Ohio Department of Mental Health and Addiction Services (OhioMHAS)

Community Plan Guidelines SFY 2021 and 2022

Enter Board Name: ADAMHS Board of Tuscarawas and Carroll Counties

The following template will help organize the required information needed to complete the SFY 2021-2022 Community Plan. This template has been organized and streamlined to assist in the creation of a forward-looking Community Plan with a focus on identifying community priorities. These community priorities should be identified via a needs assessment process and tracked to determine success in addressing the stated priorities.

Evaluating and Highlighting the Need for Services and Supports

1. Describe the community needs assessment process that led to the identification of the local priorities the Board will address. 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 evaluating needs, evaluating strengths and challenges and setting priorities for treatment and prevention for SFY 2021-2022. [ORC 340.03 (A)(1)(a)].

The ADAMHS Board consistently gathers data regarding needs, strengths, and challenges related to the behavioral health system. One of the benefits of working in small communities is the relationships that are built across systems leaders, including courts, Job and Family Services, Developmental Disabilities, law enforcement, schools, faith-based groups, recovery groups, hospitals and other first responders. When there is a concern related to the behavioral health field, these relationships lead to open and easy collaboration to discuss the issue as well as potential solutions. An example of this informal collaboration and needs assessment is the recent concern related to a potential increase in suicides in Tuscarawas County. An increase in suicides was suspected by our LOSS team leader at the beginning of the pandemic. She reached out to this director which prompted a call to the local coroner's office and hospital for additional data. This also led to a collaboration with local EMS as well as 911 dispatch. The immediate response to what could have become a trend prompted the resurgence of the suicide prevention coalition, a strategic planning event to impact suicide, daily 911 reports of suicide attempts being shared by 911 dispatch, and community outreach efforts to increase awareness of warning signs, decrease stigma, and ensure the community was aware of how to access help for themselves and a loved one. This initiative was necessary regardless but the timing of it was specifically impacted by the quick need identification and system responsiveness.

Smaller communities also lead to the same system leaders consistently attending the same collaboratives and task forces. The frequent and open communication in these meetings plays a significant role in looking outside the behavioral system walls and determining how our services are impacting other initiatives and needs in the social services realm. Often momentum is gathered during these collaborative discussions related to a topic that leads to a behavioral health initiative. For example, a strategic plan was completed at the Carroll County Family and Children First Council. One of the issues that came to light was the hesitation of residents to initiate treatment services for themselves or their children due to stigma related to behavioral health. This prompted a small subcommittee to be formed to impact stigma reduction in the rural community.

The efforts, opportunities, and messaging to decrease stigma in Carroll County were not only different from larger urban communities, but also different from what would be presented in Tuscarawas County and are being developed with input from multiple sectors including faith-based representation, consumer/family representation, and other non-traditional system partners.

As stated in the previous community plan, with the development of the Quick Response Team (QRT) and under the supervision of the Opiate Task Force (OTF) which is chaired by the ADAMHS Director, there has been significant improvement in data access. The lead EMS staff on the QRT has been diligent in collecting age, gender, location of overdose, drug, and other data to guide the efforts of the team as well as the Opiate Task Force. This data is used to develop a "heat map" that identifies the locations in Tuscarawas County, including the specific streets where most overdoses are occurring. Using the data again as we have seen overdoses increase in Tuscarawas County over the past six months returning to the epidemic level of 2017, the OTF is revisiting outreach efforts to these specific areas. These efforts include education to motel management and staff; Project Dawn/opioid overdose reversal kits being shared at motels, stores, and with the public; Deterra drug deactivation bags being shared widely and at drug take-back days; resource signage at targeted locations. These data-driven initiatives are in addition to other OTF efforts including targeting ease of access into the SUD system and exploring opportunities to increase the number of certified peer supporters in both counties.

There also continues to be ongoing work in both Tuscarawas and Carroll Counties to ensure that adults with a Severe and Persistent Mental Illness (SPMI) have a continuum of care that both intervenes prior to a crisis but also wraps around an individual following a crisis. A local police captain, who is also an ADAMHS Board member, developed a local Mental Health Collaborative that looks at the Tuscarawas County crisis intervention process from law enforcement involvement to release from hospitalization. This committee involves a representation of the different systems that touch an individual in crisis to review the current process of identification and intervention and identify opportunities to improve. The committee developed and implemented a Care Plan for individuals with an SMPI who either have had law enforcement involvement in a crisis or who have been hospitalized. Case managers discuss with clients the option of completing the Care Plan which, with the individual's consent, has demographic information, brief medical information, and information the consumer would want law enforcement to know if he or she approached the person in a crisis. The goal of the project is to empower the consumer and encourage him or her to give law enforcement the information to help de-escalate a situation and keep all safe. The development of this collaborative and changes to the crisis assessment process has also led to the implementation of mobile crisis in FY 21. This resource was ceased in FY 2009 due to funding cuts. The community, especially law enforcement, has been requesting the option be revisited. Due to a number of factors, including the crisis infrastructure development dollars from OMHAS, the provider is beginning a soft roll out of mobile crisis response the first quarter of FY 21.

In addition to the non-formal information needs assessments, the ADAMHS Board is also an active member of the community health assessment teams in both counties. Both Tuscarawas and Carroll Counties independently complete community health needs assessments (CHNA) and more recently have included behavioral health questions to assess the mental health and substance use needs of their children and adults.

These assessments then lead to the development of the community health improvement plan. In both counties, mental health and addiction service needs were identified as top priorities and the plans were developed to address.

a. If the Board's service and support needs were determined by the Board Recovery Oriented System of Care (ROSC) assessment, how will these identified service and support needs be addressed by the Board?

Recovery Oriented System of Care, or ROSC, has been called the "BluePrint for Ohio's Community Mental Health and Addiction System" and is a five-year plan for moving Ohio's mental health and addiction system from one that focuses on acute care to one that focuses on recovery management to help individuals get and stay well. This framework targets prevention and treatment services as well as recovery supports that are all focused on getting the individual and his or her family into recovery, while helping him or her integrate into the community and workforce.

The ROSC has the following five principles at its core:

Focusing on the clients and families
Ensuring timely access to care
Promoting healthy, safe, and drug-free communities
Prioritizing accountable and outcome driven financing
Locally managing systems of care

As shared in the last Community Plan, ADAMHS Boards completed a ROSC survey with local stakeholders in September 2018. This was the Boards, providers, and communities first introduction to ROSC principles. The ROSC survey assessed the impact of the five core principles in each county from the perspective of the Board; People in Recovery; Providers; and Stakeholders. There were 28 respondents from Tuscarawas County and 8 respondents from Carroll County.

	Tuscarawas	Carroll	Combined	Ohio
Number of Participants	28	8	36	2822
Overall ROSC Score (Avg)	4.70	3.86	4.51	4.58
Focus on Clients & Families	4.77	4.14	4.63	4.78
Timely Access to Care	4.70	4.11	4.57	4.68
Healthy, Safe, & Drug Free Communities	4.74	3.56	4.48	4.45
Accountable Financing	4.71	4.23	4.60	4.49
Systems of Care	4.56	3.53	4.33	4.44

Over the two years since the administration of the survey, the ADAMHS Board staff has worked to increase and strengthen collaboratives and partnerships in the community including: being elected as the Chair of the to the Carroll County Family and Children First Council; chairing the Stigma Reduction subcommittee; and partnering through program development and funding with the Carroll County Court of Common Pleas, Carroll County Municipal Court, and Carroll County Job and Family Services to develop a SOR-funded court-based navigator to ensure individuals seen in court have a direct link to treatment services. ADAMHS is also working

with the Carroll County Sheriff's Office to implement tele-psych services in their jail and maintain the option of MAT induction prior to release from incarceration for individuals with an opiate addiction.

Beginning in January 2019, ADAMHS staff began quarterly Behavioral Health Meetings with administrators, mid-level managers, providers, directors, educators, law enforcement, and other community stakeholders to discuss any concerns, questions or needs related to the behavioral health field and collaboratively develop a plan to address. These meetings have been incredibly beneficial not only to ensure the partners in Carroll County are aware of all agencies and services but they have lead to increased partnerships both within the sytem of care and with other non-traditional providers. This has also allowed ADAMHS to have an ongoing pulse on the changing needs and struggles for community members as well as system providers.

The roll-out of the Student Wellness dollars also increased the collaboration within the counties but especially in Carroll County. Carrollton schools are planning to develop a healthcare option for their students using a portion of this funding. The lead to a partnership between ADAMHS, the local community mental health provider which is also an FQHC, as well as the Carroll County Health Dept. While COVID has impacted progress toward this goal, the initiative will be revisited as things continue to return to baseline.

There has also been an increase in the services offered by two of the provider agencies in Carroll County, CommQuest Inc., and Southeast, Inc. CommQuest, who has a satellite location in Carroll County, increased their clinical and case management staff to provide increased access to services for all residents but specifically targeting the newly developed felony drug court. In FY 21, CommQuest will also begin telehealth services at the jail. In the past, a clinician provided services in the jail but this option ended when the clinician retired. To allow this to continue and in light of the pandemic, telehealth suites were purchased for the Carroll County jail to provide inmates with a SUD or MH disorder the option of connecting to services prior to release from incarceration. In addition, CommQuest staff, as well as the ADAMHS Director, participates in the Drug Court Advisory Committee which meets quarterly and reviews both the experience of the participants in accessing local resources but also takes a more global look at the SUD system of care.

Southeast, Inc., which has offices in both counties, has also increased their service delivery including the implementation of additional psychiatry time as well as a psychiatric provider that is able to work with the youth of Carroll County. Historically it has been incredibly difficult for Carroll County children to access psychiatric care in a timely manner. Often they would travel out of county after waiting months to receive this level of care. These developments are especially significant as new or expanded services of the Carroll County system of care have been difficult to develop and sustain. The primary reasons for this are lack of BH levy funds in Carroll County to support program expansion; the population size which impacts the ability to maintain a new program once it is developed due to attendance; and the hesitation of community members to seek out behavioral health services due to stigma.

In the most recent survey, Tuscarawas County respondents indicated satisfaction scores that were as high as or higher than the cumulative state averages, with the highest score focusing on client and family. The focus on client and family is defined as healthcare being most effective when delivered and based on the needs and values of individuals receiving care. According to this score, individuals and families are seen as driving the services they receive in their local communities. The lowest score in the Tuscarawas County responses is systems of care. This is the same as Carroll County. As indicated above, the system of care category refers to "healthcare that is designed and managed locally." In looking more in-depth at the System of Care items that scored the lowest in both counties, areas of concern are:

the employment of peers to strengthen or develop new programs and services;
peer-run leisure activities are available and supported;
managed care can assist in care management over the full continuum.

Developing the peer support system continues to be a work in progress. There has been an increase in the number of certified peers over the course of the last biennium. Ohio START, the peer collaborative between the behavioral health system and Job and Family Services, is functioning in both Tuscarawas and Carroll Counties as of FY 21. The peer providing this service was an ADAMHS Board member previously but left the Board to serve in the certified peer capacity. Active peer support also continues at the ORH certified recovery residence in Tuscarawas County. In addition, the local consumer operated organization (CSO) as well as one of the local treatment providers have found new and innovative ways to utilize peer support. The peer supporters at our CSO have played a vital role in the support and outreach to adults with SPMI during the pandemic. From operating online support groups, to outreach phone calls, to the creation and drop-off of care packages to individual's homes, the CSO peer supporters deserve much credit for their efforts during this time to support our residents with an SPMI that may feel isolated and increasingly symptomatic during quarantine.

An innovative approach to using certified peers being developed in response to our increasing overdose deaths. As a result of recent planning, a certified peer is connecting with the drug enforcement detective in the city with the highest overdoses to initiate communication and determine how they can collaborate. The peer and her supervisor will also be approaching the ED to discuss her on-call/on-site presence when an individual is brought in due to an overdose. This peer, who is also a member of the Quick Response Team, will do additional phone outreach to those that have overdosed as well as their families. She will offer Project Dawn kits and ensure there is a connection to services if the individual is willing.

2. Considering the Board's understanding of local needs and the strengths and challenges of the local system, please identify the Board's unique priorities in the area provided on Page 2. Please be specific about the chosen strategies for adults, children, youth, and families and populations with health equity and diversity needs in your community. OhioMHAS is still interested in any RecoveryOhio priorities Board areas my be addressing.

   Please address goals and strategies for any gaps in the Ohio Revised Code required service array identified in ORC 340.03(A)(11) and 340.033.

   Identify at least one measurement indicator, and subsequent baseline data, that will be used to track progress towards meeting the identified priority(ies).

   Information on the priorities for the ADAMHS Board of Tuscarawas and Carroll Counties is included in the chart below per this guidance.

3. Describe all environmental factors that influenced the identification of the chosen priorities within the Board area. Factors could include: economic, social and demographic factors, transportation, unemployment, uninsured/underinsured population, poverty rates, housing availability, incarceration rates, etc. Note: Regarding current environmental factors, Boards may describe the continuing impact of Behavioral Health Redesign including Medicaid Managed Care carve-in.

Many factors can influence the provision and availability of services and supports in a given area. Over the past 2 decades, reductions in state funding led to difficult local decisions affecting the availability and composition of both critical, traditional treatment options, as well as effective non-traditional interventions. For example, elimination of ODMH Safety Net funding threatened the continuation of the robust crisis intervention and stabilization system in place since the 1980s. Fundamental changes in where and how interventions were able to be handled destabilized a critical local service, causing concern and frustration among the community partners who act as referral sources. Law enforcement, courts, treatment agencies and homeless assistance providers struggled with the changes the funding reductions necessitated until all became familiar with the new normal. The board area is again experiencing change in the crisis delivery system as new players emerge and roles in the community shift. The board is moving proactively to address these new changes in an efficient and expedient manner.

The cultural diversity of the Board area adds another complicating layer to the processes of gap analysis, service planning and the respective delivery systems. There has historically been a sizable Amish community in western Tuscarawas County in addition to a growing Hispanic population attracted to jobs and opportunities in the area. While the Amish population had in the past tended to address concerns within their communities, Amish integration into the broader social and work-related communities has caused an increase in behavioral health system involvement due to referrals from local law enforcement and court. With many of these individuals not being covered by traditional healthcare coverage, more intensive treatment options become limited without significant financial backing from the Board. These concerns are mirrored in the Hispanic community. Complicating factors like cultural and language barriers exacerbate the effects of mental illness and addiction. An additional factor is that at times Hispanic individuals in a behavioral health crisis are undocumented immigrants. This severely impacts the available resources when the individual in need is not eligible for benefits.

Being an Appalachian area of Ohio, the employment in the catchment area centers on agriculture, mining, and manufacturing. The majority of our population over the age of 25 works in blue-collar, health care, or agricultural jobs, with 15.1% of Tuscarawas County residents and 12.3% of Carroll County residents receiving a bachelor's degree or higher. Despite this, 12.8% of Tuscarawas County residents and 13% of Carroll County residents live in poverty. These numbers, which are higher than the national average, have led to another wide-ranging issue facing the board service area: the availability of safe, affordable housing.

The ADAMHS Board began taking a more active role in permanent supportive housing for BH consumers beginning in 2011 with the administration of a HUD Shelter+Care grant. Since that time, the board has increased funding for two transitional housing programs, received an additional HUD CoC grant for 21 additional PSH units, and expanded the Housing Assistance Program to help fill gaps in market rate housing for BH clients. Unfortunately, rent amounts continue to increase. Buoyed by a drastic rise due to gas and oil activity in the area, rents never returned to their pre-boom levels. This has put a financial pinch on clients who rent without assistance, while also reducing the number of people the board can subsidize. While requiring HUD Housing Quality Standards for participants in the two HUD funded programs helps to ensure a basic level of safety when clients enter the programs, maintenance of these units at these levels by landlords remains a struggle.

Behavioral Health (BH) Redesign continues to impact the local delivery system in a number of ways. Licensing requirements that led to an increased need for independently licensed providers with

supervisory credentials statewide remains a concern at all local provider agencies. Qualified clinicians routinely leave smaller communities for opportunities in larger cities that can pay at higher rates. Some local agencies have had staff openings for over a year while looking for qualified candidates. The increased regulations and detailed guidelines of BH Redesign also caused some agencies to require a large amount of support from outside sources in order to meet BH Redesign standards. With little budgetary room to absorb those costs, these expenditures fell back to the Board, again reducing available resources for treatment.

Although behavioral health redesign was long overdue and created additional opportunities for our consumers, it has placed an additional financial burden on the Board and made some services difficult to provide in our service area. For one example of this additional financial strain, we need only to look again at the provision of crisis services. With behavioral health redesign came a significantly lower reimbursement for this service and our providers are unable to account for the cost difference and rely on the Board for additional subsidies. Our sole local private ambulance provider no longer accepts Medicaid for behavioral health transports, due to the reimbursement not covering the cost of the service, resulting in total cost of each transport billed to the Board. This has increased our ambulance reimbursement costs by 70%, thereby decreasing dollars for other services. Efforts have been made and continue to take place to reduce the cost of ambulance services; however, community partners are unable to assist as there are no mental health facilities in our two Counties and hospitalization distances range from 30 miles to 122 miles one way.

Psychological testing was also a service that our local contact treatment providers were forced to discontinue due to significantly reduced rates. As a Board, we will continue to work with our local providers and evaluate our crisis services process and look for opportunities to expand the service and reduce the additional subsidies to keep the services available.

Medicaid Managed Care Carve-in has been met in the community with additional financial burden on the local system, as it is now responsible to pick-up where Medicaid had traditionally covered. The Board continues to bear the burden of underfunded SUD Residential Programs for Medicaid recipients. While programs had traditionally run for 90-120 days, many are now being cut-off at 60 days by the Managed Care entities. This has resulted in treatment providers seeking alternative treatment methods or funding to meet the needs of these individuals. Recidivism rates are increasing as managed care companies are authorizing shorter stays. Providers are unable to utilize the full program because clients are no longer approved at that level of care. As a Board, we attempt to provide funding for extended stays, thereby reducing available resources.

4. Describe any child service needs resulting from finalized dispute resolution with county Family and Children First Council(s) [340.03(A)(1)(c)].

There have been no disputes filed in either Tuscarawas or Carroll County Family and Children First Councils.

5. Describe how the future outpatient service needs of persons currently receiving inpatient treatment in State Regional Psychiatric Hospitals [340.03(A)(1)(c)] are identified.

The outpatient service needs for the residents of Tuscarawas and Carroll Counties include appointments for individual therapy, IOP (if applicable), psychiatric consults, case management,

transportation, medical coverage, housing, primary care and dental care. Our local community navigator, employed by the prescreening agency, serves as a bridge between the hospital and the community. Discharge planning is worked on during weekly contact with hospital social work staff. Prior to COVID restrictions, the Navigator would go to the hospital and meet with those individuals that are inpatient from our counties and also assisted with scheduling outpatient and psychiatric appointments upon discharge. With COVID restrictions, the Navigator communicates weekly by phone with hospital social work staff to address the needs of the hospitalized individuals. The Community Navigator and the ADAMHS Manager of Community Services complete monthly phone calls with hospital staff to prepare and plan for those on-roll. These two roles also host a Community Treatment Team for those individuals who need wraparound services within the community to address identified needs or concerns brought to the team by the community and/or individual. In Tuscarawas County, we have seen the addition of a Federally Qualified Health Center (FQHC) that offers primary medical and dentistry for those in Tuscarawas County and surrounding areas. We also have Bridges to Wellness which is a program that has community health workers who can link individuals who have medical and social barriers to resources in Tuscarawas County.

The needs above are standard for those needing outpatient services; however, transportation is perhaps the largest barrier for those residing in our two-county region. We do not have a public transportation system in either of our counties. Often, individuals do not have a reliable vehicle or the funds for fuel. If the individual receives Medicaid, there is an option for transportation for Medicaid covered appointments through our local Job and Family Services agencies. However, they must have access to a phone to set up the appointment and to be reached if there is an issue.

Food insecurity continues to be a large issue within our communities. There are available food pantries, but if an individual lives on the outskirts of either county then the barrier to utilization is transportation. During COVID, there has been increased awareness and availability through our local food pantries, school districts, and senior centers for food pick up and with some delivery options.

Another barrier for an individual is finding appropriate housing especially if they do not have the funds for the first month's rent and deposit. We do have a local homeless shelter, but it is often at capacity. During COVID, the capacity has also had to be decreased due to the social distancing and isolation requirements. An individual can apply for a Metropolitan Housing voucher, but the list will be closed in Mid-August 2020 and those on the waitlist will wait over a year to obtain one. The Board currently operates two HUD-funded permanent supportive housing programs, but individuals need to be documented as homeless to be considered for these programs. The Path transitional housing program serves as a step-down directly from the state hospital or out of the crisis unit to provide clients 60-90 days of rent-free transitional housing, giving them the ability to concentrate on outpatient treatment and obtaining some type of income in order to transition back into the community. The Board also has the HAP Program that can provide one-time deposit and first month's rent for a market-rate apartment if the individual does not have another source for this. The Board has also used Crisis Flex funds to assist in situations where first month's rent and deposit is needed to get an individual into an apartment quickly.

There are times when individuals with a behavioral health diagnosis have contact with local law enforcement agencies for criminal issues. We have supported CIT training in our communities to

provide advocacy and de-escalation during these incidents. We have a strong CIT training curriculum that is offered annually to our local law enforcement agencies and first responders.

Board Local System Priorities (add as many rows as needed)			
Priorities	Goals	Strategies	Measurement
1. Crisis Services	Ensure an efficient, supportive, and collaborative crisis intervention response. This involves inclusion of new partners, strategies, and tools that are scalable and easily modified to meet the demands of rapidly changing social and community norms.	Convene a working group of community partners to assess existing and emerging crisis intervention options in the community and identify gaps as they currently exist. Begin closely tracking crisis interventions based on time-of-day and geographic locations of on-site and site-based responses in order to quickly initiate needed adjustments as quickly as possible. Work to develop and sustain mobile crisis response	Measurement indicator: Implementation of mobile crisis and data collection related to these responses Baseline data: there is currently no mobile crisis response Target: 25 individuals will receive a mobile response in FY 21
2. Housing Services for Individuals with a Behavioral Health Diagnosis	Ensuring existing housing is maintained and explore additional housing opportunities.	Maintain existing funding streams that ensure existing Permanent Supportive Housing, Transitional Housing, Housing Assistance Programs, and Group-Home Support. Continue building and expanding relationships with local landlords and housing providers by providing major-incident intervention options in an effort to help tenants retain housing and housing assistance.	Measurement indicator: The number of housing units Baseline data: Current Target: The number of units will be maintained and opportunities to expand will be explored.
3. Suicide Prevention	Stabilize and Expand suicide prevention efforts and survivor support options.	Engage local treatment professionals as well as traditional and non-traditional peer-supporters to develop a meaningful and effective intervention and survivor support system. Work with leaders in the local agri-business community to address the unique challenges facing the farming and agriculture populations. Engage youth-concentrated and youth-led organizations for strategies to communicate suicide prevention messaging in relevant ways.	Measurement indicator: Suicide Prevention Activities Baseline data: The Coalition is currently redeveloping Target: A strategic plan will be created for the next 12-24 months directing prevention activities
4. Mental Health Stigma Reduction	Establish a robust and comprehensive mental health stigma reduction campaign in an effort to normalize mental health treatment with a goal to reduce incidents of self-harm and increase treatment for chronic mental health conditions.	Utilize existing Public Relations efforts to develop a wide-ranging multi-platform media campaign equating access to mental-health treatment with access to physical health treatment.	Measurement indicator: Public Relations/Stigma Reduction efforts Baseline data: While the Board is constantly doing PR, a targeted campaign has not been used

			Target: Implement a targeted stigma reduction campaign.
5. Workforce shortage	Increase provider workforce	Explore the potential of an LSW program at Kent State University Tuscarawas Ensure Health Professional Shortage Area Designation is maintained as long as eligible. Support agencies and clinicians in the HPSA tuition repayment program by developing a process and training for provider agency staff Explore potential tuition reimbursement opportunities with Ohio Means Jobs	Measurement indicator: the development of a BH degree at a local or online university Baseline data: There is currently no program connected to Tusc-Carroll Counties Target: Discussions with the local KSU branch will lead to the development of an LSW program at the regional campus.
6. Building resilient children and families	Provide leadership in assessing and addressing gaps in youth and family prevention and wellness programs.	-Develop at trauma-informed community, targeting the PAX evidence-based model in the community and interested school systems -Continue to strengthen communication and collaboration with school systems to address the behavioral health needs of their students, including scheduling a one-on-one meeting with each superintendent and his/her team during the biennium -Work collaboratively with the CHIP subcommittees, Family and Children First Councils, and community partners to develop programming that addresses child and family resiliency skills and protective factors	Measurement indicator: k-12 Prevention Action Plans Baseline data:K-12 Prevention Action Plans Target: Schools will reach goals identified on their action plans and report this progress on the implementation report.

6. Describe the Board's planned collaborative efforts with other systems, people living with mental illness or addiction, family members, providers, and/or the general public for SFY 2021-2022 that will be needed to implement funded priorities. (Note: Highlight collaborations needed to 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?)

One of the most impactful strengths of the catchment area are the partnerships and collaborations across the systems of care and with the constituents including peers and family members. Over the course of the past decade, there has been a noticeable shift in the understanding of the population served by the behavioral health system. Factors that impacted this shift were the implementation of Crisis Intervention Team (CIT) training; panel discussions with those in recovery for EMS and LE to not only increase their understanding of mental illness but also allow them to see consumers when they are not in a state of crisis; the work of SUD prevention and intervention taskforces as well as a memorial committee lead by the mother of a son who died of an overdose; the inclusion of BH questions on the Community Health Improvement Plan (CHIP) which normalized BH by placing within a physical health assessment but also illustrated to the community the extent that BH concerns are widespread across the counties; the roll out of TIC and PAX tools to the school systems; various presentations by ADAMHS Board staff that not only review the role of the Board but also destigmatize behavioral health; the developing podcast series called Break the Stigma with individuals recovering from behavioral health concerns; grant like State Opioid Response which has provided for program development that has led to strong partnerships with both Carroll County courts also the Tuscarawas County jail system; among others.

These opportunities have expanded our partnerships across both counties and impacted how our partners view and discuss behavioral health. This has helped to foster attendance with non-traditional partners at meetings designed to achieve behavioral health initiatives. These partnerships are explained further below and are connected to the priorities identified above.

1. Crisis Services

Partnerships connected to crisis services has been expanding over the last 5 years and include collaborations related to the development of CIT programs; jail-based MAT in both counties; jail-based crisis services and assessments; crisis assessment and placement collaboratives with Cleveland Clinic/Union Hospital and Community Mental Healthcare to ensure the ease of access to crisis services and the sharing of medical and BH information to facilitate appropriate and expedient hospitalization; the adult and youth Community Teams designed to identify and impact high risk, high need youth and adults and wrap services around them to prevent decompensation or ensure planned step-down from a higher level of care. The Community Care Teams are made up of representatives from our provider network, local hospitals, emergency management services, Job and Family Services, Board of Developmental Disability, law enforcement, and social service providers. The partners participate in the presentation of a case and identify resources within their systems to help stabilize an individual and prevent crisis. In addition, the Crisis Care Collaborative continues to meet and has reviewed access to crisis care. This committee developed a pre-crisis plan to be completed by the client and provider that identifies signs of decompensation in the individual, guidance regarding triggers for escalation, and suggested methods of de-escalating a situation if the individual is in crisis, e.g. a support person's name and number. The client participates in the creation of this document that is then put in the 911 database. If law enforcement or

EMS approaches a client in crisis, data from this document is shared by 911 dispatch and the client's written requests can help guide the interaction.

Beginning in the first quarter of FY 21, mobile crisis is returning as a service in Tuscarawas and Carroll Counties. The local community mental health center has been in collaboration with law enforcement and the local emergency department to resurge this resources that has been missing from the catchment area for over a decade. It is hoped that the on-site assessment and potential planning for those that can remain safely in the community or crisis unit will reduce the trauma of transport to hospital and placement in a psychiatric facility since the client will be first seen in his or her home environment.

2. Housing Services for Individuals with a Behavioral Health Diagnosis

The development and maintenance of local federally funded housing programs began in July 2006 with a HUD Shelter + Care project. Originally administered by Tuscarawas Metropolitan Housing Authority, the ADAMHS Board assumed control of the grant in 2011. Over the course of the past 10 years, the board increased the original 23 vouchers with an additional grant for 24 vouchers. Referrals for these programs must come from local homeless and domestic violence shelters as a requirement for program eligibility. Through negotiated reduced rent amounts with local landlords, collaborations with Tuscarawas MHA, the local shelters and service providers, as well as other efficiencies, the board has been able to realize an average of 62 assisted units with these grants. Assurance of continued availability of these HUD PSH grants is maintained through consistent monitoring of program participants in coordination with local service providers, attention to concerns of participating landlords, and adherence to recommended outcomes. These efforts factor into annual rankings of all HUD funded projects in Ohio. The ADAMHS Board PSH programs typically rank within the top 25% across the state.

Though the Tuscarawas TRA and Recovery Begins at Home PSH Programs make up a large majority of the ADAMHS Board housing system, the Board has also addressed identified gaps in the local housing continuum that can affect the success of these and other housing programs. The ADAMHS Board HAP (Housing Assistance Payment) Program utilizes discretionary funding to help service-connected individuals with one -time costs related to securing market-rate or voucher-assisted housing, such as security or utility deposits, back-due utility bills, moving expenses, pest control, or other approved costs that helps remove barriers to safe, secure long-term housing. The Board works closely with BH treatment agencies as a referral source and partner to ensure resources are allocated responsibly and effectively.

Finally, the ADAMHS Board has maintained a close working relationship with a local landlord to master-lease two multi-unit apartment complexes in both Tuscarawas and Carroll Counties to provide low to no cost, short term transitional housing for individuals exiting a more restrictive level of care, such as a state hospital, SUD residential treatment facility, or crisis stabilization unit. Participants may also be leaving a living situation that is exacerbating their mental illness or threatening their sobriety in such a way that immediate access to transitional housing is necessary. All participants are expected to maintain a supportive services plan with a local service provider, and must meet regularly with ADAMHS Board staff to develop a long-term housing plan.

3. Suicide Prevention

Suicide Prevention efforts have continued in Tuscarawas and Carroll Counties since the inception of the Suicide Prevention Coalition and LOSS Teams in 2009. Ongoing efforts include the survivors of suicide support groups; youth and adult Mental Health First Aid; QPR (Question, Persuade, Refer) training as well as social and print media outreach. Community partner participation dwindled over the last few years. Primarily this can be attributed to the shift of focus toward the opiate epidemic which hit both Tuscarawas and Carroll Counties at an alarming rate. Prior to COVID, Tuscarawas and Carroll Counties were seeing the lowest opiate overdose and death rates since 2016. (These numbers have since skyrocketed in the midst of the pandemic and are being addressed by the Opiate Task Force, Anti-Drug Coalitions). Knowing that we needed to return attention to suicide prevention efforts and strengthen our prevention approach, this ADAMHS Director approached a local BH manager who agreed to lead the redevelopment of the Suicide Prevention Coalition. These began with a collaboration and sharing of resources with the Ohio Suicide Prevention Foundation. The next step was a strategic planning event that involved: law enforcement including the local sheriff; treatment providers; school counselors; representatives of the Educational Services Center; Tuscarawas County School Counselors Association; Family and Children First Council; the coroner; the director of the local consumer operated organization; NAMI representation; and ADAMHS. A strategic plan was developed from this collaborative including the following mission statement that will guide the Coalition's activities:

The mission of the Suicide Prevention Coalition is to reduce the stigma of mental health, provide emotional support, education, assistance, and intervention as necessary to all persons in crisis and those impacted by them, with the goal of reducing suicides and self-destructive behaviors.

4. Mental Health Stigma Reduction

Partnerships related to stigma reduction have taken on both active and passive roles. For example, the local NAMI branches which are funded by ADAMHS also prioritize efforts to destigmatize behavioral health. The Manager of Community Services at the ADAMHS Board is an active participant on the NAMI Board and works collaboratively on their initiatives.

Carroll County Family and Children First Council also see stigma reduction as a priority in the community as it impacts willingness to seek services. The Carroll FCFC has created a subcommittee chaired by the ADAMHS Director to develop a plan to reduce stigma through environmental strategies. The committee is researching stigma reduction approaches that would be appropriate for the rural setting, including those that would target the agriculture community. The willingness of the Carroll County Health Department to incorporate behavioral health questions into their community health needs assessment also illustrated a very positive shift in the representation of behavioral health, equally representing physical health and behavioral health as important health concerns both the assessment and community plan document. This shared perspective shift occurred in the Tusc. County CHNA as well.

While these have been more active participants in stigma reduction efforts, those that are more passive in their support are perhaps more significant. For example, each time this ADAMHS Director has been asked to speak to a group of educators or students that is viewed as a passive effort at stigma reduction. Presentations on local resources and ACES have been provided the entire staff at two local school districts at the schools request; ADAMHS was asked to participate in the strategic planning at one district to ensure BH was included; ADAMHS presented to high school juniors and seniors involved in a Leaders of Tomorrow

program to discuss anxiety and its impact on well-being; this presentation lead to the ADAMHS director being invited by one of the school staff to present the training to her high school classes; ADAMHS was invited into a local school district to debrief with staff following the death of a student and prepare the school system for the return of the students; ADAMHS in collaboration with the school counselors association hosted author Kate Fagan at the Kent State Performing Arts Center and spoke about local resources and behavioral health to an auditorium full of attendees; ADAMHS was asked to participate in the rollout of the HOPE Squad, a peer based suicide prevention program, at one local school district; and ADAMHS staff has presented to various civic groups. These invitations to discuss and de-stigmatize behavioral health are seen as opportunities not only to impact the attendees but also each child he or she is in contact with as well as his or her community connections.

ADAMHS continues to work year-round on stigma reduction and awareness efforts and intends to do this under a specific stigma-reduction framework over the course of the next biennium.

5. Workforce shortage

The impact of workforce shortage has been well-documented. In rural communities, licensed staff often leave the county for higher paying jobs in larger cities. Not only does this leave a gap in the existing system of care and a delay in access to services, this prevents the development of the continuum of care as staff isn't available to fill the vacancies that exist in the current structure. In FY 20, ADAMHS began meeting with the local dean and assistant dean at the regional campus of Kent State University (KSU). Discussions centered around the development of an LSW program locally. Through the process, Ohio Means Jobs became engaged in the collaborative to discuss tuition reimbursement opportunities available in their system. Through much work and planning, the regional campuses of KSU intended to initiate an LSW program in the fall of 2021. Additional work was to be done to partner with school systems to education students about the new track to ensure sustainability of the program and engage interested individuals. Unfortunately, COVID has halted this plan at the current time as the university adjusts to their new learning structure but the plan will be revisited this year.

6. Building resilient children and families

Much collaboration occurs with the Family and Children First Councils (FCFC) of both Tuscarawas and Carroll Counties. The ADAMHS Director is the current chair of the Carroll County FCFC and the ADAMHS Board serves as the Administrative Agent for Tusc. FCFC. The ADAMHS Manager of Community Services provides both management and supervision duties to TCFCFC staff. As building strong and resilience children and families is also a mission of FCFCS, this partnership and the cross-system attendees at both Council meetings creates a network that blankets both counties child and family serving systems.

Tusc. FCFC went through a significant change in the second half of FY 20. The Council manager, who had been trained in TIC and PAX, resigned his position leaving a gap in the knowledge and expertise of Council staff. Much work had been done to integrate the individual into both the Tuscarawas and Carroll County the school systems and ensure school staff had an understanding of ACEs, their impact on brain development, and how PAX could address concerns collaboratively in school, community and home environments. ADAMHS staff will determine how to address this initiative as the biennium continues.

Despite the loss of the Council manager, the ADAMHS Director has worked diligently to build collaborative partnerships with school superintendents across Tuscarawas and Carroll Counties. Each month the director attends superintendent meetings hosted by the Educational Services Center (ESC). The ESC

Superintendent offered ADAMHS a spot on the monthly agenda to discuss any topic related to BH and it's impact on youth. This relationship between ADAMHS and school superintendents has strengthened over the past three years, allowing for productive discussions related to the use of student wellness dollars; K-12 prevention dollars; crisis text line information; Project Dawn kits; FCFCs, etc. This partnership between BH/ADAMHS and the school system will continue to strengthen and the fruits of the collaborative efforts are already being seen in the districts programming.

Inpatient Hospital Management and Transition Planning

7. Describe what partnerships <u>will be needed</u> between the Board and the State Hospital(s), Private Hospital(s) and/or outpatient providers for the identification of needed services and supports.
    a. How will the Board coordinate the transition from the hospital to the community? (i.e.; discharge planning)
    b. Who will be responsible for this?

    Discuss any planned changes in current utilization that is expected or foreseen.

    Partnerships between the Board, the local prescreening agency, the local emergency room staff including the ED social workers, and local law enforcement continue to be the necessary coordinating bodies for the ongoing identification of needed services and supports from an individual perspective and also from a more global view. Individuals are first seen at a local ED for medical clearance. Once an individual is medically cleared, he or she is then evaluated by an assessor from the designated prescreening agency. Client preference as well as benefits are considered when hospitalization is warranted.

    Heartland Behavioral Healthcare (HBH), the regional state psychiatric hospital, has a social work department that maintains ongoing and open communication between an ADAMHS Board staff member, Community Navigator at the local prescreening agency and the individual's case manager as appropriate. The communication begins at admission and occurs regularly throughout an individual's hospitalization to ensure that a thorough discharge plan is created, treatment is available upon discharge, basic needs are met and the individual returns to the local community if at all possible. Monthly calls occur between HBH staff, the local navigator, and the ADAMHS staff to review individuals from Tuscarawas and Carroll Counties, and the ADAMHS Board directors in the HBH region meet quarterly to discuss any trends, strengths, or challenges to ensure we are working collaboratively and for the benefit of our shared client. Peer supporters are an additional partnership that continue to provide a needed connection of hope and support and to discuss local support options upon discharge including the local consumer operated organization.

    The ADAMHS Board Manager of Community Services tracks the psychiatric hospital usage for Tuscarawas and Carroll County residents assessed through our prescreening agency. Tracking elements include: reason for admission, ambulance/sedan usage, linkage to community services, discharge dates, etc. The database also tracks repeat hospitalizations to ensure we are supporting these consumers in the community with high intensity through supportive options such as the Community Treatment Team. The Manager of Community Services and the Community Navigator are responsible for the twice a month collaborative team meetings to support these repeat individuals.

The database is also used to track detox admissions and discharges of those that are hospitalized through the local system.

As a summary of some of the data elements, 25 hospitals (including the Crisis Unit) were used in FY20. Twenty-four hospitals were used in FY19 and twenty-six hospitals were used in FY18. The local crisis unit is often used as a step down from the hospital when appropriate and has also been used as a diversion from hospitalization allowing individuals to remain in the local community, engage in treatment, and see a physician if warranted.

The ADAMHS Board offers the same type of support, collaboration, and planning with private hospitals from intake to discharge; however, this is utilized less than for those in state psychiatric hospital. Regardless, the local prescreening agency typically uses the Community Navigator, crisis services staff, or the individual's case manager to ensure a thorough history and presenting symptoms are available to hospital staff and support the hospital with the development of a successful discharge plan that includes engagement in local services.

There have not been significant changes or new trends in hospital usage over the past biennium. It is possible as the COVID-19 Pandemic continues that the usage will increase due to the increased anxiety and depression that individuals are experiencing due to social isolation and the changes to service delivery.

Continuum of Care Service Inventory

8. Complete the attached spreadsheet: Inventory of Facilities, Services and Supports Currently Available to Residents of the Board Area. Instructions are found on Page 10 of the Guidelines.

   Continuum of Care definitions found in the Ohio Revised Code [ORC 340.03(A)(1)].

Alignment with Federal and State Priorities

9. The following pages of this template contains a table that provides the specific federal and state priorities for: Mental Health Block Grant (MH-BG), Substance Abuse Prevention and Treatment Block Grant (SAPT-BG), SAMHSA and OhioMHAS treatment and prevention priorities. Please complete the requested information only for those federal and state priorities that are the same as the Board's priorities. 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.

Identify at least one measurement indicator, and subsequent baseline data, that will be used to track progress towards meeting the identified priority(ies).

Priorities for ADAMHS Board of Tuscarawas and Carroll Counties				
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)	Ensure persons with an IDU disorder have access to resources that impact addiction and support recovery. Ensure agencies have a policy to provide interim services to those with an IDU disorder if timely access to services is not available.	1. Ensure the continuation of the continuum of care including MAT programs; jail-based navigators; Quick Response Team; detox, withdrawal management and residential treatment services; and recovery residences. 2. Ensure contract agencies submit to the Board the most updated policy regarding interim services if an opening is not immediately available for persons who are IDU.	Measurement indicator: agency policies Baseline data: current policies Target: Board will receive current or updated policies from all contract agencies related to timely access to services	__ 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)	Engage and prioritize pregnant women with a substance use disorder in treatment services.	1. Providers will treat the population as a priority, without regard to wait lists. 2. Agencies will screen all female clients upon initial request for services. 3. Agency staff will provide or refer to another community service agency that specializes in this population for additional support and follow-up to pregnant women in SUD treatment.	Measurement indicator: agency policies Baseline data: current agency policies Target: Board will receive current or updated policies from all contract agencies related to engagement and prioritization of treatment services to women with a SUD	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory for boards: Parents with SUDs who have dependent children	Ensure an ongoing partnership through local Family and Children First Councils	1. Maintain current Ohio START programs in Tuscarawas and	Measurement indicator: OhioSTART program	__ No assessed local need __ Lack of funds

(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)	and Job and Family Services agencies to sustain current programming for parents with and SUD. Support the ongoing development of data-driven and evidence-based prevention services.	Carroll Counties which partners a parent with a SUD and children's services involvement with a certified peer. 2. Maintain and support the universal and targeted prevention efforts of the local prevention services program. 3. Explore the option of a MOMS program locally	Baseline data: 2 programs in the catchment area Target: Maintain both programs Measurement indicator: k-12 Prevention programming Baseline data: one school has completed their action plan in the portal Target: 50% of schools will participate in the k-12 prevention funding opportunity	__ Workforce shortage __ Other (describe):
SAPT-BG: Mandatory (for OhioMHAS): Individuals with tuberculosis and other communicable diseases (e.g., AIDS.HIV, Hepatitis C, etc.)	Identify potential cases or at-risk cases of TB or other communicable diseases and ensure referral for counseling, testing and treatment	1. Agencies will obtain TB histories and TB risk assessments during initial intake. 2. Agencies will partner with local health departments or contract physicians and refer individuals for evaluation, management, education, and follow-up services.	Measurement indicator: agency policies Baseline data: current policies Target: Board will receive current or updated policies related to TB and other communicable diseases	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-BG: Mandatory (for OhioMHAS): Children with Serious Emotional Disturbances (SED)	Ensure spectrum of services that both maintains current successful programming and develops new programming and services in response to children and family need, specifically targeting early intervention and TIC	1. Maintain active engagement in FCFCs in both counties and plan a primary role in the development of services that will impact children with an SED including PAX/TIC initiatives and connection building efforts between parents and children. 2. Ensure schools in both Tuscarawas and Carroll Counties have access to TIC information and initiatives. 3. Maintain and expand partnerships with schools and ESC to support the development and	Measurement indicator: school collaborative and BH/TIC presentations by ADAMHS and the BH provider network Baseline data: 2 school year presentations regarding resources and TIC/ACEs Target: six presentations to schools regarding resources, TIC, and ACEs	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

		implementation of social emotional learning standards.		
MH-BG: Mandatory (for OhioMHAS): Adults with Serious Mental Illness (SMI)	Develop a proactive system decompensation response when possible and a high quality crisis response when necessary.	1. Support the ongoing implementation and usage of the Care Plan at the provider agencies, EMS and LE. 2. Identify options both within the current structure of the providers and through new staff or peers to provide more targeted outreach to adults with SMI. 3. Implement mobile crisis response	Measurement indicator: mobile response incidents Baseline data: -0- Target: 20 youth and adult mobile crisis intervention responses	__ 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 supportive housing	The current housing continuum will maintain and the Board and partners will explore additional options to increase supportive housing.	1. The Board will continue to fund transitional housing programs in Tuscarawas and Carroll Counties. 2. The Board will maintain an active role in the local housing continuum (HomeNET) and Region 6 of the Ohio Balance of State Continuum of Care. 3. The Board will partner with the Homeless Shelter and encourage participation in the consumer-focused Community Team Meetings 4. The Board will maintain the HUD housing programs currently operating and explore opportunities for expansion.	Measurement indicator: available housing resources Baseline data: 62 housing vouchers Target: maintain the number of vouchers and explore additional supportive housing options	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
MH-Treatment: Older Adults	Increase suicide prevention programming and education with messaging relevant to the older adult population.	1. Collaborate to resurge the Suicide Prevention Coalition who will:	Measurement indicator: suicide prevention coalition Baseline data: new coalition is in initial stages of development	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe)

		-Explore universal suicide-prevention messaging. -Identify target areas for the prevention campaign that would ensure visability by the older adult population. - Implement campaign.	Target: Coalition will be formed with a wide representation of community sectors	

Additional Priorities Consistent with SAMHSA Strategic Plan and Reported in Block Grant				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
MH/SUD Treatment in Criminal Justice system –in jails, prisons, courts, assisted outpatient treatment	Ensure both in-person and telehealth options remain available for those involved in the criminal justice system, especially those that are incarcerated	1. Continue to develop telehealth at the Carroll County jail 2. Maintain court-based services and navigation at drug courts across both counties	Measurement indicator: telehealth programs Baseline data: telehealth is functional in one county jail Target: telehealth will be functional in both county jails	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Integration of behavioral health and primary care services	Continue to support the presence of an FQHC in Tuscarawas County and support the development of the FQHC in Carroll County	1. Collaborate with FQHC, Carrollton schools and Carroll Co Health Department to support the development of the FQHC	Measurement indicator: FQHC Baseline data: -0- FQHC in Carroll County Target: and FQHC will be developed in collaboration with the CCHD, Carrollton Schools, and Community Mental Healthcare who manages the FQHC	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Recovery support services for individuals with mental illness or substance use disorders; (e.g. housing, employment, peer support, transportation)	Develop the local certified peer support system.	1. Ensure opportunities for certified peer support is explored both within and without the behavioral health system to allow for maximum opportunity for clients to get connected	Measurement indicator: utilization of peer support outside of BH system Baseline data: currently referrals for peer support are made by treatment providers Target: Referrals to the program will come from partners that are connected to BH but this isn't necessarily their primary line of duty	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Promote health equity and reduce disparities across populations (e.g. racial, ethnic & linguistic minorities, LGBT)			Measurement indicator: Baseline data: Target: *Copy and paste above for multiple indicators.*	__ No assessed local need _X_ Lack of funds _X_ Workforce shortage __ Other (describe):
Prevention and/or decrease of opiate overdoses and/or deaths	Decrease opiate overdoses and deaths which have risen to epidemic levels of 2016/2017	1. Maintain the QRT 2. Increase awareness of SUD, resources and treatment options 3. Explore SOR 2.0 opportunities	Measurement indicator: awareness efforts Baseline data: there had been less PR related to opiate specific needs prior to the pandemic Target: Increase activities related to prevention and intervention and explore SOR 2.0 opportunities to develop the system of care	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe
Promote Trauma Informed Care approach	Increase TIC focus and develop a plan to introduce PAX to schools	1. In collaboration with FCFCs, develop a plan to increase ACEs, TIC, and PAX Tools sharing with school and community	Measurement indicator: collaborations with schools Baseline data: currently 2 schools have participated in PAX Target: PAX and trainings connected with TIC and ACEs will be offered to all districts	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe

OhioMHAS Prevention Priorities				
Priorities	Goals	Strategies	Measurement	Reason for not selecting
Prevention: Ensure prevention services are available across the lifespan	Maintain a strong prevention network that is known at the state level.	1. Support and engage in activities with the Anti-Drug Coalition and other prevention initiatives	Measurement indicator: prevention activities Baseline data: there is currently a robust prevention system that ADAMHS supports Target: Maintain involvement and support with prevention activities	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):

Prevention: Increase access to evidence-based prevention	Ensure those that engage in prevention activities have access to EBP	1. Provide those engaged in prevention services access to EBPs 2. Ensure those that utilize prevention services, e.g. school systems, are aware these options exist and are best-practice	Measurement indicator: EBP prevention Baseline data: Prevention programs connected to ADAMHS are required to be evidence based Target: Maintain these services and ensure those that are developed meet this same standard	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Recovery Ohio and Prevention: Suicide prevention	Increase suicide prevention programming and education	2. Collaborate to resurge the Suicide Prevention Coalition who will: -Explore universal suicide-prevention messaging. -Identify target areas for the prevention campaign - Implement campaign.	Measurement indicator: suicide prevention coalition Baseline data: new coalition is in initial stages of development Target: Coalition will be formed with a wide representation of community sectors	__ No assessed local need __ Lack of funds __ Workforce shortage __ Other (describe):
Prevention: Integrate Problem Gambling Prevention & Screening Strategies in Community and Healthcare Organizations	Problem Gambling is currently assessed at provider agencies during the diagnostic assessment. At this time, expanding to other systems is not something the BH system is able to engage in.		Measurement indicator: Baseline data: Target:	__ No assessed local need __ Lack of funds __ Workforce shortage __X Other (describe): With competing priorities and low local numbers of gambling addiction, the Board will support current activities.

Community Plan Appendix 1: Alcohol & Other Drugs Waivers

A. Waiver Request for Ambulatory Detoxification or Medication-Assisted Treatment

ORC 340.033 allows for a process to request a time-limited waiver under section 5119.221 for the Revised Code for ambulatory detoxification and medication-assisted treatment. As stated in ORC 5119.221, the director may provide a time-limited waiver if both of the following apply:

> The board seeking the waiver has made reasonable efforts to make ambulatory detoxification and medication-assisted treatment available within the borders of the board's service district;
>
> Ambulatory detoxification and medication-assisted treatment can be made available through a contract with one or more providers located not more than thirty (30) miles from your board's service area.

To complete your waiver request for review, please include below, a brief overview of your board's "reasonable efforts" to provide ambulatory detoxification or medication-assisted treatment and attach a copy of the contract(s) with the identified provider(s) that has agreed to provide this service to your area. This information will be forwarded to the director as part of the waiver review and approval process.

B. 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

C. 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

SIGNATURE PAGE

Community Plan for the Provision of Mental Health and Addiction Services SFY 2021-2022

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

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

ADAMHS Board of Tuscarawas and Carroll Counties

_____

ADAMHS Board Name (Please print or type)

_____ _____

ADAMHS Board Executive Director Date

_____ _____

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.)].

Attached is the SFY 2021-2022 Community Plan Essential Services Inventory**. Each Board's completed SFY 2019-2020 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. **SAMHSA Treatment Locator https://www.findtreatment.gov/**