county's population represented by youth declined slightly from about 21 percent to about 18 percent. At the other end of the life cycle, the number 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. The Scripps Gerontology Center at Miami University

TABLE 5



(Sources for graph: 1) ODH, Ohio Public Health Data Warehouse, Mortality, Number of Infant Resident Deaths in Ohio Counties by Year, 2) ODH, Ohio Public Health Data Warehouse, Ohio Resident Live Births, Resident Live Births by County of Residence, updated 4/23/2019)

ranked 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.



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.[4]

Following Buss and Redburn's suggestion, we have been retooling many of our traditional outreach and service delivery strategies as the dynamics of at–risk populations in our community evolve and change.

[4] 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

Assessing Needs and Identifying Gaps

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 people living with or recovering from mental illness and addiction in assessing needs, evaluating strengths and challenges and setting priorities for treatment and prevention in SFY 2019. [ORC 340.03 (A)(1)(a)]. Describe the board's plan for on-going needs assessment in SFY 2020 if they differ from this current fiscal year.*

In their now–classic guide to needs assessment techniques, the ODMH Needs Assessment Task Group described six basic approaches: three they characterized as "data oriented" and three as "perception oriented" (see box). As noted in past *Community Plans*, we use all six approaches in our ongoing efforts to identify, understand and address our community's changing behavioral health needs.

Basic Needs Assessment Approaches[1]

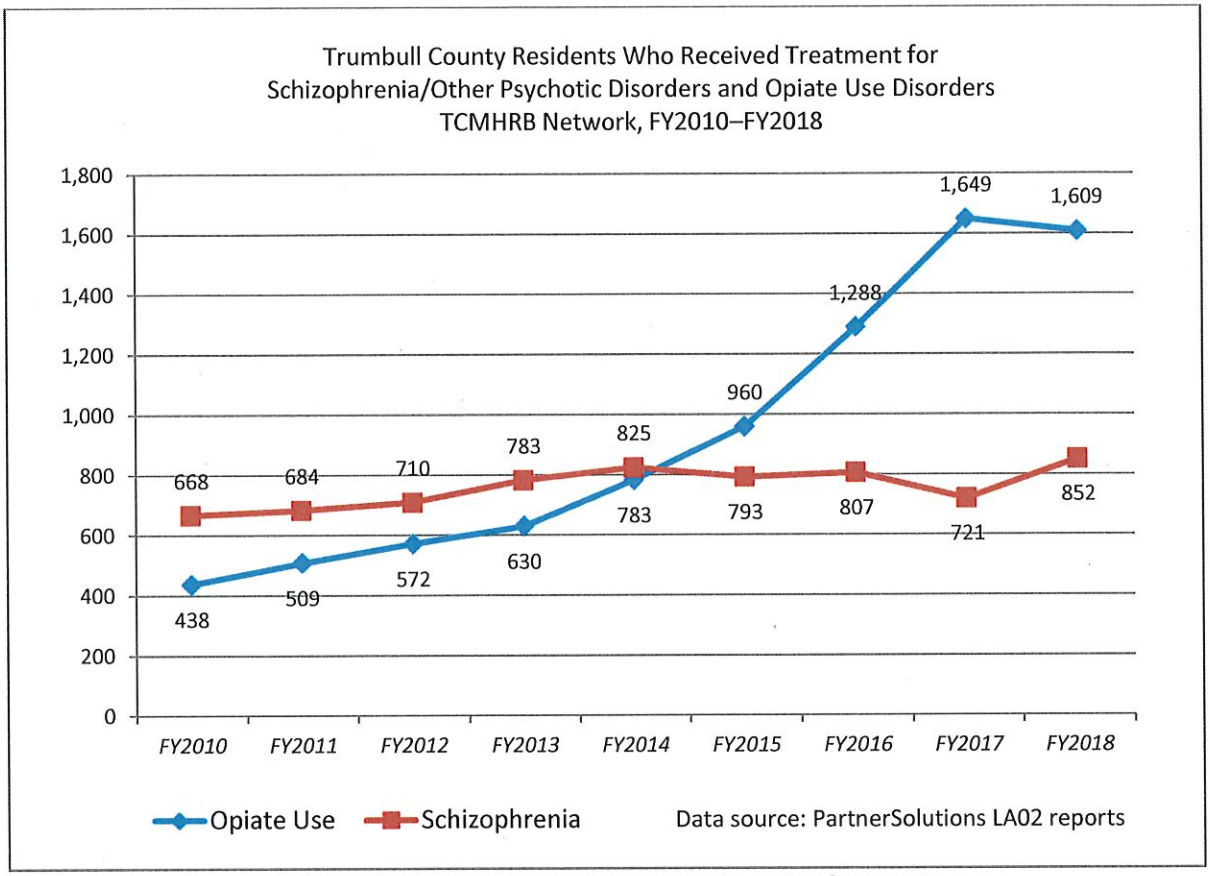
Data Oriented	Perception Oriented
1. Demographic / Social indicators	4. Key informants
2. Rates under treatment	5. Community forums
3. Epidemiological studies	6. Community surveys

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 Federal and State agencies, and private foundations/research centers (Robert Wood Johnson, Scripps), among other sources.

Rates under treatment We are a member of the Partner Solutions administrative services organization, which processes enrollment and claims for Medicaid and non–Medicaid payment systems for 12 ADAMHS Boards representing 15 counties in northeastern Ohio and nearly 15 percent of the state's total population. Partner Solutions 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 2018, the number of adults receiving treatment for schizophrenia increased by nearly 28 percent, from 668 persons in FY2010 to 852 FY2018. 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 1,649 (928 more than those with schizophrenia)

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

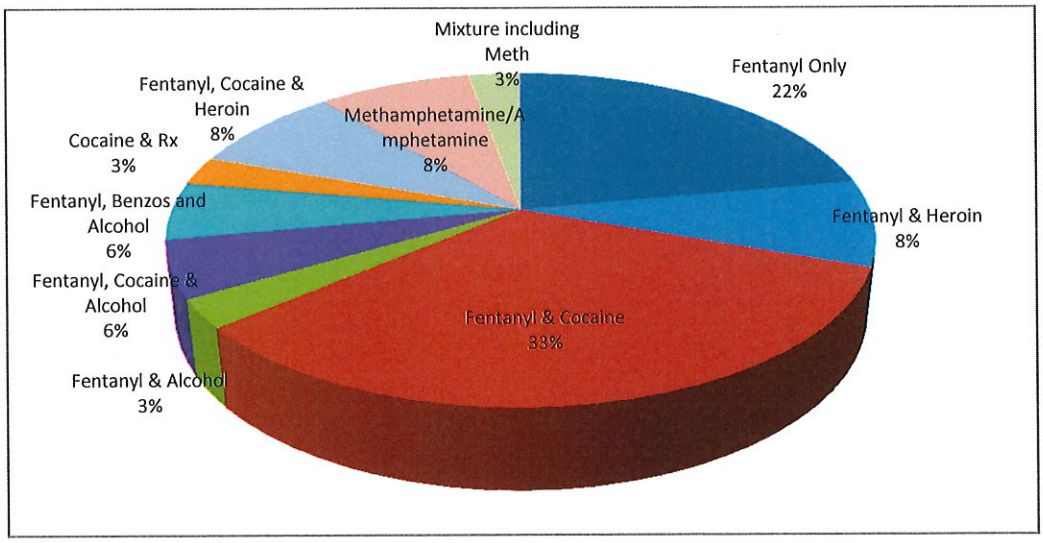
TABLE 5



GRAPH 1

2019 Toxicology Results for Fatal Overdoses

Data source: Trumbull County Coroner's Office

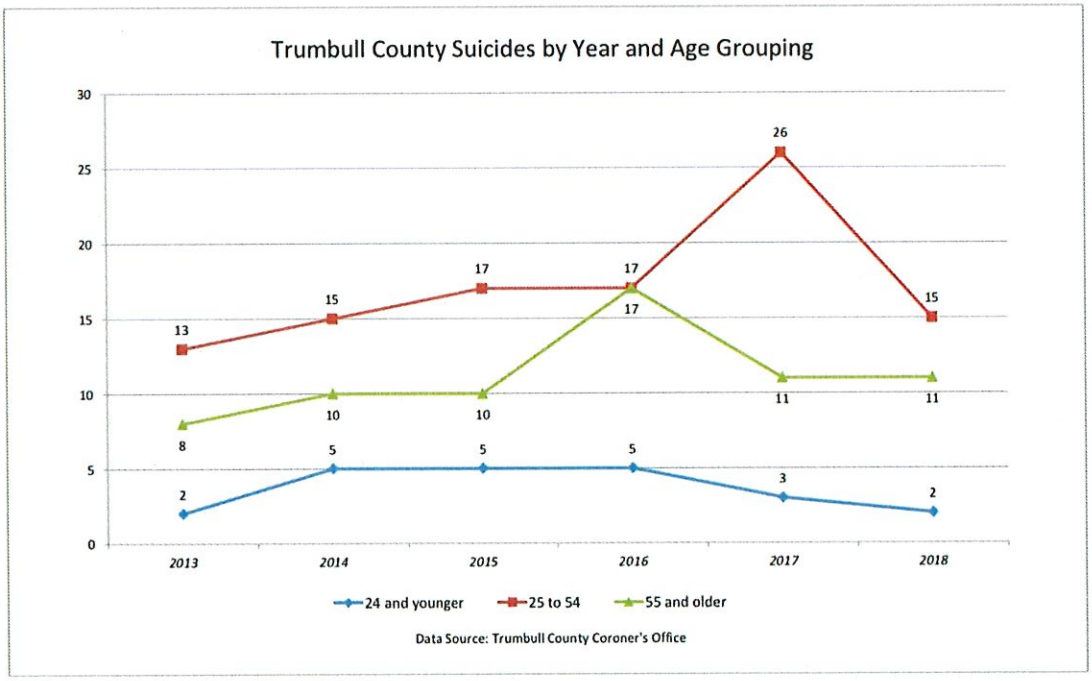


in FY2017. FY2018's decline in persons receiving opiate treatment may be at least a partial artifact of data sharing issues between ODM, OhioMHAS, and ADAMHS Boards. FY2018's decline notwithstanding, the data in Table 5 clearly show that "epidemic" in not inappropriate to describe the explosive growth of opiate and other drug addiction.

We also utilize Rates Under Treatment approaches in monitoring capacity and encounters in state psychiatric hospitals residential facilities, recovery houses, emergency shelter, and other facilities.

Epidemiology 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 and suicides. From these records we are able to see clear patterns related to race, sex, and age, and also of substances involved in fatal overdoses. From these findings it seems clear that "opiate epidemic" may be a misleading label. Based on the Coroner's data, calling what we are experiencing an "opiate and other drugs" epidemic may be more accurate. This finding has policy and budgetary implications. For example, some grants can only be used to provide treatment for opiate abuse. The data in Graph 1 show that a significant proportion of persons would not be eligible for opiate-only funding.

TABLE 6



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."[2] Question 5 (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, 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 including persons in recovery and those with lived experience of severe and persistent mental illnesses, recovery housing operators, NAMI Ohio and NAMI Mahoning Valley, law enforcement, county commissioners, etc. Of particular value in the wake of behavioral health redesign has been our Core Provider Meetings. These monthly meetings bring together executives, supervisors and administrators from provider agencies, along with staff from the TCMHRB to share "hard" information from diverse sources, e.g., state authorities, provider and board association), as well as impressions and rumors regarding enrollment, billing codes, provider credentialing, claims processing, certification, accreditation and related issues.

"The danger in using key informants is that their perspectives will be distorted and biased . . . data obtained from informants represent perceptions, not truths."[3] 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,"[4] 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-forum opportunities.

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."[5] In FY2016, we administered the Recovery Oriented System of Care (ROSC) survey to stakeholders in our network via Internet (SurveyMonkey) and paper forms. Findings were summarized in our last Community Plan). In partnership with the Ohio Association of County Behavioral Health Authorities, we re-administered the ROSC survey in FY2019 but have not received any county specific data or findings. As noted earlier, members of the Board's staff have been heavily involved in the FY2019 Community Health Needs Assessment and Community Health Improvement Plans processes of the Health Districts in

[2] Michael Quinn Patton, *Qualitative Evaluation and Research Methods, 2/e*, Newbury Park: Sage, 1990, p. 263.
[3] *Ibid*, p. 264.
[4] Needs Assessment Task Group, *Op cit.*, p. 11.
[5] Ibid, p. 13.

Trumbull and Mahoning Counties. As part of the process, a major community survey was conducted. More will be said of the findings in the next section.

b. *Describe how the board collaborated with local health departments and their 2019 State Health Improvement Process. In your response, please include, if applicable, the following: 1) collaborative efforts specific to assessing needs and gaps and setting priorities. 2) barriers or challenges the board believes will have to be overcome moving forward that will result in complimentary public health and behavioral health plans, 3) advantages, if any, realized to date with collaborative planning efforts, 4) next steps your board plans on undertaking to further alignment of public health and behavioral health community planning.*

Beginning with a series of meetings in May, 2018, staff from the TCMHRB have been involved in a two–county Community Health Needs Assessment (CHNA) project which is leading to the development of Community Health Improvement Plans (CHIP) for Trumbull and Mahoning Counties. Currently in progress, completion of our project is targeted for September–October, 2019. The members of the community collaborative carrying out the project include:

- Mercy Health Youngstown LLC
- Mercy Health Foundation Mahoning Valley
- Trumbull County Combined Health District
- Mahoning County Public Health
- Warren City Health District
- Youngstown City Health District
- Trumbull County Mental Health and Recovery Board
- Mahoning County Mental Health and Recovery Board
- Healthy Community Partnership Mahoning Valley

In addition to our working contributions, all these organizations provided financial support. The project has employed consultants from the Hospital Council of Northwest Ohio, an agency with extensive experience with community health surveys, secondary data analysis, and Ohio's CHNA and CHIP processes. The Board staff's contributions to the projects have included:

- Participated in meetings and conference calls with the consultants and the two–county teams
- Participated in discussions of the county's sociological and demographic characteristics, implications for the sampling design and for community focus groups
- Provided information about addiction, SPMI and mental health disorders, treatment and recovery supports
- Reviewed the base instrument for the community surveys, the Behavior Risk Factor Surveillance System (BRFSS 2018), recommended items for selection
- Reviewed supplemental items for possible inclusion, suggested edits

- Participated in community rollout event, June 6, 2019 at Kent State University Trumbull Campus
- Will participate in four Trumbull County CHIP meetings, June—August 2019
- Will participate in review of draft and final CHIP documents, to be prepared by consultants

This has been an interesting learning exercise, as we learned the other system's terminology, approaches, etc. and discussed areas of mutual interest, e.g., drug overdoses and Project DAWN, suicide, depression.

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

We have had no such disputes.

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

During the last year and a half, Trumbull County has experienced a complete turn-around in the number of state hospital civil admissions as compared to all previous years. This change is due mostly to the contracting of Dr. Momen at Trumbull Regional Medical Center and his understanding of the state hospital system. He has been a huge advocate of treating Trumbull County residents in our local psychiatric unit, even for longer lengths of stay, if need be. Rarely will he file a motion to transfer a patient from inpatient to Heartland Behavioral Healthcare. In addition, the Mahoning Valley has also had the addition of Generations Healthcare, a 78 bed private psychiatric hospital, which has also helped with keeping residents local.

As we have undergone these changes in local inpatient psychiatric hospitalizations, the community has also worked to increase the outpatient services so as to better care for residents in the community. The biggest gap of our community services continues to be prescriber availability. With the decrease in medical students going into the psychiatric field and older psychiatrists retiring, not only had we seen a deficit several years ago in psychiatric hours, but those hours have dramatically increased. Our providers have been working on the hiring and training of nurse practitioners in order to fill the gap, but they too remain a highly sought after group of professionals.

Another recently identified service need in our community is that of residential treatment. It has been identified by our providers that a facility is warranted in our county for adults who experience a serious and persistent mental disorder that impedes their ability to function in a less supervised community residence, but do not require inpatient treatment. The goals and objectives would be to provide a safe, supervised, supportive, but realistic living environment where individuals can work

toward achieving specific personal goals. Symptom remission and personal recovery would be paramount. To help facilitate this, the provider would partner with other community service providers and stakeholders, including addiction service providers, to afford the clients the best possible chance at remission and recovery. A facility like this exists in Mahoning County and due to the increase in the number of SPMI adults diagnosed in Trumbull County, a similar type of program would be beneficial.

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

The Recovery Oriented System of Care (ROSC) survey was re-administered to stakeholders in our network via Internet (SurveyMonkey) and paper forms in July of 2018. Seventy two (72) valid responses were received from four self–identified categories of respondent/stakeholders: persons in recovery and families (n=6), Board Members and Staff (n=19), service providers/administrators (n=37), and others (n=10). 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. We have received preliminary statewide results, but have not received county specific breakouts or raw data from OACBHA. Initial interviews with respondents indicate that the survey contained fewer "double-barreled" and ambiguously worded questions than the first iteration, which made the usefulness of some of the results questionable.

f. *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)].*

An identified gap in the Trumbull County system of care is substance use disorder treatment for adolescents at all levels of care. Trumbull County has experienced a decrease in the availability of these services over the past 5 years. Providers who previously offered such services have discontinued these population specific programs citing lack of interest/referrals. Two agencies within the County offer outpatient SUD services for adolescents. No in County agencies offer inpatient, residential or withdrawal management for adolescents.

g. *Needs and gaps associated with priorities of the Executive Budget for 2020-2021 including crisis services, criminal justice-involved populations, families involved with child welfare, and prevention/early intervention across the lifespan.*

These needs and gaps are identified in other sections throughout this document.

3. Complete Table 1: Inventory of Facilities, Services and Supports Currently Available to residents of the Board Area. (Table 1 is an Excel spreadsheet accompanying this document. Instructions are found on page 10 of the Guidelines.)

C. Priorities

4. *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? Please be specific about strategies for adults; children, youth, and families; and populations with health equity and diversity needs in your community.*

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

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

   Priorities undertaken in SFY 2019 that the board is continuing into 2020 as well as new priority areas identified for SFY 2020 may be included.

Priorities for Trumbull County Mental Health and Recovery Board				
Substance Abuse & Mental Health Block Grant Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
01 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/ County Opiate Hub/ County Overdose Fatality Review Committee 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. Increase availability of interventions available to inmates at the Trumbull County jail	1. Number of schools receiving prevention services from TCMHRB contract provider agencies. 2. Number of participants in ASAP community awareness activities. ASAP meeting and event attendance. Number of active Opiate Hub and Overdose Fatality Review Committee members. 3. 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 4. Number of patients receiving MAT 5. Number of Project DAWN kits distributed 6. Number of unintentional overdose deaths	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
02 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. Increase access to treatment 3. Promote M.O.M.S. Project 4. Participate in Trumbull County MOMS Coalition	1. Number of babies diagnosed with neo natal abstinence syndrome 2. Number of pregnant women on MAT 3. Number of participants in M.O.M.S. Project	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
03 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)	1. Decrease in number of youth involved with the child welfare system due to parental SUD 2. 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	1. Number of children maintained in the biological parents home 2. Number of reunified families 3. Number of FDTC graduations 4. Number of families enrolled in the QIC and START grants	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		evidence-based practices 4. Maintain active involvement on the Trumbull County Children Services Steering Committee for the QIC and START grants (Trumbull-SUD Initiative)		
04 SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)				__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
05 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. School-Based Prevention PreK-12 2. Early Identification 3. Treatment provided in the least restrictive environment 4. Multi-Systemic Therapy 5. High Fidelity Wraparound	1. Number of youth with SED who graduate from high school 2. Number of youth, families and childcare providers engaged in the Trumbull County Early Childhood Mental Health Consultation Initiative and the Bold Beginnings program 3. Preschool expulsion rates 4. MST Ultimate Outcomes 5. Number of Wraparound involved youth maintained in their home	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
06 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):
07 MH-Treatment: Homeless persons and persons with mental illness and/or addiction in need of supportive housing	1. Locate/engage unhoused persons 2. Improve emergency accommodations 3. Increase number of formerly homeless persons served in permanent supportive housing 4. Prevent homelessness among high-risk populations 5. Implement Coordinated Entry and Diversion for homeless individuals/families 6. Reduce the number of homeless veterans	1. PATH outreach program (Help Network of NE Ohio & Catholic Charities Regional Agency) 2. Implement OHFA grant for Christy House Emergency Shelter 3. Expand Continuum of Care Vouchers 4. CQI and Community Linkages to prioritize housing for persons leaving state hospitals and prisons 5. Recommendation to Access Points for information and referral (Christy House, Catholic Charities, Emmanuel Care Center)	1. Apply for additional Continuum of Care vouchers. 2. Completion of renovations at Christy House in FY19 3. Number of persons served with Continuum of Care vouchers and PSH 4. Monitor Christy House utilization for LOS and re-admissions by primary provider and utilization of Diversion Tool by housing providers to steer individuals towards alternative forms of support, before emergency shelters 5. Number of persons referred by each	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		6. Utilization of VASH vouchers for chronically Homeless Veterans & VA specific housing	Access Point 6. Number of veterans served through VASH Vouchers and VA Specific housing	
08 MH-Treatment: Older Adults	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 collaborative) 4. Utilization of Board levy dollars to provide case management for Medicare clients	1. Number of older adults receiving treatment	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)
Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
09 MH/SUD Treatment in Criminal Justice system –in jails, prisons, courts, assisted outpatient treatment	1. Maintain partnership with agencies, hospitals and probate court in providing AOT.	1. Continue to have agencies provide services to clients on AOT and complete reports as required by the court system.	1. The number of clients who comply with treatment.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
10 Integration of behavioral health and primary care services	Maintain partnership with One Health, our local FQHC, to provide integrated primary and behavioral health care.	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. 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.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
11 Recovery support services for individuals with mental illness or substance use disorders; (e.g. housing, employment, peer support, transportation)	1. Increase the number of Certified Peer Recovery Supporters 2. Increase the number of employed Certified Peer Recovery Supporters 3. Increase accessibility to efficient and effective recovery housing 4. Increase Recovery Supports	1. Collaborate on Peer Recovery Supporters trainings (Trumbull County Peer Recovery Support Training scheduled in FY20) 2. Increase funding line item for behavioral health agencies to hire peer supporters 3a. Contract with only Recovery House operators with homes certified by Ohio Recovery Housing (ORH). 3b. Meet regularly with recovery housing	1. Number of trained and Certified Peer Recovery Supporters 2. Number of employed Peer Recovery Supporters in Trumbull County 3a. Number of recovery houses in contract with TCMHRB 3b. Number of meetings held in FY20 3c. Number of residents receiving rental stipends in recovery houses 4a. Number of individuals referred for	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		operators providing education on behavioral health supportive services in the community 3c. Provide rent stipends to recovery houses for indigent Trumbull County residents 4a. Increase funding to BH agencies providing employment/education services to increase access for recovery house residents 4b. Increase funding for Recovery House Monitors in order to allow some transportation support to occur for employment and educational opportunities 4c. Network with Employment/Educational agencies that provide transportation services to/from programming	employment/educational services 4b&4c. Number of individuals enrolled in educational programming or employment services	
12 Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)	1. Increase understanding of various populations and issues 2. Increase trained providers	1. Collaborate with identified organizations identified as experts 2. Provide educational training programs	1. Number of providers working with different populations 2. Number and types of various training programs provided.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
13 Prevention and/or decrease of opiate overdoses and/or deaths	Reduce the number of unintentional drug overdoses by Trumbull County residents	1. Prevention programming in schools and community 2. Community Wide collaboration through ASAP coalition/ County Opiate Hub/ County Overdose Fatality Review Committee 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. Increase availability of interventions available to inmates at the Trumbull	1. Number of schools receiving prevention services from TCMHRB contract provider agencies. 2. Number of participants in ASAP community awareness activities. ASAP meeting and event attendance. Number of active Opiate Hub and Overdose Fatality Review Committee members. 3. 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 4. Number of patients receiving MAT 5. Number of Project DAWN kits distributed	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

		County jail	6. Number of unintentional overdose deaths	
14 Promote Trauma Informed Care approach	Establish Trumbull County as a Trauma Informed Community of Caring	1. Attend Trumbull County Trauma Informed Steering Committee 2. Provide trainings to enhance understanding of the lifelong impact of untreated adverse childhood experiences 3. Expand the use of the community wide trauma screening tool (ACES)	1. Number of meetings attended 2. Number of trainings provided 3. Number of agencies who adopt and implement the ACES screening tool	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
15 Prevention: Ensure prevention services are available across the lifespan	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 5. PRIDE surveys 6. 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. Amount of medications dropped off at safe disposal collection sites 4. Number of youth and families who participate in the ASAP summer track meet 5. Number of schools that administer the PRIDE surveys to their students 6. Number of units of gambling prevention provided 7. Number of individuals identified in prevention activities who become engaged in gambling treatment	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
16 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	1. Increase funding to certified prevention agencies 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	1. Number of 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	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

	practices	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 2020 Drug Summit	provided 4. Number of prevention trainings held 5. Number of participants in prevention trainings	
17 Prevention: Suicide prevention	1. Increase awareness that suicide is a public health and mental health problem in order to reduce stigma and increase individuals' ability to seek help. 2. Identify any negative suicide trends on an ongoing basis and provide information, education and training based upon the needs within the county so as to decrease/alleviate the trends.	1. Develop and implement a public awareness campaign. 2. Work with the County Coroner's office to obtain data on completed suicides. 3. Develop workshops and training materials for direct care providers, interested parties and professionals based upon trends identified through use of local data.	1. Decrease in completed suicides.	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
18 Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	1. Decrease the frequency of problem gambling. 2. Increase number of clients engaged in gambling treatment, attending recovery support groups and obtaining a sponsor. 3. Increase in gambling prevention activities.	1. All TCMHRB contract agencies integrate problem gambling screening questions in their diagnostic assessment. 2. Promote activities to build public awareness regarding what is problem gambling and how to engage in services 3. Increase gambling treatment capacity 4. Integrate gambling prevention into all prevention activities	1. Number of certified gambling treatment providers 2. Units of gambling prevention provided 3. Number of clients in gambling treatment	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
19 Crisis services	See Priorities 01 and 17 [above]	See Priorities 01 and 17 [above]	See Priorities 01 and 17 [above]
20 Criminal justice–involved populations	See Priorities 05, 09 and 13 [above]	See Priorities 05, 09 and 13 [above]	See Priorities 05, 09 and 13 [above]
21 Families involved with child welfare	See Priorities 03 and 05 [above]	See Priorities 03 and 05 [above]	See Priorities 03 and 05 [above]

22 Prevention/early intervention across the life span	See Priorities 02, 08, 15, 17, and 18 [above]	See Priorities 02, 08, 15, 17, and 18 [above]	See Priorities 02, 08, 15, 17, and 18 [above]

Collaboration

5. *Describe the board's accomplishments achieved through collaborative efforts with other systems, people living with mental illness or addiction, family members, providers, 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?)*

As part of the Trumbull County Continuum of Care the TCMHRB continues to focus on collaborative efforts with various behavioral health systems, people living with mental illness, family members, providers, and/or the general public. For example; in the FY17 Community Plan two gaps in the Trumbull County Continuum of Care were noted. Firstly, ambulatory detox with a treatment focus specific to AOD opiates was not at that time readily available. Currently, however the services are being provided by two county board contracted providers; First Step Recovery and Meridian Healthcare, as well as by other service providers. Secondly, AoD Medication Assisted Treatment (MAT) specifically for opiates in conjunction with treatment was also unavailable in FY17 Community Plan. In order to remedy this dilemma with the support of the board a partnership was formed between Compass Family and Community Services and Meridian Healthcare. In addition a capital grant from OhioMHAS was sought and obtained to help pay for building renovations so additional services on the AOD treatment spectrum could be provided.

Highlighted below are a just a few of the Board's collaborative undertakings during the past two years:

<u>The Alliance for Substance Abuse Prevention (ASAP)</u> 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 prescription medications for nonmedical use by partnering with the Trumbull County Sheriff's office and TAG Law Enforcement Task Force on drug take back events (collecting nearly over 1 million pills in 7 years), and advocating for the installation and use of permanent medication drop off locations. There are currently 16 permanent medication disposal sites in the County, a 33% increase over 2 years. The Coalition also collaborates with the local public housing authority, Mobile Meals, and senior centers to provide Deterra

medication disposal bags to seniors and individuals with a disability. Over 1000 bags have been distributed in the past 1-2 years.

School-Based Programming One of the hallmarks of Trumbull County is its collaborative spirit. Examples of strong collaborative partnerships can be found in the school-based programming that TCMHRB funds and oversees, including Early Childhood Mental Health Consultation, school-based AOD Prevention Services, school-based Mental Health/Resiliency services, School Social Work, and PAX Good Behavior Game training. In FY2019 the Board funded ECMH services in twenty preschools and one elementary school. TCMHRB contracts with three provider agencies: Homes for Kids, PsyCare and Valley Counseling to provide the services. These agencies, along with several other early childhood entities meet monthly to review programming, share information and plan accordingly. The Children's Program Coordinator of TCMHRB facilitates these meetings. The Board also contracts with three provider agencies: Compass Family and Community Services, Homes for Kids and Meridian Healthcare to provide school-based AOD prevention services, Mental Health/Resiliency services and School Social Work. In FY2019 prevention staff and school social workers provided programming in 18 Trumbull County School districts. The Children's Program Coordinator also leads a monthly cross-system prevention meeting to review school-based services, barriers and needs. This past year, the prevention committee brought on some new community partners including Youngstown State University and OSU Extension. In Fiscal Year 2019 the Board also collaborated with five local school districts, the Trumbull County Educational Service Center and the Ross Griffin Memorial Foundation to fund PAX GBG trainings for over 120 Trumbull County educators.

Family Wraparound Another long-standing example of community collaboration can be found in the Trumbull County Family Wraparound program, an initiative of the Trumbull County Family and Children First Council that supports the complex needs of multi-system youth and their families. In State Fiscal Year 2019 there were nearly one hundred 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, twenty-five 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 provides cross-system Wraparound coaching, maintains Wraparound enrollment for the county and chairs the Family Wraparound Oversight Committee, a collaboration of the five agencies that provide Wraparound Facilitation, a Parent Peer Supporter and several other child-serving agencies. The Children's Program Coordinator has also been part of the Statewide Wraparound Coaching/Leadership Team for the past four years and has served as an ENGAGE Wraparound Coach, providing technical assistance and coaching to communities throughout the state.

Our systems of care are built on a foundation of behavioral health providers who are experts at providing clinical and supportive services for individuals within a vast range of mental health and substance use disorders. All behavioral health services thought to be essential for recovery are in place in our community and are utilized with great success. This range of services includes numerous evidence-based and best practices including: supported employment, counseling, psychiatric, 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 crisis sheltering, prevention, housing assistance, recovery housing, and other services, which enhance and magnify the impact of treatment and clinical care.

The issues that continue to face 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 micro-system 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. Community treatment plans are put in place so that entities use the same clinical protocols that will be most beneficial to those clients with the highest and most challenging needs. Monthly agency director meetings are held where systems information is shared and Director level communication ensured. It is well understood within the community that Trumbull County providers are known for positive working relationships with each other and with the board. Because of great the collaboration and constant communication that takes place between entities any needed gaps may be filled as well as any duplications in services discovered.

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 Behavioral Healthcare Center and 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 FY2017 *Annual Report* listed our community partners in two categories:

<u>Contract Agencies</u>

Coleman Professional Services
Compass Family and Community Services
Forensic Psychiatric Center of NE Ohio
First Step Recovery
Travco Behavioral Health
Glenbeigh

Greater Warren-Youngstown Urban League -Christy House
Guardianship and Protective Services
Heartland Behavioral Healthcare
Help Network of NE Ohio
Homes For Kids/Child and Family Solutions, Inc.
Mercy Health
Meridian Healthcare
Neil Kennedy Recovery Centers
ONE Health Ohio
PsyCare, Inc.
Ravenwood Mental Health Center
The Salvation Army
St. Joseph's New Start Treatment Center
SUMMA Health System
Trumbull Regional Medical Center
Valley Counseling Services

Community Partners

Area Agency on Aging 11
Belmont Pines Hospital
Catholic Charities Regional Agency
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

The Trumbull County Suicide Prevention Coalition has had a very strong resurgence with multiple collaborative partners as we work to decrease the number of suicides in Trumbull County. We have a very strong ongoing relationship with our Coroner's office, which provide us with the most up to date information available as to the suicides of our residents. With this information, we have been able to strategically plan our prevention activities based upon the demographics of those persons who completed suicides. Based upon this information, we have engaged in the "ManTherapy" marketing campaign with billboards, coasters, posters, magnets and information sheets. We can then retrieve data as to the number of persons in our county who have accessed the website. In addition to this marketing campaign, we have also been working with local law enforcement, pawn shops, gun ranges, CCW instructors and the community in a gun lock campaign. We are the first county coalition nationally to request and obtain gun locks directly from the National Shooting Sports Foundation, the same organization that developed the "Project ChildSafe". We have developed cards attached to the gun locks and pass them out to whoever has a gun(s) without locks. We will give (for free) as many locks as the person has guns. To date, we have distributed over 600 gun locks throughout the county and we've also had donations for gunlocks from our local sheriff as well as from local police departments. We are also distributing the Crisis Text Line information to local schools, organizations, agencies, parents, etc.

Our wonderful collaborative partners in our coalition currently include Coleman Behavioral Health who serves as Chair of the coalition and is also a recipient of the Zero Suicide grant. In addition, we have active members from the local library, air base, mental health and substance abuse disorders agencies, local general hospitals and private psychiatric hospitals, and police.

Inpatient Hospital Management

6. *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.*

As documented in question 2d, the utilization of the state psychiatric hospital has decreased significantly and this trend is expected to continue into the future. When there are admissions to the state psychiatric hospital, the community, board and hospital staff work collaboratively in order to develop the most appropriate discharge plans possible. With the current part time involvement of a state hospital liaison funded by the TCMHRB, communication between the community and the hospital has also been fairly seamless.

Also as documented in 2d, the decrease in state hospitalization has been experienced due to the local hiring of a psychiatrist who had been the chief medical director at Northcoast Behavioral Healthcare, so he is a strong advocate of keeping residents locally hospitalized. In addition, the opening of Generations Healthcare has also assisted in the decrease of state hospitalizations. Our local providers work hard to collaborate and partner with our local inpatient programs to provide the most appropriate levels of discharge care. The TCMHRB facilitates a community meeting twice a month with community partners and local psychiatric hospitals to better plan for and provide community based services for our highest acuity clients. We have built a really good system of communication with most of our partners and we are working on building that same type of partnership with Generations Healthcare, as they have recently hired a clinical director who has worked with our community and understands our system. Some of our major hurdles have been related to Generations Healthcare and their lack of communication and poor discharge planning.

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	Identifier Number	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	Identifier Number	SERVICE	ALLOCATION

Community Plan for the Provision of Mental Health and Addiction Services SFY 2019-2020

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

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

Trumbull County Mental Health and Recovery Board

April J. Caraway, Executive Director — Date: 7-16-19

Thomas H. Harwood, Board Chairperson — Date: 7-16-19

[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 2019 -20 Community Plan Essential Services Inventory"

Attached is the SFY 19-20 Community Plan Essential Services Inventory. **Each Board's completed SFY 2018 form will be sent in separate email should the board want to use it to update information.**

The Essential Services Inventory form included with this Community Plan requires the listing of services for which the board may not contract. This element is necessary due to current Ohio Revised Code to detail the behavioral health (BH) continuum of care in each board area.

Some additional Continuum of Care (CoC) information resources have been provided below to assist in this process, but board knowledge is vitally important given the limitations of these included CoC resources. For example, the attached resources may 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 goal is to provide a complete listing of all BH providers in the board area. However, at a minimum, at least one entity must be identified for each essential service category identified in Column A of the form.

In addition to the identification of the Essential Service Category, the spreadsheet identifies the treatment focus (Column B) and Service Location (Column C) of the service as required in Ohio Revised Code. The fourth column (Column D) provides a list of the Medicaid and Non-Medicaid services associated with each of the Essential Service Categories.

In Column E, please identify the Names and Addresses of providers who deliver the Column D Medicaid/Non-Medicaid payable services associated with each Essential Service Category and in Column F indicate by "Y" or "N" whether the Board has a contract with this agency to provide the services.

Additional Sources of CoC Information

1. **Emerald Jenny Treatment Locator** https://www.emeraldjennyfoundation.org/
2. **SAMHSA Treatment Locator** https://www.findtreatment.samhsa.gov/